NATIONAL ASSOCIATION OF DEMOCRATIC LAWYERS

FOUNDATIONAL PRINCIPLES OF MEDICAL LAW AND ETHICS WORKSHOP

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1 INTRODUCTORY REMARKS

It is evident in South Africa today, that medical practitioners and medical healthcare centres, including public hospitals and privately funded hospitals, clinics and nursing homes are being sued by patients than ever before. The most recent figures released by the Minister of Health, Aaron Motsoaledi, in parliament on 30 October 2017 revealed that the Health Department since 2014, have been faced with multiple claims inter alia 1562 claims in 2014/15, 1732 in 2015/16 and 1934 in 2016/17. So far in the current financial year, 360 claims had been lodged. Pay – outs run into billions. The Eastern Cape had the biggest number of claims.

What causes the increases? Perhaps, the fact that the general public appear to be more aware of their rights, both constitutionally[1] or otherwise[2] and less hesitant to take on the medical profession, serve as strong motivating factors. Then off course there is the influence of lawyers who are perceived to be in a culling mode, who do not help the position of the medical profession.

The most common medical malpractice claims emanate from misdiagnosis, surgical mistakes, birth injuries, cosmetic blunders, foreign objects left behind after surgery and anaesthesia malpractice.

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[1] See especially the constitutional right including the right to dignity (section 10); the the right to life (section 11); the right to bodily and psychological integrity (section 12(2)); the right to privacy (section 14); the right to access health care services (section 27(1)(a); the right to emergency medical treatment (section 27(1)(b)).

[2] See The *National Health Act* 61 of 2003 governs all health institutions including, those in the public and private sectors. It sets standards aimed at sound health care services. See also *Health Professions Act* 56 of 1974 (as amended), and other ancillary legislation which have contributed towards finding a jurisprudence in South Africa. More recently, with the signing into law the *Consumer Protection Act*, the Act will still have a profound effect on the medical profession in protecting the general public against wrongful practices.

But, medicine is not an exact science and those cases are sometimes difficult to prove against medical practitioners and medical institutions against whom civil claims are instituted. Legal practitioners engaging in this type of litigation, would be wise to adequately equip themselves to handle these types of cases with the utmost care and diligence. The differences between handling these cases and RAF matters, are stark. The same caution may be rendered to those experts who assist in the litigation process.

2 THE DOCTOR/HOSPITAL – PATIENT RELATIONSHIP

The doctor/hospital – patient relationship is central to our discourse that follows. The relationship between the doctor and patient and/or the hospital and patient have a profound effect as it brings about a legal relationships and many other legal aspects that flow from there. This may include what type of legal relationship came into being and what legal obligations are assigned to the parties in law and for which they are accountable. A cursory glance at the nature of the said relationships will reveal that the relationships are essentially a private matter and governed by the law of obligations: that is to say the Law of Contact and the Law of Delict.[3] Both the contractual relationship as well as the delitual relationship have some overlapping features in so far as their obligations are concerned.

The primary obligation on the doctor or hospital towards the patient, includes a duty of reasonable care to prevent harm from occurring to the patient. When not adhered to, this may lead to liability for negligence.[4] The relationship also establishes patient autonomy in which the patient or family in emergency situations has to be consulted by the doctor or the hospital staff before treatment is commenced or corrective surgery is conducted.[5] The term 'doctor/hospital and patient relationship' has therefore given rise to medical

[3] Van Oosten "Medical Law – South Africa" in International Encyclopaedia of Law (1996) 53. The writer expresses the view that ordinarily the relationship between the parties is a contractual one but since the breach of a duty of care and negligence may underlie both a breach of contract and a delict. The same act or omission by a doctor or hospital may result in a liability for both in contract or delict. See also a discussion on the nature and effects of nature of the relationship in Lerm 'A Critical Analysis Of Exclusionary Clauses In Medical Contracts' (2008) (Unpublished Thesis University of Pretoria) 44ff. For case law see *Van Wyk v Lewis* 1924 AD 438, 450-451; *Correira v Berwind* 1986 (4) SA 60 (Z) 63; *Edouard v Administrator, Natal* 1989 (2) SA 368 (D).

[4] Van Oosten (1996) 57-58. Carstens and Pearmain *Foundational Principles of South African Medical Law* (2007) 406-407.

[5] See the discussion on the change of the paternalistic model once encountered between the doctor and patient to the modern autonomous relationship in Benatar "The Changing Doctor-patient Relationship and the New Medical Ethics" SA Journal of Continuing Medical Education Vol. 5 (April 1987) 27; Strauss "Geneesheer, Pasient en die Reg: n Delikate Driehoek" (1987) TSAR 1ff.

standards that need to be maintained and the consequences that may follow where a breach of the standards are encountered.

The medical practitioner's liability thus arises *ex contractu*, alternatively, *ex delicto* or simultaneously.[6] Consequently, a brief discussion on the salient legal aspects follow.

2.1 **THE CONTRACTUAL RELATIONSHIP**

The contractual relationship between the medical practitioner/hospital and the patient has been described as a contract of mandate [7] or a contract of service [8] Determining the cause of action, will reveal whether it is found in contract or in delict or both. Features of the contractual relationship will reveal:

- the existence of an agreement to treat or operate on the patient;
- the terms of the agreement;
- the breach of any terms agreed to;
- if the agreement was still intact when the breach occurred. [9]

The legal relationship is a consensual one [10] and it is founded upon the fact that the medical practitioners in private practice are a free agent or independent contractor. Likewise, the patient generally possesses the necessary autonomy to enter into such relationship. Consensus is reached when the medical practitioner agrees to treat the patient and the patient agrees to be treated or operated on.

A contractual relationship may arise from:

- an oral agreement, express or implied, for as long as the consensually aspect can be established; [11]

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[6] Van Oosten (1996) 57-58; Carstens and Pearmain (2007) 407

[7] The doctor is regarded as the agent and the patient the mandator. Strauss and Strydom *Die Suid Afrikaanse Geneeskundige Reg* (1967) 104; Claasen and Verschoor *Medical Negligence in South Africa* (1992) 115.

[8] De Wet and Yeats *Die Suid-Afrikaanse Kontraktereg en Handelsreg* (1978) 307ff. See also the case of *Myers v Abrahamson* 1951 (3) SA 438 (C).

[9] Van Oosten (1996) 54ff; Strauss and Strydom (1967) 104ff; Strauss Doctor Patient and the Law: A Selection of Practical Issues (1991) 3ff; Carstens and Pearman (2007) 404ff. This is particularly relevant in cases where informed consent is required, for example, the patient is fully informed of the nature of the proposed treatment; its consequences and the consequences of not having it; the risks associated with it and the alternative to it. See *Castell v De Greef* 1993 (3) SA 501 (C); Castell v De Greef 1994 (4) SA 408 (C); *Broude v McIntosh* 1998 (3) SA 60 (SCA); *Minister of Health v Treatment Action Campaign (No 2)* 2002 (5)SA 721 (CC).

[10] Van Oosten (1996) 63; Strauss (1991) 3; Claasen and Verschoor (1992) 116.

[11] Strauss and Strydom (1967) 105ff; Strauss (1991) 5; Van Oosten (1996) 54ff.

- a written agreement with express or implied term.

Ordinarily, the contract entered into between the medical practitioner and patient, takes the form of a tacit agreement with implied terms:

- the doctor undertakes to diagnose the patient's complaint and to treat him/her in the usual manner;
- that the patient will be treated with reasonable care and skill by the medical practitioner or hospital staff in treating and/or operating on the patient.[12]
- the patient undertakes to subject himself/herself to the prescribed treatment and to pay the doctor his/her fee. [13]

The effect of entering into the agreement is twofold:

- a doctor/hospital may not abstain from that what he/she or it has undertaken to do;
- the doctor/hospital may not depart or deviate from the implied terms of the agreement.

Where he/she/it does:

- it constitutes a breach of contract;
- the patient may claim for patrimonial loss but not for non-pecuniary damages;
- the doctor/hospital may forfeit the fee for services rendered. [14]

An example can be found in *Administrator of Natal v Edouard* [15] in which the hospital authority was held liable for damages resulting from a breach of contract in that the hospital doctors had failed to carry out an undertaking to perform a tubular ligation (sterilization) on a woman who subsequently fell pregnant and gave birth to a child.

Proof of the existence of the contractual relationship thus provides:

- evidentiary materials to establish contractual liability;
- successful civil litigation or a possible conviction in a criminal case.

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[12] Van Oosten (1996) 54; Claassen and Verschoor (1992) 115-116; Strauss and Strydom (1967) 106. For case law see *Kovalsky v Krige* 1910 (CTR) 822; *Coppen v Impey* 1916 (CPD) 309; *Mitchell v Dixon* 1914 (AD) 519; *Van Wyk v Lewis* 1924 (AD) 438; *Buls v Tsatsarolakis* 1976 (2) SA 891 (T).

[13] Van Oosten (1996) 54ff; Strauss (1991) 3.

[14] Van Oosten (1996) 56; Strauss and Strydom (1967) 107; Claassen and Verschoor (1992) 116.

[15] *Administrator of Natal v Edouard* 1990 (3) SA 581 (A).

It is thus vital to establish the following with regard to the contract entered into between the doctor/hospital and patient:

- if such contractual relationship came into being?
- when such contractual relationship commenced?
- what are the terms and conditions of the contractual relationship?
- in what respect the terms and conditions were not complied with?

By undertaking to treat the patient, a doctor does not however, guarantee that the patient will be cured of his/her ailment or complaint. [16] Should the medical practitioner be so unwise but fails to deliver on his undertaking, he/she will be in breach of the terms of the contract. [17]

Besides the general tacit agreements between medical practitioner and the patient, and the implied terms included therein, the parties may also decide to enter into written agreements with express terms. This is particularly relevant where:

- the doctor has to adopt unusual procedures;
- the patient is hospitalized;
- more serious operations and/or complicated treatment/surgery are undertaken.

One of the terms contained therein is that the hospital and its staff owe the patient a duty to take care. In these instances, the medical practitioner and/or his hospital will be best advised to enter into a written agreement with the patient.[18] Besides the certainty it creates in the doctor/hospital and patient relationship, it also assists with litigation in that the terms and conditions agreed to can be established more easily.[19] Besides the doctors, hospital authorities may also be held liable for damages resulting from a breach of contract where the hospital doctors and/or nursing staff have failed to carry out an undertaking to provide adequate treatment. The liability arises from the hospital authority's liability for the acts of professional negligence on the part of the employees, otherwise known as vicarious liability. [20]

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[16] Strauss (1991) 5; Claassen and Verschoor (1992) 105-110; Van Oosten (1996) 54ff. For case law see *Buls and Another v Tsatsarolakes* 1976 (2) SA 891 (T).

[17] Strauss and Strydom (1967) 107; Claassen and Verschoor (1992) 116; Van Oosten (1996) 54; See also the case of *Sutherland v White* 1911 EDL 407.

[18] Strauss and Strydom (1967) 105.

[19] Strauss (1991) 8-9; Claassen and Verschoor (1992) 118.

[20] The South African position with regard to hospital liability *ex contractu* is set out in: Van Oosten Encyclopaedia (1996) 86ff; See also Strauss (1991) 299ff; Claassen and Verschoor (1992) 98. As far as case law is concerned, see

The agreement between the medical practitioner and patient requires no legal formalities to bring about a valid contract. [21] Because most of the agreements take the form of a tacit agreement, [22] it is not that easy to establish whether a contractual relationship has been formed. This can be ascertained by:

- firstly, look at the mere conduct of the parties.
- the commencement of the relationship can generally be inferred from the patient consulting the doctor and the doctor beginning to attend to the patient; [23] or
- where a doctor is summoned to a person who is ill, the summonsing of the doctor is

an indication that the sick person instructs the doctor. The minute the doctor commences his examination and treatment of the patient, this concludes the agreement. [24]

The contractual relationship is more easily ascertained in a hospital and patient relationship. It is today standard practise that, when a patient is admitted to a hospital or clinic, the agreement is usually reduced to writing. The patient is required to sign an admission form which also serves as a consent form and which sets out *inter alia* the type of treatment or operation which the hospital/doctor/clinic will undertake. They include express terms. [25]

But, although no formalities are required to enter into a contractual relationship and the agreement generally comes into existence by mere consensus.[26] Consensus in this regard, is generally dependent on the following:

- offer and acceptance;[27]

Lower Umfolozo District War Hospital v Lowe 1937 (NPD); *Mtetwa v Minister of Health* 1989 (3) SA 600 (D); *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T); *Dube v Administrator Transvaal* 1963 (4) SA 260 (W); *Magware v Minister of Health NO* 1981(4) SA 472 (Z) ; *Soumbasis v Administrator of the Orange Free State* 1989 (0) unreported; *Pringle v Administrator, Transvaal* 1990 (2) SA 379 (W); *Collins v Administrator Cape* 1995 (4) SA 73 (C); *Clinton Parker v Administrator, Transvaal* 1996 (2) SA 37 (W); *St Augustine Hospital (Pty) Ltd v Le Breton* 1975 (1) SA 530 (D); *Buls v Tsatsarolakis* supra fn 36; *Edouard v Administrator, Natal* 1989 (2) SA 368 (D); *Administrator, Natal v Edouard* 1990 (3) SA 581 (A); *Burger v Administrateur, Kaap* 1990 (1) SA 483 (C).

[21] Van Oosten (1996) 54; Strauss and Strydom (1967) 105; See also *Myers v Abrahamson* supra 438 in which the court stated that *"the agreement between the doctor and patient being a consensual one, the law does not require the doctor and patient to go about it as though they are drawing up a deed of sale."*

[22] Van Oosten (1996) 59. See also *Buls v Tsatsarolakis* 1976 (2) SA 891 (T).

[23] Van Oosten (1996) 54.

[24] Strauss and Strydom (1967) 105.

[25] *Ex parte Dixie* 1950 (4) SA 748 (W); Van Oosten (1996) 54 states that hospitals, irrespective of whether they run privately or by the State, usually require from their patients the signing of an admission form. See also *Esterhuizen v Administrator, Transvaal* supra; *Castell v De Greef* supra.

[26] Van Oosten (1996) 54; Claasen and Verschoor (1992) 115.

[27] This can be ascertained actual communication; acceptance take place when the doctor starts treating the patient or the hospital admits the patient for treatment.

- intention to contract; [28]
- capacity to contract;[29]
- terms of the agreement;[30]

2.2. CONTRACTUAL DUTIES OF THE DOCTO/HOSPITAL STAFF

Both the medical practitioner and hospital are entrusted with a number of duties he/she/it must carry out.

In broad terms, the duties and obligations of the doctor/hospital towards the patient include: *inter alia*:

- a duty to inform the patient of the treatment to be given [31]
- receiving the patient's consent before starting treatment; [32]
- exercise the patient's instructions honestly, faithfully and with due care and skill; [33]
- a duty to complete the treatment once commenced;
- respect the confidential relationship between them and not to disclose any information about the

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[28] This occurs where a patient receives dental treatment and is given dentures or a patient is hospitalized and has an artificial limb fitted. Van Oosten (1996) 53-54. See also *Tulboch v Marsh* 1910 (TPD) 453; *Sutherland v White supra* 407; *Noakes v Niland* 1914 (CPD) 9 76; *Kruger v Baltman* 1993 (1) PH 306; *S v Progress Dental Laboratory (Pty) Ltd* 1965 (2) SA (T).

[29] One of the *essentiallia* for a valid contract between the doctor/hospital and the patient is that the parties must have the necessary contractual capacity at the time when the contract is entered into. Generally, adult patients have the capacity to enter into the agreement. Where they cannot consent, they must be assisted by a family member or curator where necessary. Strauss (1991) 3. See the *National Health Act* 61 of 2003; Children under 18 in terms of section 7(1) of the *Child Care Act* 38 of 2005of are generally assisted by their parents or legal guardians. Sometimes certain people may act as in loco parentis where parents are temporarily absent. Strauss (1991) 6-7; Van Oosten (1996) 66. Children sometimes have the legal capacity to consent for example to abortions. See the Choice on Termination of Pregnancy Act 92 of 1996. It has happened that for religious reasons parents do not want to consent to say a blood transfusion, the administrator of the hospital or medical practitioner may then seek an order of court. See *Seetal v Pravitha NO* 1983 (3) SA 827 (D); *S v L* 1992 (3) SA 713 (E) 723; *O v O* 1992 (4) SA 137 (C) 139.

[30] Any term in a contract contrary to statutes or the common law, would be against public policy. See Van Oosten (1996) 64. For case law in the general sense, see *Sasfin (Pty) Ltd v Beukes* 1989 (1) SA 1 (A).

[31] The doctor must give substantial knowledge concerning the nature and effect of the act consented to by the patient so that the patient has an idea what he or she consents to. Claassen and Verschoor (1992) 62; Strauss (1991) 6; Carstens and Pearmain (2007) 875ff. For case law see For case law see *Lymbery v Jefferies* 1925 (AD) 236 240; *Rompel v Botha* 1953 (T) unreported discussed in *Esterhuizen v Administrator, Transvaal* supra; *Castell v De Greef* supra 416-418. This includes the risks, complications, benefits, disadvantages and dangers of the proposed intervention. See Van Oosten (1996) 449-450; Isaacs v Pandie 2012 JDR 0866 (WCC).

[32] Van Oosten (1996) 63.

[33] Strauss and Strydom (1967) 111; Claassen and Verschoor (1992) 116.

patient unless, sanctioned by law. [34] But the patient's right to privacy and the doctor's duty of confidentiality are not absolute.[35]

The patient on the other hand, has a duty:

- to make himself/herself available for treatment;
- to comply with the instructions of the doctor and/or hospital staff; [36]
- to pay the medical bill once provided.

2.2.1 THE FAILURE TO CARRY OUT AN UNDERTAKING TO HEAL OR CURE

A practitioner or specialist as a general rule does not guarantee to cure the patient. [37] What he/she does, is to undertake to conduct himself/herself with reasonable knowledge, skill and diligence.[38] Where he/she warrants that he/she will heal the patient or provide a cure, but fails to achieve the result, the patient may be able to claim damages for breach of contract.[39]

2.3 THE DELICTUAL RELATIONSHIP

Mention was made earlier that a contractual relationship brings about obligations for the doctor/hospital and other healthcare providers towards the patients treated by them. Such obligations also arise from the delictual relationship between the aforementioned and their parties *ex delicto*.[40] A salient feature of the

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[34] Van Oosten (1996) 90; Carstens and Pearman (2007) 943ff. See the case law in *Parkes v Parkes* 1916 (CPD) 702; (Disclosure that patient was suffering from a sexually transmitted disease) *Jansen van Vuuren v Kruger* 1993 (4) SA 842 (A) (Disclosure that the patient was suffering from AIDS) the court in this case held that it amounted to unprofessional conduct; See also *Botha v Botha* 1972 (2) SA 599 (W) (Disclosure of fitness to be awarded custody of children in divorce trial). Section 14 of the *National Health Act* 61 of 2003 protects the right to privacy and confidentiality.

[35] Some of the defences include consent, privilege, court order or litigation, statutory authority or statutory duty and public interests. See Van Oosten (1996) 92; Strauss (1991) 106,112; Carstens and Pearmain (2007) 982ff. For case law see *Jansen van Vuuren v Kruger* ibid 850.

[36] Strauss and Strydom (1967) 115-119. For case law see *Myers v Abrahamson* supra 127. See further the *National Health Act* that imposes the following general duties inter alia compliance with the rules of the hospital or clinic; tendering accurate information regarding his or her health; full co-operation when being treated.

[37] *Kovalsky v Krige* supra 823; *Coppen v Impey* 1916 (CPD) 309; *Van Wyk v Lewis* supra 456.

[38] Van Oosten (1996) 82ff.

[39] Claassen and Verchoor (1992) 116; Strauss and Strydom (1967) 106-107; Carstens and Pearmain (2007) 642ff.

[40] *Edouard v Administrator, Natal* 1989 (2) SA 368 (D); *Administrator, Natal v Edouard* 1990 (3) SA 581(A); *Correira v Berwind* 1986 (4) 60 (ZHC); *Isaacs v Pandle* 2012 JDR 0866 (WCC); *Magware v Minister of Health NO* 1981 (4) SA 472 (Z); *Buls v Tsatsarolakis* 1976 (2) SA 891 (T).

delictual obligations includes the strong commitment to long-standing principles of medical ethics. Those principles centre round:

- adherence to the Hippocratic Oath;
- appreciating the sanctity of life and bodily integrity;
- trust and respect;
- compliance with the general duty of care and standards of conduct;
- adequate care and safety of patients;
- always acting in the best interests of the patient. [41]

Besides the duty of care owed to their patients in contract, doctors/hospitals and other health care providers also owe their patients a duty of care in delict.[42] The duty of care arises quite independently of any contract or it may exist side by side with the contractual obligation.[43] Whatever the position, there is really one duty generating alternative or concurrent remedies or causes of action. [44] Where for example, a surgeon carries out an operation in a negligent and improper manner:

- the surgeon breaches the contractual terms of the agreement; and
- breaches his/her general duty in delict to respect the patient's right of bodily integrity and security. [45]

The duty of care in modern day includes:

- competence;
- compassion;
- confidentiality;
- truthfulness.

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[41] Jones *Hippocrates* (1923) 18ff; Mason and McCall-Smith *Law of Medical Ethics* (1994) 14-17; Beauchamp and Childress *Principles of Biomedical Ethics* (1994) 1-7.

[42] Claassen and Verschoor (1992) 118; Strauss and Strydom (1967) 266; Van Oosten (1996) 57; Strauss (1991) 36-37, 331; Carstens and Pearmain (2007) 489ff; For case law see generally Kruger v Coetzee 1966 (2) SA 428 (A); *Correira v Berwind* 1986 (4) SA 60 (Z) 66ff; *Van Wyk v Lewis* supra 443-444; 455-456; *Collins v Administrator Cape* supra 66ff; *Buls v Tsatsarolakis* supra 891.

[43] There is no fundamental difference between a delict and a breach of contract and the obligation that arises for the medical practitioner/hospital is very much the same. See Strauss "A duty of care of doctor towards the patient may arise independent of contract" *SA Practise MAN Vol 9* 155 2 (1988); Claassen and Verschoor (1992) 115. See also *Correira v Berwind* 1986(4) SA 60 (Z).

[44] Claassen and Verschoor (1992) 125; Van der Merwe and Oliver *Die Onregmatige Daad in die Suid-Afrikaanse Reg* (1989) 462 ff. For case law see *Van Wyk v Lewis* supra 438; *Correira v Berwind* ibid 66.

[45] Claassen and Verschoor (1992) 118; Van der Merwe and Olivier supra ibid 467.

Some of the general duties of the doctor/hospital staff towards the patient include:

- making careful diagnosis;
- properly informing the patient about any proposed treatment or operation;
- explaining the inherent (material) risks of treatment or surgical intervention.

2.4 THE DOCTOR'S/HOSPITAL'S STANDARD OF CARE

As the work of the doctor/hospital requires some form of skill, the standard of care required of the medical practitioner is upgraded for the medical practitioner engages in an activity calling for expertise.[46] The conduct of the doctor and/or hospital staff is not measured against that of the hypothetical or fictitious reasonable person.[47] A more subjective test is being used. His / her conduct is measured against the reasonable doctor/specialist in the same position or class.[48] The term `reasonableness' signifies that what is required is not the highest possible degree of professional care and skill.[49] Nor is brilliance a requirement. The standard is pegged rather at:

- the average doctor with a general level of knowledge, ability and experience; [50] or
- the general skill and diligence possessed and exercised by members of the branch of the profession to which the practitioner belongs. [51]

The test for the standard of care is often formulated as:

- how would a reasonable competent practitioner in that branch of medicine have acted in a similar situation?

The Appellate Division per Innes ACJ put the position as follows in *Mitchell v Dixon*[52] :

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[46] Van der Merwe and Olivier supra (1989) 142; Van Oosten (1996) 81-82.

[47] Boberg *Delict: Principles and Cases Vol 1: Aquilian Liability* (1984) 346 sums up the position as "*One cannot judge a surgeon's conduct by asking how a diligens paterfamilias would have operated, for either he would not have operated at all ....*"

[48] *Kovasky v Krige* (1910) 20 CTR 822; *Van Wyk v Lewis* 1924 (AD) 438; Mitchell v Dixon 1914 AD 519.

[49] *Van Wyk v Lewis* supra 444; *R v Van Schoor* 1948 (4) SA 349 (C) 461.

[50] Strauss (1991) 36ff. For case law see *Kovasky v Krige* supra 822.

[51] Strauss (1991) 95; Carstens and Pearmain (2007) 619ff. See also *R v Van der Merwe* 1953 (3) PH 124 W.

[52] *Mitchell v Dixon* 1914 (AD) 5 19.

- *"A medical practitioner is not expected to bring to bear upon the case entrusted to him the highest possible degree of professional skill, but he is bound to employ reasonable skill and care; and he is liable for the consequences if he does not."* [53]

2.5. THE ELEVATED STANDARD OF CARE OF THE SPECIALIST

A clear distinction is drawn in South African law between the standard of care expected of the medical practitioner and the medical specialist.

Thus the test for to establish medical negligence is not the same for that of the general practitioner as opposed to that of a medical specialist.[54] Of the specialist is expected a greater degree of skill than that of a general practitioner.[55] But, the conduct of the specialist is nevertheless measured against the average or reasonable specialist in his/her class or field.[56]

2.6 MEDICAL NEGLIGENCE IN CIVIL LAW CASES

In civil litigation the doctor's/specialist/hospital staff's conduct is measured against the appropriate standard of care of:

- the reasonable doctor; or
- the reasonable specialist; or
- the reasonable nurse or other hospital staff member.

The profession to whom the above health care members belong thus formulate and regulate their own standards. But, in general terms it can be said that the medical doctor or specialist, must exercise reasonable care and skill.[57]

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[53] *Mitchell v Dixon* ibid 525; *Van Wyk v Lewis* supra 444.

[54] Van Oosten (1996) 19; Carstens and Pearmain (2007) 623ff.

[55] The distinction arises from the fact that a specialist, by definition, holds himself/herself out as possessing greater skill in his speciality than the doctor. See Strauss and Strydom (1967) 268; Strauss (1991) 151; For case law see *Van Wyk v Lewis* supra 457.

[56] Strauss and Strydom (1967) 124; Carstens and Pearmain (2007) 623. For case law see *R v Van der Merwe* supra 115; *Esterhuizen v Administrator, Transvaal* supra 723-724; *Buls v Tsatsarolakis* supra 893-894; *Pringle v Administrator, Transvaal*1990 (2) SA 379 (WLD) 384.

[57] Collins v Administrator, Cape 1995 (4) SA 73 (C); Lourens v Oldwage 2006 (2) SA 161 (SCA); Hoffman v MEC Dept of Health, Eastern Cape 2011 JDR 1081 (ECP).

2.7 WHAT IS PROFESSIONAL MEDICAL NEGLIGENCE?

Professional medical negligence refers to

- ❖ the faulty conduct of a medical practitioner or hospital staff

  whose conduct was unlawful and/or negligent.

The faulty behaviour of the medical practitioner or hospital staff is found in:

- the carelessness; or
- the imprudence of the conductor.

2.7.1 MEASURING FAULTY CONDUCT

The cardinal question in trying to establish blame would be to ask:

- ❖ how a reasonable competent practitioner or nurse in that branch of medicine would have acted in a similar situation?

The answer depends very much on:

- expert medical evidence placed before the court or say disciplinary hearing;
- whether the plaintiff (the patient or those suing on the plaintiff's behalf) has discharged the onus of proof.

What has to be shown on a balance of probabilities are:

- there was negligence; and
- he/she has suffered damages;
- the damages suffered are causally linked to the practitioner's/hospital staff's negligent conduct.[58]

3. LIABILITY OF INDEPENDENT CONTRACTORS FOR MISHAPS DURING OPERATIONS

The days of the lone medical man, scalpel in the hand and hunched over the patient is something of the past. The medical man practising modern medicine is very much dependant on the assistance of other medical people including, other specialists, i.e. anaesthetists/surgeons and theatre nurses as well as the fanciest of medical equipment and instruments. The role of modern equipment and the assistance of the anaesthetist and nursing staff are thus intrinsically linked to the practice of medicine.

[58] Strauss (1991) 331.

But, in the private healthcare set up, although they work together as a team in theatre, they are independent of each other.[59] Many dilemmas have occurred in ascertaining who would be liable for professional negligence in the event of something going amiss in the operating theatre or during post-operative treatment? Take for example the role of the anaesthetist. Metaphorically, he is the heartbeat and life support of the operating procedure in the theatre. Where the direct evidence reveals that the anaesthetist had not for example, inserted a tube properly, nor did he monitor the condition of the patient properly and he ought to have picked up the incorrectly placed or misplaced tube, he would be liable for the damage that flow from his negligence.

3.1. LIABILITY OF THE EMPLOYER FOR THE CONDUCT OF AN EMPLOYEE

An employer will generally be liable for the conduct of an employee provided all the requirements required by law can be shown to be present. The principle of vicarious liability is an important consideration when you will have to investigate who to sue. It has the effect of imputing delictual liability to another by virtue of their relationship. What needs to be shown is the presence of negligence i.e. a wrongful act of the employee, causing the damage. Vicarious liability in the general sense, will ordinarily arise in those cases where:

- a person employs another in order to perform a job; and
- the servant then does not execute the job with the expected measure of skill and care; and
- brings about harm to others.[60]

In a medical context, the potential liability of the doctor/hospital for the negligence of his/her professional assistants and nurses and other medical personnel employed by him/her will depend upon the successful implementation of the principle of vicarious liability. [61]

[59] It was held in *S v Kramer* 1987 (1) SA 877 (W) 895 that that neither the surgeon, nor, the anaesthetist, was liable for the other's negligence. Their relationship was described as *"They are not agents of one another. They are not employed and controlled by one another. Each one performs a specific specialised function as part of a team consisting of surgeon, anaesthetist and nursing staff. The one is therefore not responsible for the others conduct in their field of expertise".*

[60] Neethling et al (2006) 338; Strauss (1991) 343.

[61] Strauss supra (1991) 343.

4. TEST FOR MEDICAL NEGLIGENCE

The test generally used is the same regardless of whose conduct is measured. The question commonly used is:

- how would a reasonable competent practitioner (general practitioner or specialist) in that branch of medicine, have acted in a similar situation?
- if a reasonable practitioner (general practitioner or specialist) would have foreseen the likelihood of harm; and
- would have taken steps to guard against its occurrence;
- but, the medical practitioner (general practitioner or specialist) whose conduct is under investigation, failed to;
- this conduct would fall below the standard of care expected of a medical practitioner of his/her class. [62]

The test for negligence of an anaesthetist was described as follows in the case of *Michael v Linksfield Park Clinic (Pty) Ltd*.[63] :

- whether the arrest was foreseeable as a reasonable possibility? and further;
- whether a reasonable anaesthetist would foresee and guard against it from happening; and
- whether the arrest was reasonably avoidable? [64]

The Court held that none of the experts were asked what constitutes a reasonable specialist anaesthetist practice. The Court subsequently held that whilst the plaintiffs deserve sympathy, the evidence did not prove professional negligence.

4.1. THE DISTINCTION BETWEEN GENERAL PRACTITIONER AND THE SPECIALIST

The standard of care and skill to measure medical negligence between a general practitioner and specialist in the medical field is distinguishable. This has come about by virtue of the difference in their level of expertise and the fact that the same standard of care is not required of a general practitioner as

[62] Carstens and Pearmain (2007) 623. For case law see Van Wyk v Lewis 1924 AD 438 at 444; Oppelt v Department of Health [2015] ZACC 33; 2016 (1) SA 325 (CC); Chapeikin v Mini [2016] ZASCA 105

[63] Michael v Linksfield Park Clinic 2001(3) SA 1188 (SCA).

[64] Supra fn.166 1197 H-I.

of a specialist in their respective branches of the medical profession. Of the specialist is required a higher degree of care and skill within his or her field of speciality than a general practitioner.[65]

The standard of negligence as was seen above is upgraded from a general practitioner to the specialist. The test is set out by Innes CJ in the *locus classicus* of *Van Wyk v Lewis*: **[66]**

" ..... in deciding what is reasonable the Court will have regard to the general level of skill and diligence possessed and exercised at the time by the members of the branch of the profession to which the practitioner belongs. The evidence of qualified surgeons or physicians is of the greatest assistance in estimating that general level."

4.2 FACTORS INFLUENCING NEGLIGENCE

There are various factors that influence negligent conduct in the medical profession. They include the following factors.

4.2.1. THE *IMPERITIA CULPAE ADNUMERATUR RULE*

Although the scope of practice for specialists is defined and they may not operate that field of practice, the same cannot be said about general practitioners. Their scope of practice is not defined and there is no regulation prohibiting a general practitioner from doing the work of a specialist. There is however, a common law rule or legal principle, imperitia culpae adnumeratur that does place some kind of restriction on general practitioners doing the work of a specialist. Here, the law does recognize that a medical practitioner may be negligent where he/she undertakes work requiring a certain expertise, which the practitioner does not possess, and consequently, the patient suffered damages. **[67]** Where, for example, he/she takes on the work of a specialist his/her performance will then have to comply with the standard of conduct of the reasonable specialist, belonging to the same speciality, the practitioner professes to be a member of. **[68]**

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[65] Carstens and Pearmain (2007) 624.

[66] Van Wyk v Lewis supra 444 at 446;see also Lourens v Oldwage 2006 (2) SA 161 (SCA);Hoffman v MEC Dept of Health, Eastern Cape 2011 JDR 1081 (ECP).

[67] Carstens and Pearmain (2007) 586ff. For case law see *Dale v Hamilton* 1924 WLD 184*McDonald v Wroe* [2006] 3 All SA 565 (C).

[68] Claassen and Verschoor (1996) 15; See also *S v Mkwetshana* 1965 (2) SA 493 (N).

4.2.2. THE LOCALITY RULE

The locality rule is a principle that is applied in certain jurisdictions around the globe where, in an inquiry into the negligent conduct of a medical practitioner, the professional standard is measured judicially against the medical knowledge, care and skill or practice of that specific geographical area.[69] The application of the rule is particularly relevant in South Africa, given the geographical situation of our country and the often lack of infra – structure encountered there. Hospitals situated in rural towns and rural areas do not have the same medical facilities and equipment as those in the city. They often have to utilize inferior diagnostic and other equipment. Given the difference in circumstances, the question can be begged: what standard of care and skill is then required of a medical practitioner/hospital staff member who practices in a country town or rural area? The answer is still shrouded with uncertainty for judicially, judges seem to be divided [70] and the same applies to our legal writers.[71]

4.3. DEGREES OF NEGLIGENCE

A distinction is commonly drawn between:

- gross negligence;
- slight negligence.

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[69] Strauss and Strydom (1967) 268-270; Carstens and Pearmain (2007) 636.

[70] In the case of Van Wyk v Lewis supra the two judges hearing this matter was divided on the aspect whether the standard of knowledge, care and skill expected of a physician may be influences by the locality where the physician finds himself. Innes CJ on the one hand penned: "*The ordinary medical practitioner should exercise the same degree of skill and care, whether he carries on his work in the town or the country, in one place or another. The fact that several incompetent or careless practitioners happen to settle at the same place cannot affect the standard or diligence and skill which local patients have the right to expect.*" (444) On the other hand, Wessels AJ stated his view as follows: *"..... you cannot expect the same skill and care of a practitioner in a country town in the Union as you can of one in a large hospital in Cape Town or Johannesburg. In the same way you find with leading surgeons in the large hospitals of London, Paris and Berlin. It seems to me, therefore, that the locality where an operation is performed is an element in judging whether or not reasonable skill, care and judgement have been exercised."* (457)

[71] Gordon Turner & Price 112-113 proffers the approach adopted by Innes CJ when they suggest: *"What difference can it possibly make to the skill and care required of a practitioner in himself, whether he is attending a patient in Cape Town or in some remote farm on the edge of Kalahari desert?*" On the other hand, Carstens "The Locality Rule of Medical Malpractice" *De Rebus* (1990) 421-423 prefers the view of Wessels AJ when he states: *"..... a distinction should be drawn between the subjective abilities (such as skill, education and knowledge) and the objective circumstances in which he finds himself in a particular locality."* Carstens and Permain (2007) 637 continues to
proffer the view of Wessels AJ especially given the medical realities of South Africa.

The different degrees make no difference in either, civil or criminal litigation.[72] But, the degree of negligence might have a bearing on the gravity of the punishment/sentence imposed in criminal litigation or disciplinary hearings conducted by the HPCSA.[73]

5. CONTRIBUTORY NEGLIGENCE

Contributory negligence in itself is no total defence in either criminal or civil litigation.[74] But, contributory negligence is a useful tool when an apportionment of damages is sought in civil litigation. It serves as a strong mitigating factor in criminal cases or disciplinary hearings. An illustration of contributory negligence in the civil context appeared in the case of *Dube v Administrator, Transvaal.*[75] The test is laid down by the court as follows:

"A patient is generally not guilty of contributory negligence if his ostensible lack of care for his own health or safety was caused by the conduct of the defendant which induced or misled him to believe or assume reasonably that his action or inaction would not endanger his life or safety."

The Court subsequently held that the plaintiff was not guilty of any contributory negligence. Consequently, the plaintiff succeeded in his claim.

6. MEDICAL MISHAPS (MISTAKES) AND ERRORS OF JUDGEMENT

Because medicine is not an exact science, the medical profession is frequently faced with inherent risks and dangers. For that reason, medical practitioners are seen as human beings and not robots. The practitioner's fallibility in certain circumstances, is therefore, understood. But the law draws a distinction between medical mistakes which are regarded by law as excusable and mistakes that by law, are inexcusable and amount to negligence.[76] The same applies to errors of judgment.[77] Consequently all

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[72] Carstens and Pearmain (2007) 847.

[73] Carstens and Pearman (2007) 639, 847; Van Oosten (1996) para [162].

[74] Gordon et al (1953) 186; Strauss and Strydom (1967) 322-323; Carstens and Pearmain (2007) 639,938. For case law see *Byrne v East London Hospital Board* 1926 EDL 12 128; *Dube v Administrator, Transvaal* 1963 (4) SA 260 (SCA); *Sonny and Another v Premier of the Province of Kwazulu-Natal and Another* 2010 (1) SA 427 (KZP).

[75] In Dube v Administator, Transvaal 1963 (4) SA 260 at 270 the Plaintiff was not adequately warned to return when the swelling started to his forearm leading to the amputation of the arm. (the Volkmann Ischaemia case).

[76] Dutton (2015) 109-110 with reference to *Buthelezi v Ndaba* 2013 (5) SA 437 (SCA) in which the Court with reference to the English decision of *Hucks v Cole* [1969] 118 ULJ 469 in which Lord Denning found *'with the best will in the world things sometimes went amiss in surgical operations or medical treatment. A doctor was not to be held negligent simply something went wrong.'* A mistake is than excusable.

[77] Pringle v Administrator, Transvaal 1990 (2) SA 379 (W). The court endorses the English decision of Whitehouse v Jordan [1981] 1 All ER 267 at 276 H wherein the court stated the following with regard to

medical mishaps and errors of judgement do not necessarily constitute medical negligence.[78] Gross medical mistakes however, in most instances will result in a finding of negligence for they fall into the category 'so glaringly below proper standards as to make a finding of negligence inevitable.'[79] The legal liability for an error of judgement very much dependents upon:

- the reasonableness or unreasonableness of such error;
- whether any medical practitioner in the same class and acting with the required care and skill would have made the same error;
- if yes, the error of judgement will not amount to negligence;
- if not, liability for negligence may follow.[80]

Provided therefore, the mistake is an honest mistake or error of judgement and not so palpable a deviation, the error of judgement will be acceptable. The opposite situation was encountered In *Esterhuizen v Administrator, Transvaal* [81] the plaintiff sued the hospital for damages arising from serious burn wounds the patient sustained consequential to excessive radiation administered to her in the treatment of cancer. The hospital relied on an error of judgement causing the burns. The plaintiff argued that if it was it was so palpable that it cannot be excused. The Court found for the plaintiff as the therapist did not act in accordance with the required care and skill.

7. MISDIAGNOSIS

Besides mistakes and errors of judgment, one of the forms of the other forms of negligence that receives the most frequent attention by our courts is misdiagnosis. Of a doctor or specialist is expected the same standard of skill and care when making a diagnosis as is expected of the doctor or specialist when treating a patient or performing surgical care. If his or her standard in diagnosing the patient falls below the standard, the doctor or specialist will be negligent. But, as was seen with mistakes and errors of judgment,

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when errors of judgment are excusable and when not '*to say that a surgeon committed an error of clinical judgment is wholly ambiguous, for while some such errors may be completely consistent with the due exercise of professional skill, other acts or omissions in the course of exercising clinical judgment may be so glaringly below proper standards to make the finding of negligence inevitable.'*

[78] Van Oosten (1996) 82; Carstens and Pearmain (2007) 640.

[79] Dutton (2015) 110 with reference to Whitehouse v Jordan [19981] 1 All ER 267 cited with approval in Pringle v Administrator, Transvaal 1990 (2) SA 379 (W) at 385.

[80] Strauss (1991) 249; Claassen and Verschoor (1992) 19; Carstens and Pearmain (2007) 640; Dutton (2015). For case law see *Van Wyk v Lewis* 1924 AD 438 at 470; *Pringle v Administrator, Transvaal* 1990 (2) SA 379 (W).

[81] Esterhuizen v Administrator, Transvaal 1953 (3) SA 710 (T)..

because medicine is not an exact science, hence doctors or specialists are regarded as human beings and infallible. What follows is that a wrong diagnosis does always necessarily lead to a finding of negligence provided reasonable care and diligence is applied when making the diagnosis and an honest mistake is made.[82] Where however, the practitioner does err in his diagnosis because of a careless examination of the patient, he is she will incur liability. [83]

Our courts have for decades applied the following test to determine whether the misdiagnosis of a patient constitute negligence, namely:

- whether the diagnosis is so palpably wrong to imply;
- an absence of reasonable skill and care on the part of the doctor or specialist;
- bearing in mind the ordinary level of skill in the branch of the profession to which he or she belongs.[84]

8. FAILURE TO INFORM THE PATIENT ABOUT THE DIAGNOSIS

The medical practitioner or physician is legally obliged to share the diagnostic results and the proposed treatment with the patient. Where however, a medical practitioner commences a medical intervention without first sharing the said results with the patient and without informing him/her what treatment he/she is about to administer, and first obtaining the patient's informed consent, the medical practitioner/hospital may incur legal liability founded in:

- breach of contract;
- civil or criminal assault i.e. (violation of bodily integrity);
- civil or criminal iniuria i.e. (violation of dignity);
- negligence. [85]

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[82] The court in the English decision of *Crivon v Barnet Group Hospital Management Committee* (1959) describes the situation as *'unfortunate as it was that there was a wrong diagnosis, it was one of those misadventures, one of those chances, that life holds for people.'*

[83] Gordon et al (1959) 109-110; Van Oosten (1996) 22-24. For case law see *Mitchell v Dixon* supra 526-527; *Prowse v Kaplan* 1933 (EDL) 257.

[84] *Mitchell v Dixon* supra 526. In *Coppen v Impey* 1916 CPD 309 at 321 the court formulated the test as 'whether the diagnosis manifested a lack of reasonable skill and judgment'. See also *Blyth v van den Heever* 1980 (1) SA 191 (A).

[85] Strauss and Strydom (1967) 295; See also section 6(1) of the *National Health Act* now makes it obligatory to inform the patient of the diagnosis made. For case law see *Lymbery v Jefferies* supra 240; *Dube v Administrator, Transvaal* supra 269-270; *Richter v Estate Hammann* 1976 (3) SA 226 (C); *Castell v De Greef* supra 501.

9. FAILURE TO REFER THE PATIENT TO ANOTHER PRACTITIONER/HOSPITAL

The question can be begged: is there a duty on a medical practitioner to refer his/her patient to another practitioner for assistance? If so, when will it be necessary?

Yes, one of the medical practitioner's obligations under the duty of care is to refer the patient to another practitioner or specialist, should the situation so require. This may very well depend on the circumstances prevailing at the time. It is also a case to case phenomena.

The circumstances when it may be indicated to refer the patient, include:

- the practitioner is unable to make a diagnosis for whatever reason;
- the practitioner does not have the right medical equipment needed;
- the patient is not responding to the treatment; or
- the practitioner is acutely aware that the patient is in need of other kinds of treatment for example a patient diagnosed with cancer.

Where the medical practitioner fails to fulfil this obligation, this will lay him/her wide open to blame where the patient's condition is adversely affected. This counted heavily against the practitioner in the case of *S v Nel*.[86] The Court found that the medical practitioner was negligent in removing the placenta by hand causing excessive bleeding where a gynaecologist was available to take over the treatment.

10. FAILURE TO FOLLOW-UP ON THE PATIENT AND RENDER FURTHER TREATMENT

Once a physician has operated on a patient his duty does not stop there. He is obliged to provide post-operative care. Where he/she fails and the condition of the patient worsens resulting in damages, the physician may incur liability in contract or in delict or both.[87]

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[86] S v Nel 1987 TPD Unreported discussed by Strauss (1991) 280-281. See also Carstens and Pearmain (2007) 695-696.

[87] Strauss and Strydom (1967) 312; Claassen and Verschoor (1992) 38; Carstens and Pearmain (2007) 697. See the case of Webb v Isaacs 1915 (EDL) 273 in which the court found that the conduct of the practitioner after he splinted the patient's leg on a remote farm but failed to follow up on the progress of the patient who lived in a remote area to be negligent. The leg shortened and twisted as a result of which, it became necessary to have it re-broken and re-set.

11. NEGLIGENCE OCCURRING DURING OPERATIONS

11.1 SURGERY AND PLASTIC SURGERY

Surgical interventions are also full of risks and uncertainty.[88] Sometimes, even with the best possible care and skill being exercised, complications may set in whilst the patient is in the operating theatre. Should a patient for example, suffer a cardiac arrest while he/she is operated upon, does this necessarily point to the surgeon's negligence?

The answer depends very much on the circumstances, for example:

- whether a *novus actus intervenience* had taken place? i.e. the cardiac arrest is not as a result of any negligence on the part of the medical team.

The affect thereof is that it will absolve the doctor or surgeon from liability. If not and it is found that the practitioner is the cause, he/she will not escape liability. Examples of surgical mishaps which may occur in practice include:

- the wrong body part is operated on;
- the patient is injured during say dental intervention e.g. the jaw is broken during an operation;
- the wrong procedure is adopted during the operation.

Litigation against surgeons in this aspect of medicine is on the upswing. Psychological effects flowing from excessive scarring often form the subject matter dealt with in evidence in the cold atmosphere of our courts. The risks faced by a plastic surgeon were examined by the Court in *Castell v De Greef*. [89] In this case, the plastic surgeon performed a mastectomy on the plaintiff. The procedure also involved simultaneous reconstruction of the plaintiff's breasts. It was a high risk operation. The complications included inter alia necrosis (death) of the skin and underlying tissue, including the nipples. The operation at first glance appeared to be successful. But complications then set in. The patient confronted the surgeon who assured her the complications were normal post-surgery complications. She subsequently underwent another operation for the revision of the scarring. She eventually saw another plastic surgeon.

[88] *Pringle v Administrator, Transvaal* 1990 (2) SA 379 (WLD).
[89] *Castell v De Greef* 1993 (4) SA 408 (C). See also the case of *Michael v Linksfield Park Clinic* supra.

A series of additional surgical procedures followed at huge expense. She eventually sued for damages arising from the negligence of the first plastic surgeon.

The Court highlighted the inherent risks associated with plastic surgery. After weighing up the probabilities the Court held that the plaintiff was fully apprised of the risks to the surgery and she understood them. She gave informed consent to be operated on. It could not be established that the surgeon gave a guarantee that the plaintiff would not suffer from complications after the operation. The Court found that the surgeon could not be held liable for the sequelae of the necrosis.

12 OBSTETRICS AND GYNAECOLOGY

There has over the last few decades been a spate of cases in the field of obstetrics and gynaecology. The main stream of cases has involved:

- ❖ injuries to the foetus *in utero*; or
- ❖ injuries to the baby during or immediately after delivery.

It is especially in the latter instance where claims have been successfully proved against gynaecologists or general practitioners arising from:

- the incorrect use of forceps during a troublesome delivery;
- not performing a Caesarean section where clearly indicated;
- unwanted pregnancies and births.[90]

13. OTHER FORMS OF NEGLIGENCE WORTH MENTIONING

The following areas of medicine also feature prominently in our courts from time to time.

13.1 DRUG RELATED NEGLIGENCE

The most common acts or omissions leading to professional negligence in practice include the following:

[90] See the case of *Friedman v Glicksman* 1996 (1) SA 1134 (W); *Mukheiber v Raath* 1999 (3) SA 1065 (SCA).

- administering or prescribing the incorrect medication or drug;
- excessive administration of medication or drug i.e. failure by the physician or nurse to ascertain the correct strength and dosage of the medication or drug;
- administering or prescribing medication or drugs without first checking whether it is suitable to be administered i.e. checking for allergies etc.[91]

13.2 FAULTY MEDICAL IMPLIMENTS/EQUIPMENT

A medical practitioner may land himself or herself in legal hot water where:

- the medical practitioner uses medical equipment in circumstances where he knows or should foresee that the equipment is faulty; and
- the patient suffered personal injury or died as a result of the faulty equipment. [92]

A practitioner using instruments or equipment belonging to a hospital, will not incur liability for defective or faulty equipment provided:

- the practitioner must promptly try and have the faulty or defective equipment corrected as soon as he/she becomes aware of the fault or default. [93]

13.3 RADIOLOGY AND BURNS

X-rays and radiation procedures are today very much part of diagnostic and therapeutic medical practices. But, the practice of x-rays and radiation has shown to have their own inherent risks of harm. The emission of electromagnetic energy through x-rays, heat, light, can cause burns unless properly controlled.[94] The medical practitioner who is responsible for applying these procedures should therefore, act with the necessary skill and care. A failure to prevent a patient from suffering serious burns consequent to the over exposure of x-rays or radiation may land the practitioner in hot water and a claim for damages. [95]

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[91] Strauss and Strydom (1967) 306; Carstens and Pearmain (2007) 791-792. See also the criminal cases of *R v Van Schoor* 1948 (4) SA 349 (C); *R v Van der Merwe* 1953 (2) PH H 124 (W); *S v Shivute* 1991 (1) SACR 656(Nm).

[92] Strauss and Strydom (1967) 288; Claassen and Verschoor (1992) 52; Strauss (1991) 317; Carstens and Pearmain (2007) For case law see *Mitchell v Dixon* supra regarding the use of a defective platinum needle attached to a syringe; *S v Lombard* 1979 (TPD) unreported.

[93] Strauss v Strydom (1967) 306; Strauss (1991) 254; Carstens and Pearmain (2007) 795-796.

[94] Dada and McQuoid-Mason *Introduction to Medico-Legal Practice* (2001) 202.

[95] *Dale v Hamilton* 1924 (WLD) 184. (The tube of the equipment was placed too close to the patient); *Coppen v Impey* 1916 (CPD) 309 (Physician unskilful in using the equipment).

Where a radiologist administers radiation, his actions will be measured against the standard of the reasonable competent radiologist / specialist in the same circumstances.[96]

13.4. BLOOD TRANSFUSIONS

Blood transfusions during surgical interventions and post-operative treatment are also intrinsically linked in modern medical practice. But, this type of practice has on occasions been found to be quite a hazardous.[97]

Negligent acts or omissions in this form of medical treatment have occurred in:

- patients receiving the wrong blood grouping; or
- the wrong blood is administered to the patient;
- contaminated blood being administered to the patient.

Despite the negligent acts and omissions recognized by our writers, that does not mean, negligent acts or omissions do not occur in practice. A possible reason that can be advanced for their non-existence can perhaps be ascribed to the fact that these types of cases are settled out of court by the parties. Cases that have been reported are usually in the context of court orders being sought to administer blood transfusions to the Jehovah's Witnesses' parents who refuse to give consent in circumstances where life-threatening situations in respect of the children prevail.[98]

14. PROVING MEDICAL NEGLIGENCE IN THE COURTS

14.1 CRIMINAL LITIGATION

Depending on the facts of the case, the general practitioner or specialist may be charged with criminal law offences either under the South African common law[99] or statutory law.[100] Common law offences most

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[96] *Esterhuizen v Administrator, Transvaal* supra 710.

[97] Claassen and Verschoor (1992) 42 Strydom and Strauss (1967) 299; Strauss (1991) 24; Carstens and Peamain (2007) 809-813.

[98] Carstens and Pearmain (2007) 921-924 with reference to *Phillips v De Klerk* Unreported 1983 TPD discussed in Strauss (1991) 29. See also *Hay v B* 2003 (3) SA 492 (W).

[99] Common law crimes have frequently featured in cases involving healthcare practitioners including doctors and medical specialists. In murder cases where intention is an element of the offence see S v A 1971 (2) SA 293 (T); S v Kramer 1987 (1) SA 887 (W); S v Hartman 1975 (3) SA 532 (C); S v Mkwetshana 1965 (2) SA 493 (N). In culpable homicide cases in which negligence is an element of the offence see R v Hosiosky 1961 (1) SA 84 (W); S v Smorenburg 1992 (2) SACR 389 (C); S v Naidoo 2003 (1) SACR 347 (SCA)

[100] The statutory offences with which healthcare practitioners are most frequently charged with in the lower Courts include the Inquest Act 58 of 1959 (as amended); Mental Health Care Act 17 of 2002; Human Tissue

frequently encountered include culpable homicide, indecent assault, assault, criminal defamation and fraud. Because culpable homicide is the most frequently encountered offence, the offence has been selected to describe briefly what the State has to prove to sustain a conviction. The crime Culpable Homicide has been defined by our legal writers as 'the negligent and unlawful killing of another person.' [101] To this end, negligence is the failure to act as a reasonable medical practitioner would have acted in the circumstances. [102] The degree of negligence does not have to be "gross" to constitute criminal liability. All the State has to prove is to show the slightest deviation from the standard of the reasonable medical practitioner belonging to that class. What needs to be shown is:

- that a reasonable medical practitioner in the same circumstances:
- would have foreseen that death might ensue as a result of the conduct; and
- would have taken steps to guard against death occurring;
- but failed to take the necessary steps.[103]

Where a medical practitioner faces criminal charges in a criminal court, the State bears the onus to prove the guilt of the accused beyond reasonable doubt.[104] Where an inquest is held the presiding magistrate makes his finding on a preponderance of probabilities. The same test is applied in disciplinary hearings concerning the Health Professions Council.

14.2 CIVIL LITIGATION

Because medicine, as seen before is not an exact science, civil litigation against medical practitioners and hospitals is sometimes beset with difficulty in proving these cases. It is therefore necessary to briefly explore in this section inter alia who can sue and who can be sued as well as the proof of medical negligence.

14.2.1 WHO CAN SUE OR BE SUED?

Act 65 of 1983; National Health Care 61 of 2003; Choice on Termination of Pregnancy Act 92 of 1996 and the Sterilisation Act 44 of 1998.

[101] Snyman *Criminal Law* (2006) 422; Burchell *Principles of Criminal Law* (2005) 674; Dada and McQuoid-Mason supra 26.

[102] Dada and McQuoid-Mason Ibid.

[103] Burchell (2005) 676; Carstens and Pearmain (2007) 643ff. For case law see *S v Naidoo* 2003 (1) SA (SACR) 347 (SCA) 362 c-d.

[104] *R v Van Schoor* 1948 (4) SA 349 349-350; *S v Kramer* 1987 (1) SA 887 (W); S v Lombard and Another (Pretoria Magistrate court 1979) discussed by Strauss supra (1991) 319.

The answer to the question who may sue and who to sue depends on a number of factors. In law it is known as *locus standi* or simply put, standing to bring an action. It is usually the person who has suffered the damages that brings the action unless the law requires otherwise. We have already discussed this issue in great depth when dealing with personal injury claims but it is worth repeating the following. The broad principle is that children under the age of 18 (unless the legislation provide otherwise (see the Choice of the Termination of Pregnancy) must be duly assisted by the parents and guardians and where that is not possible, children must be assisted by a ward or official appointed by the court for example, a *Curator as Litem*. The latter category also applies to adults who due to mental incapacity or otherwise cannot bring an action in person. As to who may be sued, the general rule is that the wrongdoer has an obligation to compensate the person who has suffered the damage. The liability in this context will depend on whether the wrongdoer is found in the public health care sector or the private health care sector. It also depends, as was stated earlier on, whether the employer is vicariously liable for the conduct of the employee. In a medical context, the potential liability of the doctor/hospital for the negligence of his/her professional assistants and nurses and other medical personnel employed by him/her/it, will depend on whether the principle of vicarious liability can be invoked. The liability of doctors depends upon:

- whether those responsible for the harm to the patients, are "servants"; and
- under the control of the doctor;
- when they are servants of the doctor, their negligence is imputed to him/her.

Doctors will for example, be responsible for the conduct of their staff operating in their practices. Likewise, nurses providing assistance in nursing homes (provided they are under the doctor's control) through their negligent conduct will also bring civil liability to the doctor where the plaintiff will rely on vicarious liability [105] The same does not however, apply to a nurse working independently in say a theatre, where the nurse is employed by the hospital. [106]

14.3 ONUS OF PROOF

The general rule in civil litigation is that she or he who asserts must prove. The plaintiff upon whom the onus of proof rests in civil litigation, must prove that the damage he or she has sustained, has been caused

[105] Strauss (1991) 343.
[106] Dada and McQuoid-Mason supra fn. 10 25.

by the defendant's negligence.[107] The same applies to civil cases involving medical practitioners who are being sued for professional medical negligence.[108] It is therefore, for the patient as plaintiff, to discharge the onus of proof on a balance of probabilities.[109]

What needs to be proven by the Plaintiff is the failure of the doctor or special or any other health care provider to adhere to the general level of skill and diligence possessed and exercised at the same time by the members of the branch of the profession to which he or she belongs would normally constitute negligence.[110] But as was stated previously, the medical practitioner who is being sued is not expected to exercise the highest possible degree of professional skill, but he is bound to employ reasonable skill and care.[111] The test remains always whether or not his or her conduct fell below the standard of a reasonably competent practitioner in his or her field.[112]

It also needs to be mentioned that since these type of claims are founded in the Actio Legis Aquiliae, the following elements in bodily injury claims (the facta probanda) need to be shown and their presence shown:

- Unlawful conduct by the defendant that caused he bodily injury;
- Fault, in the sense of culpa or dolus on the part of the defendant;
- Damnum, i.e. loss to the plaintiff's patrimony, caused by the bodily injuries.[113]

14.3.1 UNLAWFULNESS

The term "unlawfulness" is also sometimes referred to as "wrongfulness" and used synonymously. Generally, it means "everyone must bear the loss they cause". Translated in Afrikaans "Die skade rus

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[107] Hoffman and Zeffert *The South African Law of Evidence* (1992) 26. For case law see *Cecilia Goliath v Member of the Executive Council for Health, Eastern Cape* [2014] ZASCA 182 para {8}.

[108] See the leading cases of *Van Wyk v Lewis* supra 444; *Pringle v Administrator, Transvaal* supra 384; *Michael v Linksfield Park Clinic (Pty) Ltd* 2001 (3) SA 1188 (SCA).

[109] Claassen and Verschoor (1992) 26; Strauss and Strydom (1967)74. For case law see *Mitchell v Dixon* supra 72; *Webb v Isaac* 1915 (EDL) 273; *Coppen v Impey* supra 138; *Van Wyk v Lewis* supra ; *Esterhuizen v Administrator, Transvaal* supra ; *Buls v Tsatsarolakis* supra; *Castell v De Greef* supra; *Oldwage v Louwrens* (2004) 1 ALL SA 532 (C); Sonny and Another v Premier Kwazulu- Natal and Another 2010 (1) SA 427 (KZP).

[110] Van Wyk v Lewis supra 444; *Cecilia Goliath v Member of the Executive Council for Health, Eastern Cape* supra Para {8} with reference to *Lillicrap, Wassenaar and Partners v Pilkington Brothers (SA) (Pty) Ltd* 1985 (1) SA 475 488C wherein it was held that a surgeon is no different from any other professional person.

[111] *Mitchell v Dickson* 1914 AD 419 at 525

[112] *Castell v De Greef* 1983 (3) SA 501 (C) at 512A-B cited with approval in *Buthelezi v Ndaba* 2013 (5) SA 437 (SCA) para {15} and quoted in *Cecilia Goliath v Member of the Executive Council for Health, Eastern Cape* supra.

[113] Dutton The Practitioner's Guide To Medical Malpractice In South African Law 2015 17

waar dit val". The effect it has in delictual action in civil claims is this: Any conduct negligently or intentionally performed, that causes harm, are regarded as wrongful or unlawful. Unlawfulness or wrongfulness is therefore an essential element of delictual liability.

It must be remembered that negligence alone, is not sufficient. What must be shown as well is that **the consequences of the conduct lead to the damages suffered.**

14.3.1.1 **The rationale for unlawfulness**

Public policy dictates that 'public policy consideration demand that a Plaintiff who is harmed, must be compensated for the loss or damage caused by the negligent conduct. [114].

But who determined public policy? It has been stated over and over, it is 'the legal convictions of the community who in turn, influences the legal policy makers of the community, i.e. the legislature and the judiciary. They will determine 'the actual prevailing convictions of the community'.

14.3.1.2 The test for unlawfulness

The general approach adopted in *Minister van Polisie v Ewels supra* lay down the following requirements: "…….. *the omission not only incites moral indignation but …… the legal convictions of the community demand that the omission ought to be regarded as unlawful and the damages suffered ought to be made good by the person who neglected to do a positive act"*. A mere omission to do something, may thus lead to an inference of unlawfulness. The aforementioned test also imposes of a legal duty which Fleming[115] describes as "'*a value judgment that the Plaintiff's interest, is deemed worthy of legal protection against the negligent interference by conduct of the kind alleged against the Defendant……. Whether or not there is a duty depends on many factors …….. morals and justice."*

Today, with the Constitution being the supreme law of the land, the legal duty is influenced by conduct that are inconsistent with norms or values.

14.3.1.3 The concept of the 'duty of care'

[114] See *Minister van Polisie v Ewels* 1975 (3) SA 590 (A) 597 A-B.

[115] The Law of Torts 4ed at 136

It must be borne in mind that, unlike in English law, the determination of the concept is affected by looking at fault and policy. In South Africa, the enquiry is distinct from the negligence enquiry.[116] .

14.3.2 UNLAWFULNESS AND FAULT

These are two distinct concept and should not be tested at the same time.[117] Therefore, do not conflate unlawfulness and negligence.[118]

14.3.3 UNLAWFULNESS IN A MEDICAL CONTEXT

The importance of unlawfulness in medical negligence cases rest on two pillars, namely:

- When unlawfulness is established or shown, a rebuttable presumption of unlawfulness operates against the Defendant.

- But, the presumption of unlawfulness may be rebutted by raising valid defences recognized by law. If established, they serve as justifications to eliminate the unlawfulness of the conduct.[119] .

14.3.3.1 UNLAWFULESS 'IN THE AIR'

It has been stated by our legal writers and the courts alike that 'unlawfulness is founded not on the conduct itself, but on the consequences of the conduct'.[120] What needs to be shown is that the conduct 'constituted an infringement of a legal interest'. In the absence of that, we are dealing with unlawfulness 'in the air'.[121]

The test was laid down in *Thomas v BMW South Africa (Pty) Ltd* [122] as "…….. an act or omission can be characterized as wrongful only if it results in dammum (damage). Until that happens, an act or omission constitutes no more than "negligence in the air".

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[116] See McIntosh v Premier Kwazulu-Natal 2008 (6) SA 1 (SCA) at [12].
[117] See *Sea Harvest Corporation (Pty) Ltd v Duncan Dock Cold Storage (Pty) Ltd* 2000 (1) SA 827 (SCA) Para [19].
[118] Dutton op cit 113.

[119] See Van der Walt & Midgley The Principles of Delict 3ed Para 85.
[120] See *Mukhieber v Raath and Another* 1999(3) SA 1065 (SCA) at 1095; Neethling et al (Lexis Nexus 2010) 34 Fn9.

[121] See *Premier, Western Cape v Fair Cape Property Developers (Pty) Ltd* 2003 (6) SA 17 (SCA).

[122] 1996 (2) SA 106 (C) at 120 B-C.

An example where the court was prepared to find unlawfulness arising from conduct that lead to damages sustained by a child still to be born and then born, with brain injuries, arose in the case of *RAF v Mtati* [123]). The facts briefly stated amount to this: A pregnant woman had sustained injuries as a result of the negligent driving of the driver of a motor vehicle. Five months after the accident, the child was born with brain damages. After a claim for damages was instituted by the Plaintiff, the Defendant entered a special plea claiming that a foetus *in utero* could not be regarded as a person (a legal subject) and the Plaintiff failed to prove unlawfulness viz a viz the driver could not have acted unlawfully towards the unborn child when he caused the accident.

But, the Supreme Court of Appeal found that the right to claim for pre-natal injuries, should be recognized on policy grounds. The Court found that it would be intolerable if our law did not grant such an action and it would result in a wrong being inflicted for which there no remedy existed. The Court introduced the nascitures fiction and consequently held that the driver owed the unborn child a legal duty despite the child not yet born, provided, the foetus is born alive and attains an existence separate from that of its mother.

14.5 DEFENCES EXCLUDING UNLAWFULNESS

Besides the medical practitioner's general duties of treating the patient with due care and skill, a practitioner may not commence treatment or touch the patient without a valid ground of justification been present.Medical intervention without legal justification has the effect of such intervention giving rise to civil liability, or even criminal sanctions.

14.6 RECOGNIZED JUSTIFIABLE GROUNDS OF JUSTIFICATION FOR MEDICAL INTERVENTION

The legal convictions of the community, as seen earlier, play a fundamental role in recognizing justifiable conduct. Those categories of grounds of justification in the conduct of medical practitioners in medical intervention include:

- informed consent;
- Emergencies;

[123] 2005 (6) SA 215 (SCA).

- Necessity;
- Negotiorum Gestio;
- Statutory authority; and
- Court orders

14.6.1 INFORMED CONSENT

Consent as was stated earlier, will only be valid where the following is present:

- Consent is freely given;
- The patient has the capacity to consent;
- Adequate information as to the nature and consequences are given in respect of the proposed treatment and alternatives, including non-treatment.

A patient's consent to medical treatment is vitiated if:

- No information is given;
- Information is inadequately given.

Where a patient refuses to be treated and the patient has full legal capacity, the medical practitioner cannot force the treatment, regardless of it being in the best interests of the patient to undergo the treatment. It aligns with the patient's right to self-determination.

It must also be understood that in certain instance, minors can consent and they need to make the health-care decisions. Instances where they make consent in terms of the Children's Act 38 of 2005 include:

- HIV testing;
- Access to contraceptives. They may also rely on the right to confidentiality.
- Right to medical treatment is afforded children over 12 years.

The Choice on Termination of Pregnancy Act Section 5(2) provides that a girl of any age can consent to a termination of pregnancy. But consultation of the child with her parents is indicated.

14.7 EMERGENCY AND OTHER DEFENSES OUTSIDE THE REALM OF THE NEED FOR INFORMED CONSENT

There are a number of situations where informed consent is not necessary to justify the treatment of a patient or the performance of surgery. Both ethical rules founded in the Health Professions Act and Nursing Act, lend justification. Those instances include:

14.7.1 MEDICAL NECESSITY

Necessity justify the treatment of a patient or even surgery being performed in circumstances where the conduct performed, does not necessary follow after the patient first consented. Here, the consent of the patient may not have been forthcoming. The patient may for instance, have been capable of consenting but, refuses to consent to treatment to his/her detriment, i.e. urgent blood transfusion is needed. What has to be shown is that an emergency situation exists or is about to happen, and that societal interests dictates that the intervention takes place.

14.7.2 NEGOTIORUM GESTIO

In these instances a patient may be unconscious, in a state of shock or otherwise, incapable of providing informed consent that is required for the urgency and necessity to save a life or preserve health. The intervention might be quite lawful without any consent.

14.7.3 THERAPEUDIC PRIVILIDGE

Here the doctor/specialist having regard to the patient's psyche does not disclose to the patient, the anticipated risk or harm for:

- fear that the patient will not cooperate;
- the refusal to cooperate is not in the best interests of the patient.

14.7.4 DEVIATIONS OR EXTENSIONS OF MEDICAL INTERVENTIONS

Generally the doctor or specialist may not materially deviate from the surgical operation agreed upon by the doctor/hospital and the patient. But, what happens in a situation where, while the surgeon carries our surgery, he/she detects another serious condition in the health of the patient? Say for example, the surgeon has agreed to remove certain tumours in an area close to the liver. Let's say during surgery, the

surgeon detects that the liver has certain tumours which, if not attended to, can lead to the death of the patient.

Will the practitioner be justified in removing the tumours of the liver as well? Yes, he/she can extend the intervention provided:

- a more reliable diagnoses could not be made prior to surgery;
- the extension would improve the patient's condition.

14.7.5 STATUTORY AUTHORITY

Certain legislation has been designed to allow for medical interventions without consent first being obtained. This includes:

- taking a blood sample relevant to criminal proceedings;
- medical treatment of a person unwilling to consent which may result in serious risk to public health.

14.7.6 COURT ORDER

Court orders are frequently sought in circumstances where there may be life threatening situations and medical interventions are absolute necessity for example:

- The so-called blood transfusion in Jehovah's Witnesses cases;
- Parents unreasonably refuse to consent to a medical procedure on behalf of the child and the best interests of the child as envisaged by Section 28 of the Constitution are disregarded.

14.7.7 OTHER DEFENCES

The law also recognizes the following general defences:

- Contributory negligence;
- Prescription;
- Error of professional judgment.

It should be borne in mind that all these defences do not absolve totally the liability of the medical practitioners. Take for example contributory negligence. On the other hand, prescription has the effect that the claim against the medical practitioner is suspended or dismissed. The successful invocation of an error of professional judgment has the effect of the medical practitioner also being absolved from liability.

14.7.7.1 CONTRIBUTORY NEGLIGENCE

Where this defence is successfully raised, the court may:

- Apportion the damage in a delictual action;
- Mitigate the sentence in criminal or disciplinary matters.

This defence can for example, be used where a patient does not:

- Follow instructions in respect of the usage of medication;
- Fails to report for further treatment;
- Ignores specific instructions, i.e. post-operative home care.

But, the doctor/hospital staff must warn the patient of the risk, harm or damages in not following the instructions.

14.7.7.2 PRESCRIPTION

The general rule is that a patient has three years in which to institute action against the doctor/hospital. The three year period commence from the date upon which the patient reasonably acquires knowledge of his/her claim, *ex contractu or ex delicto*, against the medical practitioner or hospital.

The Supreme Court of Appeal in *Truter v Deyzel*[124] looked at the position of "acquisition of knowledge". The court per Van Heerden JA, relying on section 11(d) of the Prescription Act, found that:

- the Plaintiff's claim was subject to a three-year extinctive period of prescription which began running when the debt became due;

[124] Truter v Deysel 2006 (4) SA 168 (SCA)

- this meant when the cause of action arose;
- but it did not mean first acquiring knowledge of every piece of evidence which was necessary to prove the facts;
- the acquisition of the medical opinion was not in itself a fact, but rather evidence;
- the plaintiff did not lack intellectual capacity to appreciate that a wrong had been done to him;
- there was therefore, no reason why prescription could therefore be delayed.

Applying the "once and for all rule", the court found the Plaintiff's cause of action was complete as soon as he sustained the damages.

14.7.7.3 ERROR OF JUDGMENT

An error of judgment, depending on the nature of the error, may or may not constitute negligence. It is a factual issue to be decided by the court. Where a plea of "an error of professional judgment" is successfully raised by a Defendant in an action for damages, it has the effect that the medical practitioner is absolved from delictual liability. What must however, be shown by the defendant medical practitioner, relying on this defence is:

- that this was a reasonable error of professional judgment; and
- one that another reasonable competent medical practitioner in the same profession and in the same circumstances, would also have made.

14.8. CAUSATION AND THE PROOF OF MEDICAL NEGLIGENCE

It is a requirement in our law that in order for a defendant to be legally liable, the defendant's conduct must be shown to have caused the harm to the plaintiff. Even if it is shown that the plaintiff was negligent, a plaintiff would still not succeed with his or her claim unless they establish a causal link between the negligent conduct and the sequelae.[125] In that regard, our law applies a two stage approach to determine that this has in fact taken place.

[125] Chapeikin v Mini [2016] ZASCA 105 para {48}

18.8.1. FACTUAL CAUSATION

A plaintiff will as a general rule, only succeed in proving civil/ criminal liability, if he/she/it can show that:

- ❖ the conduct of the wrongdoer or defendant caused the damage of the person suffering the harm. [126]

Factual causation in the general sense is established by:

- conclusions drawn from available facts; and
- relevant probabilities as they emerge from the evidence; [127]

The courts have for many decades applied the *sine qua non* test to establish a causal link between the act or omission and the damages.[128] It is also known as the "but for" test. It works as follows:

- ➢ an act is the cause of the result if the act cannot be thought away, without the result disappearing, simultaneously. [129]

Take for example excessive burns caused by a deviation from the prescribed protocol in administering radium treatment. Deviating from the prescribed protocol is the cause of the result.

14.8.2. LEGAL CAUSATION

Legal causation concerns the question whether the actor should be held legally liable for the damage he has caused in a wrongful and culpable manner? [130] In other words, what has to be established is:

- whether the act or omission and the harm are sufficiently close or direct for legal liability to ensue? or
- whether it is said to be too remote? [131]

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[126] Boberg (1984) 38 put the position as follows: *"The defendant is not liable unless his conduct in fact caused the plaintiff's harm."* See also Neethling et al (2006) 160. For case law see *International Shipping Company (Pty) Ltd v*
Bentley 1990 (1) SA 680 (A) 700; *Minister of Police v Skosana* 1977 (1) SA 31 (A) 34;

[127] Neethling et al ibid;

[128] *Minister of Police v Skosana* 1977 (1) SA 31 (A); *Minister of Safety and Security v Carmichele* 2004 (3) SA 305 (SCA)
327;The Premier of the Western Cape v Loots 2011 (JDR) 0250 (SCA).

[129] *Chapeikin v Mini* [2016] ZASCA 105 para {49}.

[130] Neethling et al (2006) 171.

[131] *Clinton-Parker and Dawkes v Administrator, Transvaal* 1996 (2) SA 37 (W) 55.

Factors that may affect the determination of legal causation includes the absence of a *novus actus intervenient;* proximate cause; direct cause; foreseeability and sufficient causation.[132] What plays a role in determining to limit liability is public policy.[133]

14.9. RES IPSA LOQUITUR AND THE ONUS OF PROOF

The maxim *res ipsa loquitur* (the facts speak for themselves) serves as an evidential means e.g. once the facts of the matter is shown through evidence, it gives rise to an inference of negligent conduct.**[134]** In medical cases a phenomena frequently encountered in medical negligence cases is the following:

- a swab or medical instrument is left behind in the patient after the operation.[135]

Our courts have throughout the years held that proof of facts which are sufficient to support an inference that a defendant was negligent, establishes a *prima facie* case against the defendant.[136] But cautions the court, it is not a presumption of law, but merely a permissible inference which the court may employ if upon all the facts it appears to be justified.[137] Once it is established that it is the only inference to be drawn, a duty arises and placed on the defendant that evidence need to be adduced by the defendant to show that reasonable care had indeed been exercised. In the absence of any evidence, the defendant takes the risk of a judgment being given against him.[138]

15. EVIDENCE TO BE PRESENTED IN COURT TO PROVE THE CASE

Both the evidence of lay witnesses i.e. perhaps the plaintiff and/or family members and/or other witnesses, especially medical personnel involved with the treatment or elective surgery are important to establish the merits of a case. Their importance is founded in the fact that they may have witnessed the event that led

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[132] Dutton (2015) 73ff with reference to *S v Mokgethi* 1990 (1) SA 32 (A) 46-47; Carstens and Pearmain (2007) 512ff.

[133] *Mukheiber v Raath and Another* 1994 (3) SA 1065 (SCA) 1078-1079; *Clinton Parker v Administrator, Transvaal* 1996 (2) SA 17 (W)

[134] Boberg (1985) 377-378; Neethling et al (2006)144 139.

[135] *Cecilia Goliath v Member of the Executive Council for Health Eastern Cape* [2014] ZASCA 182

[136] Cecilia Goliath v Member of the Executive Council for Health Eastern Cape supra para {10} with reference to the case of Arthur v Bezuidenhout and Mieny 1962 (2) SA 566 (A) 573E.

[137] Cecilia Goliath v Member of the Executive Council for Health Eastern Cape Ibid. with reference to Zeffert & Paizes *The South African Law of Evidence* 2 Ed 219.

[138] In Cecilia Goliath v Member of the Executive Council for Health Eastern Cape para {10} the court held that without any evidence tendered by the defendant, the court found the plaintiff had discharged the onus of proof on a preponderance of probability.

to the damages suffered by the patient. Equally, if not more important, is the placing before the court medical evidence by medical experts in medical negligence actions. Expert evidence is significant for:

- it bolster the plaintiff's case; and
- it may be pivotal to support the defendant's case.
- it may give guidance to the courts on issues relating to their expertise.
- it enables the courts to come to the correct decision when for example, assessing the evidence led to determine the factual causation. [139]

Here, the court adopts the following approach when considering the evidence:

- by way of inferential reasoning and probabilities;
- deciding on how much weight to attach to the evidence of each witness;
- by measuring the conduct against the yardstick of the average competent reasonable medical practitioner in the same circumstances.

But it is for the court to decide what evidence to accept or not to accept.[140] Our Supreme Court has formulated the following ground rules and guidelines for the courts to follow when dealing with expert evidence, namely:

- the issue of reasonableness or negligence is for the Court itself to determine;
- the determination does not involve consideration of credibility, but, the examination of opinions and the analysis of their essential reasoning;
- the governing test is the standard of conduct of the reasonable practitioner in that particular field;
- when assessing the expert opinions, establish whether they are founded on logical reasoning - in other words:
- that the opinion had a logical basis and that the expert has considered comparative risks and

[139] Hoffman and Zeffert *The South African Law of Evidence* (1992) 97; For case law see Van der Walt v De Beer 2005 (5) SA 151 (C) ;Ndaba v Buthelezi 2012 JDR 0864 (KZP) and Buthelezi v Ndaba 2013 (5) SA 437 (SCA).

[140] The position was articulated as follows by Innes CJ in *Van Wyk v Lewis* supra 447-448 *"The testimony of experienced members of the [medical] profession is of the greatest value in questions of this kind. But the decision of what is reasonable under the circumstances is for the court; it will pay high regard to the views of the profession, but it is not bound to adopt them."*

benefits;

- that the expert has reached a defensible conclusion. [141]

[141] See *Michael v Linksfield Park Clinic (Pty) Ltd*. 2001(3) SA 1188 (SCA); Buthelezi v Ndaba 2013 (5) SA 437 (SCA).

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