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An ethico-legal study on delays of Road Accident Fund Assessments in a practice in SA



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Submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, in partial fulfilment of the requirements for the degree of Master of Science in Medicine in the field of Bioethics and Health Law.

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Acknowledgements

“They only live, who live for others, the rest are more dead than alive.”

- Swami Vivekananda

I would like to express my deepest gratitude to:

- my Divine Master, Bhagwan Sri Sathya Sai Baba for his grace and blessings;
- my Mother, Sherita, for her continuous love, motivation, support and encouragement;
- my late Father, Col Teddy Kommal for his love, care and dedicated self-discipline from which I have always learnt;
- my wife, Urvashi, for her continuous love, understanding, inputs, reviews and support;
- my brother and children, for their understanding and engagements;
- Professor Ames Dhai for her care, support, positive criticism, the long consultations and encouragement.

Dedication

I dedicate this research to my family and the vulnerable patients.

Most importantly, I dedicate this to my Mum and late Dad, who understand and are a part of the long journey. Their collective sacrifices and efforts that it took to complete and reach here will always be cherished.

Abstract

Road accidents affect both economically active members of our society and other citizens. Free markets, in particular, the private sector, do not address the impact of road accidents on society and the economy. The Road Accident Fund's (RAF) mission is to provide appropriate cover to all road users within the borders of South Africa; to rehabilitate persons injured; compensate for injuries or death; and indemnify wrongdoers as a result of motor vehicle accidents in a timely, caring and sustainable manner. RAF Act, allows for 120 days within which to decide on the outcomes of valid claims. As detailed in the RAF's Annual Reports and in various court judgements, this is not the case.

Mixed methods were used in this research, which included an ethico-legal normative and empirical components. The normative ethics and legal frameworks were discussed and analysed. Delays in assessments of the victims of road accidents were evaluated in terms of the normative principles of medical ethics, namely: Autonomy, Beneficence, Non-maleficence, Justice, and Ubuntu.

The empirical component was descriptive; quantitative and qualitative. The records of 385 patients from a practice, Ayush Healthcare, in Pretoria were analysed to ascertain the delays in their assessments and their primary injuries.

Most of the patients have suffered significant delays in their assessments, ranging from is 143 to 3898 working days. Tibia and fibula injuries were the most prevalent (16.62%), followed by head injuries (15.84%).

The resulting delays in assessments in the hands of the RAF and considerations of fair compensation have led to significant delays in accessing healthcare, treatment, rehabilitation, pain relief, financial compensation, and a disrespect of the four

principles of biomedical ethics, which are autonomy, beneficence, non-maleficence, and justice. Furthermore, Ubuntu was infringed upon, both from a community and self-realisation perspective.

List of Acronyms

AMA - American Medical Association

GNP - Gross national product

ICF - International Classification of Functioning, Disability and Health

PSA - Prostate-specific antigen

RAF - Road Accident Fund

RTA - Road traffic accidents

RTMC - Road Traffic Management Corporation

WHO - World Health Organisation

WPI - Whole person impairment

CT - Computer Tomograph

List of Statutes (Acts)

The Constitution of the Republic of South Africa, 1996

Road Accident Fund Act, Act 56 of 1996

National Health Act, Act 61 of 2003

Road Accident Fund Amendment Act, Act 19 of 2005

Contingency Fees Act, Act 66 of 1997

Interpretation Act, Act 33 of 1957

List of Case Law

Road Accident Fund v Duma, Road Accident Fund v Kubeka, Road Accident Fund v Meyer, Road Accident Fund v Mokoena (202/2012, 64/2012, 164/2012, 131/2012) [2012] ZASCA 169; [2013] 1 All SA 543 (SCA); 2013 (6) SA 9 (SCA) (27 November 2012)

Kwezi obo Kwezi v Road Accident Fund (6767/2008) [2011] ZAWCHC 455 (16 September 2011)

Daniels and Others v Road Accident Fund and Others (8853/2010) [2011] ZAWCHC 104 (28 April 2011)

Law Society of South Africa and Others v Minister for Transport and Another (CCT 38/10) [2010] ZACC 25; 2011 (1) SA 400 (CC)?; 2011 (2) BCLR 150 (CC) (25 November 2010)

Ntoi v Road Accident Fund (36977/2014) [2016] ZAGPPHC 1122 (2 December 2016)

Road Accident Fund v Mphirime (1036/2016) [2017] ZASCA 140 (2 October 2017)

Myhill NO obo T B v Road Accident Fund (2010/13353) [2019] ZAGPJHC 113 (27 March 2019)

Ronald Bobroff & Partners Inc v De La Guerre; South African Association of Personal Injury Lawyers v Minister of Justice and Constitutional Development (CCT 122/13 , CCT 123/13) [2014] ZACC 2; 2014 (3) SA 134 (CC); 2014 (4)

BCLR 430 (CC) (20 February 2014)

Law Society of the Northern Provinces v Bobroff and Others (20066/2016) [2017] ZAGPPHC 704; [2017] 4 All SA 85 (GP) (20 July 2017)

Aetna Insurance Co v Minister of Justice 1960 (3) SA 273 (A)

Road Accident Fund and Another v Mdeyide 2011 (1) BCLR 1 (CC)

Dichabe obo GN v Road Accident Fund (18770/16) [2020] ZAGPPHC 250 (15 June 2020)

Table of Contents

Acknowledgements ii

Dedication iii

Abstract iv

List of Acronyms vi

List of Statutes (Acts) vii

List of Case Law viii

Table of Tables xiv

Table of Figures xiv

Chapter 1: Introduction and Overview of the Study 1

1.1 Background Literature 1

1.2 The South African Context 2

1.3 Hypothesis 6

1.4 Problem Statement 6

1.5 Rationale 7

1.6 Research Aim and Objectives 7

1.7 Research Design 8

1.8 Overview of Methodology 8

1.9 Ethics 10

1.10 Limitations 10

1.11 Overview of Chapters 10

Chapter 2: Legal frameworks and Normative Ethics 12

2.1 Introduction 12

2.2 Introduction to the origin of motor vehicle accident legislation 16

2.3 Background to the current legislation..... 16

2.3.1 Liability of the RAF..... 18

2.3.2 The main areas of compensation..... 19

2.3.3 Overview of the procedures to claims against the RAF 19

2.3.4 How claims are lodged 21

2.3.5 Serious injury claims 22

2.3.6 The future medical expenses and the RAF section 17(4(a) undertaking 23

2.3.7 How claims are lodged 25

2.3.8 Compensation of legal practitioners 26

2.3.9 Claims against the RAF 26

2.4 Ethics and medicine..... 27

2.4.1 Medical ethics and bioethics..... 27

2.4.2 Bioethics - nature and problems..... 34

2.4.4 Principles of medical ethics 36

2.4.5 Autonomy 39

2.4.6 Why do people need respect for their autonomy? 42

2.4.7 Non-maleficence 44

2.4.8 The concept of damage 46

2.4.9 Rules justified by the no-damage principle 47

2.4.10 The criterion of proper care 47

2.4.11 Beneficence 48

2.4.12 The concept of beneficence 48

2.4.13 Ideal beneficence and obligatory beneficence 49

2.4.14 Justice..... 50

2.4.15 Ubuntu..... 61

2.5 Summary **63**

Chapter 3: The Empirical Component **64**

3.1 Introduction **64**

3.1.1 Empirical Component Methodology ***64***

3.2 Problem statement **64**

3.3 Rationale **65**

3.4. Research Aim and Objectives **65**

3.4.1 Study Aims ***65***

3.4.2 Study Objectives ***65***

3.4.3 Research Design ***65***

3.4.4 Population and Sample Size ***66***

3.5 Data Collection and Analysis **66**

3.6 Limitations **67**

3.7. Summary **67**

Chapter 4: Empirical Component: Results and discussion **68**

4.1 Introduction **68**

4.2 Descriptive Statistics **68**

4.3 Primary Injuries **71**

4.4 Regression analysis **79**

4.5 Employment status of the accident victim **82**

4.5.1 Discussion ***82***

4.6 Summary **90**

Chapter 5: Conclusion and Recommendations **91**

5.1 Introduction **91**

5.2 Overview of Study **91**

Autonomy ***91***

Beneficence ***92***

Non-maleficence ***92***

Justice ***93***

5.3 Recommendations **94**

References Error! Bookmark not defined.

Appendices **106**

1. Plagiarism Declaration ***113***

2. Turnitin Report Summary ***114***

Table of Tables

Table 4 1: Univariate analysis of the time period (working days) from date of accident to date of assessment (total = 385) 70
Table 4 2: Frequencies (n) (total n = 244) and the percentages of the injuries sustained (total = 385) 72
Table 4 3: Bivariate analysis relationship between the injury type and working days delay to the assessments detailing standard deviation and interquartile range 73
Table 4 4: Bivariate analysis relationship between the injury type and working days delay to the assessments detailing the median 74

Table of Figures

Figure 4 1: Bar graph of the time period (working days) from date of accident to date of assessment (total = 385) 70
Figure 4 2: Histogram of the time period (working days) from date of accident to date of assessment (total = 385) 71
Figure 4 3: Bivariate analysis relationship between the injury type and working days delay to the assessments detailing the median compared to the mean of each injury against the time period 75
Figure 4 4: Bivariate analysis detailing the median compared to the mean of each injury against the time period 76
Figure 4 5: Bivariate analysis detailing the median compared to the mean of each injury against the time period 77
Figure 4 6: Bivariate analysis detailing the median compared to the mean of each injury against the time period 77
Figure 4 7: Bivariate analysis detailing the median compared to the mean of each injury against the time period 78
Figure 4 8: Bivariate analysis detailing the median compared to the mean of each injury against the time period 78
Figure 4 9: Regression analysis of the time period of each injury for assessment when compared to the most common injury found: tibia/fibula 80
Figure 4 10: Analysis of the log of the outcome of the regression analysis 81

Chapter 1: Introduction and Overview of the Study

1.1 Background Literature

Recent studies have shown that road traffic injuries account for 2.1% of global mortality.[1] Developing countries bear a large share of the burden and account for about 85% of the deaths, as a result of road traffic crashes.[2] Every year, over 1.2 million people are killed, and about 20 million to 50 million are injured or disabled due to road traffic accidents (RTAs).[2] The economic cost of road traffic crashes is enormous. It is estimated they cost low-income and middle-income countries 1% to 1.5% of their gross national product (GNP) and high-income countries 2% of GNP.[3]

A conservative estimate of the global cost has been placed at US$ 518 billion per year with low-income and middle-income countries accounting for US$ 65 billion—more than they receive in development assistance.[3] However, economic costs are just the tip of the iceberg. For everyone killed, injured, or disabled by a road traffic crash, there are countless others deeply affected. Many families are driven deeper into poverty by the expenses of prolonged medical care, loss of a family breadwinner, or the added burden of caring for the disabled. [2, 5] According to the World Health Organisation (WHO), road traffic injuries are a major health problem.[2] Without appropriate action, by 2020, road traffic injuries are predicted to be the third-leading contributor to the global burden of disease ahead of other health problems, such as malaria, tuberculosis, and HIV/AIDS.[4]

The WHO annual World Health Day 2004 focused on road safety with the slogan

“Road Safety is No Accident”. At that event, the joint World Health Organisation/World Bank World reported on road traffic injury prevention was launched. That report emphasised the role of public health in the prevention of road traffic injuries.[2] The report called for a “systems approach” to road safety that looks at the system as a whole, and also the interaction between the three elements of the system—namely, the roads, vehicles, and road users to identify where there is potential for intervention. The systems approach recognises that humans make mistakes, and a safe road traffic system accommodates their weaknesses.[2,5]

1.2 The South African Context

According to the Road Accident Fund (RAF), road transportation is a critical element supporting and directly contributing to growth in any economy. Road accidents are, unfortunately, a negative consequence of this economic growth, affecting both economically active members of our society and other citizens. Free markets, and in particular, the private sector, do not address the impact of road accidents on society and the economy.[6] The RAF’s mission provides appropriate cover to all road users within the borders of South Africa; to rehabilitate persons injured; compensate for injuries or death; and indemnify wrongdoers as a result of motor vehicle accidents in a timely, caring and sustainable manner; and to support the safe use of our roads.[7]

The RAF is a juristic person established by an Act of Parliament, namely, the Road Accident Fund Act, 1996 (Act No. 56 of 1996), as amended.[8] In terms of section 3 of the Act, “the object of the Fund shall be the payment of compensation in accordance with this Act for loss or damage wrongfully caused by the negligent driving of a motor vehicle.” [8] Therefore, the customer base of the RAF comprises not only the South

African public but all foreigners within the borders of the country. The RAF provides two types of covers, namely personal insurance cover to accident victims or their families, and indemnity cover to wrongdoers.[7]

For a claim to be assessed by the RAF, a range of documentation needs to be submitted to the Fund for assessment of the claim. One vital part of these documents is the medical assessment, RAF Form 4, by medical practitioners trained in terms of the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment, Sixth Edition, using the Whole Person Impairment Rating System.[9] This assessment can only be done if requested by the claimant, the RAF, or the claimant's attorney. Historically, other healthcare practitioners like occupational therapists used to complete such assessments, despite being precluded from doing so, in terms of the RAF Act, and the regulations. Due to the lucrative nature of completing the required assessments, as prescribed in the RAF Act and regulations, many non-medical practitioners, who were healthcare practitioners like occupational therapists, had unlawfully completed the said assessments and prescribed forms. Those practitioners, like occupational therapists, have claimed that in their view, the Act had allowed them to complete such assessments. This was finally clarified and prescribed upon by the Supreme Court of Appeal in 2013 in the *Road Accident Fund v Duma and Three Related Cases* (Health Professions Council of South Africa as amicus curiae) [2013] 1 All SA 543 (SCA).[10] In the Duma judgement, the court found that only medical practitioners, trained in the prescribed processes and assessments, can complete the required assessments and complete the required forms. This as a definitive finding, precluding all non-medical practitioners from further acting outside of the prescribed processes.

Once that assessment is done, in terms of RAF Regulations, “the Fund or an agent must, within 120 days from the date on which the serious injury assessment report was sent by registered post or delivered by hand to the Fund or to the agent who in terms of section 8 must handle the claim, accept or reject the serious injury assessment report or direct that the third party submit himself or herself to a further assessment.” [10] However, as detailed in the RAF’s Annual Reports, as discussed below, and in various court judgements, this is not the case.

There are two routes via which claims are handled, direct and represented. The represented cases are cases in which the claimant has an appointed legal representative acting on his/her behalf, and the claims vary in length. However, on average, these cases are seldom settled in periods of less than one year, even if the medical assessment report is submitted timeously, due to legal processes and court dates. The direct claims are managed by the RAF itself, but the direct claims route may take longer than the represented route. Some of the direct claims assessed by me or my colleagues who worked for the company, and at my practice, were older than seven to eight years from the date of the initial lodgement.

According to the RAF Annual Report 2013/14, in July 2014, 232,285 claims from the Fund were still pending finalisations. These claims, according to the Fund, were estimated to be valued at in excess of R22 billion rand.[7] In July 2014, over 40% of the pending claims were older than three years, 13% between two to three years, 18% between one to two years, and 25% of the claims were less than a year old.[7] In other words, using the Fund’s own valuations, more R8.8 billion of compensation due to

claimants were still pending over three years later, and more than R 6.82 billion was still pending between one to three years. With such large delays in finalisations of claims, it appears that there are possible severe implications for RAF victims, both in terms of financial compensation and treatment compensation.

According to the RAF Annual Report of 2019, during the 2018 and 2019 financial year, 63,784 new claims were lodged against the RAF.[11] According to the annual report, 309,710 claims were open that were either pending compensation and or pending assessment.

There is limited data on the number of road accidents in South Africa as the Road Traffic Management Corporation (RTMC), had lost all road traffic data in 2012, and to date has not implemented a proven system to record road accident statistics. In terms of the South African and international published literature, there has not been a study of the delay periods of the assessments, and their implications, legally, medically, and ethically. There is also no published data to document the assessment and/or the delay periods, and settlement periods.

This study done at Ayush Healthcare was to ascertain the delays between accidents and medical assessments of victims of road accidents and the ethico-legal implications thereof, in a practice in South Africa.

Ayush Healthcare is a dedicated medico-legal practice and provides multidisciplinary assessment for RAF victims and medical negligence claims. The practice was established in 2013. The company employs a range of medical specialists on a

contract basis to provide expert assessments in their designated fields of speciality for the road accident victim. The company provides services to both claimants, known as plaintiffs and defendants' parties, which is usually the RAF. The company's assessment is independent of the instructing party in the assessment. Findings are provided to the court to assist in making appropriate findings and awards. The company has practices in Johannesburg, Pretoria, and Durban, and services clients from these regions. The practice in Pretoria, services Gauteng and the surrounding provinces.

A delay in finalising a claim in terms of section 17 of the RAF Act, is considered as any period exceeding the 120-day period for the RAF to either accept, reject or refer the findings in a claim. However, a delay in referring the claimant for any assessment, in terms of a direct claim remains undefined in the Act.

1.3 Hypothesis

Victims of road accidents are harmed because of delays in their assessments and compensation, which includes treatment compensation and financial compensation.

1.4 Problem Statement

The resulting delays in compensation lead to delayed access to healthcare, treatment, rehabilitation, pain relief, financial compensation, and a violation of the four principles of biomedical ethics, which are autonomy, beneficence, non-maleficence, and justice. In addition, several legal principles, including justice, access to healthcare, and dignity as espoused in the Constitution of the Republic of South Africa[12] and the National Health Act[13] are eroded.

1.5 Rationale

The rationale for carrying out this research project lies in the need to document the delays in assessments, which directly results in delays in compensation. Currently, no published data exist in the literature to document the delay periods and their ethico-legal implications.

1.6 Research Aim and Objectives

Study Aims

The aim of this study is to ascertain the delays between accidents and medical assessments of victims of road accidents and the ethico-legal implications thereof, in a practice in South Africa.

Study Objectives

The objectives of this study are as follows:

- To discuss the normative ethics and legal frameworks as pertinent to road accident victims.
- To critically analyse the implications of the delayed assessments of the road accident victims from an ethico-legal perspective.
- To determine the delay periods that exist between the road accident and the statutory medical assessments, for compensation and medical fees.
- To determine the types of injuries sustained in road accidents as assessed in 2013/14.

- To describe the employment status of the accident victim, and to document the assessment recommendations.

1.7 Research Design

The research follows a normative and descriptive research design, where methods applicable to philosophical research and empirical research are employed. Normative research as described by Daniel P Sulmasy and Jeremy Sugarman, “is the branch of philosophical or theological enquiry that sets out to give answers to the following questions: What ought to be done? What ought not to be done? What kinds of persons ought we strive to become?”. It involves interpretation and critical analysis of the study context, as well as the defense of new arguments, in a systematic and critical fashion while justifying answers that are offered.[14] In this research, the normative questions asked are: “Ought we address the concerns brought about by the delays in assessments and compensation?” The descriptive component is a retrospective record review using a quantitative study design.

Hence, this study employs mixed methods that include both normative and descriptive components.

1.8 Overview of Methodology

The normative component is based on desktop and library-based research. The typical research methods and standards applicable to philosophical research are employed. The discussions involve the ethical analysis of findings from the literature and primarily involves the interpretation and critical analysis of the most important texts, postings

and relevant government legislation in order to answer the research questions.

The analysis of the relevant texts includes the definition and clarification of concepts, as well as the identification and criticisms of assumptions. The theoretical frameworks are clarified and evaluated, and the most reasonable interpretation of significant concepts found in the sources are articulated. The sources of literature include, but not limited to, research articles, books, google scholar, PubMed, Government legislation and other academic search engines for gathering the research data.

The descriptive component employs typical qualitative methodology:

Sample: Existing clinical records and claim forms from the practice of Ayush Healthcare, of Road Accident claimants.

Sample size: Sample size calculations are based on the key research questions to be answered. In this case, the key outputs are the descriptive reporting of percentages. Based on an infinite (>20,000) population, the reporting of a 50% proportion for a given outcome (50% is the worst-case in terms of sample size estimation), 5% precision, and the 5% significance level, a sample size of 385 is required.

Data analysis: Descriptive analysis of the data will be carried out as follows: Categorical variables will be summarised by frequency and percentage tabulation and illustrated with bar charts. Continuous variables will be summarised by the mean, standard deviation, median and interquartile range, and their distribution illustrated with histograms.

1.9 Ethics

Ethical clearance for this study was obtained from the Human Research Ethics Committee (Medical) at the University of the Witwatersrand in October 2015. The clearance number is: M151025 (Annexure 1).

Consent was sought from the patients seen at Ayush Healthcare, to allow the accessing of their files and information for research purposes.

Identifiable data was initially collected to remove any duplication of the files and information. Once the data was collected and recorded in Appendix 2, it was anonymised by removing all identifiers.

1.10 Limitations

In terms of the available South African and international published literature, there has not been a similar study of the delay periods of the assessments, and their implications, legally, medically, and ethically.

There is also no published data to document the assessment and/or the delay periods, and settlement periods.

1.11 Overview of Chapters

Chapter 1: Introduction and Overview of the Study

In this chapter, the concepts of road accidents and road accident victims were introduced and defined specifically in the context of South Africa. The rationale, aim, objectives and hypothesis of the study were provided. An overview of the methodology, the reliability and validity, ethics and problems were also provided.

Chapter 2: Normative Ethics and legal analysis

In this chapter, normative ethics and legal frameworks are discussed and analysed. The methodology and the argumentative strategy of the normative component of the study are described. Delays in assessments of the victims of road accidents will also be evaluated in terms of the normative Principles of Medical Ethics, namely: Autonomy, Beneficence, Non-maleficence, Justice and Ubuntu.

Chapter 3:Empirical Component

This chapter describes the methodology of the empirical component. The research design, population sample, data collection and analysis methods are described. The description and results and the outcomes of the study are also provided and discussed.

Chapter 4: Empirical Component - Results and discussion

In this chapter, the results of the empirical component of the study - descriptive statistics and analytical results are provided. These results address the objectives of the study. In this chapter, the key findings and the meaning of the key findings are discussed.

Chapter 5: Conclusion and Recommendations

In this chapter, the study is summarised, and the key findings are highlighted. Recommendations for limiting and improving outcomes for road accident victims are discussed.

Chapter 2: Legal frameworks and Normative Ethics

In this chapter, normative ethics and the legal frameworks are discussed and analysed.

In the first part of this chapter, the legal framework and some relevant court decisions are reviewed and discussed. A limited body of literature exists on the legal frameworks and how the RAF works. However, a fairly large body of legal decisions exists and provides a basis for the present study.

This chapter will also provide a theoretical framework to understand how the legislators intended the claims process to work for the benefit of road accident victims.

2.1 Introduction

A study conducted with the Flemish and Brussels health data acknowledged that motor vehicles represent a larger risk for other road users and that disability is higher among vulnerable road users in collision accidents. Higher disability is as a result of a high proportion of head injuries in bicyclists and lower extremity injuries in motorcyclists in collision accidents.[15] Vulnerable Road Users (VRU) are people who are at risk in traffic due to the absence of an outside protective shield to absorb energy during a collision. They are mainly pedestrians, bicycle riders and motorcyclists. It has been noted that deaths of VRUs outnumber vehicular drivers and occupants, in low-income countries. [2,5,15]

In South Africa, no such data has been published to date. Since 2006, The RTMC

was responsible for maintaining a database of road accident statistics. However, in 2012, the RTMC reported that in spite of their efforts to develop a multimillion-rand data system, the system crashed, losing the data from the 1930s to 2012 as no backups were made. From 2012 to date, no data in terms of road accidents has been made available by the RTMC. The only available research from South Africa on road accidents is a study titled - Psychosocial correlates of the impact of RTAs among South African drivers and passengers[18] which is similar to a study done internationally.[19] However, these studies were limited to the psychosocial impacts of road accident victims and did not analyse the harms suffered by road accident victims from the medical, legal and ethical perspectives. There was no mention of the possible implications of the delays in the assessments, and the potential long terms psychosocial effects of the delays. It is important to note that early interventions in psychosocial needs of road accident victims could result in faster healing with less morbidity and mortality.

There are two types of RAF claims: direct claims and litigated claims. Both can be classified as complex. Direct claims are delayed due to inefficiencies at the RAF, and litigated cases are delayed due to lawyers wanting to maximise their contingency fees. As recorded by Slabbert, “It is sometimes alleged that some lawyers do not think twice before delaying a case unnecessarily, calling irrelevant witnesses, or litigating despite knowing that the litigation is without merit.”[19] This may be amongst the many reasons why the RAF claims settlements are being delayed. Notably, the Law Society’s Annual Report of 2010/11 stated that “Ethics does not in this age, form an essential part of the sword or shield of the majority of legal practices. Ethics is more likely to be slashed by the slick lawyer and

trodden upon to get to the loot." [19]

Courts have been critical of the RAF's handling claims expeditiously as can be seen in a judgement by Judge Binns-Ward, that there can, therefore be no doubting that the limitations of common law and constitutional rights arising out of the aforementioned provisions of the Act create an obligation on the Fund to diligently investigate claims submitted to it and to determine, if practically possible within 120 days of receipt of the claim, whether it is liable to compensate, and if so, in what amount.[20]

The court's position has also been clarified by Judge Binns-Ward when he cited the judgement of *Aetna Insurance Co v Minister of Justice* 1960 (3) SA 273 (A) —The Fund is obliged to conduct itself in this respect with due recognition that its very reason for existence is 'to give the greatest possible protection . . . to persons who have suffered loss through a negligent or unlawful act on the part of the driver or owner of a motor vehicle.' [20]

In the majority judgement of the Constitutional Court in *Road Accident Fund and Another v Mdeyide* 2011 (1) BCLR 1 (CC) (at para 78) it was affirmed that the Fund is - a hugely important public body which renders an indispensable service to vulnerable members of society.[21]

The importance of the RAF and its duties in the Act were echoed by the Constitutional Court when it was stated that the RAF should - "…properly be seen as part of the arsenal of the state in fulfilling its constitutional duty to protect the

security of the person of the public and in particular of victims of road accidents."[21]

In terms of the delays, Judge Binns-Wards noted that during the last decade the Fund has too often failed to perform in a manner consistent with the realisation of its object of rendering an indispensable service to vulnerable members of society. This has resulted in prejudice to third party claimants, is evident from the adverse remarks made in a significant number of superior court judgements given during that period. The Fund's management cannot be unaware of this criticism; in some matters, the courts concerned directed that copies of the judgement be sent to the Chief Executive Officer or the Chairperson of the Board. The sorry history suggests that the Fund has turned a deaf ear to repeated judicial enjoinders to comply properly with its statutory obligations, alternatively, that it is materially lacking in effective resources, and that insufficient has been done by the government to address the underlying cause or reason for such incapacity.[20]

The delays in assessments of the victims of road accident will also be evaluated in terms of the normative Principles of Medical Ethics, namely: Autonomy, Beneficence, Non - maleficence and Justice.[22]

The delays in the assessments and final compensation of the claimants have become apparent through the eyes of the Courts. However, although the courts have expressed their concerns regarding infringement of the rights of the claimants as victims, there has to date not been a study of both the ethical and legal implications of such delays. Since this "research is a systematic set of activities to obtain certain answers to questions, the uncertainty principle is integral to research.' [23] Therefore,

the empirical component of the study is necessary to first ascertain the delay periods between the accident and the medical assessments, and then the ethico-legal implications of such delays.

2.2 Introduction to the origin of motor vehicle accident legislation

The origin of motor vehicle accident legislation can be traced back to the 1939 Motor Vehicle Insurance Bill, which for the first time provided for compulsory insurance of motor vehicles in South Africa. After certain amendments, this Bill became an Act, namely the Motor Vehicle Insurance Act of 1942 and came into operation on 1 May 1946.

2.3 Background to the current legislation

The original RAF Act was promulgated in 1996.[24]

The Road Accident Fund Amendment Act 19 of 2005 [25] as is effective now and came into operation from 1 August 2008 with the applicable Road Accident Fund Regulations of 2008. The amendments apply to claims arising out of motor vehicle accidents occurring on or after 1 August 2008.

The primary objectives of the amendments were to:

- "to extend the powers of the Fund regarding the conclusion of agreements;
- to alter the financial year of the Fund;
- to make new provisions regarding the Board of the Fund;
- to further regulate the Fund's obligation to compensate a third party for non-pecuniary loss, for a certain hospital or medical expenses, and for loss of

income or support; to repeal certain provisions limiting the liability of the Fund to R25 000 regarding claims;

- to abolish certain common law claims;
- to make further provision for the prescription of certain claims;
- to substitute the provision authorising the Minister to make regulations."

The above are described in the Road Accident Fund Amendment Act 19 of 2005.

The law relating to motor vehicle accident claims is an interesting blend of the law of delict, the law of insurance, and "socio-economic" legislation.

Therefore, in terms of the amended RAF Act, the RAF itself:

- Substitutes the RAF for the common law wrongdoer.
- Guarantees payment of compensation to the victim who complies with the requirements of the Act in question.
- Affords protection for the wrongdoer.

The similarities between ordinary (voluntary) motor vehicle insurance and the RAF Act (compulsory) include:

- Payment of a "premium" by way of the fuel levy for RAF claims.
- A loss of the protection for the wrongdoer, by allowing a right of recourse, because of unlawful conduct by the wrongdoer such as drunken driving, driving without a licence or failing to co-operate with the RAF.

However, in insurance claims for motor vehicle damage, the victim sues the wrongdoer

and not the insurer, whereas claims in terms of the RAF Act for bodily injuries involving motor vehicles are brought against the RAF.

The socio-economic aspects of the legislation afford the victims the assurance of payment when the requirements of the legislation are fulfilled, but because of financial constraints, certain claims against the RAF are limited to amounts (capping) that are recoverable from the RAF. Under the current legislation, the victim's common law claim against the wrongdoer for damages suffered, over and above the amounts payable by the RAF, have been abolished. After the amendments of 1 August, 2008 to the RAF Act, the heading of section 21 reads "Abolition of certain common law claims." The common law wrongdoer may not be sued for damages as a result of somebody's personal injury or death after a road accident. The only exception lies in section 21(2)(b) that still allows claims against the common law wrongdoer with emotional shock injuries sustained by someone not physically involved in the road accident.

2.3.1 Liability of the RAF

The RAF's liability arises from section 17(1) of the Act as amended. Detailed prescribed processes of how the claim is to proceed arises from the regulations promulgated by the Minister of Transport in the Gazette.

The liability extends only to personal injuries sustained because of the driving of a motor vehicle by anyone and in any location within the Republic of South Africa on a public road. The legislation provides for claims wherein the driver is known, and what is colloquially called hit-and-run claims. Claims can be launched by drivers,

passengers, pedestrians, and family members of drivers, passengers, and pedestrians involved in motor vehicle accidents.

The RAF's liability is a fault-based system, which means that someone had to have been negligent or at fault for a claim to be accepted.

2.3.2 The main areas of compensation

The RAF in terms of the Act and regulations is liable to compensate, *inter alia*, for these three losses: all past and future medical costs; all past and future loss of income; and any loss of support claims.
The RAF is also specifically liable for non-pecuniary losses, also known as general damages, where injuries result in serious injuries.

In terms of future medical costs, where proven and accepted by the RAF, the RAF does not pay for future medical costs but issues section 17(4)(a) undertaking to pay for all future medical costs incurred.

In terms of the RAF Regulations as per the RAF Act, specifically for the medical costs claims, in terms of the undertakings, the claimants had to have incurred or will incur by proof of a quotation, specific medical costs by a third-party healthcare provider.

2.3.3 Overview of the procedures to claims against the RAF

Section 24 of the Act, prescribed processes to obtain compensation from the RAF.

A claim for compensation must be set out in the prescribed manner on the prescribed

claim form known as Form 1, which is an Annexure to the regulations to the RAF Act. The medical report is part of the Form 1 that must be completed in all its particulars and supporting vouchers, and statements must accompany the claim form.

The medical report section of the claim form should be completed by the medical practitioner (or superintendent of the provincial hospital) who first treated the deceased or injured person. This is done to ensure that the medical facts as per the medical records at the treating facility, are properly documented in the medical section of the RAF Form 1 claims form.

The Form 1 was amended from 1 August 2008.

Form 1 has to be sent by registered post or delivered by hand to any of the Fund's offices. The Fund is obliged in respect of a claim delivered by hand to acknowledge receipt at the time of delivery and in writing to acknowledge the date of such a receipt. The lodgement of the claim is the demand that the third party is obliged to make.

The RAF has 120 days from the date of lodgement to investigate the claim. The 120-day period from lodgement of the claim form is calculated according to the civil method of calculation. The third party has to wait for the 120-day period to expire before issuing and/or serving a summons via its legal representative for a claim unless the RAF repudiates the claim earlier.

According to the Act, no claim is enforceable legal proceedings commenced by a summons served on the Fund before the expiring of the 120 days from the date on which the claim was lodged, and before all the requirements of the RAF as set out in

section 19(f) of the RAF Act have been complied with.

Section 19(f), also stipulates that a claimant deposes to an affidavit detailing the circumstances of the claim. This is in addition to the submission of the claim form, the RAF Form 1.

The courts have found that a failure to comply with the requirements of the claims processes, can result in the claim and/or summons being repudiated.[26]

2.3.4 How claims are lodged

The writer hereof, between 2016 and 2018 was appointed as a member of the Board of the RAF. Therefore, the writer has personal experience and understanding of the mechanisms of the RAF.

In terms of practice, there are two systems for claiming:

Direct claims: this is where a claimant of sound mind and with legal capacity lodges a claim directly to the RAF. In direct claim matters, adults who lack legal capacity due to mental impairment, guardianship, etc., and minors, can have claims lodged on their behalf by their parents and all legal guardians.

In specific cases, where warranted, curators are appointed by the courts, lodge claims on behalf of the claimant. This is less common in direct claims, but is prevalent in represented claims, as the court processes are required to appoint a curator, and it is common that within the direct claims process, the claim is managed without legal

proceedings.

Represented claims: these are claims where in the claimant or their legal guardians, are represented by a law firm, who on their behalf lodges a claim against the RAF. Commonly the attorneys in these matters are assisted by advocates in the preparation of legal summons and the pursuance of legal claims by the court processes.

Summons for claims can only be issued and served after 120 days have expired, unless the RAF repudiates a claim within 120 days.

2.3.5 Serious injury claims

Serious injury claims against the RAF are defined in section 17(1A) of the Act the RAF Regulations.[27] Those serious claims in which a claimant and or their representative alleges that the claimant has sustained an injury and/or sequela thereof, which had resulted in impairment and/or disability, need to be specifically assessed.

Such impairment and/or disability, due to the injury and/or the sequelae thereof, which results in a whole person impairment (WPI) loss of 30% or more, is quantified utilising the AMA Guides to the Evaluation of Permanent Impairment Book, sixth edition,[28] as prescribed in terms of the RAF regulation 3(1)(b)(ii).[27] The AMA Guides is based on the WHO's International Classification of Functioning, Disability and Health (ICF).' [29] Such prescribed assessments, utilising the AMA guides, is a specialised skill in which various medical practitioners are trained to complete the required assessments and the required claim form, known as the RAF Form 4.

Prior to the amendment of the RAF Act in 2005, some law firms had utilised none healthcare medical practitioners to complete the RAF Form 4. In 2012, the Supreme Court of Appeal in a decisive judgement, also known as the *Road Accident Fund v Duma* (202/12) and three related cases (Health Professions Council of South Africa as Amicus Curiae), had addressed the matters that pertain to the abuses of the processes.[30]

The court had found that only medical practitioners may complete the required Form 4, after having completed a comprehensive medical assessment, and utilising the prescribed processes in terms of the AMA guides in terms of RAF Regulations section 3(1)(a) and the Form 4 as prescribed in RAF regulation 3(3)(a). Furthermore, in terms of regulation 3(3)(c), the claims for general damages proceed, only when the statutory medical assessment has been done. In terms of regulation 3(3)(d), if the RAF is not satisfied with the claimant's RAF Form 4 in any claim, the RAF may request that the claimant be seen by a designated medical practitioner, together with relevant specialists in the field.

This final assessment, as requested by the RAF, for both direct and representative claims that have been documented in this research. Hence, inferences and findings will be made from the timelines of the original claims being lodged to the date of assessment for the statutory medical assessment as requested by the RAF.

2.3.6 The future medical expenses and the RAF section 17(4(a) undertaking

There have been many claimants who elected and preferred to be paid out directly all proven and speculative future medical costs and related accommodation costs.

However, the courts, including the Supreme Court of Appeal, have repeatedly found that the undertaking provided by the RAF is prescribed in the legislation, and more than adequately provides for mechanisms within which a claim for future medical care and/or accommodation may be provided for.

In a landmark decision in 2017, the Supreme Court of Appeal in the *Road Accident Fund v Mphirime* matter [31], the court had found:

"And to that purpose, such provisions were put. Undertakings were given not only in respect of future hospital or medical expenses but also, for example, in respect of the services rendered by a curatrix bonis, and the appointment of an assistant to assist an injured farmer in his farming enterprise. This was done under the aegis that such an undertaking related to 'the rendering of a service' as envisaged in the relevant legislation. It is accepted by both sides that until 1 August 2008, the costs occasioned by an injured party employing a domestic assistant were capable of being dealt with in this way."

[8] Until then s 17(4)(a) of the Act had been in terms similar to those already mentioned, authorising the Fund to give an undertaking to the injured claimant in respect of 'the costs of the future accommodation… in a hospital or nursing home or treatment of or rendering of a service or supplying of goods …' However, on that date, section 6 of the Road Accident Fund Amendment Act 19 of 2005 came into effect. It amended section 17 to provide, *inter alia*, the following:

'17(4) Where a claim for compensation under subsection (1) —

(a) includes a claim for the costs of the future accommodation of any person in a hospital or nursing home or treatment of or rendering of a service or supplying of goods

to him or her, the Fund or an agent shall be entitled, after furnishing the third party concerned with an undertaking to that effect or a competent court has directed the Fund or an agent to furnish such undertaking, to compensate —

(i) the third party in respect of the said costs after the costs have been incurred and on proof thereof; or

(ii) the provider of such service or treatment directly. . .

in accordance with the tariff contemplated in subsection (4B);"

Despite the findings of the courts, in the above matter, relating to the undertakings for future medical costs, many claimants most often represented by law firms have attempted to seek upfront compensation for potential future medical costs.

In a similar matter to the Mphrime matter, in *Myhill NO obo T B v Road Accident Fund*[32] the claimant had to make an upfront payment. However, in keeping with the principles of the findings of the Supreme Court of Appeal in Mphrime, such a claim was dismissed.

2.3.7 How claims are lodged

In terms of practice, there are two systems for claiming:

Direct claims: this is where it claimant of sound mind and with legal capacity lodges a claim directly of the RAF. In direct claim matters, adults who lack legal capacity due

to mental impairment, guardianship etc.; as well as minors, can have claims lodged on their behalf by their parents and all legal guardians.

In specific cases, where warranted curators as appointed by the courts, large claims on behalf of the claimant. This is less common in direct claims, but is prevalent in represented claims, as the court processes are required for the appointment of a curator, and it is common that within the direct claims process the claim is managed without legal proceedings.

Represented claims: these are claims where in the claimant or their legal guardians, are represented by a law firm, who on their behalf lodges a claim against the RAF. Commonly the attorneys in these matters assisted by advocates in the preparation of legal summons and the pursuance of legal claims by the court processes.

As detailed above, summons for claims can only be issued and served after 120 days has expired, unless the RAF repudiates a claim within 120 days.

2.3.8 Compensation of legal practitioners

The terms of the contingency fees Act, Act 66 of 1997 section 2(2), a legal practitioner may not claim over 200% of their normal fees or 25% of the claim compensation, whichever is the lesser. For decades, this legislation has been abused to the detriment of the claimants and their families. Many disingenuous lawyers have attempted to circumvent the prescript of the legislation, but the courts, have found against them.[33,34]

2.3.9 Claims against the RAF

Outstanding claims against the RAF as detailed by the Minister of Transport in December 2019, documented an actuarial or contingent liability of R292 billion.[35] According to the Minister of Transport at the end of 2019, the RAF owed R17.2 billion on claims finalised, but no funds were available to pay those claims.

According to the 2018-2019 Annual Report of the RAF, there were 234, 244 outstanding claims that had been documented from previous years but had not been finalised. [36] During the 2018 and 2019 financial year, 63,784 new claims were lodged against the RAF. According to this annual report, 309,710 claims were open that were either pending compensation and or pending assessment.

2.4 Ethics and medicine

In this part of the chapter, a review of the normative aspects of ethics and bioethics is detailed. For completeness and understanding of bioethics as detailed in the four main topics of autonomy, beneficence, non-maleficence and justice; a background analysis of the evolution of ethics and more specifically, bioethics is provided.

2.4.1 Medical ethics and bioethics

Many known medical cultures have developed some form of ethical regulation applicable to people who provide help to sick members of the community. In Western culture, ethical standards addressed to doctors were most often created by the doctors themselves, who appreciated the ethical importance of health and disease and the risky nature of their activities.

This type of ethical regulation took three primary forms: prayers, oaths, and codes of ethics. The medical prayer was personal. In it, the doctor had declared his attachment to certain ethical ideals, and at the same time asked his God or gods for support in the risky endeavour of treatment: “God sanctify my efforts, lead them and guide them through the Holy Spirit, so that I can gain beneficial knowledge and apply it successfully in the art of healing. You are the Author and Source of the medicines that save you, and all healing comes from you.” [37]

Medical oaths are public declarations of attachment - to the medical condition or, less frequently, to society as a whole - to professional, ethical ideals. As membership in a professional group was originally a matter of choice, the oaths were voluntary. In the oath, a doctor undertakes to comply with the declared standards. The most famous of the oaths is the Hippocratic oath that is often taken before the start of practical medical work in South Africa.

According to some research, the authorship of the oath was probably adopted more than one hundred years after the death of Hippocrates.[38,39] The oath forms the basis of the Geneva Declaration adopted in 1948 by the 2nd General Session of the World Medical Association, and the Medical Oath that is part of the Code of Medical Ethics. Both prayers and medical oaths functioned in the context of virtue ethics, i.e. ethics based on the assumption that morally correct behaviour flows from the permanent acquired character traits of the acting person. Prayers and oaths did not catalogue the actions desired and undesired (and if they did, then rarely or incidentally), but instead referred to the virtues a doctor should possess. The emergence of the third form of ethical regulation in the form of code changed this situation to the extent that codes focus the recipient’s attention more on the types of actions (both desired and

undesired), and less on the character traits of a doctor.

Historically, the most recent forms taken by standards of medical ethics are codes of ethics. The first medical code of ethics by T. Percival was published in 1803.[40] Compared to oaths, the norms of the code are distinguished by further versatility, that is regulating the broadest possible range of activities of a member of a professional group.[41,42] Another characteristic feature of medical codes is that they contain a catalogue of forbidden and ordered (sometimes also permitted) acts. Codex orders and prohibitions express instructions regarding proper conduct by assigning certain types of situations to selected types of conduct. The role of a physician is to apply the norms of the code, that is to recognise in professional practice the circumstances or problems covered by a given norm, and then act under that norm.

In the twentieth century, and especially in its second half, technological and socio-political changes took place that made medical ethics gain a new context. This was in the form of bioethics, understood as an interdisciplinary field of theoretical knowledge - using the findings and research methods of, e.g. philosophy, theology, psychology, jurisprudence, sociology, natural and medical sciences, and social practice. [43,44] These subjects are the moral, legal, socio-cultural and political aspects of biological and medical knowledge, the process of obtaining it, and the possible and real impact of applying this knowledge on individuals, society and the natural environment and its components. [45] The name of this new discipline was created around 1970. V.R. Potter published *Bioethics, the Science of Survival* [46,47]; independently of it, the word was coined by a group of researchers from Georgetown University, led by A. Hellegers.[48]

Potter and Hellegers, however, gave the word different meanings.

Unlike bioethics in Potter's broad sense that had encompassed medical, biological, ecological, population, or social issues, Hellegers understood bioethics more narrowly. In his view, bioethics concerned ethical problems in the diagnosis and treatment of humans, and medical research on humans. That narrower understanding of bioethics constituted a new paradigm for ethical reflection on medicine. It also created a context for the improved understanding of how decisions and ethical decisions are made differently, both at the regulatory level and at the level of decisions at the patient's bedside. Bioethics, as an interdisciplinary field of theoretical knowledge and social practice, examines the standards of scientific research and diagnostic-therapeutic conduct and creates a context for medical ethics, appropriate for a pluralist democratic society based on respect for human rights.

Macro events also had a direct influence on the accelerated development of medical or bioethics. After World War II, there had been a rapid development of research in the field of life sciences, but the memory of inhuman experiments that the Nazis conducted on prisoners of concentration camps were still fresh. The justification of the judgement of the Nuremberg Tribunal (1946–1947) contained ten principles for experimenting on humans, called the Nuremberg Code[49], which was the first international set of ethical standards for scientific research. The memory of the cruel experiments prompted the creation of such regulatory documents as the World Medical Association resolution "Principles for persons conducting research and experiments" (1954)[50] and the Helsinki Declaration (1964).

In 1979, the National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research published The Belmont Report, which contained the fundamental ethical principles of conducting medical research on humans: respect for the person, acting to benefit the individual and justice.[51,52] Advances in biomedical research resulted in unprecedented advances in medical technologies, symbolised by the first heart transplant in 1967 (criteria for determining death based on irreversible brain cessation were soon developed).[53]

New ethical problems, noticed by wider and broader society, fell on the fertile ground of the spreading democratic ideals in Western countries. Attachment to these ideals encouraged open reporting of claims and expectations of potential and real patients or participants in biomedical research in spheres far beyond political life. One fruit of these changes was the 1973 American Hospital Association A Patient's Bill of Rights, which granted patients the right to consent (or refuse consent) to the proposed health service and the right to information about the patient's health status, available treatments and prognosis.[54] The unprecedented access to effective medicine was made possible after World War II by health insurance that was popular in the USA, and public health care systems established in European countries also contributed to include subsequent members of society in the reflection on ethics in medicine. Along with the growing multiculturalism of these societies and the deepening of philosophical and religious differences, the need for public discussion on ethical standards addressed to medical professionals grew. [55]

The development at the time, and the change in thinking and detailed reformulation of the reflection on medical ethics, was expressed in perhaps the most popular textbook of medical ethics by T. Beauchamp and J. Childress, *Principles of Biomedical Ethics* (1979).[56]

That manual proposed modified principles from The Belmont Report: respect for autonomy, no harm, benefit, fairness. Those rules are not merely new rules of medical ethics, nor are they rules of conduct. Unlike the traditional views known from prayers and oaths, Beauchamp and Childress did not propose virtue ethics in the first edition of the book. Unlike the codes of medical ethics, they did not provide a catalogue of do's and don'ts addressed to doctors. The Beauchamp and Childress Handbook offers a fundamentally changed view both on medical ethics and on medical ethics in general and medical ethics and on ethical consideration in medicine.

The four principles of Beauchamp and Childress primarily served to organise ethical reflection. They do not indicate what kind of action should be taken in certain types of situations, but what aspects of a specific situation should be highlighted, and thus, which values need protection. They are less likely to recommend what to do and more to help determine how to reach an informed opinion that will be the basis for a doctor's conduct in specific circumstances.[57]

The four principles are rules of reflection on a specific situation and the values involved in it, not orders of specific behaviour. Many decisions obtained in this process may be

consistent with traditional Principles of Medical Ethics, such as the obligation to maintain medical confidentiality. Physician involvement in the decision-making process differs from the traditional approach to medical ethics, and the need to consider many reasons for a specific decision. Thus, an appropriate bioethics approach to ethical issues in medicine requires a doctor to have competencies not needed to such an extent by traditional medical ethics - the ability to reflect on a specific ethical problem independently and to take responsibility for his own decisions. The general ethical directives formulated in the framework of the bioethics paradigm encourage the physician to weigh various values instead of obeying abstract rules from which normative consequences concerning specific circumstances are derived. Although at the beginning of developing bioethics, the patient's autonomy seemed to have a significant priority over other values, over time (as evidenced by the changes introduced in subsequent editions of the Principles of Medical Ethics), other values have gained importance. In bioethics, ethical values are subject to mutual balancing, limitation, and correction that can be seen in the theoretical assumptions and practice of clinical ethical consultations.[57]

Based on bioethics, decision-making is understood as involving various values, and not as merely the implementation of this or that directive. This context takes two forms. At the level of individual clinical decisions, the priorities inpatient care is not decided by the physicians themselves. However, they set them in the process of negotiating priorities and plans for managing patients, and sometimes - if necessary - with other people involved in specific cases. At the level of social and health policy or regulatory solutions, the context of explicit norms of medical ethics is the values and ideals of a democratic society. In the context of bioethics, medical ethics is, therefore, a derivative of democratic values and ideals, and compliance with its directives expresses respect

for these values and ideals in practice.

2.4.2 Bioethics - nature and problems

The word ‘bioethics’, as it stands today, has been around for a short time. Its authors are those researchers who, according to the existing accounts[58], had coined it independently and gave it different meanings - V.R. Potter, and a group of scientists associated with A. Hellegers. These two understandings of bioethics constitute its broad and narrow concept. The broad understanding is related to Potter’s concept, while the narrow one - to Hellegers. Both were built in 1970–1971.

In 1970, V.R. Potter, a professor of oncology at the University of Wisconsin in Madison, published the article *Bioethics, the Science of Survival*, and a year later he had published *Bioethics: Bridge to the Future*[59] In those studies, Potter constructed the understanding of bioethics in a broad sense, as a scientific field using research knowledge in the field of biology. Knowledge of value systems define fundamental problems related to scientific, technological and civilisation changes that pose threats to the survival of the human species and human societies as we know it and for a quality of life that would be acceptable to them. The research discipline awarded by Potter provided solutions to these problems based on various areas of research and practice, such as clinical medicine and medical research, regulatory issues concerning, *inter alia*, population issues, the relationship between man and the natural environment and its components. Bioethics, as understood by Potter, was therefore, interdisciplinary by nature, combining research in the field of natural and social sciences with the humanities, including philosophy. Potter hoped that research of this

kind would allow a man to consciously and responsibly shape scientific progress and social life.

Potter's vision of bioethics in that broad sense is now being realised in the form of diverse research. The most important thematic areas of bioethics understood in this way, including research in the field of clinical ethics, the subject of which is the ethical aspects of dealing with patients and relations between healthcare providers and patients; ethics of scientific research and ethical aspects of the integrity of science; research on moral status animals and the ethical relationship of humans to them (often referred to as animal rights ethics), for example, in agriculture, in research, or breeding for food or entertainment purposes the ethics of human relations to the environment as a whole (often referred to as environmental ethics or environmental ethics), and its components, such as animal or plant species or ecosystems.

Bioethics, in a broad sense, also considers the individual and social perspective. In the latter approach, a special place belongs to regulatory bioethics, the subject of which is the ethical aspects of civilisation and population changes, and the actions of public authorities aimed at improving or maintaining the well-being of citizens. This perspective is important for the legal sciences as it provides analytical material and normative proposals.

The second, narrow understanding of bioethics is associated with the creation in 1971, thanks to funds from the Kennedy family, of The Kennedy Institute of Ethics, which was initially called The Joseph and Rose Kennedy Institute for the Study of Human Reproduction and Bioethics. Its first director A. Challengers, an Obstetrician and lecturer in embryo physiology and his colleagues at Georgetown University understood bioethics as a discipline whose primary focus is clinical medicine and

medical research involving human participation.[60] As the first name of the Institute had indicated, issues related to human reproduction were also of crucial importance to the researchers around Hellegers. Therefore, the understanding of bioethics was also associated with human 'survival', but in terms of medicine and research involving humans. It differs from bioethics in a broad sense from the scope of the issues studied, including clinical and research ethics and ethical aspects of the integrity of science. The word bioethics, understood in this way, is also most often used today in the field of social sciences and legal sciences, although the broad meaning of this term frequently appears in the literature on the subject.

2.4.4 Principles of medical ethics

The basic Principles of Medical Ethics were formulated as basic bioethical principles by Canadian authors, T. L. Beauchamp and J. F. Childress (Principles of biomedical ethics).[61] They are presented in a different order, differently hierarchical. Recognising that *"Salus aegroti suprema lex"* and that for the doctor, life and health are the highest good. The principle of doing good and beneficence is first. Next is the principle of non-harm, the principle of respect for autonomy, and the principle of justice.

The order of these basic principles adopted by the American and European medical bodies record that non-harm is not directly distinct.[62,63] The principle of non-harm has not been distinguished, perhaps considering that it falls within the principle of the superiority of the patient's good, which principle is listed first.

Each basic principle applies to restrictions resulting from the other three. In implementing the principle of doing good, we must consider the principle of non-harm (minimising harm), without forgetting about respect for the patient, his autonomy and

the requirement of justice, similarly with other rules.

The requirement to do good is closely related to the medical profession and concerns the doctor-patient relationship. Good here means health, doing good means counteracting evil: suffering, illness and disability. No one, like the doctor, is required of universal altruism, generalised to all - not just my patients, and even to all potential patients, those who may become patients. One can fall into the trap of paternalism when the doctor sees the good of the patient in his way, appoints himself as an expert in good (and not only in diagnostics, therapy, prevention and promotion of health) and does not consider the choices and decisions of the patient.[64]

The principle of non-harm is like the reverse of the principle of doing good. *"Non nocere"* is a universal, obligatory requirement - as a minimum ethical: "at least not hurt" every human being. In the medical profession, this is a secondary principle, subordinated to the requirement of doing good and respect for autonomy and justice. Treatment must be - if not necessarily pain and at least temporarily limited in activity - with the risk of unpleasant sensations and adverse consequences, and therefore, some kind of "harm." It is necessary to balance the expected benefits and losses, and a well-informed patient must be involved in making decisions. Consistent implementation of the *"primum non nocere"* that means "first, do no harm" principle, would lead to therapeutic negativity and limit diagnostic activities because any measure and method that helps can also harm, and many diagnostic procedures are associated with a lower or higher risk.[65]

The principle of respect for autonomy means respect for the patient's dignity, subjective treatment of the patient, the need to obtain his consent for all actions that

affect him, after being adequately informed. This principle limits medical paternalism to the necessary minimum and replaces it with a partner relationship. Respect for autonomy is respect for freedom recognised as a fundamental human right. This implies the order of truthful, comprehensible and tactful information, the requirement of confidentiality and the prohibition of “making happy” by force, acting without consent or against the will of the sick person (except in cases where the proceedings are authorised).[66]

The principle of justice primarily concerns the proper distribution of limited resources. These four basic bioethical principles can be supplemented with others, which usually can be reduced to those or derived from them (information, consent, secrecy, respect for privacy and others). In addition to the basic principles, the principle of trust and the principle of non-value are of particular practical importance.[67]

The principle of trust applies to the mutual relations between the doctor and the patient. For the proper course of the treatment process, it is necessary for the patient to trust the doctor and for the doctor to trust the patient. Such trust is indispensable for implementing the partnership when the doctor advises competently, and the patient decides freely and consciously.

The principle of non-value means a ban on making, or rather disclosing any moral assessments of the patient. The doctor has no right to assess (especially to condemn) the patient, to decide how and to what extent, he is guilty of his illness (because it is different to determine the cause and to assign blame). The doctor may not put moral censors on the patient and refuse to help the patient when such a refusal would result from a negative assessment of the patient’s behaviour. Respecting the patient’s beliefs and value system, the physician should not indoctrinate him, but may and should,

through competent medical information, enable the patient to make his own autonomous choice.

2.4.5 Autonomy

The principle of respecting the autonomous choices of other people is as deeply rooted in common morality like no other. However, not all agree on its nature and power.

The word autonomy is derived from the Greek autos (“independent”) and nomos (“rule”, “government”, “law”). It was first used to refer to the independent government of the free Hellenic city-states. Since then, the term “autonomy” has expanded to include individuals.

Autonomy in this sense means the independence of an individual, both from the coercion of others, and from internal constraints preventing real choice. An example may be the lack of adequate comprehension [68,69] the government exercises power over territory and conducts its own policy. A person with reduced autonomy is, at least, to some extent, subject to pressure from other people or unable to think or act according to his desires or previous plans. People locked up in institutions, such as prisoners or communities, often lack full autonomy. Mental limitations reduce the autonomy of the retarded, while forced imprisonment limits the autonomy of prisoners. All theories of autonomy share the belief that one can speak of autonomy when two conditions are met:

freedom (independence from controlling factors), and
spontaneous action (ability to act intentionally).

Disputes arise only in the context of the interpretation of these conditions and the question of whether there is a need for additional restrictions.[70,71]

Some theories of autonomy focus their considerations on autonomous persons, meaning individuals endowed with the abilities needed to exercise self-control - understanding, thinking, considering, independent choice, etc. Even an autonomous person, equipped with the abilities needed to exercise this power is not always able to exercise it. It may happen that his/her choices are influenced by time limitations due to illness, depression, ignorance, coercion, restrictions. However, an autonomous person who signs consent for a medical intervention does not act autonomously if, before signing the form, he or she has not read it or has read it, but did not understand it. It may also happen that non-autonomous people will sometimes find themselves in an autonomous choice.

Sometimes it is demanded that both autonomous persons and activities be made more stringent. Some theories demand that an autonomous person show extraordinary authenticity, self-control, consistency, independence, internal discipline and resistance to the promptings of authorities. There was also a requirement that the person described as autonomous should make people aware of herself and accepted in every reason justifying her action.[72] The difficulty faced by all theories of autonomy, making such exorbitant demands, including the theory of double-order desire, is that most people and actions cannot be considered autonomous. Autonomy becomes an unattainable ideal. And one cannot accept any theory that requires what is impossible for ordinary decision-makers

Autonomous action is an action taken by anyone who:

acts intentionally;

with understanding; and

without the influence of external factors determining his actions.

The first condition is not gradual. Actions are intentional or unintentional. On the other hand, the other two conditions - understanding and the absence of factors determining action - can be met to a greater or lesser degree. It follows that the autonomy of actions, depending on the fulfilment of the above conditions, is also a matter of degree. The scope for actions covered by the aforementioned conditions is spread over a scale from non-autonomous to completely autonomous. The ability to understand or independence from external pressures may not be achievable to a large extent, e.g. by children and the elderly.[73,74] Thus, we need not assume that the conditions for autonomy are a complete understanding of the situation and the absence of any external stimulus.

The answer to the question of when actions are sufficiently autonomous, and when not sufficiently, is often arbitrary. Being autonomous differs from being respected as an autonomous person. Respecting someone else's autonomy implies, at the very least, recognising the right of the individual to hold views, make choices, and act in accordance with his values and beliefs. Therefore, respect for autonomy is expressed in proper conduct, and not only in the right attitude. It involves more than just the obligations of not interfering with other people's affairs. It also requires maintaining one's ability to make autonomous choices, overcome fear and other obstacles that destroy and undermine one's autonomy. So, respect is about treating other people in a way that would make them act autonomously. Disrespect for autonomy is expressed in attitudes and actions that ignore, insult and degrade the autonomy of others, thus

denying them minimum equality.

2.4.6 Why do people need respect for their autonomy?

Leading views on contemporary interpretations can be attributed to two philosophers, Immanuel Kant and John Stuart Mill. Kant argued that respect for autonomy comes from recognising that people are valuable in themselves because they can manage their fate.[75] Persons are ends in themselves and must not be treated as a means. They will be treated as a means when we impose on them someone else's will, without respecting their own plans. Mill was interested in the autonomy, or as he preferred to say, the individuality of the people who run their lives. He argued that citizens should be allowed to live up to their convictions if they did not violate the analogous right to freedom of others. Mill also believed that we are sometimes obligated to convince others of the falsehood or harmfulness of others views.[76] Mill assumed that expression of respect for autonomy should be the non-violation of someone's freedom and its positive reinforcement, while Kant emphasised that the moral imperative of recognising someone's autonomy requires us to treat persons as ends, not as means. Ultimately, the principle of respect for autonomy gains the support of philosophies as diverse as Kantism and Utilitarianism.

The principle of autonomy in its negative form can be formulated as follows: autonomous actions should not be subject to pressure from others.

Respect for autonomy, thus has the status of a prima facie principle and may be dominated by other moral reasons. A typical example is situations in which our

autonomy is limited because the decisions, we make would jeopardise public health, harm the innocent, or require too many financial resources in relation to our possibilities. The justification for restricting our right to autonomy must refer to a more important, dominant principle. The principle of respect for autonomy does not, by itself, determine how much information we should convey to the patient, what is the limit of his freedom, or what reasons justify the waiver of autonomy.

Several accusations have recently been raised against contemporary concepts of autonomy in medical ethics that can be reduced to the remark that autonomy is not the only value, and respect for autonomy - the only moral imperative.[77,78,79] The authors of these accusations rightly emphasise that in many decisions taken in medicine, are not so much about respecting autonomy as about maintaining the capacity for autonomy and a meaningful life. The concern for autonomy is often less than the need for compassion and kindness. These accusations are valid only regarding those ethical theories which interpret the principle of autonomy extremely narrowly, or they treat it as an absolute principle or the highest in the hierarchy of all principles. Although this principle should be considered a safe-conduct, authorising the exercise of the right to manage one’s own life, it cannot be regarded as the only source of moral rights and obligations.

Respect for autonomy obliges healthcare professionals to disclose information, check that the patient understands it, and determine if it is acting voluntarily. Healthcare professionals also need to ensure that the patient makes the right decisions. As some modern Kantists believe, in demanding that we treat others as targets, it is not just a matter of not using them as a means. We should help them in achieving the goals they set themselves in life and care for those qualities that make them capable of self-

fulfilling brave choices.[80]

Autonomy is not, as some of its critics have suggested[77,81], neither an antidote to the paternalistic attitude of doctors nor a reason that justifies not taking care of difficult patients. On the contrary, the negative and positive aspect of the principle indicates that respect for others must go hand in hand with efforts to strengthen and pursue their subjective interests.[82]

2.4.7 Non-maleficence

The principle of no harm expresses the duty of intentionally not harming. In medical ethics, it was usually associated with the maxim *primum non nocere* ("first of all, do no harm").

The difference between not doing harm and doing good.

The principle of non-maleficence is recognised by many researchers of the philosophy of morality - both utilitarian and non-utilitarian views [83,84]. Some philosophers consider non-abuse and charity to be two aspects of the same principle.
William Frankena, for example, breaks down the principle of charity into four primary duties, the first of which can be described as the duty not to harm, and the next three - as the duty to do good:

1. There should be no evil or harm (which is evil) done.
2. Evil or harm should be prevented.
3. Evil or harm should be eliminated.
4. Good should increase [85]

Franken orders these principles as follows: in the event of a conflict, if the *caeteris paribus* meaning “all other things being equal” condition is met, the first duty is superior to the second, the second to the third, and the third to the fourth.

If it is considered that no harm and to do good as two components of the same principle, one ought to follow the Franken path and break the principle down into many different responsibilities.

Though non-maleficence and benevolence are similar, and moral philosophy considers them almost indistinguishable, blending them obscures the picture. Obligations not to harm others (e.g. not to steal, harm or kill someone) can be distinguished from obligations to help others (providing benefits, protecting someone’s interests or increasing good). Obligations to do no harm sometimes turn out to be stronger than obligations to help, and sometimes the opposite is true, and charity obligations prevail over obligations of no harm. Some generally believe that the duty not to harm someone is superior to the duty to save someone’s life. However, the obligation not to expose the people involved in the experiment to a minimal risk is not as strong as the obligation to save those who agreed to the experimental treatment and then found themselves in grave danger. If, in individual cases, the expected harm is small (e.g. swelling after injection) and the benefit from assisting is very large (e.g. saving a life), clearly the duty of charity should be prioritised over the duty not to harm.

The view that the principle of no harm is superior seems to be convincing, especially where doing good leads to some evil. While non-abuse is generally the most potent duty, balancing these two principles, and all moral principles, is different in different situations. There is no a priori rule that credibly prioritises the principle of no harm over the principle of charity.

It is also difficult to agree with Franken's view that the rules one to four are arranged in a significant order. Refraining from helping someone (e.g. by failing to do good or preventing or eliminating harm) can be as morally wrong as harming someone.

The harm in the form of shortening someone's life can, for example, can be caused either acting and by injecting a fatal medicine in the test; or by taking no action to assist and not connecting someone where needed to a respirator. The only difference is that sometimes we do harm, and sometimes we refrain from helping. However, this difference is morally insignificant. Thus, in my view, there are no moral differences between the four duties mentioned by Frankena, and no hierarchy can be established between them.

2.4.8 The concept of damage

Non-damage is usually defined using the terms "injury" or "harm". Injury refers to some kind of harm; it is associated with injustice, violation of rights, wrongdoing, etc.
One can feel wronged by disease, God outrage, bad fate, while not being convinced that someone has acted unfairly towards us. Conversely, one should be aware that one has been unfairly treated, although one has not been harmed, e.g. when one accidentally profits from the fact that someone did not provide the promised information. [86]

"Harm", like conscientious objection refers to the threat, frustration, and frustration of the plans of a person that can be as a result of his or her inappropriate actions; or as a result of intentional or unintended actions of other people.

Some definitions of harm are inclusive and include damage to reputation, violation of

property, privacy, and freedom. Within the framework of this concept, minor damage can be distinguished from the magnitude of the different importance we attach to particular interests. In other, narrower definitions, the harm is understood in medical and psychological terms as violating the values of health and life.

2.4.9 Rules justified by the no-damage principle

Since there are many types of damage, many detailed moral rules are supported on the principle of non-maleficence (although other principles also play a role in their justification). These rules include[87]:

l. Do not kill.

2. Do not cause pain or suffering to others.

3. Do not hurt others.

4. Do not offend others.

5. Do not deprive other goods of life.

Both the discussed principle and the above details are not absolute, but *prima facie*. As already mentioned, some philosophers adopt an ordering principle that proclaims the supremacy of rules and rules forbidding and similar attempts to build a hierarchy of principals.[88]

2.4.10 The criterion of proper care

It follows from the duty of no harm that we should not cause or expose harm. Someone may hurt someone or exposes them unintentionally, without malicious intent. Sometimes we do not hold the perpetrator of a misfortune legally or morally

responsible. Someone may be causing some misfortune which he did not want to cause, or was not even aware that he caused it. Neglecting or disregarding the criteria of proper care for others leads to deliberately exposing them to unreasonable risks or to unintentionally but recklessly exposing them to their safety. The term “neglect” refers to various forms of non-compliance, including failure to deal with the risk that individual actions they carry for others.[89]

2.4.11 Beneficence

Morality requires us not only to treat people autonomously and not to harm them but also to do good for them. This is known as “beneficence.” It is believed that there is no gap between doing harm and doing good: they are simply two poles in pursuing someone else's interest. However, the principle of beneficence potentially requires more from us than the principle of no harm. The word “no harm” is sometimes understood more broadly. It then covers not only the prevention of damage but also the removal of its effects. However, both the first and the second action require positive steps to be taken to benefit others, and in so doing, falls into beneficence rather than not harming.

Positive beneficence requires acting to benefit someone else. The utility requires us to weigh the gains and losses. Both principles must be distinguished from the virtue of beneficence and from various forms of caring or the over-obligatory ideal of showing kindness.

2.4.12 The concept of beneficence

In everyday language, the word “beneficence” means showing mercy, kindness and help. Altruism, beneficence and humanitarian action are also considered its characters. It is any action undertaken to do good to another, while goodness is a character trait or virtue consisting in the disposition to do good to others. The moral obligation to do good to others is expressed in the principle of beneficence. However, the principle of beneficence imposes on us the obligation to help others in the realisation of their vital and legitimate interests.

Beneficence and kindness played the most critical roles in specific ethical theories. Utilitarianism, for example, consciously reduces everything to the principle of benevolence (utility). The principle of utility understood in this way is not identical to the principle expressed in classical Utilitarianism, where it functions as the highest and absolute norm. Our principle should not be treated as the only one, nor as the highest in the hierarchy of principles. It is just one of many prima facie principles. Its scope is limited to balancing profits, risk and costs, i.e. estimating the usefulness of the effects of our actions, without giving it the role of an arbiter in balancing moral obligations.
The principle of utility (also known as the proportionality principle) is often accused of justifying the violation of the rights of individuals in the name of the interests of the majority. Human experiments may be justified if the resulting social benefit outweighs the risk incurred by the subjects. Undoubtedly, the recognition of the unlimited power of utility calculus leads to danger.

2.4.13 Ideal beneficence and obligatory beneficence

The most famous example of beneficence is the action of the merciful Samaritan Nino in the New Testament. In a well-known parable, a certain man, travelling from

Jerozolima to Jericho, was attacked by bandits, robbed and left “half-dead.” Two travellers passed by and did not help him. The third, a Samaritan, upon seeing him “was deeply moved [...] he bandaged his wounds, pouring oil and wine over them; then he put him on his livestock and brought him to an inn and nurtured him” (Luke 10: 33-35). Showing compassion and mercy, the good Samaritan took a protective attitude towards the wounded man and then took care of him. Both his motives and his actions were reasonable. However, the parable suggests that positive beneficence is an ideal rather than a duty since the Samaritan's act went beyond accepted standards.

The provision of good sometimes becomes a glorious ideal beyond moral obligations, and sometimes it must be waived in the name of another duty. Should we always be charitable? In answering this question, let’s consider that the actions of the person have a vital function in the moral life, whether we consider them an obligation or an ideal. However, no one can deny that many such acts, such as donating a kidney to a stranger, are morally commendable although not obligatory. Everyone will also agree that it would be difficult to find a principle of beneficence in the morality that would require great sacrifice and extraordinary altruism. Nobody is asking anyone to donate both of their kidneys for transplant. Such an unusual concept of generosity can only derive from the ideal of beneficence. We are also under no obligation to act in favour of others in every situation.

2.4.14 Justice

2.1.14.1 Justice concept

Various philosophers have attempted to explain the essence of justice using terms,

such as impartiality, merit, and entitlement.[90,91,92] These theories link justice to the fair, equal, or proper treatment of people for what we owe them or what is owed them. We speak of justice when someone deserves some good or evil due to their characteristics or circumstances in which they found themselves, e.g. they created some good or were hurt by someone. Anyone who makes an equitable claim may do so and is, therefore, entitled to what is requested. Injustice consists of committing an unjust deed or failure to act, as a result of which someone loses what he has a right to or gains what is not due to him. [91,92]

The term “distributive justice” refers to the fair, equitable, and appropriate distribution in a society characterised by legal norms that organise the conditions of social interaction. This concept encompasses strategies for distributing profits and obligations as diverse as property, resources, taxes, privileges, and opportunities. Different institutions are involved in dividing, such as the government or the health care system. Nevertheless, the term “distributive justice” is sometimes used in a broader sense, encompassing the allocation of all rights and responsibilities in society, including civil and political rights, such as voting and voting rights—freedom of expression. Distributive justice is generally distinguished from other justices, including retributive justice, meaning the fair distribution of penalties, usually performed in the context of criminal law, and restorative justice, relating to the establishment of compensation for damages caused in transactions, e.g. for breach of contract or improper treatment. We make this division in the context of civil law.

Distributive justice issues arise when there are fewer goods than candidates who strive for them. If, for example, there was enough water to melt industrial waste in it with no harm to people and other living creatures, there would be no need to limit its use. Only

when drinking water reserves are at risk, and the polluters are ruining the health of the population or destroying the natural environment must we ration the water. Similarly, in the health service, much debate revolves around the issue of whether, in the name of justice, it is worth investing in expensive health support programmes, care for the mentally disabled, and state health insurance.

The frightening example of justice entangled in transactions involving the sacrifice of certain goods for other values appears in the following case. An interdisciplinary team of outstanding doctors, ethics and lawyers considered the advantages and disadvantages of using modern technology to produce another version of an artificial heart, the so-called wholly implantable heart. The team identified three possible strategies:

1) not to produce the heart, because the venture is too expensive;

2) to produce a nuclear-powered heart;

3) produce a heart with an electric pacemaker and replaceable batteries.

Experts concluded that a heart powered by electric batteries carried the least risk to the user and was not as dangerous to his family and other people as a nuclear-powered heart. In assessing each option, the team considered the possible impact of the product on recipient's quality of life, cost of production and use, and the possibility of allocating the same funds to other medical needs. The team concluded that it would be unfair not to allocate funds to an artificial heart for those who need it due to real spending (as required by distributive justice).[93]

Balancing options are types of situations where distributive justice is applied. We put at stake not only the sum of the risks, costs and benefits of each strategy but also their distribution in society. As we have seen in the lottery, the question of fair distribution

makes us look for specific rules of justice. One principle is not enough to solve the problem of equitable distribution. It is necessary to have a few, like various versions of the principle of charity should be balanced and detailed. In its most fundamental division, the principle of justice breaks down into two other basic principles: formal and material.

2.1.14.2 The formal principle of justice

The basis of all theories of justice is the principle attributed to Aristotle: equals must be treated equally, and unequals must be treated unequally. This principle of formal justice (sometimes also called the principle of formal equality) is formal because it does not say in what respect equal people should be treated equally, nor does it provide any criterion by which we can ascertain whether two or more of them are equal. This principle only says that regardless of what considerations are important, people equal in these respects must be treated equally. Thus, no person should be treated unequally, regardless of the differences that exist between him and other people, unless we consider that the differences are significant enough to justify unequal treatment.

The apparent difficulty faced by this principle is the lack of content. That equals should be treated equally is beyond dispute. Nevertheless, how are we to define equality? When are any two people equal and when not? What differences should be considered significant and, which are not relevant when comparing individuals and groups? Presumably, all citizens should be treated the same before the law, have the same political rights and have equal access to public services. However, how far does this

equality go? I can illustrate the problem with the following example: All concepts of justice assume that aid programmes, and services intended for individuals belonging to a specific group, such as the poor or the elderly, should be available to all members of that group. Helping some people and refusing to help others is unfair within the same group. Nevertheless, is it just and unfair to refuse to help someone outside of your group in need?

Let us consider such a case. Hattie Mae Campbell, while giving birth, was denied admission to the hospital because of the valid zoning.[94] She was advised to go to the hospital where she had previously performed prenatal tests. The woman, however, did not make it. She gave birth to a boy in the car, in the parking lot, in the presence of her sister. After some time, she brought the case to court - she accused the hospital of not admitting patients without a referral from a local doctor and arbitrarily violating the constitutionally guaranteed right of everyone to receive government care. The hospital followed a patient selection policy, considering referrals from local doctors as a criterion. As a result of this strategy, people were divided into categories and depending on whether they belonged to one or the other, they were treated one way or another. The principle of formal justice has been fulfilled. Equals were treated equally, and unequal - unequally.

While the hospital's policy was formally fair, the question arises as to the fairness of the criterion by which people were differentiated.[94] The hospital must justify why it treats the two applicants differently. Some courts have found that hospital criteria are appropriate under the law. However, is it morally flawless to differentiate people seeking admission based on having or not having appropriate referrals? Any answer to this question must already imply some material, not merely a formal, principle of justice.

2.4.14.3 Material principles of justice

The rules which detail the essential features that determine equal treatment are material, as they allow for the establishment of actual criteria for distribution. Consider the principle that it is fair to distribute as needed. To say that someone needs something is to recognise that s/he will be hurt or at least hurt if her/his needs are not met. However, we are not required to divide goods and services to meet all needs, including sleeping in an alcove, sportswear, or self-locking brakes (unless we adopt an extreme version of egalitarianism). Presumably, we only want to consider basic needs. When one speaks of a basic need and as a result of it being unsatisfied, someone suffers harm or significant loss. The harm may be caused by, for example, hunger, bodily injury or failure to disclose the facts decisive about life and death.

The next steps in this analysis of the concept of basic needs and elementary goods would be to detail the material principle “to every one according to needs” and to adapt it to the needs of social policy to achieve equitable distribution. This reasoning, which is to accept the valid, material principle “to everyone as needed”. If someone would only accept a division based on free-market mechanisms, s/he would have to oppose social policy based on the above principle. All social strategies or institutional programmes that assume some distributions are based on the acceptance or rejection of some physical principles, along with procedures for their refinement and improvement.

Each of the following material principles was proposed as a valid substantive principle of distributive justice by many authors[95]:

Equally to everyone.

To everyone, according to their needs.

To everyone, according to the effort.

Each according to contribution.

To everyone, according to their merits.

To each according to free-market mechanisms.

Nothing prevents more than one principle from being adopted. Some theories of justice accept them all. The moral thesis that each principle expresses some *prima facie* duty seems to be the most credible statement. Its weight, however, cannot be determined independently of particular situations or areas in which a given principle usually applied. Thanks to the technique of additional refinement, one can even apply it to areas in which we thought it had never applied to before. It could be argued that each principle of justice is very similar to the moral rules mentioned in the previous principles. However, this need not be the case in the case of justice because the acceptance of its principles is more often questioned than the principles mentioned earlier. Nevertheless, one can accept all six suggestions and try to show that they apply at least in some contexts.

The majority of societies use the given principles when shaping their social policy. Usually, they also refer to various norms in various spheres and contexts of life. In the United States, for example, unemployment benefits and benefits and many health programmes are used on an “everyone as needed” basis (with additional criteria such

as the number of years worked). In turn, high earnings of sought-after specialists are shaped according to the free-market mechanisms, effort, merits or social utility of their work. At least, in theory, access to primary and secondary education is based on the principle of “everyone evenly.”

The proposal to incorporate each of the above principles into a single theory of justice seems appealing. However, the possibility of conflicts between them raises questions about priorities and also undermines the consistency of the theory that aims to harmonise the rules as much as possible.

2.4.14.4 Relevant features

Applying the material principles of justice refers to some essential qualities that a participant in the division must-have. Unfortunately, the justification of such features encounters severe theoretical and practical difficulties. The fact that one can consider incompatible features as necessary depending on the context explains in part the diversity of government regulation and health policies in many countries.

Sometimes, the source of recognising certain features as essential for justice can include tradition, or moral or legal principles, or social policy.

To determine what features are morally relevant and decisive for the formulation of prudent judgement, we must go a step further and adopt some method of refining the rules and balancing conflicting claims. However, we can rightly suspect that in many cases, we cannot reach an agreement. This fact led many philosophers to doubt the validity of solving the problems of justice with general material principles. John Stuart

Mill argued in his *Utilitarianism* [96] that the adoption of such different rules or principles of common morality as “everyone by effort” or “everyone according to needs” inevitably leads to a conflict of moral principles and recommendations. When two principles conflict with each other, we do not know which of them is more potent, preventing a final judgement on their relative value. Mill concluded that a sizeable body of such rules was not compatible with justice theory, introducing hopeless pluralism. John Rawls agrees with Mill on this point, stating: None of these maxims can be convincingly carried over to the dignity of the first principle [...]. Common sense maxims are at the wrong level of generality. To find the first principles, one has to go beyond them and create a theory”[84]

If one agrees with Rawls and Mill, we will be forced to conclude that generally, the material principles of justice are useless if they are not placed in the context of a rational theory.

2.4.14.5 Most frequent causes of treatment delays

Is treatment delay something bad or maybe in some circumstances, good? As always, speaking of values, one can see this as ethics. From a descriptive approach (also called comparative ethics), which is a study of people’s beliefs about morality; or a normative approach (also called prescriptive ethics) that is the study of ethical theories that prescribe how people ought to Act.[97]

Delay, which is something late or postponed, can be discussed as either morally good or morally bad. The difference depends on the basis of the delay. If it was intentional, for what purpose and what was the result? Unintentional delays can be good or bad,

depending on its origin and outcome. Intentional delays may result from compliance with the precautionary principle. The principle emphasises the need to know the consequences of an action or inaction. If the action is necessary to avoid known damage, the action should be taken. If there is no definitive proof that the action will prevent harm but is likely to produce it or increase its risk, then following the precautionary principle should be avoided or the act delayed. [98]

Delay and its ethical consequences are a common experience in medical practice. This could be the patient delaying a doctor’s visit for a symptom that the patient recognises as potentially a serious disorder. The visit is delayed by the patient's fears of what the doctor may find, and therefore, the visit may be postponed to await a spontaneous resolution of the symptom. Following the precautionary principle, the patient, considering the symptom to be serious, should not delay but seek a medical diagnosis. When the patient's symptom is evaluated by the doctor and based on the doctor's experience and the literature, there are reasons to consider the symptom to be insignificant and that a CT scan is unnecessary. At this stage, delaying spending, write-offs, and the ever-present possibility of misdiagnosis, the doctor may delay further examination and instead proceed to more careful observation of the symptom and paying attention to the comfort of the patient if necessary. Under this approach, the deadline can be appropriate and ethical. [98]

Interestingly, there have been proposals from professional organisations dealing with guidelines for medical practice based on studies and following the precautionary principle, recommendations, including delays or abandonment of certain procedures, such as the PSA test for prostate cancer, mammography, colonoscopy and chest x-ray screening. [98]

Unintentional delays in diagnosis and treatment can be linked to the physician's inability to easily access the diagnostic and consultation resources they need. However, when the delay is not based simply on the precautionary principle, it is the physician's professional responsibility to try to resolve the delay and provide the patient with the necessary professional services. [98]

In the field of medical care, a delay is unethical if it is not based on precautionary concerns, or if it is unintentional but based on the personal interests of the doctor or of the system. This is unethical because the medical practice must provide beneficence, primarily trying to “do good” for the patient and whatever personal benefit to the physician or the system is secondary. If the delay shows no concern on the part of the medical profession for the patient and the patient's symptoms or illness, then the delay is “bad” and is unethical. [98]

While all the facts are still unknown and yet to be discovered, the public is currently concerned about the apparently profound delays in the planning, assessment, diagnosis and treatment of road accident victims in South Africa. If not accidental but designed specifically to meet the personal interests of the RAF or other role players, such delays, in terms of the principles of beneficence, non-maleficence and justice, would render such behaviour unethical. [98]

The delay itself in the performance of a professional obligation may be ethically “good” or “bad,” and the ethics review should consider all the facts, including the justification presented explaining the delay. However, especially in medical practice, dealing with humans who may need prompt medical attention to preserve life and provide comfort, delays should never be hidden but always explained and dealt with promptly to be

resolved.[98]

2.4.15 Ubuntu

Ubuntu is an African philosophical concept commonly quoted through the maxim of “a person is a person through others.” It is understood that this has various meanings and interpretations by various philosophers and others. I believe based on the writings of Molefe and others, that the ubuntu philosophy can be seen as multifold.[99]

The first part, a person is recognised as a human being and their personhood. Second, a person is recognised as a part of a large community and society for their existence and moral good.

Metz, who writes extensively on ubuntu and in his moral theory, has two views of ubuntu. His first view of ubuntu holds that interpersonal relationships are the highest good.[100] In his later writings, he has held that capacity of a person or an individual is the highest good.[101] It is understood from Metz writings, that an individual’s capacity to be morally good, and the human capacity for relationships is associated with a person’s capacity, and it is that capacity that is related to dignity and ubuntu. This is understood to be a part of the relational perspective of ubuntu.

In terms of the self-realisation approach of ubuntu, it is understood that individualism is the key focus. This is understood to mean that ubuntu places value on a person realising their best moral self as the ultimate goal. Kwame Gyekye had the view that “African ethics is, thus, a character-based ethics that maintains that the quality of the

individual's character is most fundamental in our moral life."[102]

There appears to be a prevalence in the literature to focus on the value that the ubuntu philosophy promotes but it is almost silent on the conditions required for such values to develop, grow and be effective in peoples' lives.[103] Such conditions include the political and economic.

To be able to judge a person to have achieved a certain level of personhood includes a moral review that is premised on taking for granted certain factors, such as the history and politics of the environment. It is a moral evaluation when one is analysing a person's quality of character by their demonstrated virtues of care, community, generosity, and otherwise.

The history and context of an individual in society, when seen through the lens of ubuntu, requires an evaluation of that individual's history and life experiences. Some authors, views morality, particularly ubuntu, as a journey of a person towards personhood. It is understood to be a journey from mere existence to a fully bloomed exemplary human being.[99]

In understanding a person through ubuntu, there is a need to understand the South African history and political needs to creating the basic conditions of justice, to allow for the development of the person, and to allow for the judgement that personhood is possible.[99]

Therefore, if the environment and prevailing circumstances do not allow the

development and make the achievement of personhood impossible, then ubuntu cannot prevail. Hence, for judgements and reviews based on ubuntu do have a political leg insofar as it requires basic conditions to exist for ubuntu to prevail.[99]

2.5 Summary

In summary, it can be demonstrated that ethics, and more specifically, bioethics has been the evolution of human reflection and moral analysis of profession-based actions to broader principles as encompassed by the Principles of Medical Ethics.

On a deeper analysis of the various principles and their practical application, what ought to be done and is morally right, is based on the prevailing circumstances and an understanding of the correct context.

However, delays which cause harm, that cannot be justified are motivated by reason outside of acting for the best interest of the patient and his or her family. This can result in unjust outcomes, which also cause harm to the patient. Such delays and decisions can also result in conditions, particularly in South Africa, that restricts the development of an individual's self-development, and community development when seeking to develop and promote ubuntu.

In the next chapter, a discussion of the methodology used to do the qualitative and quantitative study will be detailed.

Chapter 3: The Empirical Component

3.1 Introduction

In the context that it is hypothesised that many road accident victims are harmed by delays in their assessments and treatments and that it is against what ought to be done from a bioethical and legal standpoint, a study had to be done to significantly investigate such potential delays and the implications thereof.

In this chapter, the empirical component of the research and a discussion of the methodology used to do the quantitative study will be detailed.

3.1.1 Empirical Component Methodology

Hypothesis

Victims of road accidents are harmed because of delays in their assessments and compensation, which includes treatment compensation and financial compensation.

3.2 Problem statement

The resulting delays in compensation lead to delayed access to healthcare, treatment, rehabilitation, pain relief, financial compensation, and a violation of the four principles of biomedical ethics, which are autonomy, beneficence, non-maleficence, and justice. In addition, several legal principles, including justice, access to healthcare, and dignity as espoused in the Constitution of the Republic of South Africa[12] and the National Health Act[13] are eroded.

3.3 Rationale

The rationale for carrying out this research project lies in the need to document the delays in assessments, which directly results in delays in compensation. Currently, no published data exist in the literature to document the delay periods and their ethico-legal implications.

3.4. Research Aim and Objectives

3.4.1 Study Aims

The aim of this aspect of the study is to ascertain the delays between accidents and medical assessments of victims of road accidents.

3.4.2 Study Objectives

The objectives of this aspect of the study are as follows:

To determine the delay periods that exist between the road accident and the statutory medical assessments, for compensation and medical fees.

To determine the types of injuries sustained in road accidents as assessed in 2013/14.

To describe the employment status of the accident victim, and to document the assessment recommendations.

3.4.3 Research Design

This empirical component is a retrospective record review using a quantitative study design.

3.4.4 Population and Sample Size

Sample: Existing clinical records and claim forms from the practice of Ayush Healthcare, of Road Accident claimants.

Sample size: Sample size calculations are based on the key research questions to be answered. In this case, the key outputs are the descriptive reporting of percentages. Based on an infinite (>20,000) population, the reporting of a 50% proportion for a given outcome (50% is the worst-case in terms of sample size estimation), 5% precision, and the 5% significance level, a sample size of 385 is required.[104]

Sample size for proportions was determined using the formula:

$$n = \frac{Z^2 P(1-P)}{d^2}$$

where n = sample size,

Z = Z-statistic for the chosen level of confidence,

P = expected prevalence or proportion

d = precision

3.5 Data Collection and Analysis

Descriptive analysis of the data was carried out as follows: Categorical variables were summarised by frequency and percentage tabulation and illustrated with bar charts. Continuous variables were summarised by the mean, standard deviation, median and interquartile range, and their distribution illustrated with histograms.

3.6 Limitations

Limitations have been briefly outlined in chapter 1, section 1.10.
There is no published data to document the assessment and/or the delay periods, and settlement periods.

During the analysis of the data, it was discovered that no information about the employment statuses or the assessment outcomes were available in the recorded data. Such information, on enquiry, was only recorded in the actual reports wherein an Industrial Psychologist assessment report had been requested and provided.

3.7. Summary

In this chapter, the research methodology was discussed. The sample size, the data collections and the analyses were described. The limitations were also explained. In the next chapter, the result of the analyses will be detailed and discussed.

Chapter 4: Empirical Component: Results and discussion

4.1 Introduction

The methodology for the empirical, descriptive component was detailed in the previous chapter. In the study of the various records, a detailed analysis was done of the various measure variables that all related to the patient's injuries and potential delays in assessments. This chapter focuses on the results obtained from the data captured, anonymised and analysed. The descriptive statistics of the data are presented. Categorical variables are summarised by frequency and percentage tabulation and illustrated with bar charts. Continuous variables are summarised by the mean, standard deviation, median and interquartile range, and their distribution illustrated with histograms. For completeness, a univariate, bivariate and regression analysis statistics were also added using R programming.

4.2 Descriptive Statistics

A record of the actual days between the date of the accident and the assessments were captured, as was the number of working days between the date of the accident, and the assessments were also captured. The analyses were done using the data related to the working data according to how the legal system works and the Interpretation Act 33 of 1957. The reason the said act was used, as the RAF Act does not define 'days' and therefore, the Interpretation Act provides for the interpretation to be taken as working days and not calendar days. This was used as a basis to calculate the days from injury to assessment, so that it can been seen in context of the above detailed and discussed 120 days period within which the RAF has to make a decision on a complete claim.

It has been revealed that the minimum time period between an injury and an assessment is 143 working days, and the maximum period was 3898 working days (Table 1 and 2). The mean was 1079 working days, and the median was 1036 days. The standard deviation was 526 working days, and the first and third interquartile were 721 and 1357 working days, respectively. The mean is 1079 days, which is larger than the median = 1036. This indicates that the data is skewed to the right, as shown by the histogram (Table 3).

Table 4 1: Univariate analysis of the time period (working days) from date of accident to date of assessment (total = 385)

Min	1st Qu	Median	Mean	3rd Qu	Max
143	721	1036	1079	1357	3898

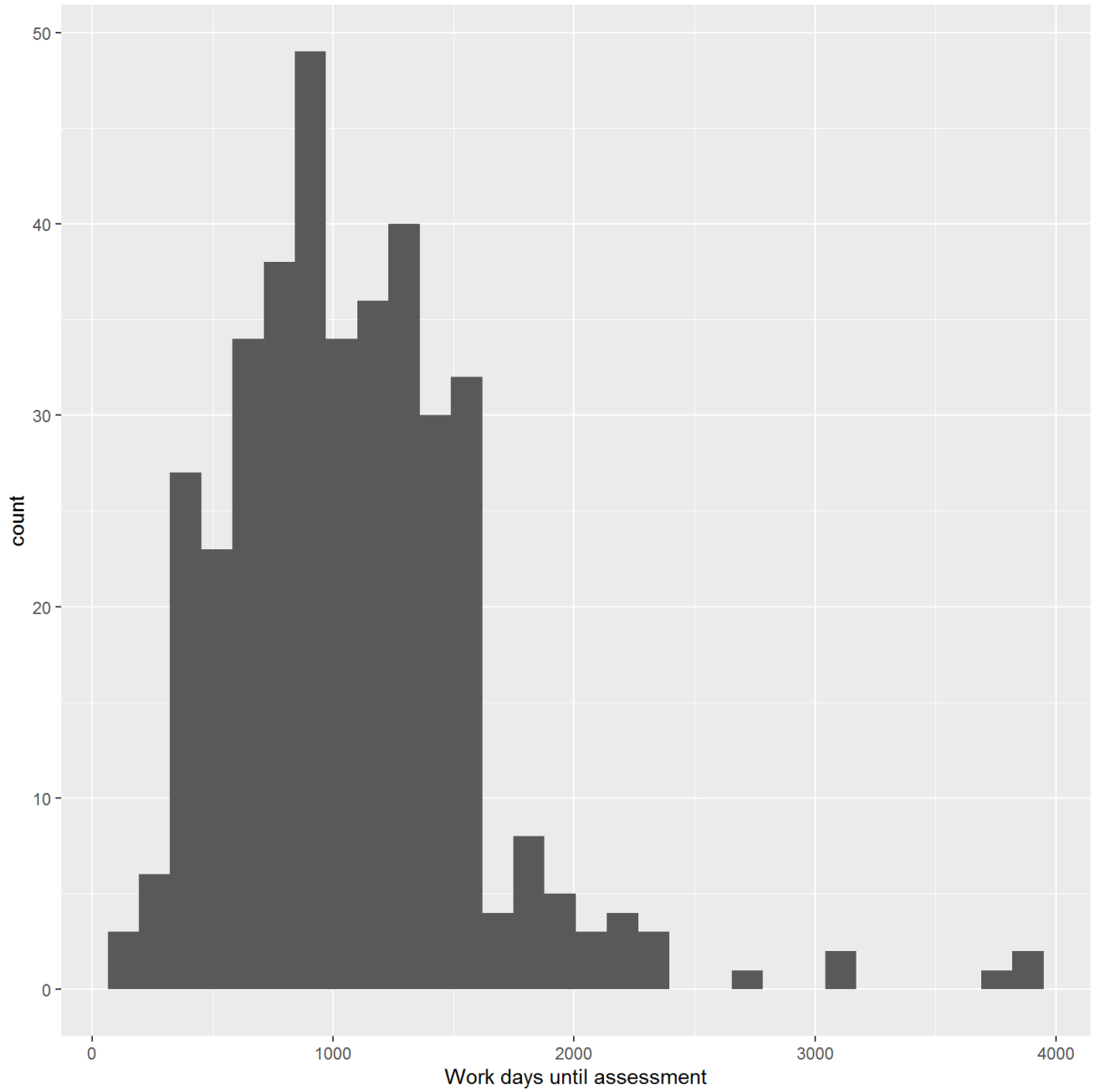


Figure 4 1: Bar graph of the time period (working days) from date of accident to date of assessment (total = 385)

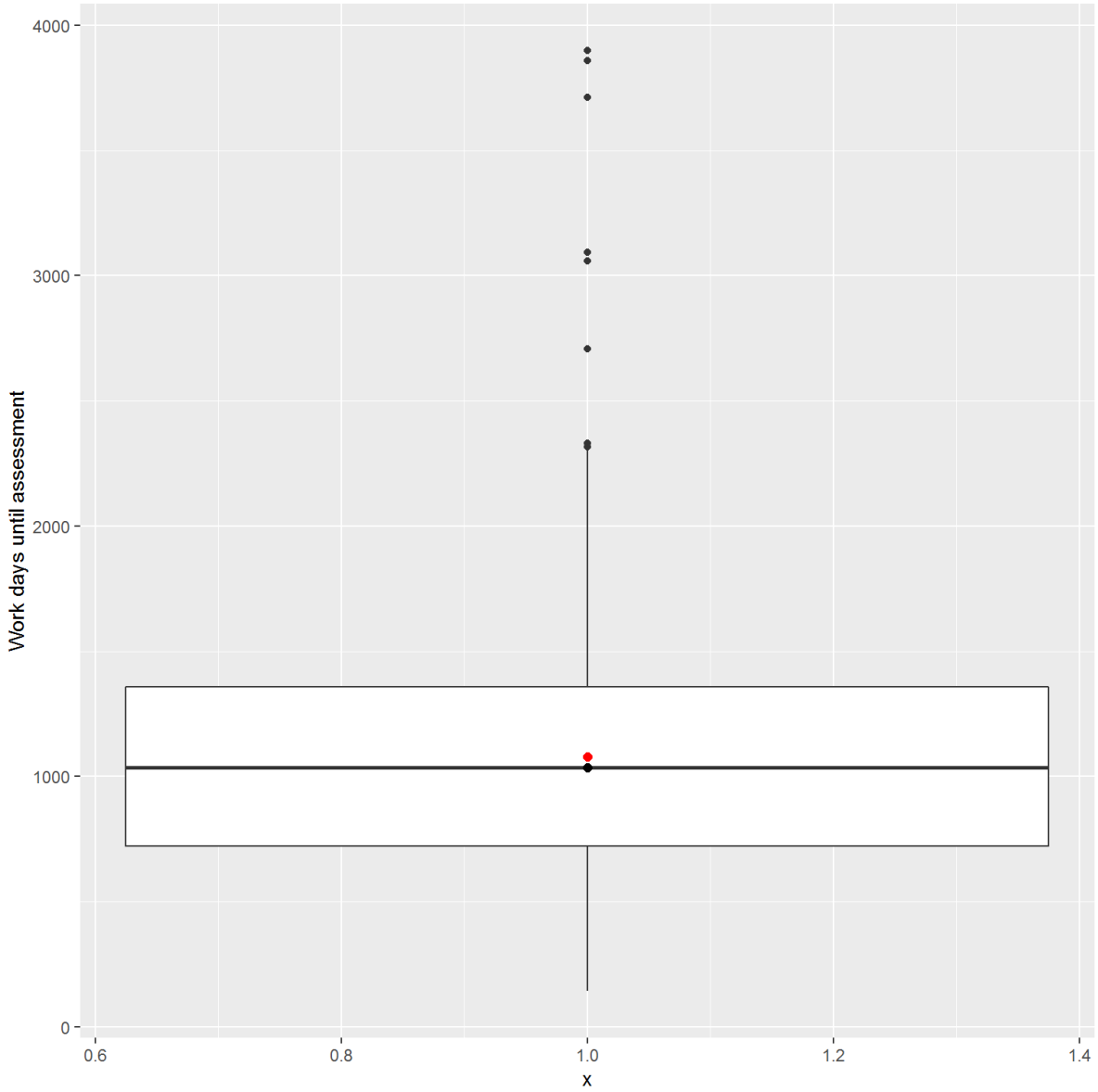


Figure 4 2: Histogram of the time period (working days) from date of accident to date of assessment (total = 385)

4.3 Primary Injuries

For the primary injuries sustained, Table 4 depicts the frequencies and numbers of the injuries sustained. The data reveals that tibia and fibula injuries were the most reported at 16.62% (64 injuries), followed by head injuries 15.84% (61 injuries). The least frequent injuries were thoracic and chest injuries, both at 1.04% (04 injuries each).

Table 4 2: Frequencies (n) (total n = 244) and the percentages of the injuries sustained (total = 385)

Injury	Frequency	Percentage
tibia/fibula	64	16.62%
Head	61	15.84%
Face	35	9.09%
Ankle	29	7.53%
shoulder	22	5.71%
Foot	21	5.45%
Femur	20	5.19%
neck/cervical spine	19	4.94%
radius/ulna	18	4.68%
Pelvis	17	4.42%
Knee	16	4.16%
Elbow	14	3.64%
humerus	12	3.12%
Wrist	12	3.12%
lumber spine	9	2.34%
Hand	8	2.08%
Chest	4	1.04%
thoracic spine	4	1.04%

Bivariate analysis

A bivariate analysis was done to assess the relationship between the injury type and the working days delay to the assessments, as summary statistics. As the working days until the assessment is a skewed data, so the median is a better representation of the data distribution. The largest median of working days until the assessment was for the elbow injury while the smallest median was for the humerus injury.

Table 4 3: Bivariate analysis relationship between the injury type and working days delay to the assessments detailing standard deviation and interquartile range

Primary injuries	Interquartile range	Standard deviation
Ankle	392.00	394.3246
Chest	430.00	415.3007
Elbow	608.00	378.4533
Face	644.50	728.1897
Femur	720.75	500.0408
Foot	437.00	329.7432
Hand	865.25	448.4612
Head	766.00	634.6407
humerus	973.00	629.2399
Knee	291.75	315.5337
lumber spine	468.00	672.6087
neck/cervical spine	605.50	383.1634
Pelvis	477.00	459.2548
radius/ulna	609.25	787.4284
shoulder	447.25	368.1411
thoracic spine	408.00	491.5435
tibia/fibula	633.50	489.0928
Wrist	349.25	298.2928

Table 4 4: Bivariate analysis relationship between the injury type and working days delay to the assessments detailing the median

Primary injuries	median
humerus	697.5
Hand	805.0
Chest	821.0
Ankle	876.0
lumber spine	942.0
thoracic spine	953.0
Head	988.0
tibia/fibula	1009.5
Knee	1046.5
Pelvis	1058.0
shoulder	1068.0
Wrist	1070.0
Foot	1074.0
radius/ulna	1116.5
neck/cervical spine	1168.0
Femur	1171.5
Face	1185.0
Elbow	1206.0

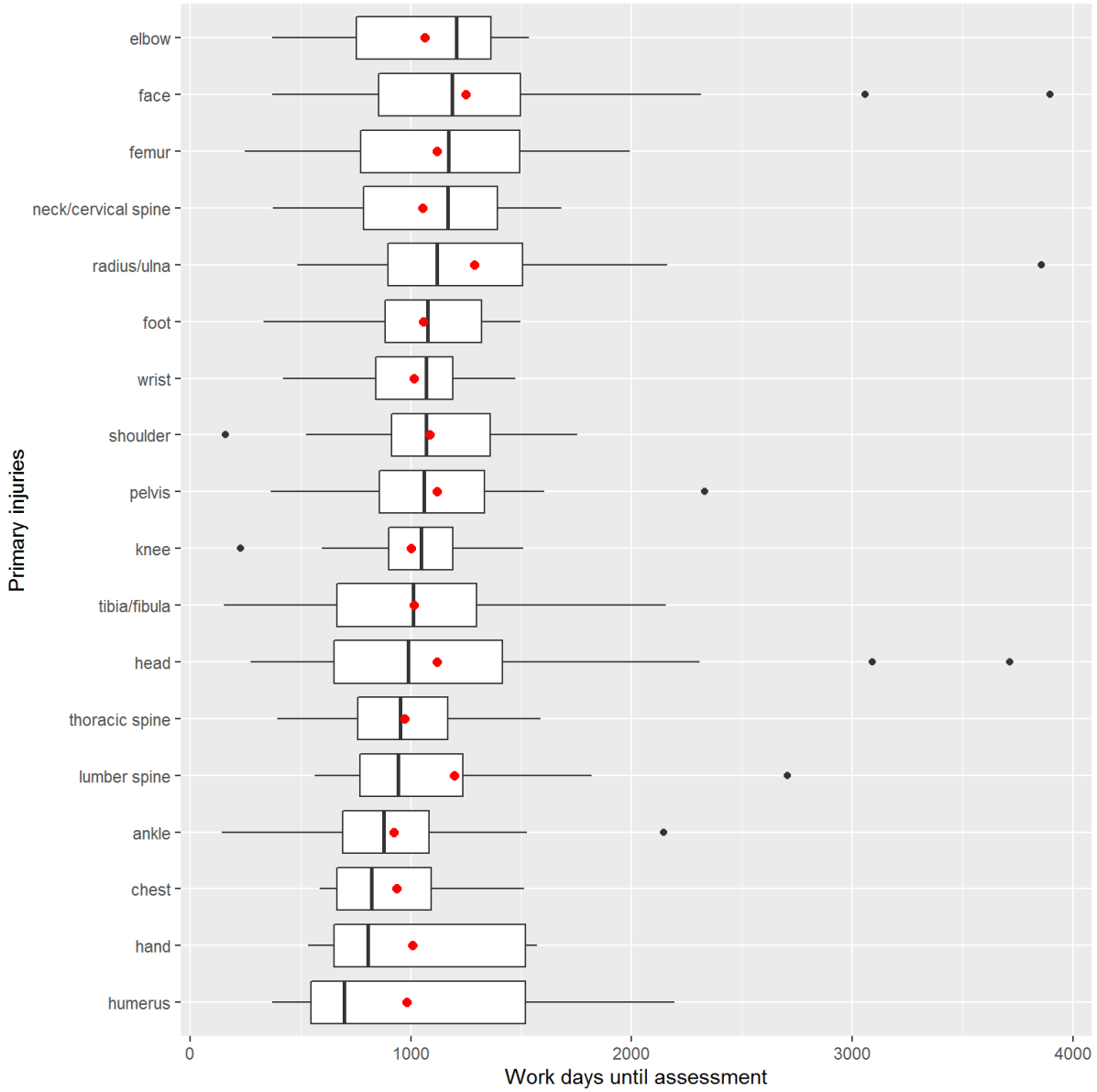


Figure 4 3: Bivariate analysis relationship between the injury type and working days delay to the assessments detailing the median compared to the mean of each injury against the time period

The faceted histograms show the same idea as the bar plot above where injuries are more represented in the data (tibia, head) than the others (thoracic spine, humerus). Some injuries have a nearly equal mean and median working days until assessment like thoracic spine and foot.

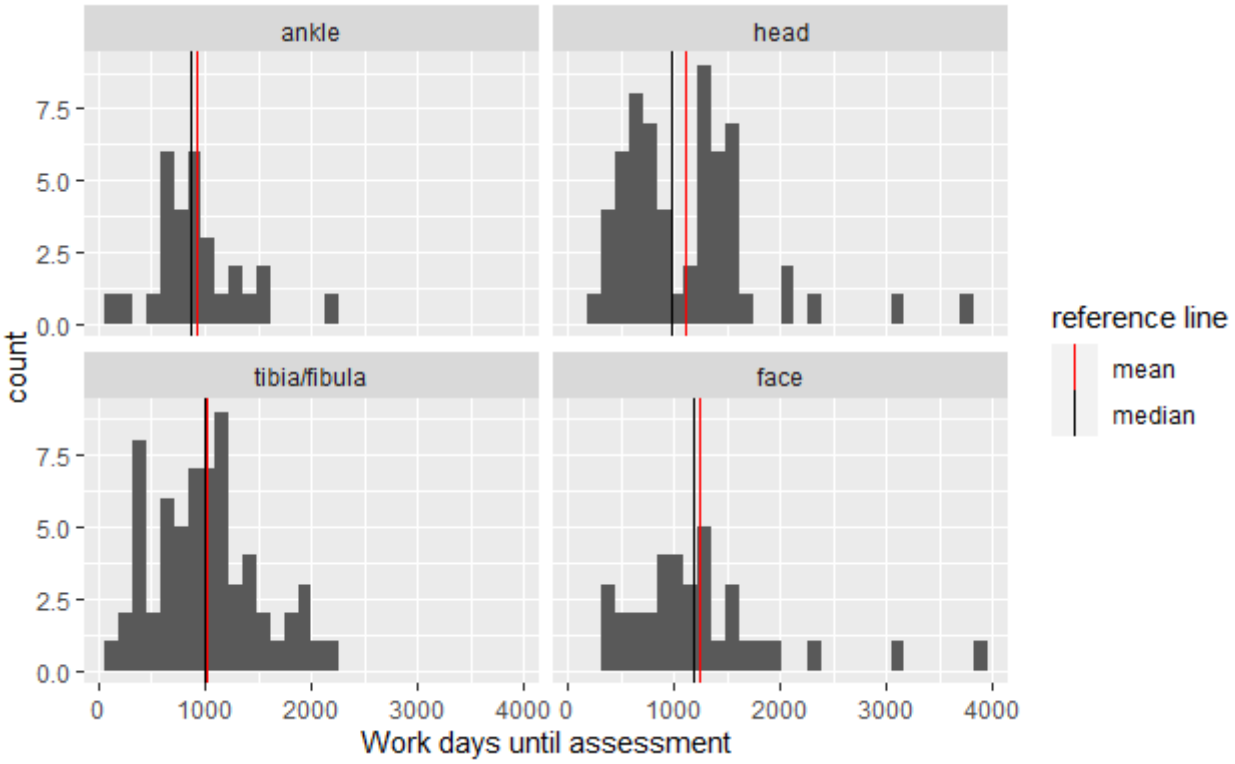


Figure 4 4: Bivariate analysis detailing the median compared to the mean of each injury against the time period

The head injuries show a bi-modal distribution. However, from a review of the data available and captured, no reasons to be ascertained, and no other factors could be found to explain its presence.

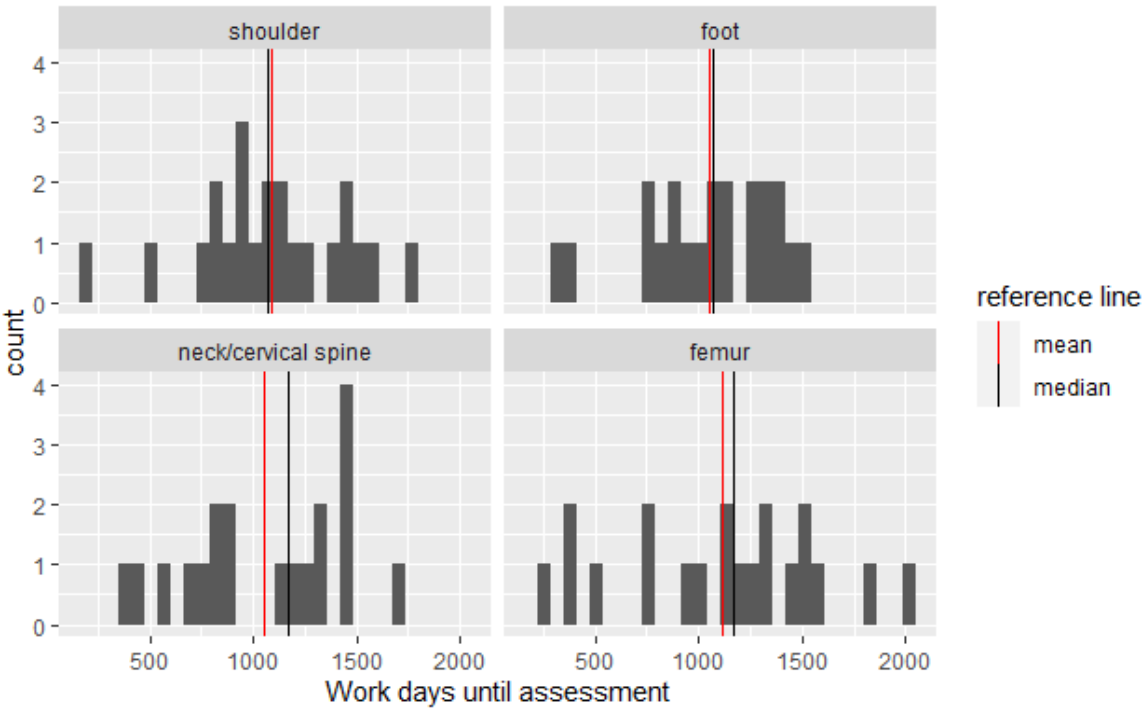


Figure 4 5: Bivariate analysis detailing the median compared to the mean of each injury against the time period

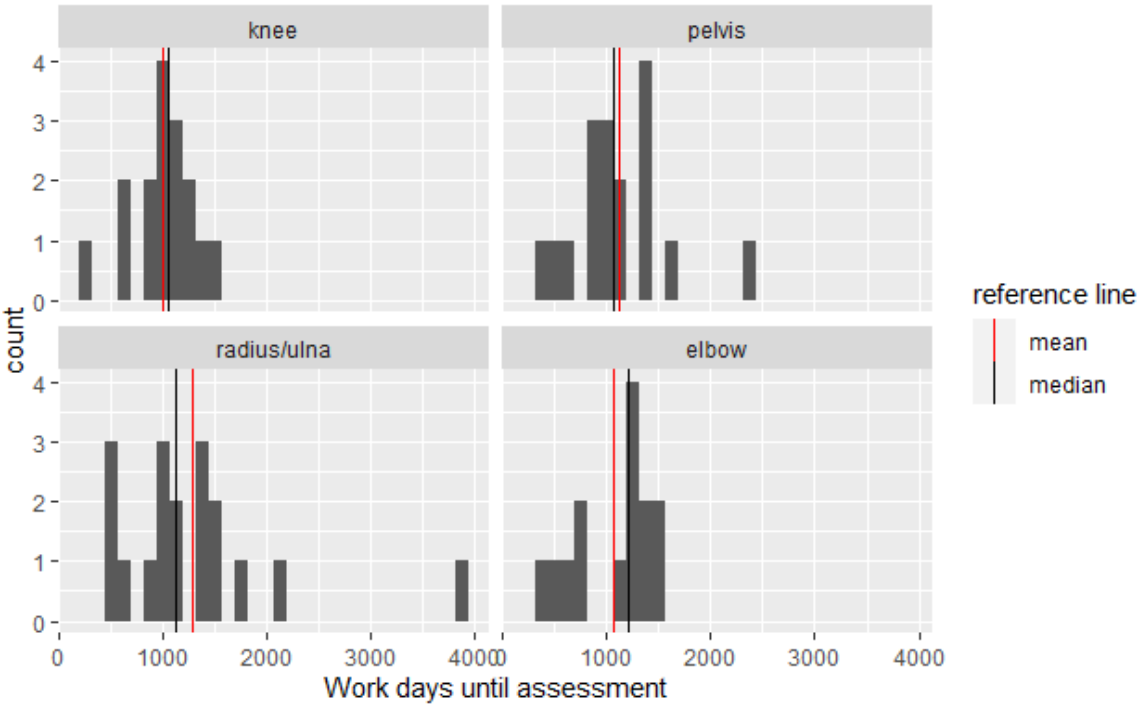


Figure 4 6: Bivariate analysis detailing the median compared to the mean of each injury against the time period

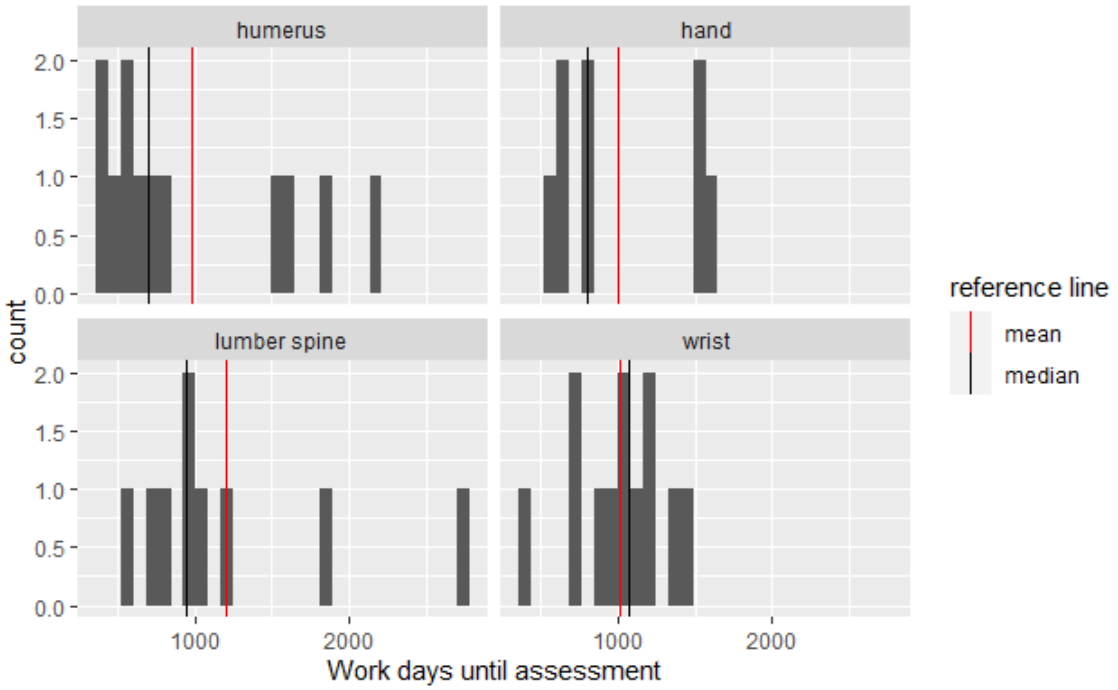


Figure 4 7: Bivariate analysis detailing the median compared to the mean of each injury against the time period

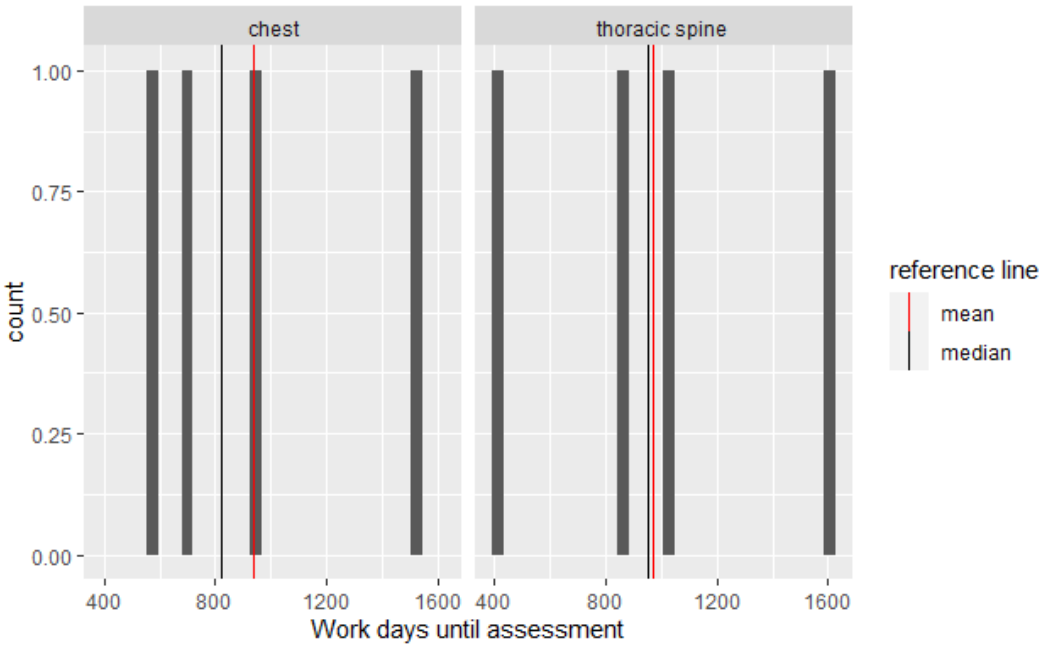


Figure 4 8: Bivariate analysis detailing the median compared to the mean of each injury against the time period

4.4 Regression analysis

A detailed regression analysis of the various injuries compared to the most frequent injury found to be the tibia/fibula injuries were done. This was done to ascertain the working days, time period and the delays in the assessment periods between the various injuries as compared to the assessment period for the tibia/fibula injuries. The mean time periods, in working days, was used.

The analysis revealed that radius and ulna injuries were greater than tibia/fibula injuries in the mean working days until assessment, followed by face injuries and then lumbar spine injuries (Table 12). All other injury types were statistically equivalent to the tibia/fibula injuries.

The linear regression assumes that the days are normally distributed. However, working days are not normally distributed as illustrated by its histogram.

Due to the skewed distribution of the result, a log of the outcome was also done (Table 13); using the log of the outcome (working days) to transform this outcome to nearly normal distribution. After using the log of the outcome, all injury types are statistically equivalent in their mean working days until assessment. This means that they are not different from each other.

All p-values are larger than 0.05

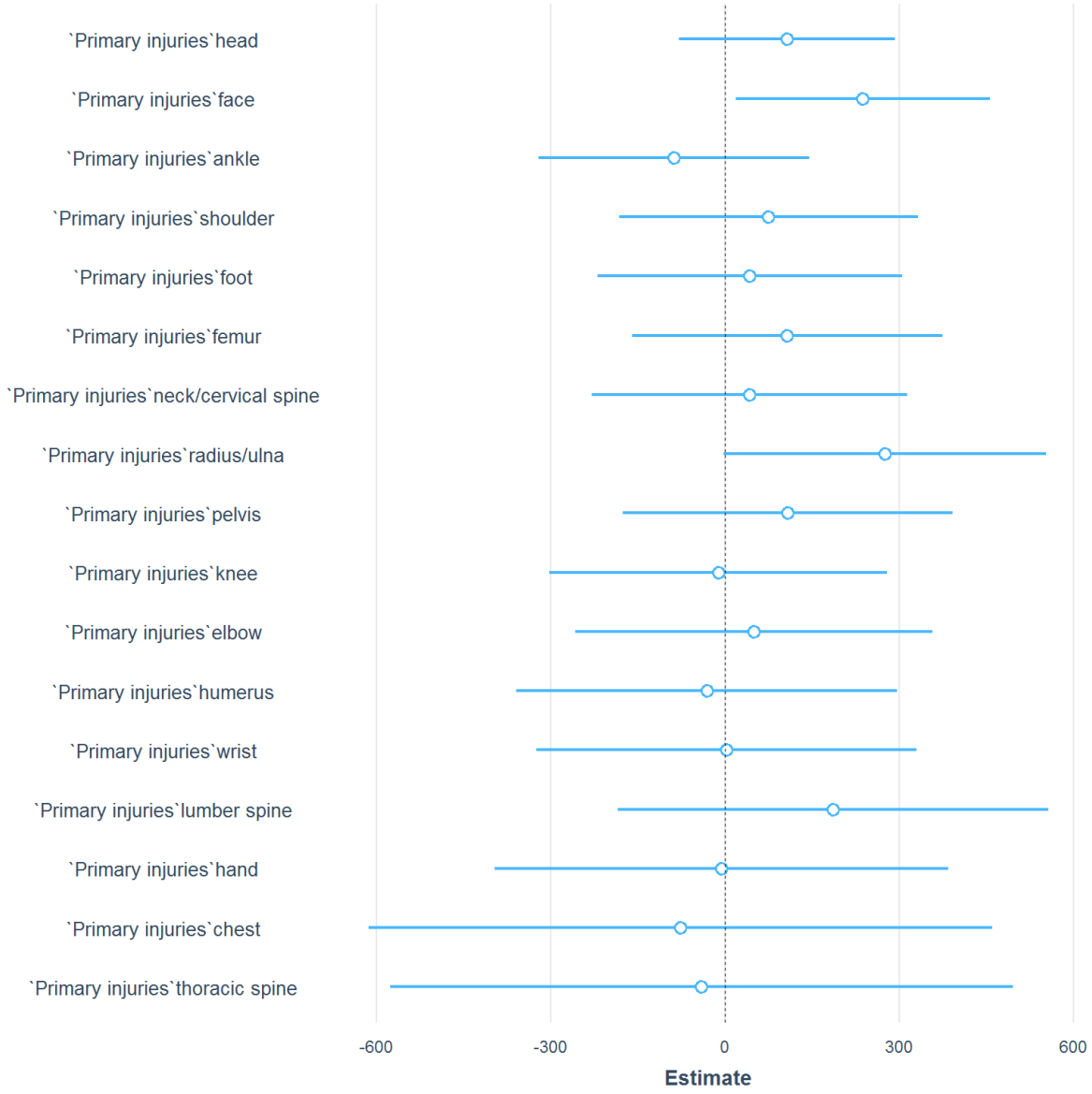


Figure 4 9: Regression analysis of the time period of each injury for assessment when compared to the most common injury found: tibia/fibula

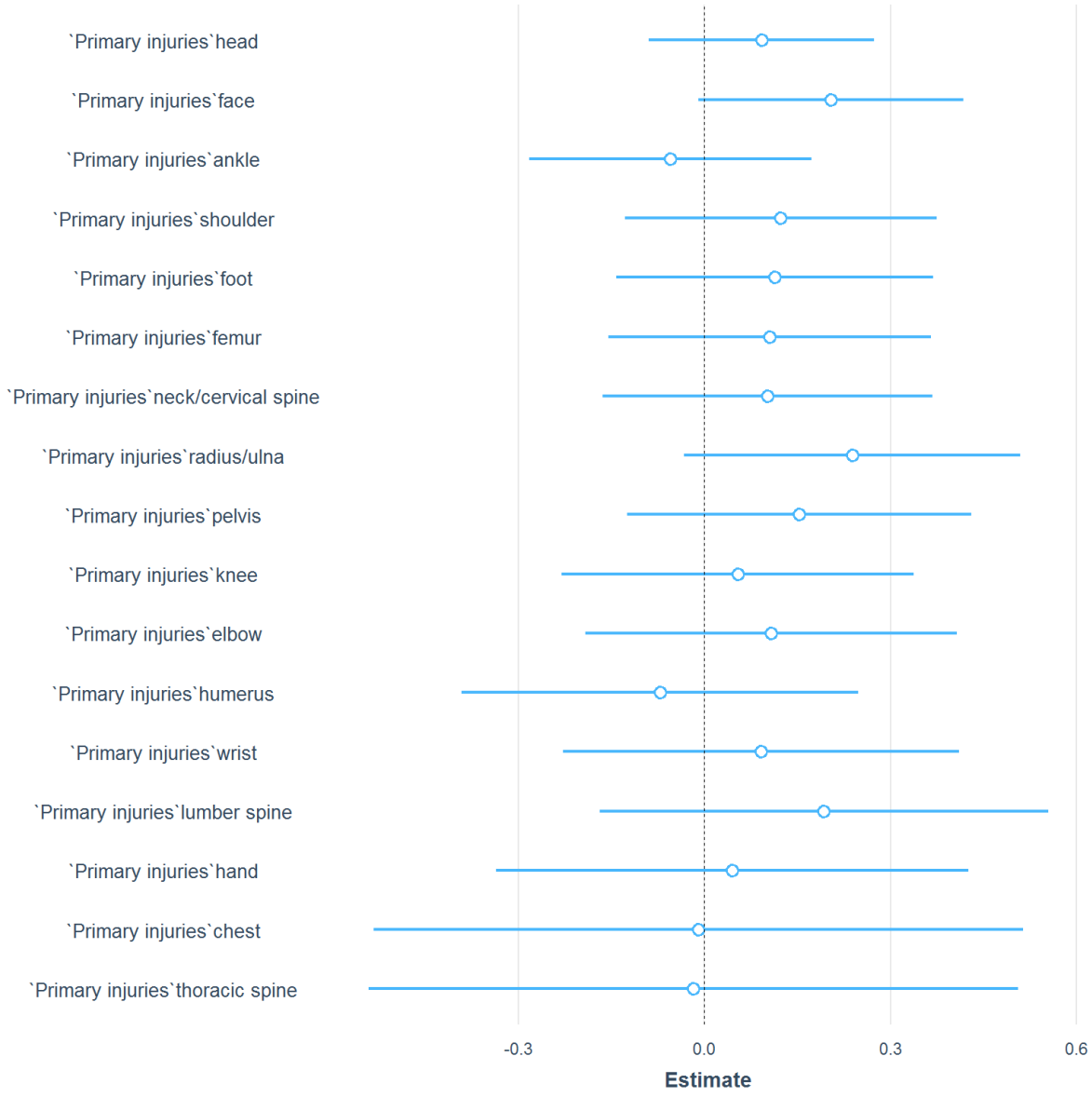


Figure 4 10: Analysis of the log of the outcome of the regression analysis

4.5 Employment status of the accident victim

Due to the nature of the records reviewed, no information could be found in the medical assessment records of any employment status of patients at the time of the accident. It is common in the medico-legal assessment for the employment at the time of injury to be recorded. However, such information is only captured by some medical and/or healthcare practitioners but not all of them.

4.5.1 Discussion

4.5.1.1 Injuries

From the data captured and the analysis done, it has been noted that tibia/fibula injuries were the most common injuries sustained. This is in keeping with the mechanism of injury that includes motor vehicles. Due to the height of the motor vehicles bonnets and the location of the lower limbs, tibia and fibula fractures are very common as noted from the analyses.

In a similar period to this study, between September 2014 and 2015, Mishra et al., in India had found that amongst 262 road accident victims, 30% of the injuries were found to be tibia related fractures.[105] In 2020, in a South African study based in KwaZulu-Natal, Singaram and Naidoo had found that 69% of the injuries sustained in motor vehicle accidents, were related to lower limb injuries, which were tibia/fibula injuries.[106]

The above findings of tibial injuries being the most prevalent correlates with the findings of the current study of an increasingly prevalence of the tibia and fibula fracture injuries as a result of motor vehicle accidents.

The regression analysis revealed that radius and ulna injuries were greater than tibia/fibula injuries in the mean working days until assessment, followed by face injuries and then lumbar spine injuries (Table 12). No causative reasons could be found to explain these delays in the assessments, except for the fact that radius and ulna injuries, which are forearm injuries, from the data appeared to be less frequent than lower limb injuries.

A possible factor that could have contributed to the delay in the facial injuries, based on my experience, is the limited availability of Plastic and Reconstructive Surgeons willing to do medico-legal assessments, and therefore there are delays in the assessments. No reasons or contributing factors could be found as to why there was also an increased delay in the assessment of lumbar spine injuries. This is because in practice, tibia/fibula injuries and lumbar spine injuries are seen by the same Orthopaedic Surgeons, and their availability is high.

All other injury types were statistically equivalent to the tibia/fibula injuries.

4.5.1.2 Delays

From the analyses of the data as above, it is noted that the minimum period between an injury and an assessment is 143 working days, and the maximum period was 3898 working days. The mean was 1079 working days, and the median was 1036 days.

From the above, it has been noted that none of the patients whose records were analysed, had been provided with an assessment date prior to the expiration of the

120 days provided in law for the RAF to make a decision. This has resulted in 100% of the patients, whose records were reviewed and analysed, being denied their right to an efficient and effective service by a dedicated state-owned entity mandated to assist them.

From the perspective of the various patients, this has resulted in all of them being denied their right to justice and a fair and just administrative system, as enshrined in the constitution[12].

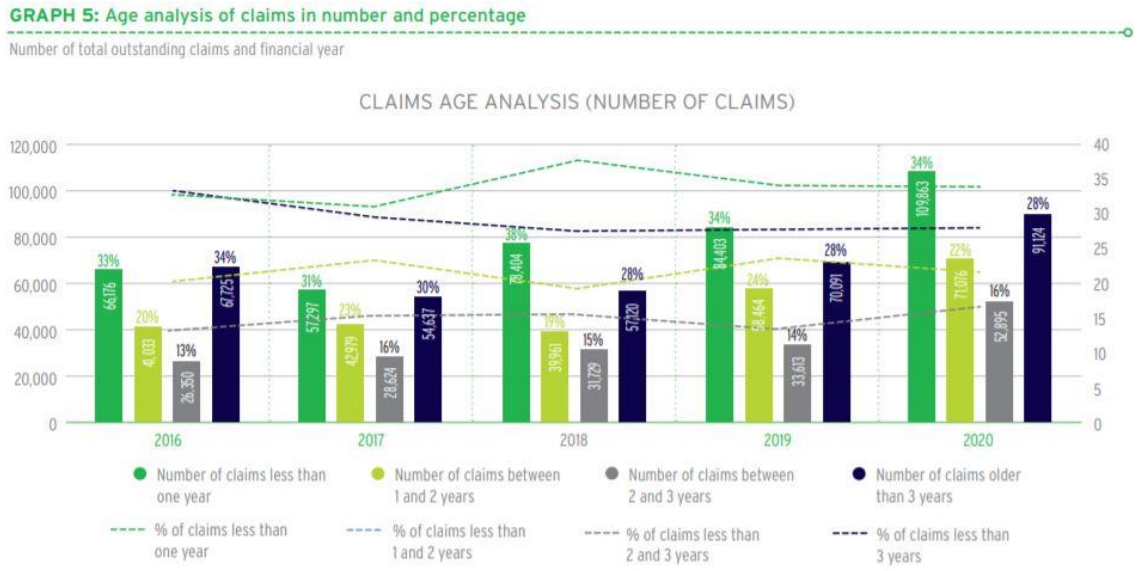
Since the actions of the RAF and or the legal representatives managing the matters have not been in the best interest of the patients, it can also be said that their collective actions have not resulted in conduct that is consistent with principles of justice and beneficence.

In the case of the delays in the assessments created by the RAF and the legal representatives, there is a resulting delay as a result of their inactions and or inefficiencies. According to the RAF's annual report 2019/20, its permanent staff complement grew to 2789 staff and claimed it had finalised 258,382 claims in the same financial year. These claims are not actually new injury claims, but also include supplier and service provider claims.[107]

That would translate to 92.64 claims managed per staff member per year. At the outset, this may appear like a large volume of work. However, across a 12-month period, that would average 7.72 claims per staff member per month.

Seen in further detail, some claims are as simple as supplier claims for services rendered or funeral expense claims. That would mean an average staff member processed less than eight claims or invoices for services per month. It is my view that this is not efficient and or effective.

Table X: from the RAF 2019/2020 annual report.[107]



In terms of the ageing of the claims of the RAF claims, the RAF appears to be proud that its claims less than 1-year-old is 34% of its pending work due. However, this also means that 66% of its claims are more than 1-year-old in its care as a statutory provider.

It is perplexing, and it was worrying that even during my time on the RAF Board (2016-18), that the RAF Management refused to document the number of claims that are in its care that are beyond the 120 days as prescribed in the RAF Act for it to make a decision.

I am not unaware from my direct experience at the Board of the RAF that the measures of efficiency during that period were directly linked to being able to achieve annual performance scores to qualify for bonuses. In 2019, as per the 2019/2020 annual report, R 120,166 million was paid for performance bonuses despite having an operating deficit in the same year of more than R 51,988 million and an accumulated liability of R 271,9 billion. That has in 2020 ballooned to R 330,640 billion.[107]

In the latest 8th edition of Principles of Biomedical Ethics, Beauchamp and Childress are of the view that the moral burden of proof is often heavier when the decision is to withhold rather than to withdraw treatments.[108] I agree. In this context, the failure of the RAF and its representatives to timeously adjudicate and manage claims does result in a withholding of access to treatment, funding and potential rehabilitation of claimants and their families. This results in prolonged direct suffering by both the claimants and their dependents.

Beauchamp and Childress had further deliberated that to have a right is completely independent of whether the person has the physical and or mental capacity to assert their rights or to exercise the pursuance of their rights.[108] It was held that a rights holder does not need to directly be the claimant itself to in a specific matter to still have a justifiable claim. They also stated that, even if a person or persons are not aware that they have a right, there is no reasonable basis for creating an impression that they do not have a claim at all. They held that many small babies, the mentally impaired individuals, and people from previously disadvantaged backgrounds might not be aware of their rights to make a claim in terms of their rights; but those individuals still

possess those rights and claims can be pursued on their behalf by the relevant and authorised representatives.

Beauchamp and Childress had also discussed and highlighted the contributions of Henry Shue, which they believe had a significant influence on both reflections on philosophical theory and views on politics in the 1980 book of Henry Shue titled *Basic Rights: Subsistence, Affluence, and U.S. Foreign Policy*.[109] In that book, Shue had distinguished specifically between rights that are there to protect people's security and their "subsistence rights" such as the right to enough food and shelter. Shue had argued that a person's subsistence rights, which he had held are "positive rights" are to be considered as basic and necessary as a personal security right, which he held as negative rights. Shue had also maintained that there was no significant dissimilarity existed in both their moral importance's as both rights are considered basic rights.

In applying Shue's perspective to bioethics, Beauchamp and Childress argue that a positive right of a person is to have a right to receive specific services from third parties, for example, a clear right to health care and a right to public health protective services, whereas a negative right is a right to be free from some intervention by others.[108]

It is also argued that some negative rights of individuals such as a right to refuse any recommended treatment or participation in any research are premised on the principles of respect for individual autonomy, while positive rights such as the individual's right to access to healthcare are premised in principles of beneficence and

justice.[110]

In the context of these vulnerable claimants, their positive rights are directly affected because of the delays in their claim's assessments and the provision of the compensations and treatments. However, it is also true that because of the failure to uphold their positive rights, their negative rights are also affected. This is because the delays and resulting prolonged denial of access denies them their autonomy and ability to regain some of their functionality and self-care that can be provided via rehabilitation, medical treatment and associated care.[108,110]

4.5.2.3 Ideal vs reality through the lens of Ubuntu

From the self-realisation perspective of Ubuntu to develop and also create value in the community, by the community, it requires structural conditions to exist that allow one to reflect on actions, development, and moral good.

In a country like South Africa, these needs are even more necessary. As one of the most disparate societies in the world in a young democracy, there is a need to reflect on how Ubuntu can truly exist while there are glaring resources disparities as a result of historical injustices.

Although this study did not record any data of the demographics of the road accident victims, it can be postulated that there is a larger number of historically disadvantaged individuals that sustain road accidents and who rely on the public healthcare system.

It is also well-know that many of the historically disadvantaged individuals live in communities with less access to healthcare services and support services than others due to the historical spatial planning in South Africa. This, therefore, creates less opportunity for treatment, lodging of claims and follow-ups on the claims matters with the RAF. The RAF Annual Report confirms, and in my experience on the board, I can confirm, that in Gauteng, there are two regional offices, while Mpumalanga, Limpopo, and the Northern Province do not have formal RAF offices.[107]

Therefore, for Ubuntu to truly prevail in South Africa, both from the community perspective and the self-realisation perspective, there needs to be political will to improve not just the efficiency of the RAF but access to the RAF and other services. This can contribute directly to improved justice and beneficence, and also reduce the harm caused by the prolonged delays found in claims in the hands of the RAF.

The courts have lamented the delays caused by the RAF and its current operating model.

To further illustrate the direct failures of the RAF and the criticisms levelled at it, in a recent judgement by Judge Neukircher in June 2020 in the matter of *Dichabe obo GN v Road Accident Fund* (18770/16) [2020] ZAGPPHC 250 (15 June 2020*),*[111] he said, "I find it extremely perturbing that the RAF's actions appear to be stymying a plaintiff's access to court and access to justice." He further commented and said that:

> "I am mindful of the fact that where one deals with State funds (as in the RAF's case), a measure of caution must always be employed. And yet, to allow lengthy postponements is also not in the interests of justice – many plaintiffs have

> suffered severe injuries and have been left with no means of income; many have lost their employment as a sequelae of their injuries or cannot work again. In today's economic environment and the effect that COVID-19 has had on the South African economy, jobs are scarce and even scarcer for someone who has been rendered vulnerable because of their injuries. For many in these circumstances, any compensation gives them a lifeline to which (if they prove their damages) they are entitled."

The above further supports the views that road accident victims are harmed by these delays.

4.6 Summary

Therefore, the resulting delays in assessments in the hands of the RAF and considerations of fair compensation have led to significantly delayed to access to healthcare, treatment, rehabilitation, pain relief, financial compensation, and a violation of the four principles of biomedical ethics, which are autonomy, beneficence, non-maleficence, and justice. It also does not allow ubuntu to prevail both from a community and self-realisation perspective.

In addition, several legal principles, including justice, access to healthcare, and dignity as espoused in the Constitution of the Republic of South Africa[12] and the National Health Act[13] are eroded against some of the most vulnerable people in South Africa.

In this chapter, the results, their findings and implications were discussed. In the next chapter, the conclusion and recommendations are detailed.

Chapter 5: Conclusion and Recommendations

5.1 Introduction

The previous chapter discussed the results of the current study and highlighted how victims of road accidents are harmed because of delays in their assessments and compensation, which includes treatment compensation and financial compensation. This chapter provides an overview of and concludes the current study.

5.2 Overview of Study

The delays in assessments of the victims of road accident were evaluated in terms of the normative Principles of Medical Ethics, namely: Autonomy, Beneficence, Non-maleficence and Justice.[22]

Autonomy

Autonomy primarily focuses on the rights of an individual to dignity and respect, freedom of thought and expression, self-determination, self-esteem and above all, choosing a path towards one's best interest. Road accidents victims are directly deprived of their right to their autonomy when they become vulnerable victims of various circumstances. They become medical patients in an already overburdened healthcare system. They further become vulnerable to the Road Accident Fund's claims system, either directly from the Fund, or via attorneys. In both circumstances, the victims are exposed and vulnerable to decisions beyond their control. The road accident victims also remain vulnerable to their injuries and their associated risks and complications.[21, 23]

Beneficence

Beneficence is the principle that espouses that the benefit for the patient is of paramount importance, and practitioners are expected to further the positive welfare of the patient. Therefore, having his/her autonomy already compromised, the accident victim is already vulnerable not only to the treating healthcare professionals but also to the healthcare and road accident claims systems. As mentioned above, the healthcare systems are already overburdened, and therefore there is the risk that the victim may not necessarily obtain the best possible care. Further, due to claims processes, and the need for legal practitioners to be engaged to finalise claims, who themselves have their own vested interests, the victim's best interests are not always served.[26]

Non-maleficence

This principle states that we should act so as not to cause harm to the patient or individual. Avoidance of harming or of aggravating his grief should receive priority over beneficence. This element becomes all the more relevant and important in the case of minimalism or therapeutic nihilism. Service may be denied, curtailed even discontinued because of the limited resources or the limitation of budgets, resulting in a violation of the principle of non-maleficence. It is a common observation in developing countries like South Africa, that services are hard to come by, and patients' needs demand that such services be provided; hence needs outstrip resources. However, due to the limitations on the part of the service provider, patients are invariably harmed.[22, 25]

Justice

Justice is essentially the underlying pillar of biomedical ethics, its core incorporates the other 3 principles. If one observes the principle of justice in health care, one would automatically observe the principles of autonomy, beneficence, non-maleficence and, of course, justice.[22, 26] It is also the basis for the rights of road accident victims in terms of the applicable laws. In South Africa, the foundation of all laws is the Constitution, and enshrined therein are specific rights towards ensuring that justice for all prevails, equitably. Access to healthcare is detailed in the Constitution, and its application is provided for in the National Health Act. Equality, dignity and protection of the rights of the impaired and disabled victims of road accidents are also fundamental human rights that are protected in the Constitution. The RAF Act is one of the many Act that has been developed, specifically to ensure that the rights of the road accident victims are protected and that fair and just compensation is awarded to the victims. The compensation is not only monetary but also for on-going medical and other therapeutic interventions and support.

This research sought to determine whether victims of road accidents are ethically harmed because of delays in their assessments and compensation, which includes treatment compensation and financial compensation. Using normative and empirical components the ideals and realities claims assessments and administration were explored. The results of this research shows that most, if not, all of the road accident victims have had their claims delayed beyond the periods provided for in the Act. The results also show that the ideals have not been upheld and that victims, who are also vulnerable patients, are ethically harmed.

5.3 Recommendations

Despite the changes in the RAF Act as amended in 2005, there are still many operational inefficiencies at the RAF which can and should be addressed by policy changes. The RAF Amendment Act had initially been proposed, but then in 2014, Road Accident Benefit Scheme (RABS) Bill had been proposed. Many in the RAF had appeared to support a changed system wherein the power to make decisions would be removed from the court systems, and power would vest in a single administrator. [112]

State Capture concerns based on my personal experience on the board appeared to have had a significant influence on many decisions, including the RABS Bill. This must be seen in the context of more than R45 billion annual income is derived from the fuel levy annually for disbursement, with no need to actively source income like other State-owned Entities.

In August 2020, the Parliamentary Committee finally refused to accept the RABS Bill in its entirety and recommended working within the current RAF Act and potential amendments.[113]

Therefore, the RAF is a well-resourced organisation but its operational efficiencies need to be improved, and corruption urgently removed. In the two years, two Board had been appointed. However, on a positive note, the RAF finally has a permanent CEO who has been appointed since August 2020. Based on media reports, he appears to be implementing a turnaround strategy.[114]

It is finally recommended that the RAF urgently implement systems that focus directly on urgently and empathetically managing claims within the 120-day period

or at least actively work towards reducing the delays.

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Appendices

INFORMED CONSENT:

- I hereby confirm that I have been informed by the study doctor, **Dr Terrence Omdutt Kommal, of Ayush Healthcare (Pty) Ltd** about the nature, conduct, benefits and risks of clinical studies which will be done for on-going research by **Dr Terrence Omdutt Kommal, of Ayush Healthcare (Pty) Ltd** for various purposes including research for postgraduate studies, including Masters, Doctoral and other research purposes.
- I have also understood the need for a clinical study. I have no objection to providing informed consent that the medical records collected/recorded information/data may be utilised by **Dr Terrence Omdutt Kommal, of Ayush Healthcare (Pty) Ltd and his delegated parties.**
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and name will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during assessment and the study can be processed in a computerised system by **Dr Terrence Omdutt Kommal, of Ayush Healthcare (Pty) Ltd** or on their behalf.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study. If I do not withdraw my consent, I explicitly agree to allow **Dr Terrence Omdutt Kommal, of Ayush Healthcare (Pty) Ltd and his delegated parties** to utilise the collected information/data for any purpose whatsoever in perpetuity.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.

PARTICIPANT:

Printed Name	Signature / Mark or Thumbprint	Date and Time

I, **Dr Terrence Omdutt Kommal, of Ayush Healthcare (Pty) Ltd,** herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

STUDY DOCTOR:
Dr Terrence Omdutt Kommal

Printed Name	**Signature**	**Date and Time**

TRANSLATOR / OTHER PERSON EXPLAINING INFORMED CONSENT……**(DESIGNATION):**

Printed Name	**Signature**	**Date and Time**

WITNESS (If applicable)**:**

Printed Name	**Signature**	**Date and Time**

INFORMED CONSENT:

INFORMED CONSENT FOR PARENTS/LEGAL GUARDIANS:
(On behalf of minors under 18 years old)

- **Dr Terrence Omdutt Kommal, of Ayush Healthcare (Pty) Ltd has provided me with informtion regarding clinical studies** for on-going research by **Dr Terrence Omdutt Kommal, of Ayush Healthcare (Pty) Ltd** for various purposes including research for postgraduate studies, including Masters, Doctoral and other research purposes and has fully explained to me the nature, risks, benefits and purpose of the study.
- The study doctor has given me the opportunity to ask any questions concerning both the medicine and the study.
- It has been explained to me that I will be free to withdraw my child from the study at any time, without any disadvantage to future care.
- I have understood everything that has been explained to me and I consent for my child to participate in this clinical study.

PARENT/LEGAL GUARDIAN:

Printed Name	**Signature / Mark or Thumbprint**	**Date and Time**

PARTICIPANT ASSENT: * (Seven (7) years old and above)

Printed Name	**Signature / Mark or Thumbprint**	**Date and Time**

(* Minors competent to understand must participate as fully as possible in the entire procedure)

STUDY DOCTOR:
Dr Terrence Omdutt Kommal

Printed Name	**Signature**	**Date and Time**

TRANSLATOR / OTHER PERSON EXPLAINING INFORMED CONSENT:……**(DESIGNATION):**

Printed Name	**Signature**	**Date and Time**

WITNESS (If applicable)**:**

INFORMED CONSENT:

- I hereby confirm that I have been informed by **Dr Terrence Omdutt Kommal, of Ayush Healthcare (Pty) Ltd** about the importance of doing clinical studies, and the benefits and risks of which will be done for on-going research by **Dr Terrence Omdutt Kommal, of Ayush Healthcare (Pty) Ltd** for various purposes including research for postgraduate studies, including Masters, Doctoral and other research purposes. These will be done retrospectively on the records, and long after my assessment and examination reports have been finalised.
- I also understand the need for studies of these medico-legal assessments. I have no objection to providing informed consent that the medical records collected/recorded information/data may be utilised by **Dr Terrence Omdutt Kommal, of Ayush Healthcare (Pty) Ltd and/or his delegated parties.**
- I agree that the results of the study, including personal details regarding my sex, age, date of birth, initials and name will be anonymously processed into a study report.
- I understand that that any such studies will be done only after research ethics approval.
- In view of the requirements of research, I agree that the data collected during assessment and the study can be processed in a computerised system by **Dr Terrence Omdutt Kommal, of Ayush Healthcare (Pty) Ltd** or on their behalf.
- I understand that I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) that I am willing to allow my data to be used in future studies.

PARTICIPANT:

Printed Name	Signature / Mark or Thumbprint	Date and Time

I, **Dr Terrence Omdutt Kommal, of Ayush Healthcare (Pty) Ltd,** herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

STUDY DOCTOR:
Dr Terrence Omdutt Kommal

Printed Name	**Signature**	**Date and Time**

TRANSLATOR / OTHER PERSON EXPLAINING INFORMED CONSENT……**(DESIGNATION):**

Printed Name	**Signature**	**Date and Time**

WITNESS (If applicable)**:**

Printed Name	**Signature**	**Date and Time**

INFORMED CONSENT:

INFORMED CONSENT FOR PARENTS/LEGAL GUARDIANS:
(On behalf of minors under 18 years old)

- I hereby confirm that I have been informed by **Dr Terrence Omdutt Kommal, of Ayush Healthcare (Pty) Ltd** about the importance of doing clinical studies, and the benefits and risks of which will be done for on-going research by **Dr Terrence Omdutt Kommal, of Ayush Healthcare (Pty) Ltd** for various purposes including research for postgraduate studies, including Masters, Doctoral and other research purposes. These will be done retrospectively on the records, and long after my assessment and examination reports have been finalised.
- I also understand the need for studies of these medico-legal assessments. I have no objection to providing informed consent that the medical records collected/recorded information/data of my child may be utilised by **Dr Terrence Omdutt Kommal, of Ayush Healthcare (Pty) Ltd and/or his delegated parties.**
- I agree that the results of the study, including personal details regarding my sex, age, date of birth, initials and name will be anonymously processed into a study report.
- I understand that that any such studies will be done only after research ethics approval.
- In view of the requirements of research, I agree that the data collected during assessment and the study can be processed in a computerised system by **Dr Terrence Omdutt Kommal, of Ayush Healthcare (Pty) Ltd** or on their behalf.
- I understand that I may, at any stage, without prejudice, withdraw my consent and withdraw my child and their participation in the study, without any disadvantage to future care.
- I have understood everything that has been explained to me and I consent for my child that I am willing to allow my child's data to be used in future studies.

PARENT/LEGAL GUARDIAN:

Printed Name	**Signature / Mark or Thumbprint**	**Date and Time**

PARTICIPANT ASSENT: * (Seven (7) years old and above)

Printed Name	**Signature / Mark or Thumbprint**	**Date and Time**

(* Minors competent to understand must participate as fully as possible in the entire procedure)

STUDY DOCTOR:
Dr Terrence Omdutt Kommal

Printed Name	**Signature**	**Date and Time**

TRANSLATOR / OTHER PERSON EXPLAINING INFORMED CONSENT:……**(DESIGNATION):**

Appendix C

Data collection form:

		To be anonymised										
	name	age	sex	location	file number	date of injury	date of assessment	Prior medical management	If yes, Sector:	Employment	Employment	Return to work capacity finding
		0-99	M/F	Province	Ayush ref			Y/N	Private/Public	time of accident	time of assessment	Yes/No/Limited capacity
1												
2												
3												
4												
5												

R14/49 Dr Terrence Omdutt Kommal

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M151025

NAME: (Principal Investigator)	Dr Terrence Omdutt Kommal
DEPARTMENT:	Steve Biko Centre for Bioethics Ayush Health Care Office, Waterkloof Ridge, Pretoria
PROJECT TITLE:	An Ethico-Legal Study on Delays of Road Accident Fund Assessments in a Practice in SA
DATE CONSIDERED:	30/10/2015
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Prof Ames Dhai
APPROVED BY:	Professor A Woodiwiss, Co-Chairperson, HREC (Medical)
DATE OF APPROVAL:	11/12/2015

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Research Office Secretary in Room 10004, 10th floor, Senate House/2nd Floor, Phillip Tobias Building, Parktown, University of the Witwatersrand. I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit the application to the Committee. **I agree to submit a yearly progress report**.

Principal Investigator Signature Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

1. Plagiarism Declaration

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

FACULTY OF HEALTH SCIENCES

PLAGIARISM DECLARATION TO BE SIGNED BY ALL HIGHER DEGREE STUDENTS

SENATE PLAGIARISM POLICY: APPENDIX ONE

I Terrence Omdutt Kommal (Student number: 927643) am a student registered for the degree of MSc(Med) (Bioethics and Health Law) in the academic year 2021.

I hereby declare the following:

- I am aware that plagiarism (the use of someone else's work without their permission and/or without acknowledging the original source) is wrong.
- I confirm that the work submitted for assessment for the above degree is my own unaided work except where I have explicitly indicated otherwise.
- I have followed the required conventions in referencing the thoughts and ideas of others.
- I understand that the University of the Witwatersrand may take disciplinary action against me if there is a belief that this is not my own unaided work or that I have failed to acknowledge the source of the ideas or words in my writing.
- I have included as an appendix a report from "Turnitin" (or other approved plagiarism detection) software indicating the level of plagiarism in my research document.

Signature:  Date: 29 March 2021

1

2. Turnitin Report Summary

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