J.N.P. JANSE VAN VUUREN AND ANOTHER NNO // M.J. KRUGER

CASE NUMBER: 675/91

A groundbreaking case that defined doctor-patient confidentiality. This case changed the conduct of health workers, has been noted internationally and informed the promulgation of POIPA.

147/93

CASE NO. 675/91

J VD M

IN THE SUPREME COURT OF SOUTH AFRICA

(APPELLATE DIVISION)

In the matter between:

J N P JANSEN VAN VUUREN AND ANOTHER NNO — APPELLANTS

and

M J KRUGER — RESPONDENT

CORAM: JOUBERT, NESTADT, KUMLEBEN, NIENABER, JJA et HARMS, AJA

DATE HEARD: 3 SEPTEMBER 1993

DATE DELIVERED: 28 SEPTEMBER 1993

J U D G M E N T

HARMS, AJA:

This is an appeal against a judgment of Levy AJ in the Witwatersrand Local Division in which he

dismissed a claim for damages for the alleged breach of the plaintiff's right to privacy. The appellants are the executors of the estate of the plaintiff, Mr McGeary, who died during the course of the trial of an AIDS-related disease. The respondent, a general medical practitioner of Brakpan, was the first defendant. The second defendant was the owner of a medical testing laboratory in the same town, but the claim against him was withdrawn shortly before the trial. The trial Judge granted the necessary leave to appeal. In what follows I shall in the main refer to the parties in their original capacities.

The factual background to the plaintiff's claim can be shortly summarized. He lived in a homosexual relationship with one van Vuuren in Brakpan. It appears that they were fairly well-known residents of that town and that the nature of their relationship was either generally known or surmised. During the

beginning of 1990 they began a business venture in and moved to Nylstroom. They had, however, retained some links with Brakpan. During that period the plaintiff applied for life insurance cover from Liberty Life Insurance Company. The company required a medical report including a report on the plaintiff's HIV status (i e whether the plaintiff was infected with the human immunodeficiency virus). The first defendant had been the plaintiff's general medical practitioner since 1983 and the plaintiff nominated him to prepare the medical report. For purposes of an HIV blood test a sample was drawn on 27 March 1990 at the second defendant's laboratory. The result was positive and the second defendant informed the first defendant accordingly. The first defendant in consequence arranged an appointment with the plaintiff in order to consult with him on the outcome. That took place on 10 April 1990. The plaintiff was extremely upset and distressed. He was

also concerned about a possible leak and raised the issue with the first defendant who promised to respect his wish to keep it confidential. The following day during the course of a game of golf with Dr van Heerden, also a general medical practitioner, and Dr Vos, a dentist, the first defendant disclosed the plaintiff's condition to them. The plaintiff and these three doctors moved in the same social circle in Brakpan; the plaintiff was engaged in a business venture with van Heerden's wife; Vos had in the past been the plaintiff's dentist; and the first defendant's ex-wife and her parents were on friendly terms with van Vuuren. Van Heerden, in due course, informed his wife. Whether Vos informed his, was not established in evidence but all assumed that he had. The news spread and the plaintiff became aware of this fact.

He was annoyed and attempted to establish the source of the breach of confidence. He telephoned

Mrs Vos. Her denial was vehement. His call to Mrs Adriana Kruger (the first defendant's ex-wife) elicited that she had heard the story and that she had been told that the second defendant was the source. She implied that it was not the first defendant, pointing out that since they were at loggerheads she had no desire to protect him. He then spoke telephonically to the first defendant who denied that he had disclosed the information to anyone; he stated that only the second defendant could have leaked the information; he expressed the opinion that Mrs Vos would probably have spread the rumour; and he advised the plaintiff to let the matter rest.

The plaintiff did not accept this advice and instituted proceedings against the two defendants in October 1990. Since the action against the second defendant was withdrawn, it does not at this stage of the judgment require any discussion.

The plaintiff's case against the first defendant was pleaded in these terms: the first defendant had been his general medical practitioner; in consequence he owed him a duty of confidentiality regarding any knowledge of the plaintiff's medical and physical condition which might have had come to his notice; he became aware of the plaintiff's HIV status; it was a term of the agreement which established the doctor-patient relationship that the first defendant and his staff would treat this information in a professional and confidential manner; in breach of the agreement and in breach of his professional duties the first defendant "wrongfully and unlawfully" disclosed the test results to third parties; in consequence the plaintiff had suffered an invasion of, and had been injured in his rights of personality and his right to privacy. Sentimental (i e non-pecuniary) damages of R50 000 were initially claimed, but the amount was increased to

R250 000 during the course of the trial.

The first defendant in his plea admitted the existence of the professional relationship, his legal duty to respect the plaintiff's confidence and the term of the agreement as alleged. What was disputed, however, was the making of any disclosures and the resultant damages. That remained his case until Dr van Heerden testified on behalf of the plaintiff. (During the cross-examination of this witness it had already become clear that the denial had been a tactical one.) The first defendant then applied for, and was granted, an amendment of his plea in terms of which, in the alternative to the denial, the absence of wrongfulness was raised on three alternative bases: (a) the communication had been made during a privileged occasion, (b) it was the truth and was made in the public interest, and (c) it was objectively reasonable in the public interest in the light of the boni mores.

The Court a quo was of the view that the plaintiff's cause of action was the actio iniuriarum and that "[t]he duty of which plaintiff alleges a breach is founded in their contractual relationship but only as the circumstance out of which the duty arises." On behalf of the appellant it was, however, argued that two alternative causes of action had in fact been pleaded, namely breach of contract and the actio iniuriarum, and that in respect of the former animus iniuriandi is not an element.

Counsel presented this argument in order to counter in advance a submission, to which I shall revert, that animus iniuriandi had not been established. It is convenient to dispose of this side-issue (that breach of contract was a self-contained cause of action in the circumstances of the case) at the outset.

The argument was premised on the fact that

the term of the contract was common cause and it proceeded on the supposition that there is no reason why the breach of an agreement not to commit an iniuria ought not to be actionable by a claim for damages. I am prepared to assume for purposes of argument that the breach of an agreement not to commit an iniuria is so actionable. But that does not derogate from the principle that only patrimonial damages can be recovered on the strength of a breach of contract: Administrator Natal v Edouard 1990 (3) SA 581 (A). The claim in the present instance is one for sentimental damages. No attempt was made to prove any other kind of loss. I agree with Levy AJ that the contract relied upon merely provides the origin of the doctor-patient relationship. In the light of the majority judgment in Lillicrap, Wassenaar & Partners v Pilkington Brothers (SA) (Pty) Ltd 1985 (1) SA 475 (A) it follows also that it is not the breach of the contract which creates the delictual

liability but the breach of the rights and duties that arise from the resultant professional relationship. The true cause of action is therefore the actio iniuriarum.

As a general rule, and irrespective of the ultimate onus, a plaintiff who relies on the actio iniuriarum must allege animus iniuriandi (Moaki v Reckitt & Colman (Africa) Ltd 1968 (3) SA 98 (A) 104E-105E; cf Minister of Justice v Hofmeyr 1993 (3) SA 131 (A) 154) - something the plaintiff had failed to do. However, as was pointed out in Jackson v SA National Institute for Crime Prevention 1976 (3) SA 1 (A) 13F-H, the averment need not be express if "the alleged injuria is obviously an infringement of personality, or where the facts pleaded allow of an inference of animus injuriandi". Counsel for the respondent accepted the aforegoing legal principles and also that the plaintiff cannot be non-suited at this stage of the proceedings

for having failed to make such an express allegation since it had always been the first defendant's understanding that this was the plaintiff's case.

The actio iniuriarum protects a person's dignitas and dignitas embraces privacy. See Jackson's case supra at 11 F-G. Although the right to privacy has on occasion been referred to as a real right or ius in rem (see e g S v A 1971 (2) SA 293 (T) 297 D-G), it is better described as a right of personality. See Joubert, Grondslae van die Persoonlikheidsreg, p 130-136. In the present case we are concerned with the alleged invasion of this right by means of a public disclosure of private facts. See Financial Mail (Pty) Ltd v Sage Holdings Ltd 1993 (2) SA 451 (A) 462 E-F; Joubert, op cit, p 136; 62A American Jurisprudence 2d p 91.

As far as the public disclosure of private medical facts is concerned, the Hippocratic Oath,

formulated by the father of medical science more than 2370 years ago, is still in use. It requires of the medical practitioner "to keep silence" about information acquired in his professional capacity relating to a patient, "counting such things to be as sacred secrets".

But the concept even pre-dates Hippocrates. Oosthuizen, Shapiro and Strauss, Professional Secrecy in South Africa, 1983, p 98, state:

> "In a work written in Sanskrit presumed to be from about 800 BC Brahmin priests were advised to carry out their medical practices by concentrating only on the treatment of a patient when they entered a house and not divulging information about the sick person to anyone else. In ancient Egypt also the priestly medical men were under strict oaths to retain the secrets given to them in confidence. They worshipped in the temples of Isis and Serapis, a healer of the sick, and also of their son, Horus, who was usually called Harpocrates by the Greeks and pictured with his finger held to his mouth. The name for medicine, ars muta (dumb art), is used in Roman poetry by Virgil in Aeneid

> XII. The Pythagorean school in Greece, to which medical men especially belonged, considered silence as one of the most important virtues."

According to the rules of the SA Medical and Dental Council ("the Council") it amounts to unprofessional conduct to reveal "any information which ought not to be divulged regarding the ailments of a patient except with the express consent of the patient". (Rule 16 is to be found in Strauss, Doctor, Patient and the Law, 3rd ed, p 454.)

The reason for the rule is twofold. On the one hand it protects the privacy of the patient. On the other it performs a public interest function. This was recognised in X v Y [1988] 2 All ER 648 (QBD) 653 a-b where Rose J said:

> "In the long run, preservation of confidentiality is the only way of securing public health; otherwise doctors will be discredited as a source of education, for future individual patients 'will

> not come forward if doctors are going to squeal on them'. Consequently, confidentiality is vital to secure public as well as private health, for unless those infected come forward they cannot be counselled and self-treatment does not provide the best care ..."

A similar view was expressed by the Supreme Court of New Jersey in Hague v Williams [1962] 181 Atlantic Reporter 2d 345 at 349:

> "A patient should be entitled freely to disclose his symptoms and condition to his doctor in order to receive proper treatment without fear that those facts may become public property. Only thus can the purpose of the relationship be fulfilled."

The duty of a physician to respect the confidentiality of his patient is not merely ethical but is also a legal duty recognised by the common law. See Melius de Villiers, The Law of Injuries, p 108. As far as present-day law is concerned, the legal nature of

the duty is accepted as axiomatic. See e g Sasfin (Pty) Ltd v Beukes 1989 (1) SA 1 (A) 31F-33G; Neethling, Persoonlikheidsreg, 3rd ed, p 236; McQuoid-Mason, The Law of Privacy in South Africa, p 193-4. However, the right of the patient and the duty of the doctor are not absolute but relative. See S v Bailey 1981 (4) SA 187 (N) 189 F-G; Sasfin case supra; Sage Holdings Ltd v Financial Mail (Pty) Ltd 1991 (2) SA 117 (W) 129H-131F; Financial Mail case supra at 462F-463B. One is, as always, weighing up conflicting interests and, as Melius de Villiers loc cit fn 29 indicated, a doctor may be justified in disclosing his knowledge "where his obligations to society would be of greater weight than his obligations to the individual" because "[t]he action of injury is one which pro publica utilitate exercetur". To determine whether a prima facie invasion of the right of privacy is justified, it appears that, in general, the principles

formulated in the context of a defence of justification in the law of defamation ought to apply. See McQuoid-Mason, op cit, p 218; Neethling, op cit, p 247. It is therefore not surprising that the defences pleaded by the first defendant in justification have the ring of defamation defences namely privilege, truth and public benefit and, in general terms, the boni mores. On appeal no reliance was placed on the defence of truth and public interest and nothing more need be said about it. The third alternative was formulated in the plea thus:

> "Gemeet teen die algemene standaard van redelikheid (die boni mores) soos van toepassing in die gemeenskap, die openbare belang en beleid [was] die bekendmaking regverdig as 'n regmatige mededeling."

It does no more than to restate the general criterion for unlawfulness (see the Financial Mail case ibid)

and adds nothing to the denial of wrongfulness. That leaves for consideration the defence of privilege.

It is convenient for present purposes to apply the test stated by Burchell, Principles of Delict, p 180, in the context of defamation to the defence of privilege of the sort now under consideration:

> "It is lawful to publish ... a statement in the discharge of a duty or the exercise of a right to a person who has a corresponding right or duty to receive the information. Even if a right or duty to publish material and a corresponding duty or right to receive it does not exist, it is sufficient if the publisher had a legitimate interest in publishing the material and the publishee had a legitimate interest in receiving the material."

The duty or right to communicate and the reciprocal duty or right to receive the communication, may be legal, social or moral. See De Waal v Ziervogel 1938 AD 112 at 121-122. (That case, it may be pointed out in

passing, incorrectly assumed that privilege negatives animus iniuriandi whereas the modern point of view is that it negatives wrongfulness: Borgin v De Villiers 1980 (3) SA 556 (A) 571 F-G; Marais v Richard 1981 (1) SA 1157 (A) 1167.) A legal duty to communicate would, for example, exist in respect of the duty of a medical practitioner to testify in court (cf Davis v Additional Magistrate Johannesburg 1989 (4) SA 299 (W) 303 E-I) or to disclose a notifiable disease in terms of section 45 of the Health Act 63 of 1977. A social or moral duty is exemplified in Hague v Williams supra where it was held that knowledge of a child's pathological heart condition was not of such a confidential nature that it prevented the physician from disclosing it extra-curially to an insurer to whom the parents had applied for life insurance on the child.

There were two versions before the Court a quo concerning the circumstances and nature of

the disclosure. Dr van Heerden testified, somewhat unwillingly, on behalf of the plaintiff. (Dr Vos had consulted with both legal teams, was available to both, but was called by neither.) The first defendant testified on his own behalf. According to van Heerden the first defendant, towards the end of the game of golf, mentioned that one of his patients had tested positive for HIV, that he was known to them and thereupon he identified the plaintiff by name. After the disclosure, he (that is van Heerden) told the others that the plaintiff had consulted him some months earlier. Van Heerden believed that in the circumstances then prevailing the information was not conveyed in a professional context and that although it was sensitive, it was not confidential. He could not, however, deny that the first defendant had requested them to treat it in confidence. The first defendant's version was this: Vos had been his patient and the plaintiff's dentist.

He was therefore concerned that the plaintiff may have infected Vos. He felt obliged to inform Vos of the plaintiff's condition to enable him to evaluate his own exposure to the virus. It was not, however, his intention to discuss the matter at that stage with him. Nevertheless, during the course of the game a general discussion about HIV-infection took place and in order to stress the immediacy of the problem, he told the two that he had a patient, known to all of them, who had been tested positively. Van Heerden then remarked that he wondered whether it was not the plaintiff since he had consulted him about an oral fungal infection. He confirmed the correctness of van Heerden's surmise and asked them to treat the information confidentially.

The trial court accepted the first defendant's version. I have some reservations about this finding but since the difference between the two versions appears to be relevant to motive only, I shall

for present purposes assume its correctness.

The plaintiff also sought to hold the first defendant liable for an alleged disclosure by one of his employees, Mrs Bibbey, to his ex-wife, Adriana. The only direct evidence relating to it was that of Adriana. Her version was that Mrs Bibbey had telephoned her in order to obtain the plaintiff's new telephone number in Nylstroom and that in the course of the discussion the information was passed. Mrs Bibbey denied it and stated that she had not been in possession of the facts when the discussion took place. Levy AJ believed Mrs Bibbey and rejected the evidence of Adriana and that of her parents who gave confirmatory evidence. There is one insurmountable obstacle in reversing these findings and that is that Adriana's version under oath was in direct conflict with what she had told the plaintiff during their conversation to which reference has been made earlier. She could not explain her about-turn.

The likely reason for it was an intensified legal and emotional battle between her and the first defendant relating to access to their child. The case must therefore be decided with reference to the disclosure on the golf course.

The objective facts that are of relevance in assessing whether the disclosure was justified, are these:

1. The HIV infection and AIDS-related illnesses are considered by many to be the major health threat of our day. In a paper by the head of the AIDS Centre at the SA Institute for Medical Research, Mrs Christie (who testified for the plaintiff) gave the following graphic description:

> "It is a modern day scourge which has already claimed the lives of thousands of people worldwide. The World Health Organisation estimates that between five to

ten million people are infected with the AIDS virus and that there will be an exponential increase in the number of AIDS cases in the next few years. In the absence of a cure or vaccine, the only way to stop the spread of this deadly disease is by prevention of infection in the first place. This is clearly the task of education which is the only current tool available to combat the AIDS epidemic.

Although the concept of 'education for prevention' is not new, it takes on special significance in the context of AIDS. For one thing, there is widespread ignorance and subsequent fear of the disease. The public is afraid of AIDS and the media has also helped to reinforce existing fear through sensationalist and sometimes inaccurate coverage on the topic. This is largely detrimental to society because it is a well-documented psychological fact that fear arousal is not conducive to learning or promoting behavioural change. In fact, fear elicits denial so that people tend to block out what they hear or see. Another difficulty in promoting socially responsible

behaviour is that AIDS deals with so many taboo subjects including: sex, blood, death, promiscuity, prostitution, abortion, homosexuality, drug use, etc. These taboos makes AIDS an uncomfortable subject to deal with and creates impediments in the learning process."

2. Levy AJ described the nature of HIV-infection and the resultant AIDS in these terms:

"A disturbing feature of HIV is that it has the characteristic that it may remain for years in its host without showing any positive symptoms in the carrier. Antibodies in the carrier develop after about 3 months, but in the interim, that carrier has become and remains a potent source of infection without demonstrating any of the symptoms of HIV and despite the absence of antibodies. AIDS is incurable and fatal and it probably is the greatest public health threat of this century. There is a lack of information concerning the nature of the disease which has led to great fear amongst the public generally

that it is easily transmittable and, of course, the fact that the disease has evidenced itself chiefly amongst homosexual and bisexual people has led to a further intolerance by the community of the victims of the disease. The disease is transmitted via body fluids, chiefly blood, semen and mother's milk, as well as the vaginal fluids. Saliva apparently, although the virus may be found in it, would not carry sufficient of the virus to infect a recipient. It is also found in urine and tears. With blood as a source of infection, there was a great spread of the disease amongst persons requiring blood transfusion, notwithstanding their non-participation in high risk behaviour and, in particular, children have become its victims through infection through a blood transfusion, particulary amongst haemophiliacs. The spread of the disease amongst persons practising normal sexual behaviour, presumably originating from homosexuals or bisexuals, or from persons who had become infected through sharing drug injection apparatus with infected persons, has led to a justifiable fear, as indicated

earlier, that the spread of the disease will reach enormous proportions in a comparatively short time. At present there appears to be no cure for the disease. Plaintiff had for some time been taking drugs thought to be of assistance in combating or repressing the activity of the virus, but as has been observed, it nevertheless led to the onset of AIDS and his death during the course of the trial. It seems to be generally accepted for the present time that there is no recognised cure for the disease, and any victim of the virus who reaches the AIDS stage, must expect his illness to be fatal. The likelihood of advancing to the A.I.D. syndrome is, apparently, very high. Some of the writers to which I have been referred, speak of a 50 per cent chance, but of greater importance perhaps in casu is the fact that such persons, while demonstrating no overt symptoms of the disease in the absence of blood tests, to reveal the presence of antibodies in the blood, nevertheless remain highly infective of any sexual partner or recipient of their blood, whether accidentally or by way of

transfusion, or through sharing needles in intravenous drug taking."

3. Even though the virus is highly infective, it is far less infectious than many other common viruses and can only be transmitted through the exchange of certain body fluids, viz semen, vaginal fluids and blood. The mode of spread of the infection generally follows well-defined routes namely unprotected sexual intercourse, the injection of infected blood, the infection of an unborn foetus whilst in the womb and, in exceptional cases, the infection of a new-born baby through the medium of breast milk.

4. Not a single case of occupationally acquired HIV has been confirmed in South Africa. Although health care workers are therefore at risk, the risk is small and arises only if through an

invasive procedure infected blood enters the worker's blood stream.

5. There are many pathogens that are more infectious than HIV, such as hepatitis B, and a medical practitioner must, in the course of his ordinary practice, take steps to prevent their spread. Some of them are usually sufficient to prevent the spread of HIV in a professional context.

6. There is a reported instance in the USA of a dentist who infected one or more of his patients but that was through the use of instruments which he had used on himself in somewhat extra-ordinary circumstances. But his own HIV infection was not occupationally acquired.

7. Reference has already been made to the Council's rule 16 which is of general application. In

addition, the Council formulated a guideline in 1989 (quoted by Strauss, op cit, p 17) in connection with HIV in these terms:

> "The health care professions are fully aware of the general rules governing confidentiality.
>
> Council is confident that if doctors fully discuss with patients the need for other health care professionals to know of their condition, in order to offer them optimal treatment and also to take precautions when dealing with them, the reasonable person of sound mind, will not withhold his consent regarding divulgence to other health care workers.
>
> If having considered the matter carefully in the light of such counselling, the patient still refuses to have other health care workers informed, the patient should be told that the doctor is duty bound to divulge this information to the other health care workers concerned with the patient. All persons receiving such information must of

> course consider themselves under the same general obligation of confidentiality as the doctor principally responsible for the patient's care.
>
> If it were found that an act or omission on the part of a medical practitioner or dentist had lead to the unnecessary exposure to HIV infection of another health care worker, the Council would see this in a very serious light and would consider disciplinary action against the practitioner concerned."

An important aspect of it is that the patient has to be informed of the doctor's obligation to make a disclosure. That gives the patient the opportunity to say why it is in fact not necessary - something that the plaintiff was denied. The first defendant not only did not seek to obtain the plaintiff's consent to a disclosure; to the contrary, he promised not to divulge the information.

8. The prestigious College of Medicine has a similar guideline.

9. There are some medical practitioners who refuse to treat known infected patients out of fear for their safety.

10. There are in the case of HIV and AIDS special circumstances justifying the protection of confidentiality. By the very nature of the disease, it is essential that persons who are at risk should seek medical advice or treatment. Disclosure of the condition has serious personal and social consequences for the patient. He is often isolated or rejected by others which may lead to increased anxiety, depression and psychological conditions that tend to hasten the onset of so-called full-blown AIDS.

11. Section 45 of the Health Act empowered the Minister of Health to declare any medical condition to be a notifiable medical condition presumably in order to promote public health. Diseases that have been declared in terms of this provision include cholera, leprosy, malaria, measles, poliomyelitis, tuberculosis and viral hepatitis. HIV infection or AIDS-related diseases are, on the other hand, not notifiable diseases.

12. Dr van Heerden had treated the plaintiff once only. That was in January 1990 during the first defendant's absence. He diagnosed, as mentioned, an oral fungal infection. It was a minor problem which, he said, would normally respond promptly to appropriate treatment. There was no evidence

of an intrusive procedure having been performed or of any risk having been created.

13. The plaintiff had consulted Dr Vos in his professional capacity prior to and during September 1987 but not since. There is no evidence of the nature of any procedure carried out by Vos on the plaintiff whether of a risky nature or not.

14. The plaintiff had settled in Nylstroom a few months before the disclosure on the golf course.

The first defendant's plea is silent in relation to the facts on which he wished to rely in support of his defence. In evidence (some of what follows has already been recounted) his case was that he had been aware of the dangers of AIDS and had wished to warn Vos against any possible "retrospective exposure"

to the virus because Vos was also his dentist, was unhygenic in his practice and was his patient. ("Retrospective exposure" was the first defendant's imprecise description of the possibility that the plaintiff had infected Vos before he was diagnosed as HIV positive.) As far as the disclosure to van Heerden is concerned, his evidence is not clear but it seems to have been his contention that it was made because van Heerden had been involved professionally with the plaintiff. Let me immediately state that the allegation that Vos was an unhygenic dentist is, in the light of the first defendant's subsequent conduct, false. After having disclosed the plaintiff's condition to Vos, he did not even advise him to have himself tested nor did he establish whether Vos had done so. And in spite of this he and his present wife continued to use Vos's services even though Vos allegedly had not changed his methods.

Although justification is an objective question (see Borgin v De Villiers supra at p 577 E-G; Delange v Costa 1989 (2) SA 857 (A) 862 E-F), Levy AJ considered the first defendant's motive in making the communication to be of paramount importance; but he did not find that the "retrospective exposure" of Vos or van Heerden justified it. As to Vos, his view was that as far as the first defendant knew the plaintiff was still his dentist and was likely to treat him in future. It was also likely that he would not, on such occasion have informed Vos of his condition in spite of having been advised otherwise by Mrs Christie. As to van Heerden, it was held (contrary to an earlier finding) that the first defendant had been unaware of the treatment during January. Nevertheless, since van Heerden was one of a group of 16 doctors in Brakpan who were on call from time to time for all off-duty practitioners in town, it was required that he should be informed for his own sake

as well as for the better treatment of the plaintiff, should the occasion arise.

Concerning these findings a number of points arise. First, since one is dealing with the issue of wrongfulness, the first defendant's honesty, bona fides and motive (except, possibly, if malice is in issue) are beside the point. See De Waal v Ziervogel supra at 122-3; Delange v Costa supra at 862 D-E and compare Tsose v Minister of Justice 1951 (3) SA 10 (A) 17. Second, at the time of the disclosure the plaintiff had moved to Nylstroom and the likelihood of him calling upon the services of either Vos or van Heerden was remote. If the argument is taken to its logical conclusion health care workers, at least those in Transvaal, would have to be informed. Third, there was no factual basis for the finding that the plaintiff would have failed to inform his future medical attendants of his illness. The evidence was merely that he did not wish to return to

Vos for treatment because he did not want to advise him of his condition for fear of local gossip. Lastly, the court was in my view correct in not relying on the "retrospective exposure" because, as indicated, there was no evidence of it in either instance.

In determining whether the first defendant had a social or moral duty to make the disclosure and whether van Heerden and Vos had a reciprocal social or moral right to receive it, the standard of the reasonable man applies. See De Waal v Ziervogel, ibid; Borgin v De Villiers, ibid. With that in mind, I am of the view that he had no such duty to transfer, nor did van Heerden and Vos have the right to receive, the information. At the risk of repetition, and in summary, I see the matter in this light: AIDS is a dangerous condition. That on its own does not detract from the right of privacy of the afflicted person, especially if that right is founded in the doctor-

patient relationship. A patient has the right to expect due compliance by the practitioner with his professional ethical standards: in this case the expectation was even more pronounced because of the express undertaking by the first defendant. Vos and van Heerden had not, objectively speaking, been at risk and there was no reason to assume that they had to fear a prospective exposure. As Levy AJ stated, the real danger to the practitioner lies with the patient whose HIV condition had not been established or (due to the incubation period) cannot yet be determined. In consequence I conclude that the communication to Vos and van Heerden was unreasonable and therefore unjustified and wrongful.

That disposes of the issues as pleaded. Counsel for the first defendant submitted, however, that, in spite of a failure to have raised the absence of animus iniuriandi in the pleadings he should be

permitted to do so now. He did not dispute the applicability of the rule laid down in the context of defamation in Suid-Afrikaanse Uitsaaikorporasie v O'Malley 1977 (3) SA 394 (A) 403 A-C, followed in May v Udwin 1981 (1) SA 1 (A) 10 E-F namely:

> "'n Blote ontkenning van die opset om te belaster sou onvoldoende wees om 'n eiser in staat te stel om te weet watter feite die verweerder die Hof gaan voorlê, en daarom sal die verweerder, in sy pleit of nadere besonderhede, die feite moet stel op grond waarvan hy beweer dat hy nie die opset gehad het om te belaster nie."

His argument was that the issue has been fully canvassed at the trial. I disagree. As stated, the issue of justification was only raised near the end of the plaintiff's case and at no stage during his case was the issue of animus iniuriandi even touched upon. The first defendant's evidence in chief did not deal with it at all. Some questions put to him during cross-

examination elicited answers that, benevolently interpreted, indicated that he was bona fide in imparting the information. That the questions were directed at establishing the wrongfulness or otherwise of the disclosure cannot be doubted. The attention of plaintiff's counsel was never directed at this new issue, probably because first defendant's did not have it in mind.

Without regard to the pleadings or the question of whether the matter had been fully canvassed, Levy AJ, as it were in passing, also non-suited the plaintiff on the ground that he had failed to establish animus iniuriandi on the part of the first defendant. The learned Judge did not set out the factual basis for his finding, and did not distinguish wrongfulness from animus iniuriandi as this extract from his judgment demonstrates:

"While the judgment of Rumpff CJ in Administrateur Natal v Trust Bank van Afrika Bpk 1979 (3) SA 824 (A) and, in particular, at 833-4, is confined in its terms to a consideration of the existence of a duty of care owed by the alleged wrongdoer to the party injured, it is nevertheless apposite to a consideration of the question whether first defendant could be said in casu to entertain an animus iniuriandi or that the invasion of plaintiff's rights of personality was wrongful, and in regard to the question of 'our ideas of morals and justice and broadly whether plaintiff's invaded interest is deemed worthy of legal protection against conduct of the kind alleged against first defendant.'"

But even if it is assumed in favour of the first defendant that the issue was fully canvassed, I am nevertheless satisfied that he did have the required animus iniuriandi. It is not necessary to set out all the reasons. The essence of this defence as argued was that the first defendant truly believed that due to Vos's alleged unhygenic procedures he (Vos) had been at

risk. I have already found that version to be false. In respect of van Heerden the defence as submitted is dependent on a belief on the part of the first defendant that van Heerden, too, had been at risk. The first defendant never suggested that in evidence. If the first defendant had had no awareness of wrongfulness and had believed that what he had done was proper, why did he mislead the plaintiff during their telephone conversation? It follows that that defence, if it was one, must fail and that the appeal must succeed.

In the light of its finding the trial court did not assess the amount of damages suffered. Counsel were agreed that the matter should not be referred back to it for that purpose. There are good reasons for complying with this request. Cf Botes v Van Deventer 1966 (3) SA 182 (A) 191G-192B. They are: only general damages are in issue, both parties have closed their case, there are no factual disputes which need to be

resolved, the plaintiff has died and the appellants at this stage do not ask for a substantial award and costs of a further hearing ought, if possible, to be avoided.

It is extremely difficult in this matter to make such an award because there are no obvious signposts. Nevertheless, the right of privacy is a valuable right and the award must reflect that fact. Aggravating factors include the fact that a professional relationship was abused notwithstanding an express undertaking to the contrary. So, too, the breach created the risk of further dissemination by others. The evidence also established that the publication of a person's HIV condition increases mental stress and that the plaintiff was seriously distressed by the disclosure. And stress hastens the onset of AIDS - something which may have occurred in this instance. On the other hand, the disclosure was limited to two

medical men who, it was reasonable to assume, would have dealt with the information with some circumspection. The nature of the plaintiff's condition was in any event such that it would inevitably have become known at some stage. He had, to an extent, already severed his links with Brakpan. There is no evidence that his friends ostracized or avoided him; it was rather a case of his having chosen to withdraw from society, something he would probably in any event have done. In the light of all this I believe that R5 000,00 will be a just award.

The appellants are entitled to their costs of the appeal, inclusive of the costs of two counsel. They are also entitled to a costs order in the court below on the Supreme Court scale. Special orders in respect to those costs are sought and I proceed to deal with them. The background facts are that, some months after the plaintiff's telephone conversations with Mrs Adriana Kruger and the first defendant, he instituted

action against both defendants. At that stage he had no evidence as to whether one or other or both (or their employees) had made the disclosure. His uncertainty is illustrated by a letter of demand written to Liberty Life Insurance, accusing it of a breach. About a week prior to the trial, the plaintiff was apprised of the golf course conversation. Before the start of the trial he withdrew his action against the second defendant. The plaintiff and the second defendant have incurred costs relating to these abortive proceedings and it was submitted that the first defendant should bear them. The reasons advanced were that during the telephone conversation the first defendant had falsely denied his involvement and had, without good cause, implicated the second defendant; and that he had pleaded a denial which proved to be false.

The submission cannot be upheld. Since the second defendant is no longer a party to the litigation,

the order sought on his behalf by the appellants must fail on that account. As to the appellants own costs, it has not been shown that the first defendant's conversation was the causa causans of the action against the second defendant because the same misleading information had been received from Adriana; further, the plaintiff in any event disbelieved the first defendant - had he believed him, he would not have sued him. The denial in the plea was also of no consequence. It was tactical and the law of procedure recognises its legitimacy. In any event, there is nothing to indicate that the withdrawal of the claim was not caused by the availability of evidence against the first defendant and the absence of evidence against the second.

A special award is also asked in respect of an answer given on behalf of the first defendant in response to a question put at the pretrial conference. Suffice it to say that the answer was, to the knowledge

of the first defendant and his legal team, incorrect. When this was raised during the course of the trial, Levy AJ put the complaint aside on the basis that the plaintiff had not been entitled to an answer. That may be so but it does not mean that if a party decides to answer unnecessarily he can misstate facts. In spite of all this, the question to be answered is whether additional costs were caused by the answer. Counsel could not point to any. It follows then that a special order is not justified on that account.

The appeal is upheld with costs, including those of two counsel and the order of the Court a quo is amended to read "Judgment for plaintiff in the sum of R5 000,00 with costs on the Supreme Court scale".

L T C HARMS
ACTING JUDGE OF APPEAL

JOUBERT, JA)
NESTADT, JA) CONCUR
KUMLEBEN, JA)
NIENABER, JA)