

# **ASPECTS OF DELICTUAL LIABILITY IN PHARMACY PRACTICE**

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## ABSTRACT

The thesis explores the various instances in which pharmacists may incur delictual liability for harm suffered by their patients or third parties. As such, it is primarily concerned with the field of professional negligence. The work focuses specifically on the wrongfulness, fault and causation enquiries in pharmacy malpractice cases. The discussion is set against the backdrop of the pharmacy profession's shift towards patient-orientated service in recent years and explores whether this change in the profession's social role has had any effect on the legal duties and standard of care to which pharmacists are currently bound. It is argued that, in light of the dangers posed by modern medicines and the extent to which pharmacists are professionally expected to involve themselves in patient care, pharmacists can no longer escape liability simply by accurately dispensing pharmaceutical products. Rather, they are expected to participate actively in avoiding drug-related injury by, for example, providing patient counselling, detecting invalid or erroneous prescriptions and monitoring prescription refills. Although the thesis places particular emphasis on the role of pharmacists in achieving risk management, it also argues that pharmacists are, in very limited circumstances, required to participate in the risk assessment process traditionally thought to fall exclusively into the realm of physicians. It is furthermore demonstrated that pharmacists can incur liability regardless of whether a patient's harm can also be partially attributed to the blameworthy conduct of another healthcare professional. Although the thesis concludes that pharmacists are currently exposed to greater risks of liability than they were in the past, it also shows that plaintiffs who seek damages from pharmacists will usually experience a number of difficulties in establishing liability. In particular, problems are likely to be encountered in satisfying a court as to the presence of factual causation, which is notoriously difficult to establish in drug-related cases.

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# CHAPTER 1

## INTRODUCTION

### 1.1 Purpose of the Thesis

The primary purpose of this thesis is to explore the various situations in which pharmacists may be held delictually liable for harm that is suffered by their patients and third parties. The study is thus, to a large extent, rooted in the field of professional negligence.

The role played by pharmacists in the provision of healthcare has changed dramatically over the past century. Pharmacists have assumed a far more patient-orientated position than they held in the past, and are currently able to play a fundamental part in ensuring that drug therapy is as safe and effective as possible. This increased exposure to patients is bound to be accompanied by an increase in instances in which a patient's harm can be causally linked to the acts or omissions of a pharmacist. As such, it must be asked whether pharmacists are currently exposed to greater risks of liability than they were when the profession's focus was strictly product-orientated.

At present, South African plaintiffs still tend to adopt a fairly conservative approach when it comes to seeking damages for healthcare mishaps. In spite of the recent expansion in pharmacists' professional responsibilities, the blame for drug-related harm still tends to be focused on other healthcare professionals, such as the prescribing physician. Any misconduct on the part of a pharmacist is thus usually dealt with via disciplinary proceedings by the South African Pharmacy Council rather than by the courts. The result is that, as of yet, South African courts have not had the opportunity to examine either the nature of the pharmacist-patient relationship, or the nature of the liability that may arise from this relationship.

This work aims to explore the current role of pharmacists in society and the effect that this is likely to have on the imposition of liability in pharmacy malpractice cases. It will also consider the various problems that plaintiffs may encounter in establishing delictual liability on the part of a pharmacist, as well as the defences that pharmacists can raise, and the precautionary measures that they can take, so as to avoid being held liable.

In order to provide a comprehensive examination of the above issues, it will, of course, be necessary to include a discussion of the common law principles that will underlie liability in cases of pharmacy malpractice. That said, it must be stressed from the outset that an exploration of the general principles of the law of delict is by no means the central purpose of this work. General principles are discussed for contextual purposes only and the focus is on specific issues that pharmacists face in practice. In addition, the work aims to examine only *some* of the aspects of delictual liability in pharmacy malpractice cases. Specifically, the elements of wrongfulness, fault and causation. The delictual elements of conduct and harm are unlikely to pose problems and discussion of these topics is thus restricted to their impact on the wrongfulness element. Although there may be instances in which pharmacists incur contractual liability, the question of concurrence of actions is not explored in this thesis.

With regard to the specific situations with which pharmacists may be confronted, the thesis will consider a wide spectrum of factual scenarios, ranging from those in which it is traditionally accepted that pharmacists can be held liable (such as when they dispense an incorrect drug) to those in which the liability of pharmacists has been the subject of heated debate (such as when they fail to provide patient-counselling). Although the majority of the discussion focuses on cases of professional *negligence*, a number of examples of intentional misconduct are also touched upon.<sup>1</sup>

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<sup>1</sup> It is also appropriate to highlight at this stage that, although the furore that has been recently sparked by the introduction of a new dispensing fee structure for pharmacists will be touched upon, it is by no means the focal point of this work and is only of relevance insofar as the fact that pharmacists are remunerated for their services, and the extent of such remuneration, may constitute policy considerations which impact upon the legal duties to which pharmacists are bound.

In addition to examining the effect that the evolution of the role of pharmacists has had on their exposure to liability, the thesis will investigate the legal implications that are likely to accompany the increased use of the Internet within pharmacy practice. The provision of pharmaceutical services over the Internet forms part of the phenomenon of 'telepharmacy'; which has been defined as '[t]he provision of pharmaceutical care through the use of telecommunications and information technologies to patients at a distance.'<sup>2</sup> The term encompasses the use of various technologies including telephone, fax, videoconferencing and computers.<sup>3</sup> As such, the concept of telepharmacy is by no means a new one. When it comes to the sale of pharmaceutical products over the Internet, however, more problems arise than when other kinds of technology are utilised. The nature of the Internet is such that pharmacists who sell medicines on-line will often find it particularly difficult to fulfil their ethical and legal duties. In light of this, it is necessary to consider whether pharmacists who provide services over the Internet are opening themselves to an increased risk of delictual liability.

## 1.2 Scope of the Work

Although, for the most part, the rules and regulations governing pharmacy practice in South Africa refer to pharmacists in general, it is important to be aware that South African pharmacies are divided into different categories and that a pharmacist's scope of practice differs depending on the kind of pharmacy for which he or she works. The Regulations Relating to the Practice of Pharmacy<sup>4</sup> identify the following five types of pharmacies: manufacturing pharmacies, wholesale pharmacies, consultant pharmacies, community pharmacies, and institutional pharmacies. Whilst manufacturing pharmacies, as their name suggests, concern themselves primarily with the manufacturing of

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<sup>2</sup> This definition was formulated in 1997 by America's National Association of Boards of Pharmacy (Anagaran 1407). Telepharmacy forms part of the general practice of telemedicine which has been defined by the National Health Information System of South Africa as '[t]he practice of medical care using interactive audio, visual and data communications' (Department of Health 'National Telemedicine Programme and Priorities In SA'; see also Anagaran 1406; Wiesemann 1122).

<sup>3</sup> Anagaran 1406.

<sup>4</sup> GNR 1158 of 20 November 2000.

medicines,<sup>5</sup> wholesale pharmacies are involved specifically in the wholesale distribution of pharmaceutical products.<sup>6</sup> Neither of these two categories of pharmacy are involved in dispensing medicines directly to the public,<sup>7</sup> and the only real interaction that they experience with individual patients occurs whilst they are conducting pharmaceutical research. Consultant pharmacies, although sometimes assisting to ensure compliance with drug therapy,<sup>8</sup> similarly play no role in the dispensing process and are primarily involved with consulting to corporate bodies. In contrast to manufacturing, wholesale and consultant pharmacies, community and institutional pharmacies provide a wide range of services for individual patients. Both kinds of pharmacy are expected to take responsibility for a patient's medicine-related needs by, for example, determining the safety and efficacy of drug therapy, dispensing prescription drugs, furnishing information and advice with regard to medicine, determining patient compliance with drug therapy, and providing pharmacist-initiated therapy.<sup>9</sup> The distinguishing factor between community pharmacies and institutional pharmacies is that institutional pharmacies are situated in either a public health facility (such as a public hospital<sup>10</sup>) or a private health facility (such as a private hospital<sup>11</sup>).<sup>12</sup>

As explained in 1.1 above, the purpose of this thesis is essentially to explore whether the pharmacy profession's shift towards patient-orientation has exposed pharmacists to an increased risk of delictual liability. It follows that the scope of the research is limited with regard to both the *kinds of pharmacies*, and the *kinds of activities* that are examined. The emphasis of the work is on those kinds of pharmacies which frequently interact with

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<sup>5</sup> Regulation 16.

<sup>6</sup> Regulation 17.

<sup>7</sup> Both manufacturing and wholesale pharmacies are only permitted to sell medicine to a wholesale pharmacy, community pharmacy or institutional pharmacy, or to persons who are authorised to purchase medicines in terms of the Medicines and Related Substances Act 101 of 1965, or to an organ of state (regulation 1).

<sup>8</sup> Regulation 19.

<sup>9</sup> Regulation 18.

<sup>10</sup> A 'public health facility' is defined as:

'[A]ny hospital, institution or facility at which provision is made for diagnostic interventions, medical or surgical treatment, and nursing or other health care, which is owned or controlled by an organ of State' (regulation 1).

<sup>11</sup> The definition of a 'private health facility' is similar to that of a public health facility, with the major distinction between the two being that private health facilities are *not* owned or controlled by organs of State (regulation 1).

<sup>12</sup> Regulation 1.

patients, and play a role in the promotion of safe and rational drug use. The thesis, in other words, focuses on the liability of pharmacists who work for community and institutional pharmacies. Although other kinds of pharmacies do interact with patients for research purposes, the liability that may arise within the research context falls outside the scope of the thesis. Rather, the discussion focuses on the dispensing process and the various activities incidental thereto.

### **1.3 Sources and Approach**

Because the vast majority of factual situations examined in this research have yet to be considered by South African courts, it has been necessary to make fairly extensive use of comparative law. The liability of pharmacists has been considered in many jurisdictions in the United States. Whilst the discussion in this thesis remains grounded in South African common law principles, frequent reference will thus be made to American cases. Not only do these decisions provide examples of the kind of situations in which a pharmacist's conduct may result in harm, they also give an indication of the arguments that can be raised for and against liability in these situations, as well as the difficulties that a plaintiff may face in establishing liability on the part of a pharmacist. Although litigation against pharmacists is nowhere near as prevalent in other countries as it is in the United States, this work will also draw upon decisions from the United Kingdom, Canada and Australia.

### **1.4 Structure of the Thesis**

The body of the thesis is structured as follows: Chapter 2 sets the contextual basis for the research by exploring the evolution of the role of pharmacists from the birth of the profession to present-day South Africa. It is against this backdrop that the common law duties to which pharmacists are currently bound must be considered. The chapter additionally provides an outline of both the statutory and ethical mechanisms presently used in the regulation of the South African pharmacy profession. Chapter 3 examines the delictual element of wrongfulness within the context of pharmacy malpractice cases. It

does this by exploring the legal duties to which pharmacists are potentially bound, as well as the patient rights which courts are likely to require pharmacists to respect. In Chapter 4, the focus shifts to the element of fault. The bulk of the chapter is spent examining the standard of care to which pharmacists should be expected to adhere when dispensing both prescription and non-prescription medicines. Finally, Chapter 5 deals with the major stumbling block that plaintiffs are likely to encounter in successfully claiming damages from pharmacists—namely, the proof of causation.

## CHAPTER 2

# THE ROLE AND REGULATION OF PHARMACISTS

### 2.1 Introduction

Before examining the specific grounds upon which a pharmacist may incur delictual liability, one must consider the role and regulation of pharmacists within South African society. The pharmacy profession has undergone profound change over the past century with the result that the pharmacist of today has very little in common with the pharmacist of years gone by.<sup>1</sup> Many<sup>2</sup> have argued that this expansion of responsibility has led to a concomitant growth of pharmacists' liability.

The actions of South African pharmacists are regulated by both legislation and the dictates of pharmacy ethics. These forms of regulation are important insofar as courts regard both statutory and ethical duties as factors which may be taken into account in determining whether a legal duty exists at common law,<sup>3</sup> the breach of which may establish wrongfulness.<sup>4</sup> Statutory and ethical duties may similarly have an impact on the conduct of the reasonable pharmacist and are consequently relevant to the negligence enquiry.<sup>5</sup>

### 2.2 The Pharmacist's Role within Society

#### 2.2.1 The Historical Evolution of the Pharmacist's Role

The history of the pharmacy profession is considerable and can be dated as far back as Assyrio-Babylonian and Egyptian times<sup>6</sup> in which medicine and the healing of illness

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<sup>1</sup> Canavan 19.

<sup>2</sup> Including Asbury, Dwyer and Green.

<sup>3</sup> *Minister van Polisie v Ewels* 1975 (3) SA (A) 596C-E; *Nkumbi v Minister of Law and Order* 1991 (3) SA 29 (E) 34J-35B (statutory duties); *Kern-Hill Co-op Furniture Ltd v Shukett* (1975) 58 DLR 3d 157 (Man CA) (ethical duties).

<sup>4</sup> See Chapter 3.

<sup>5</sup> See Chapter 4.

<sup>6</sup> Dwyer 725-726; *Brushwood Drake LR* fn 16; *Brushwood Medical Malpractice* 3.

held a place in religious ideology.<sup>7</sup> The first apothecary to establish himself in South Africa was Joachim Blanck in 1653.<sup>8</sup> It was only in the nineteenth century, however, that natural products commonly used for the treatment of ailments started being analysed for their chemical make-up and that pharmacy thus began its evolution from an art into a science.<sup>9</sup> It was also in the nineteenth century that organised pharmacy evolved as a distinct profession.<sup>10</sup> At first, apothecaries tended to play the role of both pharmacist and physician. Pharmacists not only prepared and sold drugs, but also prescribed medications and provided patients with medical advice. As medications became more complex and difficult to prepare, however, the expertise of pharmacists became increasingly concentrated on pharmaceutical products and their formulation, whilst physicians concerned themselves with the needs of the patient and the effect of medications.<sup>11</sup>

In South Africa between 1910 and 1934, large wholesale houses began to adopt mass-production methods for the manufacture of pharmaceutical products.<sup>12</sup> The advantages offered by factory production were twofold: a) it was cost-effective; and b) it guaranteed consistency in the efficacy, safety and quality of drugs.<sup>13</sup> On an international level, World War II stimulated the mass-production of pharmaceutical products and the manufacturing process thus increasingly became the responsibility of pharmaceutical corporations.<sup>14</sup> As a result, the demand for the compounding of medicines by pharmacists began to wane and the role of retail pharmacists became one of dispensing already compounded products.<sup>15</sup> Thus began what is sometimes referred to as the 'count and pour'<sup>16</sup> period of pharmacy practice.

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<sup>7</sup> Sonnedecker 4-6; Miller 93.

<sup>8</sup> Pharmaceutical Society of South Africa.

<sup>9</sup> Miller 99.

<sup>10</sup> Ryan xiii.

<sup>11</sup> Dwyer 726; Brushwood *Drake LR* fn 70; Helper and Strand 533-534.

<sup>12</sup> Ryan 95.

<sup>13</sup> Sarmiento 241; Whitney and Archambault 80.

<sup>14</sup> Dwyer 724 and 726; Brushwood *Medical Malpractice* 3; Ryan 95; Whitney and Archambault 90.

<sup>15</sup> Brushwood *Drake LR* fn 71; Brushwood *Medical Malpractice* 4; Canavan 19 and 23; Helper and Strand 534. See also Kessler 167:

'The *officina*, or apothecary's workshop, has been transformed from a production site to a service-provider and thus taken on quite a different function in the healthcare system.'

<sup>16</sup> Whitney and Archambault 79.

A significant proportion of the profits which pharmaceutical manufacturers reaped from mass-production was invested into drug research.<sup>17</sup> This led to the production of increasingly effective medications<sup>18</sup> with the result that an abundance of pharmaceutical products are currently available to healthcare professionals.<sup>19</sup> Whilst modern drugs may offer remarkable results in combating a variety of illnesses, they also tend to be more potent than the drugs of the past, thus posing greater risks of adverse reactions.<sup>20</sup> In recent decades, a strong need has consequently arisen for drug therapy to be monitored and for patients to be counselled on drug use.<sup>21</sup>

The two phenomena discussed above (namely, the usurping of pharmacists' traditional role by pharmaceutical corporations and the increased risks posed by pharmaceutical products) have, in combination, had the effect of shifting the focus of pharmacy practice from product to patient. In the first instance, it was not long before pharmacists became dissatisfied with their new role as the mechanical dispensers of drugs. Pharmacy graduates began to rebel against their profession's new role, wanting to be closer to patient care in drug therapy.<sup>22</sup> In 1979, after conducting a study into the role of pharmacists, Robbins concluded that pharmacists, particularly the younger members of the profession, had begun to recognise that the mechanical filling of prescriptions 'no longer [symbolised] the professional aspect of pharmacy'<sup>23</sup> and that their truly professional role (which required them to demonstrate their training and knowledge) was the provision of advice to patients.<sup>24</sup>

Not only have pharmacists begun to *search* for a new role within society, the increased dangers posed by today's medicines have additionally created a *need* for pharmacists to play a part in curtailing the risks inherent in contemporary drug

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<sup>17</sup> Sarmiento 241.

<sup>18</sup> Dwyer 724 and 726.

<sup>19</sup> Pötzsch 9.

<sup>20</sup> Furrow 378. Friend (quoted in Smith 'Prescription Errors' 973 fn 120), for example, has noted the following with regard to prescription errors:

'In the past, prescription errors were not likely to be so dangerous, since oftentimes the agents had very little or no pharmacologic effect. Unfortunately, this is not the case at present; an error in prescription writing can quickly lead to death.'

See also McLean 5.

<sup>21</sup> Brushwood *Drake LR* fn 72; Miller 99.

<sup>22</sup> Whitney and Archambault 80-81; Robbins 135.

<sup>23</sup> Robbins 116.

<sup>24</sup> Robbins 122. See also Knapp *et al* 165:

therapy. Thus, in *Pittman v Upjohn Co*,<sup>25</sup> the Supreme Court of Tennessee noted that '[t]he increased complexity of pharmacotherapeutics and the accompanying adverse reactions to drugs and interactions between drugs have resulted in an expanded role for pharmacists as drug therapy counsellors.'<sup>26</sup> A further metamorphosis in the function of pharmacists has, in other words, become necessary so as to make the profession more relevant to the needs of society.<sup>27</sup> The *ability* of pharmacists to take on this new role has also been greatly facilitated by the profession's move away from compounding. This is because, as dispensers rather than compounders, pharmacists currently experience greater contact with patients than they did in the past. This in turn means that pharmacists are able to detect problems and risks arising from a course of drug therapy and to intervene so as to prevent harm from eventuating.<sup>28</sup> In recent years this ability has been increased by advances in technology (eg computer systems are now available that store patient profiles and automatically warn of potential drug interactions).<sup>29</sup> Dwyer notes: 'Pharmacists are uniquely placed as readily accessible experts to supplement patients' drug therapy, to ensure optimal safety and efficacy.'<sup>30</sup> As such, pharmacists have been described as the 'gatekeepers' of the drug therapy process.<sup>31</sup>

From the above, it is evident that the pharmacy profession is becoming increasingly patient-oriented.<sup>32</sup> This, it will be seen in the course of the current chapter, has had an effect on the legal and professional rules to which pharmacists are currently bound.<sup>33</sup> Pharmacists are now using their traditional knowledge to assist in ensuring that a particular course of drug therapy is as safe and effective as possible.<sup>34</sup> Both Vivian<sup>35</sup>

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'It is patient orientation that differentiates a truly *professional* health practitioner from his product oriented colleague' (emphasis added).

<sup>25</sup> 890 SW 2d 425 (Tenn 1994).

<sup>26</sup> *Pittman v Upjohn Co* 434. See also Helper and Strand 535.

<sup>27</sup> Robbins 131.

<sup>28</sup> Dwyer 725; Furrow 434.

<sup>29</sup> Asbury 928; Furrow 434; Termini 565.

<sup>30</sup> Dwyer 727. See also West 122; Litman 135.

<sup>31</sup> Asbury 919.

<sup>32</sup> The patient-orientated practise of pharmacy that promotes safe and rational drug use is known as 'clinical pharmacy' (McLeod and Miller 1 and 8; see also rule 2.11.1 of the Rules Relating to Good Pharmacy Practice in South Africa GNR 27112 of 17 December 2004).

<sup>33</sup> In particular, it is significant that the South African Pharmacy Council's Rules Relating to Good Pharmacy Practice, in describing the philosophy underlying the concept of good pharmacy practice in South Africa, state that pharmacy is a 'dynamic, information-driven, *patient-orientated* profession' (emphasis added).

<sup>34</sup> Dwyer 724 and 726.

<sup>35</sup> Quoted in Karns 15.

and Hooper<sup>36</sup> predict that this role will continue to evolve and that pharmacists will become 'information managers', with technicians assuming pharmacist's current prescription-filling function.<sup>37</sup>

### 2.2.2 The Concept of Pharmaceutical Care

An important consideration when exploring the change of pharmacists' role within society is the emerging concept of 'pharmaceutical care' which has been advanced as a new philosophy for pharmacy practice. In 1989<sup>38</sup> Hepler and Strand defined this concept as 'the responsible provision of drug therapy for the purposes of achieving definite outcomes<sup>39</sup> that improve a patient's quality of life.'<sup>40</sup> A similar formulation was found in the South African Pharmacy Council's Rules Relating to the Services for which a Pharmacist May Levy a Fee.<sup>41</sup> The Rules defined pharmaceutical care as 'ensuring definite therapeutic outcomes for the health and quality of life of a patient in the supply of medicine.'

It is clear from these definitions that pharmaceutical care envisages a shift towards patient-orientation.<sup>42</sup> Penna submits that the relevance of pharmaceutical care is that it views pharmacists not as the mere providers of a *service*, but as the providers of *care*. He offers the following explanation:

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<sup>36</sup> Jay Hooper, when President of the Pharmaceutical Society of Australia, speculated:

'The Pharmacists of the future would not be sitting behind a counter dispensing medicines—this being undertaken by trained technicians and dispensary assistants—they would be out there interacting one-on-one with patients' (quoted in Miller 99).

<sup>37</sup> See also Whitney and Archambault 90:

'A metamorphosis has been slowly taking place, with the compounding role becoming minimal to nonexistent and the role of drug retailer and dispenser now being predominant. However, the state that now exists is only transitory. Many pharmacists have already advanced to a new form, and, when the metamorphosis is complete, the major role of the pharmacist will be that of clinical practitioner.'

<sup>38</sup> At the Pharmacy in the 21<sup>st</sup> Century Conference. It can, however, be noted that the professional philosophy encapsulated by 'pharmaceutical care' had been outlined by Helper at an earlier stage, during the 1985 Directions for Clinical Practice in Pharmacy Conference (Penna 543).

<sup>39</sup> These outcomes include the following:

'(1) cure of a disease, (2) reduction or elimination of symptoms, (3) arresting or slowing of a disease process, and (4) preventing a disease or symptoms' (Helper and Strand 535).

<sup>40</sup> Helper and Strand 539. See also Penna 544; Helper 1079.

<sup>41</sup> GNR 26904 of 15 October 2004. These Rules were withdrawn by the South African Pharmacy Council in GNR 2943 of 29 October 2004.

<sup>42</sup> Gonzalez 53-54.

'Introducing "care" into pharmacy's lexicon focuses pharmacists' attention on the patient. It does not diminish the scope or importance of what pharmacists do, but it—finally—places the patient at the centre of pharmacists' interests. As the providers of pharmaceutical care, pharmacists are concerned with the results or outcomes of their services and not merely with the act of providing those services.'<sup>43</sup>

Through the process of pharmaceutical care, a pharmacist co-operates with both the patient and other healthcare professionals in designing, implementing and monitoring a therapeutic plan in response to the needs of the particular patient.<sup>44</sup> Although the responsibilities of diagnosis and prescribing remain in the doctor's domain, pharmacists are regarded as playing an important role in '(1) *identifying* potential and actual drug-related problems, (2) *resolving* actual drug-related problems, and (3) *preventing* potential drug related-problems.'<sup>45</sup> A drug-related problem is 'an event or circumstance involving drug treatment that actually or potentially interferes with the patient's experiencing an optimum outcome of medical care.'<sup>46</sup>

It is significant that the South African Pharmacy Council's Rules Relating to Good Pharmacy Practice regard pharmaceutical care as being at the core of pharmacy activity.<sup>47</sup> Furthermore, the Regulations Relating to the Practice of Pharmacy list 'the provision of pharmaceutical care by taking responsibility for the patient's medicine related needs and being accountable for meeting these needs ...' as being one of the '[a]cts specially pertaining to the profession of a pharmacist.'<sup>48</sup> In a similar vein, one of the stated objects of the South African Pharmacy Council is 'to promote the provision of pharmaceutical care which complies with universal norms and values ... with the goal of achieving definite therapeutic outcomes for the health and quality of

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<sup>43</sup> Penna 544.

<sup>44</sup> Helper and Strand 539.

<sup>45</sup> Helper and Strand 539. Emphasis added.

<sup>46</sup> Helper and Strand 535. The following are examples of drug-related problems: A patient failing to receive treatment for a medical problem that requires drug therapy; an improper drug being selected for the treatment of a patient; a patient being treated with too little or too much of the correct drug; a patient having an adverse reaction to a drug; the occurrence of a drug-drug or drug-food interaction; the use of a drug by a patient who has no medically valid reason to use such drug (Helper and Strand 535-536).

<sup>47</sup> Rules Relating to Good Pharmacy Practice p2.

<sup>48</sup> Regulation 3(1). Regulation 18(1) goes on to highlight that the provision of such pharmaceutical care is a service to be provided by community and institutional pharmacies (see 1.2 above). Regulation 19(1) does, however, also acknowledge that pharmaceutical care can be provided by consultant pharmacies with the goal of improving compliance with drug therapy.

life of a patient.’<sup>49</sup> The stance of the South African pharmacy profession concerning the importance of pharmaceutical care clearly illustrates the profession’s commitment to fulfilling a more patient-oriented role than it did in the past.<sup>50</sup>

### **2.2.3 The Education of Pharmacists**

In response to the changes in pharmacists’ activities, pharmacy education has evolved so as to equip pharmacists with skills that are consistent with their new role.<sup>51</sup> The result is that the education of pharmacy students no longer focuses solely on the chemical properties of drugs.<sup>52</sup> Pharmacists are now trained to counsel patients regarding the use of medications and to assist physicians in determining appropriate courses of drug therapy.<sup>53</sup> This is no less so in South Africa than in foreign jurisdictions.<sup>54</sup> In terms of s2 of the Regulations Relating to Pharmacy Education and Training,<sup>55</sup> a university pharmacy curriculum must ensure that certain required outcomes<sup>56</sup> are met. These outcomes include the assurance of the optimum use of medicine as well as the provision of information regarding healthcare.

### **2.2.4 Drawing a Distinction Between Pharmacists and Physicians—Risk Assessment versus Risk Minimisation**

With the role of pharmacists becoming increasingly patient-oriented, the question arises whether pharmacists have begun to usurp the role of physicians. It is undeniable that pharmacists have the ability to play a significant role in maximising the safety

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<sup>49</sup> Section 3(c) of the Pharmacy Act 53 of 1974.

<sup>50</sup> This trend is by no means unique to South Africa. The Pharmaceutical Society of Australia, for example, has recommended that pharmaceutical care be adopted by pharmacists as a standard of practice (See the Pharmaceutical Society of Australia’s Policy on Pharmaceutical Care).

<sup>51</sup> Dwyer 727. Indeed, this is in line with good pharmacy practice: in terms of the Rules Relating to Good Pharmacy Practice, ‘[t]he education and training of pharmacists in South Africa must equip them for the roles they have to undertake in practice.’

<sup>52</sup> Green 1468.

<sup>53</sup> Green 1475.

<sup>54</sup> At Rhodes University, for example, students have to complete a course in pharmacy administration and practice (which includes practical training in skills such as client counselling) as part of their pharmacy degree (see <http://www.ru.ac.za/academic/departments/pharmacy/syllabus.htm#PAP> accessed on 03/10/06); At the University of Kwa-Zulu Natal and Nelson Mandela Metropolitan University, courses in communication and pharmaceutical care are similarly included in the pharmacy curriculum (see <http://www.ukzn.ac.za/department/data/SP-Pharmacy%20and20%Pharmacology.pdf> accessed on 03/10/06 and <http://www.nmmu.ac.za/default.asp?id=399&bhcp=1> accessed on 03/10/06).

<sup>55</sup> GNR 115 of 20 November 2000.

<sup>56</sup> Laid out in Annexure A of the Regulations.

and efficacy of drug therapy. In spite of this, the decision regarding which course of treatment a patient should follow remains (at least in the case of prescription drugs) in the hands of physicians. Brushwood<sup>57</sup> suggests that the fundamental distinction between the roles of physicians and pharmacists is that, whilst physicians are responsible for 'risk assessment', pharmacists are responsible for 'risk minimisation' or 'risk management'.<sup>58</sup> As the person who prescribes the medication, a physician (who is also aware of the medical history and condition of the particular patient<sup>59</sup>) bears the responsibility of assessing the risks and benefits posed by the available drugs. The result of this assessment will be a decision as to whether the potential benefits justify the risks.<sup>60</sup> Once the decision to prescribe a particular drug has been made, the responsibility falls upon the dispenser of the drug (the pharmacist) to make sure that the prescribed medication is used in the appropriate manner so as to ensure the best possible results from drug therapy. This may, for example, involve the pharmacist warning the patient not to consume alcohol or operate heavy machinery during the course of drug therapy. It may also entail the pharmacist monitoring the course of drug therapy so as to avoid the accumulation by a patient of excessive quantities of drugs.<sup>61</sup>

Whilst there may be good reason to draw the above distinction, it is questionable whether this classification accurately reflects the contemporary function of pharmacists. Of particular relevance in this regard are the 2004 Rules Relating to Good Pharmacy Practice which enjoin pharmacists to take responsibility not only for providing information and monitoring patients, but also for *evaluating* the needs of particular patients.<sup>62</sup> The definition of 'dispensing', as found in the Regulations Relating to the Practice of Pharmacy, is also significant insofar as it includes 'the interpretation and evaluation of a prescription.' This involves, *inter alia*, the *assessment* of a prescription with respect to its appropriateness in the particular circumstances.<sup>63</sup> It thus appears that the role of pharmacists may have begun to extend

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<sup>57</sup> Brushwood *Medical Malpractice* 43.

<sup>58</sup> Owen 699.

<sup>59</sup> *Ibid.*

<sup>60</sup> Brushwood *Medical Malpractice* 43.

<sup>61</sup> Brushwood *Medical Malpractice* 43-44

<sup>62</sup> Rules Relating to Good Pharmacy Practice p2.

<sup>63</sup> Rule 2.7.1.1(b)(ii) of the Rules Relating to Good Pharmacy Practice. Here again, it must be remembered that it is only community and institutional pharmacies that are entitled to dispense medications to the public.

beyond the borders of risk minimisation into the traditionally physician-lorded realm of risk assessment. This issue will be explored in greater depth in Chapters 3 and 4.<sup>64</sup>

## 2.3 The Regulation of Pharmacists within Society

### 2.3.1 South African Legislation Pertaining to Pharmacists

The statutory regulation of pharmacists is relevant insofar as statutory duties can be taken into consideration in establishing the elements of both wrongfulness and negligence. There are at present essentially two pieces of legislation which are fundamental to pharmacy practice in South Africa: the Pharmacy Act<sup>65</sup> and the Medicines and Related Substances Act<sup>66</sup> (the 'Medicines Act'). The Pharmacy Act deals with the establishment, objects, powers and functions of the South African Pharmacy Council, as well as the registration and education of pharmacists and the conduct of pharmacy practice. The Medicines Act is relevant insofar as it regulates the purchase and sale of medicines by pharmacists.

#### 2.3.1.1 The Pharmacy Act

The Pharmacy Act places the control and regulation of the pharmacy profession in the hands of the South African Pharmacy Council. The Council's primary object is to assist in promoting the health of the South African population.<sup>67</sup> This is achieved, *inter alia*, by promoting pharmaceutical care<sup>68</sup> and establishing, developing, maintaining and controlling universally-acceptable standards concerning the following: pharmaceutical education and training, the registration of pharmacists, the practice<sup>69</sup> and professional conduct of pharmacists and the control of registered pharmacists.<sup>70</sup> Of particular significance to this thesis is the Council's role in formulating and maintaining standards of practice and professional conduct for

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<sup>64</sup> See 3.7.1.3 and 4.4.4 below.

<sup>65</sup> Act 53 of 1974.

<sup>66</sup> Act 101 of 1965.

<sup>67</sup> Section 3(a).

<sup>68</sup> Section 3(c).

<sup>69</sup> The scope of pharmacy practice is dealt with by the Regulations Relating to the Practice of Pharmacy. These Regulations were made by the Minister of Health, in consultation with the South African Pharmacy Council, in terms of s35A(a) of the Pharmacy Act.

pharmacists. In this regard, the Pharmacy Act<sup>71</sup> permits the Council to make rules concerning a code of conduct for pharmacists and what constitutes good pharmacy practice. It is from this section that the Code of Conduct for Pharmacists and Other Persons Registered in terms of the Pharmacy Act<sup>72</sup> and the Rules Relating to Good Pharmacy Practice in South Africa emanate.

In order to practise pharmacy, a pharmacist must be registered with the South African Pharmacy Council,<sup>73</sup> which also has the power to suspend or cancel any registration entitling a person to carry on the profession of a pharmacist.<sup>74</sup> The Council has the power to inquire into allegations of misconduct and, upon finding a person guilty of misconduct, to impose any of the penalties provided for in the Act.<sup>75</sup> A person aggrieved by the imposition of such a penalty has the right to appeal to the High Court with jurisdiction in the area in which the appellant practises.<sup>76</sup> The Pharmacy Act also provides that the Council must formulate rules specifying what constitutes misconduct.<sup>77</sup> These rules have been promulgated as the Rules Relating to Acts or Omissions in respect of which the Council may take Disciplinary Steps,<sup>78</sup> also known as the Pharmacy Council's 'Ethical Rules'.<sup>79</sup>

### 2.3.1.2 The Medicines and Related Substances Act

#### (a) The Sale of Scheduled Substances

In order to appreciate the provisions of the Medicines Act, one must have a basic understanding of the distinctions between the various scheduled substances which the Act regulates. The first major distinction made by the Act is that between Schedule 0 medications and all other scheduled medicines.<sup>80</sup> Schedule 0 substances are for the treatment of minor ailments which can be easily recognised and monitored by the

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<sup>70</sup> Section 3(e).

<sup>71</sup> Section 35A(b).

<sup>72</sup> GNR 28873 of 26 May 2006.

<sup>73</sup> Section 13. See also McQuoid-Mason and Strauss par 277.

<sup>74</sup> Section 4(j). See also s38 (2) (a) (i).

<sup>75</sup> Section 39(1). See the discussion of statutory duties in 3.5.4.2 below.

<sup>76</sup> Section 45 (3).

<sup>77</sup> Section 41(1).

<sup>78</sup> GNR 599 of 31 March 1989.

<sup>79</sup> See also McQuoid-Mason and Strauss par 281.

<sup>80</sup> *Minister of Health and Another v New Clicks SA (Pty) Ltd and Others* 2006 (2) SA 311 (CC) par [214].

consumer. These substances are substantially safe, have an extremely low potential for abuse or harm from misuse and have either a low or well characterised incidence of side-effects or interactions which can be easily understood by lay people from the product labelling.<sup>81</sup> In short, Schedule 0 substances are suitable for self-treatment. The result is that they are the only scheduled medicines that can be sold by retailers.<sup>82</sup>

The second major distinction made by the Medicines Act is that between prescription and non-prescription medications.<sup>83</sup> The latter include Schedule 0, 1 and 2 substances. In terms of the Medicines Act, a pharmacist may sell these drugs without prescription.<sup>84</sup> Like Schedule 0 drugs, Schedule 1 substances are essentially appropriate for self-treatment of minor ailments. Again, these drugs are substantially safe, they have a very low potential for abuse or harm from inappropriate use. Either there is advice or counselling available regarding their side-effects and interactions, or these can be easily understood from the product labelling. Treatment can thus be monitored and self-managed, if necessary with the advice and counselling of a pharmacist.<sup>85</sup> Schedule 2 substances are those which, although considerably safe to use, require the professional advice and monitoring of a pharmacist. These drugs are used in the treatment of ailments which can be identified by the patient and verified by the pharmacist. There is thus no necessity for medical diagnosis or close medical management. The abuse and harm potential is low and any side-effects or interactions can be managed by the pharmacist.<sup>86</sup>

Schedule 3, 4, 5 and 6 substances can only be dispensed by a pharmacist upon the written or verbal instructions of an authorised prescriber.<sup>87</sup> Schedule 3 substances are drugs the long-term safety and efficacy of which have been established. Whilst they are used in the treatment of conditions that require professional diagnosis and management, they do not require close medical monitoring after the initiation of

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<sup>81</sup> Oltmann interview.

<sup>82</sup> Section 22A(3).

<sup>83</sup> *Minister of Health v New Clicks SA (Pty) Ltd* par [214].

<sup>84</sup> See s22A(4)(a)(i) and (5)(a).

<sup>85</sup> Oltmann interview.

<sup>86</sup> *Ibid.*

<sup>87</sup> Section 22(5)(b). Although, where the substance has been dispensed as a result of verbal instructions, s22A(6)(b) provides that the authorised prescriber must within seven days furnish the pharmacist with a written prescription.

therapy. Continued treatment can thus be adequately managed by a pharmacist.<sup>88</sup> In contrast, Schedule 4 substances are used in the treatment of conditions that require professional diagnosis, management *and monitoring*. This stems from the fact that their long-term safety is not well-established and may require further evaluation. Still greater risks are posed by Schedule 5 substances, which are potentially habit-forming. Schedule 5 drugs, although having a low to moderate potential for abuse and dependence, have serious side-effects and contraindications and are known to have psychoactive properties. Professional diagnosis, management and supervision are thus required when these drugs are involved.<sup>89</sup> Even greater care is needed when a patient is treated with a Schedule 6 substance. Under this category fall drugs with psychoactive properties and serious side-effects which have a moderate to high potential for abuse and dependence.<sup>90</sup>

When a drug has an extremely high potential for abuse and dependence, and is thus particularly dangerous, it will be classified as either a Schedule 7 or Schedule 8 medicine. The schedule under which a particular drug falls will depend on whether or not it has a recognised medicinal use. Drugs having no such use fall into Schedule 7 and are banned substances. Schedule 8 medicines, on the other hand, do have a recognised, but limited, medicinal use.<sup>91</sup> In terms of the Medicines Act, no person may acquire, use, possess, manufacture or supply any Schedule 7 or Schedule 8 substance unless he or she has been issued with a permit by the Director-General.<sup>92</sup>

#### (b) Other Relevant Provisions of the Act

Other provisions of the Medicines Act which will be discussed in Chapters 3 and 4 include s22F, which deals with generic substitution,<sup>93</sup> and s29, which creates a number of offences relating to the sale of drugs. Upon conviction of any of these

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<sup>88</sup> Oltmann interview.

<sup>89</sup> That this schedule has recently been divided into specified Schedule 5 substances and Schedule 5 substances, the former of which are subject to more stringent control than the latter (Oltmann interview).

<sup>90</sup> Oltmann interview.

<sup>91</sup> Oltmann interview.

<sup>92</sup> Section 22A(9)(a).

<sup>93</sup> A pharmacist must inform all members of the public of the benefits of generic substitution and must dispense a generic substitute instead of the medicine prescribed, unless expressly forbidden by the patient to do so.

offences, a person shall, in terms of s30(1), be liable to a fine or imprisonment not exceeding 10 years.

### 2.3.1.3 The Regulation of Internet Pharmacies

As of yet, there exists no South African legislation dealing specifically with the sale of medicine over the Internet.<sup>94</sup> In 2004, however, the South African Pharmacy Council took a step in the right direction by formulating guidelines concerning the practice of e-pharmacy. The current Rules Relating to Good Pharmacy Practice were published with rule 1.5 containing the minimum standards for pharmacies operating Internet sites. It is firstly significant that, in terms of this rule, any website which sells medicine directly to the public must be operated by, and constitute part of, a pharmacy licensed by the National Department of Health and recorded by the South African Pharmacy Council. A virtual pharmacy must, in other words, be attached to a physical pharmacy.<sup>95</sup>

Rule 1.5 goes on to emphasise that pharmacy websites must comply with all of the legislation relevant to pharmacies (including the Pharmacy Act and the Medicines Act) and must adhere to the dictates of good pharmacy practice. It is thus clear that an e-pharmacy supplying drugs in South Africa will be bound by all of the rules and regulations which apply to traditional brick and mortar pharmacies trading within the Republic. In addition, a pharmacy that sells drugs over the Internet will presumably be governed by existing Internet regulations.<sup>96</sup> Of particular importance may be the Electronic Communications and Transactions Act<sup>97</sup> (the 'ECT' Act)<sup>98</sup> which aims at facilitating electronic transactions in the public interest.

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<sup>94</sup> Phillips 26; Jacobs 251.

<sup>95</sup> See also Jacobs 251.

<sup>96</sup> Wiesemann 1152.

<sup>97</sup> Act 25 of 2002.

<sup>98</sup> Jacobs 252.

## 2.3.2 Pharmacy Ethics

### 2.3.2.1 The Significance of Exploring Pharmacy Ethics

The conduct of pharmacists is governed not only by legislation, but also by the ethics of the pharmacy profession. For the purposes of this thesis, a brief exploration of the ethics underlying pharmacy practice is necessary for two reasons. Firstly, although the fact that an act is unethical does not necessarily mean that it will be prohibited by law,<sup>99</sup> there often exists an overlap between moral duties and legal duties<sup>100</sup> and the former may be taken into consideration in determining whether the latter exist. The ethics which govern pharmacy practice will thus be relevant to the discussion of wrongfulness contained in Chapter 3. Secondly, pharmacy ethics will inevitably play a role in determining the standard of care to which pharmacists are bound for the purposes of the negligence enquiry (discussed in Chapter 4). Fink explains the position thus:

‘When addressing the issue of professional negligence or malpractice, it is important to bear in mind that the performance of a professional being sued will be evaluated in light of a standard of care created by his peers. In the case of a pharmacist, other pharmacists would be called to the witness stand to testify about how they would have handled the transaction that gave rise to the lawsuit. The origin for the standard of ethics is the same—one’s peers. Only the process and the potential sanctions are different. Pharmacists create ethical standards through professional organisations and legal duties of due care through their actions in daily practice. ... The law sets minimum standards of acceptable conduct, and in my view, ethics should be viewed as minimum standards.’<sup>101</sup>

Pharmacy ethics can thus be used in establishing both the legal duties and standard of care to which pharmacists are bound.<sup>102</sup>

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<sup>99</sup> Beauchamp and Childress 10. The converse of this is, of course, that the fact that an act is morally acceptable does not necessarily mean that it is permitted by law.

<sup>100</sup> Beauchamp and Walters 4.

<sup>101</sup> Fink 28-29.

<sup>102</sup> See also Giesen 669:

‘It is in the medical professional field much more than in any other social relationship between men that ethical considerations are inextricably linked with considerations of a legal nature.’

In order to understand the framework within which pharmacists make ethical decisions, it is necessary to comment briefly on normative ethics in general. Normative ethics attempts to answer the question of what gives actions their moral character.<sup>103</sup> In other words, it involves the issue of which acts are moral and for what reasons.<sup>104</sup> A common way of justifying one's moral judgments is to appeal to moral rules (such as those found in a code of ethics), which in turn are justified by principles, which are justified by an ethical theory of some kind.<sup>105</sup> What follows is thus a brief discussion of the primary ethical theories and principles underlying pharmacy ethics.

### 2.3.2.2 The Theories Underlying Healthcare Ethics

An ethical theory provides a framework of rules and principles within which a person can determine morally appropriate courses of action.<sup>106</sup> Whilst modern medical ethics (of which pharmacy ethics is a branch) has been described as 'a tapestry in which an array of philosophical theories interweave with one another,'<sup>107</sup> there are two types of ethical theory which hold particular significance. These are the consequentialist theories and the deontological theories.<sup>108</sup>

Consequentialist theories advocate that the moral character of an act is to be determined strictly by its consequences. According to these theories, the best course of action in any particular situation is the one that produces the best overall result.<sup>109</sup> The best example of a consequentialist theory is utilitarianism, the proponents of which include Jeremy Bentham and John Stuart Mill. Utilitarians judge acts as ethically right or wrong by the extent of good or bad that they promote.<sup>110</sup> This system

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<sup>103</sup> Veatch and Haddad 9.

<sup>104</sup> Beauchamp and Childress 4.

<sup>105</sup> This is known as deductivism (see Beauchamp and Childress 14-14). Note, however, that this model of justification has been criticised as being overly-simplistic and that there are other approaches that can be taken in justifying one's decisions (see Beauchamp and Childress 17-28).

<sup>106</sup> Singh and Ngwena 37; Russell and Butler 10.

<sup>107</sup> Mason and McCall Smith 5.

<sup>108</sup> Healy 31. See also Gorovitz 13-14. Other theories which may influence pharmacy ethics include virtue ethics, in which the focus is on the decision-maker's moral character (Singh and Ngwena 37-38; Loewy 20); communitarianism, which focuses on communal values and social goals (Beauchamp and Childress 77); and rights ethics, in which importance is placed on a hierarchy of rights (Shannon 4).

<sup>109</sup> Beauchamp and Childress 47. See also Shannon 3-4.

<sup>110</sup> Russell and Butler 10; Mason and McCall Smith 6; Singh and Ngwena 39; Veatch and Haddad 9.

of ethics is grounded upon the principle of utility<sup>111</sup> (or, as Bentham called it, the 'greatest happiness principle'<sup>112</sup>). The principle asserts that we must aim to maximise the good in any situation by acting in such a way as to bring about the greatest amount of pleasure.<sup>113</sup> Mill explains:

'The creed which accepts as the foundation of morals, Utility or the Greatest Happiness Principle, holds that actions are right in proportion as they tend to promote happiness, wrong as they tend to produce the reverse of happiness. By happiness is intended pleasure, and the absence of pain; by unhappiness, pain and the privation of pleasure.'<sup>114</sup>

In terms of utilitarianism, the only thing that makes an act ethically right or wrong is thus its consequences,<sup>115</sup> and the only consequences that are desirable are pleasure and freedom from pain.<sup>116</sup> The significance of this theory to the healthcare professions, which strive to promote good health and prevent disease, is obvious. It should, however, be noted that this form of consequentialism pays no heed to *who* experiences the pleasure or pain—consequences are judged impartially and one person's pleasure counts exactly as much as another's.<sup>117</sup> In this regard, it is significant that traditional pharmacy ethics (and healthcare ethics in general) is essentially committed to bringing about the best results for the *patient*.<sup>118</sup> Veatch and

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<sup>111</sup> Beauchamp and Childress 47.

<sup>112</sup> Bentham 1 fn 1.

<sup>113</sup> Russell and Butler 10. See also Beauchamp and Childress 47.

<sup>114</sup> Mill 9-10. See also Bentham 2:

'By the principle of utility is meant that principle which approves or disapproves of every action whatsoever, according to the tendency which it appears to have to augment or diminish the happiness of the party whose interest is in question: or, what is the same thing in other words, to promote or to oppose that happiness.'

Both Bentham and Mill clearly favoured a formulation of the principle of utility in which utility is assessed entirely on the basis of pleasure. For this reason, Beauchamp and Childress (48) describe Bentham and Mill as 'hedonistic' utilitarians. It should be noted, however, that not all utilitarians agree over which values should be promoted and that many have placed importance on values other than pleasure (eg knowledge, health and personal autonomy).

A further distinction should be made between act utilitarians and rule utilitarians. For the former, the primary consideration is the consequences of conduct in particular situations—moral rules are only useful insofar as they provide guidelines for moral conduct. According to the act utilitarian such rules can, however, and indeed should, be deviated from should their application fail to produce the best consequences in a specific situation. Rule utilitarians, on the other hand, judge the morality of an act by its compliance with concrete rules which are in turn justified by utility (Beauchamp and Childress 48-49).

<sup>115</sup> Russell and Butler 10; Mill 17.

<sup>116</sup> Mill 10. As explained by Bentham (1):

'Nature has placed mankind under the government of two sovereign masters, *pain* and *pleasure*. It is for them alone to point out what we ought to do, as well as to determine what we shall do.'

<sup>117</sup> Beauchamp and Walters 15.

<sup>118</sup> Although it is perhaps significant that the Rules Relating to Good Pharmacy Practice (p2) state:

Haddad thus observe that pharmacy ethics 'combines the utilitarian answer to the question of what kinds of acts are right with a particular answer to the question of to whom moral duty is owed.'<sup>119</sup>

Deontological (duty-based<sup>120</sup>) theories, rather than focusing on the consequences of acts which themselves are not regarded as having any intrinsic value,<sup>121</sup> concentrate on the morality of an act in itself.<sup>122</sup> These theories thus recognise that certain courses of conduct will be normatively correct regardless of their consequences.<sup>123</sup> The moral character of an act is determined by examining the nature of the act itself and an emphasis is placed on adherence to morally acceptable rules and principles<sup>124</sup> derived *a priori* either from reason<sup>125</sup> or some form of Divine Law.<sup>126</sup> Deontology is thus appealing insofar as it advocates that the same moral reasoning be applied consistently to people in the same or similar situations.<sup>127</sup>

The most well-known example of a deontological theory is Kantianism. Kant sought to derive a morality from pure reason by attempting to find a categorical imperative which would be agreed upon by all rational people.<sup>128</sup> A categorical imperative is an imperative which is detached from consequences and contingent events and is thus not conditional upon any further purpose.<sup>129</sup> According to Kant, the fundamental test to determine whether an act is moral is whether it can be universally applied.<sup>130</sup> One formulation of the categorical imperative identified by Kant was thus the following: 'Act as though the maxim of your action were to become by your will a universal law

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'A pharmacist's first concern must be the welfare of the patient *and of the public in general*' (emphasis added).

<sup>119</sup> Veatch and Haddad 10.

<sup>120</sup> 'Deontology' is actually derived from the Greek term *deon* which means 'duty' or 'binding' (Healy 31 fn 13).

<sup>121</sup> Beauchamp and Walters 15-16.

<sup>122</sup> Veatch and Haddad 10; Mason and McCall Smith 5; Hope *et al* 6.

<sup>123</sup> Healy 31 fn 13.

<sup>124</sup> Shannon 4; Beauchamp and Walters 12.

<sup>125</sup> Hope *et al* 4; Singh and Ngwena 38.

<sup>126</sup> Healy 31 fn 13.

<sup>127</sup> Beauchamp and Childress 62.

<sup>128</sup> Hope *et al* 6-7; Beauchamp and Childress 56-57.

<sup>129</sup> See Kant 216:

'A categorical imperative would be one that represented an action as itself objectively necessary, without regard to any further end.'

See also Caygill 99-100; MacIntyre 194 and 197.

<sup>130</sup> Villa-Vicencio 69; Loewy 18.

of nature.’<sup>131</sup> Another formulation was: ‘Act in such a way that you treat humanity, whether in your own person or in any other person always at the same time as an end never merely as a means.’<sup>132</sup> Kantian philosophy thus stresses the importance of recognising that each individual in society is a rational, wilful being whose integrity should be respected and who should never be treated exclusively as a means to some other end.<sup>133</sup> <sup>134</sup> The relevance of this to healthcare ethics is seen in the primacy currently afforded to the principle of autonomy which is discussed below.<sup>135</sup>

### 2.3.2.3 Ethical Principles Relevant to Healthcare Ethics

It was explained above that an ethical theory provides support for ethical principles. Certain ethical principles are particularly relevant to healthcare settings and thus to pharmacists. In this regard, the so-called ‘four-principle approach’ to biomedical ethics has proved popular.<sup>136</sup> The four principles upon which this approach focuses are nonmaleficence, beneficence, autonomy and justice. Together, these principles provide a framework of abstract norms in which pharmacists can function.

#### (a) Nonmaleficence and Beneficence

Nonmaleficence<sup>137</sup> involves the avoidance of harm (ie not inflicting harm), whilst beneficence involves the taking of positive steps to prevent or remove harm or to promote good.<sup>138</sup> Beneficence can thus be regarded as the positive dimension of nonmaleficence.<sup>139</sup> Although the *principle* of beneficence refers to the moral duty to benefit others, there are many beneficent acts which cannot be characterised as

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<sup>131</sup> Kant 222.

<sup>132</sup> Kant 230.

<sup>133</sup> Mason and McCall Smith 5; Russell and Butler 11; Beauchamp and Childress 58.

<sup>134</sup> Kantian ethical theory has been adopted and developed by a number of contemporary writers, including Donagan and Rawls (see Beauchamp and Childress 59-60 for further discussion).

<sup>135</sup> In 2.3.2.3(b).

<sup>136</sup> Beauchamp and Childress 37.

<sup>137</sup> This term must be distinguished from ‘nonmalevolence’ which means intending to do harm (Ascension Health ‘Beneficence’).

<sup>138</sup> Russell and Butler 34-35; Hope *et al* 8-9; Beauchamp and Childress 189 and 192.

<sup>139</sup> Shannon 7; Ascension Health ‘Beneficence’. Some philosophers even go so far as to join nonmaleficence and beneficence as a single principle. Whilst these principles are similar, there is clearly a distinction between an obligation to act negatively by refraining from harming others and an obligation to positively assist others. It is thus best to avoid conflating the principles of nonmaleficence and beneficence under one general principle (Beauchamp and Childress 190).

obligatory.<sup>140</sup> In general, individuals are not morally obliged (nor legally obliged for that matter<sup>141</sup>) to act positively so as to bring about good consequences for others. Beneficence is thus usually no more than a virtuous ideal, and a person is not regarded as acting immorally if he or she fails to act for the benefit of others.<sup>142</sup> There are, however, exceptions to this, such as where a special relationship exists between parties.<sup>143</sup> The principle can also clearly be justified by utilitarian theory, which ‘sees morality primarily in terms of the goal of promoting welfare’.<sup>144</sup>

The principle of nonmaleficence plays a pivotal role within the healthcare context. This is demonstrated by the emphasis that is placed on the maxim *primum non nocere* (first, do no harm).<sup>145</sup> The principle of beneficence also holds an important place within biomedical ethics. In this context, the principle emphasises the moral importance of making efforts to promote a patient’s well-being.<sup>146</sup> The pharmacy profession’s strong commitment to this principle is seen in the first paragraph of the Pharmacist’s Oath<sup>147</sup> which states the following: ‘I [name], as a pharmacist solemnly pledge to devote myself to the well-being of humanity and to the relief of suffering, which I now regard as my calling in life.’<sup>148</sup>

There is some controversy over what it means to benefit a patient. A patient’s health is obviously the benefit which health professionals generally aim to maximise. It must not be forgotten, however, that there are other goods which people desire. These include aesthetic beauty and financial well-being. These goods sometimes compete with good health.<sup>149</sup> Ellin argues that professionals are only under a duty to use their knowledge and skill to protect ‘those interests for the protection of which the [professional] relationship exists.’<sup>150</sup> According to this view, the relationship between patient and healthcare professional exists for the protection and advancement of the patient’s health. It is thus only this interest that the professional must be concerned

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<sup>140</sup> Beauchamp and Childress 260.

<sup>141</sup> See the discussion of omissions in 3.5.3.2(a) below.

<sup>142</sup> Beauchamp and Childress 261.

<sup>143</sup> Beauchamp and Childress 270.

<sup>144</sup> Beauchamp and Childress 55.

<sup>145</sup> Helper and Strand 539; Jonsen 99.

<sup>146</sup> Hope *et al* 8; Singh and Ngwna 36.

<sup>147</sup> Discussed in 2.3.2.4(b) below.

<sup>148</sup> Pharmacist’s Oath of the Pharmaceutical Society of South Africa.

<sup>149</sup> Veatch and Haddad 50-53.

with promoting. Whilst it does seem correct to say that a patient's health should be a healthcare professional's *primary* concern, it does not follow that the patient's other interests are irrelevant and that there is no duty to promote these interests where possible. Gettman and Arneson, for example, comment that beneficence includes reducing costs to a patient where possible.<sup>151</sup> Indeed, the Medicines Act enjoins pharmacists to inform patients of the benefits of substituting branded medicines with generic medicines and to make such a substitution unless this is expressly forbidden by the patient.<sup>152</sup> The primary purpose of this provision is to benefit patients by reducing drug costs and expenditure.<sup>153</sup>

Another contentious question is whether pharmacists should be concerned only with the benefits of *patients*.<sup>154</sup> This issue will be discussed in Chapter 3 within the context of justified breaches of patient confidentiality.<sup>155</sup>

A final point to be made concerning the twin principles of nonmaleficence and beneficence is that, as a general rule, the duty not to cause harm will be more stringent than the duty to act positively so as to benefit another person. Within the healthcare context, however, instances may arise in which these principles come into conflict and in which nonmaleficence is outweighed by beneficence. This stems from the very nature of medical treatment—whilst the purpose of drug therapy is to promote the patient's wellbeing, the nature of pharmaceutical products is such that their use inevitably places the patient at risk of harm.<sup>156</sup> Where the potential benefits of drug use are substantial in comparison to the harm posed by therapy, the principle of beneficence will be given preference over the principle of nonmaleficence.<sup>157</sup> This balancing of risks and benefits is a clear application of the principle of utility.<sup>158</sup>

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<sup>150</sup> In Ellin 135.

<sup>151</sup> Gettman and Arneson 93.

<sup>152</sup> Section 22F.

<sup>153</sup> See the National Drug Policy for South Africa 9.

<sup>154</sup> Veatch and Haddad 49.

<sup>155</sup> See 3.7.3.4 below.

<sup>156</sup> Jonsen 104.

<sup>157</sup> Beauchamp and Childress 191. Another source of moral justification for the use of drug therapy is the doctrine of double effect. This doctrine states that, if an act has two foreseeable consequences, one which is beneficial and one which is harmful, the act will not be morally prohibited so long as the harmful consequence was not directly intended by the actor (Jonsen 105; Shannon 7; see Beauchamp and Childress 206-211 for further discussion). A course of drug therapy, whilst having the potential to enhance a patient's wellbeing, will also often have the potential to bring about harmful side effects. Applying the doctrine of double effect to this situation, dispensing a drug will not be morally

## (b) Autonomy

The principle of autonomy promotes the idea that people should be permitted to control their own lives.<sup>159</sup> This principle clearly finds support in Kantian theory.<sup>160</sup> As a rule, however, consequentialist theories only support autonomy to the extent that it produces the greatest amount of good.<sup>161</sup>

Whilst, traditionally, the principles of nonmaleficence and beneficence were the central focus of biomedical ethics,<sup>162</sup> recent decades have seen a shift away from medical paternalism<sup>163</sup> towards the idea that individuals should have control over their own bodies and be able to make decisions regarding their own medical treatment. In fact, the principle of autonomy is widely regarded as the most significant principle to be embraced by contemporary medical ethics.<sup>164</sup> Respect for autonomy is the basis of the patient-centred view of healthcare. In terms of this view, although pharmacists should strive for beneficence, they should also respect the decisions of the patient.<sup>165</sup> Indeed, the recognition of autonomy has had the effect of promoting the patient 'from the recipient of treatment to being the partner in a therapeutic project.'<sup>166</sup>

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prohibited so long as the healthcare professional's primary intention in dispensing the drug is to cause the beneficial result.

<sup>158</sup> In this regard, Beauchamp and Childress (260) state the following:

'Because the moral life typically does not provide the opportunity to produce benefits or eliminate harms without creating risks or incurring costs, the principle of utility is an essential extension of the principle of positive beneficence.'

<sup>159</sup> The term 'autonomy' originates from the Greek *autonomia* which means 'living by one's own laws' (Healy 20).

<sup>160</sup> Kant regarded the principle of autonomy to be 'the sole principle of ethics' (Kant 241) and sought to base his entire moral philosophy on the autonomous principle of self-legislation (Kant 232; see also Caygill 88). According to Kant, however, individuals only act autonomously when they act morally, in accordance with his categorical imperative. Actions which, even though chosen by an individual, are motivated by self-interest, passion, impulse etc were thus not regarded by Kant as being autonomous. This is because Kant did not regard such actions as having been *freely* chosen (Beauchamp and Childress 58). This line of thinking is also supported by Rawls (see Beauchamp and Childress 59-60 for further discussion).

<sup>161</sup> Veatch and Haddad 11. Note, however, that Mill, although a utilitarian, placed fundamental importance on the principle of autonomy. This is seen in his work *On Liberty* in which he argues that the only justification for interfering with an individual's liberty is the protection of others.

<sup>162</sup> Beauchamp and Childress 38.

<sup>163</sup> Gettman and Arneson 99. Paternalism involves a failure to respect the autonomy of a patient by either interfering with, or failing to comply with, the patient's decisions concerning his or her own good (Beauchamp and Childress 274; Shannon 13; Bok 'Lying to the Sick' 143).

<sup>164</sup> Mason and McCall Smith 6. Brody has gone so far as to say that the 'history of the emergence of medical ethics as a special subject for study in the past 15 years is in many ways the history of concern for patient autonomy' (quoted in Healy 20).

<sup>165</sup> Russell and Butler 35.

<sup>166</sup> Mason and McCall Smith 6.

The principle of respect for autonomy has both negative and positive aspects. In the first instance, it involves acknowledging and respecting an individual's right to make choices and refraining from interfering in such decisions. This aspect of the principle provides a basis for the right to privacy discussed in Chapter 3.<sup>167</sup> Within some contexts, respect for autonomy also involves acting positively so as to enable people to act autonomously. Healthcare professionals, for example, have a duty to promote the distribution and understanding of information so as to foster autonomous decision-making amongst patients.<sup>168</sup> It is here that a link is found between the principle of autonomy and 'informed consent'.<sup>169</sup>

Informed consent<sup>170</sup> has been defined as 'an *autonomous authorization* by individuals of a medical intervention.'<sup>171</sup> Beauchamp and Childress suggest that, in order for informed consent to occur, there are two components that need to be present. The first is the information element. This involves *disclosing information* to a patient and ensuring that the patient *comprehends* the information disclosed.<sup>172</sup> Informed consent thus involves the process of ensuring, through disclosure and discussion, that a patient is aware of alternatives, risks and benefits<sup>173</sup> and is thus able to make an informed decision concerning a particular course of drug therapy.<sup>174</sup>

The second element which must necessarily be present in order for informed consent to occur is consent. In order for this requirement to be met, *consent* to therapy must be given *voluntarily* by a patient who is *competent* to make such a decision.<sup>175</sup> Consent must, in other words, be given without coercion or undue pressure, by someone who

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<sup>167</sup> See 3.7.3 below.

<sup>168</sup> Beauchamp and Childress 125-127. See also McLean 11:

'[P]atient autonomy is only protected where there is a meaningful choice made by the patient, on the basis of adequate information.'

<sup>169</sup> Russell and Butler 35; Hope *et al* 61. Though see O'Neill's argument that the ethical importance of informed consent is *not* rooted in the principle of autonomy (O'Neill 4).

<sup>170</sup> See also 3.6.2 below in which consent is discussed as a defence excluding wrongfulness.

<sup>171</sup> Beauchamp and Childress 143.

<sup>172</sup> Ie informed consent cannot be obtained by simply conveying the relevant information to a patient. The information must be conveyed in such a way that it is understood. See also Shannon 12.

<sup>173</sup> It should be highlighted that disclosure of both risks *and* benefits is necessary if the patient is to be enabled to weigh up properly the competing factors and reach a decision (McLean 11).

<sup>174</sup> Russell and Butler 35; Smith *et al Pharmacy Ethics* 42-43; Duncan *et al* 89 and 181. One argument that has been raised against this principle is that it rests on the erroneous premise that people are able to act autonomously when ill and reliant upon healthcare (Healy 23).

<sup>175</sup> Beauchamp and Childress 144-145. See also Gorovitz 'Informed Consent' 183; Hope *et al* 61.

has the capacity to consent.<sup>176</sup> As a rule, a person will be regarded as competent ‘if able to understand a therapy ..., to deliberate regarding the major risks and benefits, and to make a decision in light of this deliberation.’<sup>177</sup> Lack of capacity may result from factors such as age and mental impairment.<sup>178</sup> A person who lacks capacity is unable to act autonomously. Beauchamp and Childress thus provide the following definition of autonomy: ‘[P]ersonal rule of the self that is free from both controlling interferences by others and from *personal limitations that prevent meaningful choice*, such as inadequate understanding.’<sup>179</sup>

The mere fact that a patient has made a bad choice does, not necessarily mean that he or she is incompetent<sup>180</sup> and can, at most, constitute a reason for being alert to the possibility that capacity is absent.<sup>181</sup> Even when patients are competent to make decisions, however, the principle that their choices must be respected does not necessarily prohibit professionals from challenging, and attempting to change these choices. Sometimes a competent person will make a decision that is poorly reasoned or based on false beliefs. In these situations, Beauchamp and Childress make the point that ‘it may be permissible or possibly obligatory to promote autonomy by attempting to impose unwelcome information.’<sup>182</sup> When, in other words, a patient makes a decision from a position of ignorance, this decision cannot be regarded as being adequately informed. The principle of respect for autonomy thus enjoins the professional to take further steps to enable the patient to make a fully-reasoned, autonomous decision. Even if a patient’s decisions are not based on false premises, a professional may still be completely justified in attempting to change the patient’s mind through a process of rational argument. Providing patients with good reasons to change their minds will often be an important way of ensuring that they understand their decisions and is thus a means of promoting autonomous decision-making.<sup>183</sup>

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<sup>176</sup> Shannon 10 and 12.

<sup>177</sup> Beauchamp and Childress 136.

<sup>178</sup> Singh and Ngwena 35-36; Veatch and Haddad 84; Beauchamp and Childress 127.

<sup>179</sup> Beauchamp and Childress 121. Emphasis added. See also O’Neill 2-3.

<sup>180</sup> As explained by Gorovitz ‘Informed Consent’ 185:

‘The right to choose is not limited to the right to choose rightly.’

<sup>181</sup> Veatch and Haddad 87-88.

<sup>182</sup> Beauchamp and Childress 161. See also the discussion in 3.7.1.5 below on the patient’s refusal to be counselled.

<sup>183</sup> Beauchamp and Childress 166.

### (c) Justice

The principle of justice focuses on the idea that patients should be treated equally as well as the notion that limited resources must be distributed fairly.<sup>184</sup> This principle should, for example, influence a pharmacist's decision concerning how much time to spend with different patients.<sup>185</sup>

### (d) Other Relevant Principles

In spite of the prevalence of the four-principle approach to medical ethics, there are two more ethical norms that are often identified as relevant to healthcare settings. The first is fidelity (the keeping of promises). The relationship between healthcare professionals and their patients is one of trust. In light of the nature of this relationship, there is clearly a moral duty upon a professional to be true to his or her word.<sup>186</sup> Veatch and Haddad suggest that, when a relationship is formed between a healthcare professional and a patient, there are certain implied promises that arise from the relationship. This would, for example, include a promise to keep information confidential.<sup>187</sup>

Another important norm is that of veracity (truth-telling<sup>188</sup>). There currently exists no consensus over whether veracity can be regarded as an independent moral principle. Whilst some view it as standing on its own, others argue that it is derived from other principles. The latter view is supported by a number of factors. Firstly, when one lies or withholds the truth from another, one fails to respect that person's autonomy.<sup>189</sup> In

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<sup>184</sup> Hope *at al* 9; Singh and Ngwena 37. For an extensive discussion of justice in healthcare settings see Beauchamp and Childress 326-394.

<sup>185</sup> Justice as an ethical principle is supported by most deontological theories, though not necessarily by consequentialism.

<sup>186</sup> Beauchamp and Childress 430.

<sup>187</sup> Veatch and Haddad 116-117.

<sup>188</sup> In this regard, many draw a distinction between lying (intentionally making statements which one knows to be false) and deception (this includes the making of true, but misleading, statements, the creation of false impressions, and the withholding of information with the effect that the uninformed person is misled) and argue that the former constitutes a more serious moral wrong (Ellin 131-132 and 141-142; see also Jackson and Pirl 13).

<sup>189</sup> See Louwy 74:

'Truth-telling is intimately linked with problems of autonomy. Persons who hold autonomy to be an absolute principle will, under all circumstances, tell their patients the absolute and unvarnished truth.'

See also Weir 212.

particular, there exists a link between veracity and the handling of information that may affect a patient's choices. A second basis for veracity may be an implied promise between persons that the truth will be told. Obligations of veracity may thus emanate from the principle of fidelity. It should, however, be stressed that, even if veracity did not find support in other ethical principles, the duty to tell the truth plays an essential part in maintaining relationships of trust between certain persons, such as healthcare professionals and their patients.<sup>190</sup> Whatever its nature, it is thus clear that veracity plays an important role in medical ethics.

#### (e) Conflicts Between Principles

The fact that healthcare ethics is grounded upon a number of ethical principles means that the potential exists for two or more of these principles to come into conflict.<sup>191</sup> As the pharmacy profession expands to encompass more and more patient-oriented responsibilities, the ethical conflicts encountered by pharmacists inevitably become more frequent.<sup>192</sup>

In particular, conflicts arise when the application of one principle, such as autonomy or veracity, is likely to cause a patient more harm than good, thus contravening the principles of beneficence and nonmaleficence. The situation becomes even more complex when beneficence and nonmaleficence are themselves in conflict. There exists no easy answer to the question of how to resolve these difficulties. A major criticism of deontological theories is that they are often incapable of resolving conflicts between the various duties which they espouse.<sup>193</sup> Whilst consequentialist theories dictate that the morally appropriate course of action is that which brings about the best consequences, it is by no means obvious that this is the best way to approach moral dilemmas.

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<sup>190</sup> Beauchamp and Childress 396-397. See also Jackson and Pirl 9.

<sup>191</sup> Veatch 'Ethical Principles' 18.

<sup>192</sup> Jackson and Pirl 9.

#### 2.3.2.4 Ethical Rules as Found in Professional Statements of Ethical Standards

The principles discussed above are, of course, extremely general in nature and may be difficult to apply to concrete situations. The result is that a more specific, intermediate, set of rules is often used to bridge the gap between abstract ethical principles and specific factual situations.<sup>194</sup> An example would be the rule that healthcare professionals are to maintain patient confidentiality. Particular ethical rules are often found in a profession's statements of ethical standards. Although these classically take the form of codes of ethics, they may be found in other sources, such as oaths and bills of rights.<sup>195</sup>

##### (a) Codes of Ethics

Guidance for members of a particular profession is often provided in a 'code of ethics' which sets the standard of professional conduct to which practitioners are expected to adhere.<sup>196</sup> Such codes recognise that, because of the position of trust that professional people occupy in the community, they are held to a higher degree of conduct than lay people. Professional competence and ethical behaviour form the basis of the trust which society bestows upon professional people. Codes of ethics thus attempt to balance professional interests with the interests of society in general.<sup>197</sup> As such, these codes have been defined as 'the profession's interpretation of the will of Society for the conduct of the members of that profession augmented by the special knowledge which only the members of that profession possess.'<sup>198</sup> From this definition, it is evident that codes of ethics are not static in nature, but adapt in

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<sup>193</sup> Singh and Ngwena 39; Beauchamp and Childress 60-61.

<sup>194</sup> Veatch and Haddad 12. In discussing the distinction between ethical principles and ethical rules, Beauchamp and Childress (38) explain that:

'Both are normative generalisations that guide actions, but ... *rules* are more specific in content and more restricted in scope than principles.'

<sup>195</sup> Veatch 'Codes and Oaths' 1488. In *Jansen van Vuuren v Kruger* 1993 (4) SA 842 (A) 849G-850D, for example, the court referred to both the rules of the South African Medical and Dental Council and the Hippocratic Oath in determining the ethical rules to which physicians are bound.

<sup>196</sup> Dale and Appelbe 217; Raffath 62-63; Smith *et al Pharmacy Ethics* 5. See Veatch and Haddad 32-36 for a discussion of grounding ethics in a professional code of conduct.

<sup>197</sup> Smith *et al Pharmacy Ethics* 20 and 22.

<sup>198</sup> Smith *et al Pharmacy Ethics* 23. See also Giesen 669. Ozar (2159) states the following in this regard:

'[T]he content of the ethic of each profession ... is the content of an ongoing dialogue between the profession as a whole and the larger community within which it practices.'

accordance with changing societal expectations.<sup>199</sup> In this regard, it is particularly significant that the more patient-oriented role that pharmacists have recently begun to play in society is reflected in a number of the professional rules to which contemporary pharmacists are bound.

The development of a code of ethics is usually undertaken by professional associations.<sup>200</sup> A breach of the code may lead to a professional being disciplined by the association in question.<sup>201</sup> Examples of codes developed by pharmaceutical associations are the Code of Ethics and Standards of the Royal Pharmaceutical Society of Great Britain, the Code of Ethics of the American Pharmaceutical Association and the Code of Professional Conduct of the Pharmaceutical Society of Australia.<sup>202</sup> In South Africa, there are a number of documents published by the South African Pharmacy Council which can be regarded as enumerating codes of ethics for pharmacists in this country.

(i) *The Rules Relating to Good Pharmacy Practice in South Africa*<sup>203</sup>

Chapter 1 of the 1997 Rules Relating to Good Pharmacy Practice (which have since been overtaken by the 2004 Rules) dealt with ethics in pharmacy. The chapter laid out a code of ethics which was intended to set the standard of professional conduct for all pharmacists and registered pharmacy support personnel in this country.<sup>204</sup> The specific rules enunciated in the code can be summarised as follows:

- 1) The primary concern of a pharmacist in the performance of his or her duties must be the welfare of the patient and other members of the public;

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<sup>199</sup> Smith *et al Pharmacy Ethics* 27.

<sup>200</sup> Raffath 62; Smith *et al Pharmacy Ethics* 24.

<sup>201</sup> Dale and Appelbe 218.

<sup>202</sup> This code, it may be noted, is adapted from the Royal Pharmaceutical Society of Great Britain Code of Ethics.

<sup>203</sup> Unless otherwise indicated, all references to the Rules Relating to Good Pharmacy Practice are to the 2004 Rules. Although, in this section, the Rules Relating to Good Pharmacy Practice are being discussed as a source of *ethical* rules, it should be noted that good pharmacy practice is also obligatory in terms of s35A of the Pharmacy Act, regulation 20(1) of the Regulations Relating to the Practice of Pharmacy and regulation 7(a) of the Regulations Relating to the Ownership and Licensing of Pharmacies (GNR 553 of 25 April 2003) (both of which are published in terms of the Pharmacy Act), as well as regulation 18(7)(b) of the General Regulations published in terms of the Medicines Act (GNR 510 of 10 April 2003).

<sup>204</sup> 1997 Rules Relating to Good Pharmacy Practice 9.

- 2) Pharmacists must uphold the honour and dignity of the profession and not act in such a way as to bring the profession into disrepute;
- 3) Pharmacists must at all times maintain a high standard of professional conduct—the code set out eight concepts that could be regarded as constituting the core of a pharmacist's professional conduct. One of these was the safeguarding of the physical and mental well-being, the personal rights and the dignity of all patients;
- 4) Pharmacists must respect the confidentiality of information acquired in the course of professional practice;
- 5) Pharmacists must keep abreast of the progress of professional knowledge (ie continuous professional development must be ensured);
- 6) Professional independence and professional judgment must be ensured at all times;
- 7) Although available pharmaceutical services should be publicised, such publicity must not claim any superiority over the services of other pharmacists and must not bring the profession into disrepute;
- 8) The premises upon which a pharmacist conducts business must reflect the professional character of the pharmacy profession; and
- 9) Pharmacists must always endeavour to co-operate with other health care professionals.<sup>205</sup>

The codes of conduct of foreign pharmaceutical associations cover essentially the same issues as those dealt with in the 1997 South African Rules. In particular, concern for the wellbeing of patients and the duties to respect patient dignity and confidentiality and to co-operate with other health care professionals appear in most modern pharmaceutical codes of ethics.<sup>206</sup> The significance of this will be seen in Chapters 3 and 4.

The 2004 Rules relating to Good Pharmacy Practice in South Africa do not include a chapter on pharmacy ethics and in fact make very little explicit reference to ethics. It is, however, significant that the provisions of the 1997 code have not been expunged from the amended rules. Rather than having been listed together and signposted as a

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<sup>205</sup> 1997 Rules Relating to Good Pharmacy Practice Chapter 1.

code of ethics, these principles are found scattered throughout the 2004 Rules.<sup>207</sup> The Good Pharmacy Practice Rules can thus still be used as a means of determining the ethical rules accepted by the South African pharmacy profession.

(ii) *The Code of Conduct for Pharmacists*

In May 2006, the South African Pharmacy Council published for comment the Code of Conduct for Pharmacists and Other Persons Registered in terms of the Pharmacy Act. The document is intended to set the standard of professional conduct for all pharmacists and there is a great deal of overlap between the provisions of the Code and the Rules Relating to Good Pharmacy Practice.<sup>208</sup>

(iii) *The Rules Relating to Acts or Omissions in respect of which the Pharmacy Council may take Disciplinary Steps*

It was indicated above that pharmacists who fail to comply with their profession's accepted standard of behaviour may be disciplined by the profession's disciplinary committee.<sup>209</sup> In South Africa, this disciplinary function is performed by the South African Pharmacy Council. In terms of s41(1) of the Pharmacy Act, the Council has published a set of rules relating to acts or omissions in respect of which it may take disciplinary steps. These are also known as the Pharmacy Council's 'Ethical Rules'. The Rules specify a number of acts and omissions which the Council regards as unethical/unprofessional. These include the failure to furnish information for the safe and effective use of the medicine supplied,<sup>210</sup> the substitution or omission of a prescribed medicine or ingredient without the approval of the prescriber,<sup>211</sup> the failure to co-operate with other members of the healthcare professions in the interests of the patient,<sup>212</sup> the disclosure of confidential information obtained in the course of

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<sup>206</sup> These principles are, for example, found in codes of ethics in both Great Britain and Australia.

<sup>207</sup> Patient confidentiality, for example, is dealt with in rules 2.7.3.6, 2.8.2(j) and 2.9.1(e).

<sup>208</sup> The Code, for example, includes provisions concerning patient welfare, confidentiality and co-operation with other healthcare professionals.

<sup>209</sup> See also Dale and Appelbe 218.

<sup>210</sup> Rule 1.

<sup>211</sup> Rule 2.

<sup>212</sup> Rule 7.

professional activities,<sup>213</sup> and, the failure to observe the provisions of any act, rule or regulation applying to pharmacists.<sup>214</sup>

(iv) *Codes of Ethics for Virtual Pharmacies*

In the chapters that follow, it will be seen that the nature of the Internet is such that it will often be difficult for virtual pharmacies to fulfil their ethical duties. Although Internet pharmacies should be bound by the same professional requirements as their traditional counterparts,<sup>215</sup> it can be noted that, in May 2000, the Internet Healthcare Coalition introduced an International Code of Ethics for healthcare sites and services on the Internet. This 'eHealth Code of Ethics' stresses the ethical importance of, for example, disclosing accurate healthcare information and information concerning the specific site as well as the limitations of online healthcare, being truthful and respecting the privacy of Internet users. It also specifically states that '[p]hysicians, nurses, *pharmacists*, therapists, and all other healthcare professionals who provide specific, personal medical care or advice online should abide by the ethical codes that govern their professions as practitioners in face-to-face relationships.'<sup>216</sup>

(b) Oaths

Members of professions are sometimes required to swear oaths in which they publicly pledge to uphold certain professional responsibilities.<sup>217</sup> Some regard the public taking of an oath as being the very means by which a person becomes a professional and acquires professional obligations.<sup>218</sup> Ozar, however, suggests that a professional oath is merely 'a reminder to those beginning professional practice that important ethical commitments go with it and a public assurance to the larger community by the new practitioners that they understand and accept this reality.'<sup>219</sup>

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<sup>213</sup> Rule 9.

<sup>214</sup> Rule 18. This would, of course, include the failure to act in accordance with the Rules Relating to Good Pharmacy Practice.

<sup>215</sup> Phillips 26-27. See also rule 9 of the Code of Ethics of the Royal Pharmaceutical Society of Great Britain.

<sup>216</sup> eHealth Code of Ethics. Emphasis added.

<sup>217</sup> Veatch 'Codes and Oaths' 1488.

<sup>218</sup> In this regard, it is interesting that the very term 'profession' comes from the Latin word *professio*, which, in turn, is derived from the Greek verb *prophanio*, meaning 'to declare publicly' (Ozar 2158).

<sup>219</sup> See Ozar 2159.

A professional oath, like a code of ethics, is a statement of ethical standards.<sup>220</sup> It follows that the wording of the oath taken by South African pharmacy graduates is another source from which to determine the ethical rules applicable to pharmacists in this country. The promotion of wellbeing, respect for patient confidentiality and co-operation with other healthcare workers so as to achieve the desired therapeutic outcomes are again stressed in this oath.<sup>221</sup>

### (c) Bills of Rights

Statements of ethics sometimes take the form of bills of rights. Within the healthcare context, for example, the publishing of statements of patients' rights is a growing phenomenon. Whilst, with oaths and codes of ethics, the focus has traditionally been on the *duties* of professionals, statements of patients' rights concentrate on the *rights* of those receiving healthcare.<sup>222</sup> An example of such a statement is seen in the Patients' Rights Charter released by the Minister of Health as a common standard for achieving realisation of the constitutional right of access to healthcare in South Africa.<sup>223</sup> Of particular significance to this thesis is the Charter's recognition of the right to have one's confidentiality respected<sup>224</sup> and to be given full and accurate information<sup>225</sup> so as to be able to give informed consent to medical treatment.<sup>226</sup>

## 2.4 Conclusion

It is evident that the traditional role of pharmacists related primarily to pharmaceutical products and their manufacture. The result, as will be seen in Chapter 3, is that the courts have traditionally refused to hold pharmacists liable when a prescription has been accurately filled.<sup>227</sup> The emphasis on patient-oriented practice has, however, drastically increased in recent years.<sup>228</sup> Pharmacists are now educated to be providers

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<sup>220</sup> Veatch 'Codes and Oaths' 1488.

<sup>221</sup> The Pharmaceutical Society of South Africa's 'Pharmacist's Oath'.

<sup>222</sup> Beauchamp and Childress 7-8.

<sup>223</sup> See s27(1)(a) of the Constitution of the Republic of South Africa, 1996.

<sup>224</sup> Section 7 Patients' Rights Charter.

<sup>225</sup> Section 8 Patients' Rights Charter.

<sup>226</sup> See also Smith *et al Pharmacy Ethics* 249-251 for a discussion of the Patients' Bill of Rights of the American Hospital Association and Beauchamp and Walters 141-143 for criticisms of this Bill.

<sup>227</sup> Asbury 909.

<sup>228</sup> Dwyer 726.

of care (rather than merely the providers of a service) and are recognised as having a valuable role to play in guarding against drug-related problems and resolving such problems when they do manifest. In a sense, pharmacists, who began their evolution as apothecaries who prescribed drugs and were extensively involved with patient care, have moved full circle. The question that arises is whether this move towards patient-orientation has exposed pharmacists to increased liability for harm resulting from drug therapy. At the very least, this shift in social function has had an effect on the professional and statutory rules governing the pharmacy profession.

The ethical and statutory rules applicable to pharmacists are relevant insofar as they play a role in determining both the legal duties and the standard of care to which pharmacists are bound. Ethical and statutory rules are, in other words, relevant when it comes to determining whether a particular kind of conduct is a) wrongful and b) negligent. As such, both kinds of rules will be taken into consideration in Chapters 3 and 4, which deal with wrongfulness and fault respectively.

When it comes to the ethical rules applicable to pharmacists, these are rooted in ethical principles which, in turn, find their basis in various ethical theories. This chapter has explored two ethical theories in particular: consequentialist theories and deontological theories. In this regard, it is submitted that no one theory can, or should, be viewed as forming the sole basis of pharmacy ethics. In assessing the ethical nature of an act, it is dangerous to divorce the conduct entirely from its consequences. Nevertheless, it is submitted that an act's consequences cannot be the sole determinant of its morality. Indeed, if this were the case, one would find it difficult to justify the generally accepted principle in medical ethics that the autonomy of all competent patients be respected by healthcare professionals.<sup>229</sup> Rather than being supported by one particular ethical theory, healthcare ethics in general, and pharmacy ethics in particular, are based upon a number of interwoven theories. These, in turn, give rise to various ethical principles. The most important, it is submitted, are the principles of beneficence and autonomy. Although problems will inevitably arise when these two principles come into conflict, it will be seen in the following two

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<sup>229</sup> Though see fn 161 above concerning Mill's support of the principle of autonomy.

chapters that the emphasis that is currently placed on patient autonomy will often mean that this principle trumps that of beneficence.

## CHAPTER 3

### WRONGFULNESS

#### 3.1 Introduction

Before a defendant can be held liable for the loss that his or her conduct has caused the plaintiff, it must be established that the conduct in question was wrongful.<sup>1</sup> The primary purpose of this chapter is to explore the various factual situations in which a pharmacist may be considered to have acted wrongfully. After providing a general discussion of the requirement of wrongfulness, the chapter will focus on instances in which pharmacists are under a legal duty not to harm their patients or third parties. A distinction must, from the outset, be drawn between this kind of duty and the duty that pharmacists have to exercise reasonable care and skill in practising their profession (in particular, their duty to fill a prescription with care).<sup>2</sup> The content of the latter duty forms part of the negligence enquiry which will be discussed in Chapter 4.

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<sup>1</sup> *Knop v Johannesburg City Council* 1995 (2) SA 1 (A) 24D. Wrongfulness is a distinct and fundamental element of delictual liability (*Clarke v Hurst NO and Others* 1992 (4) SA 630 (D) 650J-651A and E). It should not be confused with the issue of fault.

<sup>2</sup> The way in which the idea of a 'legal duty' is formulated is not without controversy. Both Neethling *et al* (56) and Van der Walt and Midgley (par 63) adopt the approach that will be followed in this thesis, stating that a defendant's conduct will be wrongful if it breaches a legal duty *not to cause harm*. Fagan (110-115), however, disagrees with this formulation, and argues that the legal duty in question is a *duty to act without negligence*. There are a number of recent decisions in which the Supreme Court of Appeal has appeared to favour Fagan's interpretation (see, for example, *Trustees, Two Oceans Aquarium Trust v Kantey and Templer (Pty) Ltd* 2006 (3) SA 138 (SCA) pars [10] and [12]; *Minister of Transport v Du Toit* [2006] SCA 40 (RSA) par [3]). It is, however, submitted that this formulation potentially confuses the requirement of wrongfulness with that of fault. In light of the fact that the courts have stressed the importance of avoiding this confusion (*Telematrix (Pty) Ltd t/a Matrix Vehicle Tracking v Advertising Standards Authority SA* 2006 (1) SA 461 (SCA) par [14]; *Steenkamp NO v Provincial Tender Board, Eastern Cape* 2006 (3) SA 151 (SCA) pars [18]-[19]; *Trustees, Two Oceans Aquarium Trust v Kantey and Templer (Pty) Ltd* par [11]), it is submitted that any formulation that defines the test for wrongfulness with reference to negligence should be treated with caution. In this regard, it is also significant that, in its recent decision of *Steenkamp NO v Provincial Tender Board, Eastern Cape* CCT71/05 28 September 2006, the Constitutional Court defined wrongfulness as 'the failure to fulfil a *duty to prevent harm* to another' (par [39], emphasis added). See also fn 74 below.

### 3.2 The Relevance of Harm and Conduct to the Wrongfulness Enquiry

The purpose of the law of delict is essentially to compensate people for loss that they have suffered as a result of another's wrongful conduct. Both conduct (on the part of the defendant) and harm (suffered by the plaintiff) are thus elements that need to be present before delictual liability can arise. Not just any harm will provide the basis for a delictual action.<sup>3</sup> In order for one to have a claim in delict, one must have experienced either patrimonial loss, an infringement of a personality interest or pain and suffering.<sup>4</sup> The existence of a delictual remedy will thus depend not only on *whether* harm has been suffered, but also on the *type* of harm experienced. The nature of harm is also relevant insofar as it determines the nature of the delictual remedy available. Where patrimonial loss<sup>5</sup> has been suffered, the *actio legis Aquiliae* will be available. The violation of a personality interest—such as the right to one's person (*corpus*), dignity (*dignitas*) or reputation (*fama*)<sup>6</sup>—will, on the other hand, lead to a claim under the *actio iniuriarum*, whilst, where harm takes the form of pain and suffering associated with bodily injury to the plaintiff,<sup>7</sup> the Germanic remedy for pain and suffering will be appropriate.<sup>8</sup>

It is apparent that pharmacists are capable of causing various kinds of harm in the course of their activities and that there will consequently be instances in which each

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<sup>3</sup> Harm in the form of inconvenience, disappointment, fear or frustration will not, for example, provide the basis for a delictual claim (*Monumental Art Co v Kenston Pharmacy (Pty) Ltd* 1976 (2) SA 111 (C); *Wynberg Municipality v Dreyer* 1920 AD 439 at 448). Likewise, a husband whose wife has died will not succeed in claiming compensation for the loss of her comfort and society (*Union Government (Minister of Railways and Harbours) v Warneke* 1911 AD 657 at 665). Neethling *et al* (212) explain that one of the possible reasons for this is that only the damage of a person's legally recognised patrimonial and non-patrimonial interests qualifies as harm for delictual purposes. See also Boberg 30.

<sup>4</sup> Van der Walt and Midgley par 36.

<sup>5</sup> Patrimonial loss (*damnum*) occurs where the plaintiff suffers calculable pecuniary loss as a result of a diminution of his or her patrimony (Van der Walt and Midgley par 37).

<sup>6</sup> *Esselen v Argus Printing and Publishing Co Ltd and Others* 1992 (3) SA 764 (T) 770F-G. In the *Esselen* case, Hattingh J described these rights as 'absolute or primordial' and said that they are consequently 'inalienable'.

<sup>7</sup> In *Edouard v Administrator, Natal* 1989 (2) SA 368 (D) 385J, the term 'pain and suffering' was held to embrace physical pain, shock, discomfort, disfigurement and loss of amenities of life. For the Germanic remedy to be available, the pain and suffering must be related to personal injury to the plaintiff (Van der Walt and Midgley par 39). In such a case, damages will be awarded as *solatium* for the pain and suffering of the injured party (*Edouard v Administrator, Natal* 394H).

<sup>8</sup> *Hoffa NO v SA Mutual Fire and General Insurance Co Ltd* 1965 (2) SA 944 (C); *Guardian National Insurance Co Ltd v Van Gool* 1992 (4) SA 61 (A).

one of the abovementioned delictual remedies will be available against a pharmacist. Through, for example, dispensing the incorrect drug, failing to detect a prescription error or failing to provide advice concerning drug use, pharmacists may cause patients to suffer physical harm to their persons, which may lead to both *pain and suffering* and *patrimonial loss* in the form of medical expenses, loss of earning capacity etc. A pharmacist's disclosure of a patient's private information may, on the other hand, infringe the patient's right to privacy, and thus constitute an infringement of a *personality interest*.<sup>9</sup>

In addition to their functions as independent delictual elements, conduct and harm also impact on the wrongfulness requirement. As will be discussed below, there are various forms of conduct (such as omissions<sup>10</sup> and statements<sup>11</sup>) which are considered *prima facie* lawful. The same can be said regarding the kinds of harm that result from the defendant's conduct.<sup>12</sup> Whilst physical harm to person<sup>13</sup> or property<sup>14</sup> is regarded as *prima facie* wrongful,<sup>15</sup> pure economic loss is not.<sup>16</sup>

Pure economic loss is that financial loss which, although caused by the defendant's conduct, does not arise directly from harm to the plaintiff's person or property.<sup>17</sup>

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<sup>9</sup> According to South African courts, the right to privacy is embraced by the concept of *dignitas* (*O'Keeffe v Argus Printing and Publishing Co Ltd* 1954 (3) SA 244 (C) 247F-249D; *Jansen van Vuuren v Kruger* 1993 (4) SA 842 (A) 849E-F). Neethling *et al* (358) do, however, highlight that privacy is recognised as an independent personality right.

<sup>10</sup> See 3.5.3.2(a) below.

<sup>11</sup> See 3.5.3.2(b) below.

<sup>12</sup> Because wrongfulness essentially involves the causing of harm (the question being 'whether the defendant ought reasonably and practically to have prevented harm to the plaintiff'—*Carmichele v Minister of Safety and Security* 2001 (1) SA 489 (SCA) par [7]), it is not only the *conduct* of the defendant that must be scrutinised, but also the *consequences* of such conduct (*Kadir v Minister of Law and Order* 1992 (3) SA 737 (C)).

<sup>13</sup> *Malahe v Minister of Safety and Security* 1999 (1) SA 528 (SCA) 540.

<sup>14</sup> *Knop v Johannesburg City Council* 26E.

<sup>15</sup> See also *Trustees for the Time Being of Two Oceans Aquarium Trust v Kantey and Templer (Pty) Ltd* par [10]; *Minister of Safety and Security v Van Duivenboden* 2002 (6) SA 431 (SCA) par [12].

<sup>16</sup> In *Gouda Boerdery BK v Transnet* 2005 (5) SA 490 (SCA) at par [12], the Supreme Court of Appeal noted:

'[T]he issue of wrongfulness is more often than not uncontentious as the plaintiff's action will be founded upon conduct which, if held to be culpable, would be *prima facie* wrongful. Typically this is so where the negligent conduct takes the form of a positive act which causes physical harm. Where the element of wrongfulness gains importance is in relation to liability for omissions and pure economic loss.'

<sup>17</sup> *Lillicrap, Wassenaar and Partners v Pilkington Bros (SA) (Pty) Ltd* 1985 (1) SA 475 (A) 498D-E. For an illustration of the distinction between physical loss and pure economic loss, see *Spartan Steel and Alloys Ltd v Martin and Co (Contractors) Ltd* [1973] 1 QB 27 (CA); *Shell and BP South Africa Petroleum Refineries (Pty) Ltd and Others v Osborne Panama SA* 1980 (3) SA 653 (D).

While it is possible for the causation of pure economic loss to form the basis of delictual liability,<sup>18</sup> conduct which brings about this form of harm will not be regarded as *prima facie* wrongful. The main reasons for this are the fear of creating indeterminate liability<sup>19</sup> and the belief that the law of delict should be prevented from encroaching into other areas of the law.<sup>20</sup> When a plaintiff claims for pure economic loss, a court will thus have to consider whether it is socially desirable to impose liability on the facts before it.<sup>21</sup> Of particular importance will be whether the loss is finite and the number of potential plaintiffs limited.<sup>22</sup> Whether there are any other legal remedies available to the plaintiff (such as those for breach of contract) will also be an important consideration.<sup>23</sup>

Situations do arise, albeit infrequently, in which the conduct of a pharmacist brings about pure economic loss. An example was seen in *Troppe v Scarf*<sup>24</sup> in which the plaintiffs claimed for the costs of raising an unwanted child who had been conceived after the defendant pharmacist negligently dispensed tranquilisers instead of the prescribed birth control pills.<sup>25</sup> In situations such as this, the loss being claimed is not

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<sup>18</sup> *Administrateur, Natal v Trust Bank van Africa Bpk* 1979 (3) SA 824 (A).

<sup>19</sup> Boberg 104; Van der Walt and Midgley par 68; *Zimbabwe Banking Corporation Ltd v Pyramid Motor Corporation (Pvt)* 1985 (4) SA 553 (ZS) 564C.

<sup>20</sup> In particular, the courts have been reluctant to impose the law of delict within a contractual setting. Thus, in *Lillicrap, Wassenaar and Partners v Pilkington Bros (SA) (Pty) Ltd* the court held that it was undesirable to extend the Aquilian remedy to the duties subsisting between the parties to a contract (see 500F-501B). See also *Trustees, Two Oceans Aquarium Trust v Kantey and Templer (Pty) Ltd* par [24], in which the court went so far as to hold that there was no reason to extend the Aquilian action 'to rescue a plaintiff who was in the position to avoid the risk of harm by contractual means, but who failed to do so.' Where, in other words, the parties have the *ability* to formulate the rights and duties that will govern their relationship, it is inappropriate to allow for a delictual remedy. This is the case regardless of whether the parties did in fact set out the various obligations to which they would be bound. In its recent decision of *Steenkamp NO v Provincial Tender Board, Eastern Cape (SCA)*, the Supreme Court of Appeal again cautioned against allowing the law of delict to seep unnecessarily into other areas of the law (in this case, the field of administrative law).

<sup>21</sup> *Zimbabwe Banking Corporation Ltd v Pyramid Motor Corporation (Pvt) Ltd* 564D.

<sup>22</sup> Boberg 104. For an example of a case in which the provision of a remedy would have created indeterminate liability see *Weller and Co and Another v Foot and Mouth Disease Research Institute* [1966] 1 QB 569.

<sup>23</sup> See fn 20 above and accompanying text.

<sup>24</sup> 187 NW 2d 511 513 (Mich App 1971).

<sup>25</sup> The case, in other words, involved a claim for 'wrongful conception', as opposed to a claim for 'wrongful birth' or 'wrongful life' (see *Mukheiber v Raath and Another* 1999 (3) SA 1965 (SCA) par [1]). The first time that the South African Appellate Division had the opportunity to deal with such an action was in *Administrator, Natal v Edouard* 1990 (3) SA 581 (A). In that case, however, the respondent's claim for damages was based on breach of contract, not delict. Though a delictual action for wrongful conception arose in *Mukheiber v Raath*, the court's main focus in the *Mukheiber* case was on the nature of the defendant's conduct (which took the form of a negligent misstatement) rather than the nature of the plaintiffs' harm (pure economic loss). In neither *Edouard* nor *Mukheiber* was the claim for wrongful conception brought against a pharmacist.

connected to any physical harm.<sup>26</sup> These claims can thus be distinguished from claims for medical expenses, loss of wages etc, which flow from bodily injury of some sort.<sup>27</sup>

Although it is possible for a defendant pharmacist to be held liable when the harm suffered is purely economic, the nature of the plaintiff's loss may militate against the imposition of liability in such instances. Before it will find a defendant liable, a court will, in particular, have to be satisfied that, by affording the plaintiff a remedy, it will not be opening the floodgates to a multitude of potential claims.<sup>28</sup> In the *Troppe* case, the pharmacist was held liable. It is submitted that an application of South African law to the facts of *Troppe* would render a similar result. In particular, it is significant that, in cases of wrongful conception, harm is not suffered by an indeterminate number of people. The imposition of liability is thus unlikely to result in a multitude of claims against the defendant.<sup>29</sup> When, as in most cases of pharmacy malpractice, the plaintiff's harm is physical in nature, it will of course be unnecessary to take such

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<sup>26</sup> According to Tager, pregnancy and childbirth do not constitute physical injury (Tager 297). Note, however, that in *Administrator, Natal v Edouard*, the respondent's claim was not only for pure economic loss. The respondent additionally claimed damages for discomfort, pain and suffering and loss of amenities of life suffered by his wife as a result of the unplanned pregnancy and childbirth. The Appellate Division disposed of this claim on the basis that, in South African law, a breach of contract does not give rise to a claim for non-patrimonial loss. It thus failed to comment on whether harm in the form of pain and suffering was actually present on this set of facts.

<sup>27</sup> Tager 297.

<sup>28</sup> The courts will also, of course, consider whether there are any non-delictual remedies available to the plaintiff.

<sup>29</sup> Although there are a number of policy arguments that can be raised against awarding damages for wrongful conception, these have been rejected by South African courts. In *Administer, Natal v Edouard* 589F-G, for example, the court noted that the majority of objections against this kind of claim constitute mere variations of two basic themes:

'(i) [T]hat the birth of a normal healthy child cannot be treated as a wrong against his parents, and (ii) that as a matter of law the birth of such a child is such a blessed event that the benefits flowing from parenthood as a matter of law cancel or outweigh the financial burden brought about by the obligation to maintain the child.'

As to (i), the court held (at 590E-F) that, in wrongful conception cases, the 'wrong' consists not of the unwanted birth itself, but of the conduct (ie the delict or breach of contract) which led to the birth and the consequent financial loss (this reasoning was endorsed in *Mukheiber v Raath* par [46]). With regard to (ii), it was held (at 591B-592A) that, even if it is accepted that the birth of a child is always a blessed event (this itself being a somewhat dubious premise), this does not mean that parents who, for *socio-economic reasons*, have taken steps to prevent the conception of a child should be burdened with the complete costs of raising the child should the birth be the result of another's negligent conduct. In *Mukheiber v Raath* 1081E-F, the Supreme Court of Appeal subsequently held that a claim for wrongful conception should be available *regardless* of the parent(s)' motive for not wanting to conceive.

Other objections to the award of damages for wrongful conception include that it is undesirable for a child to learn that his or her birth resulted in an award of damages and that an award of damages interferes with the sanctity of the relationship between parent and child by transferring a parent's duty to maintain his or her child to someone else. Such arguments have similarly been disposed of by the courts (see *Administer, Natal v Edouard* 592B-593D).

factors into consideration as the defendant's actions will be regarded as *prima facie* wrongful.

### 3.3 The Reasonableness Criterion

Wrongfulness is established through an application of the general criterion of reasonableness<sup>30</sup> ('algemene redelikhedsmaatstaf'<sup>31</sup>) which takes into account the *boni mores* and legal convictions of the community as assessed by the court.<sup>32</sup> The decision essentially involves a value judgment which has regard to all the circumstances of the case<sup>33</sup> as well as considerations of policy.<sup>34</sup> The court must balance the interests of the parties concerned<sup>35</sup> in a socially acceptable (ie reasonable) manner<sup>36</sup> and must be sure to consider the consequences of recognising or denying liability in a given case.<sup>37</sup>

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<sup>30</sup> Even those courts which have formulated the concept of a legal duty as a duty not to act negligently (see fn 2 above) have held that the enquiry into wrongfulness is one which 'concerns the reasonableness of imposing liability on the defendant' and have stressed that reasonableness in this context differs from reasonableness as an element of the negligence enquiry (*Trustees, Two Oceans Aquarium Trust v Kantey and Templer (Pty) Ltd* par [11]).

<sup>31</sup> *Marais v Richard* 1981 (1) SA 1157 (A) 1168C-E. See also *Ramsay v Minister van Polisie en Andere* 1981 (4) SA 802 (A) 811A.

<sup>32</sup> *Financial Mail (Pty) Ltd v Sage Holdings Ltd* 1993 (2) SA 451 (A) 462F-G:

'[I]n demarcating the boundary between lawfulness and unlawfulness in this field, the Court must have regard to the particular facts of the case and judge them in the light of contemporary *boni mores* and the general sense of justice in the community as perceived by the court.'

See also *Knop v Johannesburg City Council* 24I and 27I; *Natal Fresh Produce Growers' Association v Agroserve (Pty) Ltd* 1990 (4) SA 749 (N) 753I; *Carmichele v Minister of Safety and Security* par [7]; *SM Goldstein and Co (Pty) Ltd v Cathkin Park Hotel (Pty) Ltd* 2000 (4) SA 1019 (SCA) par [7]; *Olitzki Property Holdings v State Tender Board and Another* 2001 (3) SA 1247 (SCA) par [11]; *Van Eeden v Minister of Safety and Security* 2003 (1) SA 389 (SCA) par [9]; *Cape Town Municipality v Bakkerud* 2000 (3) SA 1049 (SCA) par [14]; *Clarke v Hurst NO* 651I and 653B; *Trope v South African Reserve Bank and Another* 1992 (3) SA 208 (T) 214C-E; *Trustees, Two Oceans Aquarium Trust v Kantey and Templer (Pty) Ltd* par [12].

<sup>33</sup> *Indac Electronics (Pty) Ltd v Volkskas Bank Ltd* 1992 (1) SA 783 (A) 797F; *SM Goldstein and Co (Pty) Ltd v Cathkin Park Hotel (Pty) Ltd* par [7]; *Van Eeden v Minister of Safety and Security* par [9].

<sup>34</sup> *Indac Electronics (Pty) Ltd v Volkskas Bank Ltd*; *Natal Fresh Produce Growers' Association v Agroserve (Pty) Ltd* 753J; *Trope v South African Reserve Bank* 214B-D; *Lillicrap, Wassenaar and Partners v Pilkington Brothers (SA) (Pty) Ltd* 498H; *SM Goldstein and Co (Pty) Ltd v Cathkin Park Hotel (Pty) Ltd* par [7]; *Olitzki Property Holdings v State Tender Board* par [11]; *Van Eeden v Minister of Safety and Security* par [9]; *Steenkamp NO v Provincial Tender Board, Eastern Cape* (CC) par [41].

<sup>35</sup> *Financial Mail (Pty) Ltd v Sage Holdings Ltd* 462H; *Coronation Brick (Pty) Ltd v Strachan Construction Co (Pty) Ltd* 1982 (4) SA 371 (D) 384E.

<sup>36</sup> Boberg 33.

<sup>37</sup> *Natal Fresh Produce Growers' Association v Agroserve (Pty) Ltd* 753J-754A; *Minister of Law and Order v Kadir* 1995 (1) SA 303 (A) 318E-H; *Coronation Brick (Pty) Ltd v Strachan Construction Co (Pty) Ltd* 384E.

In light of the importance which the legal convictions of the community play in the wrongfulness enquiry, it must be remembered that society's legal convictions do not remain stagnant, but are in a constant state of flux.<sup>38</sup> It follows that wrongfulness should not be regarded as a requirement characterised by rigidity, but should rather be considered an inherently open-ended and flexible concept.<sup>39</sup> As discussed in the previous chapter, the role that pharmacists play in society has experienced drastic change in recent years. One effect of this change may well be that conduct previously considered reasonable will now be regarded as wrongful<sup>40</sup> and that pharmacists are consequently exposed to greater liability than they were in the past.

### 3.4 Scope of Liability

In foreign jurisdictions,<sup>41</sup> courts have been very hesitant to place duties on pharmacists to do anything more than accurately fill prescriptions.<sup>42</sup> It must thus be asked whether plaintiffs in South Africa are likely to be met with similar reluctance. South African courts have, in a number of decisions, highlighted the conservative approach that our judiciary adopts concerning the extension of liability under the *lex Aquilia*. In *Lillicrap, Wassenaar and Partners v Pilkington Brothers (SA) (Pty) Ltd*,<sup>43</sup> for example, the Appellate Division stated that South African courts are only prepared to extend the scope of the Aquilian action to new situations where 'there are positive policy considerations which favour such an extension.'<sup>44</sup> It must, however, be remembered that the *Lillicrap* decision was one which concerned the extension of delictual liability for pure economic loss which, as explained above, is *prima facie* lawful. In the vast majority of pharmacy malpractice cases, the plaintiff's harm is likely to be physical in nature, and thus *prima facie* wrongful. If this is the case, it is

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<sup>38</sup> *Cape Town Municipality v Bakkerud* par [14]. See also *Amod v Multilateral Motor Vehicle Accidents Fund (Commission for Gender Equality Intervening)* 1999 (4) SA 1319 (SCA) par [23]; *Ries v Boland Bank PKS Ltd and Another* 2000 (4) SA 955 (C) 968G-H.

<sup>39</sup> *Van Eeden v Minister of Safety and Security* par [11].

<sup>40</sup> The corollary of this is, of course, that, because of pharmacists' change of role, it is possible that conduct previously considered wrongful may now be regarded as reasonable.

<sup>41</sup> Most notably, the United States.

<sup>42</sup> *Brushwood Drake LR 2*.

<sup>43</sup> 1985 (1) SA 475 (A).

<sup>44</sup> *Lillicrap, Wassenaar and Partners v Pilkington Bros (SA) (Pty) Ltd* 504G. See also *Trustees, Two Oceans Aquarium Trust v Kantey and Templer (Pty) Ltd* par [12]; *Natal Fresh Produce Growers' Association v Agroserve (Pty) Ltd* 754B-C; *Macadamia Finance Ltd v De Wet* 1991 (4) SA 273 (T) 278.

submitted that the courts will be far less tentative in concluding that it is reasonable to impose liability upon the defendant pharmacist.

Even when arguing for increased liability, it is important to be aware of the dangers that accompany unlimited expansion. A distinction must be drawn between realistic and unrealistic expectations towards pharmacists so as not to place an unreasonable burden upon them.<sup>45</sup> Although it is important for the law to evolve so as to reflect the role that pharmacists currently play in society, courts should also be careful to ensure that the new legal responsibilities imposed on pharmacists do not exceed the expectations which society *actually* places upon them.<sup>46</sup>

### 3.5 The Rights-Based and Duty-Based Approaches to Wrongfulness

#### 3.5.1 The Relevance of Rights and Duties to the Wrongfulness Enquiry

A framework for the wrongfulness enquiry is provided by the concepts of rights and duties.<sup>47</sup> It is thus sometimes said that conduct is wrongful where it either:

- a) infringes a legally-recognised right of the plaintiff, or
- b) breaches a legal duty owed by the defendant.<sup>48</sup>

Regardless of the route that one follows, the real enquiry remains whether the defendant's conduct is legally acceptable or legally reprehensible. One's conclusion, whether it follows a rights-based enquiry or a duty-based one, will thus be reached through an appeal to the legal convictions of the community.<sup>49</sup> The application of either approach should, in other words, arrive at the same criterion for unlawfulness.<sup>50</sup> In spite of this, there are some situations in which it is convenient to question whether the defendant had a *duty* to act, and others in which an enquiry into the plaintiff's

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<sup>45</sup> Brushwood *Drake LR* 4-5.

<sup>46</sup> Gonzalez 54.

<sup>47</sup> Van der Walt and Midgley par 60.

<sup>48</sup> *Ibid.*

<sup>49</sup> See discussion in 3.5.2 and 3.5.3.1 below.

<sup>50</sup> *Coronation Brick (Pty) Ltd v Stachan Construction Co (Pty) Ltd* 380B.

*rights* is more appropriate. For this reason, it is necessary to consider each approach in greater detail.

### 3.5.2 Infringement of a Legally-Recognised Right

Where a subjective right of the plaintiff has been infringed, the defendant's conduct may be considered wrongful.<sup>51</sup> There are various categories of subjective rights, one of which is personality rights—ie rights that have as their objects aspects of personality.<sup>52</sup> Conduct infringes a subjective right when it 'unjustifiably disturbs or interferes with the holder's capacities of disposal, use and enjoyment in regard to the object of the right.'<sup>53</sup> The question of whether a specific interference is unjustifiable is answered by an application of the *boni mores*/legal convictions of the community.<sup>54</sup>

One example of a personality right is the right to physical integrity.<sup>55</sup> This right will be infringed when a pharmacist unjustifiably causes a patient physical harm. Another is the right to privacy (which is generally regarded as forming part of a person's *dignitas*<sup>56</sup>). In South Africa, the right to privacy is currently afforded protection by s14 of the Constitution,<sup>57</sup> although the right has long been recognised at common law.<sup>58</sup> In its most comprehensive interpretation of this right to date,<sup>59</sup> *Bernstein v Bester*,<sup>60</sup> the Constitutional Court held that the right protects the 'inner sanctum' of a person's life from erosion by conflicting rights of the community.<sup>61</sup> It characterised the right to privacy as existing on a continuum and becoming more attenuated the

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<sup>51</sup>The doctrine of subjective rights was accepted in *Universiteit van Pretoria v Tommie Meyer Films (Edms) Bpk* 1977 (4) SA 376 (T).

<sup>52</sup> Classification by Joubert (quoted in *Universiteit van Pretoria v Tommie Meyer Films (Edms) Bpk* 382H-383C).

<sup>53</sup> *Clarke v Hurst NO* 651G-H.

<sup>54</sup> *Clarke v Hurst NO* 651H; *Universiteit van Pretoria v Tommie Meyer Films (Edms) Bpk* 387C.

<sup>55</sup> See *Whittaker v Roos and Bateman*; *Morant v Roos and Bateman* 1912 AD 92 at 122.

<sup>56</sup> See fn 9 above.

<sup>57</sup> Section 14 provides:

- 'Everyone has the right to privacy, which includes the right not to have –
- (a) their person or home searched;
  - (b) their property searched;
  - (c) their possessions seized; or
  - (d) the privacy of their communications infringed.'

<sup>58</sup> *Currie and De Waal* 316.

<sup>59</sup> *Currie and De Waal* 317.

<sup>60</sup> 1996 (4) BCLR 449 (CC).

<sup>61</sup> *Bernstein v Bester* par [67].

more a person relates with the world.<sup>62</sup> Privacy can similarly be described by employing the imagery of concentric spheres. In this regard, Beauchamp and Walter explain that patients, in disclosing personal information about their bodies and minds to healthcare professionals, admit the professionals into the inner sphere (or, in the words of the Constitutional Court, 'inner sanctum') of their lives.<sup>63</sup>

The scope of the right to privacy was explained slightly differently by Langa DP in *Investigating Directorate: Serious Economic Offences and Others v Hyundai Motor Distributors (Pty) Ltd and Others: In re Hyundai Motor Distributors (Pty) Ltd and Others v Smit NO and Others*.<sup>64</sup> 'Wherever a person has the ability to decide what he or she wishes to disclose to the public and the expectation that such a decision will be respected is reasonable, the right to privacy will come into play.'<sup>65</sup> In *Financial Mail (Pty) Ltd v Sage Holdings Ltd*,<sup>66</sup> the Appellate Division identified two forms of invasion of privacy:

- a) the unlawful<sup>67</sup> intrusion upon the privacy of another, and
- b) the unlawful publication of private facts<sup>68</sup> about another.<sup>69</sup>

An example of the latter form of invasion which has been recognised at common law is the disclosure of private facts about another contrary to the existence of a confidential relationship.<sup>70</sup> This kind of infringement of the right to privacy will be

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<sup>62</sup> *Investigating Directorate: Serious Economic Offences and Others v Hyundai Motor Distributors (Pty) Ltd and Others: In re Hyundai Motor Distributors (Pty) Ltd and Others v Smit NO and Others* 2001 (1) SA 545 (CC).

<sup>63</sup> Beauchamp and Walters 171.

<sup>64</sup> 2001 (1) SA 545 (CC).

<sup>65</sup> *Investigating Directorate: SEO v Hyundai Motor Distributors (Pty) Ltd* par [16]. This approach is similar that taken in the United States and Canada (see *Bernstein v Bester* pars [75]-[76]). As indicated in *Bernstein*, an expectation of privacy will be more likely to be considered reasonable in the personal sphere of one's life. This is, however, not to say that it will never be reasonable to harbour an expectation of privacy with regard to activities falling outside the personal sphere.

<sup>66</sup> 1993 (2) SA 451 (A).

<sup>67</sup> Although an invasion of individual privacy is *prima facie* unlawful (*Protea Technology Ltd and Another v Wainer and Others* [1997] 3 All SA 594 (W) 610G), not all invasions of privacy will in fact be unlawful (*Financial Mail (Pty) Ltd v Sage Holdings Ltd* 462F).

<sup>68</sup> If others are already aware of the facts, the disclosure will not constitute an invasion of privacy (Van der Walt and Midgley par 81).

<sup>69</sup> *Financial Mail (Pty) Ltd v Sage Holdings Ltd* 462E-F.

<sup>70</sup> *Bernstein v Bester* par [69]. See also *Jansen van Vuuren v Kruger* (doctor-patient relationship); *O v O* 1995 (4) SA 482 (W) (religious adviser-church member); *Swanepoel v Minister van Veiligheid en Sekuriteit* 1999 (4) SA 549 (T) (police-informant).

explored in greater depth during the discussion of the pharmacist's duty of confidentiality.<sup>71</sup>

### 3.5.3 Breach of a Legal Duty

#### 3.5.3.1 General

As has been noted, the rights-based approach is merely one method of determining wrongfulness.<sup>72</sup> There are circumstances in which it is more appropriate to deal with the wrongfulness enquiry by establishing whether a legal duty has been breached. A legal duty can be defined as a duty to avoid or, in the case of omissions, to prevent injury to the plaintiff (ie a duty not to harm the plaintiff, or to prevent harm to the plaintiff, as the case may be<sup>73</sup>).<sup>74</sup> The question of whether there is a legal duty to prevent loss is a conclusion of law<sup>75</sup> which depends on a value judgment as to whether the plaintiff's interest is worthy of protection against interference by the defendant.<sup>76</sup> The decision is again one based on reasonableness, which takes into account considerations of policy and the legal convictions of the community.<sup>77</sup>

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<sup>71</sup> See 3.7.3.3 below.

<sup>72</sup> Neethling *et al* 55-56.

<sup>73</sup> Upon these formulations, it is seen that a legal duty is essentially a legal expression of the moral principles of nonmaleficence and beneficence. See 2.3.2.3(a) above.

<sup>74</sup> When exploring the common law duties pertaining to pharmacists, and especially when consulting foreign authorities with regard to pharmacists' liability, one must be aware of the distinction between the legal duty approach (which is followed in South Africa) and the English duty of care doctrine (in which the tort law of many countries is based).

There are two elements of a duty of care, namely: the duty issue and the negligence issue (*Administrateur, Natal v Trust Bank van Afrika* 833D). When applying this approach, one initially determines the existence of a duty of care by considering whether a reasonable person would foresee the possibility of harm to the plaintiff and take precautionary measures to prevent it (*Peri-Urban Areas Health Board v Munarin* 1965 (3) SA 367 (A) 373F-G; *Langley Fox Building Partnership (Pty) Ltd v De Valence* 1991 (1) SA 10 (A) 12H-I). Once the existence of a duty of care has been established, the defendant's behaviour is measured against the particular content of the duty which is determined by postulating what the actual behaviour of, and care taken by, a reasonable person in the position of the defendant would have been (Van der Walt and Midgley par 64). The court, in other words, considers whether the defendant exercised the same standard of care that a reasonable person would have in the same circumstances (Neethling *et al* 149).

It is clear that the duty of care approach collapses the fault and wrongfulness enquiries into one. The question of whether a *legal duty* is present is, on the other hand, quite distinct from the negligence enquiry (see *Minister of Safety and Security v Van Duivenboden* par [12; *Gouda Boerdery Bk v Transnet* par [12]). In establishing a legal duty, the foreseeability of harm is a relevant consideration. Foreseeability of harm is not, however, the *only* relevant factor in this enquiry (see 3.5.4 below; see also *Steenkamp NO v Provincial Tender Board, Eastern Cape* (SCA) par [18] and (CC) par [42]).

<sup>75</sup> *Knop v Johannesburg City Council* 27F-G.

<sup>76</sup> *Olitzki Property Holdings v State Tender Board* par [11].

<sup>77</sup> *Ibid.*

### 3.5.3.2 Situations in which it is Convenient to Use the Duty-Based Approach in Determining Wrongfulness

#### (a) Omissions

In *Sea Harvest Corporation v Duncan Dock Cold Storage*,<sup>78</sup> Scott JA said the following with regard to omissions:

'It is essentially in relation to liability for omissions and pure economic loss that the element of wrongfulness gains importance. Liability for omissions has been a source of judicial uncertainty since Roman times. The underlying difficulty arises from the notion that, while one must not cause harm to another, one is generally speaking entitled in law to mind one's own business ... the question that has to be answered is whether in all the circumstances the omission can be said to have been wrongful or, as it is sometimes stated, whether there existed a legal duty to act. ... To find the answer the Court is obliged to make what in effect is a value judgment based, *inter alia*, on its perceptions of the legal convictions of the community and on considerations of policy.'<sup>79</sup>

Conduct in the form of an omission is *prima facie* lawful.<sup>80</sup> An omission will thus only be wrongful if the defendant is under a legal duty to act positively yet fails to discharge this duty.<sup>81</sup> The question is whether it is reasonable to expect the defendant to have taken positive measures to prevent the harm to the plaintiff.<sup>82</sup> The determining factor is thus again that of reasonableness, as determined by the legal convictions of the community<sup>83</sup> (and not merely the moral indignation which the omission invokes<sup>84</sup>). The mere fact that a defendant is able to both foresee and prevent harm to

<sup>78</sup> 2000 (1) SA 827 (SCA).

<sup>79</sup> 2000 (1) SA 827 (SCA) par [19]. See also *Cape Town Municipality v Bakkerud* par [1]; *Silva's Fishing Corporation (Pty) Ltd v Maweza* 1957 (2) SA 256 (A) 261C-D; *Minister of Safety and Security v Van Duivenboden* par [12].

<sup>80</sup> *Minister of Safety and Security v Van Duivenboden* par [12].

<sup>81</sup> *Van Eeden v Minister of Safety and Security* par [9]; *Moses v Minister of Safety and Security* 2000 (3) SA 106 (C) 113G-I. Legal duties to act positively so as to prevent the plaintiff from suffering harm give effect to the ethical principle of beneficence. In light of the fact that, in general, there does not even exist a *moral* duty to act for the benefit of others (see discussion in 2.3.2.3(a) above), it is not surprising that a *legal* duty to act positively will only exist in exceptional circumstances.

<sup>82</sup> *Carmichele v Minister of Safety and Security* par [7]; *Van Eeden v Minister of Safety and Security* par [9].

<sup>83</sup> The 'regsoortuiging van die gemeenskap' (*Minister van Polisie v Ewels* 1975 (3) SA 590 (A) 597A-B). See also Corbett 57.

<sup>84</sup> In *Clarke v Hurst NO* 652G, the court noted that society's *legal* convictions must be distinguished from its *moral* convictions. Morality does, however, inevitably play a role in shaping the legal convictions of a particular society. This has led Boberg (266) to comment that the distinction between



the plaintiff will be insufficient to create a legal duty as foreseeability and preventability are the prerequisites of *fault*, not wrongfulness.<sup>85</sup>

There are certain factors the presence of which may justify a court in imposing liability for an omission.<sup>86</sup> One such factor is the defendant's control of a potentially dangerous thing.<sup>87</sup> The fact that one controls something that is potentially dangerous usually places one under an obligation to take positive steps to prevent the danger from arising.<sup>88</sup> In this regard, it is significant that pharmacists, by the very nature of their profession, are in charge of substances that are potentially dangerous. The American Restatement of Torts goes so far as to afford drugs special status as 'unavoidably unsafe' products.<sup>89</sup> As such, pharmacists may well be under a legal duty to take positive steps to ensure that drug use is as safe as possible.

#### (b) Statements

The defendant's conduct may take the form of a statement (eg where a pharmacist provides a patient with either written or verbal information concerning drugs and drug use). A statement that is inaccurate constitutes a misrepresentation. Although it has been recognised that a misrepresentation may impose delictual liability,<sup>90</sup> such conduct is not considered *prima facie* wrongful.<sup>91</sup> In

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the legal and the moral convictions of the community is 'a tenuous one in practice'. See also *Coronation Brick (Pty) Ltd v Strachan Construction Co (Pty) Ltd* 384D; *Cape Town Municipality v Bakkerud* par [14]; *Minister of Law and Order v Kadir* 320B-C.

<sup>85</sup> Boberg 211.

<sup>86</sup> Boberg argues that these established categories of liability do not merely constitute guidelines but should be regarded as 'crystallised instances where it has been authoritatively decided that an omission is unreasonable and hence wrongful, so that it is no longer open to the court to hold otherwise' (Boberg 267). Van der Walt and Midgley (par 65), on the other hand, submit that, although the presence of any of these factors will *influence* a court's decision as to wrongfulness, none of them constitutes an overriding factor in the wrongfulness enquiry.

<sup>87</sup> See *Graham v Cape Metropolitan Council* 1999 (3) SA 356 (C) 370B-C; *Faiga v Body Corporate of Dumbarton Oaks and Another* 1997 (2) SA 651 (W) 66C-E; *Administrateur, Transvaal v Van der Merwe* 1994 (4) SA 347 (A) 360E-G.

<sup>88</sup> Van der Walt and Midgley par 65.

<sup>89</sup> See *Brushwood and Lively* 30.

<sup>90</sup> *Administrateur, Natal v Trust Bank van Afrika Bpk; Bayer South Africa (Pty) Ltd v Frost* 1991 (4) SA 559 (A). These cases involved *negligent* misrepresentations. See comments below concerning the relevance of the distinction between negligent and fraudulent misrepresentations in the law of delict.

<sup>91</sup> Van der Walt and Midgley par 66. It is, however, significant that the harm caused by a pharmacist's misstatements is likely to be physical in nature and that conduct that causes physical harm is *prima facie* wrongful. In such instances, the nature of the plaintiff's harm will thus have to be weighed against the nature of the defendant's conduct in establishing wrongfulness. This issue is explored in greater depth in 3.7.2.1 below.

the leading decision *Administrateur, Natal v Trust Bank van Afrika Bpk*<sup>92</sup> the Appellate Division held that, even though a misstatement may form the basis of a delictual action, it is important that the danger of limitless liability<sup>93</sup> is avoided by asking whether, on the facts, the defendant is under a legal duty not to make a misstatement to the plaintiff.<sup>94</sup> Even if a legal duty is present, the duty will not be absolute in nature, but will merely require that the defendant take reasonable care to ensure the accuracy of the statement before making it.<sup>95</sup>

In establishing the existence of such a duty, there are a number of factors which may be relevant: the nature of the harm caused by the statement, the purpose of the statement and the defendant's knowledge thereof;<sup>96</sup> whether any steps were taken to ensure the accuracy of the statement;<sup>97</sup> whether the statement related to technical matters about which the plaintiff would be ignorant,<sup>98</sup> but the defendant would be knowledgeable;<sup>99</sup> the nature of the relationship between the parties;<sup>100</sup> the context within which the statement was made;<sup>101</sup> and, whether the defendant was aware (or ought reasonably have been aware) that the plaintiff would place reliance on the statement and that the plaintiff could suffer serious harm if the statement was incorrect.<sup>102</sup> Another important consideration is whether the misstatement was

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<sup>92</sup> 1979 (3) SA 824 (A).

<sup>93</sup> The nature of statements is such that they have the ability to travel much faster and further than actions, thereby resulting in indeterminate liability (Boberg 58; see also Hutchison 524-531).

<sup>94</sup> *Administrateur, Natal v Trust Bank van Afrika Bpk* 832H-833B. See also *Bayer SA (Pty) Ltd v Frost* 568B-E; *Siman and Co (Pty) Ltd v Barclays National Bank Ltd* 904E-F. In *Mukheiber v Raath* 1070C the court emphasised the importance that public policy plays in this enquiry. See also Corbett 59:

'[T]he law must keep in step with the attitudes of society and consider whether on the particular facts society would require the imposition of liability.'

<sup>95</sup> Corbett 59. See also *Bayer v Frost* 574J.

<sup>96</sup> *Standard Chartered Bank of Canada v Nedperm Bank Ltd* 1994 (4) SA 747 (A) 770E-F.

<sup>97</sup> Van der Walt and Midgley par 66.

<sup>98</sup> Is the nature of the statement (*Standard Chartered Bank of Canada v Nedperm Bank Ltd* 770C-D).

<sup>99</sup> *Bayer v Frost SA (Pty) Ltd* 575C-D; *Mukheiber v Raath* par [28]; *Siman and Co (Pty) Ltd v Barclays National Bank Ltd* 913H.

<sup>100</sup> *Bayer SA (Pty) Ltd v Frost* 575A; *Mukheiber v Raath* par [28]; *Aucamp and Others v University of Stellenbosch* 2002 (4) SA 544 (C) par [70]; *Siman and Co (Pty) Ltd v Barclays National Bank Ltd* 913H; *Standard Chartered Bank of Canada v Nedperm Bank Ltd* 770H-I.

<sup>101</sup> *Siman and Co (Pty) Ltd v Barclays National Bank Ltd* 913H; *Standard Chartered Bank of Canada v Nedperm Bank Ltd* 770B.

<sup>102</sup> *Bayer v Frost* 575B-D; *Mukheiber v Raath* par [28]; *Aucamp v University of Stellenbosch* par [70]; *Siman v Barclays National Bank* 915A; *Standard Chartered Bank of Canada v Nedperm Bank Ltd* 770G.

negligent or intentional.<sup>103</sup> In the absence of a recognised defence, a defendant who makes a statement with the intention to injure will automatically incur liability.<sup>104</sup>

Whilst misrepresentations are usually made by positive conduct in the form of statements, it is significant that they may also be made by omissions in the form of silence or non-disclosure.<sup>105</sup> Where this is the case, the usual principles concerning omissions are applied<sup>106</sup> and the defendant's silence will only be wrongful if there exists a duty to act positively by speaking.<sup>107</sup>

### 3.5.4 Factors Relevant in Establishing Wrongfulness

#### 3.5.4.1 General

It is not possible to lay down concrete rules for establishing the presence of wrongfulness in particular situations. Nevertheless, the courts have provided certain *guidelines* which may assist in determining whether a defendant's conduct was wrongful.<sup>108</sup> Thus, in reaching its conclusion, a court should have regard, *inter alia*, to the probable or possible extent of foreseeable harm; the degree of risk that such harm would be suffered as a result of the defendant's conduct; whether reasonably practicable measures to avert the loss were available to the defendant; the chances of such measures being successful; and, whether the cost of the preventative measures would have been reasonably proportionate to the loss which the plaintiff could have suffered as a result of the defendant's conduct.<sup>109</sup> Also of importance is the relationship between the parties;<sup>110</sup> any expert knowledge or special skills on the part

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<sup>103</sup> Van der Walt and Midgley par 66.

<sup>104</sup> *Boswell v Minister of Police* 1978 (3) SA 268 (E) 273H-275A.

<sup>105</sup> The withholding of information may result in the creation of a false impression.

<sup>106</sup> See discussion on omissions in 3.5.3.2(a) above.

<sup>107</sup> *McCann v Goodall Group Operations (Pty) Ltd* 1995 (2) SA 718 (C) 723C-725G and 726B-D. See the discussion of the pharmacist's duty to warn in 3.7.1 below.

<sup>108</sup> *Coronation Brick (Pty) Ltd v Strachan Construction Co (Pty) Ltd* 384 C-D.

<sup>109</sup> *Coronation Brick (Pty) Ltd v Strachan Construction Co (Pty) Ltd* 384F-G. See also *Mpongwana v Minister of Safety and Security* 1999 (2) SA 794 (C) 803I-J (nature and extent of harm); *Franschhoekse Wynkelder (Ko-operatief) Bpk v SAR and H* 1981 (3) SA 36 (C) 41C (degree of risk that harm will materialise); *Van Eeden v Minister of Safety and Security* par [24] (availability of protective measures and likelihood of their success).

<sup>110</sup> *Siman and Co (Pty) Ltd v Barclays National Bank Ltd* 913H. But see *Van Eeden v Minister of Safety and Security* par [23] in which it was held that a special relationship between the parties is not an absolute prerequisite for the existence of a legal duty.

of the defendant;<sup>111</sup> whether there are any other practical and effective remedies available to the plaintiff;<sup>112</sup> whether the loss is finite and the potential plaintiffs are identifiable and limited in number;<sup>113</sup> the values of the Constitution;<sup>114</sup> the origin of the duty (eg statute); the nature of the fault; considerations of convenience;<sup>115</sup> and, whether there are any general considerations of public policy and fairness that favour denial of a remedy.<sup>116</sup>

#### 3.5.4.2 Breach of a Statutory Duty

Statutes may be relevant for the purposes of establishing delictual liability in two instances:

- a) the statute itself may confer a right of action, or
- b) the statute may provide the basis for inferring that a legal duty exists at common law.<sup>117</sup>

In either case, a process of statutory interpretation will be necessary.<sup>118</sup> The particular statute must be interpreted in order to establish whether it was intended to provide a civil remedy.<sup>119</sup> It must be considered as a whole, with attention being given to 'its objects and provisions, the circumstances in which it was enacted, and the kind of mischief it was designed to prevent.'<sup>120</sup> The fact that a statute fails to expressly confer

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<sup>111</sup> *Zimbabwe Banking Corporation Ltd v Pyramid Motor Corporation (Pvt) 564F; Siman and Co (Pty) Ltd v Barclays National Bank Ltd 913H.*

<sup>112</sup> *Van Eeden v Minister of Safety and Security* par [19].

<sup>113</sup> *Zimbabwe Banking Corporation Ltd v Pyramid Motor Corporation (Pvt) 564E.*

<sup>114</sup> *Van Eeden v Minister of Safety and Security* par [12]-[13].

<sup>115</sup> *Van der Walt and Midgley* par 63.

<sup>116</sup> *Siman and Co (Pty) Ltd v Barclays National Bank Ltd 914B.*

<sup>117</sup> *Olitzki Property Holdings v State Tender Board* par [12]. See also *Steenkamp NO v Provincial Tender Board, Eastern Cape (SCA)* par [19].

<sup>118</sup> *Olitzki Property Holdings v State Tender Board* par [12]; *Steenkamp NO v Provincial Tender Board, Eastern Cape (SCA)* par [20]:

'A statutory and a common-law duty may, in a given case, overlap. If the legal duty invoked is imposed by a statutory provision the focal question is one of statutory interpretation: does the statute confer a right of action or provide the basis for inferring that a legal duty exists at common law?'

<sup>119</sup> *Knop v Johannesburg City Council 28C and 31D; Olitzki Property Holdings v State Tender Board* par [12]; *Da Silva and Another v Coutinho 1971 (3) SA 123 (A) 134H-135A.*

<sup>120</sup> *Olitzki Property Holdings v State Tender Board* par [12]. See also *Knop v Johannesburg City Council 28C-D.*

a damages remedy does not mean that such a remedy was not intended.<sup>121</sup> If, on the other hand, the statute has provided for some other means by which aggrieved parties can obtain relief, it can usually be implied that the legislature did not intend to confer a civil right of action.<sup>122</sup> The remedies provided by the current pharmacy legislation will be discussed at the end of this section.

In the United States, courts have been reluctant to find pharmacists liable on the basis of statutory duties alone. It is frequently reasoned that the statute in question was not intended to create civil remedies. It has, for example, been held that statutory provisions concerning pharmaceutical care are intended merely to *regulate* pharmacists and not to create private causes of action.<sup>123</sup> Similar arguments, it is submitted, can be levelled against the South African legislation pertaining to pharmacists. The primary function of the existing statutory framework does appear to be the regulation of pharmacy practice in general, and, more specifically, the regulation of the purchase and sale of medications.<sup>124</sup> Even if the existing Acts and regulations do have other purposes,<sup>125</sup> there is no indication that one of these is the creation of civil duties. It is thus submitted that the statutes currently in place do not *themselves* impose legal duties upon pharmacists.

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<sup>121</sup> *Olitzki Property Holdings v State Tender Board* par [15].

<sup>122</sup> *Knop v Johannesburg City Council* 33B-C. See, however, Stradford J's comment in *Coetzee v Fick and Another* 1926 TPD 213 at 216 that 'we have no right to assume, merely from the fact that a special remedy is laid down in a statute as a remedy for a breach of a right given under statute, that other remedies are necessarily excluded.' This *dictum* was also applied by a full bench of the Natal Provincial Division in *Balagooroo Sensithalwag Educational Trust v Soobramoney* 1965 (3) SA 627 (N). Indeed, even if a statute has provided a special remedy, the determining factor remains the intention of the legislature. It must therefore be asked whether the legislature, in prescribing a special remedy, intended to exclude ordinary remedies (*Coetzee v Fick* 216). In *The Liquidator of the Cape Central Railways v Nothling* (1890) 8 SC 25 at 29, for example, the court decided that, on the facts, it was clear that the legislature had intended to provide what it deemed to be the appropriate remedy for breach of the statutory duty to the exclusion of every other remedy.

<sup>123</sup> *Johnson v Walgreen Co* 675 So2d 1036 (Fla App Ct 1996).

<sup>124</sup> As explained in 2.3.1 above, the Pharmacy Act is essentially intended to provide for the establishment, objects, powers and functions of the South African Pharmacy Council as well as the regulation and education of pharmacists and the conduct of pharmacy practice. The Medicines Act, on the other hand, has the purpose of regulating the purchase and sale of medicines by pharmacists.

<sup>125</sup> The Medicines Act, for example, appears to have the purpose of promoting the rational use of drugs. This can be deduced from looking at certain background material (which, according to *S v Makwanyane and Another* 1995 (3) SA 391 (CC) par [19], may be taken into account when interpreting a piece of legislation). In *Minister of Health v New Clicks SA (Pty) Ltd* par [199] Chaskalson CJ, when interpreting the provisions of the Medicines Act, referred to an explanatory memorandum which accompanied the Medicines and Related Substances Amendment Bill 72 of 1977 when it was introduced to Parliament. According to the memorandum, the Bill's primary purpose was to bring the Medicines Act into line with the Department of Health's National Drug Policy. One of the major health objectives addressed by the Policy is the promotion of rational and informed drug use (see in particular Chapter 17 of the Policy).

Even if it is established that a statute is intended to provide a civil remedy, the plaintiff must still prove that he or she is a person for whose benefit the statutory duty was imposed<sup>126</sup> and that the harm and the manner in which it occurred was of a nature contemplated by the statute.<sup>127</sup> This may, at times, prove problematic. In *McKibbin v Bax*,<sup>128</sup> for example, a person who was not a pharmacist sold a poisonous drug in a pharmacy without attaching a 'poison' label. The purchaser of the drug then gave it to a third party as a joke. Whilst the sale of the poison did constitute a breach of a statute (which required pharmacist-only sale and the attachment of a poison label), the court held that the pharmacy was not liable to the third party as the harm that had been suffered was not of the sort that the statute was designed to prevent.

Whilst it has been argued that existing pharmacy statutes and regulations do not themselves give rise to civil remedies, they may still be taken into consideration in establishing the existence of legal duties at *common law*.<sup>129</sup> A plaintiff's entitlement to claim damages may, in other words, arise from an application of common law principles with regard being had to the existence of a statutory duty.<sup>130</sup> In *Minister van Polisie v Ewels*,<sup>131</sup> for example, the Appellate Division held that s5 of the Police

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<sup>126</sup> *Ellis v Vickerman* 1954 (3) SA 1001 (C) 1004A. The statute should have been enacted for the protection of individual interests rather than the interests of the public in general.

<sup>127</sup> Van der Walt and Midgley par 74; Neethling *et al* 74-75. See also *Gorris v Scott* (1874) LR 9 Ex 125.

<sup>128</sup> 79 Neb 577 113 NW 158 (1907).

<sup>129</sup> Though note the Supreme Court of Appeal's comment in *Steenkamp NO v Provincial Tender Board, Eastern Cape* (SCA) (par [22]) that 'if the breach of a statutory duty, on a conspectus of the statute, can give rise to a damages claim, a common-law legal duty cannot arise. If the statute points in the other direction, namely that there is no liability, the common-law cannot provide relief to the plaintiff because that would be contrary to the statutory scheme.' This statement, it is submitted, requires qualification, particularly in light of the *Ewels* decision (discussed below). If the intention of the legislature was clearly to *exclude* a civil remedy, then, of course, delictual damages will not be available. The mere fact that a statute does not directly confer a right of action does not, however, necessarily mean that common law relief will be contrary to the statutory scheme. The *Steenkamp* decision went on appeal and the comments of the Constitutional Court in its judgment were nowhere near as restrictive as those of the Supreme Court of Appeal. The Constitutional Court stated that the fact that a particular statute does *not* grant an action for damages is an important consideration to bear in mind (par [47]). It was, however, stressed throughout the majority judgment that whether delictual liability ought to attach to a particular breach of statute is entirely dependant upon factual context and the relevant policy considerations. The importance of basing the decision as to wrongfulness upon an assessment of the relevant normative principles was also stressed in the minority judgment (per Langa CJ and O'Regan J, Mokgoro J concurring) which expressly rejected the approach taken by Harms JA in the Supreme Court of Appeal decision and held that the applicant was owed a legal duty at common law in spite of the fact that the statute in question failed to provide a claim for damages.

<sup>130</sup> *Olitzki Property Holdings v State Tender Board* par [15].

<sup>131</sup> 1975 (3) SA 590 (A).

Act<sup>132</sup> could be taken into account in spite of the fact that it did not appear from the Act that the legislature had intended for this section to create a civil duty. This, it is submitted, is the correct manner in which to approach the statutory provisions applying to South African pharmacists. Interestingly enough, American courts, despite their reluctance to extract civil causes of action directly from pharmacy legislation, have tended to refer to state pharmacy practice Acts when determining the common law duties owed by members of the profession.<sup>133</sup>

Where one is concerned with a common law duty, the most important test is that of reasonableness.<sup>134</sup> Even when a statutory duty is taken into account, conduct will therefore not be wrongful because of the breach of the statutory duty *per se*, but rather because it is reasonable in the circumstances to permit the plaintiff to claim damages.<sup>135</sup> As was highlighted in the *Ewels* decision,<sup>136</sup> the fact that a statute has been breached is only *one* factor relevant to the enquiry.<sup>137</sup> This was confirmed in *Mpongwana v Minister of Safety and Security*<sup>138</sup> in which Comrie J said that, in the case of an omission, something more than the breach of a statutory duty will be needed to found liability. It follows that the fact that a statutory duty has been breached must not be viewed in isolation. It is also necessary to consider whether there are other factors supporting the existence of a legal duty.<sup>139</sup>

The fact that a statute provides aggrieved parties with a special remedy again becomes relevant at this stage. The provision of such a remedy not only demonstrates an intention on the part of the legislature to exclude civil claims for damages, but also, in

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<sup>132</sup> Act 7 of 1958.

<sup>133</sup> See, for example, *Pittman v Upjohn Company* 890 SW2d 425 (Tenn 1994).

<sup>134</sup> *Olitzki Property Holdings v State Tender Board* par [12]; *Knop v Johannesburg City Council* 271.

<sup>135</sup> *Olitzki Property Holdings v State Tender Board* par [12].

<sup>136</sup> *Minister van Polisie v Ewels* 596.

<sup>137</sup> See also *Minister of Law and Order v Kadir* 319B.

<sup>138</sup> 1999 (2) SA 794 (C).

<sup>139</sup> Note also that the weight that is given to the existence of a statutory duty depends on the circumstances. In *Minister van Polisie v Ewels*, the plaintiff was assaulted in a police station, in sight of a number of policemen who could easily have taken steps to prevent the assault. In this context, the court felt that it was important to take s5 of the Police Act (which provided that one of the functions of the police is to prevent crime) into account. These circumstances could be distinguished from those found in *Minister of Law and Order v Kadir* in which the court had to determine whether the police can be held civilly liable for failing to record particulars at the scene of an accident. As a result, the court in *Kadir* did not give the same weight to s5 of the Police Act (which also placed a duty on the police to investigate offences) as the section was afforded in *Ewels*.

terms of broader policy considerations, that there is no need to provide the plaintiff with a remedy at common law.<sup>140</sup>

In Chapter 2<sup>141</sup> it was explained that the Pharmacy Act permits the Pharmacy Council to impose certain penalties upon pharmacists who fail to observe any of the profession's rules or regulations.<sup>142</sup> These include a reprimand and/or caution, suspension from practising any acts forming part of that person's scope of practice, removal from the register, and a fine. It is however submitted that the legislature's intention in providing these penalties was not to exclude every other remedy. Of particular relevance in this regard is the fact that the remedies provided by the Pharmacy Act are disciplinary, rather than compensatory, in nature. They thus fail to provide relief for a person who has suffered harm as a result of a pharmacist's breach of the existing rules or regulations. As such, it cannot be argued that the existence of these statutory remedies means that there is no need to provide the plaintiff with a claim for damages at common law.

The Medicines Act provides that certain conduct shall constitute an offence which, upon conviction, may lead to the imposition of a fine or imprisonment not exceeding 10 years.<sup>143</sup> The same sanctions are included in the General Regulations made in terms of the Medicines Act<sup>144</sup> for failures to comply with various regulations. In this regard, the decision of *Da Silva v Coutinho*<sup>145</sup> is important. In that case, the Appellate Division held that the fact that a statute provides for a *criminal sanction*, does not indicate an intention to exclude a remedy in *delict*.<sup>146</sup> In light of *Da Silva*, it is obvious that an intention to exclude civil remedies cannot be inferred solely from the Medicines Act's provision for criminal penalties.

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<sup>140</sup> *Knop v Johannesburg City Council* 33C. As was noted in 3.5.4 above, one of the factors relevant in establishing the existence of a legal duty is whether there are any other practical and effective remedies available to the plaintiff.

<sup>141</sup> In 2.3.1.1.

<sup>142</sup> Section 45 of the Pharmacy Act. See also the Rules Relating to the Acts or Omissions in respect of which the Council may take Disciplinary Steps.

<sup>143</sup> Section 30(1).

<sup>144</sup> Regulation 42.

<sup>145</sup> 1971 (3) SA 123 (A).

<sup>146</sup> *Da Silva v Coutinho* 135G-H:

'[W]here the sanction expressly provided is an ordinary criminal penalty it is difficult to see what particular significance that penalty has in relation to the Legislature's unexpressed intention in respect of civil remedies.'

### 3.5.4.3 Breach of an Ethical Duty (Professional Standard)

The previous chapter explained the various ethical duties that pharmacists, as professionals, owe their patients. The breach of an ethical duty is significant insofar as it may lead to a pharmacist being disciplined by the South African Pharmacy Council. This sanction contrasts with that emanating from the breach of a legal duty not to harm the plaintiff, which usually results in a court awarding damages in terms of the *lex Aquilia*, the Germanic remedy or the *actio iniuriarum*. It is thus evident that legal duties and ethical duties, although they often overlap,<sup>147</sup> are not identical.<sup>148</sup> The existence of an ethical duty may, however, provide an indication that a legal duty exists. In *S v Frames (Cape Town) (Pty) Ltd and Another*,<sup>149</sup> for example, the court, in discussing whether optometrists or optical dispensers are under a legal duty to check the spectacles which they give to customers, noted that, even though such an obligation may not be created by legislation, an optometrist or optical dispenser is nevertheless a member of a profession which is held to a set of professional standards as laid down by its regulating body. The court held: 'Failure to behave in accordance with those standards renders that person subject to discipline by the Council. It also opens that person to a suit at the instance of the purchaser on the grounds of professional negligence or breach of contract.'<sup>150</sup> In establishing whether or not a defendant is under a particular legal duty, the existence of an ethical duty will be treated in much the same way as the presence of a statutory duty—it will be regarded as one factor in the overarching reasonableness enquiry.<sup>151</sup>

In America, just as courts have been reluctant to take statutory duties into consideration in establishing legal duties, so too have they often refused to consider professional standards of practice when determining whether legal duties exist.<sup>152</sup> In *Adkins v Mong*,<sup>153</sup> for example, the court refused to take the Standards of Practice of the American Pharmaceutical Association into account, stating that the Association is

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<sup>147</sup> See Giesen 669.

<sup>148</sup> *Midgley Lawyers' Professional Liability* 199.

<sup>149</sup> 1995 (8) BCLR 981 (C).

<sup>150</sup> *S v Frames (Cape Town) (Pty) Ltd* 991C-D.

<sup>151</sup> Note also that the ethical duties to which South African pharmacists are bound overlap quite extensively with the statutory duties applicable to the profession.

<sup>152</sup> Owen 684.

<sup>153</sup> 425 NW 2d 151 (Mich Ct App 1988).

not a legal authority and would not be treated as such. The *Adkins* approach appears to be somewhat drastic. Professional codes of conduct, and the ethical duties which they enumerate, are, at the very least, useful in that they provide an indication of what society expects of pharmacists, as well as what pharmacists expect of themselves.<sup>154</sup> Furthermore, as long as it is remembered that the existence of an ethical duty is merely *one* factor to be considered as part of the overall reasonableness enquiry, there is no danger of professional associations assuming the role of legal authorities which dictate the legal duties applicable to their members. Giesen thus states:

‘[T]he medical profession cannot lay down the law in regard to it. Yet, it will often be necessary for the law and for society and, thus, for the courts if called upon, to take cognizance of established codes of medical ethics: *not*, as professionals would perhaps wish, as conclusive evidence of the legal duty or legally acceptable standards, but in order to understand from what educational professional background and ethical commitment [healthcare professionals] normally proceed when exercising their profession *vis-à-vis* their patients.’<sup>155</sup>

The hostility exhibited by the court in *Adkins* perhaps stemmed from a misunderstanding of the role to be played by codes of ethics in the wrongfulness enquiry. There is a vast difference between accepting that professional standards may play a *contributory* role in establishing a legal duty and regarding professional standards as the *sole* criterion for determining the existence of such a duty.

If, on the other hand, one does take professional codes into account, one must be aware that what purports to be a professional *standard* may, in reality, merely be a *goal* towards which the profession aspires.<sup>156</sup> Fink explains the position thus:

‘Professional ethics may be viewed from two entirely different perspectives. On the one hand, as a deftly drafted set of standards that establish lofty ideals of conduct, a code of ethics represents a goal or target for professional standards. On the other hand, a code of ethics may be viewed as a set of minimum criteria for professional comportment.’<sup>157</sup>

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<sup>154</sup> Brushwood *Drake LR* 54.

<sup>155</sup> Giesen 669.

<sup>156</sup> *Ibid.*

<sup>157</sup> Fink 23.

Fink then proceeds to voice his approval of the latter view.<sup>158</sup> In a similar vein, McGraw<sup>159</sup> observes that there are two *kinds* of professional codes of ethics. The first type of code is one which can be enforced in a meaningful way. A breach of the code may, for example, result in an economic or legal penalty or in the offending professional being expelled from the community governed by the code. The second kind of code is one which cannot be enforced by the profession in question. As such, it is 'merely a *suggestion* of the virtues or values to which a member of the occupation should aspire.'<sup>160</sup>

The ethical rules enumerated by the South African pharmacy profession are clearly an example of the first kind of code of ethics identified by McGraw. This is evidenced by the fact that the South African Pharmacy Council is entitled to take disciplinary steps against a member of the profession who fails to observe any rule applying to pharmacists.<sup>161</sup> The penalties available to the Council include the imposition of a fine as well as the suspension of the offender from practising for a specified period and the removal of his or her name from the register. A breach of professional ethics may, in other words, result in a pharmacist suffering an economic penalty or being excluded from the pharmacy profession.

It is submitted that the potential consequences of breaching the pharmacy profession's code of ethics indicate that the rules are, for the most part, 'minimum criteria for professional comportment' rather than 'lofty ideals of conduct'. Indeed, the Rules Relating to Good Pharmacy Practice specifically hold themselves out to be minimum standards of practice. Nevertheless, the mere fact that it is possible for professional codes to perform two such diverse functions is, it is submitted, good enough reason to approach such codes tentatively and not to allow the existence of a particular standard of practice to form the sole basis for founding liability at common law. One must also be aware that, even though a code of conduct may generally be enforceable, *specific*

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<sup>158</sup> Fink 24.

<sup>159</sup> McGraw 4.

<sup>160</sup> McGraw 4. Emphasis added.

<sup>161</sup> See s18 of the Pharmacy Council's Ethical Rules.

rules within that code may be framed in permissive, rather than peremptory, language and consequently fail to establish *standards* of practice.<sup>162</sup>

#### 3.5.4.4 The Relationship Between the Parties and Societal Expectations

The relationship between the parties may constitute an important factor in establishing the existence of a legal duty. Likewise, in *Kadir v Minister of Law and Order*<sup>163</sup> emphasis was placed on the role of public expectation in the creation of a legal duty.<sup>164</sup> Brushwood has suggested that the duties to which pharmacists are subject are a result of the nature of the relationship which exists between pharmacists and their patients as well as societal expectations. The relationship between pharmacists and their patients is one of trust. Pharmaceutical medicines differ from other products in that their purchasers do not have the skill or the knowledge required to inspect and evaluate drugs and thereby protect themselves. The result is that pharmacists, who hold their position of public trust because of their special knowledge and skill, are expected by society to protect patients to whom medications are dispensed.<sup>165</sup>

### 3.6 Defences Excluding Wrongfulness (Grounds of Justification)

#### 3.6.1 General

Grounds of justification are circumstances in which the defendant's conduct, whilst *prima facie* wrongful, is in fact reasonable and hence lawful.<sup>166</sup> They are rooted in

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<sup>162</sup> McGraw 4. Compare the following rules from the Rules Relating to Good Pharmacy Practice—rule 2.25:

'A pharmacist *may* review a patient's overall medicine requirements to ensure the effective use of medicine, following a diagnosis(es) made by another health care professional, in order to maximise therapeutic outcomes';

rule 2.7.3.1(a):

'In cases of uncertainty, the pharmacist or pharmacist intern *must* make every effort to contact the prescriber. If it is impossible to contact the prescriber, the pharmacist *must* use his/her professional judgment and decide, in all circumstances, what course of action would be in the best interest of the patient' (emphasis added).

<sup>163</sup> *Kadir v Minister of Law and Order* 740G-J. In this regard, note that public expectation is not merely a *hope* that a person will act as desired, but a conviction that he or she *ought* to do so.

<sup>164</sup> Although the Appellate Division failed to place the same weight on social expectations as the court *a quo* (*Minister of Law and Order v Kadir* 306H-J).

<sup>165</sup> *Brushwood Case Study* 7, 8 11, 13, 14.

<sup>166</sup> See *Argus Printing and Publishing Co Ltd v Inkatha Freedom Party* 1992 (3) SA 579 (A) 588G-I. In *Clarke v Hurst NO* (650I-J), Thirion J described the grounds of justification as follows:

public policy<sup>167</sup> and thus constitute expressions of a society's legal convictions.<sup>168</sup> Although the existing grounds of justification do not constitute a *numerus clausus*<sup>169</sup> of defences excluding wrongfulness (the primary consideration remaining that of reasonableness),<sup>170</sup> there are a number of crystallised grounds which, as will be seen in the discussion of specific situations below, are likely to prove particularly useful to pharmacists and which therefore require further discussion. The first, consent, may be raised by a pharmacist whenever the patient consented to, or assumed the risk of, the harm upon which the latter's claim is based. The others (necessity, statutory authority, privilege and truth and public benefit) may prove to be important in cases involving breaches of confidentiality.

### 3.6.2 Consent

#### 3.6.2.1 The Requirements of Consent

A defendant's actions will be lawful if the person who suffered harm as a result of such actions consented to either injury or the risk thereof.<sup>171</sup> This principle is embodied in the maxim *volenti non fit iniuria* ('a willing person is not wronged; he who consents cannot be injured').<sup>172</sup> As was indicated in the previous chapter's discussion of informed consent,<sup>173</sup> there are a number of requirements that must be met before an individual's consent will have the effect of excluding liability. Firstly,

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'The stereotyped grounds of justification are specific grounds of justification of otherwise wrongful conduct which with the passage of time have become crystallised, with their own rules limiting the scope of their application.'

<sup>167</sup> *O v O* 1995 (4) SA 482 (W) 486H; *Mohamed and Another v Jassiem* 1996 (1) SA 673 (A) 710D; *Borgin v De Villiers and Another* 1980 (3) SA 556 (A) 571F-G; *Argus Printing and Publishing v Inkatha Freedom Party* 588I.

<sup>168</sup> Van der Walt and Midgley par 85; Neethling *et al* 76.

<sup>169</sup> See *Clarke v Hurst NO* 650H-I:

'The fallacy in counsel's argument lies in the fact that it assumes that conduct which is *prima facie* unlawful can in law only be justified under one or other of the stereotyped categories of grounds of justification, such as self-defence, consent, necessity, etc. There is, however, not a *numerus clausus* of grounds of justification.'

See also *Argus Printing and Publishing Co Ltd v Inkatha Freedom Party* 589D-E.

<sup>170</sup> *Argus Printing and Publishing Co Ltd v Inkatha Freedom Party* 588I and 590C-D; *O v O* 487D-G. See also Van der Walt and Midgley par 85 in which it is suggested that 'in every instance the overarching defence available to a person is the defence of reasonableness.'

<sup>171</sup> *Castell v De Greef* 1994 (4) SA 408 (C) 425G-H.

<sup>172</sup> Neethling *et al* 98; Boberg 724.

<sup>173</sup> See 2.3.2.3(b) above.

one can only consent to, or assume, a risk of which one is aware.<sup>174</sup> One must, in other words, have full knowledge of the nature and extent of the harm or risk involved.<sup>175</sup> One must also appreciate the nature and extent of the relevant harm or risk<sup>176</sup> and voluntarily<sup>177</sup> consent<sup>178</sup> to it.<sup>179</sup> Whilst in *Waring and Gillow Ltd v Sherborne*<sup>180</sup> it was cautioned that ‘knowledge does not invariably imply appreciation, and both together are not necessarily equivalent to consent,’<sup>181</sup> the Appellate Division has since accepted that if, in *addition* to knowledge and appreciation of danger, the plaintiff foresaw the risk of injury, and the injury suffered falls within the ambit of the risk foreseen, consent will usually have been established.<sup>182</sup>

Due to the fact that consent is a legal act, one can only give valid consent if one has the capacity to do so.<sup>183</sup> Van der Walt and Midgley explain that a person is regarded as having the requisite capacity ‘if he or she has the mental capability and maturity to evaluate responsibly the nature, extent and implications of the consent or assumption of risk.’<sup>184</sup>

### 3.6.2.2 The Degree of Knowledge that is Necessary for Consent to be Valid

As indicated above, a plaintiff’s consent will be valid only if he or she has knowledge of the nature and extent of the harm or risk involved. Within the healthcare context, patients will ordinarily only possess the necessary knowledge to consent to drug therapy if a healthcare professional has informed them of the risks involved. It is for this reason that healthcare professionals are often said to be under a duty to disclose information concerning the risks posed by treatment.<sup>185</sup> The question which arises is *how much* information needs to be provided in order for valid consent to be obtained.

<sup>174</sup> See in general *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T).

<sup>175</sup> *Castell v De Greef* (1994) 425H.

<sup>176</sup> *Castell v De Greef* (1994) 425H-I; *Esterhuizen v Administrator, Transvaal* 719D.

<sup>177</sup> See *R v McCoy* 1953 (2) SA 4 (SR) 10A-H; Neethling *et al* 101 fn 367.

<sup>178</sup> *Castell v De Greef* (1994) 425I; *Esterhuizen v Administrator, Transvaal* 719D.

<sup>179</sup> As summarised by Innes CJ in *Waring and Gillow Ltd v Sherborne* 1904 TS 340 at 344:

‘[I]t must be clearly shown that the risk was known, that it was realised, and that it was voluntarily undertaken. Knowledge, appreciation, consent – these are the essential elements.’

<sup>180</sup> 1904 TS 340.

<sup>181</sup> *Waring and Gillow Ltd v Sherborne* 344.

<sup>182</sup> *SANTAM Insurance Co Ltd v Vorster* 1973 (4) SA 764 (A) 781B-C.

<sup>183</sup> Boberg 731.

<sup>184</sup> Van der Walt and Midgley par 96. See also discussion in 2.3.2.3(b) above.

<sup>185</sup> Ie risk assessment information. As to whether *pharmacists* are under a duty to disclose such information, see 3.7.1.3 below.

The provision of extensive information not only places an undue burden upon healthcare professionals,<sup>186</sup> but is also undesirable as it hinders, rather than promotes, patient understanding, thereby producing uninformed decisions<sup>187</sup> and failing to achieve the objective of obtaining informed consent. In discussing product liability in general, Twerski *et al* have had the following to say:

‘Warnings, in order to be effective, must be selective. They must call the consumer’s attention to a danger that has a real probability of occurring and whose impact will be significant. One must warn with discrimination since the consumer is being asked to discriminate and to react accordingly. The story of the boy who cried wolf is an analogy worth contemplating when considering the imposition of a warning in a case of rather marginal risk.’<sup>188</sup>

Consent, in other words, need not be complete in order to be adequate.<sup>189</sup> This has also been recognised by O’Neill who stresses that the focus should be on obtaining *genuine* consent and that this is not always best achieved by seeking the most *specific* consent possible.<sup>190</sup>

In South Africa, the courts have accepted that only the *material* risks<sup>191</sup> inherent in the proposed treatment need to be disclosed by a medical practitioner.<sup>192</sup> The question that arises is from which perspective the materiality of a risk should be decided. In this regard, there are a number of options available. The first is the standard of the *reasonable professional*. Here, the extent and nature of information to be disclosed depends on professional standards of practice. Secondly, the question can be answered with reference to the *reasonable person*: Would a reasonable person attach significance to the information in deciding whether to consent to therapy?<sup>193</sup> Finally, one could apply a subjective standard—namely, the informational needs of the

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<sup>186</sup> See *Esterhuizen v Administrator, Transvaal* 721A-B in which it was argued that medical professionals would be placed in an intolerable position if it were held that they owed their patients a duty of having to inform them of *all* the risks associated with treatment.

<sup>187</sup> *Beauchamp and Childress* 159. See also *Veatch and Haddad* 101.

<sup>188</sup> *Twerski et al* 514.

<sup>189</sup> *Beauchamp and Childress* 158; *Veatch and Haddad* 92. Giesen (315) explains that a duty of disclosure ‘will not extend to what upholders of medical professional privilege describe with horror as “total disclosure”; disclosure, that is of all risks, however remotely they may lurk, achieving no end but to fill the patient awe, fear and possibly despair.’ See also Giesen 316.

<sup>190</sup> O’Neill 5-6.

<sup>191</sup> Sometimes also referred to as the ‘real’ or ‘substantial’ risks (*McLean* 9-10).

<sup>192</sup> See *Castell v De Greef* (1994).

<sup>193</sup> This is sometimes referred to as the ‘reasonable patient test’ or the ‘objective test’ (see Giesen 297).

*specific patient* with whom the professional is dealing. What, in other words, would that patient regard as relevant in reaching a decision?<sup>194 195</sup>

In *Castell v De Greef*<sup>196</sup> a full bench of the Cape Provincial Division held on appeal that a risk will be regarded as material if:

- a) 'a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it; or
- b) the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it.'<sup>197</sup>

South African courts thus adopt a combination of the second and third approaches discussed above in determining which information should be disclosed to a patient.<sup>198</sup>

This is essentially the same test proposed by Giesen,<sup>199</sup> who begins by stating:

'There is no objection ... to accepting the "reasonable patient" test as a starting point in formulating an acceptable standard of disclosure. It will normally lead the physician to a correct assessment of the average patient's *minimum* informational needs.'<sup>200</sup>

He then proceeds to suggest that, in order to give proper recognition to patient autonomy, this objective patient-based standard 'must be supplemented by a more subjective patient-based standard, better attuned to the values of each person and his or her inalienable right of self-determination, and better able to manage situations beyond the limitations of the objective test.'<sup>201</sup>

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<sup>194</sup> This test is known as the 'individual patient test' or the 'subjective test' (see Giesen 297).

<sup>195</sup> Beauchamp and Childress 147-150. For a comprehensive analysis of these three approaches, see Giesen 271-309. See also Klar *et al* pars 143.1 and 144.

<sup>196</sup> 1994 (4) SA 408 (C).

<sup>197</sup> *Castell v De Greef* (1994) 426F-H. The court thus diverged from the judgment of the court *a quo* (1993 (3) SA 501 (C)) in which it was held (at 517G-J) that the appropriate standard for determining the nature and extent of warnings is that of the reasonable doctor.

<sup>198</sup> The problem with the first approach is that it allows the scope of the duty of disclosure to be determined by the medical profession itself and thus affords no recognition to patient autonomy (see Giesen 276 and 282).

<sup>199</sup> And is also an approach which is in line with developments in other common law countries such as Canada, the United States and Australia, as well as views in Europe (*Castell v De Greef* (1994) 426E-F).

<sup>200</sup> Giesen 303.

<sup>201</sup> Giesen 304.

A final point to note about the *De Greef* decision is that the court expressly recognised that the duty to inform patients of material risks is subject to the so-called therapeutic privilege<sup>202</sup> which allows medical practitioners intentionally to withhold information which may be harmful to their patients.<sup>203</sup> In deciding the extent to which information should be disclosed, it is, in other words, acceptable to balance the principle of patient autonomy against the principles of beneficence and nonmaleficence. Even though a patient can only make a completely autonomous choice if aware of *all* the risks involved,<sup>204</sup> beneficence and nonmaleficence may require that certain information be withheld from a patient if the disclosure of such information poses a risk of harm. In this regard, some have argued that the withholding of information will only be ethically justified if it is based on the reasonable judgment that to provide the information will cause greater harm than nondisclosure.<sup>205</sup> Indeed, such an approach would be in line with utilitarian ethical theory.<sup>206</sup>

### 3.6.2.3 Disclaimers

If a pharmacist can prove that a patient, who was in possession of the requisite capacity and was aware of and appreciated the risk of harm, voluntarily consented to or assumed the risk, the pharmacist will usually be able to escape liability should the harm consented to eventuate. The defence of consent may prove particularly relevant to pharmacies which sell drugs over the Internet and make use of disclaimers.<sup>207</sup>

A disclaimer is essentially a notice which aims at limiting or excluding potential liability.<sup>208</sup> Disclaimers can be argued to have two possible legal bases. From a delictual perspective, a person who uses a website after having read a disclaimer can be argued to have voluntarily assumed the risk of harm. Provided that all of the requirements for valid consent are present, a disclaimer may, in other words, have the

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<sup>202</sup> *Castell v De Greef* (1994) 426H.

<sup>203</sup> *Beauchamp and Childress* 150-151. The practice of withholding information for the benefit of a patient is also sometimes referred to as 'benevolent deception' (*Beauchamp and Childress* 399).

<sup>204</sup> *McLean* 8-9.

<sup>205</sup> *Healy* 34. The harm caused by nondisclosure would include the detrimental effect that such conduct may have on the relationship of trust between pharmacist and patient.

<sup>206</sup> Discussed in 2.3.2.2 above.

<sup>207</sup> This issue is comprehensively discussed in 3.7.2.3 below.

<sup>208</sup> *Midgley 'Cyberspace Issues'* 398.

effect of excluding wrongfulness. Alternatively, one can argue that a disclaimer amounts to a contractual exclusion clause in terms of which persons who make use of a website agree not to sue should harm arise.<sup>209</sup>

Regardless of the route of argument which one adopts, the end result is essentially the same: the pharmacy operating the website is shielded from delictual liability.<sup>210</sup> It is, however, submitted that, in most cases involving disclaimers, a defendant is likely to be met by greater success by arguing that he or she was contractually exempted from liability. This is because, in order to escape liability on the ground of *volenti non fit iniuria*, a defendant will have to establish that the plaintiff was not only aware of the disclaimer, but also appreciated it and consented to it.<sup>211</sup> A defendant who relies upon a contractual exclusion clause will have a far lighter burden of proof. In *Durban's Water Wonderland (Pty) Ltd v Botha and Another*<sup>212</sup> the Supreme Court of Appeal held that the legal principles applicable to 'ticket cases' apply *mutatis mutandis* to cases in which reliance is placed on the display of notices containing contractual terms such as disclaimers.<sup>213</sup> When a plaintiff has either read and accepted the terms of a disclaimer, or seen a disclaimer and realised that it contains contractual terms, but not bothered to read it, actual consensus will be present and the defendant will be able to escape liability. Even if actual consensus cannot be established, a defendant may be able to prove that the plaintiff is bound by the disclaimer on the basis of quasi-mutual assent.<sup>214</sup> In the absence of a subjective agreement, a contract may, according to the doctrine of quasi-mutual assent, be confirmed if one party acts in such a manner that

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<sup>209</sup> Midgley 'Cyberspace Issues' 398. For a general discussion of the effects of exclusion clauses on delictual liability see Van der Walt and Midgley par 55.

<sup>210</sup> Note, however, that in *Jameson's Minors v Central South African Railways* 1908 TS 575 it was held (at 588-589) that, although a person who contractually accepts all risk of injury is not entitled to claim damages should he or she suffer harm, such an agreement does not bar third parties (such as dependants) from suing the person who caused the harm.

<sup>211</sup> In *Payne v Minister of Transport* 1995 (4) SA 153 (C), for example, the defendant initially argued that the plaintiff had undertaken not to hold the defendant liable in the event of harm, and, alternatively, that the plaintiff had voluntarily assumed the risk of harm. The defendant, however, abandoned the second argument due to the fact that it had failed to establish knowledge, appreciation and consent. See also *Union National South British Insurance Co Ltd v South African Railways and Harbours* 1979 (1) SA 1 (A) in which the court rejected the defence of *volenti non fit iniuria*, holding (at 9H) that the mere presence of a notice displaying a warning of danger was not enough to establish that the warning had been read and appreciated and that the risk had been consented to.

<sup>212</sup> 1999 (1) SA 982 (SCA).

<sup>213</sup> *Durban's Water Wonderland (Pty) Ltd v Botha* 991D.

<sup>214</sup> *Durban's Water Wonderland (Pty) Ltd v Botha* 991D-H.

the other party reasonably believes that an agreement was reached.<sup>215</sup> Whether a defendant can reasonably assume that, by proceeding to use its services, the plaintiff assented to the terms of the disclaimer depends on whether the defendant did what was reasonably sufficient to bring the disclaimer to the plaintiff's attention.<sup>216</sup> If the defendant can show that appropriate steps were taken to bring the disclaimer to the attention of the plaintiff, the defendant will be able to escape liability regardless of whether the plaintiff actually read, understood and consented to the disclaimer.

### 3.6.3 Necessity

Van der Walt and Midgley define an act of necessity as 'lawful conduct directed against an innocent person<sup>217</sup> for the purpose of protecting an interest of the actor or a third party<sup>218</sup> (including the innocent person) against a dangerous situation.'<sup>219</sup> Necessity will only succeed as a defence if danger existed or was inevitable and could not reasonably have been averted by other means.<sup>220</sup> The existence of such a state of affairs is determined objectively.<sup>221</sup> Any interest, including that of privacy,<sup>222</sup> may be infringed on the basis of necessity<sup>223</sup> as long as the interest infringed is not more important than the interest being protected and the defendant has not caused more harm than was necessary to avert the danger.<sup>224</sup>

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<sup>215</sup> *Smith v Hughes* [1871] 6 QB 597 at 607. See also *Sonap Petroleum (SA) (Pty) Ltd v Pappadogianis* 1992 (3) SA 234 (A) 239I-240B.

<sup>216</sup> *Durban's Water Wonderland (Pty) Ltd v Botha* 991H-I. See also *Micor Shipping (Pty) Ltd v Tregger Golf and Sports (Pty) Ltd and Another* 1977 (2) SA 709 (W) 713H-714B; *King's Car Hire (Pty) Ltd v Wakeling* 1970 (4) SA 640 (N) 643D-F. For a general discussion of the law relating to ticket cases see Kerr 344-347; Christie 204-209; Van der Merwe *et al* 277-278.

<sup>217</sup> In this regard, necessity can be distinguished from private defence—a ground of justification which can be invoked when the defendant infringed the interests of a person who threatened to violate the interests of the defendant or a third party (see in general Van der Walt and Midgley par 88).

<sup>218</sup> Eg *S v Pretorius* 1975 (2) SA 85 (SWA).

<sup>219</sup> Van der Walt and Midgley par 87. See also *S v Adams, S v Werner* 1981 (1) SA 187 (A) 220A-B; *S v Bailey* 1982 (3) SA 772 (A) 796A.

<sup>220</sup> Van der Walt and Midgley par 87; Neethling *et al* 92.

<sup>221</sup> *Chetty v Minister of Police* 1976 (2) 450 (N) 452G-H. For an example of a case in which a state of danger did not exist, in spite of the appellant's belief that it did, see *S v Pretorius*.

<sup>222</sup> See discussion in 3.7.3.4 below.

<sup>223</sup> Neethling *et al* (90 fn 279) gives the example of a doctor who needs to examine an unconscious person. This would constitute an invasion of the latter's physical privacy (see fn 419 below).

<sup>224</sup> *R v Mahomed and Another* 1938 AD 30 at 36.

### 3.6.4 Statutory Authority

If the defendant's conduct, whilst infringing an interest of the plaintiff, is authorised by statute, it will be justified and thus be lawful.<sup>225</sup> In order for the defendant's conduct to be justified on this ground, the statute in question must have authorised the infringement of the interest concerned. Whether this is the case will depend on the intention of the legislature,<sup>226</sup> as determined by an application of the ordinary rules of statutory interpretation.<sup>227</sup> Of particular relevance will be whether the statute is directory or permissive in nature. If it is directory, it can be implied that the legislature intended to legalise an infringement of the plaintiff's rights.<sup>228</sup> Where, on the other hand, the statute is permissive, the presumption is that the legislature did not intend to authorise the infringement of the interest.<sup>229</sup>

Even once it has been established that one's conduct was authorised by statute, one's actions will only be justified if they fall within the limits of the authority conferred by the statute.<sup>230</sup> One must additionally have acted with care and taken all reasonable precautions to minimise injury to others.<sup>231</sup>

### 3.6.5 Privilege

The defence of privilege, although usually raised in the context of defamation, is relevant to this thesis insofar as it may justify the disclosure of confidential information. The Appellate Division has explained the defence as follows:

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<sup>225</sup> *Simon's Town Municipality v Dews and Another* 1993 (1) SA 191 (A) 195I and 196F-G.

<sup>226</sup> As put in *Johannesburg Municipality v African Reality Trust Ltd* 1927 AD 163 at 172, the question is:

'Did [the Legislature] intend that immunity from consequences should accompany the grant of authority, or did it intend that the authority should either not be exercised at all to the legal prejudice of others, or that if so exercised there should be an accompanying liability to make good any consequential damage?'

See also *Simon's Town Municipality v Dews* 195J.

<sup>227</sup> *Simon's Town Municipality v Dews* 195J-196A.

<sup>228</sup> *Johannesburg Municipality v African Reality Trust Ltd* 172.

<sup>229</sup> Neethling *et al* 106.

<sup>230</sup> *Simon's Town Municipality v Dews* 196G and 196J.

<sup>231</sup> *Simon's Town Municipality v Dews* 196BC. See also *Johannesburg City Council v Television and Electrical Distributors* 1997 (1) SA 157 (A) 165G-I:

'[S]tatutory authority that impliedly, and within limits, permits an infringement of rights does not sanction negligent conduct causing harm.'

‘Where the person publishing the defamatory matter is under a legal, moral or social duty to do so or has a legitimate interest in so doing, and the person to whom it is published has a similar duty or interest to receive it, then the occasion of the publication would be privileged.’<sup>232</sup>

The existence of a social or moral duty within this context is determined by an application of the reasonable person test.<sup>233</sup>

### 3.6.6 Truth and Public Benefit

Another defence which originates in the law of defamation and might provide pharmacists with a justification for breaching patient confidentiality is that of truth and public benefit.<sup>234</sup> As the name of the defence suggests, truth alone will not justify a disclosure of private information. Disclosure must additionally be in the public interest,<sup>235</sup> as determined by the legal convictions of the community.<sup>236</sup>

## 3.7 Specific Situations

### 3.7.1 Failure to Warn or Counsel

#### 3.7.1.1 The Classification of Information According to its Purpose

There are two distinct purposes for providing patients with information. The first is to decrease the risk of side effects and increase the benefits of a course of drug therapy.<sup>237</sup> The provision of this form of information has, in other words, the objective

<sup>232</sup> *Ehmhe v Grunewald* 1921 AD 575 at 581. See also *Borgin v De Villiers and Another* 1980 (3) SA 556 (A) 577D-E.

<sup>233</sup> *De Waal v Ziervogel* 1938 AD 112 at 123:

‘[T]he question which the Court has to decide ... is not was the defendant in fact speaking from a sense of duty but did the circumstances in the eyes of a reasonable man create a duty or an interest which entitles the defendant to speak?’

See also *Jansen van Vuuren v Kruger* 856D-E; *Borgin v De Villiers* 577E-G.

<sup>234</sup> *Argus Printing and Publishing Co Ltd v Inkatha Freedom Party* 589F.

<sup>235</sup> Van der Walt and Midgley par 98.

<sup>236</sup> *Borgin v De Villiers* 577G; *Argus Printing and Publishing Co Ltd v Inkatha Freedom Party* 589F-G.

<sup>237</sup> Asbury 939. As stated by Gonzalez (53):

‘The complexity of modern drug therapy expounds the reality that providing patient instructions and warnings is often as critical to successful drug treatment as the accurate dispensing of the prescription.’

This is also recognised in rule 2.8 of the Rules Relating to Good Pharmacy Practice.

of achieving risk management. It is thus known as 'risk management information' or 'risk minimisation information'.<sup>238</sup> The second purpose of counselling is to enable patients to assess the risks and benefits of drug therapy and for healthcare professionals to thereby obtain informed consent. This is achieved by providing a patient with 'risk assessment information'. It is obviously necessary for patients, at some stage, to be provided with both risk minimisation and risk assessment information. The issue which arises is whether *pharmacists* should be held responsible for the provision of information, and, if so, which kind(s) of information pharmacists should be expected to provide. This essentially involves two questions:

- a) Can pharmacists incur delictual liability for failing to ensure that patients understand *how to use* drugs (ie for failing to provide risk minimisation information)? This forms part of the greater question concerning whether pharmacists are required to actively promote safe and effective drug use.
  
- b) Can pharmacists incur delictual liability for failing to ensure that patients are aware of the possible *side effects* of medications (ie for failing to provide risk assessment information)?

The failure to provide either kind of information clearly constitutes an omission. As such, liability will only ensue should a duty to speak be established. There are, however, a number of preliminary matters that must be understood before exploring the duties of pharmacists in this regard.

Firstly, the classification of information as either risk assessment information or risk minimisation information will not always be as clear-cut as one might like. Some degree of overlap does occur. It can, for example, be accepted that information concerning the side effects of drugs constitutes risk assessment information. Information concerning what to do in the event of an adverse reaction would, on the other hand, constitute risk minimisation information. In order to communicate the latter kind of information effectively, one will, however, often need to explain the

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<sup>238</sup> This information may even have the purpose of minimising risks to third parties (eg advising a patient not to drive or operate heavy machinery whilst on a particular course of drug therapy protects the safety of not only the patient, but third parties as well).

symptoms for which patients should be alert. Risk management may, in other words, involve a discussion of some of the side effects of drug therapy.

Secondly, it should be noted that, in spite of occasional overlap in the content of risk assessment information and risk minimisation information, the fact that these two categories of warnings are provided for different purposes means that a duty to provide one kind of information will be based on different policy considerations than a duty to provide the other.<sup>239</sup> It follows that the wrongfulness of a pharmacist's failure to provide information may well hinge on the nature of the information that the pharmacist has failed to provide.<sup>240</sup> For this reason, the discussion that follows will begin by exploring whether pharmacists are under a duty to provide risk minimisation information and will then consider whether there is a separate, coexisting duty to provide risk assessment information.

The third point is that the existence of each kind of duty needs to be explored within the context of both pharmacist-initiated therapy and the filling of prescriptions. Whilst both kinds of dispensing will be commented on in this chapter, the primary focus will be on the dispensing of prescription drugs. There are two reasons for this. Firstly, a duty to provide counselling concerning the use of over-the-counter (OTC) medications<sup>241</sup> forms part of a pharmacist's duty to exercise reasonable care and skill in the exercise of his or her profession and is thus more appropriate to explore during the negligence enquiry discussed in Chapter 4. Secondly, it is the provision of information with regard to prescription drugs that generates the most controversy: When a physician advises a patient to embark on a particular course of drug therapy, the primary duty for ensuring that the patient knows how to use the prescribed medication and is aware of the risks involved therewith lies with the prescribing *physician*. When, on the other hand, a pharmacist recommends the use of an OTC drug, there is usually no other healthcare professional who can shoulder the duty to counsel.

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<sup>239</sup> See Powell *et al* par 12-222.

<sup>240</sup> Cruz 243.

<sup>241</sup> Ie Schedule 0, 1 and 2 medications, all of which may be dispensed by a pharmacist without prescription. See 2.3.1.2(a) above.

Finally, in this chapter, only the duties of pharmacists with regard to valid prescriptions that are *prima facie* correct will be explored. The duties that arise when a pharmacist is provided with an invalid or erroneous prescription will be examined in the next chapter.<sup>242</sup>

### 3.7.1.2 The Provision of Risk Minimisation Information

There are a number of factors which indicate that it is reasonable to expect pharmacists to counsel patients about the use of drugs. These include the expert knowledge which pharmacists possess regarding drugs and drug use, the fact that pharmacists are in control of potentially dangerous substances<sup>243</sup> and the relationship of trust that exists between pharmacists and their patients. A further factor supporting the imposition of liability is that, although the failure to counsel constitutes an omission, the harm which may be caused by such a failure is often physical in nature.

As was discussed in the previous chapter, pharmacy practice has become increasingly patient-orientated in recent years. This is highlighted by the fact that the South African pharmacy profession currently views the concept of pharmaceutical care as a standard which lies at the core of pharmacy practice. This concept recognises that pharmacists have an important role to play in preventing potential drug-related problems—ie in providing risk management. Indeed, pharmacists, who both possess the necessary knowledge of drugs and sit at the end of the chain of drug distribution, are in the perfect position to ensure that drug therapy is as safe and effective as possible. This fact has been recognised in South Africa's National Health Policy which includes the establishment of an enhanced role for pharmacists as one of the means through which rational drug use can be achieved.<sup>244</sup>

The statutes, regulations and professional codes discussed in Chapter 2 place clear statutory and ethical duties upon pharmacists to provide patients with risk minimisation information. To begin with, s18(1) of the Medicines Act provides that

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<sup>242</sup> See 4.4.3 and 4.4.4 below.

<sup>243</sup> In *Graham v Cape Metropolitan Council* (370B-C) it was held that a local authority in control of a dangerous road 'is under a duty to warn road users specifically of the nature of the hazard and the risk involved.' A duty to provide warnings when in control of a dangerous situation was similarly acknowledged in *Faiga v Body Corporate of Dumbarton Oaks* (666C-E).

<sup>244</sup> National Health Policy 17-19.

no person shall sell a medicine or scheduled substance unless the packaging in which it is sold bears a label stating prescribed particulars, which include directions as to the manner in which such medicine or scheduled substance should be used.<sup>245</sup> In addition to this, the Regulations Relating to the Practice of Pharmacy state that the provision of information and advice with regard to the use of medicine is one of the acts ‘specially pertaining to the profession of a pharmacist.’<sup>246</sup> These Regulations also define ‘dispensing’ as:

‘[T]he interpretation and evaluation of a prescription, the selection, manipulation or compounding of the medicine, the labelling and supply of the medicine in an appropriate container according to the Medicines Act and the provision of information and instructions by a pharmacist to ensure the safe and effective use of medicines.’<sup>247</sup>

In light of this definition, the dispensing process can be divided into three phases: a) the interpretation and evaluation of the prescription;<sup>248</sup> b) the preparation<sup>249</sup> and labelling of the prescribed medicine;<sup>250</sup> and c) the *provision of information and instructions to ensure safe and effective use of the medication.*<sup>251</sup>

The professional duty to provide patients with information to promote the safe and effective use of medicine is stressed in the Pharmacy Council’s Ethical Rules<sup>252</sup> as well as its Rules Relating to Good Pharmacy Practice. The latter state that the provision of information and the counselling of patients (or patients’ caregivers) so as to promote the safe and effective use of medicines are ‘general objectives and requirements of pharmaceutical services.’<sup>253</sup> The Rules also refer to these functions when discussing the underlying philosophy of the pharmacy profession<sup>254</sup> and the

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<sup>245</sup> Regulation 8(4)(iii) of the General Regulations published in terms of the Medicines Act. See discussion in 3.7.1.4 below concerning whether written information is sufficient to satisfy the duty to provide risk management information.

<sup>246</sup> Regulation 3(1)(c). See also regulations 16(3), 17(2), 18(1)(c) and 19(1)(b).

<sup>247</sup> Regulation 1.

<sup>248</sup> See 4.4.3 and 4.4.4 below.

<sup>249</sup> See 4.4.2 below.

<sup>250</sup> To be dealt with in 3.7.2 below.

<sup>251</sup> See rule 2.7.1 of the Rules Relating to Good Pharmacy Practice.

<sup>252</sup> Section 1 of these Rules provides that pharmacists act unethically when they fail to furnish advice or information for the safe and effective use of the medicines which they supply.

<sup>253</sup> Rules Relating to Good Pharmacy Practice in South Africa p3-4.

<sup>254</sup> Rules Relating to Good Pharmacy Practice in South Africa p1.

scope of pharmacy practice.<sup>255</sup> Minimum standards for patient information and advice are found in rule 2.8. This rule provides that, when asked to fill a prescription, pharmacists must counsel patients (or patients' caregivers) and provide them with the necessary advice and information concerning the safe and effective use of prescribed medicines so as to maximise therapeutic outcomes.<sup>256</sup> That the provision of such information is professionally expected of pharmacists is also clear from the fact that South African universities now train pharmacists to be able to ensure the optimum use of medicine. This is done, *inter alia*, by providing courses in client counselling.<sup>257</sup>

From the above, it is evident that South African pharmacists are under both statutory and ethical duties to provide patients with risk management information. This trend is not restricted to South Africa. The Pharmacy Board of New South Wales, for example, has made the following statement with regard to the professional responsibilities of pharmacists in the provision of counselling:

'When a prescription is dispensed ... a pharmacist should be satisfied that the patient understands how to use the medication correctly. Usually, this will entail the pharmacist's counselling the patient, or the patient's agent, and/or providing written information.'<sup>258</sup>

Likewise, in the United States, the National Association of Boards of Pharmacy's Model Rules for Pharmaceutical Care state that pharmacists should review patient records upon the presentation of a prescription and counsel patients with the purpose of enhancing drug therapy. This involves a discussion of the following: 'Common severe side or adverse effects or interactions and therapeutic contraindications that may be encountered, including their avoidance, and the action required if they occur.'<sup>259</sup> In 1990 the Omnibus Budget Reconciliation Act (OBRA-90) was passed, requiring all states to enact legislation requiring pharmacists to offer counselling to Medicaid patients<sup>260</sup> about such matters as 'directions, dosage, precautions, use and any potentially significant side effects or interactions.'<sup>261</sup> In response to this, many

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<sup>255</sup> Rules Relating to Good Pharmacy Practice in South Africa p2.

<sup>256</sup> Rule 2.8.2 (a) and (e).

<sup>257</sup> See discussion in 2.2.3 above.

<sup>258</sup> Quoted in Dwyer 733.

<sup>259</sup> Gonzalez 73.

<sup>260</sup> Karns 8-9; Asbury 933.

<sup>261</sup> Asbury 933-934.

states have opted to enact statutes requiring mandatory consultation by pharmacists with *all* patients.<sup>262</sup> The provisions of these statutes have, in some cases, been successfully used in establishing a legal duty to warn.<sup>263</sup>

Returning to the South African position, a contravention of the abovementioned section of the Medicines Act constitutes an offence<sup>264</sup> upon the conviction of which an individual may be liable to a fine or imprisonment.<sup>265</sup> A failure to adhere to the Pharmacy Council's rules concerning the provision of information may, on the other hand, result in disciplinary action being taken by the Council. Neither of these forms of sanction provides a practical and effective remedy to individuals who suffer harm as a result of ignorantly misusing pharmaceutical products. This constitutes yet another policy consideration in support of imposing liability upon South African pharmacists who fail to provide risk management information.

In spite of the abovementioned policy factors that support the existence of a legal duty to provide patients with risk minimisation information, it is important to consider whether there are any general considerations of public policy and fairness that favour the *denial* of liability. There are a number of arguments against the imposition of liability which need to be explored.

(i) *Lack of Patient-Specific Knowledge*

It is sometimes argued that pharmacists do not have sufficient information concerning the medical histories and conditions of patients to be able to provide patients with adequate warnings.<sup>266</sup> It is true that a healthcare professional who is in possession of patient-specific knowledge will usually be able to play a more effective role in risk management than one who lacks such information. There are, however, two flaws in the argument that pharmacists are unable to provide risk management information due to lack of patient-specific knowledge. The first is that this argument fails to take into account that there are some warnings that may be conveyed on the basis of general

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<sup>262</sup> Gonzalez 74-75.

<sup>263</sup> See for example *Dooley v Everett* 805 SW 2d 380 (Tenn App Ct 1991) in which the Tennessee Pharmacy Act was relied upon. See also the general discussion of statutory duties in 3.5.4.2.

<sup>264</sup> Section 29(b) of the Medicines Act.

<sup>265</sup> Section 30(1) of the Medicines Act.

<sup>266</sup> *Eldridge v Eli Lilly and Co* 485 NE 2d 551 (Ill App Ct 1985) 553.

drug-related pharmaceutical knowledge,<sup>267</sup> without knowledge of the medical history of the patient concerned.<sup>268</sup> Dwyer lists the following as examples of the kind of information about which pharmacists should be expected to provide warnings:

- the need to be alert for adverse effects;
- the need to avoid other drugs (including alcohol) or kinds of food that may interact with the drug which has been prescribed; and
- the need to take care if conducting certain activities (such as driving or operating heavy machinery) during the course of drug therapy.<sup>269</sup>

All of these examples involve the provision of risk minimisation information which is not necessarily dependant on the medical history or condition of a particular patient.

The second problem with denying liability on the basis of lack of patient-specific knowledge is that, whilst, traditionally, pharmacists may not have had access to patient-specific information, in modern times, they are generally required to maintain extensive patient profiles.<sup>270</sup> The Rules Relating to Good Pharmacy Practice stress that pharmacists must have access to as much information as is needed to meet the individual needs of each patient, including the medical records of that patient,<sup>271</sup> and must be aware of the essential medical information about each person to whom they render a service.<sup>272</sup> Rule 2.9 provides certain minimum standards for the keeping of patient medication records whilst rule 2.25.1 deals with patient information. These two rules provide that patient medication records must be developed (preferably with the use of computer technology)<sup>273</sup> and must contain certain information, including a list of all prescription and OTC medications obtained by the patient from the pharmacy in the past year, any allergies, chronic conditions or diseases which the patient may have, and any reactions or possible reactions of the patient towards medicine.<sup>274</sup>

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<sup>267</sup> Brushwood *Drake LR* 29-30.

<sup>268</sup> Casmere 444; Milot 1019.

<sup>269</sup> Dwyer 742-743. See also Cruz 242.

<sup>270</sup> Gonzalez 60.

<sup>271</sup> Rule 2.8.2(b).

<sup>272</sup> Rules p3.

<sup>273</sup> Rule 2.9.1(a).

<sup>274</sup> Rule 2.9.1(c).

It is conceded that the establishment and maintenance of extensive patient profile systems may well, at present, represent more of a goal than a standard practice within the South African pharmacy profession. Whilst pharmacists have always been expected to possess knowledge concerning drugs, the expectation that they possess patient-specific knowledge is a recent development which has accompanied the profession's move towards patient-orientation. In spite of this, it must be accepted that there are times at which pharmacists *will* be privy to patient-specific knowledge<sup>275</sup> and in which they can thus be expected to make use of this information in performing risk management and be regarded as acting unlawfully if they fail to do so. In other words, conduct which is wrongful in one context (where a pharmacist possesses certain information) may be completely lawful in another (where information is not possessed).<sup>276</sup>

(ii) *Interference with Physician-Patient Relationship*

Another argument that is frequently raised in the United States in support of the non-recognition of a duty to counsel is that such a duty, if imposed, would interfere with the physician-patient relationship,<sup>277</sup> possibly confusing patients<sup>278</sup> and causing them to lose trust in their physicians<sup>279</sup> and even to discontinue using the drug in question.<sup>280</sup> The argument is thus essentially that warnings from pharmacists are *undesirable*, because they have the potential to cause harm. It also assumes that warnings from pharmacists are *unnecessary*, because a duty to warn already rests upon physicians. This argument can, of course, only be raised in relation to drugs that have actually been prescribed by other healthcare professionals. Where therapy is initiated by a pharmacist, the provision of information is most certainly both

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<sup>275</sup> In *Hand v Krakowski* 89 AD 2d 551, 453 NYS 2d 121 (1982), for example, the pharmacist was aware that the patient was an alcoholic, whereas in *Ferguson v Williams* 92 NC App 336, 374 SE 2d 438 (1988), the patient told the pharmacist that he was allergic to Percodan.

<sup>276</sup> This approach is consistent with the comment in *Kadir v Minister of Law and Order* 742E-F that decisions as to wrongfulness are custom-made for the *particular* situation before the court. See also Owen's article on the American approach to the duty to warn in which it is highlighted that American courts have only recognised such a duty where some *additional factor* (such as the possession of patient-specific information) is present. (See, in particular, Owen 688.)

<sup>277</sup> Casmere 438; Owen 683.

<sup>278</sup> Asbury 917; Termini 556.

<sup>279</sup> Brushwood *Drake LR* 43.

<sup>280</sup> Termini 556.

necessary and desirable as the pharmacist is the only professional with whom the patient is likely to have contact.

With regard to prescription medications, it is true that when a pharmacist provides a patient with information which either has not been divulged by the prescribing physician or is in conflict with that imparted by the prescriber, damage may be caused to the physician-patient relationship. It does not, however, follow that the provision of information by pharmacists is completely undesirable. In this regard, it is submitted that the following are necessary considerations:

- a) the *extent* to which a pharmacist's provision of risk management information intrudes upon the relationship between doctor and patient; and
- b) whether a pharmacist's provision of risk management information has any *desirable* consequences.

Brushwood argues that the role that can be played by pharmacists in the provision of warnings hinges on the distinction between risk assessment information and risk management information.<sup>281</sup> In Chapter 2 it was explained that, whilst the primary task of doctors is risk assessment, pharmacists are more suited to risk management.<sup>282</sup> It follows that, in addition to being *able* to supply risk management information, a legal requirement that pharmacists provide such information is not inconsistent with their professional role. Risk minimisation information is not intended to provide a basis upon which patients can decide whether or not to take a particular drug. The provision of this kind of information is rather meant to assist patients in managing the side effects and adverse reactions that may result from drug use.<sup>283</sup> It aims at causing patients to change their lifestyle during the course of drug therapy so that the therapy is as safe and effective as possible.<sup>284</sup> As such, the provision of risk management information by pharmacists will usually have no direct bearing on whether a patient

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<sup>281</sup> Brushwood *Drake LR* 29-31.

<sup>282</sup> See 2.2.4 above. Whether the role of pharmacists can be regarded as having seeped into the risk assessment domain is considered at 3.7.1.3 below.

<sup>283</sup> Owen 699.

<sup>284</sup> Green 1466; Brushwood *Drake LR* 30.

embarks on a course of drug therapy and consequently will not interfere with the *assessment* function performed by physicians.<sup>285</sup>

There are, additionally, a number of desirable consequences that accompany the provision of risk management information by pharmacists. This practice may both add value to the drug therapy process and complement the *physician-pharmacist* relationship. This is, firstly, because the provision of information by pharmacists will enhance patient understanding of *how* to use a drug after the physician has determined *which* drug should be used.<sup>286</sup> Secondly, by providing information, the pharmacist will *supplement* and *reinforce* the advice already given by physicians<sup>287</sup> and a culture of shared responsibility and mutual trust will be fostered between members of the healthcare 'team'.<sup>288</sup> Litman explains the position thus:

'[T]he pharmacist, the physician and the [healthcare] industry must work together, in concert, to see that the best possible treatment is not only dispensed, but is achieved and followed by patients as well. Although each must retain his/her own professional role within the prescribed tenants of his/her profession, each must also look to the other as partners rather than competitors—as fellow professionals who in the eyes of the public are involved not in a conspiracy to gain excess profits at the patient's expense, but rather as co-workers in providing the best possible medical care that science permits.'<sup>289</sup>

Indeed, the complexity of modern drug therapy makes it unreasonable to expect one professional to control the entire process alone.<sup>290</sup> An approach to drug therapy that focuses on co-operation between professionals with the purpose of adding to their effectiveness and improving the quality of patient care is also in line with the

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<sup>285</sup> This is not to say that physicians play no role in the risk *management* process or that they themselves are not under a duty to provide risk minimisation information concerning the drugs that they prescribe. It does, however, mean that courts, in placing a similar duty upon pharmacists, will not be intruding upon the *primary* function of physicians. In performing their roles in the drug distribution process, there is inevitably going to be some degree of overlap between the functions performed by various members of the healthcare team and it is submitted that there is no reason why two different healthcare professionals should not be placed under duties which, although independent of one another, are similar in nature. This is particularly true in light of the culture of shared responsibility that is advocated in this thesis.

<sup>286</sup> Casmere 444-445. As the last healthcare professional to have contact with a patient, the pharmacist is in the most strategic position to work with the physician in influencing patient compliance with drug therapy (West 122).

<sup>287</sup> Gonzalez 60; Brushwood *Drake LR* 44.

<sup>288</sup> Dwyer 743; Brushwood *Drake LR* 45; Owen 697; *Hooks Super X, Inc v McLoughlin* 519.

<sup>289</sup> Litman 138-139.

<sup>290</sup> Helper and Strand 541. See also Penna 546.

professional duties to which South African pharmacists are currently subject. The Pharmacy Council's Ethical Rules provide that the failure of a pharmacist, in the interests of a patient, to co-operate with colleagues or members of other health-service professions constitutes unethical conduct.<sup>291</sup> This commitment to co-operation is further emphasised in the Rules Relating to Good Pharmacy Practice<sup>292</sup> as well as the Pharmacist's Oath of the Pharmaceutical Society of South Africa and the Pharmacist's Code of Conduct.<sup>293</sup>

As a result of the above, it is submitted that the provision of risk management information cannot generally be regarded as undesirable. The positive consequences arising from the provision of risk management information by pharmacists also indicate that the provision of such information is *necessary*, even when counselling has already been given by physicians. Another factor which indicates that warnings by pharmacists are not superfluous is that, although physicians generally possess more patient-specific knowledge than pharmacists (and are thus in a better position to determine which drug should be used), pharmacists are more knowledgeable than doctors with regard to drug-specific information.<sup>294</sup> Raffath explains:

'Courses and clinical internships in pharmacology, pharmaceutics, toxicology, pharmacokinetics, biochemistry, and the like provide the pharmacist with a more extensive formal training than a physician or a nurse in the area of pharmaceuticals. Only the most widely read and dedicated physicians could feasibly reach the pharmacist's level of expertise in this very narrow area of drug therapy.'<sup>295</sup>

In other words, when it comes to drug-specific information (such as adverse reactions and how to avoid them), pharmacists will usually be in a *better* position to counsel patients than physicians are.

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<sup>291</sup> Rule 7.

<sup>292</sup> The rules (p2) provide that 'the ongoing relationship with other health care professionals should be seen as a therapeutic alliance involving mutual trust and confidence in all matters relating to pharmacotherapeutics.'

<sup>293</sup> Section 1.5.

<sup>294</sup> Owen 697.

<sup>295</sup> Raffath 62.

A final problem with placing such importance on the physician-patient relationship is that the *pharmacist-patient* relationship is neglected.<sup>296</sup> As has been noted, pharmacists, because of their special knowledge and skill, hold a position of public trust. There is a social expectation that pharmacists protect patients when filling prescriptions and this relationship of trust is quite independent of the physician-patient relationship.<sup>297</sup>

(iii) *Excessive Burden*

Another major argument which has been advanced against the recognition of a duty to counsel is that such a duty would place too great a burden upon pharmacists.<sup>298</sup> In particular, it has been submitted that to place a duty to warn upon pharmacists would require them to provide every patient with all information about every drug. This, of course, would be impossible,<sup>299</sup> especially in light of the limited time and resources which pharmacists have at their disposal. One American judgment to follow this line of reasoning was that of *Ingram v Hook's Drugs, Inc*<sup>300</sup> in which a pharmacy was sued for failing to inform a patient that Valium may cause drowsiness. In rejecting the plaintiff's claim, the court stated:

'Ingram's position would require a pharmacist filling a prescription for Valium to give the entire list of side effects and cautionary statements. Such a voluminous warning would only confuse the normal customer and be of dubious value.'<sup>301</sup>

In this regard, it is submitted that, if it were accepted that pharmacists have a legal duty to counsel patients, this would not mean that such a duty would be unlimited. Even if one is advocating the existence of a duty to counsel, one must accept that pharmacists *should not* be expected to provide patients with every piece of cautionary information related to a dispensed drug. Not only would this place a heavy burden upon pharmacists, but there is also danger in over-warning or providing unnecessary warnings. This may harm a patient by causing him or her to decide not to use the drug

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<sup>296</sup> *Brushwood Drake LR* 43.

<sup>297</sup> *Casmere* 444.

<sup>298</sup> *Casmere* 434 and 440; *Owen* 683.

<sup>299</sup> *Brushwood Drake* 23.

<sup>300</sup> 476 NE 2d 881 (Ind Ct App 1985).

<sup>301</sup> *Ingram v Hook's Drugs, Inc* 887.

or to alter the beneficial way in which the drug is being used.<sup>302</sup> The overuse of warnings may further be detrimental in that it may decrease patients' understanding of information or cause them to have complete disregard for warnings.<sup>303</sup> In order to have the desired impact in promoting safe and effective drug use, risk management information must, in other words, be given selectively.<sup>304</sup>

(iv) *Insufficient Compensation*

The final policy argument against the recognition of a duty to provide risk management counselling is that pharmacists are not adequately compensated for such a task.<sup>305</sup> The issue of compensation for pharmaceutical services has recently been the subject of heated controversy in South Africa. In an attempt to make medicines more affordable so as to give effect to the state's obligations in terms of s27 of the Constitution,<sup>306</sup> the Medicines Act was amended to provide, *inter alia*, for the establishment of a Pricing Committee to make recommendations concerning the introduction of a pricing system for medicines sold in South Africa. The amended provisions came into force in May 2003 and, in due course, the Minister of Health, on the recommendations of the Pricing Committee, introduced regulations which laid out a pricing system for the sale of medicines.<sup>307</sup> The Regulations contemplate a single exit price (SEP) to be set for every medicine sold in South Africa.<sup>308</sup> All those involved in the chain of distribution are restricted from selling a drug at a price higher than the SEP.<sup>309</sup> Pharmacists are, however, entitled to an 'appropriate' dispensing fee for their services.<sup>310</sup> According to the Pricing Committee's report on the Draft

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<sup>302</sup> Brushwood *Drake LR* fn 13.

<sup>303</sup> Twerski *et al* 521.

<sup>304</sup> It also must not be forgotten that the ambit of any duty to provide risk management information will inevitably be curtailed by the negligence enquiry. A defendant's conduct, even if wrongful, will only be negligent if it fails to accord to the conduct of the reasonable person (or, in the case of pharmacists, the reasonable pharmacist). In light of the inconvenience and potential danger involved in providing excessive warnings, it is submitted that the extent of risk management counselling provided by the reasonable pharmacist would be limited.

<sup>305</sup> Brushwood *Drake LR* 24.

<sup>306</sup> Section 27 of the Constitution provides that everyone has the right to healthcare services and that the state is under an obligation to take reasonable legislative steps and other measures to achieve the progressive realization of this right.

<sup>307</sup> The Regulations Relating to a Transparent Pricing System for Medicines and Scheduled Substances GNR 553 of 30 April 2004.

<sup>308</sup> Regulation 2.

<sup>309</sup> Regulations 2, 5(1) and 6.

<sup>310</sup> Section 22G(2)(b) Medicines Act.

Regulations submitted in December 2003, this dispensing fee is intended to cover the following services:

'[T]he interpretation and evaluation of a prescription, the selection, manipulation or compounding of the medicine, the labelling and supply of the medicine in an appropriate container and *the provision of information and instruction by a pharmacist to ensure the safe and effective use of medicine by the patient.*'<sup>311</sup>

The fee, in other words, covers all professional services provided by pharmacists,<sup>312</sup> including the provision of risk management information. The first point to note is therefore that pharmacists *are* currently compensated for providing this kind of information.

As to the adequacy of compensation, the maximum dispensing fees initially found in the Regulations<sup>313</sup> were challenged before the Constitutional Court<sup>314</sup> which held that, whilst the regulatory scheme as a whole was acceptable, the dispensing fee (which, it was argued, threatened the economic viability of pharmacies) was not appropriate and was thus inconsistent with the Medicines Act. The court remitted this issue to the Pricing Committee and the Minister of Health for reconsideration and the new dispensing fee structure was announced by the Department of Health on 31 October 2006.<sup>315</sup> It pertains to all medicines from Schedule 1 upwards and is structured in four tiers. Where the SEP is less than R75, the maximum dispensing fee is R4 plus 33% of the price. A fee of R25 plus 6% of the price can be charged for dispensing medicines that cost between R75 and R250, whilst drugs costing between R250 and R1000 may attract a dispensing fee of no more than R33 plus 3% of their price. Finally, the maximum dispensing fee for medicines costing over R1000 is R50 plus 1.5% of the price. The Regulations also provide for an annual SEP increase.<sup>316</sup> It is thus evident that efforts are being made to ensure that pharmacists receive fair compensation for

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<sup>311</sup> Quoted in *Minister of Health v New Clicks SA (Pty) Ltd* par [331]. Emphasis added.

<sup>312</sup> *Minister of Health v New Clicks SA (Pty) Ltd* par [564].

<sup>313</sup> Regulations 10 and 11 initially provided that the maximum dispensing fee with regard to OTC medications was 16% for products which cost under R100 and R16 for products costing more than R100. When it came to prescription medications, the maximum fee for dispensing was 26% for products which were under R100 and R26 for products in excess of this amount.

<sup>314</sup> *Minister of Health v New Clicks SA (Pty) Ltd*.

<sup>315</sup> Although pharmacists have been given until 1 January 2007 to comply with the new model.

<sup>316</sup> Announcement of the New Dispensing Fee for Medicine.

their services.<sup>317</sup> Even if this were not the case, it is, nonetheless, submitted that a failure to receive adequate compensation should not weigh heavily as a policy consideration in determining the existence of a legal duty to prevent harm.<sup>318</sup>

The question which remains to be answered is whether, in light of the above, it is reasonable to impose liability on pharmacists who fail to provide their patients with risk management information. Are pharmacists, in other words, under a legal duty to ensure that patients understand how to use pharmaceutical products? The above discussion has highlighted a number of important policy considerations which favour the imposition of such a duty. The various arguments against liability have, on the other hand, been largely rebutted. It is consequently submitted that South African courts are likely to find pharmacists liable for harm suffered by patients who have not received appropriate risk management counselling. From this, it does not necessarily follow, however, that pharmacists are currently under a legal duty to provide patients with risk *assessment* information. The existence of such a duty depends on different policy considerations which now fall to be examined.

#### 3.7.1.3 The Provision of Risk Assessment Information

In Chapter 2 it was explained that the principle of autonomy generally requires that individuals make their own decisions concerning medical treatment.<sup>319</sup> This decision-making process is facilitated by the process of informed consent—ie the disclosure of the risks and benefits of the proposed course of drug therapy. The significance that South African society places on the concept of informed consent is evidenced by the Department of Health's Patients' Rights Charter as well as the National Drug Policy for South Africa, both of which emphasise the importance of the informed use of medicine.<sup>320</sup> That it is necessary to obtain informed consent is thus undisputed. The

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<sup>317</sup> Note, however, that the new dispensing fee structure has been met by resistance by the Pharmacy Stakeholders' Forum, which feels that the fees are still insufficient to cover the operating costs of pharmacies. For an indication of the effect that the new model will have on the affordability of pharmaceutical products, see the Department of Health's 'Comparison of Medicine Prices Before and After Implementation of the SEP Regulations'.

<sup>318</sup> Penna (546) in fact makes some interesting criticisms of fee-for-service systems and essentially argues that such systems discourage healthcare professionals from providing continuous care.

<sup>319</sup> See 2.3.2.3(b) above.

<sup>320</sup> Section 2 of the Charter emphasises the right of patients to participate in decision-making on matters affecting their health, whilst s8 states that everyone has the right to be given full and accurate

point of controversy is whether the duty to provide risk assessment information so as to gain informed consent lies solely on the shoulders of physicians, or whether pharmacists also have a legal duty to provide such information (or, for that matter, to ensure that it has been provided by another professional and understood by the patient).

In *Castell v De Greef* the plaintiff claimed that the defendant, a plastic surgeon, had been under a legal duty to warn her, prior to an operation, of the material risks of the procedure. The defendant's breach of this duty, it was argued, had resulted in the plaintiff undergoing a procedure that she would have refused had disclosure occurred, and was consequently the cause of the plaintiff's harm. The court stressed that, although in foreign jurisdictions, cases such as this are dealt with by questioning whether there existed a duty of care and whether such a duty was breached,<sup>321</sup> in this country the enquiry is 'whether the defence of *volenti* has been established and in particular whether the patient's consent has been properly informed consent.'<sup>322</sup> It follows that, in South Africa, a plaintiff's claim will be unsuccessful if it can be established that the patient received, and understood, risk assessment information and, on this basis, consented to or voluntarily assumed the risk of harm. If this were the case, wrongfulness will be excluded regardless of *who* the information came from.

Giesen comments that 'while it is acceptable to say that correct and adequate information may come from *any* source, it is quite clear from the case law of most jurisdictions that the duty to provide proper information is that of the physician, and nobody else.'<sup>323</sup> Indeed, American courts have indicated that the duty to provide warnings about prescription drugs lies solely with the prescribing physician<sup>324</sup> who, as the professional who evaluates the needs of the patient and assesses the risks of a course of treatment, is in the best position to determine how much information the

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information about the nature of their illness and the proposed treatment thereof. Chapter 7 of the Policy has the aim of 'supporting the informed and appropriate use of drugs by the community.'

<sup>321</sup> *Castell v De Greef* (2004) 425E-F.

<sup>322</sup> *Castell v De Greef* (2004) 423C.

<sup>323</sup> Giesen 371. See also 372 where Giesen stresses that the physician is the appropriate professional to discharge the legal duty of disclosure.

<sup>324</sup> *Eldridge v Eli Lilly and Co.*

patient should be given.<sup>325</sup> In *Coyle v Richardson-Merrel, Inc.*,<sup>326</sup> for example, the court stated:

‘While [the] patient is entitled to know, and a doctor has a duty to inform the patient of any dangers or side effects associated with a drug recommended for treatment, we see no sound reason for imposing on pharmacists the duty to supply information about the risks of drugs that have already been prescribed. On the contrary, such a rule would have the effect of undermining the physician-patient relationship by engendering fear, doubt, and second guessing.’<sup>327</sup>

One must, however, be aware that, in the United States, one of the major reasons for which courts have been reluctant to burden pharmacists with a duty to warn has been the existence of the so-called ‘learned intermediary’ doctrine. According to this doctrine, a manufacturer has a duty to provide warnings concerning its products. This duty will be satisfied if the manufacturer provides the physician with all of the necessary information concerning the product. The physician thus becomes the channel through which the patient receives the warning.<sup>328</sup> He or she is the learned (or ‘informed’) intermediary who falls between the manufacturer and the patient and who is the appropriate person to provide the patient with advice about the risks associated with a particular drug.<sup>329</sup> Because the physician is the middleman between the manufacturer and the patient, pharmacists in the United States have been regarded as having no duty to warn.<sup>330</sup> Some American academics<sup>331</sup> have argued that the learned intermediary doctrine has been misapplied in pharmacist duty to warn cases. The purpose of the doctrine is to shift the duty to warn a patient from the manufacturer to the physician because the physician is more proximate to the patient and in a better position to provide warnings. Bearing in mind that a pharmacist may be considered even more proximate to the patient, there appears to be no solid reason why the doctrine should shield pharmacists from liability.<sup>332</sup>

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<sup>325</sup> Green 1459-1460.

<sup>326</sup> 584 A 2d 1383 (Pa 1991).

<sup>327</sup> *Coyle v Richardson-Merrel, Inc* 1386.

<sup>328</sup> Gonzalez 59; Casmere 439; Milot 1021.

<sup>329</sup> Apter 197; Termini 552.

<sup>330</sup> Green 1459.

<sup>331</sup> Such as Brushwood.

<sup>332</sup> Casmere 445-446.

Regardless of whether the learned intermediary doctrine has or has not been accurately applied by American courts, it is significant that no equivalent of this doctrine exists in South African law. If anything, the South African legislature appears to regard the provision of risk assessment information as a task of *all* healthcare professionals, not merely physicians. This is seen in the National Health Act<sup>333</sup> which states that *every* healthcare provider (including pharmacists<sup>334</sup>) must provide patients with information concerning, *inter alia*, the range of treatments available to them and the risks and benefits associated with each option.<sup>335</sup>

The South African pharmacy profession itself does currently appear to harbour an expectation that its members involve themselves not only in the process of risk minimisation, but also in risk assessment. The Rules Relating to Good Pharmacy Practice state that the evaluation of patients' medicine-related needs forms part of the scope of the practice of pharmacy.<sup>336</sup> Likewise, the definition of dispensing in the Regulations Relating to the Practice of Pharmacy includes the *evaluation* of a prescription.<sup>337</sup> In the spirit of this general expectation, the profession expects pharmacists to provide patients with risk assessment information. Rule 2.8 of the Rules Relating to Good Pharmacy Practice thus provides that patient information must not only enhance the outcome of medical treatment by promoting effective drug use, but also respect patient *autonomy* by empowering patients to make *informed decisions* regarding their medical treatments.<sup>338</sup> In the United States, some courts have placed a restrictive interpretation on statutes and regulatory provisions requiring patient counselling. In *McKee v American Home Products Corp*,<sup>339</sup> for example, the court held that such a provision applied only to risk minimisation information such as 'whether to take the drug on an empty or full stomach, substances to avoid while using the drug, or not to drive or use heavy machinery while taking the drug.'<sup>340</sup> The fact that the South African Rules refer specifically to the role of pharmacists in

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<sup>333</sup> Act 61 of 2003.

<sup>334</sup> The Act's definition of a 'healthcare provider' includes any person providing health services in terms of the Pharmacy Act (s1).

<sup>335</sup> Section 6(1).

<sup>336</sup> Rules p2.

<sup>337</sup> This assessment function is further discussed in 4.4.3 and 4.4.4 below in relation to the failure to detect invalid or inaccurate prescriptions.

<sup>338</sup> Rule 2.8.1.

<sup>339</sup> 113 Wash 2d 701, 782 P 2d 1045 (1989).

<sup>340</sup> *McKee v American Home Products Corp* 1052.

promoting patient autonomy, however, excludes the inference that the professional duty to counsel extends solely to risk minimisation information.

With regard to a pharmacist's *ability* to provide risk assessment information, it is significant that, just as in the case of risk management counselling, there are risk assessment warnings which can be given in the absence of patient-specific information. Certain drugs, for example, have a high known probability of side effects and thus pose a material risk of harm to all patients, regardless of their personal medical conditions and histories.<sup>341</sup> Indeed, the fact that pharmacists are invariably more knowledgeable than physicians when it comes to drug-specific information means that there may well be reason to expect them to provide information about the risks of drug therapy. It must also again be stressed that, in light of the growing professional expectation that pharmacists possess patient-specific information, pharmacists will, at times, be aware of the peculiar susceptibilities of specific patients and thus be in a position to provide information about unusual side effects where appropriate.

One practical issue affecting the ability of pharmacists to provide risk assessment counselling to all patients is the extent of information that they may be expected to give. In light of the legal approach taken to the provision of risk assessment warnings by medical practitioners in general, there appears no danger of pharmacists ever being expected to provide information concerning *all* known risks.<sup>342</sup> At most, pharmacists will be expected to supply information regarding the material risks of drug therapy—ie those risks which a reasonable patient would attach significance to or which the pharmacist is aware, or should be aware, that the particular patient attaches significance to.<sup>343</sup> With regard to the individual patient standard of disclosure—this can of course only be applied to pharmacists who are in possession of, or should be in possession of, patient-specific knowledge. It follows that a duty to provide risk assessment information would not place an unreasonable burden upon pharmacists.<sup>344</sup>

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<sup>341</sup> Raffath 67; Milot 1019-1020.

<sup>342</sup> There is no reason why pharmacists should be subject to a different standard from other healthcare professionals (Milot 1020).

<sup>343</sup> See discussion of *Castell v De Greef* at 3.6.2.2 above.

<sup>344</sup> It should also be remembered that the court in *Castell v De Greef* (2004) qualified the duty to provide information by stating that information may be intentionally withheld if its disclosure would

The discussion thus far has demonstrated that, in South Africa, it does not appear that prescribers are the only healthcare professionals expected to provide patients with risk assessment information so as to obtain informed consent. Both the legislature and the pharmacy profession in this country expect pharmacists to take some degree of responsibility for risk assessment by providing patients with information concerning the risks and benefits of drug therapy. Pharmacists also clearly have the ability to supply patients with information of this nature and an expectation that they provide such information is not unduly burdensome. In determining whether pharmacists are under a legal duty to provide risk assessment information, one needs to weigh these considerations against the fact that pharmacists who supply risk assessment counselling are performing a function traditionally reserved for physicians and are consequently interfering with the doctor-patient relationship. Although this will not necessarily be the *determining* factor in a court's decision whether to saddle a pharmacist with liability, it will undoubtedly be a weighty consideration in the wrongfulness enquiry. Whether South African courts will be prepared to impose liability upon pharmacists who fail to supply risk assessment information concerning prescription drugs is thus unclear.

Arguments based on the physician-patient relationship cannot, of course, be raised when drug therapy has been initiated by the pharmacist. In these instances, it is submitted that the pharmacist, as the only healthcare professional with whom the patient has contact, will undoubtedly be under a duty to supply risk assessment information. If such information is not provided, the patient will usually be unable to give informed consent to the risks accompanying the course of drug therapy and the pharmacist will consequently be unable to avoid liability should such risks materialise. It must furthermore again be stressed that, even if the courts find that pharmacists are bound to provide risk assessment information concerning *prescription* drugs, a failure to provide such information will not result in liability if sufficient risk assessment counselling has been provided by another professional.

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harm the patient. Where, in other words, the provision of certain information is likely to cause more harm than benefit, a pharmacist's failure to disclose such information may be lawful.

#### 3.7.1.4 Assuring Understanding Amongst Patients

Although the terms ‘duty to warn’ and ‘duty to counsel’ have thus far been used interchangeably, a distinction can be made between them. Whilst a duty to *warn* technically involves a duty merely to provide a patient with information,<sup>345</sup> a duty to *counsel* suggests a duty additionally to assist a patient in understanding information and (in the case of risk assessment information) making a decision.<sup>346</sup> The latter duty is thus more extensive than the former. As should be evident from the discussion thus far, in South Africa, it would appear that pharmacists are under a duty to counsel rather than merely to warn. To provide information without ensuring that it is understood does little to further the objectives of promoting effective drug therapy and obtaining informed consent.

In light of the need to ensure that information is not only received, but also understood, a question arises concerning whether warnings and instructions can be satisfactorily provided in written format. The provision of written information offers a number of advantages that verbal patient counselling does not. Written information can be distributed quickly and ensures that all patients receive complete information which they can retain and refer to whenever necessary. It must, however, be stressed that, in order to serve any purpose at all, written information must be presented in a manner that the average patient is likely to understand.<sup>347</sup> Although it is often useful to provide patients with written information, this should, furthermore, not be regarded as a substitute for verbal counselling. As put by McLeod and Miller, written instructions ‘should not be viewed as being the total educational process,’ but ‘should be used to complement and reinforce the verbal instructions communicated to patients.’<sup>348</sup>

A major problem with supplying information in written format,<sup>349</sup> and indeed, with promoting understanding in general, is that different patients will inevitably have

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<sup>345</sup> Casmere 426 fn 3.

<sup>346</sup> Brushwood *Drake LR 2* fn 1. It has already been explained that informed consent is only present if a patient fully appreciates the risks to which he or she is consenting.

<sup>347</sup> McLeod and Miller 58.

<sup>348</sup> McLeod and Miller 58-59.

<sup>349</sup> For further problems with supplying patients with only written information, see the discussion in 3.7.1.6 below on the provision of information by virtual pharmacies.

varying levels of comprehension.<sup>350</sup> Particularly in a country such as South Africa in which the majority of the population are second, or even third, language English speakers (who may easily misinterpret information<sup>351</sup>) and in which many have received little or no formal education, the distinction between a duty to provide information and a duty to ensure that it is understood is an important one.<sup>352</sup> This is especially true when the relevant information is complex in nature (which healthcare information often is<sup>353</sup>) or when the dosage regimen is somewhat unusual.<sup>354</sup> Language and educational barriers on the part of patients are not the only potential bar to understanding. Gorovitz observes that '[h]eighted anxiety associated with illness, the effects of medication, the regression that is commonly exhibited by patients, the mechanisms of denial, and many other factors can also interfere [with understanding] and commonly do.'<sup>355</sup> The result is that the process of patient counselling will often prove far more difficult than a pharmacist initially anticipates.<sup>356</sup>

The National Health Act states that healthcare providers, when supplying risk assessment information, must, if possible, provide the information in a language which the patient understands and in a manner that takes into account the patient's level of literacy.<sup>357</sup> In a similar vein, rule 2.8 of the Rules Relating to Good Pharmacy Practice<sup>358</sup> specifies that pharmacists must assess the ability of each patient to understand the information in question and must be able to modify their approaches accordingly.<sup>359</sup> Pharmacists, in other words, need to adapt their explanations to the level of understanding exhibited by particular patients. The successful communication of information may, for example, necessitate the use of visual images<sup>360</sup> or the

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<sup>350</sup> *Minister of Health v New Clicks SA (Pty) Ltd*; *Beauchamp and Childress* 157.

<sup>351</sup> *Hardin* 365.

<sup>352</sup> As Ingelfinger (180) points out:

'The trouble with informed consent is that it is not educated consent.'

<sup>353</sup> *Hardin* 364.

<sup>354</sup> Dwyer 746. *Hardin* (364) observes that the complexity of drug regimens is likely to increase as more and more pharmaceutical products are introduced to the market.

<sup>355</sup> Gorovitz 'Informed Consent' 184.

<sup>356</sup> Gorovitz 'Informed Consent' 183.

<sup>357</sup> Section 6(2).

<sup>358</sup> This rule enumerates the minimum standards for patient information and advice.

<sup>359</sup> Rule 2.8.2 (i). See also s1.1.3 of the Code of Conduct for Pharmacists.

<sup>360</sup> *Hardin* 365.

drawing of analogies between the medical information provided and events with which the patient is more familiar.<sup>361</sup>

### 3.7.1.5 A Patient's Refusal to be Counselling

Assuming that pharmacists are under a duty to provide their patients with information (either risk assessment or risk management), and that patients thus possess a corresponding right to receive such information, the question arises whether this right can be waived. Can patients, in other words, voluntarily relinquish their rights to be counselled, thus relieving pharmacists of their duties in this regard? Within the context of informed consent, this essentially amounts to a patient renouncing his or her decision-making authority and delegating such authority to a healthcare professional,<sup>362</sup> whether this professional be a physician (in the case of prescription medications) or a pharmacist (in the case of OTC drugs).

The issue is essentially whether a pharmacist's failure to provide counselling is still wrongful if the cause of the omission is a patient's refusal to be counselled. From an ethical perspective, as long as patients are aware of the dangers involved in not receiving information, to force unwanted information upon them will itself constitute an infringement of autonomy.<sup>363</sup> The principle of beneficence may, however, outweigh a patient's decision not to receive information, even if this decision is both informed and voluntary.

In the United States, the OBRA-90<sup>364</sup> explicitly states that pharmacists are not required to provide consultation where a patient refuses it.<sup>365</sup> On this basis, the California Court of Appeals in *Hooper v Thrifty Payless*<sup>366</sup> held that no *common law duty* rests upon a pharmacist to provide counselling to a patient who has refused it.

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<sup>361</sup> Eg Beauchamp and Childress (158), for example, suggest that the risks posed by a course of therapy can either be explained in terms of numeric probabilities or by drawing a comparison with the risks posed by everyday activities such as driving a car.

<sup>362</sup> Beauchamp and Childress 162.

<sup>363</sup> Beauchamp and Childress 401. Indeed, Giesen (375) describes waiver as 'one legal form of exercising one's right to self-determination.' See also 2.3.2.3(b) above.

<sup>364</sup> Discussed in 3.7.1.2 above.

<sup>365</sup> Vivian 'Refusing Counselling' 3.

<sup>366</sup> 2002 (unreported). See discussion in Vivian 'Refusing Counselling'.

Brushwood, however, has cautioned that, even in light of the provisions of the OBRA-90, not every refusal of counselling constitutes a waiver:

'Although patients can waive the right to be counselled about drug therapy, the law contemplates an informed right. If a clerk or other personnel asks, "You don't want to wait 45 minutes to be counselled by the pharmacist, do you?" and the patient or caregiver answers, "No", this is not the type of informed refusal that Congress anticipated. A refusal can be considered effective only if the patient truly understood the offer and elected to decline the counselling. A patient who refuses counselling because the pharmacist or someone else in the pharmacy has made it clear that the pharmacist really does not want to be bothered with counselling has not received the benefit of the services that OBRA-90 intends.'<sup>367</sup>

In South Africa, the *locus classicus* on waiver is *Laws v Rutherford*.<sup>368</sup> In that case the Appellate Division held that, for waiver to be established, it must be shown that 'the respondent, with full knowledge of her right, decided to abandon it, whether expressly or by conduct plainly inconsistent with the intention to enforce it.'<sup>369</sup> It can thus be seen that a defendant who wishes to avoid liability on the basis of waiver will need to prove that the plaintiff:

- a) was *aware* of the right being waived, and
- b) had the *intention* of waiving the right.

It is accordingly submitted that in South Africa, as in the United States, one will be able validly to waive one's right to receive information only if one has full knowledge of the existence of this right and intends to abandon it. Whether this is the case will be a question of fact, the answer to which depends on the circumstances.<sup>370</sup> In this regard, our courts have stressed the importance of taking into account that there is a

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<sup>367</sup> Quoted in Vivian 'Refusing Counselling' 4 fn 8. In *Hooper v Thrifty Payless*, the plaintiff had been offered an unqualified opportunity to be counselled by a pharmacist and thus could not argue that his waiver was ineffective.

<sup>368</sup> 1924 AD 261.

<sup>369</sup> *Laws v Rutherford* 263. See also *Alfred McAlpine and Son (Pty) Ltd v Transvaal Provincial Administration* 1977 (4) SA 310 (T) 324A; *Hepner v Roodepoort-Maraisberg Town Council* 1962 (4) SA 772 (A) 778H-779A:

'The *facta probanda* would be full knowledge of the rights in question and express waiver or waiver by plainly inconsistent conduct, ie knowledge of a particular kind and surrender of the right in a particular manner.'

<sup>370</sup> *Laws v Rutherford* 263. See also Beauchamp and Childress (163) who, although accepting that it is possible to waive a right to receive information, warn against allowing waivers to become commonplace in medical practice and stress that there is a need to consider each waiver separately.

strong improbability that a person will lightly waive rights which have been conferred upon him or her by law.<sup>371</sup> It follows that defendant pharmacists may well face difficulty in convincing a court that a waiver of the right to receive information has occurred.

### 3.7.1.6 The Ability of Virtual Pharmacies to Provide Satisfactory Information

Having argued that South African courts are likely to hold that pharmacists have a legal duty to provide their patients with, at the very least, risk minimisation information, the above discussion has demonstrated that this duty will not be an easy one for pharmacists to satisfy. This stems primarily from the fact that the duty requires pharmacists not only to provide patients with information, but also to ensure that patients understand the information with which they are supplied. A pharmacist's approach in providing information about drugs and drug use will accordingly need to be adapted on a patient-by-patient basis. When drugs are ordered on-line, it becomes particularly difficult to ensure that each and every patient understands the information provided. Internet pharmacies enable patients to obtain drugs without ever speaking to a pharmacist.<sup>372</sup> The fact that any consultation occurring over the Internet is necessarily distant and impersonal<sup>373</sup> makes the use of Internet pharmacies more appealing to some patients. It also, however, renders the question whether it is possible for a pharmacist to provide patients with adequate counselling via this medium.

In light of the difficulties inherent in patient counselling in general, it is not surprising that some, such as Patel,<sup>374</sup> have argued that, in order for pharmaceutical care to be adequately provided, it is essential for some form of direct contact to occur between pharmacist and patient. The issue of how to combine the technology currently available to healthcare professionals with face-to-face interaction is indeed a great challenge. In the future, this problem may be overcome to some degree by further

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<sup>371</sup> See *Kannemeyer v Gloriosa* 1953 (1) SA 580 (W) 585H-586A; *Le Roux v Odendaal and Others* 1954 (4) SA 432 (N) 441D-F; *Alfred McAlpine and Son (Pty) Ltd v Transvaal Provincial Administration* 324D; *Cassim v Kadir* 1962 (2) SA 473 (N) 478B; *Bay Loan Investment (Pty) Ltd v Bay View (Pty) Ltd* 1971 (4) SA 538 (C) 540E-H; *Financial Mail (Pty) Ltd v Sage Holdings Ltd* 469B-C.

<sup>372</sup> Rost 623.

<sup>373</sup> Tyler 282.

<sup>374</sup> Patel 1. See also Penna 547.

advancements in, and greater use of, technology. In 1999, for example, Angaran noted that there were reports of some American pharmacies using videoconferencing as a means of counselling patients from a distance.<sup>375</sup> Interestingly enough, the South African Department of Health has also recognised the valuable role that telemedicine can play in improving access to high quality and cost-effective healthcare services. It follows that South Africans are likely to see greater use of technology in the provision of healthcare services in the near future.<sup>376</sup> At present, however, the primary means of conveying healthcare information over the Internet is through writing.

There are a number of problems with Internet sites providing healthcare information in written format. Firstly, there is no guarantee that the information will be read by the patient. The situation becomes particularly problematic when the website permits patients to bypass pages containing healthcare information and proceed directly to the ordering stage.<sup>377</sup> Pharmacists will, it is submitted, battle to establish that patients have waived the right to receive counselling in such instances. Even if patients do read all of the instructions and warnings provided on the website, there is no mechanism to ensure that this information is understood. A further problem is that the information posted on pharmacy web-sites must necessarily be general in nature. This means that, unless further correspondence with a pharmacist occurs, a patient will not be informed of the risks relevant to his or her particular circumstances. This becomes particularly dangerous with OTC medications, which are bought without ever having contact with a healthcare professional.

Some of the problems with the on-line sale of medicines were highlighted in *Deutscher Apothekerverband eV v 0800 Doc Morris NV and Another*.<sup>378</sup> In that case, the European Court of Justice had to decide, *inter alia*, whether a prohibition of the sale of medicinal products over the Internet by mail order was justified.<sup>379</sup> The

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<sup>375</sup> Angaran 1409 and 1414. See also Tyler 288 fn 198.

<sup>376</sup> Department of Health 'Establishment of a Telemedicine System for South Africa'.

<sup>377</sup> Carlini 172-173.

<sup>378</sup> 11 December 2003 case no C-322/01. See also Jacobs for a discussion of the *Deutscher* case and its relevance to South African law.

<sup>379</sup> The claimant in this case challenged the sale of medicine over the Internet, arguing that this was prohibited by German legislation. Whilst the matter originally came before a German national court, the court stayed the proceedings, referring a number of questions to the European Court of Justice for a preliminary ruling. One such question was whether a prohibition of the sale of medicine over the

claimant (an association with the aim of protecting and promoting the economic and social interests of pharmacists<sup>380</sup>) argued that the purpose of prohibiting the mail order sale of medicine was to ensure that, when purchasing drugs, patients are provided with individual information and advice.<sup>381</sup> The Greek and Austrian Governments both supported this view, submitting that, even if a patient can obtain advice over the Internet or via telephone, this is no substitute for the direct face-to-face counselling that can be provided in a traditional pharmacy. This is because '[t]he customer's physical and psychological state, his bearing, his lifestyle and his current medication are factors which must be taken into account during such a consultation.'<sup>382</sup> The defendants (who were involved in selling both prescription and non-prescription drugs over the Internet) responded by arguing that, when pharmaceutical products are sold via the Internet, the necessary information is provided by the pharmacist in writing and that, patients with further queries are able to contact the pharmacist either by telephone or writing (eg via e-mail). The defendants proceeded to point out that, even when drugs are bought from a traditional pharmacy, they are often collected by someone other than the patient for whom they are intended. It therefore cannot be argued that there is a need for patients to be physically present when purchasing medicine from pharmacies.<sup>383</sup>

The court held that, with regard to non-prescription medication, it is possible to provide adequate advice and information when such products are sold by mail order. The court further noted that it is possible to reduce the risk of incorrect use of medicine by increasing the number of interactive on-line features through which a patient must proceed before being able to purchase a drug.<sup>384</sup> When it came to prescription medicines, however, the court found that a prohibition upon the sale of these kinds of drugs over the Internet was justified. It emphasised the fact that prescription medicines must be more stringently controlled because they pose greater risks than OTC drugs.<sup>385</sup>

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Internet infringed the free movement of goods in terms of articles 28 and 30 of the Treaty establishing the European Community (24 December 2002).

<sup>380</sup> *Deutscher Apothekerverband eV v 0800 Doc Morris NV* par [34].

<sup>381</sup> *Deutscher Apothekerverband eV v 0800 Doc Morris NV* par [81].

<sup>382</sup> *Deutscher Apothekerverband eV v 0800 Doc Morris NV* par [82].

<sup>383</sup> *Deutscher Apothekerverband eV v 0800 Doc Morris NV* pars [91]-[93].

<sup>384</sup> *Deutscher Apothekerverband eV v 0800 Doc Morris NV* pars [113]-[114].

<sup>385</sup> *Deutscher Apothekerverband eV v 0800 Doc Morris NV* pars [117]-[124].

Rule 2.7.5 of the South African Pharmacy Council's Rules Relating to Good Pharmacy Practice, although not referring specifically to e-pharmacies, requires that, when medicine is delivered, all efforts must be made to enable face-to-face counselling between pharmacist and patient.<sup>386</sup> When a pharmacist does not personally deliver the medicine to the patient, the rule further provides that the patient must be furnished with comprehensive written instructions, including information on how to use the medicine correctly.<sup>387</sup> Rule 1.5(a) requires that, when drugs are dispensed via the Internet, a pharmacist must be available for consultation with patients.<sup>388</sup>

It is submitted that, as provided by the Rules and touched upon by the court in *Deutscher*, pharmacists who sell drugs over the Internet (and indeed pharmacists who provide drugs to any patient who they have not personally counselled) must, at the very least, provide easy-to-understand written information and encourage patients to contact them with any problems or queries.

In the face of the difficulties presented by patient counselling, it is also important to remember that patients are able to waive their rights to receive counselling. As long as pharmacists take steps to ensure that their patients understand that they have a right to be counselled and are aware of the dangers that may result if counselling is not received, a patient's refusal to be counselled will insulate the pharmacist from liability. The waiver of rights may become particularly relevant to pharmacies that render services over the Internet. As long as Internet pharmacies clearly inform patients of the limitations of on-line healthcare,<sup>389</sup> it can be argued that patients who still insist on ordering drugs on-line have waived their rights to adequate counselling.

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<sup>386</sup> Rule 2.7.5(a). See also s1.9.7 of the Code of Conduct for Pharmacists.

<sup>387</sup> Rule 2.7.5(b). See also Jacobs 255.

<sup>388</sup> See also rules 1.5(c)(v) and 1.5(e)(i)-(ii) in this regard.

<sup>389</sup> Internet pharmacies are encouraged to do this by rule 6 of the eHealth Code of Ethics.

### 3.7.2 Improper Labelling and Directions

#### 3.7.2.1 Are Pharmacists Under a Legal Duty to Ensure the Accuracy of the Information which they Provide?

Regardless of whether or not pharmacists are under a duty to counsel their patients, a question arises concerning whether, when pharmacists *do* provide information, they are under a duty to ensure that it is correct. Can pharmacists, in other words, be held delictually liable for making misstatements concerning drugs or drug use? Misstatements may be made either verbally, when counselling a patient; or in writing, such as when a pharmacist labels a product with incorrect information.<sup>390</sup> The provision of inaccurate risk minimisation information (eg when a patient is advised to take a drug more frequently or in greater dosages than prescribed<sup>391</sup>) may result in a patient using a drug incorrectly and thus suffering harm. The provision of inaccurate risk assessment information may, on the other hand, induce a patient to undergo therapy to which he or she would not have consented if in possession of the correct information.

It was explained above<sup>392</sup> that misstatements are not *prima facie* wrongful. In order for liability to arise, the defendant must therefore be under a legal duty to avoid harm to the plaintiff by taking steps to ensure the accuracy of a statement before making it. In most of the South African cases dealing with misstatements as a ground for delictual liability, the plaintiff's harm has taken the form of pure economic loss.<sup>393</sup> Where inaccurate drug information is provided, however, the patient's harm is likely to be *physical* in nature. Particularly where one is dealing with a potent medication

<sup>390</sup> The danger of mislabelling products is highlighted by Fleming (189):

'[A]rsenic labelled salt is fraught with greater peril than dynamite labelled dynamite.'

One way in which mislabelling may occur is through the switching of labels between two bottles of medicine, as was the case in *Kautzman v James* 66 So 2d 36 (Fla 1953). In this case, the switch of labels resulted in the plaintiff ingesting medicine prescribed for external use.

<sup>391</sup> In *Marx v Schultz* (1919) 207 Mich 655, 175 NW 182, for example, the prescription stated that the patient was to take three drops of a solution of arsenic. The pharmacist, however, mistakenly directed the patient to take a full teaspoon of the solution.

<sup>392</sup> See 3.5.3.2(b) above.

<sup>393</sup> Eg *Administrateur, Natal v Trust Bank*; *Mukheiber v Raath*; *Aucamp v University of Stellenbosch*; *Standard Chartered Bank of Canada v Nedperm Bank Ltd*; *Siman and Co (Pty) Ltd v Barclays National Bank Ltd*. The fact that pure economic loss is *prima facie* lawful clearly contributed to the courts' cautious approach to establishing a legal duty in these cases. Hutchinson (527) has even gone so far as to say that 'too much has been made of the distinction between words and deeds' and that 'the really vital distinction is that between physical and financial harm.'

with a narrow therapeutic index, the physical harm suffered by a patient may be severe.<sup>394</sup> Bearing in mind that conduct which causes physical harm is generally regarded as *prima facie* unlawful, it is obvious that this will again be an important consideration in establishing wrongfulness. The fact that a misstatement has caused physical harm will not, however, necessarily be the *overriding* factor and the other considerations for establishing a legal duty remain relevant.<sup>395</sup>

There are a number of factors, apart from the nature of the harm, that point towards the existence of a legal duty upon pharmacists to ensure the accuracy of healthcare information.<sup>396</sup> Statements made by pharmacists concerning drugs and drug use are generally made in a professional context in circumstances in which it is clear that they are to be taken seriously. The purpose of providing information is, as discussed in the previous section, either to obtain informed consent or to ensure that a course of drug therapy is as safe and effective as possible. All pharmacists are aware of this fact (or at least ought reasonably to be aware of it) as well as the fact that patients place reliance on information obtained from their pharmacists and could suffer serious harm if they are given inaccurate information.<sup>397</sup> Furthermore, statements concerning drug therapy relate to matters in respect of which the average patient is ignorant and pharmacists are knowledgeable. Indeed, pharmacists profess skill and knowledge in this field and a professional relationship exists between pharmacists and their patients in terms of which the patient relies upon the special skills of the pharmacist. A final policy factor that indicates that pharmacists may be held delictually liable for harm resulting from the provision of inaccurate information is that pharmacists and other healthcare professionals are under a statutory duty to avoid making misleading statements.<sup>398</sup> Against all of these factors, there are no obvious policy considerations

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<sup>394</sup> Brushwood *Medical Malpractice* 161.

<sup>395</sup> Van der Walt and Midgley par 66.

<sup>396</sup> See 3.5.4.2 above.

<sup>397</sup> The foreseeability of harm will, however, depend on the drug which is being dispensed as well as the patient to whom it is being dispensed (see 4.3.3.1 below).

<sup>398</sup> The Medicines Act provides that any person who, when selling a medicine or scheduled substance, makes a false or misleading statement in connection therewith, or sells any medicine or scheduled substance in a container upon which a false or misleading statement pertaining to that substance is written, will be guilty of an offence (s29(h)-(i)) and, upon conviction, be liable to a fine or imprisonment for a period not exceeding ten years (s30). In 3.5.4.2 above it was explained that the fact that a statute provides for a criminal sanction does not indicate an intention on the part of the legislature to exclude a delictual remedy. It follows that the mere fact that the Medicines Act lays down criminal sanctions for the provision of inaccurate healthcare information does not exclude the possibility of a healthcare professional being held delictually liable for such conduct.

favouring the denial of liability. It is thus submitted that South African pharmacists are under a legal duty to provide their patients with accurate information.

### 3.7.2.2 The Intentional Provision of Inaccurate Information

It has already been explained<sup>399</sup> that statements made with the intention to injure automatically bring about liability. A pharmacist who, for example, directs a patient to take a dosage of medicine stronger than that prescribed with the *intention of causing the patient harm*, will be civilly liable for any harm that does eventuate.

Veatch and Haddad<sup>400</sup> raise the interesting question of what should be done when pharmacists knowingly lie to their patients with the *intent of benefiting the patient*. This query raises some controversial ethical issues. When pharmacists act in this manner they are, in effect, giving preference to the principle of beneficence and breaching the principles of veracity and autonomy (as well as that of fidelity if one can imply a promise to tell the truth from the pharmacist-patient relationship<sup>401</sup>). In doing this, a pharmacist adopts a paternalistic stance which is frowned upon in contemporary bioethics.<sup>402</sup> Such actions can be justified by an appeal to consequentialism should the benefit to the patient outweigh the harm caused by lying. Many deontological theories, however, regard the intentional provision of inaccurate information as unethical no matter what the consequences.

It is submitted that the relevant ethical considerations provide a fairly strong basis for courts to find that lying for the benefit of a patient constitutes wrongful conduct. One of the policy considerations weighing *against* a finding of unlawfulness may, on the other hand, be the good motive of the pharmacist.<sup>403</sup> Although the courts have accepted that information may be intentionally *withheld* for a patient's benefit, it must be remembered that, in our law, omissions are *prima facie* lawful and that the courts may well refuse to look upon the positive provision of inaccurate information in as favourable a light.

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<sup>399</sup> In 3.5.3.2(b) above.

<sup>400</sup> Veatch and Haddad 101.

<sup>401</sup> See Veatch and Haddad 104.

<sup>402</sup> See 2.3.2.3(b) above.

<sup>403</sup> For a discussion of the effect that motive has on the element of *fault*, see 4.2.2 below.

### 3.7.2.3 The Effect of Disclaimers Used by Internet Pharmacies

Websites dealing with healthcare issues typically attempt to limit their liability (particularly for harm caused by reliance upon false information) by means of disclaimers.<sup>404</sup> An example is seen in the following notice which is posted on the site of a virtual pharmacy, Rxstore.md:<sup>405</sup>

'This drug information is for your information purposes only, it is not intended that this information covers all uses, directions, drug interactions, precautions, or adverse effects of your medication. This is only general information, and should not be relied on for any purpose. It should not be construed as containing specific instructions for any particular patient. We disclaim all responsibility for the accuracy and reliability of this information, and/or any consequences arising from the use of this information, including damage or adverse consequences to persons or property, however such damages or consequences arise. No warranty, either expressed or implied, is made in regard to this information.'<sup>406</sup>

In terms of rule 1.5(h) of the Rules Relating to Good Pharmacy Practice, a pharmacy may not escape professional liability on the basis of a disclaimer posted on its website. It follows that a pharmacy which posts incorrect information on its site may be disciplined by the South African Pharmacy Council regardless of whether or not a disclaimer appeared on the site.

Whether rule 1.5(h) will have any influence on a court's decision concerning delictual liability remains to be seen. As a rule, however, courts already tend to tread tentatively when dealing with disclaimers, particularly those which are framed too widely.<sup>407</sup> It was explained above<sup>408</sup> that defendants who have made use of disclaimers are likely to argue that delictual liability has been contractually excluded. In order for such an argument to succeed, it must, at the very least, be demonstrated that the defendant pharmacy took reasonable steps to draw the attention of site users to the disclaimer in question. It follows that pharmacies that operate over the Internet

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<sup>404</sup> Tyler 272.

<sup>405</sup> <http://www.rxstore.md/> (accessed 22/08/06).

<sup>406</sup> Rxstore.md is also an example of an e-pharmacy which allows patients to obtain prescriptions by completing an on-line questionnaire. This practice is discussed in greater detail 4.4.5 below.

<sup>407</sup> Midgley 'Cyberspace Issues' 398.

<sup>408</sup> In 3.6.2.3.

should take steps to ensure that any disclaimers are prominently displayed on the website so that any reasonable person using the site would not fail to observe them.

Should a pharmacy prefer to rely on the defence of voluntarily assumption of risk, it is submitted that the disclaimer must not only be prominently displayed (so as to ensure that it is seen by patients), but must also be written in an easy-to-understand manner so that it is appreciated by the majority of patients. In light of the third requirement of *volenti non fit iniuria* (namely, that consent be present), pharmacies would also be well-advised to require that patients acknowledge that they have read, and that they agree to, the disclaimer before they are able to order drugs via the site.

In sum, it has been argued in this section that, regardless of whether or not pharmacists are under a duty to counsel their patients regarding drugs and drug use, a pharmacist who *does* supply patients with healthcare information is under a duty to take steps to ensure its accuracy. Pharmacists who fail to do so act unlawfully and thereby risk being held liable should the patient suffer harm. The primary way in which Internet pharmacies in particular can avoid incurring liability for the provision of inaccurate information is through the use of disclaimers. In order to be effective, these should, however, at the very least, be displayed in such a manner that they are observed by most patients.

### **3.7.3 The Disclosure of Private Information**

#### **3.7.3.1 When Will the Right to Privacy be Infringed?**

In 3.5.2 above, it was explained that conduct may be wrongful if it infringes an individual's right to privacy. In *Financial Mail (Pty) Ltd v Sage Holdings Ltd* the Appellate Division accepted that an invasion of privacy occurs when *private* facts about another are *unlawfully* publicised. The first question that needs to be addressed in this section is thus whether pharmacists have access to private information about their patients. If the answer is 'no', then there is no need to proceed any further. An affirmative answer, however, will give rise to a second question—namely: does a pharmacist act unlawfully in publicising a patient's private information? Should the second question be answered in the affirmative, it can be concluded that a pharmacist

may be successfully sued in delict for infringing a patient's right to privacy. If this is the case, it must be asked whether there are any defences that have the potential to exclude wrongfulness in such instances.

### 3.7.3.2 Do Pharmacists Have Access to Private Information?

In order to determine whether pharmacists have access to private information, one must first clarify what kind of information actually falls into this category. Both Giesen<sup>409</sup> and Parent<sup>410</sup> describe private information<sup>411</sup> as including those facts which a reasonable person would want to remain secret, or which the person in question wishes to remain secret. In *National Media Ltd v Jooste*,<sup>412</sup> the court supported the use of the reasonable person test by holding that the facts to be protected by the right to privacy are those the disclosure of which will 'cause mental distress and injury to anyone possessed of ordinary feelings and intelligence, situated in like circumstances as the complainant.'<sup>413</sup> Upon this formulation, it is submitted that information regarding one's state of health will ordinarily constitute private information. Indeed, this kind of information concerns the inner sphere of one's life which the right to privacy is intended to protect.<sup>414</sup>

Seeing as information about one's health qualifies as private information, it must now be determined whether pharmacists have access to this kind of information. The discussion in 3.7.1 above concerning the pharmacist's duty to counsel clearly illustrated that the shift towards a culture of pharmaceutical care has brought with it an expectation that contemporary pharmacists obtain and record patient-specific information. The result is that many pharmacists currently have access to personal information (eg information concerning patients' medical histories) which patients may well wish to remain private.

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<sup>409</sup> Giesen 408.

<sup>410</sup> Parent 216.

<sup>411</sup> In this regard, note that the terms 'personal' and 'confidential' information are often used interchangeably with 'private' information (which will be the term preferred in this thesis). Thus, whilst Giesen refers to *confidential* information, Parent uses the term *personal* information.

<sup>412</sup> 1996 (3) SA 262 (A).

<sup>413</sup> *National Media Ltd v Jooste* 270J.

<sup>414</sup> See discussion of *Bernstein v Bester* in 3.5.2 above.

Even pharmacists with no record of patient-specific information are, at the very least, aware of the medications that their patients are using.<sup>415</sup> The fact that many of the drugs currently on the market are used exclusively for the treatment of specific ailments means that disclosing information about the medicine which a patient is using has the potential to convey a significant amount of information about the patient.<sup>416</sup> Information about which drugs a patient is using is thus surely private in nature. This was recognised by Schnell as far back as 1983 when they argued that, even though the Ethical Rules pertaining to South African pharmacists at that time only prohibited the disclosure of the nature of the disease or ailment being treated, the fact that the disclosure of the actual medication could indicate the nature of the disease or ailment meant that the prohibition logically extended to revealing the kind of medication being used.<sup>417</sup>

### 3.7.3.3 Will a Pharmacist's Disclosure of Private Information Generally be Unlawful?

The fact that pharmacists have access to information falling within the private realm of their patients' lives means that it is possible for a pharmacist to publicise private facts about a patient. Such publication, in order to result in delictual liability, must, however, be unlawful. One instance in which our courts have accepted that a disclosure of private information is unlawful is where a confidential relationship exists between the person who discloses the information and the person to whom the information relates.<sup>418</sup> Where such a relationship exists, one person has a reasonable expectation that his or her private information will not be disclosed to third parties.<sup>419</sup>

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<sup>415</sup> This is so not only because it is the pharmacist who dispenses the medication, but because, in terms of s22A(6)(a) of the Medicines Act and regulation 11 of the General Regulations published in terms of the Act, pharmacists are legally obliged to keep a prescription book or other permanent record in which prescribed particulars of every sale of schedule 2-6 medicines are kept. The particulars prescribed by the Regulations include the name and dosage of the medication prescribed, as well as the name and address of the patient (regulation 11(1)). Prescription records must be kept for a period of at least five years after the date of the last entry made therein (regulation 11(3)). In addition to this, prescriptions themselves are to be endorsed and retained for at least five years (s22A(6)(q) of the Medicines Act).

<sup>416</sup> Brushwood *Medical Malpractice* 38 and 175.

<sup>417</sup> Schnell *et al* 19. See also *R v Department of Health, Ex parte Source Informatics Ltd* [2000] 2 WLR 940 at 946H.

<sup>418</sup> See fn 70 above and accompanying text.

<sup>419</sup> The holding of an expectation that one's private information will not be disclosed to third parties is fundamental to the very concept of confidentiality. Confidentiality can be defined as concerning 'the communication of private and personal information from one person to another where it is *expected* that the recipient of the information, such as a health professional, *will not ordinarily disclose* the confidential information to third parties' (Winslade 495, emphasis added). (A similar definition is provided by Duncan 83.)

A disclosure of the information will thus, in most instances, constitute an infringement of the right to privacy.<sup>420</sup>

As a general rule, the relationship between professionals and their clients is such that the professional is expected to refrain from disclosing information confided within the context of the relationship. Indeed, confidentiality is commonly regarded as one of the defining characteristics of a professional relationship.<sup>421</sup> It is submitted that, in this regard, the pharmacy profession is no different from any other. This is particularly so in light of the position of trust that pharmacists hold within society.<sup>422</sup> The fact that private information is confided to pharmacists within (and indeed as a result of) a relationship of trust leads the public to harbour a justifiable expectation that pharmacists, like other trusted members of the healthcare professions, will not disclose this information to third parties.<sup>423</sup>

That this expectation is reasonable is also supported by the various ethical principles upon which pharmacy practice is based. Of particular relevance is the principle of fidelity—one view of the provider-patient relationship is that it is based on implied promises, one of which is that the information obtained by a healthcare provider within this relationship will not be disclosed to a third party without the patient's permission.<sup>424</sup> In *Jansen van Vuuren v Kruger*,<sup>425</sup> for example, it was argued that a term of the agreement which established the doctor-patient relationship was that the

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This definition highlights that confidentiality depends not only on the nature of the information involved, but also on the context within which the information is disclosed and the relationship between the person disclosing the information and the recipient thereof. It is also important insofar as it illustrates that, although privacy and confidentiality are often regarded as identical concepts (see fn 411 above), there is an important difference between them in that, unlike privacy, confidentiality can only exist within a relational context. This is because, in order for confidentiality to be established, one must necessarily relinquish one's privacy by disclosing private information to another (Winslade 495; Beauchamp and Childress 418). In this regard, it can also be noted that, unlike confidentiality, the very *definition* of privacy depends on the context within which the term is being invoked (Gettman and Arneson 137-138). There are four different conceptions of privacy: physical privacy (freedom from physical contact with others); proprietary privacy (which concerns ownership of human personality); decisional privacy (the ability to make autonomous choices about personal matters); and informational privacy (which involves the concealment and selective disclosure of information) (Ozar 2120-2123). It is only the last two forms of privacy which require confidentiality.

<sup>420</sup> See discussion of *Investigating Directorate: SEO v Hyundai Motor Distributors (Pty) Ltd* in 3.5.2 above.

<sup>421</sup> Powell and Stewart par 2-147.

<sup>422</sup> See 3.5.4.4 above.

<sup>423</sup> That confidentiality assumes a relationship of trust is clear from the term itself, *con* and *fides* meaning 'with fidelity' (Winslade 495-496; see also Beauchamp and Childress 420).

<sup>424</sup> Veatch and Haddad 11-12 and 117; Hope *et al* 82; Benatar 11.

<sup>425</sup> *Jansen van Vuuren v Kruger* 848B-C.

doctor and his staff would treat information concerning the patient's HIV status in a professional and confidential manner. There appears no reason why such a promise should not be implied as underlying the relationship between a patient and any other healthcare provider who has access to personal information.

The expectation that private information will not be disclosed is also supported by the principle of respect for patient autonomy<sup>426</sup> (which implies that one should have the right to decide who has access to one's personal information<sup>427</sup>) and even the principle of nonmaleficence (due to the fact that the disclosure of a patient's personal information will, in many instances, cause the patient some form of harm<sup>428</sup>).

These principles also underlie the expectation currently held by the South African pharmacy *profession* that its members maintain patient confidentiality in most instances.<sup>429</sup> The Pharmacy Council's Ethical Rules expressly stipulate that the disclosure of confidential information obtained in the course of a pharmacist's professional activities is an act in respect of which the Council may take disciplinary steps.<sup>430</sup> The importance of confidentiality as a minimum standard of pharmacy practice has also been stressed by the Council in the Rules Relating to Good Pharmacy Practice<sup>431</sup> and the Code of Conduct for Pharmacists.<sup>432</sup> The Pharmaceutical Society of South Africa has expressed its commitment to patient

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<sup>426</sup> In *Bernstein v Bester* par [65], the court cited Rainer Forst 'How Not to Speak about Identity: The Concept of the Person in *A Theory of Justice*' (1992) 18 *Philosophy and Social Criticism* in explaining that 'rights, like the right to privacy, are based ... on the notion of what is necessary to have one's own autonomous identity.' See also *National Coalition for Gay and Lesbian Equality v Minister of Justice* 1999 (1) SA 6 (CC) par [23] in this regard.

<sup>427</sup> Hope *et al* 82; Bok 232. This forms part of what the German Constitutional Court has referred as 'informational self-determination' ('*Informationelle Selbstbestimmung*' *Census* decision 65 BVerfGE 1 (1983) of the German Constitutional Court, quoted in Currie and De Waal 323). See, however, Parent's argument (Parent 217) that the right to privacy should not be regarded as falling under the principle of autonomy.

<sup>428</sup> Note, however, that (as is discussed in 3.7.3.4 below) instances do arise in which the disclosure of private information is in the best interests of either the patient or a third party. In such cases, the principle of beneficence will fall into conflict with the principles of autonomy and fidelity.

<sup>429</sup> There are instances in which the profession recognises that the disclosure of personal information is justified.

<sup>430</sup> Rule 9.

<sup>431</sup> Rule 2.7.3.6 prohibits the disclosure of information about the affairs of any person which has been obtained in the course of dispensing a prescription and subsequent rules prohibit the disclosure of information obtained during the provision of specific services. Eg, rule 2.13.1.3(b) (confidentiality in the provision of screening and monitoring services), rule 2.13.5.8(d) (confidentiality in the performance of HIV tests), rule 2.14.4(a) (confidentiality in the provision of immunisation services), rule 2.15.4(b) (confidentiality in the provision of reproductive health services).

<sup>432</sup> Section 1.3.

confidentiality in its Pharmacist's Oath in which pharmacists pledge '[n]ot to divulge improperly any personal or confidential matter, directly or indirectly, confided to [them] by [their] patients or clients, even after [the patient's or client's] death.'

From the above, it is evident that the relationship that exists between pharmacist and patient is confidential in nature. It follows that, in the absence of a ground of justification, the courts are likely to regard a pharmacist's disclosure of private information as unlawful. This assertion is supported by the interest that the public has in maintaining confidentiality in certain instances.<sup>433</sup> In relation to healthcare professionals in general, this interest in confidentiality is usually explained by reasoning that it is in the public interest that patients trust members of the healthcare professions and are able to make full disclosures to them without worrying that the personal information divulged will become public knowledge.<sup>434</sup> Confidentiality is, in other words, necessary for the maintenance of the fiduciary relationship which exists between healthcare professionals and their patients.<sup>435</sup> Like other healthcare professionals, pharmacists hold a position of public trust. It is in the public interest that this trust is maintained and that patients are not afraid to discuss sensitive, and sometimes embarrassing, health matters with their pharmacists. This is especially necessary in light of the profession's move towards patient-orientation.

The interest that society holds in maintaining confidentiality between patients and healthcare professionals has found expression in s34 of the Medicines Act, which expressly prohibits the disclosure of any information relating to the business or affairs of any person which one has acquired in the exercise of one's powers, or the performance of one's functions under the Act. The fact that the supply of medicines and the keeping of prescriptions and prescription records are regulated by the Medicines Act means that any information which a pharmacist has obtained in

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<sup>433</sup> Hope *et al* (88) go so far as to suggest that confidentiality should be viewed as a public interest and *not* a private interest.

<sup>434</sup> McQuoid-Mason 17; Hope *at al* 81 and 88; Benatar 12; Beauchamp and Walters 170-171; Ozar 2121; Bok 233; Beauchamp and Childress 422. Partlett (146) submits that the rationale for protecting confidentiality in *any* sphere is the same:

'[T]he promotion of co-operative relationships between individuals.'

He states that the law assists people in society in pursuing certain ends (such as personal and public health) by facilitating the pursuit of co-operative relationships in which people can freely impart and convey information without fear that this information will be disclosed to third parties.

<sup>435</sup> Beauchamp and Childress 422.

supplying a drug to a patient or from a prescription or prescription record is, in terms of the statute, confidential.<sup>436</sup> The National Health Act similarly provides that all information concerning patients (including information relating to a patient's health status or treatment) is confidential and may not ordinarily be disclosed.<sup>437</sup>

It is submitted that these statutory duties, in combination with the ethical duties and societal expectations discussed above, indicate that a pharmacist's disclosure of a patient's private information will, *in most instances*, be wrongful. What remains is to consider the instances in which the disclosure of healthcare information is justified and thus lawful.

#### 3.7.3.4 Instances in which Pharmacists May Lawfully Disclose Private Information

Although the public does have an interest in maintaining confidentiality between pharmacist and patient, it also has an interest in being kept informed of matters which are of public concern. In determining the lawfulness of a particular disclosure, it may be necessary to weigh these competing interests against one another.<sup>438</sup> It will also often be necessary to balance the competing interests of individuals against each other<sup>439</sup> and against the interests of society. Indeed, a patient's right to privacy and a care-giver's corresponding duty of confidentiality are not absolute<sup>440</sup> and there are instances in which a pharmacist is justified in disclosing a patient's private information. In *O v O*<sup>441</sup> the court even defined confidentiality as 'a duty not to disclose certain information only *unless displaced by a greater moral or social duty to impart what has been learned.*'<sup>442</sup>

In considering the instances in which a pharmacist's disclosure of confidential information may be lawful, the Appellate Division's discussion of confidentiality in *Jansen van Vuuren v Kruger* provides a useful starting point. In that case, the court

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<sup>436</sup> Schnell 20.

<sup>437</sup> Section 14.

<sup>438</sup> *Financial Mail (Pty) Ltd v Sage Holdings Ltd* 464A.

<sup>439</sup> For an example, see *S v I and Another* 1976 (1) SA 781 (RA) in which the court had to weigh a husband's right to privacy against his wife's interest in obtaining evidence of his infidelity.

<sup>440</sup> *Jansen van Vuuren v Kruger* 850F-G. See also *Protea Technology v Wainer* 611F-G in which it was stated that confidentiality is not an absolute right under the Constitution.

<sup>441</sup> *O v O* 485C-E.

<sup>442</sup> Emphasis added.

had to decide whether a medical practitioner had acted wrongfully in disclosing his patient's HIV status to a dentist and another medical practitioner during a game of golf. The court stated that, in general, the defences formulated within the context of the law of defamation ought to be applicable when dealing with infringements of privacy.<sup>443</sup> The defences of privilege, truth and public benefit<sup>444</sup> and fair comment are thus available.

The defence of privilege is of particular significance within the healthcare context. This is because a patient's medical condition may place third parties at risk. If a healthcare professional, such as a pharmacist, knows (or should know) that a third party is likely to suffer harm if unaware of a patient's condition, there may well be a moral (and even *legal*) duty to disclose the relevant information and a corresponding interest in receiving it. Thus, in *Jansen van Vuuren*, in which privilege was raised as a ground of justification, the defence may have succeeded had it been established that the parties to whom the deceased's HIV status was disclosed had an interest in receiving this information because they were at risk of exposure to the disease.<sup>445</sup> As it so happened, the court found that these parties were not at risk and thus had no right

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<sup>443</sup> *Jansen van Vuuren v Kruger* 850H.

<sup>444</sup> Note that the Appellate Division rejected the suggestion that public interest may, on its own, constitute a ground of justification (*Neethling v The Weekly Mail* 1994 (1) SA 708 (A)). Nevertheless, in *National Media Ltd v Bogoshi* 1998 (4) SA 1196 (SCA), a new defence of reasonable publication was created. Van der Walt and Midgley (par 102) submit that the court in this case appears to have recognised a public interest privilege.

<sup>445</sup> An interesting decision in this regard is that of the New South Wales Supreme Court in *PD v Dr Nicholas Harvey and 1 Ors* [2003] NSWSC 487. In that case, a couple who were planning to marry arranged to be tested for HIV at the same medical practice. Whilst the plaintiff tested negative, her fiancé tested positive. No one from the practice informed the plaintiff of her fiancé's HIV status, with the result that she contracted the virus. The decision was complicated by the fact that the Public Health Act prohibited healthcare professionals from disclosing a patient's HIV status without consent. In light of this statute, the court refused to hold that the defendants had a legal duty to directly inform the plaintiff that she was at risk of contracting HIV (see par [59]: '[T]he failure to do what the law prohibits cannot be the basis of a civil action against a medical practitioner'). Nevertheless, the court did hold that the defendants had a general duty to take reasonable steps to protect the plaintiff from foreseeable harm (par [75]). This could have been done without breaching her fiancé's confidentiality. The defendants could, for example, have counselled the fiancé regarding the need to alert the plaintiff of his HIV status (par [78]). In light of the fact that no such steps were taken, the plaintiff succeeded in her action for damages.

In South Africa, the disclosure of a patient's HIV status without consent is not directly prohibited by statute. The Health Professions Council of South Africa, whilst recognising that there is at present no legal clarity on whether one can disclose private information to people who are at a clear risk of danger, has suggested that healthcare professionals are under a positive ethical duty to make such disclosures when infected patients refuse to disclose the information themselves (Health Professions Council of SA 'Guidelines for the Management of Patients with HIV Infection or AIDS; see also McQuoid-Mason 21; Giesen 410; Bok 236).

to receive the information. Nor did the first defendant have a social or moral duty to make the disclosure.<sup>446</sup>

Even if a third party does have an interest in disclosure, this will still have to be balanced against the interests of the patient and the public in maintaining confidentiality. In this regard, it is submitted that the third party's interests will need to be fairly substantial before they will justify disclosure.<sup>447</sup> When the patient's condition is trivial in nature or the chances of it affecting the third party are remote, disclosure may be unreasonable. It is also submitted that, even if the interests of a third party are strong, a pharmacist will battle to establish that his or her disclosure was reasonable if he or she, prior to disclosure, did not at least attempt to persuade the patient to personally disclose the information or to obtain the patient's consent to disclosure. This assertion is supported by the *Jansen van Vuuren* case in which the court took note of the fact that the first defendant had neither sought the deceased's consent to disclosure, nor informed the deceased that he regarded himself to be under an obligation to disclose the information.<sup>448</sup>

Although not likely to be raised as frequently as privilege, the defence of truth and public benefit will become relevant when the disclosure of confidential information is in the public interest. The Code of Conduct for Pharmacists states that this may be the case if the information will assist in the prevention, detection or prosecution of a serious crime or when the disclosure could prevent a serious risk to public health.<sup>449</sup>

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<sup>446</sup> *Jansen van Vuuren v Kruger* 856D-G.

<sup>447</sup> Giesen (409) states that the interests of a third party or the public will need to 'considerably outweigh' the patient's privacy interests before a departure from the duty of confidentiality will be justified. See also Beauchamp and Childress 423.

<sup>448</sup> *Jansen van Vuuren v Kruger* 854D-H. The court did this after referring to a 1989 guideline of the South African Medical and Dental Association in which it was stated that patients should be counselled on the need for other healthcare professionals to be informed of their conditions and, if they still refuse to consent to a disclosure, should be told that the doctor is under a duty to disclose the information. At present, the Health Professions Council of South Africa's 'Guidelines for the Management of Patients with HIV Infection or AIDS' similarly stress that a decision to disclose healthcare information to a third party must be made in consultation with the patient. The Guidelines recommend that, before disclosing a patient's HIV status to someone who is at risk of infection, a healthcare professional should counsel the patient as to the importance of disclosing his or her status to those at risk and, if the patient refuses to personally disclose this information, provide counselling on the healthcare professional's ethical duty to make disclosure and request the patient's consent to do so. See also Beauchamp and Childress 426:

'Health care professionals are usually under an obligation to seek alternative ways of realising benefit or preventing harm before disclosing information.'

<sup>449</sup> Section 1.3.3(e).

In addition to those defences arising from the law of defamation, there are other grounds of justification that may be raised by a pharmacist accused of unlawfully breaching patient confidentiality. The most obvious of these is consent. When a patient has consented to the disclosure of private information, such disclosure will usually be justified. In order for consent to render disclosure lawful, however, the patient must have consented to the content of the particular disclosure, the manner in which information is to be disclosed and the persons to whom it is to be disclosed.<sup>450</sup> The patient must, in other words, have had full knowledge and appreciation of what he or she was consenting to.

One sometimes finds that pharmaceutical codes of ethics<sup>451</sup> permit the disclosure of private information, without consent, if this is in the interests of the patient concerned. It is, however, becoming increasingly accepted that this exception to the duty of confidentiality is overly paternalistic.<sup>452</sup> In recent years, the trend has thus been to exclude this exception to confidentiality from codes of ethics.<sup>453</sup> In spite of the ethical controversy that surrounds disclosure for the benefit of the patient, one may well find that a pharmacist is able to justify such disclosure on the ground of necessity.<sup>454</sup> This defence could also be raised as a justification for disclosure in the interests of a third party. In order for necessity to succeed as a defence, however, the interest protected by disclosure must outweigh the patient's interest in confidentiality. A further point to note in this regard is that necessity will only justify a defendant's conduct if the danger in question could not have been averted by less drastic measures. It is thus submitted that a pharmacist will only be able to rely on necessity as a justification for

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<sup>450</sup> McQuoid-Mason 22. Indeed, it was held in *National Media Ltd v Jooste* 271I that not only is a person entitled to decide *what* private facts may be made public, he or she is also entitled to decide *when* and *under what conditions* such facts may be made public. See also Partlett 150.

<sup>451</sup> Including the Ethical Rules of the South African Pharmacy Council.

<sup>452</sup> Benatar 13. This is not surprising when one considers the emphasis that the medical professions currently place on patient autonomy.

<sup>453</sup> Eg, the Code of the American Pharmaceutical Association used to provide:

'A pharmacist should respect the confidential and personal nature of professional records; *except where the best interest of the patient requires* or the law demands, a pharmacist should not disclose such information to anyone without proper patient authorisation' (emphasis added).

In 1995, however, the Code was revised and now merely states:

'A pharmacist promotes the good of every patient in a caring, compassionate, and confidential manner' (Veatch and Haddad 121).

<sup>454</sup> Disclosure may also potentially be justified on the ground of statutory authority (discussed directly below). This is because the National Health Act provides that healthcare providers may disclose private information if such disclosure is in the interests of their patients (s15(1)).

disclosure if he or she first attempted to convince the patient to personally disclose the information or to consent to disclosure by the pharmacist.

It was explained above<sup>455</sup> that a defendant's conduct will be justified if authorised by statute. It follows that if a pharmacist has been given statutory authority to disclose private information, disclosure will be lawful as long as it falls within the limits of the authority conferred. An example of the kind of disclosures authorised by statute are those concerning notifiable diseases.<sup>456</sup> It is also generally accepted that medical professionals are entitled to disclose any information which they are required to disclose in terms of a court order.<sup>457</sup> This is recognised in the Medicines Act, s34 of which permits pharmacists to disclose private information if they are required to do so by a competent court or under any law.<sup>458</sup>

Whilst on the topic of instances in which a pharmacist's disclosure of information will be lawful, there remains one issue which bears mention. It is generally accepted that, in order for information to be private or 'personal', it must be possible to link the information to the individual to whom it relates.<sup>459</sup> It follows that information concerning which *doctors* tend to prescribe which drugs (as opposes to which *patients* have been prescribed which drugs) can be freely distributed by pharmacists to third parties.<sup>460</sup> In the English case of *R v Department of Health, Ex parte Source Informatics Ltd*,<sup>461</sup> it was, for example, held that, whilst pharmacists owe their patients an undoubted duty of confidentiality,<sup>462</sup> the law's concern in this regard is

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<sup>455</sup> In 3.6.4.

<sup>456</sup> See ss 32 and 45 of the Health Act 63 of 1977; Declaration of Medical Conditions to be Notifiable Conditions in terms of the Health Act GNR 328 of 22 February 1991.

<sup>457</sup> *McQuoid-Mason* 17 and 20.

<sup>458</sup> This ground of justification is also recognised by the pharmacy profession. Rule 9 of the Pharmacy Council's Ethical Rules states that, where confidential information must be furnished to a person authorised in law to request it, its disclosure will not be a disciplinary offence. A similar provision is found in rule 2.7.3.6 of the Rules Relating to Good Pharmacy Practice as well as s1.3.3(b)-(c) of the Code of Conduct for Pharmacists.

<sup>459</sup> Section 1 of the Promotion of Access to Information Act 2 of 2002, for example, defines 'personal information' as information about an identifiable individual (including information about an individual's physical or mental health and medical history). A similar definition is found in s1(a)-(b) of the ECT Act.

<sup>460</sup> *Powell et al* par 2-157. This is of course assuming that pharmacists do not owe *physicians* a duty of confidentiality or that, if such a duty is owed, information concerning the drugs prescribed by physicians is not private in nature.

<sup>461</sup> [2000] 2 WLR 940.

<sup>462</sup> *R v Department of Health, Ex parte Source Informatics Ltd* 946B.

the protection of the patient's personal privacy.<sup>463</sup> The disclosure by a pharmacist of anonymous information was therefore found not to have breached the duty of confidentiality.<sup>464</sup>

### 3.7.3.5 Computers and the Preservation of Patient Confidentiality

In the course of this section, it has been established that, due to the confidential relationship that exists between pharmacists and their patients, a pharmacist's disclosure of private patient information will usually constitute an unlawful infringement of the right to privacy. A duty of confidentiality does not, however, simply provide that healthcare professionals must refrain from disclosing their patients' private information. It also enjoins professionals to actively protect private information from leakage.<sup>465</sup> A professional should not, in other words, allow a patient's private information to be accessed by third parties. There are numerous ways in which a leakage of information may occur. A pharmacist may, for example, discuss a patient's condition (either with the patient or with another healthcare provider) within earshot of third parties.<sup>466</sup> The most susceptible kind of breach of patient privacy has, however, been said to be that which occurs in electronic form.<sup>467</sup>

Although computerised networks offer numerous benefits to patients and healthcare professionals alike, they have a major shortfall in that they are insecure in nature and consequently pose a threat to patient privacy.<sup>468</sup> Nowadays, it is possible for information stored in a single computer to travel throughout the world in a matter of seconds.<sup>469</sup> When information is transferred over the Internet, or stored in computers linked to a network, there is always the possibility that it may be accessed by

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<sup>463</sup> *R v Department of Health, Ex parte Source Informatics Ltd* 953B-D.

<sup>464</sup> The court held that pharmacists could not be held liable for disclosing anonymised information concerning doctors' prescribing habits to a company which would then sell this information to pharmaceutical companies so that they could market their products more effectively. This was in spite of the fact that the Department of Health had, in a policy document, expressed its view that anonymisation does not remove the duty of confidence towards the patients who are the subject of the data.

<sup>465</sup> *Winslade* 501; *Beauchamp and Childress* 418.

<sup>466</sup> See discussion in 4.5.1 below.

<sup>467</sup> *Gettman and Arneson* 155; *Beauchamp and Walters* 173.

<sup>468</sup> *Gettman and Arneson* 143.

<sup>469</sup> *Angaran* 1418.

hackers.<sup>470</sup> Particularly when messages are sent via e-mail, there is also a high risk of the information being intercepted.<sup>471</sup> Whilst these are problems faced by any pharmacy making use of a computer attached to the Internet or some other form of network, they are obviously magnified when the actual sale of drugs is conducted over the Internet.

In spite of the security problems inherent in the use of computers and the Internet, there are steps which pharmacies can take to prevent confidential information from falling into the wrong hands. In order to avoid being found liable, Internet pharmacies in particular should use secure technology and encrypt transactions during transmission.<sup>472</sup> Indeed, the eHealth Code of Ethics provides that Internet pharmacies must take reasonable steps to prevent unauthorised persons from accessing personal data. The Code states that these steps may include 'encrypting data, protecting files with passwords, or using appropriate security software for all transactions involving users' personal medical or financial data.'<sup>473</sup> A similar provision is found in the Code of Ethics of the Royal Pharmaceutical Society of Great Britain.<sup>474</sup> Although the rules and regulations pertaining to South African pharmacists are silent about the maintenance of privacy over the Internet, it is submitted that the general duty of confidentiality which binds pharmacists in this country requires pharmacists to take appropriate steps to maintain confidentiality when it is threatened.<sup>475</sup>

The discussion in 3.7.3.4 above demonstrated that pharmacists who are sued for breaching patient confidentiality will have various defences at their disposal. There is one defence in particular that Internet pharmacies may use to shield themselves from

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<sup>470</sup> Jones 'Internet Prescribing' 2; Rost 625; Weismann 1137.

<sup>471</sup> Midgley 'Cyberspace Issues' 405.

<sup>472</sup> Rost 625; Ozar 2121.

<sup>473</sup> Rule 5.

<sup>474</sup> Rule 9(a)(i) of the Code enjoins pharmacists to encrypt patient data transmissions so as to prevent confidential information from being accessed by the Internet Service Provider or any other unauthorised party.

<sup>475</sup> It is also perhaps worth noting that Chapter 8 of the ECT Act contains a section concerning the protection of personal information obtained through electronic transactions. The Chapter enumerates a number of universally-accepted data protection principles (Goodburn and Ngoye 173)—of particular relevance is s51(6) which specifically states that the information collected during an electronic transaction is not to be disclosed to a third party unless this is required or permitted by law or specifically authorised by the individual to whom the information pertains. (Note, however, that, in terms of s50(2), subscription to these principles occurs on a *voluntary* basis.)

liability for breaches of confidentiality. Midgley<sup>476</sup> suggests that Internet users are generally aware of the possibility of their messages being intercepted and may thus have given express or tacit consent to interception. It may, in other words, be argued that Internet users voluntarily assume the risk of a third party gaining access to information transferred over the Internet. Such an argument can certainly be raised if patients have been explicitly warned (as the eHealth Code of Ethics suggests they should be<sup>477</sup>) of the risks they face in ordering drugs or corresponding with pharmacists over the Internet.

Although it has been argued in this section that South African pharmacists may be held delictually liable for failing to maintain patient confidentiality, it is submitted that patients will seldom be successful in claiming damages from a pharmacist on this basis. This can be partially attributed to the various defences that may render the pharmacist's disclosure lawful. The wrongfulness enquiry is not, however, the only stage at which plaintiffs are likely to run into difficulties. As will be seen in Chapter 4 the requirement of fault will also sometimes be difficult to establish in cases involving breaches of confidentiality.<sup>478</sup>

### **3.8 Conclusion**

The primary purpose of this chapter has been to explore a number of the specific factual situations in which a pharmacist's conduct may be considered wrongful and consequently result in delictual liability. Although none of the situations discussed above have yet come before South African courts, it is likely to be found that, in light of the pharmacy profession's shift towards patient-orientation, pharmacists are under a legal duty to do far more than accurately fill prescriptions. This is particularly so in light of the various statutory and ethical duties to which pharmacists are currently bound, all of which will surely play a contributory role in establishing the wrongfulness of a pharmacist's conduct. Other policy factors that may play a part in determining questions of wrongfulness include the dangerous nature of the products with which pharmacists deal, the expert knowledge which pharmacists possess, the

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<sup>476</sup> Midgley 'Cyberspace Issues' 400.

<sup>477</sup> Rule 4. See also Jones 'Internet Prescribing' 4.

<sup>478</sup> See 4.4.1 below.

position of trust which they hold as a result of this knowledge, and the fact that, in many instances, the harm caused by the pharmacist will be physical in nature.

It has been seen that, in determining whether a defendant's conduct was wrongful, it is useful to ask whether the conduct breached a legal duty owed by the defendant to the plaintiff or, alternatively, infringed one of the plaintiff's legally recognised rights. A duty-based approach will be particularly appropriate when the defendant's conduct takes the form of an omission, such as a failure to provide patient-counselling. In this regard, the chapter has established that the courts are likely to find that pharmacists have a duty to ensure that their patients know how to use pharmaceutical products (ie a duty to provide risk management counselling). When it comes to the supply of risk assessment counselling, however, the position is not as certain. Whilst there surely exists a duty to provide risk assessment information when drug therapy has been initiated by the *pharmacist*, the same cannot necessarily be said when prescription medications are involved.

What *is* evident is that, in those instances where pharmacists are under a duty to counsel, they will be unable to discharge this duty by merely providing the information concerned. In order to avoid liability successfully, a pharmacist must additionally ensure that the information is *understood*. This is likely to be particularly difficult when a pharmacist sells drugs over the Internet. What is also clear is that, if pharmacists *do* supply their patients with information regarding drugs and drug use, they are under a duty to ensure that the information that they provide is *accurate*. It does not follow that every failure to provide information, or every provision of inaccurate information, will necessarily be wrongful. If a patient refuses to accept the counselling offered, or decides to order drugs over the Internet in spite of the risks inherent in this process, a pharmacist may well be able to establish that the risk of harm was voluntarily assumed and thereby escape liability.

An instance in which it is more appropriate to follow a rights-based approach in determining wrongfulness is where pharmacists disclose private information about their patients. Not only do pharmacists have access to this kind of information, but, because of the relationship of confidentiality that exists between them and their patients, a disclosure of this nature will often be unlawful and consequently attract

delictual liability. Fortunately for pharmacists, there are various defences upon which they can rely so as to exclude wrongfulness when a patient bases his or her claim on an infringement of the right to privacy. The defences of privilege, truth and public benefit, consent, necessity and statutory authority may all assist a pharmacist in avoiding liability in such cases.

## CHAPTER 4

### FAULT

#### 4.1 Introduction

In order for one to incur delictual liability, it is not sufficient that one acts wrongfully: one's conduct must also be blameworthy.<sup>1</sup> There must, in other words, be fault in the form of either intention (*dolus*) or negligence (*culpa*).<sup>2</sup>

Conduct may form the basis of the *actio legis Aquiliae* or the Germanic remedy for pain and suffering regardless of whether it is intentional or merely negligent. The same cannot, however, be said when the plaintiff's claim is based on the *actio iniuriarum*. When, for example, a pharmacist discloses private information concerning a patient, thereby infringing the patient's right to privacy, a claim for damages will only be successful if fault was present in the form of intention.<sup>3</sup> For this reason, a brief discussion of intention is included in this chapter. That said, the vast majority of actions brought against pharmacists are likely to stem from physical harm and thus be based on the *lex Aquiliae* and/or the Germanic remedy with fault *usually* taking the form of negligence. The primary focus of this chapter will thus be the standard of care to which pharmacists are expected to adhere if they wish to avoid delictual liability. In particular, it will be asked whether it is negligent for a pharmacist to fill a prescription incorrectly or to fail to detect and rectify potential problems with drug therapy. The standard of care applicable within the context of pharmacist-initiated therapy will also be explored.

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<sup>1</sup> *Minister of Safety and Security v Van Duivenboden* par [12].

<sup>2</sup> Boberg 268. Where *dolus* is present, the defendant acted in a volitional state of mind. *Culpa*, on the other hand, involves conduct which falls short of the standard of the reasonable person (*S v Ngubane* 1985 (3) SA 677 (A) 686E).

<sup>3</sup> Neethling *et al* 120.

## 4.2 Intention

### 4.2.1 The Elements of Intention

Intention<sup>4</sup> fulfils the fault requirement of both the *lex Aquilia* and the Germanic remedy and is an indispensable component of the *actio iniuriarum*. This form of fault concerns the defendant's subjective state of mind and encompasses two elements:<sup>5</sup>

- a) the direction of the will towards the attainment of the result caused; and
- b) the consciousness that one's conduct is wrongful.<sup>6</sup>

The first element of intention will obviously be present when the causation of the plaintiff's harm was the defendant's *primary* object. In such instances, the defendant's intention takes the form of *dolus directus*. The first requirement of intention will also, however, be met when the plaintiff's harm was a *necessary* and foreseen consequence of attaining the defendant's primary object (*dolus indirectus*); as well as when the harm was a *possible* and foreseen consequence of attaining the defendant's primary object (*dolus eventualis*).<sup>7</sup> Because the intention enquiry is an entirely subjective one,<sup>8</sup> intent will only be regarded as present once it is established that the defendant in fact foresaw the possibility of harm. In the absence of such foresight, the defendant's conduct will, at most, be negligent<sup>9</sup> and will thus be insufficient to produce liability under the *actio iniuriarum*. In addition, intention in the form of *dolus eventualis* can only be present if one has reconciled oneself with the possibility of harm occurring. The defendant must, in other words, have both appreciated that the act may result in harm, and acted recklessly as to whether harm resulted or not.<sup>10</sup>

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<sup>4</sup> Also known as *dolus* or *animus injuriandi* (*Maisel v Van Naeren* 1960 (4) SA 836 (C) 840F-G).

<sup>5</sup> Neethling *et al* 123; Van der Walt and Midgley par 105.

<sup>6</sup> *Dantex Investment Holdings (Pty) Ltd v Brenner* 1989 (1) SA 390 (A) 398D. See also *Maisel v Van Naeren* 840E-F; *Suid-Afrikaanse Uitsaaikorporasie v O'Malley* 1977 (3) SA 394 (A) 403C-D and 405G-H; *Matlou v Makhubedu* 1978 (1) SA 946 (A) 962A; *Ramsay v Minister van Polisie* 807C and 818F-G; *Pakendorf en Andere v De Flamingh* 1982 (3) SA 146 (A) 157E; *Nydoo en Andere v Vengtas* 1965 (1) SA 1 (A) 15A.

<sup>7</sup> Boberg 268-269; Van der Walt and Midgley par 105; Neethling *et al* 123-124.

<sup>8</sup> *Khumalo v Holomisa* 2002 (5) SA 401 (CC) par [20].

<sup>9</sup> Boberg 269.

<sup>10</sup> *S v Mini* 1963 (3) SA 188 (A) 192G.

Due to the fact that awareness of the wrongful nature of one's conduct is an element of intention, a defendant who mistakenly held the *bona fide* belief that his or her conduct was lawful (eg because he or she mistakenly believed that a ground of justification was present<sup>11</sup>) cannot be regarded as having acted intentionally.<sup>12</sup> When the plaintiff's claim is in terms of the *actio iniuriarum*, this will effectively mean that the defendant is not liable.<sup>13</sup> Although some courts have held that a mistake, in order to exclude intent, must be reasonable,<sup>14</sup> others have regarded *any* mistake concerning a relevant fact or the law to be sufficient.<sup>15</sup>

#### 4.2.2 The Relationship Between Intention and Motive

When determining the presence or absence of fault, it is important to draw a distinction between the concepts of intention and motive. Whilst having intent involves directing one's will towards the attainment of a particular result, motive refers to one's *reason* for wanting to attain that result.<sup>16</sup> Motive can thus be described as 'the actuating impulse preceding intention'.<sup>17</sup> The courts have stressed that intention can exist even in the absence of an improper motive.<sup>18</sup> The corollary of this is, of course, that a laudable motive on the part of the defendant does not necessarily exclude the existence of intention.<sup>19</sup> This is not to say that a defendant's motive is of no legal relevance whatsoever. Motive may provide evidence as to a defendant's true

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<sup>11</sup> Neethling *et al* 126.

<sup>12</sup> See in general *Maisel v Van Naeren*.

<sup>13</sup> Mistake is not the only defence capable of excluding intent. Others include jest, provocation, intoxication and emotional distress (Van der Walt and Midgley pars 108-113). It is, however, submitted that, apart from mistake, the defences excluding intent are unlikely to play a significant role in pharmacy malpractice cases.

<sup>14</sup> These cases have tended to involve claims against the media (eg *Hassen v Post Newspapers (Pty) Ltd and Others* 1965 (3) SA 562 (W); *National Media Limited v Bogoshi*).

<sup>15</sup> *Maisel v Van Naeren*; *Nydoo v Vengtas*. The latter approach is consistent with the subjective nature of intent, and is thus supported by Neethling *et al* (126). On this point, Van der Walt agrees. Midgley, on the other hand, argues that the reasonableness requirement should apply to all defendants (Van der Walt and Midgley par 109).

<sup>16</sup> Neethling *et al* 127.

<sup>17</sup> *Gluckman v Schneider* 1936 AD 151 at 159.

<sup>18</sup> *Whittaker v Roos and Bateman*; *Morant v Roos and Bateman* 1912 AD 92 at 131; *Gluckman v Schneider* 160.

<sup>19</sup> *Esterhuizen v Administrator, Transvaal* 722G; *Whittaker v Roos and Bateman*; *Morant v Roos and Bateman* 129 and 131.

intention—particularly insofar as it indicates whether or not the defendant was aware that his or her conduct was wrongful.<sup>20</sup>

## 4.3 Negligence

### 4.3.1 The Test for Negligence

Fault in the form of negligence arises when a person fails to adhere to the standard of conduct that is legally required of him or her.<sup>21</sup> The standard of care to be complied with is that of the reasonable person<sup>22</sup> (the '*diligens paterfamilias* of Roman law—the average prudent person'<sup>23</sup>). Negligence, in other words, concerns the failure to discharge a duty to exercise reasonable care and skill.<sup>24</sup> It thus differs from intention in that, rather than representing a state of mind, it consists of a particular standard of behaviour,<sup>25</sup> namely: *conduct involving an unreasonable risk of harm*.<sup>26</sup> From this formulation, it is evident that a person does not act negligently simply by participating in conduct that may cause harm.<sup>27</sup> Most human activities involve some degree of danger—the dispensing of pharmaceutical products will, for example, *always* pose some risk of injury. Conduct will be negligent only if the risk of harm that it brings about is unreasonable. The test for establishing the presence of negligence was authoritatively formulated by the Appellate Division in *Kruger v Coetzee*:

'For the purposes of liability *culpa* arises if—

<sup>20</sup> *Moaki v Reckitt and Colman (Africa) Ltd* 1968 (3) SA 98 (A) 104C; *Van der Walt and Midgley* par 107; *Neethling et al* 127.

<sup>21</sup> *Farmer v Robinson Gold Mining Co Ltd* 1917 AD 501 at 521; *Mitchell v Dixon* 1914 AD 519 at 525; *Mukheiber v Raath* par [31]; *S v Ngubane* 686F.

<sup>22</sup> *Kruger v Coetzee* 1966 (2) SA 428 (A) 430E; *Cape Town Municipality v Paine* 1923 AD 207 at 216-217; *Farmer v Robinson Gold Mining Co Ltd* 521; *Transvaal and Rhodesian Estate Ltd v Golding* 1917 AD 18 at 28.

<sup>23</sup> *Cape Town Municipality v Paine* 216. *Neethling et al* (132) explain that 'the reasonable person serves as the *legal personification* of those qualities which the community expects from its members in their daily contact with one another.' Since it is impossible to lay down concrete rules for the infinite number of situations with which a court may be faced, the reasonable person test serves as an abstract formula which ensures individualisation in the handling of negligence cases (*Fleming* 117).

<sup>24</sup> *Cape Town Municipality v Paine* 216; *Farmer v Robinson Gold Mining Co Ltd* 521. Although negligence involves the *failure* to take reasonable steps to prevent harm, it must not be confused with an omission. Negligence is a form of *fault*. Both positive acts and omissions can be negligent. An omission, on the other hand, is a form of *conduct* which may be either intentional or negligent (*Neethling et al* 131). See also *Cape Town Municipality v Bakkerud* par [9].

<sup>25</sup> *Claassen and Verschoor* 5.

<sup>26</sup> *Fleming* 114 and 117. See also *S v Ngubane* 686E.

<sup>27</sup> *Fleming* 127.

- (a) a *diligens paterfamilias* in the position of the defendant—
- (i) would foresee the reasonable possibility of his conduct injuring another in his person or property and causing him patrimonial loss; and
  - (ii) would take reasonable steps to guard against such occurrence; and
- (b) the defendant failed to take such steps.’<sup>28</sup>

Where the defendant is an expert, and thus has knowledge and skill superior to other members of society, the required standard of care is raised and the test to be applied is that of the *reasonable expert*. The justification for holding experts to a higher standard of care is that ‘[m]ore is reasonably to be expected of a skilled professional than an untrained layman.’<sup>29</sup> Boberg explains the position thus:

‘Obviously the ordinary reasonable man test of negligence cannot be applied to an activity calling for expertise that the ordinary man does not possess. One cannot judge a surgeon’s conduct by asking how a *diligens paterfamilias* would have operated, for either he would not have operated at all (which is most likely) or, if he would have operated (in some rare emergency), he would no doubt have done worse than even the most barbarous surgeon.’<sup>30</sup>

It follows that, in pharmacy malpractice cases, the defendant’s actions will be judged against the hypothetical conduct of the *reasonable pharmacist*. People who undertake to act as qualified pharmacists are required, firstly, to possess a reasonable degree of knowledge and skill<sup>31</sup> with regard to the pharmaceutical tasks which they perform, and secondly, to exercise reasonable care in performing these tasks.<sup>32</sup> In determining whether these standards have been met, the question to be asked is whether a reasonable pharmacist in the position of the defendant would have foreseen the reasonable possibility of harm and taken steps to guard against its occurrence.<sup>33</sup>

<sup>28</sup> *Kruger v Coetzee* 430E-F. From this evaluation, it is evident that the standard of care is partly objective and partly subjective. The fact that the standard takes into account the circumstances of the defendant distinguishes reasonableness as a criterion for determining fault from reasonableness as a criterion for determining wrongfulness (Boberg 269).

<sup>29</sup> *Powell v ABSA Bank t/a Volkskas Bank* 1998 (2) SA 807 (SE) 819C-F.

<sup>30</sup> Boberg 346. See also *Collins v Administrator, Cape* 1995 (4) SA 73 (C) 81J-82A; *Guardian National Insurance Co Ltd v Weyers* 1988 (1) SA 255 (A) 263D-E; *Mukheiber v Raath* par [32].

<sup>31</sup> Giesen (91) defines ‘skill’ as ‘that special competence which is not part of the ordinary equipment of the *diligens paterfamilias* or of the reasonable man ... but the result of aptitude developed by special training and experience.’

<sup>32</sup> *Mouton v Die Mynwerkersunie* 1977 (1) SA 119 (A) 142H. See also Brushwood ‘Case Study’ 4; Giesen 91; Klar *et al* par 148-149.

<sup>33</sup> See McQuoid-Mason and Strauss par 282.

### 4.3.2 Determining the Requisite Standard of Care

#### 4.3.2.1 General

Brushwood<sup>34</sup> describes the standard of care to which pharmacists are subject as follows:

‘A pharmacist is bound to exercise the skill generally possessed by well-educated pharmacists who are considered competent in their profession rather than the highest skill and learning, which can only be attained by a few men and women of rare genius, endowments or opportunities.’<sup>35</sup>

Indeed, South African courts have stressed that it is not the highest level of competence that is required from experts.<sup>36</sup> It is sufficient that the reasonable and ordinary care and skill of an ordinary (or ‘average’) person practising the profession is exercised.<sup>37</sup> Pharmacists will accordingly be held to the standard of a reasonably competent person in their profession. In this regard, it is significant that, just as conduct which was once lawful can become unlawful with the passage of time, so too will the standard of care applicable to pharmacists evolve over the years.<sup>38</sup> Practices which at one stage were reasonable may, in light of advances in medical knowledge, become unreasonable.<sup>39</sup> Mistakes which were once acceptable may similarly be rendered negligent by changes in the profession’s standards of practice and the publication of written standards by the South African Pharmacy Council.<sup>40</sup>

#### 4.3.2.2 General Practice and Codes of Professional Ethics

In *Van Wyk v Lewis* the Appellate Division explained that, in determining the requisite standard of care, regard must be had to ‘the general level of skill and diligence possessed and exercised at the time by the members of the branch of the

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<sup>34</sup> Brushwood *Medical Malpractice* 189.

<sup>35</sup> See also *Casmere* 430 and 428 fn 23.

<sup>36</sup> *Powell v ABSA Bank* 819F; *Van Wyk v Lewis* 1924 AD 438 at 444; *Mitchell v Dixon* 525; *Bulls v Tsatsarolakis* 1976 (2) SA 891 (T) 893H-894A. See also Claassen and Verschoor 13-14.

<sup>37</sup> *Hope et al* 43; Brushwood ‘Case Study’ 4; Giesen 99; Dwyer 744.

<sup>38</sup> Jones par 3.46.

<sup>39</sup> See Jones pars 3.46-3.50.

<sup>40</sup> See Powell and Stewart par 2-124.

profession to which the practitioner belongs.’<sup>41</sup> It follows that general practice is an important consideration in determining the foresight and conduct of the reasonable professional. This is one of the reasons why professional statements of ethics (which provide an indication as to what the profession considers to be reasonable conduct) are relevant in malpractice cases.<sup>42</sup> Gonzalez, for example, observes that the standards of practice of the American Pharmaceutical Association ‘serve as the litmus test for pharmacy practice.’<sup>43</sup> Indeed, these standards have been used successfully by American plaintiffs in describing the standard of care to which pharmacists are bound.<sup>44</sup> In the English case of *Prendergast v Sam and Dee Ltd*<sup>45</sup> the court similarly used the Pharmaceutical Society’s Code of Ethics and the Guidance Notes issued therewith in determining the standard of conduct expected by the pharmacy profession.

Although the standards of practice applying to pharmacists in South Africa will be an important tool in determining the conduct of the reasonable pharmacist, it must be remembered that the courts will not be *bound* by the views and general practice of the pharmacy profession. Even a practice accepted by the majority of a profession’s members may involve unreasonable risks and thus be negligent.<sup>46</sup> At the end of the day, the requisite standard of care is that which the court believes members of the profession *should* achieve, and not that which members of the profession *do* in fact achieve.<sup>47</sup> A profession’s standards of practice, although constituting a guide to reasonableness, are thus not necessarily the determining factor in the negligence enquiry.<sup>48</sup>

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<sup>41</sup> *Van Wyk v Lewis* 444. It is unrealistic to require that an identical standard is met by people who come from different branches of the same profession (Powell and Stewart par 2-118 – 2-120).

<sup>42</sup> See 2.3.2.4 above.

<sup>43</sup> Gonzalez 73.

<sup>44</sup> *Pittman v Upjohn Company; Dooley v Everett; Lasley v Shrake’s Country Club Pharmacy, Inc* 880 P 2d 1129 (Ariz Ct App 1994).

<sup>45</sup> (1989) 1 *Med Law R* 36.

<sup>46</sup> Fleming 133; Lewis 132-133; Jones par 3.23; Powell and Stewart par 2-117.

<sup>47</sup> *Van Wyk v Lewis* 448. McQuoid-Mason and Strauss par 282; McQuoid-Mason 23; Hope *et al* 44; Klar *et al* par 174; Dwyer 745. In *Hajgato v London Health Association* (1982) 36 OR 2d 669 at 693A, Callaghan J noted that the courts have ‘a right to strike down substandard approved practice when common sense dictates such a result. No profession is above the law and the courts on behalf of the public have a critical role to play in monitoring and precipitating changes where required in professional standards.’ For further discussion, see Powell and Stewart pars 2-116 - 2-117; Giesen 108-110 and 117-120.

<sup>48</sup> Fleming 121; Claassen and Verschoor 22; Jones pars 3.09 and 3.15; Van der Walt and Midgley par 123.

#### 4.3.2.3 Statutory Duties

In the last chapter, it was established that, although conduct will not be wrongful because of the breach of a statutory duty *per se*, the fact that a statutory duty was breached may be a factor that contributes to a court's conclusion that conduct was unlawful.<sup>49</sup> For the most part, statutory duties appear to play a similar role within the negligence enquiry. South African courts have accepted that the *only* time when the breach of a statutory duty will automatically amount to negligence will be when a statute prescribes that certain precautions be taken so as to protect the safety of a particular class of persons.<sup>50</sup> In all other cases, the weight of authority accepts that negligence will not arise from the breach of a statutory duty *per se*. Such a breach may, however, be taken into consideration in determining how a reasonable person would have acted if in the defendant's position.<sup>51</sup> Even when the defendant's conduct breaches a statutory duty, negligence will, in other words, usually still be determined by an application of the reasonable person test.<sup>52</sup> The corollary of this is, of course, that conduct may be negligent even if it is in accordance with a particular statutory duty.<sup>53</sup>

#### 4.3.2.4 Legitimate Assumptions

In speculating as to the conduct of a reasonable person (or expert), an important factor will be the assumptions that such a person would make concerning the conduct of others. In pharmacy malpractice cases, it will, for example, be necessary to consider the assumptions that a reasonable pharmacist would make concerning the conduct of patients and prescribing physicians. For the most part, one is entitled to assume that others will act reasonably. As stated in *Butters v Cape Town Municipality*,<sup>54</sup>

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<sup>49</sup> See 3.5.4.2 above.

<sup>50</sup> *Sand and Co Ltd v South African Railways and Harbours* 1948 (1) SA 230 (W) 243.

<sup>51</sup> *Clairwood Motor Transport Co Ltd v Akal and Sons* 1959 (1) SA 183 (N) 184D-E; *De Jong v Industrial Merchandising Co (Pvt) Ltd* 1972 (4) SA 441 (R) 444H-445C; *Steenkamp v Steyn* 1944 AD 536 at 553-556; *S v Pula* 1972 (4) SA 258 (NC) 259E-260C.

<sup>52</sup> *Bekker v Du Toit* 1974 (3) SA 248 (O). See, however, *Morley v Wicks* 1925 WLD 13 and *Good v Posner* 1934 OPD 90 in which the doctrine of 'statutory negligence' was accepted.

<sup>53</sup> See *Geldenhuis v South African Railways and Harbours* 1964 (2) SA 230 (C).

<sup>54</sup> 1993 (3) SA 521 (C).

'it is true that up to a point one is entitled, generally speaking, to assume that others will conduct themselves reasonably, sensibly and in compliance with the law, rather than recklessly, negligently, foolishly or in breach of the applicable laws, regulations, rules or established conventions.'<sup>55</sup>

There will, however, be situations in which a reasonable person would foresee the possibility of others behaving negligently and would take precautions to prevent harm.<sup>56</sup> If, in other words, one has reason to believe that others will act negligently, one must adjust one's conduct accordingly so as to avoid the risk of harm.<sup>57</sup> The courts have, for example, held that, although attorneys can usually assume that opinions by counsel are free from error,<sup>58</sup> they will be unable to escape liability if there are indications that a particular opinion is deficient in some respect.<sup>59</sup> As put by Fleming, the '[l]iberty to act on an expectation of non-negligence in others ceases as soon as there are indications that they are, or are likely to be, acting imprudently.'<sup>60</sup> Fleming goes on to caution that 'the greater the risk [of harm] the more tentative must be the assumption that others will conduct themselves with reasonable care.'<sup>61</sup> This comment is particularly pertinent to pharmacy practice, in which the risk posed to patients will, at times, be immense.

#### 4.3.2.5 Errors of Judgment

Professional people should not be considered infallible.<sup>62</sup> In medical practice in general, there will obviously be times when healthcare professionals make judgment calls which turn out to be wrong. This does not, however, necessarily mean that they have acted incompetently or negligently.<sup>63</sup> Judgment errors on the part of

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<sup>55</sup> *Butters v Cape Town Municipality* 530H-I. See also *Moore v Minister of Posts and Telegraphs* 1949 (1) SA 815 (A) 825-826; *Southern Insurance Association Ltd v Dannenberg* 1976 (3) SA 253 (A) 260B-261B; *Masureik (t/a Lotus Corporation) v Welkom Municipality* 1995 (4) SA 745 (O) 763H; *Roeloffze v M Ranchod and Sons (Pvt) Ltd* 1972 (4) SA 80 (RA) 85A-C.

<sup>56</sup> *Butters v Cape Town Municipality* 531C-D.

<sup>57</sup> *Moore v Minister of Posts and Telegraphs* 826. See also Van der Walt and Midgley par 123.

<sup>58</sup> *Honey and Blackenberg v Law* 1966 (2) SA 43 (R) 46H.

<sup>59</sup> *S v Longdistance (Pty) Ltd en 'n Ander* 1986 (3) SA 437 (N); *S v Waglines (Pty) Ltd and Another* 1986 (4) SA 1135 (N). See also Midgley *Thesis* 234.

<sup>60</sup> Fleming 135.

<sup>61</sup> *Ibid.*

<sup>62</sup> Claassen and Verschoor 20.

<sup>63</sup> Healy 49. See also Giesen 162; Claassen and Verschoor 20.

professionals therefore do not automatically lead to a finding of negligence.<sup>64</sup> When harm results from an error of judgment, the question remains whether the defendant exercised reasonable care, skill and diligence.<sup>65</sup> In *Whitehouse v Jordan and Another*<sup>66</sup> the House of Lords explained the position thus:

'Merely to describe something as an error of judgment tells us nothing about whether it is negligent or not. The true position is that an error of judgment may, or may not, be negligent; it depends on the nature of the error; if it is one that would not have been made by a reasonably competent professional man professing to have the standard and type of skill that the defendant held himself out as having, and acting with ordinary care, then it is negligent. If, on the other hand, it is an error that a man, acting with ordinary care might have made, then it was not negligence.'<sup>67</sup>

As can be seen from this quote, a professional may very well act negligently in making a judgment error. The point, however, is that the presence of negligence cannot be inferred from the mere fact that such an error has been made. In order to be negligent, the error must additionally be one that would not have been made by a reasonable professional.

#### 4.3.2.6 Beginners

A question arises concerning the standard of care that can be expected from those who are beginners in a particular profession, and who thus lack the degree of skill and experience possessed by general practitioners. In most instances, beginners will not be held to the same standard of care as experienced practitioners.<sup>68</sup> Van der Walt and Midgley submit, however, that '[w]here a beginner's lack of skill generally exposes the public to an appreciable risk of serious harm, no allowance should be made for that lack of proficiency and experience.'<sup>69</sup> The magnitude of the risk created by a

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<sup>64</sup> See *Union Government (Minister of Railways and Harbours) v Buur* 1914 AD 273 at 286:

'Even if the defendant contended that the former course of action was a wiser one and that contention were upheld, it would not follow that the plaintiff's conduct amounted to negligence.'

<sup>65</sup> *Honey and Blackenberg v Law* 46H-47A; *Pringle v Administrator, Transvaal* 1990 (2) SA 379 (W) 395H-396I.

<sup>66</sup> [1981] 1 WLR 246.

<sup>67</sup> *Whitehouse v Jordan* 263.

<sup>68</sup> Van der Walt and Midgley par 126. See for example *Clark v Welsh* 1976 (3) SA 493 (N). Though beginners will, of course, be expected to take steps so as to avoid harm being caused by his or her lack of experience (Van der Walt and Midgley par 126).

<sup>69</sup> Van der Walt and Midgley par 126.

beginner's activities may, in other words, make it necessary to hold him or her to the same standard of care as a reasonably proficient and experienced practitioner. Indeed, South African courts have stressed that, when one engages in an inherently dangerous activity, one must be held to a high standard of care.<sup>70</sup> A person who drives a motor vehicle is, for example, held to the standard of a reasonably careful and skilful driver, regardless of his or her actual level of experience.<sup>71</sup>

Within the pharmacy profession, this issue comes into play when harm is caused by a pharmacy student or intern.<sup>72</sup> In the American case of *Brown v Southern Baptist Hospital*<sup>73</sup> it was argued that, in light of the fact that pharmacist interns are permitted to perform the same functions as pharmacists, the former should be held to the same standard of care as the latter. Interestingly enough, the court rejected this argument, holding that it would be unfair to hold pharmacist interns to the same standard of care as pharmacists. The court noted with approval the following instruction, which was given to the jury by the trial judge:

'Now, considering the alleged negligence of [the intern] you must consider whether the [the intern] acted as a reasonable woman who was a student extern while she was in the course and scope of her duties as an extern. You must consider the fact that she was a student and that she was not held out to be an accomplished professional or not held out to be a pharmacist. She is not held out to the standards of malpractice, *she is held to the standards of what a reasonable man or woman should have done under the circumstances considering her education and her status as a student.*'<sup>74</sup>

There certainly are policy considerations that favour the approach adopted in *Brown*. Pharmacists perform an important social function and, as such, it is necessary to create an environment in which beginners are encouraged to acquire skill and

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<sup>70</sup> *Simon's Town Municipality v Dews* 194C.

<sup>71</sup> *R v Van Dyl* 1939 EDL 203 at 206:

'[H]owever short his period of experience may be, a person who drives a car along a public road must show all such care and diligence as should be exercised by a reasonable man, and if he falls short of that standard of care and diligence, he is guilty of negligence.'

See also *Palm v Elsley* 1974 (2) SA 381 (C) 383E-384B.

<sup>72</sup> This issue is discussed further in 4.4.9 below.

<sup>73</sup> La App 556 (1998).

<sup>74</sup> Quoted in Brushwood and Mullan 'Preceptor Responsibility' 59. Emphasis added. See Jones par 3.80 and accompanying footnotes for a discussion of foreign cases that stress the importance of taking into account the education, stage of training and experience of intern *doctors* during the negligence enquiry.

experience in pharmacy practice.<sup>75</sup> The threat of being held liable for mistakes which, although negligent if judged by the standard of an experienced pharmacist, are reasonable for someone who has just completed, or is in the process of completing, his or her pharmacy degree makes it difficult for such a culture of learning to be established. In *S v Mkwetshana*<sup>76</sup> the Natal Provincial Division was urged to adopt a similar approach to that taken in *Brown*. It was argued that, in establishing the negligence of a defendant medical practitioner who was in the process of completing his internship, the court should take cognisance of the fact that, as an intern, the defendant was comparatively inexperienced.<sup>77</sup> The court in this case did not expressly state whether intern doctors should be held to the same standard of care as experienced practitioners. It did, however, hold that an intern's lack of experience cannot excuse him or her from liability for administering a potentially dangerous drug in a manner that makes it dangerous. Indeed, it is submitted that the dangerous nature of pharmaceutical products is such that, in many instances, South African courts will not be prepared to make an allowance for a pharmacy student or intern's lack of experience.

#### 4.3.2.7 The Performance of Tasks Beyond One's Competence

It is an accepted principle of our law that persons who engage in potentially dangerous activities, or activities for which expert knowledge is required,<sup>78</sup> are expected to ensure that they possess the skill necessary to avert danger.<sup>79</sup> It follows that professionals who lack the skill or expertise to deal with a particular matter should recognise their limitations<sup>80</sup> and refer the matter to someone else.<sup>81</sup> If one fails to do so, one cannot later argue that one ought, as a result of one's lack of skill, be judged by a standard lower than that of the average, reasonable practitioner.<sup>82</sup> The very performance of a task that is beyond one's competence constitutes a failure to act

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<sup>75</sup> Van der Walt and Midgley par 126.

<sup>76</sup> 1965 (2) SA 439 (N).

<sup>77</sup> *S v Mkwetshana* 496F-G.

<sup>78</sup> Neethling *et al* 137.

<sup>79</sup> *Simon's Town Municipality v Dews* 194C; *Durr v Absa Bank Ltd and Another* 1997 (3) SA 448 (SCA) 462G and 468E-J.

<sup>80</sup> Jones par 3.80. See also *Minister of Safety and Security and Another v Rudman and Another* 2005 (2) SA 16 (SCA) Par [70].

<sup>81</sup> Klar *et al* par 154.

<sup>82</sup> Jones pars 3.74-3.76.

reasonably and is thus negligent.<sup>83</sup> A pharmacist will, for example, act negligently if he or she attempts to make a complex diagnosis that exceeds his or her level of expertise.

There also exists some degree of overlap between this issue and the negligence of beginners. Beginners who undertake tasks falling beyond their level of skill will be regarded as having acted negligently. In *S v Mkwetshana* it was, for example, held that the fact that an intern administers a potentially dangerous drug in spite of his or her inexperience means that the intern has acted negligently.<sup>84</sup> It follows that, regardless of the standard of care to which pharmacy students and interns are held, they will be negligent if they, without assistance, undertake complex tasks for which they lack the necessary expertise.

### 4.3.3 The Legs of the Negligence Test

#### 4.3.3.1 The Foreseeability of Harm

Foreseeability of harm is a necessary condition of negligence. If a particular danger is not foreseeable, the defendant cannot be negligent because the reasonable person in his or her position would not take precautions against unforeseeable consequences.<sup>85</sup> It is not, however, sufficient that the mere possibility of harm is foreseeable. What is required is foresight of the *reasonable* possibility of harm.<sup>86</sup> This was emphasised in *Stratton v Spoornet*<sup>87</sup> in which Preiss J took it to mean a possibility which is not too remote or fanciful.<sup>88</sup> The foreseeability of harm thus depends on the likelihood that a particular risk will materialise.<sup>89</sup> Foreseeability is also dependant on the severity of the harm should it arise.<sup>90</sup>

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<sup>83</sup> Jones par 3.78. This principle is embodied in the maxim *imperitia culpa adnumeratur* (Neethling *et al* 137; Van der Walt and Midgley par 121).

<sup>84</sup> *S v Mkwetshana* 497A-E.

<sup>85</sup> Jones par 3.55.

<sup>86</sup> *Mkhatswa v Minister of Defence* 2000 (1) SA 1104 (SCA) par [23].

<sup>87</sup> 1994 (1) SA 803 (T) 809H.

<sup>88</sup> See also Fleming 127:

‘Conduct cannot be treated as negligent unless there is more than a mere theoretical chance that it will miscarry *and* thereby subject others to harm.’

<sup>89</sup> In *Butters v Cape Town Municipality* 533F Thring J observed that an interrelationship exists between the foreseeability of harm and the likelihood of the risk of harm materialising.

<sup>90</sup> Claassen and Verschoor 10.

Both the likelihood of harm eventuating and the severity of harm are relative in nature. Certain conduct may, in other words, pose a greater risk of harm to one person than to another. Even when two people run equal risks of suffering injury, the one may be likely to suffer more extensive harm. This means that the same conduct may be negligent towards one person but not another.<sup>91</sup> Within the context of pharmacy practice, for example, particular patients may have peculiar susceptibilities which mean that they face either a 'greater risk of injury' or a 'risk of greater injury'<sup>92</sup> than others. The same can be said in relation to different kinds of pharmaceutical products. There are certain categories of drugs which require special care on the part of their dispensers because they pose a high risk of serious harm regardless of who is using them. Other drugs are, in general, either unlikely to cause harm or only prone to cause harm of a trivial nature. It follows that, just as the information to which pharmacists have access may be drug-specific or patient-specific, what is foreseeable by the reasonable pharmacist will also be dependant on the particular drug(s) with which and patient with whom the pharmacist is dealing.<sup>93</sup>

When the probability of harm occurring depends upon characteristics of a patient, rather than a drug, there may be times when a reasonable pharmacist would not foresee the reasonable possibility of harm. (Although the professional expectation that patient-specific information be kept by pharmacists would certainly be an important factor in determining the foresight of a reasonable pharmacist in such instances.<sup>94</sup>) If, however, the defendant was *in fact* aware of a patient's susceptibilities, then a reasonable pharmacist in the defendant's position would have foreseen harm. Such was the case in *Hand v Krakowski*<sup>95</sup> where the pharmacist knew that the patient was an alcoholic and should thus have foreseen that dispensing psychotropic drugs which interact with alcohol was likely to result in harm.

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<sup>91</sup> Fleming 128.

<sup>92</sup> Fleming 128. See also *Brushwood Drake LR 14-15*; *Dwyer 744*; *Milot 1019-1020*; *Leesley v West 518 NE 2d 758 762 (Ill App Ct 1988)*. Steyn (98), in discussing negligence within the context of psychiatry, makes the following point:

'[F]ew drugs that help anybody will not hurt somebody, and all potent drugs, no matter how skilfully administered can cause untoward effects in some patients.'

<sup>93</sup> See *Brushwood Drake LR 14-15*; *Dwyer 744*.

<sup>94</sup> See 3.7.1.2 above.

<sup>95</sup> 551 453 NYS 2d 121 (1982). See also *Milot 1019-1020*.

Boberg identifies two questions which are raised by the reasonable foresight test:

- a) 'Must the harm that actually occurred have been foreseeable or does it suffice that *some* harm, of whatever kind, was foreseeable?'<sup>96</sup>
- b) 'To whom must harm have been foreseeable: a person in the plaintiff's position, or anyone?'<sup>97</sup>

With regard to a), although it is accepted that neither the extent of harm<sup>98</sup> nor the precise manner in which the harm occurred<sup>99</sup> need have been foreseeable, there has been some debate concerning whether the reasonable person must have been able to foresee the *general kind* of harm which in fact eventuated. According to the *absolute* approach,<sup>100</sup> it is sufficient that the reasonable person would have foreseen harm. The nature of the harm foreseen is irrelevant. The *relative* approach,<sup>101</sup> on the other hand, stipulates that the general *nature and manner* of harm needs to be foreseen.<sup>102</sup> It is the second approach that has found the most favour amongst South African academics<sup>103</sup> and courts.<sup>104</sup> In pharmacy malpractice cases, the distinction between the two approaches may become relevant when an adverse drug reaction results in a patient harming a third party in an unforeseeable manner. In *Kinney v Hutchinson*,<sup>105</sup> for example, the plaintiff was shot by a person who had a reaction after consuming medication together with alcohol. On these facts, the court refused to hold the pharmacist liable.

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<sup>96</sup> Boberg 275.

<sup>97</sup> Boberg 274-275.

<sup>98</sup> *Botes v Van Deventer* 1966 (3) SA 182 (A) 191A:

'Hy kan ook nie aanspreeklikheid vryspring deur bewys dat die omvang of afmetings van die skade nie voorsienbaar was nie.'

<sup>99</sup> *Herschel v Mrupe* 1954 (3) SA 464 (A) 474D-E; *Standard Chartered Bank of Canada v Nedperm Bank Ltd* 768G; *Robinson v Roseman* 1964 (1) SA 710 (T) 715H-716A.

<sup>100</sup> Applied in *Groenewald v Groenewald* 1998 (2) SA 1106 (SCA).

<sup>101</sup> Applied in *Mukheiber v Raath* par [31] and *Sea Harvest Corporation (Pty) Ltd v Duncan Dock Cold Storage (Pty) Ltd* pars [23]-[24].

<sup>102</sup> For further discussion of the different approaches to foreseeability see Boberg 275-279 and Dean 47-50.

<sup>103</sup> Most notably Boberg (Boberg 275-278; Boberg *Annual Survey* 201). See also Neethling *et al* 138-141.

<sup>104</sup> See for example *Stratton v Spoornet* 810A-811B in which the court held that, although a reasonable person in the position of the defendant would have foreseen the occurrence of some kind of harm (harm resulting from a collision between a train and a child), the kind of harm that actually eventuated (harm resulting from a child climbing a pylon at the side of a railway line) would not have been foreseen as a reasonable possibility. As a result, negligence on the part of the defendant had not been established.

<sup>105</sup> 449 So 2d (La Ct App 1984).

The foreseeability requirement can be applied not only to the kind of harm suffered, but also to the person who suffered it.<sup>106</sup> It is suggested by some that, in order for the defendant's conduct to be negligent, the class of persons to which the plaintiff belonged must have been foreseeable.<sup>107</sup> This was the approach adopted by the court in *Workmen's Compensation Commissioner v De Villiers*.<sup>108</sup> Van der Walt and Midgley also support the idea that this requirement forms part of the test for negligence,<sup>109</sup> whilst Boberg argues that 'our law *does* require that the plaintiff be foreseeable, for the care that a reasonable man takes in the given circumstances depends partly on whom he is dealing with.'<sup>110</sup>

The foreseeability of the plaintiff will become relevant in pharmacy malpractice cases in which harm is suffered by a person who could not reasonably have been expected to come into contact with the dispensed drug. This will be the case when a drug has been ingested by a person other than the patient for whom it was intended. In the American decision of *Pittman v Upjohn Co*,<sup>111</sup> for example, the court held that, whilst it was reasonably foreseeable that the patient for whom a drug had been prescribed was at risk of injury, it was not foreseeable that her grandson would ingest the medication and suffer harm.<sup>112</sup> As a result, the pharmacist could not be held liable for the harm suffered by the patient's grandson. Even if the foreseeable plaintiff doctrine is accepted, the outcome of a case will, however, be greatly influenced by the knowledge which the defendant in fact possessed (or should have possessed). Thus, in the Canadian decision of *Williams v Jones*,<sup>113</sup> the court held that, seeing as the defendant pharmacist *knew* that both the patient and his wife were alcoholics, the possibility of the patient's wife ingesting some of a drug prescribed for alcoholism was reasonably foreseeable. This was in spite of the fact that that the drug had been prescribed solely for her husband.<sup>114</sup>

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<sup>106</sup> Boberg 308.

<sup>107</sup> This is known as the 'foreseeable plaintiff theory' and has its roots in *Hay or Bourhill v Young* 1943 AC 92 (Neethling *et al* 193 fn 110).

<sup>108</sup> 1949 (1) SA 474 (C).

<sup>109</sup> Van der Walt and Midgley par 120.

<sup>110</sup> Boberg 309.

<sup>111</sup> 890 SW 2d 425 (Tenn 1994).

<sup>112</sup> *Pittman v Upjohn Co* 435.

<sup>113</sup> (1977) 79 DLR (3d) 670 (BCSC).

<sup>114</sup> *Williams v Jones* 675-676.

A final point to note about foreseeability is that it will be assessed with reference to the date of the alleged negligence rather than the date of the trial. In the context of medical malpractice cases, this means that a court will take into account only that medical knowledge that existed when the incident took place and that advances that have occurred in medical knowledge since that date, but before the time of the trial, will be disregarded.<sup>115</sup>

#### 4.3.3.2 The Preventability of Harm

Even if it has been established that a reasonable person would have foreseen the possibility of harm, the defendant will be regarded as negligent only if the reasonable person would also have taken steps to avoid such harm.<sup>116</sup> When determining preventability, one must first consider the *magnitude* of the harm—ie the likelihood of the harm resulting and the severity of the harm if it does eventuate. If the harm is likely to be of a serious nature if it occurs, the reasonable person will guard against it unless the chances of it occurring are extremely slim.<sup>117</sup> Similarly, if the chances of harm eventuating are substantial, the reasonable person will take preventative measures unless the harm, if it occurs, is likely to be particularly trivial in nature.<sup>118</sup>

In *Ngubane v South African Transport Services*,<sup>119</sup> the Appellate Division accepted that, in addition to the magnitude of the risk, the *utility* (social value<sup>120</sup>) of the

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<sup>115</sup> Claassen and Verschoor 15-16; Powell and Stewart par 12-073. See for example *Roe v Ministry of Health and Others* [1954] All ER 131 (CA). Although healthcare professionals are obviously expected to acquaint themselves with new developments in medicine (Claassen and Verschoor 16; Jones par 3.46).

<sup>116</sup> See *Herschel v Mrupe* 475C in which Schreiner JA, with reference to *Donoghue v Stevenson* 1932 AC 562 at 580, emphasised that 'the situation must be such that the reasonable man not only would have foreseen the harm but would have "governed his conduct accordingly" and "guarded against" the danger.'

<sup>117</sup> If this is the case, the harm may not even be foreseeable. In *Stratton v Spoornet*, for example, even though the kind of harm was extremely serious, the likelihood of it occurring was so slight that it would not have been foreseen by the reasonable person. See also *South African Railways and Harbours v Reed* 1965 (3) SA 439 (A) 443E-G. In *Lomagundi Sheetmetal and Engineering v Basson* 1973 (4) SA 523 (RAD) 525E-G, however, it was found that the severity of the harm which may have resulted would have led a reasonable person to take preventative measures in spite of the fact that the likelihood of the harm occurring was minimal.

<sup>118</sup> *Herschel v Mrupe* 477A-C.

<sup>119</sup> 1991 (1) SA 756 (A) 777E-778A.

<sup>120</sup> *Ngubane v SA Transport Services* 777E-F. See also *S v Mkwanazi* 1967 (2) SA 593 (N) 596G-597B.

defendant's conduct and the *burden* (cost or difficulty)<sup>121</sup> of taking precautionary measures<sup>122</sup> are relevant factors in determining whether a reasonable person would have acted to prevent harm to the plaintiff.<sup>123</sup> These factors may outweigh the likelihood and seriousness of harm, in which case no preventative measures need have been taken by the defendant. If, however, the magnitude of the risk outweighs the other two factors, a reasonable person would take steps to avoid the risk.<sup>124</sup> If the defendant did not attempt to prevent the risk, he or she will consequently be negligent.

The mere taking of preventative measures will not necessarily be enough for the defendant to escape liability. For a defendant to avoid being found negligent, the measures which he or she took must have been reasonable. Reasonableness is, of course, established by comparing the precautions taken by the defendant to those which a reasonable person would have taken if in the defendant's position. The precautions taken by a reasonable person will depend on the circumstances<sup>125</sup> and will again be determined by balancing the magnitude of the risk against the utility of the defendant's conduct and the burden of guarding against harm.<sup>126</sup> It follows that the preventative measures expected of the defendant will be influenced by the degree of danger which a particular situation involves.<sup>127</sup> As explained by Fleming, 'there is only one single standard of care, but it may demand greater or less precaution depending on the nature of the particular risk.'<sup>128</sup> The extent of care and skill that a pharmacist is under a duty to exercise will thus depend on the level of danger to which a patient is exposed. A greater measure of care will obviously be expected

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<sup>121</sup> In *Lomagundi Sheetmetal and Engineering v Basson* 525G-H, for example, the fact that the difficulties involved in guarding against the risk were minimal was a factor which indicated that a reasonable person would have taken precautionary measures. In *Botes v Van Deventer*, on the other hand, the court found that the expense of taking precautionary measures was so substantial that a reasonable person, whilst foreseeing the possibility of harm, would not have acted to prevent it.

<sup>122</sup> See *Lomagundi Sheetmetal and Engineering v Basson* 525A-G in this regard. See also Jones par 3.57-3.67.

<sup>123</sup> See also *Herschel v Mrupe* 477A-C; *SA Railways and Harbours v Reed* 443E-G; *S v Mkwanazi* 596F-G; *Khupa v South African Transport Services* 1990 (2) SA 627 (W) 630D-E.

<sup>124</sup> Such was the case in *Khupa v SA Transport Services* 637G-I, *Lomagundi Sheetmetal and Engineering v Basson* and *S v Mkwanazi* 596G-597B. For an example involving a pharmacist, see *Hoar v Rasmusen* 229 Wis 509 282 NW 652 (1938) in which the court held that any possible utility of the act of supplying a medicine other than that which the doctor prescribed was outweighed by the risk of harm to the patient.

<sup>125</sup> Boberg 333.

<sup>126</sup> Boberg 334.

<sup>127</sup> Klar *et al* par 151:

'The degree of care required by the law is commensurate with the potential danger.'

See also *Riff v Morgan Pharmacy* 508 A 2d 1247 1251 (Pa Super Ct 1986); Jones par 3.58.

<sup>128</sup> Fleming 136.

when dealing with potentially lethal medicines than when non-toxic drugs are involved.<sup>129</sup> Similarly, greater precautions will need to be taken when a pharmacist is aware that a patient has peculiar susceptibilities and is therefore at a greater risk of harm than others.<sup>130</sup>

## 4.4 Specific Situations

### 4.4.1 Infringement of the Right to Privacy

When a pharmacist has disclosed private information concerning a patient and thereby infringed the patient's right to privacy, the plaintiff's claim will be based on the *actio iniuriarum*. It follows that a pharmacist's breach of confidentiality will only result in liability if it was intentional. A plaintiff may run into difficulties when the pharmacist's disclosure of information has not been direct in nature. This may be the case where, for example, a pharmacist discusses a patient's condition with another healthcare professional (such as the prescribing physician or another pharmacist), or with the patient within clear earshot of people who have no right to the information concerned.<sup>131</sup> Private information may similarly be indirectly disclosed when a prescription or prescription book is left in a place where it can be seen by others or when computerised information is not protected by sufficient safeguards.

Bearing in mind that intention may take the form of *dolus directus*, *dolus indirectus* and *dolus eventualis*, it is clear that the mere fact that the disclosure of information was not the pharmacist's primary object will not necessarily mean that the pharmacist's conduct was not intentional. In such instances, it is, however, essential to

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<sup>129</sup> Claassen and Verschoor 14-15. The poisonous nature of many of the drugs dispensed by pharmacists and the serious consequences that may result if a pharmacist fails to exercise an adequate degree of care means that the standard of care required from pharmacists will often be very high (Brushwood 'Case Study' 5-6, 8 and 14). In *Tremnlay v Kimball* 107 Me 53 77A 405 (1910) it was thus held that 'ordinary care' for pharmacists means that 'the highest practicable degree of prudence, thoughtfulness and vigilance and the most exact and reliable safeguards' must be taken. See also Giesen 106; *Konis v State Transport Authority* 58 ALJR 531 (1984) at 534.

<sup>130</sup> A higher standard of care will, in other words, be expected if a pharmacist has special knowledge of circumstances that increase the risk to the patient (McQuoid-Mason 24; *Collins v Administrator, Cape* 82E-F).

<sup>131</sup> In this regard, it is significant that, in terms of rule 1.2.13 of the Rules Relating to Good Pharmacy Practice, '[a] minimum standard for pharmacies where medicines are supplied to the public is a suitable area for the furnishing of advice to patients in a reasonably private environment.'

remember that intention will only be present if the defendant pharmacist in fact *foresaw* the possibility of the private information being disclosed. The defendant must additionally have reconciled himself or herself with the possibility that his or her actions may result in the patient's private information being leaked to a third party. In the examples given above, pharmacists will, in other words, only be held liable when they knowingly act with reckless disregard for a patient's privacy. The fine line that exists between this form of intention and gross negligence means that a plaintiff may well face difficulties in convincing a court that the pharmacist's conduct was in fact intentional. If all that can be shown is that the pharmacist acted negligently, an action based on the *actio iniuriarum* will be unsuccessful and the plaintiff will be without a remedy for breach of confidentiality.

As far as the second element of intention (consciousness of wrongfulness) is concerned, it is submitted that the fact that the rules and regulations applying to pharmacists place such emphasis on patient confidentiality<sup>132</sup> means that, in most instances, pharmacists will be well aware that the disclosure of confidential information is wrongful. When a pharmacist discloses private information for the benefit of the patient, the first requirement of intention will still be met. The fact that the pharmacist has a laudable motive for breaching patient confidentiality may, however, provide an indication that the pharmacist believed the disclosure to be lawful.<sup>133</sup> If this is the case, intention will not be present. Any other *bona fide* mistake regarding law or fact (eg the mistaken belief that the patient consented to disclosure) will similarly result in the pharmacist escaping liability due to lack of intention.

#### 4.4.2 Dispensing and Compounding Errors

The most common error made by pharmacists is said to be the dispensing of an incorrect drug.<sup>134</sup> Mistakes of this nature may be the result of various factors,

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<sup>132</sup> See 3.7.3.3 above.

<sup>133</sup> Even if one requires that the mistake be reasonable in order to exclude intention, a belief that it is lawful to disclose information for a patient's benefit is likely to be considered reasonable. This is due to the fact that the South African Pharmacy Council's Ethical Rules permit disclosure in the interest of the patient (rule 9).

<sup>134</sup> Brushwood *Medical Malpractice* 155. See Pretorius 'Avoiding Dispensing Errors' for a comment on the prevalence of dispensing errors in South African pharmacies. Cases in which a pharmacist incorrectly fills a prescription should be distinguished from cases in which a pharmacist *correctly* fills

including misreading of prescriptions (this may occur when pharmacists are overworked<sup>135</sup> or where the handwriting of the prescriber is unclear<sup>136</sup>), improper retrieval from the storage area,<sup>137</sup> similar names or appearance of drugs,<sup>138</sup> and the use of chemical symbols in the prescription of medications.<sup>139</sup> Even when a pharmacist dispenses the correct drug, there is always the possibility that the drug has been given in the incorrect form<sup>140</sup> or dosage.<sup>141</sup> Such mistakes can have particularly serious consequences when they involve a drug for which the toxic dose is only slightly higher than the therapeutic dose.<sup>142</sup> Further errors may be made in compounding a prescribed medication. A pharmacist may, for example, use incorrect proportions of the prescribed ingredients<sup>143</sup> or include or substitute a harmful ingredient<sup>144</sup> not mentioned in the prescription.<sup>145</sup> Due to the fact that the compounding of medicines is

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an invalid or improper prescription (Travers 275). These situations are discussed in 4.4.3 and 4.4.4 below.

<sup>135</sup> In one set of misconduct proceedings before the Nevada Pharmacy Board, an elderly patient died after a pharmacist gave her heart medication instead of the diuretic product that had been prescribed. The evidence suggested that the reason for the error was that the pharmacy in question gave its pharmacists too large a workload (Dwyer 749-750).

<sup>136</sup> Eg *McLean v United States* 613 F 2d 603 (5<sup>th</sup> Cir 1980). When a physician verbally conveys a prescription to a pharmacist, similar mistakes may result from slurred speech as was the case in *Troppi v Scarf* in which a spoken miscommunication led to a patient being given Nardil (a tranquilizer) instead of Norinyl (a contraceptive). For further discussion of the problem of spoken miscommunications, see Allinson.

<sup>137</sup> *Brushwood Medical Malpractice*. See also *Pauler v Stewart's Pharmacies, Limited* 48 Hawaii 618 (1958); *Moon v Harco Drugs Inc* 435 So 2d 218 (Ala 1983); *Harris v Groth* 31 Wash App 876 645 P2d 1104 (1982).

<sup>138</sup> Dwyer 750.

<sup>139</sup> Dwyer (749), for example, refers to a situation which occurred in New South Wales and which, although not litigated upon, became the subject of professional misconduct proceedings: A prescription stipulated that the patient be given NaHCO<sub>3</sub> (Sodium Bicarbonate). The pharmacist, however, mistakenly dispensed Li<sub>2</sub>CO<sub>3</sub> (Lithium Carbonate—a potent anti-depressant).

<sup>140</sup> Eg in *Philbrick v Weinberger* 228 Cal App 2d 681 39 Cal Rptr 617 (1964) the prescription directed the pharmacist to dispense Neo Decadron Ophthalmic ointment. Due to an error on the part of the pharmacist, however, Neo Decadron Topical Cream was dispensed.

<sup>141</sup> Eg in *MacKay v Crown Drug Co* 420 P 2d 883 (Okla 1966) a prescription calling for one-tenth milligram tablets of a particular drug was filled with one milligram tablets after the pharmacist overlooked the decimal point contained in the prescription (reading '.1' as '1'). See also *Cazes v Raisinger* 430 So 2d 104 (La Ct App 1983) and *Lou v Smith* 285 Ark 249 685 SW 2d 809 (1985).

<sup>142</sup> *Brushwood Medical Malpractice* 158.

<sup>143</sup> Eg in *Adams v American Druggist Insurance Co* 245 So 2d 808 (La Ct App 1971), a prescription designed as a cure for skin pigmentation called for 0.5 percent bichloride of mercury and 1 percent salicylic acid. The pharmacist, however, prepared a solution containing 6.56 percent bichloride of mercury and 4.08 percent salicylic acid. The result was that the customer suffered first and second degree burns to her face and an increase in her skin pigmentation. See also *Watkins v Jacobs Pharmacy Co* 48 Ga App 38 171 SE 830 (1934).

<sup>144</sup> This resulted in liability in the following American cases *Connie's Prescription Shop v McCann* 316 P 2d 823 (Okla 1957); *Cody v Toller Drug Co* 232 Iowa 475 5 NW 2d 824 (1942); *Tombari v Conners* 85 Conn 231 82 A 640 (1912), *Moore v Pywell* 29 App DC 312 (1907), *Faulkner v Birch* 120 Ill App 281 (1905); *Boeck v Katz Drug Co* 155 Kan 656 127 P 2d 506 (1942); *McCubbin v Hastings* 27 La Ann 713 (1875); *Hoar v Rasmusen*.

<sup>145</sup> *Brushwood Medical Malpractice* 160.

no longer the primary function of pharmacists,<sup>146</sup> compounding errors are not likely to occur frequently in practice. The fact that a small percentage of prescriptions still require extemporaneous preparation of compounds by pharmacists<sup>147</sup> does, however, make it necessary to explore whether pharmacists can incur civil liability for mistakes of this nature.

Having established that it is possible for pharmacists to make mistakes when dispensing and compounding pharmaceutical products, it is important to determine the standard of care that is expected from pharmacists when performing these functions. Pharmacists are under a duty to exercise reasonable care and skill in practising their profession. One of the primary functions performed in pharmacy practice is the filling of prescriptions. It follows that, when dispensing or compounding medications in accordance with a prescription, pharmacists are obliged to exercise reasonable care and skill.<sup>148</sup> A failure to do so will not be condoned simply because the error was the product of overwork, stress,<sup>149</sup> improper retrieval, misreading of prescriptions<sup>150</sup> or any of the other excuses mentioned above.<sup>151</sup> In determining the standard of care to which pharmacists are expected to adhere when performing their dispensing and compounding functions, one must look to the conduct of the reasonable pharmacist.

It is obvious that a reasonable pharmacist would foresee the reasonable possibility of harm resulting from the provision of an incorrect drug or dosage. Such harm could be caused either by using the incorrect drug, or failing to receive the intended medication.<sup>152</sup> One must thus proceed to the second leg of the *Kruger v Coetzee* test

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<sup>146</sup> See 2.2.1 above.

<sup>147</sup> Brushwood *Medical Malpractice* 159.

<sup>148</sup> See Dwyer 748.

<sup>149</sup> Giesen 96.

<sup>150</sup> Where, for example, a prescription is poorly written, the reasonable pharmacist would be alert to the possibility of misreading the prescription and would take steps to confirm the prescription with the prescribing physician so as to ensure that the correct drug is dispensed (see *Prendergast v Sam and Dee Ltd* (1989) 1 *Med Law R* 36).

<sup>151</sup> As noted by the New South Wales Supreme Court in the unreported 1983 decision of *Karaolani v Kazacos* (quoted in Dwyer 749):

‘[The pharmacist] held a privileged and responsible position in the community ... where the lack of reasonable care may well cause death or disability ... It is appalling to think that a pharmacist is permitted to locate mixtures in close proximity which might be mistakenly dispensed with results such as has occurred in this instance.’

<sup>152</sup> The extent to which harm is foreseeable will, of course, depend on the drugs and the patient involved.

and ask whether a reasonable pharmacist would take steps to prevent such harm. Whilst the service that pharmacists provide in dispensing prescription drugs to the public has an important social value, the inherently dangerous nature of the products involved means that proper safety measures must be taken.<sup>153</sup> This is especially the case when preventative measures are not prohibitively expensive or onerous.<sup>154</sup> A pharmacist can prevent dispensing and compounding mistakes simply by paying the appropriate degree of attention to detail when filling a prescription. It is thus evident that the precautionary measures required to prevent harm are not so burdensome as to outweigh the magnitude of the risk faced by a patient who has been provided with the incorrect medication or dosage. It follows that a reasonable pharmacist would take steps to guard against the creation of such risk.

That a reasonable pharmacist would take precautionary measures to prevent dispensing and compounding errors is also clear from the rules and regulations pertaining to pharmacists in South Africa. In terms of the Rules Relating to Good Pharmacy Practice,<sup>155</sup> the dispensing process involves, *inter alia*, identifying the medicine prescribed and checking the pharmaceutical form, strength, appropriate dosage, presentation, method of administration and duration of treatment. The Rules go on to provide that all dispensing procedures must be carefully checked for accuracy and completeness.<sup>156</sup> They also lay down stringent requirements regarding compounding procedures.<sup>157</sup>

Having established that a reasonable pharmacist would both foresee the possibility of harm resulting from a dispensing or compounding error and take steps to prevent such harm from eventuating, it follows that, when a pharmacist makes a careless mistake in dispensing or compounding a medicine, fault will be present in the form of negligence.<sup>158</sup> In the United States, it has been clearly established that a pharmacist

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<sup>153</sup> See Van der Walt and Midgley par 122.

<sup>154</sup> Indeed, Fleming (131) observes that, just as the burden of avoiding harm will militate against the plaintiff, the relative ease of taking preventative measures will militate against the defendant.

<sup>155</sup> Rule 2.7.1.1(a)(vi).

<sup>156</sup> Rule 2.7.1.2.1(e).

<sup>157</sup> Rule 2.18.

<sup>158</sup> It does not necessarily follow that the plaintiff will be able to establish liability. In particular, plaintiffs are likely to encounter problems when the drug dispensed by the pharmacist, although incorrect, is unidentifiable and hence cannot be causally linked to the harm suffered. This issue is discussed in greater depth in 5.4.1.2 below.

may be held liable for dispensing the incorrect medication.<sup>159</sup> Brushwood<sup>160</sup> goes so far as to comment:

'It is difficult to imagine a case in which the pharmacist would not be responsible for the wrong drug error. ... Under such circumstances, the delivery of the wrong drug leads to a presumption of negligence, for all practical purposes impossible to rebut.'<sup>161</sup>

The same approach has been adopted by courts and academics in England,<sup>162</sup> Australia<sup>163</sup> and Canada.<sup>164</sup>

The only South African case to deal directly with a dispensing error is the 1893 decision of *Willet and Co v W Palmer*<sup>165</sup> in which a chemist supplied carbolic acid in response to a note requesting carbolic oil.<sup>166</sup> The court held that, on these facts, civil liability had been established.<sup>167</sup> This was in spite of the fact that the note presented to the pharmacist was illegible. The court held that the chemist had acted unreasonably in failing to confirm the contents of the poorly written note with the person who wrote it.<sup>168</sup>

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<sup>159</sup> Brushwood *Medical Malpractice* 155 and 188; Brushwood *Drake LR* 18; Asbury 909-910 and 930. American cases in which pharmacists have been held liable for dispensing the incorrect drug include: *Troppe v Scarf*; *Adams v American Druggist Insurance Co*; *Martin v Manning* 207 Ala 360 92 So 659 (1922); *Jones v Walgreen Co* 265 Ill App 308 (1932); *Marigny v Dejoie* 172 So 808 (La App 1937); *Tremblay v Kimball*; *French Drug Co v Jones* 367 So 2d 431 3 ALR 4th 259 (1978 Miss); *Spry v Kiser* 179 NC 417 102 SE 708 (1920); *Whitty v Daw Drug Co* 68 Misc 2d 385 326 NYS 2d 885 (1971); *McLean v United States*; *Burke v Bean* 363 SW 2d 366 (Tex 1962); *Thomsen v Rexall Drug and Chemical Co* 235 Cal App 2d 775 45 Cal Rptr 642 (1965); *Pauler v Stewart's Pharmacies, Limited*. See fn 144 above for incorrect compounding.

<sup>160</sup> Brushwood *Medical Malpractice* 156.

<sup>161</sup> See also Brushwood and Mullan 'Corporate Pharmacy's Responsibility' 669. A similar comment is made by an Australian academic (Dwyer) who, in commenting on a case involving incorrect compounding, states that 'it would seem uncontested that the pharmacist ... fell below the standard to be expected of the average, competent pharmacist in the circumstances' (Dwyer 751).

<sup>162</sup> See *Prendergast v Sam and Dee Ltd* (discussed in 4.4.4 below) in which a pharmacist was held liable for dispensing 5mg tablets of Daonil instead of the prescribed 250mg tablets of Amoxil.

<sup>163</sup> Reynolds; Dwyer 478-479. In the unreported decision of *Karaolani v Kazacos* (discussed by Dwyer 749), the New South Wales Supreme Court was faced with a situation in which a pharmacist had mistakenly used carbolic acid instead of alcohol in preparing a prescription for ear drops. The defendant in this case did, however, admit liability and a discussion of negligence was thus unnecessary.

<sup>164</sup> See *Williams v Jones* in which a pharmacist was held liable for dispensing formaldehyde instead of paraldehyde (the prescribed drug).

<sup>165</sup> (1893) 8 EDC 141.

<sup>166</sup> This resulted in injury to a horse to which the substance was applied.

<sup>167</sup> This was in spite of the fact that the note requesting the substance was illegible.

<sup>168</sup> *Willet and Co v W Palmer* 143. Interestingly enough, rule 2.7.1.2.1(f) of the Rules Relating to Good Pharmacy Practice provides that pharmacists are to sign prescriptions which they have filled, thereby accepting liability for the correctness of their dispensing. As to the wrongfulness of a pharmacist's

A final point to note is that pharmacists who *intentionally* dispense products other than those called for in prescriptions will, as a rule, be delictually liable for any resultant harm to the plaintiff.<sup>169</sup> The primary exception to this is where a pharmacist intentionally substitutes a *generic product* for the drug prescribed. Provided that the generic product in question is appropriate for use by the patient, such conduct is likely to be in accordance with the actions of the reasonable pharmacist. This is particularly so in light of the fact that both the Medicines Act<sup>170</sup> and the Rules Relating to Good Pharmacy Practice<sup>171</sup> require generic substitution unless such substitution is forbidden by the patient.<sup>172</sup>

#### 4.4.3 Detection of Invalid Prescriptions

Seeing that one of a pharmacist's primary functions is the dispensing of pharmaceutical products in accordance with prescriptions, it must be asked whether the standard of care applicable to prescription processing requires pharmacists to establish the authenticity of prescriptions and to intervene so as to prevent invalid prescriptions from being filled.<sup>173</sup>

The definition of 'dispensing' provided in the Regulations Relating to the Practice of Pharmacy includes the *interpretation and evaluation* of prescriptions. In this regard, the Rules Relating to Good Pharmacy Practice state that the first step in interpreting and evaluating a prescription involves receiving the prescription and confirming the integrity thereof.<sup>174</sup> The Rules accordingly stipulate that pharmacies must have

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conduct in dispensing an incorrect drug, see the *obiter* comments of Josman AJ in *S v Frames (Cape Town) (Pty) Ltd* 991F-G.

<sup>169</sup> One situation in which this may occur is where an illegal pharmacy website dispenses counterfeit, contaminated, expired or illegal drugs (Rost 624-625; Carlini 172).

<sup>170</sup> Section 22F(1)(b). The fact that generic substitution is required by the Medicines Act also provides pharmacists with a defence excluding *wrongfulness*. This is because their conduct is authorised by statute.

<sup>171</sup> Rule 2.7.3.11(1).

<sup>172</sup> The position will, of course, be different if the pharmacist provides the patient with the *incorrect* generic product.

<sup>173</sup> A pharmacist who dispenses a prescription-only medication without having been presented with *any* prescription clearly acts negligently. This practice has been observed amongst some Internet pharmacies (Korenchuk; Rost 623). These sites occasionally state that they will only send the requested drug on condition that the patient sees a doctor before *taking* the medication. It is, however, submitted that precautionary measures of this nature will be insufficient to shield pharmacists from liability.

<sup>174</sup> Rule 2.7.1.1(a).

adequate procedures for ensuring the legality/authenticity of prescriptions.<sup>175</sup> They also expressly provide that pharmacists must make themselves familiar with probable methods of prescription forgery<sup>176</sup> and must exercise *reasonable care* in satisfying themselves that prescriptions are genuine.<sup>177</sup> The standards of practice applicable to South African pharmacists therefore indicate that it is general practice for pharmacists to be alert for invalid prescriptions. In light of the risk of harm that is created should such a prescription not be detected, it is submitted that a reasonable pharmacist would indeed attempt to ensure that the prescriptions which he or she fills are authentic.

If there is reason to suspect that a prescription is invalid, a reasonable pharmacist would, it is submitted, take steps to verify the prescription's authenticity. This would usually involve contacting the prescribing physician.<sup>178</sup> If this is impossible, the Rules Relating to Good Pharmacy Practice provide that the pharmacist must use his or her professional judgment to decide what course of action is in the patient's best interests and may go so far as to refuse to dispense the prescription.<sup>179</sup> This kind of precautionary measure is discussed in greater detail in 4.4.4.2 below.

The filling of electronic prescriptions may prove to be particularly problematic for pharmacists. On the one hand, this form of prescription may significantly reduce the chances of dispensing errors<sup>180</sup> because electronic prescriptions are far less likely to be misread than handwritten prescriptions. On the other hand, it may be the case that electronic prescriptions are easier to fabricate than other kinds of prescriptions<sup>181</sup> and

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<sup>175</sup> Rule 2.7.1.1(a)(ii). Indeed, such procedures are necessary to fulfil the requirement of the Medicines Act (s22A(5)(b)) that Schedule 3-6 drugs only be sold upon the prescription of an *authorised* prescriber.

<sup>176</sup> In the United States, the Department of Justice's Drug Enforcement Administration has produced a Pharmacist's Guide to Prescription Fraud which identifies a number of ways in which prescription fraud may be perpetrated. These include the following: prescriptions for fictitious patients can be written on stolen prescription pads; legitimate prescriptions can be altered so as to call for more of a drug than prescribed by the physician; prescription pads from a legitimate doctor can be printed with a different call back number which is answered by an accomplice who verifies the prescription; computers can be used to create prescriptions for non-existent doctors or to copy legitimate prescriptions (US Department of Justice Drug Enforcement Administration 'A Pharmacist's Guide to Prescription Fraud').

<sup>177</sup> Rule 2.7.3.2.

<sup>178</sup> See rule 2.7.1.1(c) of the Rules Relating to Good Pharmacy Practice. In this regard, pharmacists would be well-advised to look up the prescriber's number in a telephone book. This is because the number appearing on the prescription may be that of a 'fake doctor' (Vivian and Brushwood 34).

<sup>179</sup> Rule 2.7.3.1(a)-(b).

<sup>180</sup> Nunnelley 4.

<sup>181</sup> *Ibid.*

that prescription fraud is more difficult to *detect* in the former than the in latter. Although the Rules Relating to Good Pharmacy Practice do require that, when a drug is dispensed in accordance with an electronic prescription, the original prescription must follow within seven working days,<sup>182</sup> this merely ensures that any prescription fraud is detected after a false prescription has been filled and does nothing to prevent the prescription from being filled to begin with.

The difficulty in detecting invalid electronic prescriptions is one of the problems that faces Internet pharmacies.<sup>183</sup> As was acknowledged in the *Deutscher* case, there are, however, other factors that make it difficult for Internet pharmacies to detect prescription fraud. In *Deutscher* the European Court of Justice noted the Irish Government's argument that the sale of prescription medicine over the Internet should be completely prohibited, as, to allow the sale of drugs via this medium greatly increases the risk of prescription fraud and misuse. This, it was argued, is because the process of checking the authenticity of prescriptions 'is facilitated by local knowledge and experience of pharmacists who are in close and daily contact with patients and doctors in their region.'<sup>184</sup> The court held that, with regard to non-prescription medications, it was not evident that patients could unlawfully acquire and abuse drugs with greater ease over the Internet than through a traditional pharmacy.<sup>185</sup> An absolute prohibition on the sale of non-prescription medicine by mail order was thus unjustified. When it came to prescription drugs, however, the court recognised that such substances pose higher risks to patients than OTC medications. It thus stated that, when prescription drugs are involved, there exists a

'need to be able to check effectively and responsibly the authenticity of doctors' prescriptions and to ensure that the medicine is handed over either to the customer himself, or to a person to whom its collection has been entrusted by the customer.'<sup>186</sup>

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<sup>182</sup> Rules 1.5(b)(iii) and 2.7.1.1(a)(iii). The same provision is made concerning telephonic prescriptions, although, in terms of s22A(5)(b) of the Medicines Act, a drug can only be dispensed upon the verbal instructions of a prescriber who is known to the pharmacist.

<sup>183</sup> This is due to the fact that prescriptions received by Internet pharmacies are likely to be in electronic form. Note, however, that even pharmacies that do not sell drugs via the Internet may receive prescriptions via fax or e-mail. Problems concerning electronic prescriptions are therefore not exclusive to Internet pharmacies.

<sup>184</sup> *Deutscher Apothekerverband eV v 0800 Doc Morris NV* par [89].

<sup>185</sup> *Deutscher Apothekerverband eV v 0800 Doc Morris NV* par [114].

<sup>186</sup> *Deutscher Apothekerverband eV v 0800 Doc Morris NV* par [119].

The court consequently held that it is justifiable to prohibit mail order sales of prescription medicines.<sup>187</sup>

It is submitted that the dangers posed by prescription drugs, coupled with the relative ease with which electronic prescriptions can be forged, means that the reasonable pharmacist will exercise a greater measure of care when filling a prescription that has been presented in electronic form than when dealing with other kinds of prescriptions. Greater care still should be observed when dispensing products that have been ordered on-line. This does not necessarily mean that pharmacists are bound to verify the accuracy of *every* electronic prescription with the prescribing physician. If a prescription is in no way unusual and exhibits no indications that it may be a forgery, the reasonable pharmacist may well agree to fill it without taking steps to verify its accuracy. It is, however, submitted that the problems presented by electronic prescriptions and on-line ordering would induce the reasonable pharmacist to be more alert for abnormalities in the prescription than would ordinarily be the case.<sup>188</sup>

#### 4.4.4 Failure to Detect Prescription Errors

There may be times when a pharmacist is faced with a prescription which, although valid (in the sense that it has been issued by an authorised prescriber), contains indications of potential harm to a patient and is thus *prima facie* incorrect. The circumstances may also be such that the pharmacist's knowledge of a particular patient should alert the pharmacist to the fact that the prescribed drug may cause harm. In these situations, a question arises concerning whether pharmacists act negligently when they fail to detect and act on prescription errors made by physicians. Accepting that pharmacists have a duty to detect invalid prescriptions, do they, in

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<sup>187</sup> Jacobs (248) stresses that the court in this case did not itself prohibit the sale of prescription medicines over the Internet. All it did was hold that certain provisions of German legislation which prohibited these kinds of sales were compatible with European Community legislation, whilst provisions prohibiting the sale of non-prescription drugs were not. German law has since undergone certain amendments and currently permits the sale of both prescription and non-prescription medicines via the Internet through licensed German pharmacies (section 43(1) of the *Arzneimittelgesetz*—the German law on medicinal products—as amended). See Jacobs 248-249 for a more detailed discussion of the changes that German law has undergone in the aftermath of the *Deutscher* case.

<sup>188</sup> For a discussion of whether the very dispensing of pharmaceutical products over the Internet is negligent, see 4.5 below.

other words, also have a duty to detect valid prescriptions that pose a risk of harm, and to intervene so as to prevent such harm from eventuating?<sup>189</sup>

#### 4.4.4.1 The Reasonable Pharmacist's Detection of Prescription Errors

##### (a) The Assumptions Made by the Reasonable Pharmacist

In determining whether a reasonable pharmacist would attempt to detect prescription errors, it is, firstly, necessary to consider the assumptions that such an expert would make about the conduct of others. The question is essentially whether a reasonable pharmacist would assume that the prescribing physician took reasonable care in writing the prescription. Would a reasonable pharmacist, in other words, rely on the accuracy of another professional's directions? An affirmative answer to this question would mean that pharmacists do not act negligently when they fail to detect prescription errors.

It is submitted that, as a general rule, the reasonable pharmacist would assume that the prescribing physician has acted reasonably. As such, it will be unnecessary for pharmacists to second-guess *every* prescription with which they are presented. Bearing in mind that a prescription error will often have severe consequences, pharmacists should, however, tread *cautiously* in making assumptions as to the reasonableness of a physician's conduct. When faced with clear indications that their assumptions are incorrect, pharmacists must adjust their conduct accordingly. As stated in *Riff v Morgan Pharmacy*:

'Fallibility is a condition of human existence. Doctors, like other mortals, will from time to time err through ignorance or inadvertence. An error in the practice of medicine can be fatal; and so it is reasonable that the medical community including physicians, [and] pharmacists ... have established professional standards which require vigilance not only with respect to primary functions, but also regarding the acts and omissions of other professionals and support personal in the health care team. Each has an affirmative duty to be, to a limited extent, his brother's keeper.'<sup>190</sup>

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<sup>189</sup> Mullan and Brushwood 'Potentially Addictive Medication' 310.

<sup>190</sup> *Riff v Morgan Pharmacy* 1253.

If a pharmacist is presented with a prescription which appears, in light of the pharmacist's knowledge concerning the drug and the patient, to be appropriate, it is submitted that the pharmacist can assume the prescription to be correct. This is in spite of the fact that it remains possible that an error was made by the physician. Any indication that a prescription error has been made will, however, render unreasonable the assumption that the prescriber was not negligent.

In *Jones v Walgreen Co*<sup>191</sup> the Illinois Court of Appeal observed that pharmacists, because of their special skill and knowledge, 'may know that the physician has erred in his prescription and that to fill it might cause death or serious injury to the patient.'<sup>192</sup> Smith has similarly emphasised that pharmacists, as a result of their extensive drug education and the fact that drug manufacturers provide them with warnings concerning drugs, are 'in the best position to most easily detect physicians' prescription errors.'<sup>193</sup> There are, it is submitted, two kinds of situation in which a reasonable pharmacist might be alerted to potential prescription errors. The first involves prescriptions which are *prima facie* incorrect, whilst the second covers instances in which the pharmacist's knowledge enables him or her to detect problems that are not apparent from the face of the prescription.

#### (b) Errors Appearing From the Face of the Prescription

A reasonable pharmacist is knowledgeable about the drugs which he or she dispenses. Such a person will, for example, be aware of the effects of unusual dosages and combinations of drugs. It follows that a reasonable pharmacist has the ability to detect an error appearing from the face of a prescription (such as a potential drug-drug interaction). It is further submitted that a reasonable pharmacist will, in spite of his or her assumption that the prescriber has acted reasonably, generally be alert for errors of this nature. In *McKee v American Home Products Corp*<sup>194</sup> the Washington Supreme Court, whilst refusing to find the pharmacist liable in the circumstances, acknowledged that 'pharmacists have a duty to be alert for patent errors in a prescription, for example: obvious lethal dosages, inadequacies in the instructions,

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<sup>191</sup> 265 Ill App 308 (1932).

<sup>192</sup> *Jones v Walgreen Co* 320.

<sup>193</sup> Smith 'Prescription Errors' 974.

<sup>194</sup> 113 Wash 2d 701 782 P 2d 1045 (1989).

known contraindications, or incompatible prescriptions, and to take corrective measures.<sup>195</sup> In *Riff v Morgan Pharmacy* another American court found that it is not the duty of a pharmacist merely to supply drugs unquestioningly: A pharmacist is held to a much higher duty.<sup>196</sup> English courts have similarly expected pharmacists to detect errors from the face of prescriptions. In the unreported decision of *Dwyer and Dwyer v Roderick, Jackson and Cross Chemists (Banbury) Ltd*,<sup>197</sup> for example, the prescription called for a drug<sup>198</sup> to be dispensed in a dangerously high dosage and was thus *prima facie* incorrect. The court held that '[i]t is quite clear that [pharmacists] have to exercise an independent judgment to ensure that the drug is apt for the patient as well as that it conforms to the physician's requirements.'<sup>199</sup> This decision was followed by the Queen's Bench Division in *Prendergast v Sam and Dee Ltd*. Whilst, in *Prendergast*, the pharmacist dispensed the incorrect drug as a result of misreading a poorly-written prescription, the case is relevant to the issue of prescription errors in that the court held that *even if* the prescription could reasonably have been read, it still contained sufficient indicators for the pharmacist to have known that there was something wrong with it. The court consequently held that, in failing to pay adequate attention to the prescription and merely dispensing the medication mechanically, the defendant had failed to exercise the standard of ordinary care and skill expected of pharmacists and had thus acted negligently. This decision was confirmed on appeal.<sup>200</sup>

South African courts have at no stage dealt directly with the detection of prescription errors by pharmacists. It is, however, submitted that a pharmacist's reliance upon the opinion of a physician is analogous to an attorney's reliance upon the opinion of counsel. Our courts have dealt with the latter and the current position appears to be that, although it will not usually be negligent for an attorney to rely upon counsel's opinion, '[c]ounsel's work must be perused carefully to ascertain errors and oversights.'<sup>201</sup> That pharmacists are expected to detect prescription errors is

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<sup>195</sup> *McKee v American Home Products Corp* 1053.

<sup>196</sup> *Riff v Morgan Pharmacy* 1247. See also *Dooley v Everett*.

<sup>197</sup> (1983) 127 SJ 809. Discussed in *Prendergast v Sam and Dee Ltd* and *Dwyer* 751-752.

<sup>198</sup> Ergotamine.

<sup>199</sup> Cited in *Prendergast v Sam and Dee Ltd*.

<sup>200</sup> See also *Collins v Hertfordshire County Council and Another* [1947] 1 KB 598 (discussed in 4.4.4.2 below).

<sup>201</sup> *Midgley Thesis* 234. See also fns 58-59 above and accompanying text. In *S v Frames (Cape) Town (Pty) Ltd* an obiter comment was also made (at 991F-G) that pharmacists may face civil liability if they fail to 'check that [a] prescription is or appears to be appropriate for its purchaser's requirements'.

additionally illustrated by the profession's standards of practice. As indicated above, the definition of dispensing which appears in the Regulations Relating to the Practice of Pharmacy includes the interpretation and *evaluation* of prescriptions. This is expanded upon in the Rules Relating to Good Pharmacy Practice which provide:

'Each prescription must be professionally assessed by a pharmacist with respect to:

- (i) therapeutic aspects (Pharmaceutical and Pharmacological) ie
  - the safety of the medicine;
  - possible contra-indications;
  - drug/drug interactions;
  - drug/disease interactions;
  - treatment duplications;
- (ii) appropriateness for the individual and the indication for which the medication is prescribed;
- (iii) social, legal and economic aspects.<sup>202</sup>

In light of these professional expectations, it is submitted that the reasonable pharmacist would pay enough attention to the prescriptions with which he or she is presented to detect the presence of *prima facie* errors that pose harm to the patient.<sup>203</sup> The effort involved in detecting errors of this nature is certainly not so arduous as to outweigh the risk of harm to the patient.

### (c) Errors that are Not Evident From the Face of the Prescription

Even when an error does not appear from the face of a prescription, it can be argued that a reasonable pharmacist will usually have sufficient knowledge to enable him or her to detect potential mistakes on the part of the prescriber.<sup>204</sup> This follows from the statutory requirement that pharmacists maintain records of all Schedule 2-6 drugs that

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<sup>202</sup> Rule 2.7.1.1(b). Similar provisions are found in rule 2.11.3 which deals with prescription monitoring as a minimum standard for clinical pharmaceutical services in institutional pharmacies. The evaluation of a patient's medicine-related needs also forms an important component of the concept of pharmaceutical care (see Penna 544) and is thus recognised as falling within the scope of pharmacy practice (regulation 3(a) of the Regulations Relating to the Practice of Pharmacy and p2 of the Rules Relating to Good Pharmacy Practice). This evaluation includes determining the safety of drug therapy which would clearly cover prescription assessment.

<sup>203</sup> This will particularly be the case when the prescription calls for dangerous drugs to be dispensed.

<sup>204</sup> See Dwyer 746.

have been dispensed to a patient within the last five years<sup>205</sup> and the professional expectation that information concerning the dispensing of Schedule 0 and 1 substances be kept for a period of one year.<sup>206</sup> Records of this nature make it possible for pharmacists to determine whether a prescribed drug may interact with another prescription or over-the-counter (OTC) medication already being taken by a patient, in spite of the fact that these drugs do not appear on the face of the prescription. Indeed, the South African Pharmacy Council, in its Minimum Standards for Record Keeping Procedures<sup>207</sup> stresses that medication records must enable pharmacists to detect problems of this nature.<sup>208</sup> The Minimum Standards additionally provide that medication records must make it possible for pharmacists to identify a patient's known disease conditions and to thereby determine whether a new prescription is likely to be unsafe for a particular patient.<sup>209</sup> It follows that a pharmacist who fails to maintain adequate records, or fails to check them upon filling a new prescription, may well be found to have acted negligently.<sup>210</sup>

#### 4.4.4.2 The Preventative Measures Taken by the Reasonable Pharmacist

Having established that there are instances in which the reasonable pharmacist would detect the presence of potential prescription errors, it must be asked what steps, if any, such a pharmacist would take so as to guard the patient from harm.<sup>211</sup> The likelihood and severity of harm will again be entirely dependant on the kinds of drugs involved (remembering that prescription drugs will often be potent in nature) and the

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<sup>205</sup> Section 22A(6)(a) of the Medicines Act and regulation 11 of the General Regulations published in terms of the Act.

<sup>206</sup> See rule 2.9.1(viii) of the Minimum Standards for Record Keeping Procedures.

<sup>207</sup> Found in rule 2.9 of the Rules Relating to Good Pharmacy Practice.

<sup>208</sup> Rule 2.9.1(d)(ii)-(iii).

<sup>209</sup> Rule 2.9.1(d)(ii)-(iii). See also the discussion in 3.7.1.2 above concerning pharmacists' obligation to keep records of patient-specific information.

<sup>210</sup> Even if it is argued that the rules laid down by the Pharmacy Council concerning the maintenance of patient-specific information do not mirror general practice and are merely goals to which pharmacists must aspire, the fact remains that there *are* instances in which pharmacists have access to patient-specific information. In *Hand v Krakowski*, for example, the records of the dispensing pharmacist indicated that the prescribed drugs were contraindicated by the patient's condition. The court thus held that the pharmacist was aware of, or should reasonably have been aware of, the contraindication. It follows that pharmacists who do maintain patient profile systems will be expected to check this information prior to dispensing prescriptions. A failure to do so will constitute a failure to exercise reasonable care in dispensing a prescription and will consequently be negligent.

<sup>211</sup> In *Kruger v Coetzee* 431F-G the Appellate Division stressed that, in order to be successful in a claim based on negligence, a plaintiff must prove what reasonable steps could have been taken by the defendant to prevent the risk from materialising.

susceptibilities of the particular patient. Although the steps taken by the reasonable pharmacist will be influenced by the magnitude of risk involved, it is submitted that, in the majority of instances, a reasonable pharmacist, having identified a potential problem with a prescription, will attempt to verify its accuracy with the prescribing physician. Indeed, this is the preventative measure most often expected by foreign courts. In its 1947 decision of *Collins v Hertfordshire County Council and Another*<sup>212</sup> the English King's Bench Division, for example, found that the defendant pharmacist, upon receiving an order to dispense a dangerous drug in an 'unheard of dosage', should have taken steps to verify that there was no mistake in the prescription.<sup>213</sup> By failing to do so, the defendant had 'disregarded every sort of plain and ordinary safeguard for the making up of dangerous drugs'<sup>214</sup> and had thus acted negligently.<sup>215</sup> This decision was followed by that of *Prendergast v Sam and Dee Ltd* in which the English Court of Appeal stated that '[i]t is established law that a pharmacist has a duty to satisfy himself about any prescription which he makes up and, in the case of doubt, to refer back to the doctor.'<sup>216</sup> In the United States, courts have similarly accepted that a pharmacist can escape liability by contacting the prescribing physician and that, if this is done, it is unnecessary to warn the patient of the error.<sup>217</sup> Although South African courts have yet to pronounce on the matter, the South African Pharmacy Council's Rules Relating to Good Pharmacy Practice do recognise the importance of communicating with the prescriber concerning any problems which have been detected in a prescription.<sup>218</sup>

An expectation that pharmacists notify prescribers of potential prescription errors is not unduly burdensome<sup>219</sup> and will not weigh heavily against the magnitude of risk in

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<sup>212</sup> [1947] 1 KB 598.

<sup>213</sup> *Collins v Hertfordshire CC* 620.

<sup>214</sup> *Ibid.*

<sup>215</sup> The pharmacist in this case made up a prescription for a large quantity of dangerous substances (cocaine and adrenalin) based on the instructions of a very junior doctor who had mistaken the directions of a surgeon.

<sup>216</sup> On the facts of this case, the court was satisfied that there were arrangements available for the pharmacist to have made contact with the doctor so as to query the prescription.

<sup>217</sup> *Brushwood Drake LR* fn 31. See also *Riff v Morgan Pharmacy; Kampe v Howard Stark Professional Pharmacy, Inc* 841 SW 2d 223 (Mo Ct App 1992). Note, however, that some American courts have denied the existence of a common law duty to notify physicians of prescription errors. In this regard, see *Jones v Irvin* 602 F Supp 399 (SD Ill 1985) and *Eldridge v Eli Lilly and Co.*

<sup>218</sup> Rule 2.7.1.1(c). See also rule 3.7.3.1(a) which provides that, if it is impossible for a pharmacist to contact the prescriber, the pharmacist must 'use his/her professional judgment and decide, in all circumstances, what course of action would be in the best interest of the patient.'

<sup>219</sup> Smith 'Prescription Errors' 974.

most instances.<sup>220</sup> Once pharmacists have discussed their concerns with prescribers, it is further submitted that the applicable standard of care will not usually require them to take further steps and, for example, discuss errors with their patients. A reasonable pharmacist would attempt to avoid causing patients to lose confidence in their doctors, as this would potentially render drug therapy less effective. Especially when one considers the ease with which a prescription error can be corrected by a physician who has been alerted to its existence, there appears no reason why there should be a duty to notify the patient that the original prescription is erroneous.<sup>221</sup>

One instance in which a higher degree of care may be required is where a physician affirms the accuracy of a prescription which a pharmacist feels has the potential to cause serious harm. Where this occurs, one must ask whether a reasonable pharmacist would take *further* precautionary measures by, for example, warning the patient of the dangers associated with treatment, refusing to dispense the prescription, or even retaining the prescription so as to prevent the patient from obtaining the drug(s) from another pharmacist. Smith<sup>222</sup> argues that, when a disagreement arises between pharmacist and physician concerning the safety of a prescription, the ultimate responsibility should be borne by the physician, who has extensive knowledge of the patient's medical condition and history and who may thus be aware that an unusual prescription is justified.<sup>223</sup> Vivian,<sup>224</sup> on the other hand, suggests that pharmacists are expected to act as 'gatekeeper[s] for the questionable judgment of others' and that, even if a physician confirms the accuracy of an excessive dose, a pharmacist may

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<sup>220</sup> In notifying physicians of prescription errors, pharmacists also do not infringe on the risk assessment role of physicians, but rather perform a risk minimisation function. Whilst the physician should always be regarded as the professional primarily responsible for risk assessment, it is essential to recognise that, as the gatekeepers of the drug distribution process, pharmacists are in a position to prevent the occurrence of harm when errors have been made by other links in the chain of distribution. See Smith 'Prescription Errors' 974:

'[P]ublic policy mandates that pharmacists have increased responsibility over prescription errors because pharmacists are the last, and perhaps the only, protection patients have against incorrect prescriptions.'

<sup>221</sup> Smith 'Prescription Errors' 976.

<sup>222</sup> Smith 'Prescription Errors' 975.

<sup>223</sup> See also *McKee v American Home Products Corp* 1055-1056 in which the Washington Supreme Court held that, whilst pharmacists have a duty to be alert for clear mistakes in a prescription, they do *not* have a duty to question a physician's judgment concerning the propriety of a prescription or to warn a patient of the dangers associated with drug use. In *Coyle v Richardson-Merrell, Inc* the court similarly noted that 'the pharmacist presented with a prescription ordered by a duly licensed physician is not at liberty to substitute his judgment of the product's safety for the patient for that of the physician.'

<sup>224</sup> Vivian 'Prescribing Errors'.

need to exercise independent judgment, rather than merely following bad orders. The Rules Relating to Good Pharmacy Practice are not silent in this regard. They provide:

'Where a problem cannot be resolved and there appears to be a potential risk to the patient, the pharmacist *may* decide not to dispense the prescription *even if* the prescriber confirms that the product should be dispensed. In taking this decision, however, the pharmacist should *assess the relative harm, which may result from this refusal* and use his/her professional judgment to decide what course of action would be in the best interest of the patient.'<sup>225</sup>

It is, firstly, significant that the language of this rule is permissive rather than peremptory. The rule thus fails to impose a professional *duty* not to dispense a prescription when harm is foreseeable. Secondly, this rule is important in that it emphasises that pharmacists must not be too hasty in refusing to dispense a prescription and must take the consequences of such refusal into account. Indeed, the central role held by physicians in risk assessment must never be overlooked and pharmacists must be cautious of attempting to usurp this role. Pharmacists must also be aware that refusing to dispense a product is not necessarily the safest option and that patients may be placed at risk of serious harm if they fail to receive needed medications.<sup>226</sup> Thirdly, it is noteworthy that the rule makes no reference to the magnitude of the risk to which a patient is exposed. In determining the actions of the reasonable pharmacist, the magnitude of the risk involved will, however, be a determining factor.

In *Ngubane v SA Transport Services* it was accepted that reasonable steps are not necessarily those which ensure that no harm whatsoever will eventuate.<sup>227</sup> As a result, it will be unnecessary for pharmacists to go to extraordinary lengths to prevent all forms of foreseeable harm. It was, however, explained above that the standard of care to which pharmacists are bound depends on the level of danger to which their patients are exposed. It follows that, if a physician insists on prescribing a drug or combination of drugs which a pharmacist believes to pose a material risk to the patient, the pharmacist may well be under a duty to do more than merely notify the prescriber of the problem. It is submitted that, in situations of this nature, pharmacists will usually

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<sup>225</sup> Rule 2.7.3.1(b). Emphasis added.

<sup>226</sup> Brushwood and Lively 31-32.

<sup>227</sup> *Ngubane v SA Transport Services* 776G.

be able to escape liability merely by warning patients of their concerns.<sup>228</sup> A duty to contradict the prescriber directly by refusing to fill the prescription will, it is submitted, only arise when the prescription is extremely likely to cause severe harm. This was essentially the approach adopted in the American case of *People's Service Drug Stores v Somerville*.<sup>229</sup> The court in that case recognised that '[i]t would be a dangerous principle to establish that a druggist cannot safely fill a prescription merely because it is out of the ordinary [as, if] that were done, many patients might die from being denied unusual remedies in extreme cases.'<sup>230</sup> The court thus held that, where a prescription is merely out of the ordinary, the only duty upon a pharmacist is to make enquiries of the physician. The court, however, went on to suggest that if *the prescription is obviously fatal*, the pharmacist has a *duty to contradict the physician*.

Brushwood and Lively suggest that once 'a prescriber has verified the correctness of an unusual prescription order and the patient has been counselled but is willing to accept the risk of the medication, there is a presumptive right to have the prescription product dispensed and the pharmacist has a duty to dispense it.'<sup>231</sup> They proceed to comment that '[t]he presumption can be overcome only when the risk presented by the unusual prescription order is so great that there is a strong likelihood that the patient will die.'<sup>232</sup> Their argument, in other words, is that, barring situations in which a prescription presents a high risk of death, a pharmacist not only has no duty to refuse to fill a prescription, but in fact has a *positive obligation* to dispense the medication prescribed.<sup>233</sup> Brushwood and Lively support this contention by submitting that patients are often placed at risk of harm when pharmacists refuse to fill their prescriptions. They additionally argue that a pharmacist who refuses to dispense a product which a patient, having been informed of the risks, continues to request constitutes an infringement of patient autonomy. When the filling of a prescription is likely to be lethal, this infringement can be justified by an appeal to the principle of beneficence.<sup>234</sup> No such justification exists, however, when the potential

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<sup>228</sup> By providing such warnings, pharmacists, at the very least, obtain informed consent and thus shield themselves from liability.

<sup>229</sup> 161 Md 662 158 A 12 (1932).

<sup>230</sup> *People's Service Drug Stores v Somerville* 13.

<sup>231</sup> Brushwood and Lively 30.

<sup>232</sup> *Ibid.*

<sup>233</sup> Brushwood and Lively 30.

<sup>234</sup> Brushwood and Lively 31-32.

harm is less severe. These issues will, it is submitted, be important considerations for any pharmacist who is contemplating refusing to dispense prescription drugs. In particular, it is submitted that a reasonable pharmacist would weigh the magnitude of risk accompanying the filling of a dangerous prescription against the magnitude of risk faced by the patient if not provided with the needed medication. If the latter is foreseeably greater than the former, a pharmacist who refuses to fill the prescription may well be acting negligently.

In sum, the steps taken by a reasonable pharmacist will depend on both the magnitude of the risk and the likelihood of it occurring. In this regard, the following conclusions can be drawn:

- a) *Whenever* a pharmacist detects (or should reasonably detect) a potential prescription error, he or she is under a duty to contact the prescriber so as to confirm the prescription's accuracy;
- b) If, after the accuracy of the prescription has been verified, the pharmacist continues to believe (or should reasonably continue to believe) that the patient faces a material risk of harm, the pharmacist has a duty to discuss the matter with the patient;
- c) If the pharmacist believes (or should reasonably believe) that the prescription is likely to cause severe harm or death, he or she is under a duty to refuse to dispense it, regardless of the patient's informed request to have the prescription filled;
- d) The refusal to fill a prescription in situations other than that described in c) may, in some cases, itself be negligent.

Situations will, of course, arise in which the pharmacist makes a judgment call to defer to the opinion of the physician and the patient suffers harm as a result. The pharmacist may, in other words, make a judgment error. This may, for example, be due to the mistaken belief that the prescription did not pose material harm to the particular patient,<sup>235</sup> or the belief that the physician was in a better position to judge what was best for the patient. The mere fact that a choice was made which turned out

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<sup>235</sup> Which may, in turn, be the result of a pharmacist being in possession of insufficient patient-specific information.

to be wrong will be insufficient to render the pharmacist's conduct blameworthy. In order for the pharmacist's actions to be negligent, it must be shown that the error would not have been made by a reasonable pharmacist.<sup>236</sup> In many instances, bowing to the decision of a physician will be a reasonable error of judgment and will therefore not be negligent.

#### 4.4.5 Dispensing Drugs that Have Been Prescribed Over the Internet

Connected to the issue of detecting prescription errors is the dispensing of drugs that have been prescribed via the Internet.<sup>237</sup> The fairly recent phenomenon of Internet prescribing is often associated with Internet pharmacies. Some e-pharmacies actually combine normal pharmacy activity with the prescribing function by offering an on-line consultation with a doctor. Patients are usually required to complete an on-line questionnaire which is then perused by a physician who, if satisfied, prescribes the appropriate medication.<sup>238</sup> In other instances, however, pharmacies may be presented with prescriptions originating from on-line doctors with whom they are not affiliated.

There are obviously a number of dangers inherent in prescribing drugs over the Internet. The fact that no physical contact occurs between patient and physician makes it extremely easy for a patient to falsify information.<sup>239</sup> This will particularly be the case when the answers to the questionnaire are pre-selected. Even when a patient is attempting to be honest, the wording used in an on-line questionnaire may be too technical for the average layperson to understand and the patient may underestimate the importance of the questions asked.<sup>240</sup> Of course, not all doctors who

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<sup>236</sup> See discussion of judgment errors in 4.3.2.5 above.

<sup>237</sup> At this stage, it is appropriate to consider the difference between *dispensing* drugs over the Internet and *prescribing* drugs over the Internet. Friedman (143) explains the position thus:

'Internet drug dispensing involves the delivery of a valid prescription by a patient's personal physician to a pharmacy operating a website and the pharmacy's delivery of the drug to the patient. Internet drug prescribing, on the other hand, is the act of providing the patient with an order for a [prescription] drug that would entitle the patient to receive the drug.'

<sup>238</sup> Friedman 143.

<sup>239</sup> Nunnelley 5; Rost 624; Carlini 192. See also Tyler 288:

'Further compounding the problem of liability in Internet practice, the physician cannot see, touch or listen to the patients before treating them. Additionally, the physician cannot know whether the patient is a poor historian, a liar, a charlatan, or someone with Munchausen's syndrome.' (A person with Munchausen's syndrome lies so as to fake illnesses. Such patients are often very knowledgeable about the symptoms of a disease. Tyler 288 fn 199.)

<sup>240</sup> Rost 624; Carlini 191-192. A number of instances have been documented in which physicians, in spite being in possession of *accurate* patient-specific information, have prescribed medications which

prescribe drugs over the Internet do so on the basis of a simple questionnaire. Some e-doctors insist upon more extensive interaction with patients.<sup>241</sup> Patients may, for example, be required to fill in their medical history and describe their current illness after which a live consultation occurs between doctor and patient.<sup>242</sup> It is, however, submitted that, even when more vigilant procedures are utilised in obtaining patient information, the practice of Internet prescribing remains fraught with problems.

The primary danger in Internet prescribing is that physicians who prescribe drugs via the Internet have an extremely limited ability to determine the correct course of drug therapy and identify the dangers involved in prescribing specific medications.<sup>243</sup> In the absence of a physical examination, the possibility of misdiagnosis is high. There is consequently a severe risk of patients receiving inappropriate medications which either cause direct harm, or cause their undiagnosed medical conditions to worsen.<sup>244</sup>

The Ethical Rules of Conduct for Practitioners Registered Under the Health Professions Act<sup>245</sup> provide:

‘A practitioner may prescribe or supply medication: *Provided that* such practitioner has ascertained the diagnosis of the patient concerned through a *personal examination* of such patient or by virtue of a *report by another practitioner* under whose treatment such patient is or has been.’<sup>246</sup>

It follows that physicians who prescribe drugs over the Internet will often be acting unethically. In many instances, such conduct will also, it is submitted, fail to measure up to the standard of care set by the reasonable physician and will thus be negligent.<sup>247</sup> If this is the case, the question arises whether a *pharmacist* will be

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are inappropriate, and even dangerous, for the patient concerned (Nunnelley 5). In one example, a reporter completed an on-line consultation with the details of a cat and was able to purchase Viagra (Carlini 159). In instances such as these, the physician has clearly acted negligently. Insofar as pharmacists are concerned, it is submitted that the principles discussed directly above concerning the detection of prescription errors will be applicable.

<sup>241</sup> Tyler 285-286.

<sup>242</sup> Wiesemann 1139; Carlini 174.

<sup>243</sup> Friedman 145 fn 17 and 159.

<sup>244</sup> National Association of Boards of Pharmacy ‘VIPPS Program’.

<sup>245</sup> GNR 717 of 4 August 2006.

<sup>246</sup> Rule 23(5). This rule does not, however, apply to patients with chronic diseases (rule 23(6)).

<sup>247</sup> Indeed, in the United States, the Federation of State Medical Boards’ report on Professional Conduct and Ethics stated that the ‘[p]rescribing of medications by physicians based solely on an

considered negligent if he or she dispenses a prescription drug whilst knowing that the physician who prescribed it did so via the Internet. It is submitted that a reasonable pharmacist who knows that a prescription was issued over the Internet will, at the very least, be alert to the fact that the prescription is potentially unsafe and will consequently exercise greater care in checking whether the prescription is appropriate for a patient than would ordinarily be the case.

#### 4.4.6 Monitoring Prescription Refills

It has been explained above that pharmacists are under a duty to exercise reasonable care and skill in filling prescriptions. It must now be considered whether pharmacists will fall short of the required standard of care if they fail to detect problems with drug therapy whilst *refilling* prescriptions.

##### 4.4.6.1 Prescription Errors

Some overlap does exist between the issue of refill monitoring and the detection of prescription errors. Just as physicians may err by prescribing drugs in unsafe dosages, so too may they act negligently by prescribing the continued use of medications over an unsafe period of time. A pharmacist's failure to detect an error of this nature may well amount to negligence. Where, for example, a particular drug is known to be effective only for a few weeks (as was the case in *McKee v American Home Products Corp*<sup>248</sup>), a pharmacist may be acting negligently in continuing to fill the prescription over a longer period.

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electronic medical questionnaire clearly fails to meet an acceptable standard of care and is outside the bounds of professional conduct' (Friedman 158; see also Jones 'Internet Prescribing' 2; Friedman 163-166; Carlini 179; Wiesemann 1147-1148; Korenchuk 3). This is not to say that a physician can *never* issue a prescription without conducting a face-to-face consultation with, or physical examination of, a patient. If, for example, a physician already knows, and possesses a medical record concerning, a patient, it may be unnecessary for a physical visit to occur (Brushwood 'Regulation of Internet Pharmacy' 99). There are also a limited number of conditions that can be safely diagnosed through merely holding a conversation with a patient (Wiesemann 1139). As such, some physicians regard the Internet as a 'logical extension of *limited forms* of medical care for a *highly defined* subset of medical problems.' (Kerry Archer and Steven Kohler. Quoted in Wiesemann 1138. Emphasis added. Archer and Kohler were the founders of 'Cyberdocs.com', the first virtual doctor's office to be opened on the Internet—the site was launched in October 1996 and, seven months later, affiliated with 'CyberPharmacy' so as to allow medications to be delivered via the Internet.)

<sup>248</sup> In the *McKee* case, the defendant pharmacy continued to fill the plaintiff's prescription for Plegine (a dangerous and potentially addictive amphetamine used for weight control) for ten years when it was known that the drug would only be effective for a few weeks.

When a pharmacist feels that the refilling of a prescription is unwise, he or she essentially believes that an error has been made by the prescriber. The principles discussed at 4.4.4 above concerning the detection of prescription errors will thus surely be applicable. Just as in the case of other prescription errors, it is again possible to draw a distinction between those errors that can be detected from the face of the prescription and those that cannot. This is apparent from the Medicines Act, which provides that the sale of Schedule 2-4 substances may only be repeated if the prescriber has indicated on the prescription the *number of times* that the drug may be dispensed.<sup>249</sup> A prescription for Schedule 5 substances must, in addition, indicate the intervals at which the drug may be dispensed.<sup>250</sup> The result is that, where a physician has made an error concerning the period of drug therapy, the reasonable pharmacist would often detect the mistake from the face of the prescription the first time that it is presented.

One prescription can, in terms of the Medicines Act,<sup>251</sup> only allow the sale of a substance to be repeated over a six-month period. Once this period has lapsed, a physician may, however issue a new prescription for the same drug.<sup>252</sup> It follows that there will be instances in which the original prescription gives no indication of an error and in which problems only become evident at a later stage. As was discussed above,<sup>253</sup> pharmacists are legally required to possess records of the prescription drugs that they have dispensed. This, in combination with their professional knowledge concerning drugs, means that, even when no problems appear from the face of a

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<sup>249</sup> Section 22A(6)(f).

<sup>250</sup> Section 22A(6)(g). In terms s22A(6)(i) of the Medicines Act, the sale of Schedule 6 substances must not be repeated without a new prescription being issued. If a pharmacist refills a prescription more frequently than directed by the prescriber, there is no question that he or she would have failed to exercise reasonable care.

<sup>251</sup> Section 22A(6)(f).

<sup>252</sup> Section 22A(6)(h) of the Medicines Act does, however, provide that Schedule 5 medications can only be prescribed for longer than six months if the prescriber has consulted another medical practitioner (or psychiatrist—depending on the purpose for which the drug is to be used) before issuing a new prescription. In most instances, a pharmacist will thus be able to assume that repeated prescriptions for Schedule 5 substances are reasonable.

<sup>253</sup> In 4.4.4.1.

prescription, pharmacists are in a position to detect whether a course of treatment is likely to harm the patient and to take steps to prevent such harm from occurring.<sup>254</sup>

#### 4.4.6.2 Detecting Other Problems with Drug Therapy

Prescription errors on the part of physicians are not the only kind of problem that pharmacists may detect in refilling prescriptions. Helper and Strand observe that '[m]any causes of unsatisfactory outcomes can be detected by careful monitoring.'<sup>255</sup> If a patient is undergoing a prolonged course of treatment, the dispensing pharmacist may well be in a position to monitor whether the patient is reacting well to the medication and receiving the full benefit thereof.<sup>256</sup> Pharmacists will, in particular, often be in the best position to know when a patient is refilling prescriptions at too fast a rate.<sup>257</sup> Such conduct may be indicative of drug addiction. This has led a number of American courts to recognise that pharmacists have a duty to monitor prescription refills so as to prevent patients from accumulating excessive quantities of dangerous drugs.<sup>258</sup> Excessive drug use may also indicate that the patient's condition is worsening, that the patient is not receiving the full benefit of the medication,<sup>259</sup> or even that drugs are being diverted for illicit purposes.<sup>260</sup>

As with the detection of prescription errors, there definitely exists a professional expectation that pharmacists monitor their patients' courses of drug therapy. The Pharmacy Council's Rules Relating to Good Pharmacy Practice provide that, after having dispensed medicine(s) to a patient, a pharmacist must assess the patient for

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<sup>254</sup> If a patient fills prescriptions at a number of different pharmacies, it is, of course, unlikely that a reasonable pharmacist would foresee the potential for harm. Negligence on the part of the dispensing pharmacists will consequently be extremely difficult to establish in such cases (Dwyer 746-747).

<sup>255</sup> Helper and Strand 535.

<sup>256</sup> Gonzalez 66.

<sup>257</sup> Mullan and Brushwood 'Potentially Addictive Medication' 310. See *Hooks SuperX, Inc v McLaughlin* 642 NE 2d 514 (Ind 1994) in which a pharmacy dispensed 1 072 tablets over a sixty-day period on twenty-four separate refills. A course of treatment which should have lasted for 138 days was finished in less than half this time.

<sup>258</sup> *Brushwood Medical Malpractice 44*; *Speer v United States* 512 F Supp 670 (ND Tex 1981); *Hooks SuperX, Inc v McLaughlin*. American judicial decisions have not, however, been consistent in this regard (Gonzalez 69). In *Kintigh v Abbott Pharmacy* 505 NW 2d 657 (Mich Ct App 1993); *Jones v Irvin*; *Adkins v Mong* and *Pysz v Henry's Drug Store* 457 So 2d 561 (Fla Dist Ct App 1984), for example, the court held that pharmacists are *not* under a duty to monitor patients for addiction or excessive drug use.

<sup>259</sup> Gonzalez 66.

<sup>260</sup> Mullan and Brushwood 'Potentially Addictive Medication' 309.

signs of compliance, effectiveness and safety of the drug therapy and should identify areas for modification, implement the required modifications and revise the patient record accordingly.<sup>261</sup> The Code of Conduct for Pharmacists also stresses the need for pharmacists to prevent the misuse of drugs.<sup>262</sup> Indeed, this monitoring function forms a fundamental part of the concept of pharmaceutical care<sup>263</sup> and is necessitated by the fact that other healthcare professionals may not be in the position to detect problems with drug therapy. This would, for example, be the case when a patient obtains a number of prescriptions for the same drug from *different* physicians. It is consequently submitted that a reasonable pharmacist will, when refilling prescriptions, be alert for potential problems with drug therapy. The degree of vigilance with which a reasonable pharmacist will monitor patients, as well as the steps taken by such a pharmacist upon detection of a problem will, of course, depend on the magnitude of the risk. This, in turn, will be influenced by both the potency of the prescribed drug(s) and the susceptibilities of the patient for whom they are prescribed.

#### 4.4.7 The Provision of Patient Counselling Regarding Prescription Drugs

In Chapter 3 it was established that, as far as prescription drugs are concerned, South African pharmacists are *probably* under a legal duty to provide risk minimisation counselling<sup>264</sup> and are *potentially* under a legal duty to provide risk assessment counselling.<sup>265</sup> Assuming that such duties exist, a pharmacist's failure to counsel will be wrongful. The question which thus arises is whether such a failure will also be blameworthy.

At this stage, it must be remembered that the defendant will have acted negligently only if a reasonable pharmacist in his or her position would have both foreseen the possibility of harm and taken steps to avoid such harm. It follows that a pharmacist will be expected to provide information only if a reasonable expert in his or her position would have foreseen that, in the absence of counselling, the patient may

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<sup>261</sup> Rule 2.7.1.3.2.1.1.

<sup>262</sup> Section 1.9.5.

<sup>263</sup> This is recognised in regulation 3(1)(a) of the Regulations Relating to Pharmacy Practice as well as the Rules Relating to Good Pharmacy Practice (p2).

<sup>264</sup> 3.7.1.2 above.

<sup>265</sup> 3.7.1.3 above.

suffer harm. This, in turn, will depend largely on the knowledge that the defendant pharmacist had, or should reasonably have had, concerning the patient. If, for example, a pharmacist is unaware of a patient's peculiar susceptibilities, it may be unnecessary to provide certain warnings, as the possibility of harm would not be foreseen by a reasonable pharmacist in his or her position.

It is submitted that the primary factor that may cause a reasonable pharmacist *not to* provide patient counselling will be the belief that satisfactory counselling has already been supplied by another healthcare professional. In the absence of indications to the contrary, pharmacists are entitled to assume that physicians will act reasonably. In general, the assumption can thus be made that prescribing physicians will provide their patients with the relevant risk assessment and risk minimisation information. Bearing in mind that patients who do not possess sufficient information will often face a fairly significant risk of harm, pharmacists must nevertheless be tentative in making this assumption. Pharmacists would be well-advised, at the very least, to ask patients whether their physicians have provided them with information about the prescribed drug and the use thereof. Ideally, patients should also be asked to *explain* what their doctors have told them. This precaution ensures not only that patients have *received* the relevant information, but also that the information has been *understood*.

#### **4.4.8 Negligence in the Dispensing of Over-the-Counter Drugs**

It is not only prescription drugs that have the potential to cause harm.<sup>266</sup> OTC medications (ie Schedule 0-2 substances) may also result in physical injury to a patient's person which, in turn, may cause a patient to suffer both patrimonial loss and pain and suffering. As a result, it is necessary to consider the negligence of pharmacists in relation to the dispensing of OTC drugs.

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<sup>266</sup> Dwyer 727.

#### 4.4.8.1 Failure to Exercise Reasonable Care and Skill in Recommending the Use of OTC Products

The fact that pharmacists have a duty to exercise reasonable care and skill in practising their profession means that reasonable care must be exercised when advising a patient who seeks recommendations concerning OTC drug use. The standards of practice of the South African pharmacy profession emphasise that pharmacists, when asked to make recommendations, must obtain sufficient information to ensure that they are able to assess the situation properly.<sup>267</sup> This should include information concerning ‘who has the problem, what the symptoms are, how long the condition has persisted, any action that has already been taken, and which medicines the person concerned is already using.’<sup>268</sup> Indeed, common sense indicates that it would be unreasonable for a pharmacist to recommend the use of a pharmaceutical product if not in possession of such information.

When they question patients in order to obtain the necessary information, it is submitted that, in the absence of indications to the contrary, pharmacists may legitimately assume that the patient has provided honest answers to the questions asked.<sup>269</sup> Thus, unless a pharmacist has reason to believe that a particular patient is lying, it will be reasonable for the pharmacist to rely on the information provided by the patient in assessing the appropriate course of action. It follows that, if a pharmacist makes a recommendation on the basis of incorrect information that has been provided by a patient, and the patient suffers harm, the only fault that will be present will be the patient’s and the pharmacist will not be held liable for the harm suffered. This differs from situations in which pharmacists are (or should reasonably be) in possession of *accurate information* concerning their patients. In such cases, the recommendation of an inappropriate medication will be far more likely to result in liability. Nevertheless, the mere fact that a pharmacist made a recommendation which has turned out to be wrong (ie the mere fact that the pharmacist made a judgment error) will not necessarily mean that he or she acted negligently. The question remains whether, in advising a patient to use a particular medication, the pharmacist exercised

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<sup>267</sup> See rule 2.12 of the Rules Relating to Good Pharmacy Practice.

<sup>268</sup> Rule 2.12.1.1(a).

<sup>269</sup> See Klar *et al* par 158.

reasonable care and skill. If the recommended drug is obviously inappropriate when considered in light of the patient's condition and the substances which the patient is already using, the appropriate standard of care will not have been met and the pharmacist's conduct will thus be negligent.<sup>270</sup>

There will be times when the very act of advising a patient to self-medicate rather than visiting a physician will be negligent.<sup>271</sup> As was explained in 4.3.2.7 above, one acts negligently when one performs a task which is beyond one's competence. It follows that, when a pharmacist is faced with a patient requiring a complex diagnosis falling beyond the pharmacist's level of expertise, the reasonable course of action is to advise the patient to seek the opinion of a medical practitioner.

#### 4.5.8.1 Failure to Provide Patients with Risk Minimisation Counselling Concerning OTC Drugs

It must be asked whether the fact that the law expects pharmacists to exercise reasonable care in dispensing pharmaceutical products means that pharmacists will be negligent if they fail to provide risk management warnings concerning OTC medications. When the product concerned, whilst being an OTC drug, has been recommended by a physician, it is submitted that the same considerations discussed above with regard to prescription drugs will be relevant. The real issue is thus whether warnings must be provided if the drug has not been prescribed by another professional, but rather recommended by the pharmacist or requested independently by the patient.

When a pharmacist dispenses an OTC drug, in the absence of a prescription, he or she is likely to be the only healthcare professional with whom the patient interacts. A reasonable pharmacist would thus in most instances foresee that, should he or she fail to provide the patient with advice concerning how to use the drug, the patient may suffer harm.

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<sup>270</sup> This would be the case where, for example, a pharmacist advises a patient to use an OTC medication which is known to interact with a prescription drug which the patient is using.

<sup>271</sup> McLeod and Miller 40.

With regard to the steps that a reasonable pharmacist would take so as to prevent harm, it was explained in the last chapter that the South African pharmacy profession expects pharmacists to furnish advice and information for the safe and effective use of medicines which they have supplied.<sup>272</sup> The Rules Relating to Good Pharmacy Practice<sup>273</sup> make specific reference to instances in which pharmacists *recommend* the use of an OTC product.<sup>274</sup> The Rules provide that, when pharmacists have initiated drug therapy, they should do their best to ensure that the patient knows how to administer doses of the drug and is aware of any common severe side effects, interactions (including drug/drug, drug/food and drug/alcohol interactions) or contraindications that may be encountered. The patient should also be given advice concerning how to avoid such side effects, interactions and contraindications and what action to take should they occur.<sup>275</sup>

Indeed, it is submitted that when a pharmacist recommends the use of an OTC drug which has not been prescribed by another professional and which is reasonably likely to cause harm to a patient if used incorrectly, the pharmacist, in order to meet the requisite standard of care, will usually need to provide some form of counselling on the use of the drug. The same principle, it is submitted, should apply when a pharmacist dispenses a drug which a patient has independently requested. The extent of counselling required will, of course, depend on the likelihood and potential severity of the harm, bearing in mind that OTC medications are generally less potent than prescription medications, carrying lower abuse and harm potentials.

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<sup>272</sup> Rule 1 of the South African Pharmacy Council's Ethical Rules.

<sup>273</sup> Rule 2.12.1.2(b).

<sup>274</sup> In the United States, courts have accepted that a pharmacist who recommends the use of a particular OTC product *warrants* that the product is appropriate for the use for which and the patient for whom it is recommended. The patient is thus entitled to rely solely on the pharmacist's recommendation. The result has been that American courts have required pharmacists to provide patients with warnings concerning the OTC drugs which they have recommended (Green 1465; *Brushwood Medical Malpractice* 166-167). The leading case in this regard is *Fuhs v Barber* 140 Kan 373 36 P 3d 962 (1934).

<sup>275</sup> The General Regulations published in terms of the Medicines and Related Substances Act also require the labelling of medicines (regulation 8), the provision of packet inserts (regulation 9) and the provision of patient information leaflets (regulation 10) when OTC medications are dispensed. The Regulations stipulate that specifications as to use, as well as warnings regarding side effects, contraindications etc, must be included in these written sources of information. See, however, the discussion in 3.7.1.4 above concerning the problems with the provision of written information.

#### 4.4.8.2 Failure to Monitor the Use of OTC Drugs

The potential for abuse is not exclusive to prescription medications. It is not uncommon for individuals to become addicted to OTC drugs such as cough medicine.<sup>276</sup> In such instances, the pharmacist will usually be the only medical professional with the opportunity to detect addiction and thus the only professional with the ability to prevent harm to the patient.<sup>277</sup> It is consequently submitted that, if there are indications that a patient is abusing an OTC medication, a reasonable pharmacist will take steps to avoid harm, even if these measures merely involve discussing the matter with the patient.<sup>278</sup>

#### 4.4.9 Harm Caused by the Conduct of Assistants, Students and Interns

Pharmacists are not the only individuals who interact with, and render services to, patients within a pharmacy. Various tasks may also be performed by pharmacist's assistants (who qualify as support personnel), students in the process of completing their BPharm degrees, and interns who, having obtained their degrees, are completing their practical training period before being registered as pharmacists.<sup>279</sup> Pharmacist's assistants are permitted to perform a variety of acts and services within a pharmacy setting. Because of the wide range of functions performed by pharmacist's assistants, they are divided into two categories: basic and post-basic.<sup>280</sup> Individuals who are registered under the former category are entitled to, *inter alia*, sell Schedule 1 medicines, assist in the compounding of medications and provide healthcare

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<sup>276</sup> See Anon 'Over-the-Counter Drug Abuse' for a discussion of the prevalence of addiction to detromethorphan (a cough-suppressing ingredient found in more than 125 OTC products).

<sup>277</sup> Many OTC products are likely to harm patients if used over prolonged periods of time (McLeod and Miller 40).

<sup>278</sup> The Code of Conduct for Pharmacist goes so far as to state that a pharmacist should refuse to dispense a substance if it is apparent that its purchase is not for a genuine medicinal purpose or if there are indications that the substance is being overused (s1.9.5(c)).

<sup>279</sup> After having completed one's BPharm degree, one is required to complete a twelve-month practical training period as a pharmacist intern before one may be registered as a pharmacist. The purpose of this experience is to give pharmacist interns an opportunity to apply their theoretical knowledge in practice and to gain practical experience (Pharmacy Council 'Training of Pharmacists'; rule 3.3.1 of the Rules Relating to Good Pharmacy Practice).

<sup>280</sup> Those undergoing practical training to register as pharmacist's assistants are similarly divided into pharmacist's assistant (learner basic) and pharmacist's assistant (learner post-basic), depending on the category of pharmacist's assistant in which they wish to register (Pharmacy Council 'Training of Pharmacist's Assistants'). Learner pharmacist's assistants are permitted to perform those acts falling within the scope of pharmacist's assistants under the direct personal supervision of a pharmacist (regulations 10 and 13 of the Regulations Relating to the Practice of Pharmacy).

information. The latter category of pharmacist's assistants can additionally perform such functions as the selling of Schedule 2 drugs, the preparation and labelling of prescriptions and the provision of instructions regarding the correct use of medicine.<sup>281</sup> Pharmacy students can essentially provide the same services as pharmacist's assistants (whether a student is entitled to perform basic or post-basic functions depends on how far along the student is in his or her studies).<sup>282</sup> There are also certain conditions under which a pharmacy student may perform those functions falling within the scope of practice of a pharmacist.<sup>283</sup> Pharmacist interns, on the other hand, are permitted to perform all of the acts falling within the scope of practice of a pharmacist's assistant (post-basic) as well as those acts falling within the scope of practice of a pharmacist.<sup>284</sup>

There are two questions that can be asked concerning assistants, students and interns:

- a) Does the standard of care to which assistants, students and interns are held differ from that imposed upon pharmacists?
- b) What are the duties of *pharmacists* in relation to the supervision of assistants, students and interns and when can a supervising pharmacist be held personally liable for harm caused by the actions of these individuals?

Insofar as the first question is concerned, it was established in 4.3.2.6 above that, because of the dangerous nature of the products with which they deal, pharmacy students and interns are likely to be held to the same standard of care as experienced pharmacists. This will at least be the case when they are performing functions that fall within the scope of practice of a pharmacist. It is additionally submitted that, when pharmacist's assistants perform tasks such as the preparation of prescriptions and the provision of risk management information, they will be held to the same standard that pharmacists are bound by when performing these functions. When a student, intern or assistant performs complex tasks for which he or she lacks the requisite expertise, he

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<sup>281</sup> For a full list of functions falling within the scope of practice of pharmacist's assistants, see regulations 9 and 11 of the Regulations Relating to the Practice of Pharmacy.

<sup>282</sup> Regulation 7 of the Regulations Relating to the Practice of Pharmacy.

<sup>283</sup> Regulation 8 of the Regulations Relating to the Practice of Pharmacy.

<sup>284</sup> Regulations 5 and 6 of the Regulations Relating to the Practice of Pharmacy.

or she will, of course, be acting negligently in terms of the *impertia culpa* *adnumeratur* principle.<sup>285</sup>

With regard to question b) above, the Regulations Relating to the Practice of Pharmacy provide that *all* of the services that can be rendered by assistants, students and interns must be performed 'under the direct personal supervision of a pharmacist.'<sup>286</sup> Similar provisions are found in the Medicines Act in relation to the sale of scheduled substances,<sup>287</sup> as well as the Rules Relating to Good Pharmacy Practice which stipulate that all dispensing must be done either by, or under the supervision of, a pharmacist,<sup>288</sup> who must see every prescription that is dispensed.<sup>289</sup> In light of these provisions, it is submitted that a pharmacist who either fails to supervise his or her assistants/students/interns in the performance of their functions, or fails to exercise reasonable care and skill in providing such supervision, will have acted negligently and may thus be held personally liable should harm to a patient result.<sup>290</sup>

Particularly in the case of pharmacy students and interns, the very purpose of requiring the supervision of a qualified pharmacist is that mistakes are likely to be made during the learning process and the public needs to be protected from these mistakes.<sup>291</sup> In *Brown v Southern Baptist Hospital* an American court was faced with a situation in which a patient had been harmed by a pharmacy intern's error in compounding a solution. Although the intern admitted that she had not followed the correct compounding procedure, the court found that the substantial cause of harm

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<sup>285</sup> See 4.3.2.7 above.

<sup>286</sup> Regulations 5-11 and 13. Though see regulation 12 which provides certain instances in which a pharmacist's assistant (post-basic) may act under the *indirect* personal supervision of a pharmacist.

<sup>287</sup> Section 22A, subsections (4)(a)(i) and (5)(a)-(b). These subsections do, however, merely refer to the personal supervision of a pharmacist and fail to state whether such supervision must be direct or indirect.

<sup>288</sup> Rule 2.7.2(a).

<sup>289</sup> Rule 2.7.2(d). See also rule 2.7.2(e) which states that, in relation to pharmacist's assistants (post-basic) the supervising pharmacist must be available in the pharmacy to intervene, to advise and to check the dispensing of any prescriptions.

<sup>290</sup> Interestingly enough, the Rules Relating to Good Pharmacy Practice state that the supervising pharmacist will bear the *legal and professional responsibility* associated with the dispensing process (rule 2.7.2(c)). This provision, it is submitted, is, at most, a general statement of law. In determining whether a supervising pharmacist can be held liable, the test remains that of the reasonable pharmacist. A reasonable pharmacist would not always have acted so as to prevent harm to the plaintiff, and it follows that a supervising pharmacist will not always be liable for harm resulting from the conduct of those under his or her supervision.

<sup>291</sup> Brushwood and Mullan 'Preceptor Responsibility' 58.

was the negligence, not of the intern, but of the *pharmacist*. The court stressed that the very reason that the pharmacist was supervising the intern was to prevent mistakes of this nature. In light of the fact that there were moments during which the pharmacist had admittedly been unable to see the bottles from which the intern drew fluids during the compounding process, the pharmacist had failed to meet the requisite standard of care.<sup>292</sup>

Brushwood and Mullan observe that the *Brown* decision places pharmacists in a very difficult position in that it requires ‘minute-by-minute oversight of pharmacy interns.’<sup>293</sup> In practice, this level of supervision will be difficult, if not impossible, to achieve—especially when a pharmacist is supervising more than one person. When determining the standard of care to which a pharmacist must adhere when supervising the conduct of others, it must be remembered that the magnitude of the harm is only one factor that our courts take into account. Against this consideration must be balanced the burden of taking precautionary measures. It is submitted that, although a reasonable pharmacist would provide some degree of supervision, he or she would not usually be prepared to provide ‘minute-by-minute oversight’ and that this standard is far too onerous. That said, a reasonable pharmacist would adjust his or her conduct according to the degree of risk posed by the tasks being performed by those under his or her supervision. It follows that, when the task undertaken by an assistant/student/intern may cause serious harm to a patient if performed incorrectly, the supervising pharmacist may well be required to be more vigilant in his or her supervision than would ordinarily be the case.

#### 4.5 Conclusion

The diversity which exists between the various pharmaceutical products currently on the market means that what constitutes negligent conduct with regard to one drug will often be entirely reasonable with regard to another. Fewer precautions may, for example, be required when handling a Schedule 2 substance than when a Schedule 6 substance is involved. The same can be said concerning patients with different

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<sup>292</sup> See discussion in Brushwood and Mullan ‘Preceptor Responsibility’ 58-59.

<sup>293</sup> Brushwood and Mullan ‘Preceptor Responsibility’ 60.

conditions and susceptibilities. The liability of a pharmacist will, in other words, depend entirely on the particular factual matrix with which the court is faced. As such, it is difficult to make general statements regarding the instances in which pharmacists will and will not be negligent. What *is* evident, however, is that, although negligence in pharmacy practice will be more readily concluded in some circumstances than others,<sup>294</sup> pharmacists are no longer safe in presuming that, as long as they have filled a prescription in strict accordance with the prescriber's instructions, they will be shielded from liability.

When it comes to the dispensing of OTC medications, it must be remembered that, whilst these usually pose less risk than prescription drugs, the fact that pharmacists are often the only healthcare professionals with whom patients using OTC drugs have contact means that particular care must be taken in recommending and dispensing these products and monitoring the use thereof.

A final comment must also be made concerning the dispensing of pharmaceutical products that have been ordered on-line. In the course of the last two chapters, a number of problems have been identified with the dispensing of drugs via the Internet. In particular, the nature of the Internet makes it difficult to provide appropriate patient counselling, to protect patient information from being leaked to third parties, and to detect prescription fraud.<sup>295</sup> Faced with these difficulties, it must be asked whether the very act of dispensing a pharmaceutical product over the Internet is negligent. Whilst some pharmacists may prefer to tread the path of caution and refrain from operating Internet sites due to the problems associated therewith, it is submitted that this is not the degree of care to which pharmacists must conform in order to avoid being found negligent.<sup>296</sup>

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<sup>294</sup> Dwyer 745.

<sup>295</sup> Note, however, that many of these problems do not arise exclusively within the context of Internet drug sales. Pharmacies which operate courier, mail-order or postal services are likely to encounter similar difficulties with regard to counselling patients and ensuring the authenticity of prescriptions.

<sup>296</sup> See *Herschel v Mrupe* 1954 (3) SA 464 (A) 490F:

'The concept of the *bonus paterfamilias* is not that of a timorous faint heart always in trepidation lest he or others suffer some injury; on the contrary, he ventures out into the world, engages in affairs and takes reasonable chances.'

The primary motivation for this submission is the utility of allowing patients to fill prescriptions or purchase OTC products on-line. Internet pharmacies offer numerous benefits. The most obvious advantage is that they enable patients to obtain medications without the inconvenience of having to travel to a pharmacy. This is particularly beneficial to elderly and disabled patients, who are unable to reach a traditional pharmacy without assistance, as well as to those who live in remote areas.<sup>297</sup> For individuals who suffer from socially stigmatised conditions or who wish to purchase 'lifestyle' drugs, such as Viagra, birth control pills and diet pills, the cloak of privacy which the Internet offers is particularly attractive.<sup>298</sup> One can place one's order or seek the relevant medical advice from the privacy of one's own home, without risking the embarrassment of running into an acquaintance whilst discussing the matter with one's local pharmacist.<sup>299</sup> Another potential benefit is that patients who visit e-pharmacies have more time to think about the questions they want to ask than would be the case if they were standing at the front of a queue at the counter of the local pharmacy.<sup>300</sup> Virtual pharmacies are additionally appealing owing to the fact that they are able to refill prescriptions automatically.<sup>301</sup> In light of the social benefits presented by e-pharmacies, it is submitted that, even when faced with the dangers inherent in dispensing pharmaceutical products over the Internet, a reasonable pharmacist would not refrain from this activity. The dispensing of drugs by e-pharmacies is thus not negligent *per se*.

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<sup>297</sup> Carlini 158; Rost 622; Nunnelley 3; Friedman 140; Lee 1-2.

<sup>298</sup> Friedman 141; Tyler 285; Nunnelley 4.

<sup>298</sup> Carlini 171; Rost 622; Jones 'Internet Prescribing'; Nunnelley 4.

<sup>299</sup> Carlini 171; Rost 622; Jones 'Internet Prescribing'; National Association of Boards of Pharmacy 'VIPPS Program'.

<sup>300</sup> *Detscher Apothekerverband eV v 0800 Doc Morris NV* par [113].

<sup>301</sup> Nunnelley 4. See also Brushwood 'Regulation of Internet Pharmacy' 77-78 for a discussion of the Internet pharmacy's ability to overcome the problems which hamper the realisation of pharmaceutical care in traditional pharmacies.

# CHAPTER 5

## CAUSATION

### 5.1 Introduction

Even if it has been established that a pharmacist's conduct was both wrongful and blameworthy, the pharmacist will still incur delictual liability only if the plaintiff can demonstrate the presence of a causal *nexus* between such conduct and the harm experienced.<sup>1</sup> Brushwood says: 'Simply because a mistake was made and harm later occurred does not mean that the mistake caused the harm.'<sup>2</sup> Before a causal link will be recognised for the purpose of establishing liability, the following requirements must be met:

- a) the conduct of the defendant must have factually caused (or materially contributed to) the plaintiff's harm, *and*
- b) the factual link between the conduct and the harm must be sufficiently close for legal liability to arise.<sup>3</sup>

Both factual and legal causation must, in other words, be present. These dual aspects of causation are diverse in nature and one will face different problems in attempting to establish each step of the causation enquiry.<sup>4</sup> This chapter will consequently begin by outlining the law concerning the two aspects of causation and will then proceed to explore the various problems that may arise in proving each of these in pharmacy malpractice cases.

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<sup>1</sup> Neethling *et al* 174; Van der Walt and Midgley par 128; Jones par 5.01; Giesen 163 and 166.

<sup>2</sup> Brushwood 'Patient Injury' 2384.

<sup>3</sup> *Minister of Police v Skosana* 1977 (1) SA 31 (A) 34F-G; *Tuck v Commissioner for Inland Revenue* 1988 (3) SA 819 (A) 832G-I; *Siman and Co (Pty) Ltd v Barclays National Bank Ltd* 914F-G; *International Shipping Co (Pty) Ltd v Bentley* 1990 (1) SA 680 (A) 700E-I. South Africa is not the only country that approaches causation in this manner. This 'double test' (or 'bifurcation of causal questions'—Hart and Honoré 110) is used in most legal systems as a means of dealing with the issue of causation (Giesen 165).

<sup>4</sup> Hart and Honoré 111.

## 5.2 Factual Causation

The first step in establishing causation is to show that the defendant's conduct was causally relevant.<sup>5</sup> Factual causation will be present when a factual link exists between the actions of the defendant and the harm suffered by the plaintiff.<sup>6</sup> It is thus necessary to consider the ways in which the presence of such a link can be established.

### 5.2.1 Tests for Establishing Factual Causation

#### 5.2.1.1 The *Conditio Sine Qua Non* Test

The test for factual causation adopted by the Appellate Division<sup>7</sup> is the *conditio sine qua non* test (also known as the 'but-for'<sup>8</sup> test<sup>9</sup>).<sup>10</sup> In applying this test, a court asks whether the harm<sup>11</sup> suffered by the plaintiff would have occurred in the absence of the defendant's conduct.<sup>12</sup> The test, in other words, recognises that a factual link can only exist between a particular act and a particular consequence if the act was a necessary condition for the existence of the consequence.<sup>13</sup> When the defendant's conduct was positive in nature, the application of the test involves mentally *eliminating* the

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<sup>5</sup> Fleming 219.

<sup>6</sup> *Tuck v Commissioner for Inland Revenue* 832H.

<sup>7</sup> *Minister of Police v Skosana*. See also *Siman and Co (Pty) Ltd v Barclays National Bank Ltd*; *S v Daniëls* 1983 (3) SA 275 (A); *S v Van As* 1967 (4) SA 594 (A); *Da Silva v Coutinho* 1971 (3) SA 123 (A); *International Shipping Co (Pty) Ltd v Bentley*; *S v Mokgethi* 1990 (1) SA 32 (A); *Groenewald v Groenewald* 1113; *Mukheiber v Raath* 1077J.

<sup>8</sup> The literal meaning of *conditio sine qua non* is 'a condition (or antecedent) without which ... not'. The term, in other words, refers to an act in the absence of which a particular consequence would not have materialised (Snyman 76).

<sup>9</sup> Note, however, that Snyman (77-78) is of the opinion that *conditio sine qua non* cannot be described as a *test* in establishing causation. He argues that the *conditio sine qua non* theory can only be applied once one has already decided from the facts whether a causal link is present and that the significance of the theory is that it can be used, once this decision has been made, in order to *check* whether the decision is correct. Similar views are held by Van Rensburg who argues that the *conditio sine qua non* 'test' does no more than express a conclusion which has already been deduced from experience (Boberg 384).

<sup>10</sup> This approach is also favoured by most writers (Boberg 380; Neethling *et al* 175). Note, however, that it has been severely criticised by Van Rensburg (see Boberg 384; Neethling *et al* 176-180).

<sup>11</sup> Not the event that produces the harm (Boberg 380).

<sup>12</sup> *Siman and Co (Pty) Ltd v Barclays National Bank Ltd* 915A; *Minister of Police v Skosana* 35C.

<sup>13</sup> Van der Walt and Midgley par 130; Trindade and Cane 475. As put by Fleming (219):

'Whether a particular condition qualifies as a causally relevant factor will depend on whether it was *necessary* to complete a set of conditions jointly *sufficient* to account for the given occurrence.'

conduct and determining whether the plaintiff's harm would still have resulted.<sup>14</sup> When, on the other hand, conduct takes the form of an omission (eg a failure to provide warnings), positive conduct must be mentally *inserted* into the sequence of events in order to establish whether the plaintiff would still have suffered harm had the defendant acted positively.<sup>15 16</sup>

#### 5.2.1.2 The Common Sense Approach

The *conditio sine qua non* test is not the sole method of determining factual causation.<sup>17</sup> In some cases the test may not be an appropriate method of determining the existence of a factual link and its application may lead to absurd results. This will be the case where, although the defendant's actions are not a *conditio sine qua non* of the plaintiff's harm, knowledge and experience indicate that the conduct is a factual cause of the harm.<sup>18</sup> This was illustrated in *Portwood v Svamvur*,<sup>19</sup> in which the plaintiff had been savagely attacked by the defendant's dog. It was held that the dog's savage nature, although not a *conditio sine qua non* of the plaintiff's injuries, remained a cause thereof.<sup>20</sup> Beadle CJ<sup>21</sup> commented that he was 'not deterred from maintaining this view by the fact that such ingenuity as [he] may possess [could not assist him] to arrive at the same conclusion by employing any of the accepted tests beloved by lawyers.'

It is thus evident that, in some instances, a deviation from the but-for test will be necessary and a court will have to appeal to the dictates of common sense in

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<sup>14</sup> *International Shipping Co (Pty) Ltd v Bentley* 700F-G; *Siman and Co (Pty) Ltd v Barclays National Bank Ltd* 915B-D.

<sup>15</sup> *Siman and Co (Pty) Ltd v Barclays National Bank Ltd* 915E-F. See, for example, *S v Van As* and *Minister of Police v Skosana* 35E-37B.

<sup>16</sup> For further discussion of the application of the *conditio sine qua non* test see Van der Walt and Midgley par 130.

<sup>17</sup> This is recognised in both South Africa and foreign jurisdictions. See for example the decision of the House of Lords in *Chester v Afshar* [2005] 2 AC 176, the Australian case of *March v E and MH Stramare Pty Ltd* (1991) 171 CLR 506 (HC) 508 and the Canadian decision of *Athey v Leonati* (1996) DLR (4<sup>th</sup>) 235 (SCC) par 14.

<sup>18</sup> Midgley 'Revisiting Factual Causation' 278.

<sup>19</sup> 1970 (4) SA 8 (RA) 15F-G.

<sup>20</sup> This decision has, however, been severely criticised for seeking to establish a causal link between the plaintiff's harm and something other than the defendant's conduct (ie the dog's savage nature). See Boberg 413-414.

<sup>21</sup> *Portwood v Svamvur* 15F-G.

establishing factual causation.<sup>22</sup> This was recognised in *Ncoyo v Commissioner of Police, Ciskei and Others*<sup>23</sup> in which the court observed that '[w]hilst the enquiry as to the factual causation is generally conducted by applying the so-called "but for test", it is important to bear in mind that the Courts have often resorted to a common-sense approach as well.'<sup>24</sup> It is submitted that two of the instances in which a resort to this approach will be necessary are where the mental elimination of the defendant's conduct is inappropriate and where multiple causes are involved. The problems which arise in these situations will now be explored.

It was explained above that, where the defendant's conduct is positive in nature, the but-for test requires that the conduct be mentally eliminated whereas conduct in the form of an omission calls for a process of mental substitution. In *Siman and Co (Pty) Ltd v Barclays National Bank Ltd*,<sup>25</sup> however, the Appellate Division held that 'there are cases involving positive conduct where the application of the but-for rule requires the hypothetical substitution of a lawful course of conduct.'<sup>26</sup> In the *Siman* case, the court thus substituted non-negligent conduct (the provision of accurate information) for negligent conduct (the making of a misstatement). In reaching its decision, the court made reference to a New Zealand case, *Smith v Auckland Hospital Board*,<sup>27</sup> in which a surgeon informed the plaintiff that there were no serious risks involved with a particular medical procedure. The procedure did in fact involve a slight risk of losing a limb and this risk eventuated. In establishing the presence of causation, the court considered whether the harm would have resulted if the plaintiff had been given the correct information instead of whether the harm would have occurred if no advice had been given at all. It is clear that, in a case such as this, the mental substitution of non-negligent conduct would lead to a different conclusion from the mere elimination of

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<sup>22</sup> *Portwood v Svamyur* 15F-G. See also *Ncoyo v Commissioner of Police, Ciskei and Others* 1998 (1) SA 128 (CK) 137F-G. In *Siman and Co (Pty) Ltd v Barclays National Bank Ltd* 917H-918A, Corbett JA indicated that common sense does not only become relevant when the *conditio sine qua non* test is inappropriate. He stated that 'in applying the but-for test the Court should not overlook the importance of applying common sense standards to the facts of the case.' Midgley ('Revisiting Factual Causation' 294) takes this to mean that common sense provides a standard against which to judge the application of the but-for test. If an application of the test renders a conclusion which is in conflict with common sense, it will be necessary to consider another means of establishing factual causation. In this regard, see also the discussion at 5.2.1.3 below on the role of policy in establishing factual causation.

<sup>23</sup> 1998 (1) SA 128 (Ck).

<sup>24</sup> *Ncoyo v Commissioner of Police, Ciskei* 137F-G.

<sup>25</sup> *Siman and Co (Pty) Ltd v Barclays National Bank Ltd* 915F-H.

<sup>26</sup> *Siman and Co (Pty) Ltd v Barclays National Bank Ltd* 915G.

<sup>27</sup> [1965] NZLR 191.

negligent conduct. On the facts of *Smith*, the elimination of the negligent conduct in its entirety would leave one with a hypothetical situation in which the plaintiff was provided with no information concerning the side effects of the procedure and thus, in all likelihood, would still have agreed to undergo it. An application of the *conditio sine qua non* test would thus lead one to conclude that the harm would have eventuated in the absence of the defendant's conduct and factual causation would not be established. If, however, on the same facts, one replaces negligent positive conduct with non-negligent positive conduct, one faces a hypothetical situation in which it is possible that the plaintiff would make an informed decision not to undergo the procedure in question, in which case no harm would result. The substitution process would, in other words, lead one to conclude that factual causation was present.

Whilst the above substitution may produce a result that is more intuitively correct than the elimination, it does not necessarily follow that the court in *Siman* was correct in its application of the but-for test. Van der Walt and Midgley make the point that this kind of reasoning attempts to establish a causal link between *negligence* and harm when the real issue is whether a link exists between *conduct* and harm.<sup>28</sup> In this regard, Boberg recognises that: '[l]egal liability depends upon the existence of a causal relationship between the plaintiff's harm and the actor's *conduct*, not his negligence. Negligence is an attribute that attaches to conduct when it falls short of legal norms, and cannot in itself cause anything.'<sup>29</sup> It follows that, by concentrating on the negligent nature of the defendant's conduct, rather than the conduct itself, the court in *Siman* failed to resolve the question of whether the defendant's conduct was a factual cause of the plaintiff's harm.

This does not mean that in cases such as *Siman* and *Smith*, a court is bound by the result of the but-for test. As explained above, the *conditio sine qua non* test, although the standard test for establishing factual causation, will occasionally lead to absurd results. In such instances, the common sense approach can be used as an alternative.<sup>30</sup>

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<sup>28</sup> Van der Walt and Midgley par 130 fn 6.

<sup>29</sup> Boberg 413. See also Boberg 384 and the discussion of Van Rensburg in fn 30 below.

<sup>30</sup> The approach advocated by Van Rensburg, although controversial, may also be useful in this regard. Negligence, says Van Rensburg, is incapable of *causing* anything. Once a causal connection between conduct and harm has been established, it is, however, important to determine whether the negligent quality of the act was *relevant* in bringing about the harm (Boberg 384). Thus, although Van Rensburg adopts the approach that negligent conduct should be substituted with non-negligent conduct, this 'is

Within the context of pharmacy malpractice in particular, it is submitted that it is inappropriate to establish causation through an application of the but-for test when a pharmacist dispenses the incorrect drug or provides a patient with inaccurate information. In such instances, the mere elimination of the defendant's blameworthy conduct will often fail to leave one with a conclusion that is satisfactory in logic. As a result, it will often be more appropriate for the courts to resort to the common sense approach in cases such as these.

A second instance in which it will be necessary to discard the *conditio sine qua non* test for the common sense approach will be where multiple causes are involved.<sup>31</sup> Multiple causation may arise in a number of ways. One may, firstly, be faced with a situation involving 'alternative' or 'hypothetical' causes. Where this is the case, the defendant's actions bring about (or accelerate) a consequence which would have eventually resulted in the normal course of events. An example would be where a pharmacist's conduct causes the death of someone who was already dying from a pre-existing disease or condition. The alternative cause (in this example, the disease) may already exist or may be likely to come about at a later stage. It has not, however, yet brought about the consequence. As such, it is not a real cause.<sup>32</sup> The presence of an alternative cause will have no effect on the application of the but-for test. This is because the defendant's conduct was a necessary condition of the course of events which *actually* took place, whereas the alternative cause was not.<sup>33</sup>

Of greater relevance to this thesis are cases involving what are sometimes referred to as 'additional causes'. These may take the form of multiple *sufficient* causes or multiple *contributory* causes. In the case of the former, two or more sufficient causes combine to cause the harm. The causes are independent of one another in the sense

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not an application of the *sine qua non* test or an enquiry into causation, but an enquiry into whether the actor's departure from legal norms was relevant to produce the result complained of (Boberg 399). The question, in other words, is whether the quality of the defendant's conduct was relevant in bringing about the plaintiff's harm. Van Rensburg offers the following example: A chemist sells a container of poisonous pills to someone for photographic purposes and fails to mark the container 'Poison'. The person who purchased the pills has a blind wife who, mistaking the pills for headache tablets, ingests them and dies as a result. According to Van Rensburg, one cannot say that the chemist's conduct in this example (ie supplying the pills) did not cause the harm in question. It did. The negligence aspect of the conduct (ie omitting to mark the pills) was, however, irrelevant in the circumstances (Boberg 398).

<sup>31</sup> *Portwood v Svamvur* 14E-H.

<sup>32</sup> Giesen 214.

<sup>33</sup> Fleming 225.

that, had one not occurred, exactly the same consequence would still have resulted.<sup>34</sup> The defendant's conduct, though a sufficient condition of the plaintiff's harm, is thus not a necessary condition of such harm.<sup>35</sup> The application of the but-for test in these circumstances clearly renders absurd results. Fleming explains the situation thus:

'If both factors were culpable, it would be idiotic for the victim to be denied redress while each defendant was endlessly shifting the blame to the other; moreover, it would be whimsical if a fully sufficient cause did not qualify when a less than sufficient cause does.'<sup>36</sup>

In such instances, it will thus be necessary for the court to resort to the common sense approach in determining whether the defendant's conduct was a cause of the plaintiff's harm.

If, in the absence of one of the causes, the harm would not have occurred or would not have had the effect that it did (eg where one cause compounds upon the harm brought about by the other), one will be dealing with an instance of multiple contributory causes. Multiple contributory causes, in other words, each contribute to bring about the harm and cannot operate independently as sufficient conditions of the harm.<sup>37</sup> The plaintiff may be exposed to these factors at different times, or they may operate at the same time to produce more loss than any one of them operating in isolation would have produced.<sup>38</sup> The problems discussed above are not likely to arise in instances of multiple contributory causes and the but-for test will thus usually be an appropriate means of dealing with such cases. Where one is faced with a set of multiple contributory causes that are separated by time, one should, however, bear in mind that one of the causes may constitute a *novus actus interveniens*.<sup>39</sup>

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<sup>34</sup> Hart and Honoré 237; Trindade and Cane 489. See also *Minister of Police v Skosana* 43G-F:

'It may be difficult, for instance, in the case of simultaneous but independently motivated acts which might equally effectively have caused the specific result, to determine whose act was the cause of that result.'

<sup>35</sup> Trindade and Cane 487.

<sup>36</sup> Fleming 222.

<sup>37</sup> Hart and Honoré 237; Trindade and Cane 489.

<sup>38</sup> Trindade and Cane 477.

<sup>39</sup> A *novus actus interveniens* is an 'independent, unconnected and extraneous causative factor or event' (*Tuck v Commissioner for Inland Revenue* 832J-833A) which occurs between the defendant's conduct and the plaintiff's harm, thus breaking the chain of causation (*Snyman* 83).

### 5.2.1.3 The Role of Policy in Establishing a Factual Link

In order to succeed in a delictual claim, the plaintiff does not have to prove that the defendant's conduct *definitely* caused the harm suffered. The causal link between conduct and harm merely needs to be established on a balance of probabilities.<sup>40</sup> It will, however, be seen below that even probability will sometimes be extremely difficult to prove in cases involving medical injury.<sup>41</sup> Fortunately for the plaintiff in such cases, courts will be prepared to make inferences from the available facts.<sup>42</sup> In *Jones v Great Western Railway Co*<sup>43</sup> the court stated that '[w]here the coincidence of cause and effect is not a matter of actual observation there is necessarily a hiatus in the direct evidence, but this may be legitimately bridged by an inference from the facts actually observed and proved.' A court's willingness to draw an inference will depend upon its subjective assessment of the evidence. Jones points out that this in turn may be influenced by policy considerations.<sup>44</sup> Indeed, where the proof of factual causation has been rendered difficult by scientific uncertainty (as in the cases discussed below), the courts have taken steps to ease the plaintiff's burden of proof.<sup>45</sup> Whilst policy itself does not constitute a test for causation in such cases, it does form the basis of the court's decision to follow an approach other than the traditional *conditio sine qua non* formulation. Normative considerations, in other words, influence a court's decision regarding which test should be applied so as to establish factual causation on a particular set of facts.<sup>46</sup>

Commenting on the Australian law of torts, Trindade and Cane state:

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<sup>40</sup> Trindade and Cane 478-479; Fleming 227. For pharmacy malpractice cases in which this was recognised, see *Rexall Drug Co v Nihill* 276 F 2d 637 (9<sup>th</sup> Cir 1960) and *Holbrook v Rose* 458 SW 2d 155 (Ky 1970). See also *Thomsen v Rexall Drug and Chemical Co* (discussed in 5.4.1.2 and 5.4.1.4 below).

<sup>41</sup> See also Jones par 5.11.

<sup>42</sup> Fleming 227.

<sup>43</sup> 47 TLR 39 (130) 45.

<sup>44</sup> Jones par 5.13. See also Healy 192:

'In most cases of medical causation, there can be no conclusive scientific knowledge of how precisely the various causes took effect and led to the plaintiff's injuries. The court is forced to speculate according to degrees of probability, and ultimately to state a preference for one proposition over another. Fact, in this sense, is a statement of belief.'

<sup>45</sup> Jones par 5.13.

<sup>46</sup> See Midgley 'Revisiting Factual Causation'.

'Where the events in issue are the subject of expert evidence, as in cases where the question is the causation of some disease, it has been said that even if the medical evidence only supports the view that the alleged causal link was *possible* (rather than more *probable* than not), the court may act on its own 'intuitive reasoning' and decide on all the evidence ... that the allegation of causal link in this particular case is made out.'<sup>47</sup>

The authors make the point that, although this approach has no logical justification, it is supported by policy considerations.<sup>48</sup>

Likewise, the House of Lords has, in some instances, held that it is unnecessary for a plaintiff to prove that his or her harm would not have resulted in the absence of the defendant's conduct. All that need be proved is that, on a balance of probabilities, the conduct *materially contributed* to the harm<sup>49</sup> or that it materially contributed to the increase of *risk* of harm.<sup>50</sup> The House of Lords has further been prepared to infer that the conduct materially contributed to the harm even when it was impossible to show whether this was in fact the case.<sup>51</sup> As explained by Lord Wilberforce in *McGhee v National Coal Board*, the 'evidential gap' may need to be bridged by drawing inferences of fact which, strictly speaking, the available evidence does not support.<sup>52</sup> Such inferences are drawn on the basis of policy.<sup>53</sup>

In *Minister of Police v Skosana* the Appellate Division commented that, in South Africa, an enquiry into factual causation involves 'the question as to whether the act or omission caused *or materially contributed to* ... the harm giving rise to the claim.'<sup>54</sup> From this statement, it appears that our law accepts that the material

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<sup>47</sup> *Trindade and Cane* 465. Emphasis added.

<sup>48</sup> *Trindade and Cane* 465.

<sup>49</sup> *Bonnington Castings Ltd v Wardlaw* [1956] AC 613.

<sup>50</sup> *McGee v National Coal Board* [1972] 3 All ER 1008. Although the defendant will only be held liable on this basis if the risk to which he or she contributed falls within the duty which the defendant owes the plaintiff.

<sup>51</sup> *Nicholson v Atlas Steel Foundry and Engineering Co Ltd* [1957] 1 All ER 776. See also Jones pars 5.14-5.28.

<sup>52</sup> *McGhee v National Coal Board* 1013E-F.

<sup>53</sup> Jones par 5.22.

<sup>54</sup> *Minister of Police v Skosana* 34E-F. Emphasis added. See also *Kakamas Bestuursraad v Louw* 1960 (2) SA 202 (A) 220D-E and 222A-C. With regard to the question of what constitutes a material contribution, Lord Reid in *Bonnington Castings v Wardlaw* (618-619) stated the following:

'A contribution which comes within the exception *de minimus non curat lex* is not material, but I think that any contribution which does not fall within that exception must be material. I do not see how there can be something too large to come within the *de minimus* principle, yet too small to be material.'

contribution test may be applied when it is impossible to establish that a particular act is the cause of a particular consequence. Midgley, however, observes that South African courts have yet to develop this aspect of the *Skosana* test.<sup>55</sup> He further cautions our courts to tread carefully should they wish to extend liability to those instances in which the defendant has merely increased the risk of harm as such a formulation has the potential to render the test for causation over-inclusive.<sup>56</sup>

Nevertheless, it is clear from the above that, in some cases, a plaintiff will be able to establish a factual link on the basis of an acceptable hypothesis rather than a probable cause. This results from the fact that, in instances in which the application of the but-for test renders a result which, whilst not logically absurd, is unjust, courts, allowing themselves to be influenced by policy considerations, will stray from the traditional approach to causation and follow a route which produces a more equitable result.

### 5.2.2 The Courts' Approach with Regard to Competing Expert Evidence

A plaintiff will be faced with particular difficulty when the opinions of experts are in conflict. In *Michael and Another v Linksfield Park Clinic (Pty) Ltd and Another*<sup>57</sup> the Supreme Court of Appeal emphasised that, in evaluating the views of experts, a court will have to 'determine whether and to what extent their opinions advanced are founded on logical reasoning.'<sup>58</sup> The same point was recently stressed in *Louwrens v Oldwage*<sup>59</sup> in which it was additionally held that, where the views of two experts are both capable of logical support, the court must determine how the sets of evidence stand in relation to one another, viewed in light of the probabilities.<sup>60</sup>

It is thus clear that, in most instances, a conflict in the opinions of experts will be dealt with by examining the premises upon which the opinions are based.<sup>61</sup> If, however, there is a conflict of expert testimony in a case where 'the rationale for the

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<sup>55</sup> Midgley 'Revisiting Factual Causation' 297.

<sup>56</sup> Midgley 'Revisiting Factual Causation' 301-302.

<sup>57</sup> 2001 (3) SA 1188 (SCA) par [34].

<sup>58</sup> Par [36].

<sup>59</sup> 2006 (2) SA 161 (SCA).

<sup>60</sup> *Louwrens v Oldwage* par [27]. See also pars [22]-[25] for the court's analysis of the competing expert evidence.

<sup>61</sup> *Zeffertt et al* 305.

opinion is utterly beyond the grasp of the usual trier of fact,<sup>62</sup> the dispute may be resolved on the basis of the credibility of the experts as was the case in *Geldenhuis v Minister of Safety and Security and Another*.<sup>63</sup> Where, however, the court is faced with expert testimonies which, although completely irreconcilable, are equally probable, the Supreme Court of Appeal has held that the only option available is to order absolution from the instance.<sup>64</sup>

## 5.3 Legal Causation

### 5.3.1 General

Whilst, in order for a defendant to be liable, factual causation must necessarily be present, factual causation is not a sufficient condition for delictual liability.<sup>65</sup> It was seen above that the *conditio sine qua non* test can, at times, be under-inclusive, thus necessitating an appeal to principles of policy and common sense. The concept of legal causation is designed to deal with those situations in which the but-for test is *over-inclusive*.<sup>66</sup> The factual causes of a particular consequence can be practically unlimited. There thus exists a need to curtail the ambit of liability.<sup>67</sup> This is done through the concept of legal causation<sup>68</sup> which deals with the question of whether the defendant *should* be held liable for the harm which he or she has factually caused.<sup>69</sup> In

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<sup>62</sup> *Ibid.*

<sup>63</sup> 2002 (4) SA 719 (C) 732D:

‘Where in a case such as the present when the experts differ, the Court must decide which of the competing experts is the most credible.’

The *Geldenhuis* case is further discussed in 5.4.1.4 below.

<sup>64</sup> *City of Johannesburg v Debbie Investments CC* 2006 JDR 0221 (SCA) par [36]. See also *GS Fouche Vervoer BK v Intercap Bus Service* 2005 JDR 0658 (C) par [108].

<sup>65</sup> *Boberg* 380; *Fleming* 220; *Van der Walt and Midgley* par 132; *Snyman* 79.

<sup>66</sup> *Trindade and Cane* 476.

<sup>67</sup> *Napier v Collet* 1995 (3) SA 140 (A) 143F; *Ncogo v Commissioner of Police, Ciskei* 138C-D. See also *Fleming* 218.

<sup>68</sup> Legal causation is not, however, the only mechanism for limiting liability. The enquiries into wrongfulness and negligence also serve this purpose. The issue of legal causation will thus often be tacitly dealt with during the wrongfulness and negligence enquiries (*Neethling et al* 183, 185 and 200). There are even those who advocate that, as long as a relative approach is taken to wrongfulness and negligence, no enquiry need be made into legal causation and the presence of factual causation alone will be enough to establish liability (*Boberg* 439-440; see also *Mukheiber v Raath* pars [36]-[41]).

<sup>69</sup> *Giesen* 170. Whilst the enquiry into factual causation filters out irrelevant events which had no effect on the outcome, the concept of legal causation is used as a filter to eliminate consequences for which the defendant should not be held liable (*Jones* par 5.09; *Fleming* 220; *Giesen* 172 and 176). As such, the issue is not technically one of causation, but rather of placing a limit upon the conduct for which the defendant may be held liable (*Giesen* 174).

*Tuck v Commissioner for Inland Revenue*<sup>70</sup> Corbett JA explained that ‘[the enquiry into legal causation] raises the question as to whether the link between the act or omission and the harm is sufficiently close or direct for legal liability to ensue; or whether the harm is, as it is said, “too remote”.’ If, in other words, the link between cause and effect is too tenuous, legal causation will not be present and the defendant will not be held liable.

### 5.3.2 The Test for Establishing Legal Causation

#### 5.3.2.1 Previous Tests

The decision as to the existence of legal causation is one that is rooted in policy and common sense.<sup>71</sup> In the past, there was debate concerning the criterion to be used in establishing legal causation. The most significant approaches were the direct consequences theory<sup>72</sup> and the foreseeability theory.<sup>73</sup>

In terms of the direct consequences theory, a defendant will be liable for the physical<sup>74</sup> consequences which follow his or her conduct directly without the operation of a *novus actus interveniens*.<sup>75</sup> A *novus actus interveniens* is an act or event which occurs after the conduct of the defendant and causally contributes to the harm of the plaintiff, thereby breaking the chain of causation and relieving the defendant of liability for the plaintiff’s loss. This issue is discussed in greater detail below.<sup>76</sup>

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<sup>70</sup> *Tuck v Commissioner for Inland Revenue* 833I. See also *International Shipping Co (Pty) Ltd v Bentley* 700H-I.

<sup>71</sup> *Mukheiber v Raath* pars [40] and [42]-[54]; *Van der Spuy v Minister of Correctional Services* 2004 (2) SA 463 (SECLD) 474J-457A; *General Accident Insurance Co South Africa Ltd v Xhego and Others* 1992 (1) SA 580 (A). See also *Liesbosch Dredger v SS Edison* [1933] AC 449 at 460:

‘In the varied web of affairs, the law must extract some consequences as relevant, not perhaps on grounds of pure logic but simply for practical reasons.’

<sup>72</sup> See *In re Polemis v Furness, Withy and Co Ltd* [1921] 3 KB 560.

<sup>73</sup> See *Overseas Tankship (UK) v Morts Dock and Engineering Co (The Wagon Mound)* [1961] 1 All ER 404.

<sup>74</sup> *Owners of Dredger Liesbosch v Owners of Steamship Edison* [1933] AC 449 at 461.

<sup>75</sup> Ie Those consequences ‘which follow in sequence from the effect of the defendant’s act upon existing conditions and forces already in operation at the time, without the intervention of any external forces which come into operation after the act has been committed’ (Van der Walt and Midgley par 134). See also *Boberg* 440; *Neethling et al* 192.

<sup>76</sup> See 5.3.2.2 and 5.3.2.3.

The foreseeability theory, on the other hand, dictates that liability will arise if the general nature<sup>77</sup> of the harm suffered by the plaintiff was reasonably foreseeable.<sup>78</sup> The foreseeability theory must be distinguished from the adequate cause theory. According to the latter approach, legal causation will be present when, in light of human experience, the actions of the defendant are likely, in the normal course of events, to bring about the harm suffered by the plaintiff.<sup>79</sup> It must, in other words, 'be typical of such an act to bring about the result in question.'<sup>80</sup> This theory differs from the foreseeability theory in that the normality of the consequence is judged from a completely objective stand point and not from the position of the defendant.<sup>81</sup>

The foreseeability test used in establishing causation also differs from the foreseeability test that is used to determine negligence. The distinction lies in the fact that the latter test does not deal with the foreseeability of harm in isolation, but also takes the issue of preventability into account.<sup>82</sup>

### 5.3.2.2 The Current Position

In *S v Mokgethi*<sup>83</sup> the Appellate Division endorsed the use of a flexible approach with regard to legal causation which attempts to reach a conclusion that is fair and just.<sup>84</sup> This does not mean that the above tests no longer play a role. They can still operate as subsidiary tests in the application of the flexible approach.<sup>85</sup> Indeed, Van der Walt and Midgley<sup>86</sup> submit that 'strong policy considerations would have to exist if a court were to hold that consequences which were neither foreseeable nor direct were none

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<sup>77</sup> See Boberg 443 for further discussion.

<sup>78</sup> *Smit v Abrahams* 1992 (3) SA 158 (C) 163J-164A; *Standard Chartered Bank of Canada v Nedperm Bank* 768I-J.

<sup>79</sup> Neethling *et al* 190; Van der Walt and Midgley par 137.

<sup>80</sup> Snyman 81. See also Neethling *et al* 190 fn 9.

<sup>81</sup> Boberg 446; Van der Walt and Midgley par 137. Giesen (189) explains that:

'[A]dequacy is but a variation of foreseeability in its objective form, and foreseeability in its objective form is but a variation of adequacy ...'

<sup>82</sup> Van der Walt and Midgley par 136 fn 5.

<sup>83</sup> 1990 (1) SA 32 (A) 39D-41B.

<sup>84</sup> This decision was confirmed in the following cases *International Shipping Co v Bentley* 701D-F; *Smit v Abrahams* 1994 (4) SA 1 (A) 14F-G; *Standard Chartered Bank of Canada v Nedperm Bank Ltd* 764J-765B. Snyman (85), however, suggests that this test may well be too vague and argues that the adequate cause theory is the most suitable means of handling legal causation.

<sup>85</sup> *Smit v Abrahams* (A) 17E-F.

<sup>86</sup> Van der Walt and Midgley par 132.

the less sufficiently close for the purposes of liability.<sup>87</sup> In *Standard Chartered Bank of Canada v Nedperm Bank Ltd*<sup>88</sup> the court thus recognised that ‘the test to be applied is a flexible one in which factors such as reasonable foreseeability, directness, the absence or presence of a *novus actus interveniens*, legal policy, reasonability, fairness and justice all play their part.’<sup>89</sup>

As a result, the foreseeability test will still often play an important role in determining legal causation.<sup>90</sup> The direct consequences theory, on the other hand, will be relevant in establishing legal causation when the harm suffered by the plaintiff was not reasonably foreseeable.<sup>91</sup> A prime example of such a situation would be a so-called ‘egg-skull’ case.<sup>92</sup> These cases arise when a plaintiff, because of some personal weakness, suffers greater harm from the defendant’s conduct than would ordinarily be the case.<sup>93</sup> In the context of pharmacy malpractice, an example would be where a patient’s pre-existing allergies render the patient particularly susceptible to a certain kind of harm.<sup>94</sup> The rule in such cases is that, where the *general* nature of harm is foreseeable, the defendant ‘must take his victim as he finds him’ and will be liable regardless of any pre-existing weakness which the plaintiff may have had.<sup>95</sup> This kind of case can also be dealt with by applying the adequate cause theory. This is because

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<sup>87</sup> For further discussion see Neethling 187-189.

<sup>88</sup> 1994 (4) SA 747 (A).

<sup>89</sup> *Standard Chartered Bank of Canada v Nedperm Bank Ltd* 765A-B.

<sup>90</sup> See for example *Standard Chartered Bank of Canada v Nedperm Bank Ltd*.

<sup>91</sup> See Van der Walt and Midgley par 134.

<sup>92</sup> Although Giesen (190) suggests that the injury which results in egg-skull cases ‘is always foreseeable on the basis that particularly susceptible plaintiffs are common enough to come within the range of the defendant’s reasonable contemplation.’ Within the context of medical malpractice in particular, Jones (par 5.81) furthermore suggests that a medical practitioner should be able to foresee the unusual complications which may arise from negligent treatment. See also Giesen 195 for other ways in which the foreseeability theory can be rationalised so as to cover egg-skull cases.

<sup>93</sup> See for example *Wilson v Birt (Pty) Ltd* 1963 (2) SA 508 (D).

<sup>94</sup> See Giesen 167. Although it can be argued that, seeing that a pharmacist is under a duty to be aware of a patient’s pre-existing weaknesses, such weaknesses will always be reasonably foreseeable. In most instances, it should thus be possible to apply the foreseeability theory.

<sup>95</sup> This rule (also known as the ‘*talem qualem*’—‘just as he is’—rule—Neethling *et al* 208 fn 205; Fleming 234) originated in *Dulieu v White and Sons* [1901] 2 KB 669 at 667:

‘If a man is negligently run over or otherwise negligently injured in his body, it is no answer to the sufferer’s claim for damages that he would have suffered less injury, or no injury at all, if he had not had unusually thin skin or an unusually weak heart.’

See also *Potgieter v Rondalia Assurance Corporation of SA Ltd* 1970 (1) SA 705 (N) 713C-714A. Note, however, that in *Smit v Abrahams* (A) 15F-G, the court took the view that a pre-existing weakness on the part of the plaintiff is merely another fact which needs to be considered in determining legal causation through the application of the flexible approach. According to this decision, the primary considerations thus remain reasonableness, fairness and justice. See also Neethling *et al* 209 in this regard.

the theory analyses the situation from a completely objective perspective. The fact that the plaintiff had a pre-existing weakness will thus be taken into account in determining legal causation even if the defendant was unaware of the plaintiff's condition.<sup>96</sup>

The concept of a *novus actus interveniens* also continues to be of relevance. When an act or event intervenes between the conduct of the defendant and the harm suffered by the plaintiff, and actively operates in bringing about the harm,<sup>97</sup> the question arises whether the intervening act or event should be treated as the sole cause of harm.<sup>98</sup> If it can be, it is known as a *novus actus interveniens*. A *novus actus interveniens* is thus an 'independent, unconnected and extraneous causative factor or event'<sup>99</sup> which occurs between the defendant's conduct and the plaintiff's harm, thus breaking the chain of causation.<sup>100</sup> The result is that the defendant's actions, even if blameworthy and wrongful, cannot be regarded as the legal cause of the plaintiff's loss.

If an event is reasonably foreseeable, it will not constitute a *novus actus interveniens*.<sup>101</sup> In this regard, Boberg<sup>102</sup> emphasises that, in determining whether a particular event constitutes a *novus actus interveniens*, the question is whether the *intervening event* is foreseeable, not whether the *ultimate result* (ie the harm to the plaintiff) is foreseeable. On this basis, he criticises the decision in *Alston and Another v Marine and Trade Insurance Co Ltd*.<sup>103</sup> In the *Alston* case the plaintiff suffered brain injury in a road accident and consequently developed depression for which he was given a drug called parstellin. He ate cheese whilst on this course of drug therapy and this caused him to suffer a stroke. The court held that legal causation was absent

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<sup>96</sup> Snyman 82 and 91.

<sup>97</sup> Fleming 246; Giesen 206.

<sup>98</sup> Trindade and Cane 485.

<sup>99</sup> *Tuck v Commissioner for Inland Revenue* 832J-833A.

<sup>100</sup> Snyman 83.

<sup>101</sup> *Vigarito v Afrox Ltd* 1996 (3) SA 450 (W) 464H:

'[I]t is important to bear in mind that a subsequent intervening event will only qualify as a *novus actus interveniens*, in law, if it is not reasonably foreseeable.'

See also *Joffe and Co Ltd v Hoskins*; *Joffe and Co Ltd v Bonamour* 1941 AD 431 at 456; *Fischbach v Pretoria City Council* 1969 (2) SA 693 (T) 699G-700G; *Ebrahim v Minister of Law and Order* 1993 (2) SA 559 (T) 566B-H; *Kruger v Van der Merwe and Another* 1966 (2) 266 (A) 273E-H. In order for the causal link to remain intact, it is not necessary that the precise nature or exact manner of the intervening event be foreseeable, it is sufficient that a reasonable person would have foreseen the general kind of act that occurred (*S v Stavast* 1964 (3) SA 617 (T) 621C).

<sup>102</sup> Boberg 441.

<sup>103</sup> 1964 (4) SA 112 (W).

due to the fact that the stroke was the result of a superseding cause (the eating of cheese) for which the defendant could not be held responsible. Boberg<sup>104</sup> makes the point that this reasoning is flawed because no link in the causal chain between the negligent driving and the eventual stroke was extraordinary or unforeseeable (indeed, it could not be said that the eating of cheese was an unusual thing for the plaintiff to have done). The only thing that was unforeseeable was the *result* of the chain of events in question (ie the stroke). No *novus actus interveniens* was thus present. This does not necessarily mean that the court should have decided that legal causation existed in this case. It does, however, mean that the court should have followed a different route in reaching the conclusion which it did. If, for example, the foreseeability theory had been applied, it is likely that the link between the negligent driving and the plaintiff's stroke would have been considered too tenuous for liability to ensue.

The *Alston* case and its criticism by Boberg are, it is submitted, particularly relevant to cases in which a pharmacist has either failed to provide a patient with adequate risk management information or has provided incorrect information in this regard. In the absence of instructions to modify his or her behaviour during drug therapy, it is not unforeseeable that a patient may act in a potentially dangerous manner. This will especially be the case when (as in *Alston*) a patient has not been informed of the need to avoid combining particular foods or medications with the prescribed drug. If the patient does act in a foreseeable manner, the fact that the result of the conduct is unusual should not, on a proper application of the relevant legal principles, render the act a *novus actus interveniens*. Where medical science is generally aware of the possibility that a patient on a specific course of drug therapy may suffer harm if he or she acts in a particular way, it is submitted that a defendant pharmacist will face great difficulty in convincing a court that legal causation was not present. Where, however, a particular reaction has not yet been scientifically documented (or where the chances of it occurring are extremely small), its occurrence will be unforeseeable and unusual and, in accordance with the dictates of fairness and justice advocated by the flexible approach, it is thus likely that legal causation will be found to be absent.

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<sup>104</sup> Boberg 466.

### 5.3.2.3 Suicide Cases

It is clear from the above that the conduct of the person who suffers harm (usually the plaintiff) may constitute a *novus actus interveniens*.<sup>105</sup> Of particular importance for the discussion below are the South African cases dealing with whether an individual's voluntary act of committing (or attempting to commit) suicide qualifies as a *novus actus interveniens* so as to insulate a defendant whose actions contributed to the harm from liability. In the criminal cases of *R v Nbakwa*<sup>106</sup> and *S v Gordon*<sup>107</sup> it was held that, even when an accused provides a means for the deceased to commit suicide, *knowing* that the deceased will use this means to kill himself or herself, the deceased's voluntary and independent act of bringing about his or her own death is sufficient to break the causal link.<sup>108</sup>

A civil case in which it was argued that the deceased's deliberate act of suicide constituted a *novus actus interveniens* was *Road Accident Fund v Russell*<sup>109</sup> in which a man suffered brain injury in a vehicle collision. As a result of the brain injury, he developed severe depression and eventually committed suicide. The Supreme Court of Appeal made reference to English authorities which establish that, when a person commits suicide whilst not of sound mind, he or she cannot be said to have acted with unimpaired volition in forming the intention to commit suicide and that such suicide

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<sup>105</sup> See for example *Mafesa v Parity Versekeringsmaatskappy Bpk (in Likwidasie)* 1968 (2) SA 603 (O) (in which the negligence of the plaintiff was an intervening cause which broke the chain of causation) as well as the following cases which involved intentional conduct by the person who suffered harm: *R v Nbakwa* 1956 (2) SA 557 (SR); *S v Gordon* 1962 (4) 727 (N); *Ex parte die Minister van Justisie: In re S v Grotjohn* 1970 (2) SA 355 (A).

<sup>106</sup> 1956 (2) SA 557 (SR).

<sup>107</sup> 1962 (4) 727 (N).

<sup>108</sup> *R v Nbakwa* 559C-E; *S v Gordon* 731A-B. The facts of these cases could be distinguished from a situation such as that which arose in *R v Peverett* 1940 AD 213 in which the accused did not merely provide the deceased with a means to commit suicide, but personally completed all of the steps necessary to bring about the death of the deceased. The *Nbakwa* and *Gordan* decisions can also be contrasted with that of *Ex parte die Minister van Justisie: In re S v Grotjohn* in which the Appellate Division (at 364F-G) stated the following:

'Die gevolgtrekking kan kwalik vermy word dat hy wat die gesogte of nodige middel vir 'n voorgenome selfmoord verskaf, 'n oorsaaklike deel daaraan het as dit uitgevoer word; en as hy dit willens *en wetens* doen met die vereiste opset dat 'n end gemaak word aan die lewe van die persoon wat selfmoord wil pleeg, dan is hy skuldig aan moord, al geskied die laaste daad deur die nie-misdadige hand van die selfmoordenaar, want dan is hy wederregtelik en opsetlik aandadigdaaraan dat hy 'n ander se lewe beëindig is' (emphasis added).

<sup>109</sup> 2001 (2) SA 34 (SCA).

thus fails to constitute a *novus actus interveniens*.<sup>110</sup> On this basis, the court in *Russell* held the following:

‘[E]ven though the deceased’s act of suicide may be said to have been deliberate, the weight of the evidence proves on the probabilities that the deceased’s mind was impaired to a material degree by the brain injury and resultant depression. Consequently his ability to make a balanced decision was deleteriously affected. Hence his act of suicide, though deliberate, did not amount to a *novus actus interveniens*.’<sup>111</sup>

The *Nbakwa* and *Gordon* decisions are clearly in conflict with the generally accepted principle that an event cannot constitute a *novus actus interveniens* if it is reasonably foreseeable. It is further submitted that the judgment in *Russell* fails to provide an accurate reflection of the legal principles governing legal causation. As noted by Trindade and Cane, ‘it does not seem correct to say that the reason why deliberate, intentional acts break the causal chain is that they *are* deliberate and intentional.’<sup>112</sup> Indeed, it would appear far more appropriate to ask whether the intervening act was truly *independent* of the defendant’s conduct (in the sense that it was not a response to the situation created by the defendant) than to question whether it was *voluntary*. In the *Russell* case the court was faced with two causative acts—the negligent conduct of the driver and the deceased’s act of committing suicide. Hart and Honoré<sup>113</sup> make the point that, where, in such a factual sequence, the second act was not truly voluntary and its non-voluntary characteristic was produced by the first act (‘as when the first act drives the victim mad and he then commits suicide’<sup>114</sup>), then the first act caused the second. If this is the case, it is submitted that the suicide will not be independent and unconnected to the defendant’s blameworthy conduct and will consequently be insufficient to break the causal link. Applying this approach to the facts of *Russell*, the court accepted that the deceased’s brain injury (which was caused by the accident) ‘probably caused, or was the major factor in inducing, the depression’.<sup>115</sup> The fact that the deceased was unable to make a balanced decision was thus the result of the first

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<sup>110</sup> Pars [20]-[24]. Particular reference was made to the English cases of *Reeves v Commissioner of Police of the Metropolis* [1999] 3 All ER 897 (HL) and *Kirkham v Chief Constable of the Greater Manchester Police* [1990] 2 QB 283 (CA). See also Fleming 254; Jones par 5.59.

<sup>111</sup> *Road Accident Fund v Russell* par [25].

<sup>112</sup> Trindade and Cane 494.

<sup>113</sup> Hart and Honoré 242.

<sup>114</sup> *Ibid.*

<sup>115</sup> *Road Accident Fund v Russell* par [13].

act in the causal sequence. It follows that the suicide of the deceased was connected to the defendant's conduct and for *this* reason (not the fact that the deceased was unable to make balanced decisions), the suicide did not constitute a *novus actus interveniens*.

The facts of *Russel* can be distinguished from situations in which there exists no link between the defendant's actions and the plaintiff's state of mind or wish to bring about self harm. Where this is the case, the intervening event will be unconnected to the defendant's conduct and it is submitted that the question of whether or not the event constitutes a *novus actus interveniens* should depend on whether it was *foreseeable* rather than whether it was voluntary.

Bearing in mind that the approach which South African courts currently apply with regard to legal causation is a flexible one, it remains possible for a court to find that the defendant's conduct was not a legal cause of the deceased's death even if the actions of the deceased were foreseeable. It is, however, submitted that this decision should be one based on considerations of fairness, justice and policy rather than the purported presence of a *novus actus interveniens*.

#### 5.3.2.4 Multiple Causation

For legal causation to be established, it is not necessary that the defendant's conduct be the *only* cause of the plaintiff's harm.<sup>116</sup> Where multiple causation is concerned, the test adopted in *S v Mokgethi* remains applicable. There are, however, various rules relating to the divisibility of harm and the onus of proof. Whatever their nature, additional causes may occur either simultaneously or at different times. When the harm is brought about by the contemporaneous actions of two or more people, or where it is caused partly by a person and partly by natural forces (eg where harm is caused partly by a pharmacist's conduct and partly by the diseased state of the patient), the harm will be presumed to be indivisible. The effect of this is that, unless the *defendant* rebuts the presumption by proving which part of the loss he or she caused, the defendant will be liable for all of the harm suffered. As put by Hand J in

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<sup>116</sup> Snyman 86.

*Navigazione Libera v Newton Creek*:<sup>117</sup> '[T]he single tortfeasor cannot be allowed to escape through the meshes of a logical net. He is a wrongdoer. Let him unravel the casuistries resulting from his wrong.' It follows that the only onus resting on the plaintiff in such a case is to prove that the defendant's conduct played a material part in bringing about the harm in question.<sup>118</sup> Even if other causal factors played a greater role than the conduct of the defendant in generating the consequence, the plaintiff, upon establishing that the defendant's actions contributed to the harm, will be entitled to one hundred percent of his or her damages.<sup>119</sup>

If, on the other hand, the harm is initially caused by one person and then compounded upon by another,<sup>120</sup> the plaintiff will not be assisted by a presumption of indivisibility and must prove which part of the harm was caused by the defendant's actions.<sup>121</sup>

When it comes to alternative causes, these are not strictly an issue of causation and thus fail to relieve the defendant of liability. They will, however, be taken into account in assessing damages,<sup>122</sup> which will be reduced to the extent that the hypothetical cause would have caused the plaintiff's loss.<sup>123</sup> Thus, if a defendant's actions cause the death of a patient who, as a result of some pre-existing disease, would in any event have died shortly afterwards, the damages are likely to be nominal.<sup>124</sup>

### 5.3.2.5 Legal Causation in Regard to Intended Consequences

As a general rule, legal causation will be present where the consequences in question were in fact the defendant's intended result.<sup>125</sup> It is thus clear that where a patient's

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<sup>117</sup> 98 F 2d 694 (1938).

<sup>118</sup> Boberg 404-406; Van der Walt and Midgley par 138. See for example *Kakamas Bestuursraad v Louw*.

<sup>119</sup> Nelson-Jones and Burton 49; See Fleming 229-230 for the reasoning which underlies this rule.

<sup>120</sup> See for example *Bekker and Another v Constantia Insurance Co Ltd* 1983 (1) PH J13 (E).

<sup>121</sup> Boberg 404-406; Van der Walt and Midgley par 138.

<sup>122</sup> Giesen 201.

<sup>123</sup> Jones par 5.47; Giesen 216.

<sup>124</sup> Giesen 217.

<sup>125</sup> *Quinn v Leathem* 1901 AC 495 (HC) 537:

'The intention to injure the plaintiff negatives all excuses and disposes of any question of remoteness of damage.'

See also *Thandai v Minister of Law and Order* 1991 (1) SA 702 (E) 705F-G. For further discussion, see Neethling *et al* 195-199.

confidentiality has been infringed (and intention thus has to be established for a successful claim), legal causation will seldom be an issue.<sup>126</sup>

## 5.4 Specific Situations

### 5.4.1 Difficulties in Establishing Factual Causation

Whilst, in the majority of cases involving personal injury, factual causation will be fairly easy to establish, this is not the situation in drug-related cases. In medical litigation, in general, the proof of causation will often be the most problematic part of the plaintiff's case.<sup>127</sup> As a result, it is important to explore the various hurdles that a plaintiff may face in attempting to prove that the conduct of the defendant pharmacist was the factual cause of the harm suffered.

#### 5.4.1.1 Cases in which Pharmacists Fail to Provide Patients with Information

It was explained in 5.2.1.1 that, when the defendant's conduct takes the form of an omission, an application of the but-for test requires that positive conduct be mentally inserted into the course of events so as to determine whether the plaintiff would have suffered harm had the defendant acted positively. It follows that where a pharmacist negligently fails to provide a patient with healthcare information and the patient subsequently suffers harm, liability will only arise if the plaintiff is able to establish that, had information been provided by the *pharmacist*, the harm would not have occurred. With regard to risk *assessment* information, the plaintiff will have to establish not only that the undisclosed risk materialised and caused the injury,<sup>128</sup> but also that he or she would have declined to undergo the treatment had the pharmacist disclosed the risk in question.<sup>129</sup> Where, on the other hand, risk *minimisation*

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<sup>126</sup> See Van der Walt and Midgley par 133.

<sup>127</sup> Healy 191; Goldberg and Dodds-Smith 101; Giesen 163; Brushwood *Medical Malpractice* 195; Nelson-Jones and Burton 41; Jones par 5.03.

<sup>128</sup> Healy 201.

<sup>129</sup> Nelson-Jones and Burton 42; Jones par 5.08. In this regard, Healy (202) submits that although '[e]vidence that the plaintiff's treatment would be necessary at some point in the future is not generally a defence to liability, ... proof that without the treatment the plaintiff's condition would have deteriorated rapidly will case doubt on the plaintiff's testimony that he would not have undergone the treatment knowing its full risks.'

information is concerned, it will have to be shown that the plaintiff would have adhered to the pharmacist's instructions. If sufficient information was in fact provided by the prescribing *physician*, the plaintiff will obviously be unable to establish liability on the part of the pharmacist.<sup>130</sup> Even when it is proved that *no* information was provided by the prescribing physician, the but-for test will still be difficult to apply in cases involving omissions. This is because a court can only speculate as to what may have happened had the defendant in fact acted. Fleming points out that particular difficulty arises in failure to warn cases as it is highly speculative whether the provision of warnings would have prevented the harm.<sup>131</sup>

One particular problem that a court faces in determining whether a causal link exists between a pharmacist's failure to provide information and a patient's harm is the weight to be given to the patient's subjective opinion that he or she would have acted in a particular manner if given the information.<sup>132</sup> The Supreme Court of California has noted the following with regard to a physician's failure to provide risk assessment information:

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See also the recent English case of *Chester v Afshar* [2005] 2 AC 176 in which a surgeon failed to warn his patient of the risk that a particular surgery may cause serious neurological damage. The facts showed that, had she been warned of the risk, the patient still would have undergone the surgery, only at a later date. The surgeon's failure to warn was not, in other words, a necessary condition of the harm suffered. In spite of this, the court held that the facts of the case necessitated a 'narrow and modest' departure from the normal approach to causation (pars [23]-[24]). The dictates of justice indicated that the surgeon was the factual cause of his patient's injuries as, to hold otherwise would 'strip the surgeon's duty of all content and practical force' (par [87]). In this regard see the discussion in 5.2.1.3 above on the role played by policy considerations in determining factual causation.

<sup>130</sup> Giesen (179), in discussing the liability of *physicians*, states that '[a] physician's failure to warn may ... be causally irrelevant if the person endangered ... already knew about the danger without it.'

<sup>131</sup> Fleming 221. See also Healy (212):

'The disclosure action clearly suffers from a significant epistemological and evidential gap, caused by the impossibility of knowing factually what the patient would have decided under different conditions at a point of time lost forever to the past.'

Similar problems may arise when, although a patient is given information, the information is incorrect. In such instances, a plaintiff may need to prove that he or she acted in a particular way (in which he or she would not otherwise have acted) because of the belief that the information was true (Boberg 59; *Perlman v Zoutendyk* 1934 CPD 151). Corbett (59) stresses the importance of paying proper attention to the issue of causation in cases involving misstatements and ensuring that the false information was the cause of the plaintiff's harm. Thus, in *Kautzman v James*, the plaintiff did not succeed because it was found that the switch in labels (which resulted in the plaintiff ingesting medicine prescribed for external use) had not been the cause of the harm suffered. The harm had instead resulted from the pharmacist informing the patient of the mistake. This resulted in the patient becoming extremely nervous and developing a peptic ulcer. No doubt the court's decision would have been different had the provision of inaccurate information been the direct cause of harm to the plaintiff. Indeed, in *Model Drug Co v Patton* 208 Ky 112, 270 SW 988 (1925), in which the plaintiff was severely injured after a switch of labels similar to that in the *Kautzman* case, the court held that liability had been established.

<sup>132</sup> Healy 203-204.

'Since at the time of the trial the uncommunicated hazard has materialized, it would be surprising if the patient-plaintiff did not claim that had he been informed of the dangers he would have declined treatment. Subjectively, he may believe so with the 20/20 vision of hindsight, but we doubt that justice will be served by placing the physician in jeopardy of the patient's bitterness and disillusionment.'<sup>133</sup>

It follows that a completely subjective approach cannot be applied in determining how the plaintiff would probably have acted had the information been disclosed. The result is that some courts<sup>134</sup> have leaned towards the opposite extreme, and adopted a completely objective assessment of causation in failure to warn cases.<sup>135</sup> In the objective approach, the focus is on how a reasonable person would have acted if in possession of the undisclosed information. The problem with this approach is that it ignores the fact that, according to the doctrine of informed consent, the personal decisions of individuals should be respected, whether such decisions are reasonable or not.<sup>136</sup> For this reason, courts in Canada and England have tended to favour the application of a hybrid test which attempts to establish some degree of compromise between the subjective and objective approaches.<sup>137</sup>

The tension between the objective and subjective approaches was considered by South Africa's Supreme Court of Appeal in *Minister of Safety and Security and Another v Carmichele*.<sup>138</sup> The court, in establishing causation, had to postulate as to the judgment that a particular magistrate, exercising discretion, would have given had a particular application for bail been opposed. It held that, although '[f]actual issues cannot be decided differently depending on the type of case,' it had to concede 'that it would be inappropriate for a particular judicial officer to testify in relation to the hypothetical question of how he or she decided a particular case.'<sup>139</sup> It thus concluded that the appropriate manner in which to determine causation was to ask what the particular magistrate would *on a balance of probabilities* have done had the

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<sup>133</sup> *Cobbs v Grant* 502 P 2d 1 (1972) 11-12.

<sup>134</sup> Eg the Supreme Court of California in *Cobbs v Grant*.

<sup>135</sup> Healy 204-211.

<sup>136</sup> Healy (205) thus observes that this approach discriminates between patients who are originally given the appropriate information, and thus afforded the choice to act unreasonably if they so wish, and those to whom disclosure is not made. See also the discussion of informed consent in 2.3.2.3(b) above.

<sup>137</sup> See discussion in Healy 211-212.

<sup>138</sup> 2004 (3) SA 305 (SCA).

<sup>139</sup> *Minister of Safety and Security v Carmichele* par [59].

application been opposed.<sup>140</sup> The court, in other words, favoured an approach which was partially subjective and partially objective.

It is submitted that the *Carmichele* approach is an appropriate method of establishing causation in failure to warn cases. When faced with cases of this nature, courts should guard against viewing causation from either an exclusively subjective or an exclusively objective perspective and should take both subjective *and* objective factors into consideration when determining the causative effect of the defendant's omission. Nevertheless, it is obvious that a patient will have difficulty convincing a court, after the risk has materialised, that he or she would, on a balance of probabilities, not have undergone drug therapy if the circumstances are such that a reasonable person would have consented to therapy if in possession of the relevant information. As such, the principle of patient autonomy will necessarily be eroded to some degree in failure to warn cases and plaintiffs will often face great difficulty in establishing that it was the pharmacist's omission that led to the harm suffered.

#### 5.4.1.2 Identity of Drug Unknown

The second kind of problem is one that may arise when a pharmacist errs by dispensing the incorrect drug. When a pharmacist has dispensed a drug that is different from the one asked for or prescribed, the situation may be such that the identity of the dispensed drug cannot be established. This may be because, by the time it is discovered that an incorrect drug has been dispensed, the drug has already been ingested and eliminated from the patient's body.<sup>141</sup> Alternatively, the drug may be impossible to identify due to the fact that by the time the harm arises, there are no traces of the drug. This was what happened in *Thomsen v Rexall Drug and Chemical Co.*<sup>142</sup> In this case, the plaintiff's prescription for hydrodiuril (which comes in the form of small pink pills) was filled with large white or yellow pills. The harm to the plaintiff only arose some time after the dispensing error had been detected and rectified. Upon detection of the problem, the pills originally dispensed to the patient were returned to the pharmacy where they disappeared.

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<sup>140</sup> *Ibid.*

<sup>141</sup> Brushwood *Medical Malpractice* 195.

<sup>142</sup> 235 Cal App 2d 775 45 Cal Rptr 652 (1965).

It is obvious that the proof of causation will be particularly difficult in cases of this nature. In order to impose liability on the defendant, the court will necessarily have to draw an inference as to what kind of drug was in fact dispensed. Whether or not it will be prepared to do so will, of course, depend on the particular factual matrix with which it is confronted. In *Thomsen*, for example, the court was prepared to draw the necessary inference based on the fact that the harm suffered by the plaintiff could have been caused by a penicillin or sulfa drug, both of which commonly come in the form of large white pills.<sup>143</sup>

#### 5.4.1.3 Causes of Condition Unknown

When an incorrect drug is dispensed, the identity of which is *known*, it may still be difficult, if not impossible to prove that it was the drug that caused the injury. In drug-related cases, factual causation can usually only be proved if an expert testifies that, according to accepted scientific knowledge, the defendant's conduct contributed to the harm suffered by the plaintiff.<sup>144</sup> There are, however, a number of problems that may arise in this regard. The first kind of dilemma will emerge where the causes of a particular kind of harm have yet to be scientifically established and are thus subject to controversy.<sup>145</sup> This was seen in the case of *Ocean Accident and Guarantee Corporation Ltd v Koch*.<sup>146</sup> Whilst this was not a pharmacy malpractice case, it provides a useful illustration of how difficult it will be to establish causation when the cause of a particular medical condition is uncertain.

In the *Ocean Accident* case, the Appellate Division was faced with the following situation: As a result of a motor vehicle accident, the respondent sustained an injury to his neck. The respondent averred that this injury caused him to suffer nervous strain and tension which led to coronary thrombosis. Whilst the court accepted that the accident had caused the respondent's heightened anxiety, it was more apprehensive about whether the respondent's nervous state had been the cause of the thrombosis. Although some authorities recognised that heightened anxiety may cause a

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<sup>143</sup> For an example of a case in which the court was not prepared to reach such a conclusion see *Fagan v McRae* 169 NYS 577 (1918).

<sup>144</sup> *Brushwood Medical Malpractice* 195.

<sup>145</sup> *Jones* par 5.10.

<sup>146</sup> 1963 (4) SA 147 (A).

thrombosis, the literature on the subject mentioned a number of possible causes of this condition,<sup>147</sup> many of which were present in the respondent's case. There was also nothing to suggest that heightened anxiety was even a common cause of coronary thrombosis, let alone a predominant cause of this condition.<sup>148</sup> This led Beyers JA to the following conclusion:

'In my opinion it cannot ... be stated with the necessary degree of certainty that in this case the heightened state of anxiety was the cause of the respondent's coronary thrombosis. One may have a grave suspicion that the heightened state of anxiety was a contributing factor, but mere suspicion, although grave, is not sufficient to discharge the onus of proof.'<sup>149</sup>

Even if it is scientifically certain that actions such as those of the defendant are *able* to bring about the kind of harm suffered by the plaintiff, it may not be possible for medical science to determine whether the conduct acted as a cause in a *particular* set of facts. The harm may have resulted from a number of causes acting simultaneously or from some other factor which is unrelated to the conduct of the defendant pharmacist<sup>150</sup> (such as the diseased state of the patient<sup>151</sup> or, for that matter, the conduct of another healthcare professional<sup>152</sup>).

The result of the above is that it will often be difficult for an expert witness to say that the plaintiff's condition was more probably than not the result of the defendant's conduct. Often, the most that an expert will be able to say is that the defendant's conduct may *possibly* have caused the condition or that it increased the risk of the condition.<sup>153</sup> As has been discussed, this may force a court to draw inferences on the basis of *policy* so as to establish the existence of a causal link between the conduct and the harm.

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<sup>147</sup> Eg animal fats in the diet, a high intake of carbohydrates, age, obesity and exertion.

<sup>148</sup> *Ocean Accident and Guarantee Corp Ltd v Koch* 151C-E.

<sup>149</sup> *Ocean Accident and Guarantee Corp Ltd v Koch* 151F.

<sup>150</sup> Nelson-Jones and Burton 42-43; Jones par 5.12.

<sup>151</sup> See Healy 191-192.

<sup>152</sup> This may be the case when both the pharmacist and the physician have made separate mistakes, only one of which caused the plaintiff's harm. See Brushwood 'Patient Injury'.

<sup>153</sup> Trindade and Cane 480; Healy 192.

#### 5.4.1.4 Conflicting Expert Opinions

The uncertainty surrounding the causes of medical conditions will often mean that a case is further complicated by conflicting expert opinions. An example of this was seen in *Thomsen v Rexall Drug and Chemical Co* in which the plaintiff suffered from vasculitis, the exact cause of which is unknown. Proof in this case was made even more difficult by the fact that the identity of the drug dispensed to the patient was also unknown,<sup>154</sup> as well as the fact that a period of several weeks can elapse between the appearance of vasculitis and its cause. The doctor who testified for the plaintiff was of the opinion that the erroneously filled prescription was the most likely cause of the plaintiff's condition. He testified that, judging from the appearance of the medication dispensed by the pharmacist, it may well have been a penicillin or sulfa drug, both of which are possible causes of vasculitis. The defendants' medical experts, on the other hand, believed that the plaintiff's vasculitis was merely a complication of the arthritis from which she suffered. A third doctor, who had treated the plaintiff for four years, thought that the vasculitis was caused by an excessive ingestion of cortisone (which the plaintiff used to alleviate the symptoms of her arthritis).<sup>155</sup>

It was explained above that a conflict in expert testimony will usually be resolved by examining the reasonableness of the opinions before the court. In the *Thomsen* case, the court held that, although the identity of the drug which the patient ingested and the cause of the condition from which the patient suffered were unknown, the inference that the condition had been caused by the drug was reasonable. The defendant pharmacist was consequently held liable. Similarly in his minority judgment in the *Ocean Accident* case, Holmes JA balanced all of the probabilities and favoured the cause which seemed to be the 'more reasonable and plausible'<sup>156</sup> among a number of conceivable causes<sup>157</sup> even though his conclusion was not the *only* reasonable one.

In *Geldenhuis v Minister of Safety and Security and Another*, the court was also faced with conflicting expert opinions. In this case the court based its decision on an analysis of the credibility of the respective witnesses. Whilst one witness had given

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<sup>154</sup> See 5.4.1.2 above.

<sup>155</sup> *Thomsen v Rexall Drug and Chemical Co* 780-782.

<sup>156</sup> *Ocean Accident and Guarantee Corp v Koch* 159H.

<sup>157</sup> Discussed in 5.4.1.3 above.

his evidence in an objective, dispassionate manner, the other had not been impartial, but had rather done all that was possible to promote the defendant's case, even when this had meant relying on speculative reasons. The court consequently preferred the evidence of the former expert above that of the latter.<sup>158</sup>

With regard to the approach adopted in *Geldenhuis*, it must be stressed that this method of choosing the most favourable expert opinion will only be resorted to if the matter before the court is so complex that the court is completely unable to understand the reasoning which underlies the experts' opinions. As a general rule, courts are expected 'not to allow the opinion of witnesses to take the place of their own findings of fact.'<sup>159</sup> This means that, where possible, 'determination will not depend upon considerations of credibility but rather the examination of the opinions and the analysis of their essential reasoning, preparatory to the court's reaching its own conclusion on the issue raised.'<sup>160</sup>

#### 5.4.1.5 Multiple Causes

It was alluded to above that a patient's medical condition will often be the result of multiple causes. Where multiple sufficient causes are involved, causation will need to be established on the basis of the common sense approach. Thus, in *Thomsen v Rexall Drug and Chemical Co*, Bray J held the following:

'[The but-for rule] fails in the type of situation where several causes concur to bring about an event and either one of them operating alone would have been sufficient to cause the result ... This case appears to fall into that category since apparently the plaintiff's vasculitis could have been caused by cortisone or as well, the ingestion of the erroneous prescription. In such situations, it is recognized that neither cause can be absolved from responsibility on the ground that identical harm would have occurred without it. The proper rule for such situations is that the defendant's conduct is a cause of the event as it is a material element and a substantial factor in bringing it about.'<sup>161</sup>

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<sup>158</sup> *Geldenhuis v Minister of Safety and Security* 732G-I and 733H-J.

<sup>159</sup> *R v Jacobs* 1940 TPD 142 at 146-147.

<sup>160</sup> *Michael and Another v Linksfeld Park Clinic (Pty) Ltd and Another* 2001 (3) SA 1188 (SCA) par [34].

<sup>161</sup> *Thomsen v Rexall Drug and Chemical Co Ltd* 782.

Often, however, the situation will be such that the pharmacist does not cause the harm in its entirety, but merely compounds upon harm which already exists. This will be the case when, although the patient has a pre-existing ailment, the actions of the pharmacist have the effect of worsening the condition.<sup>162</sup> In many of these situations, the *conditio sine qua non* test will be an appropriate method of establishing causation. Where it is inappropriate to eliminate the defendant's positive conduct, it may, however, be necessary for courts to resort to the common sense approach. In *Fuhs v Barber*, for example, the pharmacist advised a patient who was using a prescribed ointment for the relief of poison ivy to discontinue using the product and to use a different remedy instead. The pharmacist failed, however, to instruct the patient to wash his skin before applying the new product. The patient followed the pharmacist's advice and the new ointment interacted with the residue of the old, causing the patient to suffer permanent skin damage.

The patient in *Fuhs* would not have suffered the additional harm had it not been for the pharmacist's advice. The issue in this case was not, however, whether the pharmacist's provision of advice was the cause of the harm, but rather whether the provision of advice without the appropriate warnings was the cause of the harm. On facts such as these, it is thus submitted that it will be inappropriate to eliminate the defendant's conduct in its entirety and that an application of the common sense approach will be more suitable.

#### **5.4.2 Difficulties in Establishing Legal Causation**

When a patient intentionally misuses a drug, an issue arises concerning whether the conduct of the pharmacist in dispensing the medication can be regarded as the legal cause of any resultant harm. In particular, it must be considered whether a pharmacist can be held liable for failing to prevent a patient's suicide.

The question is essentially the following: Does the act of a patient in voluntarily taking a drug in an inappropriate manner constitute a *novus actus interveniens*<sup>163</sup> and thus break the causal link? In 5.3.2.3, it was explained that a number of courts have

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<sup>162</sup> Eg *Fuhs v Barber*.

<sup>163</sup> *Brushwood Medical Malpractice* 198.

adopted the approach that self harm, if undertaken with a clear mind, will sever the causal *nexus* between the defendant's conduct and the plaintiff's harm. It is, however, submitted that the question should turn on whether the misuse was foreseeable when the drug was dispensed.<sup>164</sup>

In the United States, courts have tended to find that a patient's act of intentionally misusing a drug constitutes an independent intervening act which shields the pharmacist from liability.<sup>165</sup> The emphasis in most of these cases has, however, been on the fact that the circumstances in which the drugs were sold (even if the drugs were toxic in nature<sup>166</sup>) were not such as to render the act of suicide reasonably foreseeable. Brushwood<sup>167</sup> suggests that, when it is reasonably foreseeable that a patient may use a dispensed drug to commit suicide, a pharmacist should incur liability if he or she fails to take steps to prevent such harm. He states:

[The court in *Riesbeck Drug Co v Wray*<sup>168</sup>] explained that a pharmacist cannot reasonably be expected to foresee that a suicide will result "solely from the sale of substances or instrumentalities with which human life can be taken". The negative implication of this statement is that under certain circumstances the pharmacist will have knowledge of facts from which the pharmacist will reasonably be expected to foresee that suicide will result. Although the simple sale of a toxic substance does not give the pharmacist sufficient information to foresee suicide, [the *Riesbeck* case] anticipates that under certain circumstances a sufficient level of knowledge will exist to make suicide foreseeable to a pharmacist.<sup>169</sup>

Brushwood argues that when a patient's suicide is foreseeable, it cannot constitute a superseding cause.<sup>170</sup> He criticises the decision of *Speer v United States*<sup>171</sup> in which the court held that the patient's suicide was unforeseeable. In this case, the pharmacy had a computerised prescription system containing information on all refills which it dispensed. The deceased was a psychiatric patient who was being treated with potentially toxic antidepressant medication. The patient's pattern of refills provided a

<sup>164</sup> See Brushwood *Drake LR* 50.

<sup>165</sup> See for example *Eckerd's Inc v McGee* 19 Tenn App 277 86 SW 2d 570 (1935); *Scott v Greenville Pharmacy Inc* 212 SC 485 48 SE 2d 324 (1935); *Runyan v Reid* 510 P2d 943 (Okla 1973); *Speer v United States*; *Moss v Meyer* 117 Ill App 3d 862 454 NE2d 48 (1983).

<sup>166</sup> See *Speer v United States*.

<sup>167</sup> Brushwood 'Suicide by Drug Overdose'.

<sup>168</sup> 39 NE 2d 776 (Ind App 1942).

<sup>169</sup> Brushwood 'Suicide by Drug Overdose' 441.

<sup>170</sup> *Ibid.*

<sup>171</sup> 512 F Supp 670 (ND Tex 1981).

clear indication that the dispensed drugs were either being overused or stockpiled for use at a later stage. On these facts, Brushwood argues that the court should have concluded that the patient's suicide was 'not an extraordinary event from the perspective of a professional drug expert' and that, as a result, it did not constitute a superseding cause.<sup>172</sup> He goes on to make the following point:

'[T]he holding of [the court in *Speer*] that suicide was unforeseeable is inconsistent with its own holding that there is a duty to monitor refills and prevent the accumulation of excess quantities of medication. The reason that pharmacists should perform this function must be that misuse of drugs is the foreseeable result of too-frequent prescription refills.'<sup>173</sup>

Bearing in mind that, to constitute a *novus actus interveniens*, an event must be unforeseeable, it is submitted that Brushwood is correct in his assertion that the intentional conduct of a patient, when foreseeable, will not amount to a *novus actus interveniens*. This does not necessarily mean that legal causation will be present. In such instances, the courts will apply the flexible approach enumerated in *S v Mokgethi* and will thus base their decisions on considerations of fairness, justice and policy. It is, however, submitted that, when a patient's misuse of a drug is reasonably foreseeable, policy considerations will often require that a pharmacist be held liable. If pharmacists were permitted to avoid liability merely by arguing that a patient's misuse of a drug was voluntary in nature, the duty of pharmacists to monitor patients' drug therapy so as to avoid the accumulation by patients of dangerous drugs would be rendered practically meaningless.

#### 5.4.3 The Pharmacist's Conduct as a *Novus Actus Interveniens*

The conduct of a pharmacist may *itself* constitute a *novus actus interveniens* which breaks the causal link between the conduct of the *physician* and the harm to the plaintiff. In this regard, the principles discussed above will remain applicable. Often, the negligence of another professional will not be reasonably foreseeable and its occurrence will thus sever the causal *nexus*.<sup>174</sup> This will particularly be the case when a pharmacist dispenses the incorrect drug or dosage. If the pharmacist's conduct was,

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<sup>172</sup> Brushwood 'Suicide by Drug Overdose' 440-442.

<sup>173</sup> Brushwood 'Suicide by Drug Overdose' 441.

<sup>174</sup> See Jones pars 5.50-5.52.

however, foreseeable, the physician will be unable to escape liability by arguing that the causal link was broken. This was seen in *Prendergast v Sam and Dee Ltd*<sup>175</sup> in which the physician wrote the name of a particular drug in a manner that was difficult to read. The court held that the writing on the prescription reasonably permitted misreading by the pharmacist. It was thus reasonably foreseeable that the pharmacist might dispense the incorrect drug.

## 5.5 Conclusion

There are a number of points from the above discussion that should be highlighted. The first is that in cases of pharmacy malpractice, there will be times when an application of the traditional *conditio sine qua non* formulation will be inappropriate, and in which courts will consequently be forced to rely on considerations of common sense in determining whether factual causation is present. Secondly, it is evident that a plaintiff who wishes to establish that his or her harm was caused by a pharmacist's negligent conduct will often be faced with a very difficult task. This will particularly be the case when the pharmacist's conduct takes the form of an omission (such as a failure to warn); when the patient suffers harm after ingesting an unknown drug; and when scientific controversy surrounds the causes of the kind of harm suffered. Fortunately, the courts have recognised that it may be impossible for a plaintiff to adduce firm proof that the defendant's conduct probably caused or contributed to the harm. In these cases, the court may be willing to infer that causation probably existed on the basis of policy. Whether such an inference is drawn in a particular case will, however, depend heavily on the facts before the court as well as the reasons given by expert witnesses to substantiate their opinions.

Whilst the majority of hurdles will arise during the enquiry into factual causation, harm that follows the misuse of a drug will raise the additional issue of whether the conduct of the patient intervenes in such a way as to sever the causal connection between the defendant's conduct and the harm suffered.

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<sup>175</sup> Discussed in 4.4.4 above.

## CHAPTER 6

### SHARED RESPONSIBILITY

#### 6.1 Introduction

This thesis has argued that pharmacists are currently exposed to greater risks of liability than they were in the past. The final issue which warrants discussion is whether the pharmacist will always be expected to shoulder the full extent of responsibility for a patient's drug-related harm.

Responsibility for the harm that follows a delict will not always be carried by one person alone. There will be times when a plaintiff's harm can be causally linked to the blameworthy conduct of more than one individual, and it is necessary to consider the effect that this will have on the extent of a defendant's liability. The first class of cases that require exploration are those in which the *plaintiff* acted negligently, and thereby assisted in bringing about his or her own harm. Thereafter, the discussion will turn to instances in which the fault of a *third party* has contributed to the harm suffered by the plaintiff.

One must also be aware that, in some instances, the fact that a plaintiff's harm has been caused by one person only will not preclude the plaintiff from claiming damages from someone else. This will be the case when someone is vicariously liable for the blameworthy conduct of another. Because these cases represent another example of instances in which the responsibility for harm is shared between a number of people, vicarious liability will also be discussed in this chapter.

## 6.2 Contributory Fault

Although the plaintiff's contributory negligence used to constitute a complete defence against liability,<sup>1</sup> this is no longer the case.<sup>2</sup> At most, negligence on the part of the plaintiff will have the effect of reducing the *extent* of the defendant's liability.<sup>3</sup> The position is currently governed by s1(1)(a) of the Apportionment of Damages Act<sup>4</sup> which provides:

'Where any person suffers damage which is caused partly by his own fault and partly by the fault of any other person, a claim in respect of that damage shall not be defeated by reason of the fault of the claimant but the damages recoverable in respect thereof shall be reduced by the court to such extent as the court may deem just and equitable having regard to the degree in which the claimant was at fault in relation to the damage.'

In determining the extent to which the defendant's liability is to be reduced, a court must thus have regard to 'the degree in which the claimant was at fault'. The court must, in other words, assess the degree to which the plaintiff's conduct deviated from the standard of the reasonable person<sup>5</sup> and, in light of this, determine a reduction that is 'just and equitable'.<sup>6</sup>

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<sup>1</sup> *Thoroughbred Breeders' Association v Price Waterhouse* 2001 (4) SA 551 (SCA) per Olivier JA par [3]. For a discussion of the position at common law, see Van der Walt and Midgley par 167 and Neethling *et al* 156-157.

<sup>2</sup> *Randbond Investments (Pty) Ltd v FPS (Northern Region) (Pty) Ltd* 1992 (2) SA 603 (W) 620B-C.

<sup>3</sup> Van der Walt and Midgley par 167.

<sup>4</sup> Act 34 of 1956.

<sup>5</sup> *South British Insurance Co Ltd v Smit* 1962 (3) SA 826 (A) 836C-D. Not the degree to which the actions of the plaintiff *caused* the harm suffered (Van der Walt and Midgley par 169).

<sup>6</sup> Even though s1 of the Apportionment of Damages Act refers only to the degree that the *plaintiff* was at fault, South African courts have tended to deal with cases of contributory negligence by assessing the extent to which both the plaintiff *and* the defendant deviated from the norm of the *bonus paterfamilias*. They have, in other words *compared* the degrees of fault of the plaintiff and the defendant and thereby determined how damages should be apportioned. See, for example, *Jones v SANTAM Bpk* 1965 (2) SA 542 (A); *General Accident Versekeringsmaatskappy SA Bpk v Uijs* 1993 (4) SA 228 (A); *South British Insurance Co Ltd v Smit* 836B-D. Note also that an apportionment of damages may occur even if the plaintiff's conduct did not relate to the occurrence of the harmful event itself, but merely increased the *extent* of harm that was suffered as a result of the event's occurrence (*Union National South British Insurance Co Ltd v Vitoria* 1982 (1) SA 444 (A)).

As a general rule, it is submitted that, in order for the Apportionment of Damages Act to apply, the plaintiff's negligence must have preceded the occurrence of harm.<sup>7</sup> This does not necessarily mean that the plaintiff's negligent conduct must have preceded that of the defendant. Where, for example, a patient who has been using a particular drug for a number of weeks negligently fails to detect that a pharmacist has refilled a prescription with a substance that is patently different to the drugs previously dispensed, the Act should still be applicable. It must, however, be remembered that actions that occur between the defendant's conduct and the plaintiff's harm may constitute a *novus actus interveniens*.<sup>8</sup> If this is the case, the defendant will not have committed a delict and the question of contributory fault will thus not arise.

Even when the plaintiff acts negligently only after the occurrence of harm, the defendant will not necessarily be held liable for all of the plaintiff's damages. Plaintiffs have a duty to mitigate their loss.<sup>9</sup> A plaintiff who fails to take reasonable steps to minimise his or her loss will consequently not be entitled to claim for the damages caused by such omission.<sup>10</sup> A patient who fails to seek medical advice or treatment after experiencing an adverse reaction and thereby increases the extent of harm suffered will, for example, be unable to claim the full extent of his or her damages from the defendant pharmacist. This consequence is not, however, a result of the application of the Apportionment of Damages Act.

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<sup>7</sup> A slightly different approach was taken in *Gibson v Berkowitz and Another* 1996 (4) SA 1029 (W). In that case, the defendants' conduct had caused physical injury to the plaintiff which resulted in the plaintiff experiencing severe depression. The plaintiff was claiming damages for the costs associated with her depressed condition. The court held (at 1051H-1052D) that contributory fault will only be present if the plaintiff's negligent conduct precedes the occurrence, not of the harm itself, but of the *event which led to the harm* (in this case, the plaintiff's conduct should, in other words, have preceded the occurrence of the physical injury which led to the depression). Although the accuracy of the court's analysis of contributory fault is open to question, this issue is not relevant to the present discussion.

<sup>8</sup> *Gibson v Berkowitz* 1052E.

<sup>9</sup> *De Pinto and Another v Rensea Investments (Pty) Ltd* 1977 (4) SA 529 (A).

<sup>10</sup> It has, for example, been held that a plaintiff who has suffered personal injury is not entitled to indulge in expensive treatment at a private hospital at the defendant's expense if the same level of treatment can be obtained at a public institution (*Williams v Oosthuizen* 1981 (4) SA 182 (C)).

If the defendant *intentionally* caused harm to the plaintiff, the plaintiff's negligence will not result in an apportionment of damages. Likewise, a plaintiff who has intentionally contributed to his or her own loss will not be entitled to damages, even if the defendant's conduct was negligent.<sup>11</sup> It follows that a patient who, for example, knowingly provides a pharmacist with a forged prescription will not be entitled to damages from the pharmacist even if a reasonable pharmacist would have detected that the prescription was invalid and refused to dispense it.<sup>12</sup> When both the plaintiff and the defendant acted intentionally, it is, however, unclear whether the Act will apply.<sup>13</sup>

### 6.3 Joint Wrongdoers

The second instance in which one defendant will not be solely responsible for the plaintiff's harm, is when the harm was contributed to, not by the plaintiff, but by a third party. At common law, a distinction was drawn between joint wrongdoers and concurrent (or 'several') wrongdoers. Into the former category fell people who, acting together in pursuing a particular purpose, jointly committed a delict. Concurrent wrongdoers, on the other hand, were people whose independent delictual acts combined to produce the plaintiff's harm. Under the common law, both joint and concurrent wrongdoers were jointly and severally liable for the harm that they had assisted in bringing about.<sup>14</sup> At present, the position is regulated by s2 of the Apportionment of Damages Act which aims to provide for the apportionment of liability amongst joint wrongdoers.<sup>15</sup> In terms of the Act, the common law distinction between joint and concurrent wrongdoers has been abolished and 'joint wrongdoers' are defined so as to include both categories.<sup>16</sup>

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<sup>11</sup> *Wapnick v Durban City Garage* 1984 (2) SA 414 (D) 418C-D.

<sup>12</sup> The pharmacist may, however, be liable to a third party who has suffered harm as a result of the patient's injury or death. See 6.3 below.

<sup>13</sup> *Wapnick v Durban City Garage* 418E. Though see Van der Walt and Midgley's argument that the Apportionment of Damages Act does not apply in such instances (Van der Walt and Midgley par 170; see also Neethling *et al* 158-159).

<sup>14</sup> *Nedcor Bank Ltd t/a Nedbank v Lloyd-Gray Lithographers (Pty) Ltd* 2000 (4) 915 (SCA) par [10]. See also *Naude and Du Plessis v Mercier* 1917 AD 32 at 38.

<sup>15</sup> *Minister of Communications v Renown Food Products* 1988 (4) SA 151 (C) 154B.

<sup>16</sup> This is seen in s2(1) of the Act, which provides:

'Where it is alleged that two or more persons are jointly or severally liable in delict to a third person (hereinafter referred to as the plaintiff) for the same damage, such persons (hereinafter referred to as joint wrongdoers) may be sued in the same action.'

It must, from the outset, be stressed that individuals will only be regarded as joint wrongdoers (and the Apportionment of Damages Act will thus only apply) if their combined conduct resulted in the *same* harm. Where, in other words, the separate conduct of two or more individuals causes the plaintiff to suffer *separate* harmful consequences, each wrongdoer will be liable only for that harm which he or she in fact caused.<sup>17</sup> It is also evident that, in order for persons to be joint wrongdoers, a causal link must exist between the plaintiff's harm and the conduct of each wrongdoer. If two people both act negligently, but the plaintiff's harm can only be linked to the conduct of one, the other will not be liable. An example of this is seen in the American case of *Hayes v Travellers Insurance Company*.<sup>18</sup> In that case, negligence was established on the part of both the dispensing pharmacist (who filled one of the plaintiff's prescriptions with the incorrect drug) and the prescribing psychiatrist (who prescribed drugs that were inappropriate for the plaintiff's condition). The court found that the psychiatrist's incorrect prescription, and not the pharmacist's dispensing error, had been the causative factor in the plaintiff's harm. The result was that the pharmacist could not be held liable.

In terms of the Apportionment of Damages Act, joint wrongdoers may be sued in the same action.<sup>19</sup> If any joint wrongdoer is not sued in the plaintiff's original action, either the plaintiff, or any joint wrongdoer who *is* being sued, may give notice of the action prior to the close of pleadings.<sup>20</sup> Such notice does not mean that the joint wrongdoer who has not been sued will automatically become a defendant in the action (although, upon

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Also note that, in the Apportionment of Damages Act, the term 'joint wrongdoers' is used in two senses. In the first sense, the term is used to refer to persons who are merely *alleged* to be joint wrongdoers, whilst, in the second, it is used to describe persons who are *in fact* joint wrongdoers against whom judgment has been given. For further discussion, see *Wapnick v Durban City Garage* 421B-422D.

<sup>17</sup> *Mkwanazi v Van der Merwe* 1970 (1) SA 609 (A) 622B-D; *New Heriot Gold Mining Co Ltd v Union Government (Minister of Railways and Harbours)* 1916 AD 415 at 442; *Minister of Communications v Renown Food Products* 153D-F.

<sup>18</sup> Discussed in Brushwood 'Patient Injury'. The citation that Brushwood provides is: 1992 Westlaw 350797 (La App 1992).

<sup>19</sup> Section 2(1). If judgment is given against two or more joint wrongdoers, a court may order that damages be paid by the joint wrongdoers jointly and severally (in which case it may apportion the damages payable by the joint wrongdoers *inter se*) or apportion the damages awarded and give judgment separately against each joint wrongdoer (s2(8)(a)). A joint wrongdoer who pays the judgment debt in full, or who pays more than the amount apportioned to him, may recover a contribution from any other joint wrongdoer (ss2(6)(a) and 2(8)(b)).

<sup>20</sup> Section 2(2).

receiving notice, this person may intervene as a defendant<sup>21</sup>). The court may, however, apportion the degree of fault between the defendant and the third party by means of a declaratory order.<sup>22</sup> Both the plaintiff and the defendant in such actions would also be well-advised to ensure that notice is given. This is because, if no notice is given, the plaintiff will not be permitted to sue the other joint wrongdoer, and a defendant against whom judgment is given will be disallowed from claiming a contribution from such person,<sup>23</sup> without the leave of the court. In order to obtain leave, good cause must be shown as to why notice was not given.<sup>24</sup>

When a patient suffers harm from the use of a prescription drug, such harm will seldom be *solely* attributable to the pharmacist's negligent conduct. Often, another healthcare professional (such as the prescribing physician) will also have played a role in bringing about the harm. A patient who fails to receive risk management counselling from a pharmacist will, for example, be unlikely to suffer harm unless the person who prescribed the treatment also neglected his or her duty to counsel. Similarly, although a pharmacist may act negligently by failing to detect a prescription error, this does not alter the fact that the error would never have arisen had it not been for the prescriber's negligence. Even a pharmacist's dispensing error may, in some instances, be traced back to negligent conduct on the part of the physician. It can, for example, be argued that a physician who fails to ensure that a prescription is written in a legible manner is partially to blame for any harm that results should the prescription be misread and an incorrect drug be dispensed.<sup>25</sup> In such cases, the pharmacist and the prescriber will be joint wrongdoers and the plaintiff's damages may be apportioned between them. The situation may also be such that a pharmacist's *patient* is a joint wrongdoer. This will be the case when the

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<sup>21</sup> *Ibid.*

<sup>22</sup> See *Shield Insurance Co Ltd v Zervoudakis* 1967 (4) SA 735 (E) 739B-D.

<sup>23</sup> Subject to the provisions of s2(4)(b), a joint wrongdoer against whom judgment has been given for the full amount of the plaintiff's damages is entitled to such a contribution as is just and equitable having regard to the degree in which the other joint wrongdoer was at fault in relation to the damages suffered by the plaintiff and the damages awarded (s2(6)(a)). A joint wrongdoer from whom a contribution is claimed may raise any defence that the wrongdoer who is claiming the contribution could have raised against the plaintiff (s2(6)(c)).

<sup>24</sup> Section 2(4). Reasons must, in other words, be given as to why notice was not given timeously. In *Wapnick v Durban City Garage* it was also held that the person applying for leave of the court must show that the third party is *prima facie* a joint wrongdoer (422H-423C).

<sup>25</sup> See *Prendergast v Sam and Dee Ltd.*

patient acted negligently, thereby contributing to his or her own injury or death, and causing harm to a third party<sup>26</sup> (such as a breadwinner, in the case of injury; or dependant, in the case of death).

Unlike s1 of the Apportionment of Damages Act, there is nothing in s2 which indicates that the section applies only to wrongdoers who acted negligently. It follows that a person who acted intentionally can qualify as a joint wrongdoer.<sup>27</sup> Although it is presently unclear whether an apportionment of damages can occur when one wrongdoer acted intentionally and the other negligently (such as when a third party suffers harm as a result of the filling of an invalid prescription which was intentionally presented by the patient and which the dispensing pharmacist negligently failed to detect), Van der Walt and Midgley submit that such apportionment should be allowed.<sup>28</sup>

#### 6.4 Vicarious Liability

Vicarious liability exists when one person is strictly liable for another's delict.<sup>29</sup> Rather than being based on a defendant's blameworthy conduct, this form of liability is rooted in considerations of social policy.<sup>30</sup> Of particular importance in this regard is the need to provide the victims of delicts with defendants who are able to pay damages.<sup>31</sup>

In order for one person to be held liable for the delict of another, a relationship must exist between the parties, and the person who commits the delict must do so whilst acting on behalf of the person who is held vicariously liable.<sup>32</sup> It is thus trite that an employer will

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<sup>26</sup> See s2(1B) of the Apportionment of Damages Act.

<sup>27</sup> See *Randbond Investments (Pty) Ltd v FPS (Northern Region) (Pty) Ltd* 619E-621E.

<sup>28</sup> Van der Walt and Midgley par 173.

<sup>29</sup> Neethling *et al* 373; Van der Walt and Midgley par 29.

<sup>30</sup> *Mhlongo and Another NO v Minister of Police* 1978 (2) SA 551 (A) 567H; *Ess Kay Electronics Pte Ltd v FNB of Southern Africa Ltd* 2001 (1) SA 1214 (SCA) par [8].

<sup>31</sup> *Messina Associated Carriers v Kleinhaus* 2001 (3) SA 868 (SCA) par [10]. For a discussion of some of the other theories that have been advanced as justifications for vicarious liability see Neethling *et al* 373-374.

<sup>32</sup> Van der Walt and Midgley par 29.

be vicariously liable for delicts committed by an employee in the course and scope of his or her employment.<sup>33</sup>

In determining whether an employment relationship exists between two parties, the Supreme Court of Appeal has stressed that there is no universal principle that will be applicable in every case and has favoured the use of a multi-faceted test which takes into account 'all relevant factors, including questions of policy and fairness.'<sup>34</sup> Thus, although the presence of a right of supervision or control provides a strong indication that an employment relationship exists, it has been recognised that there may well be other factors from which the nature of the relationship can be inferred.<sup>35</sup> The courts have, for example, accepted that, in spite of the fact that doctors are given a fair amount of discretion when performing their functions,<sup>36</sup> their employers can be held liable for any delicts that they commit in the course of their employment.<sup>37</sup> It follows that the courts are likely to find that the owners of pharmacies<sup>38</sup> may be held vicariously liable for the delicts of employee pharmacists.

As to whether the delict was committed during the course and scope of employment, the Appellate Division has accepted that this requirement will be met when an employee commits a delict whilst 'engaged in the affairs or business of his employer'<sup>39</sup> and where the employee's activity relates to 'what the employee was generally employed or specifically instructed to do.'<sup>40</sup> The specific situations examined in this thesis have all involved instances in which pharmacists perform in a blameworthy manner the functions for which they are employed. It is thus submitted that, should a pharmacist cause harm in

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<sup>33</sup> *Mkhize v Martens* 1914 AD 382 at 390:

'[A] master is answerable for the torts of his servant committed in the course of his employment, bearing in mind that an act done by a servant solely for his own interests and purposes, and outside his authority, is not done in the course of his employment, even though it may have been done during his employment.'

<sup>34</sup> *Van der Berg v Coopers and Lybrand Trust (Pty) Ltd* 2001 (2) SA 242 (SCA) par [40]. See also *Midway Two Engineering and Construction Services v Transnet Bpk* 1998 (3) SA 17 (SCA) 23H-I.

<sup>35</sup> *Smit v Workmen's Compensation Commissioner* 1979 (1) SA 51 (A) 62D-G.

<sup>36</sup> *Van der Walt and Midgley* par 29.

<sup>37</sup> See *Esterhuizen v Administrator, Transvaal*.

<sup>38</sup> As to who is entitled to own a pharmacy, see the Regulations relating to the Ownership and Licensing of Pharmacists and s22A of the Pharmacy Act.

<sup>39</sup> *Minister of Law and Order v Ngobo* 1992 (4) SA 822 (A) 827B.

<sup>40</sup> *Minister of Safety and Security v Jordaan t/a Jordaan's Transport* 2000 (4) SA 21 (SCA) par [5].

any of the ways discussed in this thesis, he or she would have done so during the course and scope of his or her employment and that the pharmacist's employer may consequently be held vicariously liable.

## 6.5 Conclusion

Because of the product-oriented role with which the pharmacy profession has traditionally concerned itself, pharmacists who have performed their dispensing function in an accurate manner have, for many years, been able to escape liability for drug-related harm. Throughout the course of this thesis it has, however, been shown that this position is beginning to change. Even though there does still appear to be a hesitance on the part of patients to institute legal proceedings against their pharmacists, it is apparent that, when foreign courts *have* been faced with allegations of pharmacy malpractice, they have been prepared to hold that the common law requires contemporary pharmacists to do more than simply dispense the correct drug in the correct form and dosage. Whilst South African courts have yet to explore the common law duties arising from the pharmacist-patient relationship, both the ethical and statutory duties which govern the pharmacy profession in South Africa indicate that courts in this country are likely to adopt a similar approach to those in foreign jurisdictions. Indeed, increased exposure to liability can be viewed as a logical consequence of the increase in pharmacist-patient interaction in recent years and the fact that pharmacists are no longer viewed as the mere mechanical dispensers of drugs, but rather as fundamental role-players in the risk management process.

In the face of increased exposure to liability, one consolation for members of the pharmacy profession is that liability on the part of a pharmacist will often be very difficult for a plaintiff to establish. Another is that, when a patient suffers drug-related harm, the pharmacist will seldom be the only individual to whom such harm can be causally linked. There will be instances in which the patient has also acted in a blameworthy manner, and thereby contributed to his or her own loss. When it is the patient who claims damages, this will have the effect of reducing the extent of the pharmacist's liability. When, on the other hand, damages are claimed by a third party, the

patient may be regarded as a joint wrongdoer. In such instances, a pharmacist who has paid the full amount of the plaintiff's damages will be able to claim a contribution from the patient or, in the case of death, the patient's estate.

Where prescription drugs are involved, there are a number of healthcare professionals involved in the drug-distribution process and it will often be possible for a plaintiff's harm to be attributed to more than one of these professionals. Again, the result is that, even if the dispensing pharmacist has committed a delict, he or she will not be responsible for the full amount of the plaintiff's damages.

A final point which bears mention is that, in light of the fact that pharmacists are currently exposed to greater risks of liability than they were in the past, pharmacy owners would be well-advised to attempt to ensure that their employees adhere to standards of good pharmacy practice. When an employee pharmacist disregards these standards, his or her conduct may well constitute a delict for which the pharmacy owner can be held vicariously liable.

