

**MEDICAL NEGLIGENCE AS A *NOVUS ACTUS INTERVENIENS* : AN ANALYSIS
OF THE SOUTH AFRICAN DELICTUAL JURISPRUDENCE**

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DECLARATION

I, **MATUMBA RENDANI MARGARET** student number **11630292**, declare that this LLM dissertation has been composed solely by me and that it has not been submitted, in whole or in part, in any previous application for a degree. Except where stated otherwise by reference or acknowledgment, the work presented is entirely my own.

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I would also like to acknowledge my family for all the help and words of encouragement. With great gratitude, I would like to acknowledge my Mother for everything.

DEDICATION

This work is wholly dedicated to medical and legal practitioners as well as students. It is hoped that this study will contribute a lot to both the medical and legal fields.

Thank you

TABLE OF CASES

Blyth v Van den Heever 1980 (1) SA 191 (A).

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Children's Act 38 of 2005

Mental Health Care Act 17 of 2002

Nursing Act 33 of 2005

CHARTER

Patient's rights charter

ABBREVIATIONS

MEC- Member of Executive Council

HPCSA-Health Professions Council of South Africa

TABLE OF CONTENTS

| | |
|--|-----|
| DECLARATION..... | i |
| ACKNOWLEDGEMENT..... | ii |
| DEDICATION..... | iii |
| TABLE OF CASES | iv |
| STATUTES..... | vi |
| CHARTER..... | vi |
| ABBREVIATIONS..... | vi |
| ABSTRACT..... | 1 |
| CHAPTER ONE..... | 2 |
| INTRODUCTION..... | 2 |
| 1.1 BACKGROUND TO THE STUDY..... | 6 |
| 1.2. RESEARCH PROBLEM..... | 6 |
| 1.3. AIMS AND OBJECTIVES..... | 8 |
| 1.3.1 Aim..... | 8 |
| 1.3.2 Objectives..... | 8 |
| 1.4. RESEARCH QUESTION..... | 8 |
| 1.5. LITERATURE REVIEW..... | 8 |
| 1.6. PROPOSED METHODOLOGY..... | 16 |
| 1.7. DEFINITION OF KEY CONCEPTS..... | 17 |
| 1.7.1. Medical negligence | 17 |
| 1.7.2. <i>Novus Actus Interveniens</i> | 17 |
| 1.7.3. Causation..... | 17 |
| 1.7.4. Healthcare provider..... | 18 |
| 1.7.5. Victim..... | 18 |
| 1.7.6. Patient..... | 18 |

| | |
|---|----|
| 1.7.7. Delict..... | 18 |
| 1.8. PROPOSED STRUCTURE OVERVIEW OF CHAPTERS..... | 18 |
| CHAPTER ONE: INTRODUCTION..... | 19 |
| CHAPTER TWO: MEDICAL NEGLIGENCE: WHAT DOES IT INVOLVE?..... | 19 |
| CHAPTER THREE: STATUTORY PROVISIONS ON MEDICAL NEGLIGENCE...19 | |
| CHAPTER FOUR: PROBING THE REASONS BEHIND THE INCREASE IN MEDICAL NEGLIGENCE CLAIMS..... | 19 |
| CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATIONS..... | 19 |
| 1.9. STUDY LIMITATIONS..... | 20 |
| 1.10. ETHICAL CONSIDERATION..... | 20 |
| CHAPTER TWO..... | 22 |
| MEDICAL NEGLIGENCE: WHAT DOES IT INVOLVE?..... | 22 |
| 2.1. Introduction..... | 22 |
| 2.2. Meaning of medical negligence..... | 23 |
| 2.3. Elements of medical negligence..... | 24 |
| 2.3.1. Action/Conduct..... | 25 |
| 2.3.2. Wrongfulness/Unlawfulness..... | 25 |
| 2.3.3. Causation..... | 28 |
| 2.3.3.1. Factual causation..... | 28 |
| 2.3.3.2. Legal causation..... | 30 |
| 2.3.4. Fault..... | 31 |
| 2.4. Harm/Damages..... | 34 |
| 2.5. Categories/ Forms of medical negligence..... | 35 |
| 2.5.1. Failure to keep records of treatment..... | 36 |
| 2.5.2. Sub-standard medical care..... | 37 |

| | |
|---|-----------|
| 2.5.3. Lack of reasonable degree of care and skill..... | 39 |
| 2.5.4. Medical misdiagnosis..... | 41 |
| 2.5.5. Failure to refer a patient to a specialist..... | 43 |
| 2.5.6. Negligent or inappropriate administration of Medication | 44 |
| 2.5.7. Wrongful conception, birth and life..... | 45 |
| 2.6. Reporting of medical negligence cases..... | 47 |
| 2.7. Chapter conclusion..... | 49 |
| CHAPTER THREE..... | 50 |
| STATUTORY PROVISIONS ON MEDICAL NEGLIGENCE..... | 50 |
| 3.1 Introduction..... | 50 |
| 3.2 Patients' rights charter..... | 51 |
| 3.3 Legislation that impact on the healthcare system in South Africa..... | 52 |
| 3.3.1 Constitution Act 108 of 1996..... | 52 |
| 3.3.2 National Health Act 61 of 2003..... | 54 |
| 3.3.3 Consumer Protection Act 68 of 2008..... | 55 |
| 3.3.4 Children's Act 38 of 2005..... | 56 |
| 3.3.5 Mental Health Care Act 17 of 2002..... | 56 |
| 3.3.6 Health Professions Act 56 of 1974 | 57 |
| 3.3.7 Nursing Act 33 of 2005..... | 57 |
| 3.4 The Patients' Right Charter in South Africa's Health Legislation..... | 58 |
| 3.4.1 Access to healthcare..... | 58 |
| 3.4.2 The right to a healthy and safe environment..... | 60 |
| 3.4.3 The right to Medical Informed Consent and participation in decision making..... | 61 |
| 3.4.4 The Right to confidentiality and privacy..... | 67 |

| | |
|---|------------|
| 3.4.5 The right to be referred for a second opinion..... | 71 |
| 3.4.6 The right to refuse treatment..... | 71 |
| 3.4.7 The right to continuity of care..... | 73 |
| 3.4.8 The right to complain about health services..... | 73 |
| 3.4.9 The right to be treated by a named healthcare provider..... | 74 |
| 3.5 Chapter conclusion..... | 74 |
| CHAPTER FOUR..... | 76 |
| PROBING THE REASONS BEHIND AN INCREASE IN MEDICAL NEGLIGENCE CLAIMS..... | 76 |
| 4.1 Introduction | 76 |
| 4.2. medical negligence claims in Gauteng Province as an example..... | 78 |
| 4.2.1 Deteriorating conditions in state hospitals..... | 79 |
| 4.2.2 Lack of professionalism and Failure to adhere to basic..... | 81 |
| 4.2.3 Legislation and case law development..... | 87 |
| 4.2.4 The Role of Lawyers..... | 90 |
| 4.2.5 Patients' awareness of their rights..... | 91 |
| 4.3. Chapter conclusion. | 92 |
| CHAPTER FIVE | 94 |
| CONCLUSION AND RECOMMENDATIONS..... | 94 |
| 5.1 Overview of the preceding chapters..... | 93 |
| 5.2 Recommendations | 96 |
| 5.3 Areas for future research..... | 98 |
| BIBLIOGRAPHY..... | 100 |
| BOOKS..... | 100 |
| JOURNAL ARTICLES..... | 101 |

| | |
|-----------------------------|------------|
| ONLINE ARTICLES..... | 104 |
| DISSERTATIONS..... | 105 |

ABSTRACT

The South African Constitution guarantees equal rights to everyone. The right to equality is specifically protected in Section 9 of the Constitution. Section 9(1) states that 'everyone is equal before the law and has the right to equal protection and benefit of the law'. However, ensuring equality of treatment between the victim of medical negligence and the health service provider has not enjoyed a satisfactory judicial approach. The causes of death or harm suffered by the patient poses a serious problem in the medico-legal investigation. The major focus of this proposed dissertation is the impact on the chain of causation from the victim's perspective because of medical negligence and the South African courts' approach in such matters. The courts do not seem to have satisfactorily applied the principles of *novus actus interveniens* in such cases. The proposed research hopes to expose unfair discrimination against the victim of medical negligence through its analysis of the courts' approach in medical negligence claims. The approach used by the courts will be critically analysed to determine whether the degree of legal or judicial protectionism in favour of the medical profession is adequate. In recent times, government health service providers have inundated government health departments with claims arising from medical negligence. Although this could seem beneficial from the victim's perspective as any relief obtained could be enforced on the assets of the relevant health department, the success level is relatively low as the concept of *novus actus interveniens* has continued to pose a great challenge to the victim in proving a claim against the medical personnel. This research sought to find out how the protection of victims of medical negligence could be enhanced in spite of the common law defence of *novus actus interveniens* available to the health service providers.

CHAPTER ONE

INTRODUCTION

1.1. BACKGROUND TO THE STUDY

Medical negligence is becoming a serious problem worldwide with some studies suggesting that it is the third leading cause of death in North American hospitals.¹ Harm resulting from medical negligence is currently an issue of concern in South Africa. The patient may sue the Doctor for damages. There may be a disciplinary enquiry in terms of the Health Professions Act. This could result in suspension or striking off the doctor from the roll. In the case of death an investigation as to the cause of the death may be held in the form of an Inquest.

The cause of death poses a serious problem in the medico-legal investigation.² The need to identify the cause of harm is not only considerably important for the family of the deceased but it is relevant to criminal and delictual proceedings while seeking reliefs by or for the victims. The burden is often laid at the doors of lawyers, medical practitioners, police establishments, health institutions, training institutions and others,³ to establish cause of harm suffered by the victim.

The primary objective of an investigation is to determine the cause and manner of death. These could lead to an infinite chain of causation. The research is centred on that element of delict referred to as causation. The proposed study seeks to determine where the blame lies in harms resulting from medical negligence. The approach adopted by the court in dealing with such matters will be closely scrutinised to ascertain the extent of protection afforded to the victims. Causal link between defendant's conduct and victim's harm is a requirement for a successful action in delict.⁴ Causation consists of two elements: factual and legal causation. These two elements determine whether a party can be held liable for damages caused to another.

¹FAQ about Medical Negligence & Malpractice Claims-Adele Van der Walt Inc.' available at <http://www.medicallaw.co.za/articles/medical-negligence-malpractice-claims-attorneys-14012016.html> (accessed 23 March 2017).

² H.A. Shapiro, LS Smith & I.A. Loftus "Forensic Medicine" available at <https://lawblogs.files.wordpress.com/2014/01/forensic-medicine-study-guide.pdf> (accessed 23 July 2016).

³ I. Dutton, *The Practitioner's Guide to Medical Practice in South Africa* (Cape Town: SuberInk, 2015) v.

⁴ Neethling, Potgieter & Visser *Law of Delict* 6th ed (South Africa: LexisNexis, 2012) 183.

A full and lengthy explanation of both elements can be found in the case of *Groenewald v Groenewald*,⁵ where the court held that factual causation relates to the question as to whether the defendant's wrongful act was a cause of the plaintiff's loss.⁶ The enquiry as to factual causation is conducted by applying the 'but-for' test.⁷ The test is designated to determine whether the postulated cause can be identified as a *causa sine qua non* of the loss/harm in question.⁸ *Causa sine qua non* is not perfect, it has loopholes. The test is always about whether the practitioner exercised a reasonable skill and care, or whether his conduct fell below the standard of a reasonable competent practitioner in his field.⁹ Legal causation is the second element which is about the remoteness or closeness of the wrongful act of the defendant to the harm or loss suffered by the victim. It is about determining whether the wrongful act is closely or directly connected to the loss for legal liability to ensue that is whether, as it is said, the loss is too remote.¹⁰ Flexible approach is applied to determine legal causation. "Factors such as reasonable foreseeability, directness, the absence or presence of a *novus actus interveniens*, legal policy, reasonability, fairness and justice all play their part".¹¹

In *Groenewald v Groenewald*,¹² the appellant raised the concept of *novus actus interveniens* as a defence. *Novus actus interveniens* is either the basis for liability or a defence. The appellant was trying to use this concept to break the chain of causation. The appellant physically assaulted the respondent, threatened to kill her and locked her in the suite of offices from which they had been conducting a video production business. The respondent attempted to escape through the window but sustained injuries when she fell from the third floor of the building. The appellant submitted that the conduct by the respondent of lowering herself from the ledge while trying to escape constituted a *novus actus interveniens*. The court however held that the respondent's conduct did not affect the chain of causation to such an extent that the appellant should by reason of such conduct not be held liable for the damages suffered by the respondent.

⁵ 1998 (2) SA 1106 SCA.

⁶ *Ibid*, 1124.

⁷ *Ibid*, 1125.

⁸ *Ibid*.

⁹ *Castell v De Greef* 1993(3) SA 501 (C) at 512A-B.

¹⁰ *Groenewald* (note 5 above).

¹¹ *Ibid*, 1126.

¹² 1998 (2) SA 1106 SCA.

A number of statutory instruments regulates the practice of the medical profession in the Republic of South Africa.¹³ The most important statute regulating medical practice is the Health Professions Act 56 of 1974. The Act provides for the establishment of the Health Professions Council of South Africa (HPCSA). The HPCSA is the statutory regulatory body responsible for, inter alia, controlling and exercising authority in respect of all matters affecting the training of persons in, and the manner of the exercise of the practices pursued in connection with, the diagnosis, treatment or prevention of physical or mental defects, illnesses or deficiencies in human kind. Briefly, the Act provides for control over the education, training, registration, and practices of a variety of health professionals. The potency of the regulatory body in reining in acts of medical negligence on the part of the healthcare providers is in doubt.

Statistics show that health care providers such as obstetricians, gynaecologists, neurosurgeons, neonatologists and orthopaedics are often involved in healthcare related litigation.¹⁴ Failure by these healthcare providers to adhere to the general level of skill and diligence exercised in their profession would normally constitute negligence.¹⁵ Liability is complicated by the fact that some of these medical personnel are indemnified; the employers are held vicariously liable for their acts or omissions.¹⁶

The defence of *novus actus interveniens* was raised in the case of *MEC Health, Eastern Cape v Mkhitha*.¹⁷ The plaintiff was a passenger in a motor vehicle that was involved in a collision on 23 June 2011 and he sustained injuries as a result. The healthcare providers at BOH failed to take the necessary x-rays of the plaintiff's leg, which would have indicated that there was a mal-alignment of her right leg. As a result thereof, the leg healed with a 15 degree angulation, which she alleged was as a result of the hospital's negligence

¹³ LC Coetzee & P Carstens 'Medical malpractice and compensation in South Africa' (2011) 86(3) *Chicago-Kent Law Review* 1263.

¹⁴ News24 'SA's shocking medical malpractice crisis' 10 March 2015 available at <http://www.health24.com/News/Public-Health/SAs-shocking-medical-malpractice-crisis-20150309>. (accessed 11 May 2017).

¹⁵ *Van Wyk v Lewis* 1924 AD 438 at 444.

¹⁶ G Howarth, 'Can private Obstetric care be saved in South Africa?' *The South African Journal of Bioethics & Law*, available at http://www.sajbl.org.za/index.php/sajbl/LexisNexis_article/view/319/372 (accessed 25 May 2017).

¹⁷ (1221/15) [2016] ZASCA 176.

Novus actus interveniens is a Latin phrase, which means a new intervening act. An act or event that breaks the causal connection between a wrong or crime committed by the defendants and subsequent developments. The new event relieves the defendant from the responsibility for the harm suffered by the victim. Van der Walt and Midgely observed that:

The concept of *novus actus interveniens* has the effect of completely neutralising the causative potency of the defendant's original conduct, for it indicates that, even though the causative link remains factually intact, the link between the conduct and the harm is too tenuous.¹⁸

The nature and effect of medical negligence is illustrated by the facts of *Topham v Member of Executive Committee for the Department of Health, Mpumalanga*.¹⁹ The claim arose from the alleged failure of a doctor employed at hospital, to diagnose a hip dislocation operation. Her vital signs were recorded by the nursing staff and she was then examined by a newly admitted intern, but he failed to diagnose her hip dislocation.²⁰ Upon her re-admission, after consulting a general practitioner in private practice, on 8 May 2006. He referred her for x-rays and diagnosed a dislocated right hip. He then referred her to the hospital. The medical personnel at the hospital agreed with this diagnosis and treated her for this condition until her discharge on 1 June 2006.²¹

Topham case illustrates medical negligence by a way of failing to diagnose the patient and this resulted because the healthcare failed to conduct x-ray while it was necessary.²² It would seem that the law only frowns at the conduct of the healthcare providers when their professional behaviour are considered to have descended into the realms of unjustifiable assault, unreasonable neglect and error that could not have been prevented, and only when such an act of negligence or malpractice has resulted in demonstrable harm to the victim.²³ The doctor and the other personnel were alleged to have been negligent in that they neglected to diagnose her dislocated right hip; failed to realise that there were abnormalities of the right hip joint; neglected to treat her for the anterior dislocation of the right hip properly and

¹⁸ J.C. Van der Walt & J.R Midgely, *Principles of Delict* (South Africa: L 2005) 207.

¹⁹ (351/2012) [2013] ZASCA 65 (27 May 2013).

²⁰ M Loubser, L Midgely & A. Mukheibir, L. Niesing & D, Perumal *The Law of Delict in South Africa* (New York: Oxford University Press, 2012) 100.

²¹ *Ibid.*

²² *Ibid.*

²³ *Ibid.*

timeously; and failed to take such steps as were reasonable to ensure that she did not suffer any harm or damage other than what would normally follow from the investigation and treatment of her condition. That negligence, according to the appellant, resulted in a complication known as ‘avascular necrosis’ involving her right femur head. She consequently claimed damages from the defendant.²⁴

In this proposed study, the degree of medical negligence will be examined to show that medical negligence could constitute a *novus actus interveniens*, giving rise to the harm suffered by the victim. The proposed study will also seek to ascertain the framework of legal principles

1.2. RESEARCH PROBLEM

The medical law is one of the fastest growing fields of law with a large number of both civil and disciplinary cases flowing from it.²⁵ Medical negligence may result in the death of a patient leading to the healthcare provider being found guilty of culpable homicide. In highly exceptional cases, a doctor may even be found guilty of murder. The question is always that of determining at what point it could be conclusively said that the negligence of the healthcare provider has broken the chain of causation and has assumed the new cause of harm suffered by the victim.

Private law, more specifically the law of contract and the law of delict, primarily govern the relationship between healthcare provider and the patient.²⁶ The patient who consults a healthcare provider in private practice enters into a contractual relationship with the healthcare provider, and a patient who presents himself/herself for medical treatment at a public hospital enters into a contractual relationship with the relevant healthcare establishment.²⁷ The responsibility of the healthcare provider in that contract is to examine the patient, to diagnose his or her ailment, and to treat the patient with such professional skill, competence, and judgment as the average or ordinary healthcare practitioner in the particular branch of the profession possesses, and with the amount of care that may reasonably be expected from such a practitioner. The healthcare provider 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

²⁴ Ibid.

²⁵ G.M Scharf ‘The medico-legal pitfalls of the medical expert witness’ University of South Africa (2011) vii.

²⁶ L.C. Coetzee & P. Carsten (note 13 above) 1268.

²⁷ Ibid 1269.

employ reasonable skill and care.²⁸ Both the hospital authority and the staff of the hospital may incur liability for the negligent conduct of the healthcare provider.

A large percentage of South Africans depend on the public health sector for health care. In terms of the law of delict, healthcare providers are expected to exercise reasonable care to prevent harm from occurring to their patients. Should a patient suffer damage or loss as a result of a healthcare provider's failure to take reasonable care, the hospital may incur liability for negligence. A healthcare practitioner or hospital that intentionally violates the patient's physical integrity may be held liable for assault, whilst a medical personnel or hospital that intentionally violates the patient's privacy may incur liability for *injuria*.²⁹

The number and value of medical negligence claims in South Africa have continued to increase.³⁰ Medical malpractice liability is incurred when victims suffer damage, which may be attributed to sub-standard care provided by the health care practitioner, or hospital personnel involved in their treatment.³¹ The increase in claims is attributed to a decline in medical professionalism and the standard of care.³² Suzan Erasmus observes:

Misconduct by medical professionals can take many forms ranging from failure to keep record of the treatment, changing records, not treating patients in a timely manner, wrong diagnosis, incorrect accounting, and incorrect prescriptions, leaving surgery equipment in the patient, defrauding medical aid schemes, not monitoring patients, and not following acceptable procedures in follow-ups on post-surgery treatments.³³

Victims of such malpractice or negligence can lodge complaints with the HPCSA. One of the functions of the HPCSA is to implement procedures for handling crisis situations which may threaten patient safety and care. The body investigates the allegations and if the medical professional or institution is found guilty, the body awards penalties such as fines and suspension from practice. This study seeks to open up the delictual option available to patients who have suffered harm arising from medical negligence.

²⁸ *Mitchell v Dickson* 1914 AD 419 at 525.

²⁹ Coetzee & Carstens (note 24 above) 1271.

³⁰ P van der Heever, 'Medical Malpractice: The other side' 2016 (49) *De Rebus* para 1.

³¹ *Ibid.*

³² Susan Erasmus, Health24, 'Suing Doctors in SA' February 2014 available at <http://www.health24.com/lifestyle/woman/your-life/suing-doctors-in-sa-20120721> (accessed 12 February 2017).

³³ *Ibid.*

1.3. AIMS AND OBJECTIVES

1.3.1 Aim

The aim of this research is to determine how best the victims of medical negligence can be protected under the law by holding healthcare providers delictually accountable for their negligent conducts that cause harm to patients.

1.3.2 Objectives

In seeking to actualise the above aim, the researcher will pursue the following objectives:

- To identify and examine factors that are causing a rapid increase in medical negligence litigation.
- To critically analyse how the existing courts' approach is failing to bring justice to the victims of medical negligence.
- To ascertain whether penalties imposed for injuries arising from medical negligence are adequate to serve as deterrence to other medical personnel who may act negligently.
- To make appropriate recommendations and provide guidelines on how to improve the operational effectiveness of the sanctions or penalties imposed on the medical personnel whose conduct is found to have fallen below the standard of practice of the medical profession.

1.4. RESEARCH QUESTION

A research question is an answerable inquiry into a specific concern or issue.³⁴ It is an initial step in a research project³⁵, and the research question provides the direction for the research inquiry. A research question does not state how to do something, but offers a vague or broad proposition. In the light of the above, this research work will seek to find out the extent to which victims of medical negligence are protected under the South African law.

1.5. LITERATURE REVIEW

³⁴ 'Writing Research Question: Purpose & Example' available at <http://study.com/academy/lesson/writing-research-questions-purpose-examples.html> (accessed 22 June 2017).

³⁵ Ibid.

It is important to critically analyse published material on a particular topic. Literature review is a search and evaluation of the available published work in one's chosen area of research. It documents the state of art with respect to the subject or topic of research.³⁶ It seeks to show the readers that the researcher has an in depth grasp of the subject and understands where the research fits into and adds to an existing body of agreed knowledge.³⁷ It is in this context that works that are relevant to the proposed research are reviewed.

Odunsi and Nwafor³⁸ address the importance of Physician-Patient relationship and medical confidentiality from a human rights-based approach. A 'Human Rights Based Approach' is about empowering people to know and claim their rights and increasing the ability and accountability of individuals and institutions who are responsible for respecting, protecting and fulfilling rights.³⁹ The right to privacy states that physicians are generally obliged to refrain from divulging information which their patients pass to them in confidence to third parties.⁴⁰ The relationship of a physician with a patient is founded on trust and confidence.⁴¹ For the healthcare provider to be able to assist patients, he/she must have all the necessary information about the illness. However, the healthcare provider is under an obligation not to disclose the

³⁶ 'Guide to academic writing: University of Western Cape' available at <file:///C:/Users/11630292/Downloads/Academic%20Writing%20Guide.pdf> (accessed 20 June 2017)

³⁷ Ibid.

³⁸ S.B. Odunsi & A.O. Nwafor 'Medical Confidentiality: Right of HIV/AIDS patient and the third party interest' (2006) 16 (2) Lesotho Law Journal 249-271.

³⁹ Developing the over-arching Principles and NCS, what is meant by a 'Human Rights Based Approach'? Available at <http://www.newcarestandards.scot/wp-content/uploads/2015/10/Human-Rights-Based-Approach.pdf> (accessed 29 June 2017) see also Care about Right? What is Human Rights Based Approach? Available at <http://careaboutrights.scottishhumanrights.com/whatisahumanrightsbasedapproach.html> where it was also reported that a human rights based approach is about ensuring that both the standards and the principles of human rights are integrated into policymaking as well as the day to day running of organisations. It also means increasing the ability of those with responsibility for fulfilling rights to recognise and know how to respect those rights, and make sure they can be held to account. (accessed 29 June 2017).

⁴⁰ Odunsi & Nwafor (note 36 above) 251.

⁴¹ Ibid. see also Confidentiality and Privacy: What is the difference? Available at <related:safpj.co.za/index.php/safpj/article/download/1393/1523> confidentiality and healthcare in South Africa where it was pointed out that confidentiality is linked to the value of trust in doctor-patient relations. In this encounter, a patient communicates to the doctor particular information which is of a personal nature. The patient expects that the doctor will, as bearer of this trust, not divulge that information to a third party without the confider's permission. (accessed 29 June 2017).

patient's information. The state is by law under the obligation to protect and respect the rights of the patients in all situations.⁴²

Nwafor and Nwafor⁴³ also address the importance of the responsibility that patients share with the physician for their own healthcare. They describe the relationship of a physician and patient as a fiduciary type of relationship.⁴⁴ Patients have a right to expect that health care providers will hold their information in confidence.⁴⁵ Disclosing the patient's information by the healthcare provider to a third party is a negligent conduct. Patient confidentiality is enshrined in the law. For example, the National Health Act 61 of 2003 makes it an offence to disclose patients' information without their consent, except in certain circumstances.⁴⁶

Carstens⁴⁷ assessed the validity and applicability of medical negligence as a *novus actus interveniens*. He showed that in almost every murder or culpable homicide case the prosecution usually argues that the first person who inflicted the life threatening wound is always the legal cause of the deceased's death despite the medical negligence that may have occurred on the part of the healthcare provider. According to Carstens, the courts usually 'degrade' medical negligence in order to rule that such negligence, in policy consideration, shall not be regarded as a *novus actus interveniens*.⁴⁸ While Carstens' discussion proceeds from a criminal law perspective, the study will discuss the concept of *novus actus interveniens* from a delictual liability standpoint.

Carstens is of the opinion that cases of medical negligence are, in reality, cases of medical misadventure and not really of medical negligence. Carstens further states that the recent South African criminal cases strongly suggest the presence of medical misadventure in the context of reasonable errors of professional

⁴² Nwafor G.C. & Nwafor A.O. 'The Healthcare Providers-Patients Relationship and State Obligations in Times of Public Health Emergency' (2016) 9 *African Journal of Legal Studies* 1-13.

⁴³ Ibid.

⁴⁴ Ibid 3.

⁴⁵ Health Professions Council of South Africa, Guidelines for Good Practice in the Health Care Professions, Confidentiality: Protecting and Providing Information 2nd ed Available at http://www.hpcsa.co.za/downloads/conduct_ethics/rules/confidentiality_protecting_providing_info.pdf page 3 (accessed 21 June 2017).

⁴⁶ See ss 14(1), 14(2) and 15 of the National Health Act 61 of 2003.

⁴⁷ Carstens PA 'Medical negligence as a causative factor in South African criminal law: *novus actus interveniens* or mere misadventure' (2006) 19(2) *South African Journal of Criminal Justice* 192-211

⁴⁸ Ibid.

judgement.⁴⁹ While Carstens' proposition is materially centred on medical misadventure, this research work aims to prove, using decided cases, that medical negligence can be a *novus actus interveniens* depending in the context. The healthcare providers are presumed to be aware of their duty of care and skill to their patients; therefore, medical negligence cannot be treated simply as misadventure. The healthcare providers are aware of the results that may flow from their conduct if a patient is not given the required care. The courts will however have to find the existence of negligence in the *novus actus interveniens* that caused harm to hold the healthcare provider responsible for the harm suffered by the victim.

Carstens⁵⁰ discussed a number of cases that are related to medical negligence. In most cases the court failed to hold that medical negligence was in fact the factual and legal cause of the victim's death. He further evaluated the judicial recognition of improper medical treatment as neither abnormal nor extra-ordinary.⁵¹ Carstens observed that the South African public hospitals are in a crisis and gravely compromised due to lack of resources and shortage of medical staff.⁵² In his conclusion, Carstens submitted that whether medical negligence is the *novus actus interveniens* still remains an open question.⁵³ Indeed, South African public hospitals lack resources and medical staff. However, this should not be used as an excuse by medical personnel for being negligent. In this research work, guidelines and recommendations will be provided as would enable the court to hold that medical negligence could constitute a *novus actus interveniens* that leads to harm suffered by the victim for which the healthcare provider should be held liable.

Belscher and Permezel⁵⁴ drew attention to the duty of the medical practitioner. The health care provider has a duty to the patient of providing a certain standard of care and skill. For negligence to be proved, there must be a breach of that duty and the patient must have suffered damage.⁵⁵ The health care provider is under an increasing threat of medico-legal action. If the death of the patient occurs whilst in

⁴⁹ Ibid.

⁵⁰ P Carstens & D Pearmain 'Medical recognition of substandard medical treatment in South African public hospital: the slippery slope of policy consideration and implications for liability in the context of medical negligence' (2008) 23 (1) *South African Public Law* 168-180.

⁵¹ Ibid.

⁵² Ibid.

⁵³ Ibid.

⁵⁴ N.A. Belsecher, M Permezel, *Obstetrics and the New-born* (London, Philadelphia: Saunders, 1997)

39.

⁵⁵ Ibid.

the care of a medical provider, it should be determined whether it was avoidable or unavoidable. That being the case, the South African courts seem to have given greater credence to the evidence of the healthcare provider under whose care a patient would have died. The prosecution in South Africa always argues that the person who inflicted the first life threatening wound is the legal cause of death. In doing so, it is favouring the healthcare provider.⁵⁶ The present state of the law is overwhelmingly in favour of the healthcare provider. The research work will seek to show that the death of the victim in the care of the healthcare provider could be as a result of negligence for which the healthcare provider should be held liable.

Swanepoel⁵⁷ focuses on the inability of the mentally ill person to appreciate the unlawfulness of his or her conduct. Swanepoel's objective is to show that only a mentally ill person cannot be held responsible for his or her action that is unlawful. However, a healthcare provider is a fit and proper person who knows what is right and what is wrong. The healthcare provider acts negligently because the law does not always hold him/her liable.⁵⁸ This research work seeks to proffer reasons why the law should punish such acts of medical negligence even when they are viewed as *novus actus interveniens*. When a medical practitioner is exercising his or her duties to the patient in a negligent manner, he should bear the consequences flowing from such negligence.

*Nöthling-Slabbert*⁵⁹ argues that in most cases related to medical negligence, the onus of proof lies on the patient to establish civil liability of the healthcare provider. "Where the presence or absence of negligence depends upon something not absolute but relative, it must be ascertained from a consideration and examination of all the surrounding factors and circumstances viewed as a whole".⁶⁰ This statement contradicts the approach used by the South African courts because in most cases the surrounding circumstances that could give rise to medical negligence are inadequately considered. The person who is mostly looked at when a person dies due to an injury inflicted by another is the one who inflicted the injury and not the

⁵⁶ Ibid.

⁵⁷ M. Swanepoel 'Legal aspect regarding mentally ill offender in South Africa' (2015) 18 (1) *Potchefstroom Electronic Law Journal* 3238-3258.

⁵⁸ Ibid.

⁵⁹ M. Nöthling-Slabbert, *Medical law in South Africa* (Netherlands: Kluwer Law International, 2011) available at <https://books.google.co.za/medical+law+in+south+africa+by+slabbert.hl> (accessed 23 April 2017).

⁶⁰ Ibid.

healthcare provider in whose care the patient died. The courts do not seem to give sufficient consideration to the events that occurred after such patient is admitted in the hospital. This study will reveal the importance of considering the events that occur in the hospital from the time a patient is admitted and the procedures that the healthcare provider followed in treating a patient.

Carstens and Pearmain⁶¹ have contributed significantly in the field of medical jurisprudence. They have carefully examined structures and elements of a number of issues in their work. They have discussed the regulation of the medical profession in South Africa and professional medical negligence and vicarious liability. It was found in most cases that patients tend to sue the hospital for medical negligence that resulted in death or disability. This is because any judgment obtained against an establishment is easier to enforce due to availability of assets. It is probable that the healthcare providers act negligently knowing that even if a lawsuit is instituted against them, they will not lose anything since the government is the one that will pay for damages suffered by the victim. This research work seeks to show why the healthcare providers must be held liable directly for some of their actions so as to encourage them to treat their patients attentively and conscientiously.

Van der Heever⁶² assessed the difficulties that the courts often encounter when adjudicating on causation in medical negligence. The author points out that patients lose a chance to recover once they are taken to the hospital if the medical practitioners act carelessly. This is so because the hospital is the only place that the patient hopes to receive care and when they do not, they lose hope. Van der Heever gives guidelines for understanding and applying causation in the law relating to medical negligence. The South African justice system seems to consider medical negligence and causation at the same level. This negates the fact that medical negligence is sometimes the cause of death of a patient. This study will argue that medical negligence should be treated as a causative factor that can lead to the death of a patient.

⁶¹ P.Carstens & D.Pearmain *Foundational principles of South African medical law* (Cape Town: LexisNexis, 2007) 20.

⁶² P van der Heever *Application of the doctrine of loss of a chance to recover in medical negligence cases in South Africa* (South Africa: Pretoria University Press, 2007) 39.

Pienaar⁶³ only outlined what could be the possible reasons for the rapid increase in medical negligence litigation. The two main causes of the increase are lack of professionalism on the part of the medical practitioners and the patients increasing awareness of their rights. A number of patient-centred legislations are discussed and the Consumer Protection Act 68 of 2008 is one of them. This Act provides a new list of responsibilities with which medical practitioners are tasked. There is an indemnity clause enacted by this Act which is inserted in the form that must be signed by the patient. The aim of the clause is to exempt the healthcare provider from liability for any action that could lead to injury or death of the patient. In this way, the healthcare providers are protected when treating a patient. This suggests that South African courts must give strict interpretations to legislation affecting victims of medical negligence to find relief against the healthcare providers.

Van der Heever⁶⁴ suggests that it is untenable and out of touch with modern approaches adopted in other common law countries for South African courts to continue to exclude the operation of the maxim *res ipsa loquitur* in medical negligence cases.⁶⁵ The main case that is discussed in Heever's book is *Van Wyk v Lewis*. The approach used by the South African courts is compared to other countries' approaches. Heever recommends the application of *res ipsa loquitur* maxim in medical negligence and related medical malpractice issues in South Africa. Indeed, *res ipsa loquitur* should be applied to medical negligence to a certain degree, especially where the healthcare providers' negligence is an obvious cause of harm.

In the case of *Napier v Collett*,⁶⁶ the court dealt with factual causal link between an accident and the later death of the racehorse. Collett and another owned a horse, named "shooting party", which had died after an accident. The horse sustained an injury while running in a race. Three surgeons, after discussing amongst themselves, agreed that surgical treatment of the animal's injury should be attempted. The horse died while undergoing arthroscopic surgery, it was first placed under general

⁶³ L. Pienaar 'Investigating the reasons behind the increase in medical negligence claims' PELJ / PER 2016(19). DOI available at <http://dx.doi.org/10.17159/1727-3781/2016/v19i0a1101> (accessed 21 March 2017).

⁶⁴ P van der Heever *Res ipsa loquitur and medical negligence: A comparative study* (Cape Town: Juta, 2011) 20.

⁶⁵ *Ibid.*

⁶⁶ 1995 (3) SA 140 (A).

anaesthetic. The medical cause of death was either heart failure or lung collapse or a combination of the two conditions precipitated by the anaesthetic. The question then is whether there was a sufficiently close relationship between the accident and the death to render one the legal cause of the other.⁶⁷

The final judgement reached by the court was that the horse died as a result of the administration of the anaesthetic during the operation. Even though the court did not use the phrase *novus actus interveniens*, this matter definitely involved the effect of intervening factors on legal causation. In cases like these, the test to be applied is a flexible one in which factors such as the absence or presence of *novus actus interveniens*; legal policy, reasonability, fairness and justice all play their part.⁶⁸ This case simply shows that even a mistaken diagnosis by the professional healthcare provider may lead to death.

The concept of *novus actus interveniens* was also discussed in the case of *Road Accident Fund v Russell*.⁶⁹ The respondent's husband committed suicide after sustaining injuries as a result of motor collision and at the same time he was suffering from depression. The central issue that the court was faced with was whether death by suicide of a person of impaired mind and judgment constituted a *novus actus interveniens*.⁷⁰ The court relied on the principle that a person who is not of sound mind cannot be said to have acted with unimpaired volition in forming the decision to commit suicide and that such suicide does not constitute a *novus actus interveniens*. The suicide was not *novus actus interveniens* but was causally connected to the negligence of the insured driver. The decision to commit suicide, when of sound mind was regarded as a *novus actus interveniens* in the case of *Reeves v Commissioner of Police of the Metropolis*.⁷¹

*Blyth v Van den Heever*⁷² dealt with the issue of factual causation in a medical negligence claim. The plaintiff had sustained an injury to his right radius and ulna.⁷³ After the respondent (a medical practitioner) operated to reduce the fracture sepsis set in, together with an ischemic condition, the plaintiff ultimately lost the use of the

⁶⁷ Ibid para 13.

⁶⁸ D Visser, *Unjustified Enrichment* (Cape-Town: Juta, 2008) at 747.

⁶⁹ 2001 (2) SA 34 (SCA).

⁷⁰ Ibid at 39.

⁷¹ (1993) 3 ALL ER 897.

⁷² 1980 (1) SA 191 (A).

⁷³ Dutton (note 3 above) 64.

arm. The issue that the court had to decide was whether there was a factual nexus between the allegedly negligent conduct and the harm suffered. The court found on appeal that the respondent had been negligent in his post-operative treatment of the appellant in that he had failed to diagnose and take the necessary prompt action for ischemia as a reasonably skilled and careful medical practitioner would have done, and that if he had done so, the fractures would have probably healed and full use of the arm would have been regained, his negligence had caused or contributed to the ultimate catastrophe.

The court in this case did a full analysis of the medical facts, and that assisted it in holding the medical practitioner liable for medical negligence. The test that fits in the above mentioned facts is a direct consequence one. This test provided that the defendant is liable for all consequences which flow directly from his negligent or wrongful conduct.⁷⁴ The direct consequences test is also known as the proximate cause and it originated from the English case of *In re Polemis and Furness, Withy & co Ltd.*⁷⁵ However, the direct consequences test has not found much favour in the South African delictual liability.⁷⁶ This work discusses the merits for an increased application of the direct consequence test in medical negligence cases to enhance the protection of victims.

1.6. METHODOLOGY

Research means a diligent and systematic inquiry or investigation into a subject in order to discover facts or principles.⁷⁷ A certain systematic, theoretical analysis method must be used in conducting research. Research methodology is a systematic way to solve the research problem. A research methodology addresses how data is collected and analysed. There are a number of methodologies that a researcher can use to collect and analyse data. These include qualitative, quantitative and mixed methods.

⁷⁴ J. Burchell *Principles of delict* (Cape Town: Juta, 1993) 119.

⁷⁵ [1921] 3 KB 560.

⁷⁶ *Ibid*, 95.

⁷⁷ G Remelts 'Research,' what is it? 'available at <https://www.calvin.edu/academic/rit/webBook/chapter4/Sec1/what/> (accessed 21 May 2017)

Qualitative research seeks to explore a specific phenomenon, not prove or make a prediction.⁷⁸ The qualitative method provides rich, contextual explorations of the topic that are often personally or culturally meaningful.⁷⁹ On the other hand, quantitative research is used to quantify the problem by way of generating numerical data or data that can be transformed into useable statistics.⁸⁰ It is used to quantify attitudes, opinions, behaviours, and other defined variables – and generalize results from a larger sample population.⁸¹ Mixed methods research is when a researcher combines elements of qualitative and quantitative approaches for the purpose of breadth and depth of understanding and corroboration. These methods of research are in the main, more appropriate for a sociological inquiry. This research is a doctrinal work, which is concerned with the examination of legal doctrines through the analysis of legal rules.⁸² The researcher will rely on both primary and secondary sources in conducting this research. Primary sources will include legislation and judicial decisions on the subject matter of research. Secondary sources are opinions of writers expressed in written works such as books, journal articles and internet sources.

1.7. DEFINITION OF KEY CONCEPTS

Researchers seek to avoid misunderstandings in human communication that result from people bringing different meanings to the words they use in speaking and writing. They do so by clearly explaining the meanings they assign to key terms in their work. A proper use of definitions also conveys a strong sense of consistency and accuracy as regards the research work as a whole. Terms that will be used frequently during the course of this research are accordingly defined below.

1.7.1. Medical negligence

⁷⁸ Erica Loop ‘Different types of methodologies’ available at <http://classroom.synonym.com/different-types-methodologies-7459438.html> (accessed 21 May 2017).

⁷⁹ Ibid.

⁸⁰ Suzan E Wyse ‘What is the difference between qualitative research and quantitative research’ available at <https://www.snapsurveys.com/blog/what-is-the-difference-between-qualitative-research-and-quantitative-research/> (accessed 23 May 2017).

⁸¹ Ibid.

⁸² Paul Chynoweth ‘legal research-school of social and political science’ available at http://zzz.sps.ed.ac.uk/_data/assets/pdf_file/0005/66542/Legal_Research_Chynoweth_-_Salford_Uni..pdf (accessed 22 May 2017).

The word medical negligence refers to an improper, unskilled or negligent treatment of a patient by the healthcare provider. Medical malpractice is used as synonymous with medical negligence; therefore, the two words will be used interchangeably.

1.7.2. *Novus Actus Interveniens*

The phrase *novus actus interveniens* is a Latin term which means an independent, unconnected and extraneous factor which actively contributes to the occurrence of harm after the victim's original harm has occurred.⁸³

1.7.3. Causation

The Merriam Webster Dictionary⁸⁴ defines causation as the relationship of cause and effect of an act or omission and damages alleged in a claim or the relationship between an event or situation and a possible reason or cause.

1.7.4. Healthcare provider

This is defined as an individual, institution or agency that provides health services to healthcare consumers.⁸⁵

1.7.5. Victim

The Oxford English Dictionary⁸⁶ defines victim as a person harmed, injured, or killed as a result of a crime, accident, or other event or action.

1.7.6. Patient

The Merriam Webster Dictionary⁸⁷ defines patient as an individual awaiting or under medical care and treatment. A patient is also defined as a person receiving or registered to receive medical treatment.⁸⁸

1.7.7. Delict

⁸³ M Loubser, L Midgely & Andre Mukheibir, Liezel Niesing & Devina Perumal *The law of Delict in South Africa* (New York: Oxford University Press,2012) 99.

⁸⁴ Causation- Definition and more from the free Merriam' Available at <https://www.merriam-webster.com/dictionary/causation> (accessed 03 June 2017).

⁸⁵ Healthcare provider-medical dictionary-The free dictionary' available at <http://medical-dictionary.thefreedictionary.com/health+care+provider> (accessed 10 June 2017).

⁸⁶ 'Victim-English oxford dictionaries' available at <https://en.oxforddictionaries.com/definition/victim> (accessed 10 June 2017).

⁸⁷ 'Patient-Definition and more from the free Merriam' available at <https://www.merriam-webster.com/dictionary/patient> (accessed 10 June 2017).

⁸⁸ 'Patient-Oxford English living dictionary' available at <https://en.oxforddictionaries.com/definition/patient> (accessed 10 June 2017)

This is defined as a civil law term which imposes liability on a person who causes injury to another, or for injury caused by a person or thing under his custody.⁸⁹ For a conduct to qualify as a delict, these elements must be present: wrongfulness, fault, causation and harm.

1.8. STRUCTURE (OVERVIEW OF CHAPTERS)

This research is divided into five chapters as follows:

CHAPTER ONE: INTRODUCTION

This is the introductory chapter which aims at orientating the reader and explaining the significance of this research work. The chapter covers the introduction, aims and objectives, statement of problems, literature review, research question, research methodology, and definition of key concepts and limitations of the study.

CHAPTER TWO: MEDICAL NEGLIGENCE: WHAT DOES IT INVOLVE?

In this chapter, the concept of medical negligence will be rigorously explained. Four medical negligence elements will be discussed. Circumstances where the healthcare provider shall be held liable for their negligence will be discussed as well. All information about how one can report a medical negligence or error will be furnished. The aim of this chapter is to supply all the necessary information about the subject of medical negligence.

CHAPTER THREE: STATUTORY PROVISIONS ON MEDICAL NEGLIGENCE

This chapter will focus on statutory provisions on medical negligence. It will analyse those provisions and indicate how some infringe on the rights of the victims of medical negligence to a fair trial and equality. The procedure that the South African courts have adopted in delictual matters will be fully analysed.

CHAPTER FOUR: PROBING THE REASONS BEHIND THE INCREASE IN MEDICAL NEGLIGENCE CLAIMS

Chapter four deals with reasons behind an increase in both claims and volume of medical negligence litigation. It will lend credit to the suggestion that the Medical law

⁸⁹ 'Delict definition-Duhaime's Law Dictionary' available at <http://www.duhaime.org/LegalDictionary/D/Delict.aspx> (accessed 10 June 2017).

has become undoubtedly the fastest growing field of law with a large number of both civil and disciplinary cases flowing from it.

CHAPTER FIVE: CONCLUSION AND RECOMMENDATIONS

This is the last chapter of the study. It deals with the conclusions and recommendations on how medical negligence claims should be handled. Considerations will be given to an improvement in the detection of sub-standard care and the institution of appropriate corrective measures or disciplinary process.

1.9. STUDY LIMITATIONS

Although this research will be carefully prepared, there are still some limitations and shortcomings. First, the law library resources are limited, some of the books that are supposed to be used in this study are not reachable. The quality of a doctrinal research heavily depends on the skills of the researcher. This researcher's skills are still evolving and will have some bearing on the presentation of legal arguments in the work. The scope and depth of discussion in this research may not attain the level of an experienced scholar. The collection of data method is another limitation. This research is a desktop study. Therefore, the researcher will rely partly on secondary sources whose authenticity cannot be verified. This topic is particularly challenging and by its nature it covers a wide range of legal, medical and ethical areas of expertise which the researcher is at present striving to acquire.

1.10. ETHICAL CONSIDERATION

Ethics is the branch of philosophy which deals with the dynamics of decision making concerning what is right and wrong.⁹⁰ It is, therefore, critical that the researcher understands the basic of ethics in research and how this might affect the research outcome. Most research involving human beings is directed towards advancing human welfare, knowledge and understanding. Researchers have a clear responsibility to ensure that they recognise and protect the rights and general well-

⁹⁰ Georgia Fouka & Marianna Mantzorou 'What are the Major Ethical Issues in Conducting Research? Is there a Conflict between the Research Ethics and the Nature of Nursing?' (2011) vol 5 issue 1 Health Science Journal 4.

being of their participants, regardless of the nature of their research. This research will, however, not involve human participation. The research will acknowledge all the sources and consulted materials and will avoid plagiarism.

CHAPTER TWO

MEDICAL NEGLIGENCE: WHAT DOES IT INVOLVE?

In most modern societies, people's health is a major factor in both personal and social development. In South Africa, every person has constitutional rights to access health services and to be treated in a way that would improve the person's health.⁹¹ The issue of quality healthcare has continued to be a subject of public debate and general concern.⁹² One's economic class determines the level of healthcare that one receives. It is however of great concern that even within the limits of available resources, some healthcare providers have not shown the greatest skill and diligence in handling matters relating to their patients. This chapter discusses the concept of medical negligence as a *novus actus interveniens*. The chapter reveals circumstances under which the negligent healthcare provider could be held liable for their negligence.

2.1. Introduction

The issue of *novus actus interveniens*, while applicable to all instances of delict are often seen in cases of medical negligence/malpractice where the malpractice is a secondary intervening factor.⁹³ Some members of the public do not know how and where to lodge a complaint against a healthcare provider whom they believe has acted unethically or caused them harm.

South African law of delict is based on fault principle, and in the medical malpractice arena, it usually applies when there is negligent conduct for which healthcare providers could be held liable.⁹⁴ This means that, if a healthcare provider's treatment, diagnosis or any other conduct carried out in his or her capacity as a medical professional is negligently performed and causes harm to the patient, the negligent healthcare provider may, in principle, be held liable. However, medical negligence belongs to the category of personal injury, which is often very difficult to prove. There

⁹¹ Section 27, 'Health and Democracy' available at <http://section27.org.za/2007/06/health-and-democracy/> (accessed 21 July 2017).

⁹² NP Moyakhe, 'Quality healthcare: an attainable goal for all South Africans' *The South African Journal of Bioethics and Law*, available at <http://www.sajbl.org.za/index.php/sajbl/article/view/355/378> (accessed 27 July 2017).

⁹³ Hogan Lovell 'Novus actus interveniens' February 2017 available at <https://www.hoganlovells.com/en/publications/novus-actus-interveniens> (accessed 12 July 2017)

⁹⁴ 'Delict explained' available at <http://www.jgs.co.za/index.php/litigation/delict-explained> (accessed 23 July 2017).

is currently no legislation in South Africa which specifically addresses legal claims in the medical field. Claims based on medical negligence are dealt with under the common law.⁹⁵ Carstens and Pearmain have attributed the increasing number of such claims to high poverty levels in the society which is aggravated by the deteriorating medical facilities in the public healthcare institutions and a shortage of personal.⁹⁶ It is imperative that the healthcare providers function optimally within the limits of available resources in dealing with their patients.

2.2. Meaning of medical negligence

Medical negligence occurs when a patient suffers harm as a result of a preventable conduct of the healthcare provider.⁹⁷ Medical negligence also means a negative consequence of medical treatment that the healthcare provider could have prevented.⁹⁸ Medical malpractice occurs because of an improper, unskilled or negligent treatment of a patient by a healthcare provider.⁹⁹ Medical professional's conduct that results in personal injury to a patient is seen as a negligent act¹⁰⁰ when a medical professional's conduct do not meet the accepted standard of practice.¹⁰¹ The terms medical negligence and medical malpractice are used interchangeably since negligence is at the heart of medical malpractice.¹⁰² It is negligent to engage in any potentially dangerous activity unless one has the skill and knowledge associated with the proper discharge of the duties connected with such an activity.¹⁰³

Negligence refers to a certain standard of human behavior and failure to measure up to this standard. The essence of the concept of negligence is that the defendant's conduct is compared to an objective standard of a reasonable person. To determine whether a person acted negligently, a comparison is made with the notional 'reasonable person'. The test for criminal and civil medical negligence is the same; the only difference lies in the weight of proof. The position of the wrongdoer who

⁹⁵ 'Medico-legal claims' (2017) 141 (33) *South African Law Reform Commission* (SALRC) 4.

⁹⁶ P Carstens and D Pearmain (note 45 above) 168-180.

⁹⁷ Davidson England Attorneys, 'The layman's guide to medical negligence' available at <http://davidsonengland.co.za/medical-negligence-law/> (accessed 11 July 2017).

⁹⁸ 'Medical Negligence Claims & Compensation in South Africa' available at <https://www.claimhelp.co.za/medical-negligence/> (accessed 11 July 2017).

⁹⁹ 'Medical malpractice definition' available at <http://legdictionary.thefreedictionary.com/Medical+Malpractice> (accessed 03 July 2017).

¹⁰⁰ 'Medical Malpractice Claims' available at <https://www.dsclaw.co.za/medical-malpractice-claims> (accessed 22 July 2017).

¹⁰¹ Ibid.

¹⁰² Dutton (note 71 above) 86.

¹⁰³ *Durr v Absa Bank Ltd and another* (424/96) [1997] ZASCA 44: [1997] 3 All SA 1 (A).

possesses proficiency or expertise in respect of the alleged negligent conduct stands as something of an exception. In the case of *Kruger v Coetzee*,¹⁰⁴ the court laid down the test for negligence. Holmes JA states:

For the purposes of liability, *culpa* arises if:

- A diligens paterfamilias* in the position of the defendant:
- (i) Would foresee the reasonable possibility of his conduct injuring another in his person or property and causing him patrimonial loss; and
 - (ii) Would take reasonable steps to guard against such occurrence; and
 - (iii) The defendant failed to take such steps.

The concept of medical negligence was illustrated in *Van der Merwe v The Premier of Gauteng*¹⁰⁵ where the plaintiff sued the premier of Gauteng on the basis that the medical staff were negligent in treating his injured index right finger which resulted in the amputation of the finger. The plaintiff avers that at no stage from the time of his admission until the time of the first operation that he was ever advised by any medical practitioner that if his finger was to be saved, the operation had to be performed within the first six hours of the injury. Alternatively, the plaintiff avers that the medical staff failed to inform him that they did not have the necessary theatre facilities at that time to perform the operation and to consider alternative hospitals in the neighborhood for the operation to be performed. The court held the defendant liable for damages suffered by the plaintiff arising from the amputation of the plaintiff's finger. This case illustrates that negligence could lie not just on what the healthcare provider does, but also on what the healthcare provider fails to do.

2.3. Elements of medical negligence

Medical negligence embraces professional misconduct committed either intentionally or negligently.¹⁰⁶ Medical professionals must comply with the standard of care, namely to treat their patients the way that any other reasonable medical provider with the same qualification would do.¹⁰⁷ For a conduct to be classified as a medical negligence, the following elements need to be present:

¹⁰⁴ 1966 (2) SA 428 (A).

¹⁰⁵ [2010] ZAGPJHC 11.

¹⁰⁶ CG Marnewick, *Litigation skills for South African Lawyers* 3 Ed (Cape Town, LexisNexis 2012) at 85.

¹⁰⁷ National Health Insurance 'Health for all South Africans' available at <http://www.health.gov.za/index.php/component/.../383-national-health-insurance?...2176...> (accessed 28 August 2017).

2.3.1. Action/Conduct

Conduct is an act or omission that gives rise to harm. Conduct is a general prerequisite for delictual liability. The harm that is suffered by the patient should be the result of the action or omission by the healthcare provider. A duty of care exists where a healthcare provider or healthcare institution undertakes care or treatment of a patient.¹⁰⁸ A negligent act could be a medical procedure that is incorrectly carried out, an incorrect diagnosis or the prescription of a wrong medication.¹⁰⁹ This means that the healthcare provider failed to observe a duty of care that they owe to the patient. The harm occurs because of a breach of duty of care that is owed to the patient by the healthcare provider. In order for the patient to prove the existence of this element in his or her case, he or she must present convincing evidence that the healthcare provider concerned could have reasonably foreseen the consequences of his or her action and did not guard against such an eventuality. It must further be proved that the healthcare provider's action fell short of the standards the law considers reasonable in the circumstances.

In *M v Member of the Executive Council, Department of Health, Eastern Cape*,¹¹⁰ the plaintiff's case was that in causing the injury, the defendant's employees who owed a duty to conduct a proper surgical procedure with reasonable professional care, failed in that duty and were therefore negligent. The plaintiff underwent surgery (a laparoscopic cholecystectomy, i.e. the removal of a gallbladder) at the Livingstone Hospital in Port Elizabeth. During this surgery, she sustained injuries to her common bile duct because the bile leaked into her abdominal cavity, causing her to become very ill. She was readmitted to the Livingstone Hospital after seven days of suffering from acute bile peritonitis. After two days, a second operation was performed to repair her bile duct. The plaintiff was in the hospital's intensive care unit for 9 days and remained in hospital for two weeks. The plaintiff subsequently instituted an action against the defendant for damages.

¹⁰⁸ Susan Erasmus, Health24, 'Suing Doctors in SA' February 2014 available at <http://www.health24.com/lifestyle/woman/your-life/suing-doctors-in-sa-20120721> (accessed 12 February 2017).

¹⁰⁹ England Davison "The Layman's Guide to Medical Negligence" available at <http://davidsonengland.co.za/medical-negligence-law/> (accessed 27 August 2017).

¹¹⁰ [2016] ZAECPHC 74 (13 December 2016).

The plaintiff's argument was that had the cholecystectomy been performed correctly and with the correct instruments, the plaintiff's bile duct would not have been injured. The expert witnesses opined that the iatrogenic bile duct injury in question was caused negligently because with the application of care, diligence and skill of a reasonable surgeon, the injury to the plaintiff would not have occurred. It was noted that the injury was not noticed by any of the staff while the operation was in progress and failure to recognise an injury by the healthcare provider is regarded as negligence. The court found that the conduct of the healthcare professionals fell below the standard obtainable in the field and were therefore liable for the injury suffered by the plaintiff.

2.3.2. Wrongfulness/Unlawfulness

The conduct of the defendant must have been wrongful. Wrongfulness is a legal conclusion that a court draws from the facts before it.¹¹¹ The element of wrongfulness has been described as a measure of control that the courts use in circumstances where most right-minded people, including judges, will regard the imposition of liability as untenable, despite the presence of all elements of delictual liability.¹¹² The healthcare provider or healthcare institutions must have failed to observe the expected standard of medical care to invoke the concept of wrongfulness. If a patient suffers medical damages following an operation or surgery, it does not necessarily mean that the patient is a victim of medical negligence. That can only be the case if the healthcare provider failed to follow the correct procedure.

The element of wrongfulness constitutes a fundamental and distinct prerequisite for delictual liability.¹¹³ In the overwhelming majority of medical negligence cases, the issue of unlawfulness is uncontentious and very often not even expressly dealt with.¹¹⁴ The reasons for this are; firstly, a rebuttable presumption of unlawfulness frequently operates due to the principle that it is *prima facie* unlawful to cause physical injury to another by positive conduct. This presumption is often not contested in practice.¹¹⁵ Secondly, the defenses raised in these matters, if

¹¹¹ Van Der Walt & Midgley (note 17 above) 65.

¹¹² *Fourway Haulage SA v SA National Roads Agency Ltd* 2009 (2) SA 150 SCA para 31.

¹¹³ *Sea Harvest Corporation (pty) Ltd v Duncan Dock Cold Storage Ltd* 2000 (1) SA 827 (SCA) para 19.

¹¹⁴ *Lillicrap, Wassenaar and Partners v Pilkington Brothers (SA) (Pty) Ltd* 1985 (1) SA 475 A at 497.

¹¹⁵ Anton Fagan 'Rethinking Wrongfulness in the Law of Delict' (2005) 122 (1) *South African Law Journal* 90.

established, serve as justification for *prima facie* unlawful conduct, and conclusively eliminate the unlawfulness of the conduct.¹¹⁶

The test for wrongfulness has been repeatedly recognized by the courts. The conduct is wrongful if it either infringes a legally recognized right of the plaintiff or constitutes the breach of a legal duty owed by the defendant to the plaintiff. The ‘test’ to determine if there is wrongfulness is referred to as “the legal convictions of the community” test (also called *boni mores*).¹¹⁷ In other words, the courts ask whether the conduct was so unreasonable in the eyes of the community that one should be held to have committed, not merely a moral wrong, but a legal wrong.¹¹⁸

There would be no need for the requirements of unlawfulness if the law was prepared to impose liability for any harm to another which was caused negligently or intentionally.¹¹⁹ In the South African law, it is not enough that harm was caused intentionally or negligently, it must also have been caused wrongfully.¹²⁰ In order to be liable for the loss suffered by someone else, the act or omission of the defendant must have been wrongful and negligent.¹²¹ Negligence should only be determined after wrongfulness has been established. This is because, in some instances, the act may be negligent but not necessarily wrongful. The main function of wrongfulness is to indicate that a legally recognized interest of a person has been infringed in an unreasonable manner or in a *contra bonos mores*¹²² manner.

For instance, in *Oppelt v Head: Health, Department of Health Provincial Administration: Western Cape*,¹²³ the case concerned a delictual claim arising from delayed medical treatment after the applicant sustained spinal cord injuries that left him paralyzed. The plaintiff’s claim was that the hospital failed to provide him with

¹¹⁶ Van der Walt & Midgely (note 109 above) para 85.

¹¹⁷ The presumption of negligence (section 34) available at <http://www.daff.gov.za/doaDev/sideMenu/ForestryWeb/webapp/Documents/ForestFire/192.168.10.11/nvffa.nsf/1974327a06c616da42256dff0046dc16/4cebe8548525b66a42256dfe0074beed02ec.html?OpenDocument> (accesses 21 August 2017).

¹¹⁸ Presumption of negligence (section 34) available at <http://www.daff.gov.za/doaDev/sideMenu/ForestryWeb/webapp/Documents/ForestFire/192.168.10.11/nvffa.nsf/1974327a06c616da42256dff0046dc16/4cebe8548525b66a42256dfe0074beed02ec.html?OpenDocument> (accessed 23 September 2017).

¹¹⁹ Dutton (note 100 above) 35.

¹²⁰ Anton Fagan (note 113 above).

¹²¹ J Neethling ‘The conflation of wrongfulness and negligence: Is it always such a bad thing for the law of delict?’ (2006) 123 (2) *South African Law Journal* 205.

¹²² *Western Cape v Faircape Property Developers (Pty) Ltd* 2003 (6) SA 13 (SCA) para 31-32.

¹²³ [2015] ZACC 33.

medical care in time. Unreasonable delays on the part of the respondent's employees justified the conclusion that the applicant was refused emergency medical treatment contrary to the provision of section 27(3) of the Constitution. The court held that the employees of the respondent had wrongfully and negligently failed to treat the applicant's spinal cord injury by way of a closed reduction procedure, within four hours of its occurrence. It concluded that the respondent was liable for the applicant's proven damages.

2.3.3. Causation

No area of law is straightforward or benign but is potentially perilous than the question of causation in medical law cases.¹²⁴ In *International Shipping Company (Pty) Ltd v Bentley*,¹²⁵ the basic principle of causation was established and the court stated that only causal connection could give rise to legal liability. The defendant can only be held delictually liable if his or her conduct is the cause of the harm in question. In other words, the action or omission must be the most probable cause of harm. If a healthcare provider prescribes an incorrect medicine, and it does not cause any harm, then he or she cannot be held liable.

Causation is particularly difficult to prove because the effects of the allegedly negligent treatment must be distinguished from those of the patient's underlying condition which gave rise to the need for treatment. Challenges with causation in the law of delict arise in proving two enquiries of factual and legal causation. The factual causation relates to the question of whether the negligent act or omission in question caused or materially contributed to the harm-giving rise to the claim.¹²⁶ If the court is satisfied that the conduct caused the harm in question, then it proceeds to the inquiry into the second challenge. Legal causation is the second challenge that the court has to determine. Its aim is to determine whether the conduct is sufficiently linked to the harm for legal liability to ensue. These two pronged arms of causation in delict are now discussed in detail below.

2.3.3.1. Factual causation

¹²⁴ Dutton (note 117 above) 59.

¹²⁵ 1990 (1) SA 680 (A) at 700.

¹²⁶ Van der Walt & Midgely (note 114 above) para 70.

As it is stated above, the factual causation comprises a factual enquiry. The aim of factual causation is to determine from the facts before the court if the conduct in question either caused the harmful results or not. In most of the delictual cases, the facts are such that the actual factual cause of the plaintiff's harm can be determined on preponderance of probabilities. The plaintiff need not establish the causal link with certainty, but only on balance of probabilities.¹²⁷ The test that the courts use to ascertain factual causation is called the *conditio sine qua non* (or 'but-for' test).

This test implies that the defendant's conduct must have been the necessary condition for the plaintiff's harm.¹²⁸ This test mostly finds application in cases that are straightforward. These are the cases that have only one cause for the plaintiff's harm. In ambiguous cases that have more than one competing but independent causes for the plaintiff's harm, the test is difficult to apply.¹²⁹ It is burdensome to determine on balance of probabilities which of the possible causes actually caused the plaintiff's harm.

The application of the 'but-for' test differs depending on whether the conduct that resulted in harm is a positive act or an omission. For a positive act, one applies the process of mental elimination.¹³⁰ The conduct must be removed from the mind of the person making an assessment, and the question asked whether the harm to the plaintiff would still have occurred.¹³¹ Corbett CJ, in *International Shipping Co (Pty) Ltd v Bentley*¹³² stated that the enquiry as to factual causation is generally conducted by applying the so called 'but-for' test, which is designated to determine whether a postulated cause can be identified as a *causa sine qua non* of the harm/ loss in question. Failure to provide standard medical care that results in harm to the patient may be treated as a factual cause.

In *Blyth v Van den Heever*,¹³³ Corbett JA dealt with the issue of factual causation in medical negligence claim. The plaintiff sustained an injury to his right radius and ulna, and ultimately lost the use of the arm. After the defendant (healthcare provider)

¹²⁷ Dutton (note 122 above).

¹²⁸ Jerome Veldsman 'Factual causation: One size does not fit all'. (2013) 32 *De Rebus* 247.

¹²⁹ Ibid.

¹³⁰ Loubser *et al* (note 81 above) at 72.

¹³¹ Dutton (note 125 above) 61.

¹³² 1990 (1) SA 680 (A).

¹³³ 1980 (1) SA 191 (A).

had operated to reduce the fracture sepsis set in together with an ischemic condition, the plaintiff suffered much pain. The court had to decide whether there was a factual connection between the allegedly negligent conduct of the defendant and the harm suffered by the plaintiff. The court found that the defendant failed to diagnose and treat the injury as a reasonably skilled and careful healthcare provider would have done, and that, but for this negligent failure, the fractures would have healed and the use of the arm regained. The defendant's negligence had therefore caused the loss of the use of the arm, causation was established and the defendant was held liable.

2.3.3.2. Legal causation

The next question that the court must determine after finding the existence of factual causation is legal causation. Factual causation on its own is not sufficient to establish liability. Legal causation is a normative issue; it entails a judicial enquiry where legal policy and other normative issues play a role.¹³⁴ It aims at determining if the factual link is strong enough to occasion liability. The court will confirm that the defendant caused the harm if the harm is closely connected to the conduct of the defendant. Where the harm is not linked closely enough to the defendant's conduct, the court may hold that there is no legal causation or the harm caused by the defendant is too remote to the injury suffered by the plaintiff.¹³⁵ If legal causation fails to be established, the liability will not apply.

The test for legal causation is a flexible one in which factors such as reasonable foreseeability, directness, the absence or presence of *novus actus interveniens*, legal policy, reasonability, fairness and justice all play their parts.¹³⁶ Remoteness may be determined in diverse ways. For many years, courts used a number of tests wherein some judges favour direct consequence test,¹³⁷ some the foreseeability test,¹³⁸ some the adequate cause test.¹³⁹ Legal causation is actually an element of responsibility since it determines liability but such liability is limited by remoteness or proximate cause. This research discusses instances where legal causation has to be

¹³⁴ Loubser *et al* (note 128 above) 70.

¹³⁵ *Ibid.*

¹³⁶ *Groenewald v Groenewald* [1998] 2 All SA 335 (A).

¹³⁷ Dutton (note 129 above) 74.

¹³⁸ *Ibid.*

¹³⁹ *Ibid.*

determined while there is presence of an intervening factor that breaks the causal connection.

In instances where an independent factor that is not foreseeable actively contributes to the harm after the defendant's original harm has occurred (*novus actus interveniens*), the courts do apply the flexible test to determine legal causation. The presence of such an intervening factor usually breaks the causal connection between the conduct of the defendant and the harm in question. An important factor in assessing whether a new cause has occurred is whether the intervening conduct or event is considered abnormal in the light of human experience.¹⁴⁰

The flexible approach was employed in *S v Mokgethi*¹⁴¹ where the bank teller was shot during robbery. The victim survived the shooting, but his lower body was permanently paralysed and was confined to a wheelchair. He was later re-admitted to hospital suffering from serious pressure sores, which developed because he had failed to change his position in the wheelchair frequently according to medical advice. This resulted in severe septicaemia, which eventually affected his organs and caused him to die. The question that arose was whether the gun shot caused the man's death. The court held that the wounding of the deceased could not be regarded as the legal cause of the deceased death for the purpose of a charge of murder. It further held that the gunshot was a *sine qua non* for his death and not the legal cause. It could seem that the subsequent conduct of the victim had broken the chain of causation making it impossible for the court to convict the offender.

2.3.4 Fault

Fault is another essential element that is required to determine delictual liability. To establish delictual liability, it is not enough to show that harm was caused wrongfully, but one must show that the defendant was at fault. Fault generally takes two forms; which are intention and negligence. This research focuses on the negligent part of fault. The essence of the concept of negligence is that the defendant's conduct is compared to an objective standard: that of a reasonable person.¹⁴² This research

¹⁴⁰ J Neethling, JM Potgieter & PJ Visser, *Law of Delict* 6 ed (Durban, LexisNexis Butterworths 2010) at 195-96.

¹⁴¹ 1990 (1) SA 32 (A).

¹⁴² Dutton (note 135 above) 86.

considers the reasonable medical practitioner test as the suitable concept for determining the objective assessment of negligence.

Dutton¹⁴³ posits that it is an exception for a healthcare provider who possesses proficiency or expertise to be in a position where he is held responsible for allegedly being negligent. The reasonable 'expert test' is identical to the reasonable person in all respect, except that a reasonable measure of the relevant expertise is added.¹⁴⁴ The expert must act with skills and caution as a reasonable member of a particular profession. In order for negligence to be ascertained, the reasonable person must have foreseen his/her conduct causing harm/damages to another and he/ she must have failed to take reasonable steps to prevent that harm. A reasonable healthcare provider is only expected to show reasonable skill and care while treating the patient.

In *Vermeulen v Medi-Clinic Ltd*,¹⁴⁵ the plaintiff was admitted to Medi-Clinic's hospital for treatment for malaria. There he developed a bedsore in the area of his sacrum, which in turn caused nerve damage, which left him paralyzed. Mr Vermeulen instituted action against the hospital alleging that the nursing staff was negligent by not employing sufficient measures (such as turning him regularly) to avoid the onset of the bedsore. The hospital in turn denied negligence on its part and contended that the bedsore was unavoidable in Mr Vermeulen's case as turning him whilst critically ill would have been life threatening. The court found in favour of the plaintiff.

The court was faced with the issue of how to evaluate the conflicting opinions of the expert on what constitutes reasonable conduct. The defendant called a few experts who all agreed that the patient was gravely ill, and that in general, it is unsafe to reposition, move or turn a patient who is critically ill if that patient's mean blood pressure is low. The expert that was called by the plaintiff opined that most pressure sores are preventable while some are unavoidable. She opined that the most effective strategy to prevent a pressure sore from forming is to turn the patient every four hours from one side to another or on his back if he is stable. But she pointed out that this strategy is unsuitable for extremely unstable' patients. She suggested that a pressure sore for such patients can be prevented by either putting 'a very soft pillow' underneath the buttocks of the patient for half an hour or by treating them on a

¹⁴³ Ibid at 88.

¹⁴⁴ Ibid.

¹⁴⁵ (504/13) [2014] ZASCA 150 (26 September 2014).

nimbus mattress, although its use does not absolve the nurses from applying further pressure care. She emphasised that the nature of the pressure care that was applied to the patient was inadequate. It was also her opinion that the plaintiff should not have been left seated in a Lazy-Boy chair for hours. These version of evidence was preferred by the court

Some writers have argued that the standard of care and skill, in context of medical negligence, required from a general practitioner is to be distinguished from the standard of care of a medical specialist.¹⁴⁶ In simple terms, if the healthcare provider is a general medical practitioner, the test is that of the reasonable general practitioner.¹⁴⁷ If the healthcare provider is a medical specialist, the test that is used is that of a reasonable specialist with reference to the specific field of medical specialization.¹⁴⁸ The degree of skill that is expected from the medical specialist is measured against the average or reasonable specialist attached to the branch of profession to which he/she belongs.¹⁴⁹ This is the judicial approach expressed by Roper J in *R v Van der Merwe*¹⁵⁰ as follows:

When a general medical practitioner is tried, the test is not what a specialist would or would not have done in the circumstances, because a general practitioner is not expected to have the same degree of knowledge and skill and experience as a specialist has. When a specialist tells you that, he would do this and that, it does not mean that you should expect the general practitioner to act in the same way. However, the question that needs to be asked is what is the common knowledge in the branch of the profession to which the practitioner belongs? What is the common knowledge and accepted practice among the practitioners?

The medical profession is considered an upstanding profession because it helps in prolonging life. However, for the healthcare providers to fulfill their duties without the risk of being accused of negligence, or lacking skill or expertise in a particular area, they should ask for help or refer patients to specialists. The patient usually approaches a healthcare provider or healthcare institution because of its reputation.

¹⁴⁶ L.C. Coetzee & P. Carstens 'Medical Malpractice and Compensation in South Africa' (2011) 86 (3) *Chicago-Kent Law Review* 1263 available at: <http://scholarship.kentlaw.iit.edu/xcklawreview/vol86/iss3/10> (accessed 13 April 2017) 1281.

¹⁴⁷ Ibid.

¹⁴⁸ Ibid.

¹⁴⁹ P Carstens & D Pearmain, *Foundational Principles of South African Medical Law* (Cape Town, LexisNexis 2007) 623 the authors expressed the view that the yardstick for measuring the conduct of the specialist should be the branch of the profession to which the specialist belongs.

¹⁵⁰ 1953(2) PH 11 124 (W) 128.

In doing so, the patient does not expect the healthcare provider to harm him/her in any manner because of their negligence.

It is not in all situations that the healthcare provider will be able to save the life of the patient, but he is expected to employ his special knowledge and skill in the most appropriate manner keeping in mind the interest of the patient who has entrusted his life to him. One of the duties of the healthcare provider is to treat the patient attentively and conscientiously. The healthcare provider shall familiarize himself/herself with the patient's ailment. To be aware of the patient's health history, it is essential to read the patient's file before examining him/her. After determining the medical history and examining the patient, the healthcare provider should be able to prescribe the right medication and to tell the patient about the advantages, disadvantages, risks and alternatives regarding a proposed treatment or medical procedure. Where the healthcare provider has religiously complied with the set down procedure, and yet the patient dies or does not get the results expected, the healthcare provider cannot be held liable for negligence.

2.4. Harm/Damages

Harm is also an essential element of delictual liability. The plaintiff must prove that there is some medical harm suffered. In medical cases, it is difficult to identify such harm because the courts compare what happened to the patient with what would probably have happened if there was no medical negligence. In instances where there are several medical effects, experts are called upon to determine the actual cause of harm in question. The harm or damages claimed must be recognized in delict. In other words, the harm must be legally recognized or actionable.

Harm falls in one of the two broad categories: patrimonial harm or non-patrimonial harm. The latter is the one that is applicable in medico-legal cases. It is sub-divided into pain, suffering, and infringement of personality interest.¹⁵¹ The concept of pain and suffering is about losing the sense and amenities of life. The plaintiff claiming for pain and suffering must have had a physical injury. Damages are awarded to a plaintiff as part of compensatory damages to cover all those losses that are not easily quantifiable. When awarding delictual damages, courts have to determine the difference between the present financial position of the plaintiff and the state he or

¹⁵¹ Loubser et al (note 132 above) 50.

she would have been in had the delict not occurred.¹⁵² The plaintiff must also prove that the harm was foreseeable and preventable but the healthcare provider failed to do so. The damages cover the actual loss, probable future loss, and compensation for pain and disability.¹⁵³

2.5. Categories/Forms of medical negligence

Misconduct by healthcare provider may take many forms ranging from failure to keep records of treatment, wrong diagnosis, negligence or incompetence, ill-treating and not caring for patients, fraudulent conduct and improper professional conduct.¹⁵⁴ This research focuses on wrong diagnosis, negligent or inappropriate administration of drugs,¹⁵⁵ sub-standard surgical procedures,¹⁵⁶ failure to follow acceptable procedures and follow-ups on post-surgery treatments¹⁵⁷, failure to refer a patient to a specialist or a practitioner with particular skill¹⁵⁸ and failure to properly manage care of patient, which in some cases result in a patient's death.¹⁵⁹ The research explains each category mentioned above in order to show how each of these circumstances is treated as a *novus actus interveniens*.

Some of the healthcare providers fail to uphold the ethics and high values of their profession. They also lack critical thinking, problem solving and decision making skills. In those circumstances, they are unable to deal with a variety of ethical quandary in healthcare contexts.¹⁶⁰ If the healthcare providers are equipped with skills on ethics, moral theories and professional codes of conduct, they would know when their conduct is unethical and is likely to result in negligence. They would then foresee the consequences that may flow from their conduct.

¹⁵² Deon Francis and Reshana Pillay 'South Africa: General Damages In General' available at <http://www.mondaq.com/southafrica/x/155988/Personal+Injury/General+Damages+In+General> (accessed 25 September 2017)

¹⁵³ *Fulton v Road Accident Fund* [2012] ZAGPJHC 3.

¹⁵⁴ WA Hoffmann & N Nortjé 'Patterns of unprofessional conduct by medical practitioners in South Africa 2007–2013' (2016) 58 (3) *South African Family Practice* 108-113.

¹⁵⁵ *Ibid* at 10.

¹⁵⁶ SC East & CH Snyckers 'Orthopaedic litigation in South Africa: A review of the Medical Protection Society data base involving orthopaedic members over the last 10 years' (2011) 10(3) *South African Orthopaedic Journal* 78.

¹⁵⁷ Suzan Erasmus (note 106 above).

¹⁵⁸ Dutton (note 140) 106.

¹⁵⁹ Hoffmann & Nortjé (note 152 above) 110.

¹⁶⁰ Nortjé N & Hoffmann WA 'Ethical misconduct by registered psychologists in South Africa during the period 2007-2013' (2015) 45(2) *South African Journal of Psychology* at 270.

The burden lies on the plaintiff to prove on preponderance of evidence that the defendant's conduct is actually the main cause of the harm suffered. The plaintiff must prove the existence of the duty owed to him/her by the healthcare provider. Evidence must be provided to show that the healthcare provider deviated from the standard of care expected from him/her while treating the patient. The standard of care could be either that of a general practitioner or that of an expert practitioner. That deviation from the standard of care must amount to a breach of duty that is owed to the plaintiff. It must further be proved that there is a causal connection between the injury suffered by the plaintiff and the act of the healthcare provider. All the elements of a delict must be proved by the plaintiff in order for liability against the healthcare provider to ensue.

2.5.1. Failure to keep records of treatment

It is good practice for every healthcare organization to have records management policy in place.¹⁶¹ Good record keeping is an integral part of good professional practice.¹⁶² Healthcare record may be defined as any relevant record made by a healthcare practitioner at the time of or subsequent to a consultation and/or examination or the application of health management.¹⁶³ It is the duty of the treating healthcare provider to keep records of management of the patient under his care. Medical record keeping is the only way that the healthcare provider can prove in the court of law that the treatment was carried out properly. Health records include the hand-written notes by the healthcare provider, referral letters to and from other healthcare providers,¹⁶⁴ laboratory reports, audiovisual records such as photographs, videos and tape recordings¹⁶⁵ and other forms completed during health interaction.

The keeping of health/medical records enables the healthcare provider, among others, to further diagnose or for ongoing medical management of the patient. Such records act as direct evidence in litigation or for occupational disease or injury

¹⁶¹Medical Chronicle 'Retention of Medical Records' 11 June 2013 available at <https://www.medicalchronicle.co.za/retention-of-medical-records/> (accessed 14 August 2017).

¹⁶²'Medical Records in South Africa: An MPS Guide' June 2014 available at <http://www.medicalprotection.org/southafrica/advice-booklets/medical-records-in-south-africa-an-mps-guide> (accessed 14 August 2017)

¹⁶³Health Professions Council of South Africa 'Guidelines on the Keeping of Patient Records' (2008) available at http://www.hpcsa.co.za/downloads/conduct_ethics/rules/generic_ethical_rules/booklet_14_keeping_of_patience_records.pdf (accessed 14 August 2017)

¹⁶⁴Ibid.

¹⁶⁵Ibid.

compensation purposes. They are also used as research data and promote good clinical and laboratory practice. This research discusses the importance of medical records as direct evidence in litigation. In cases of medical negligence, the court may request the healthcare provider to provide to the court any medical records of the patient and any other information relevant to the case before the court. It is potentially a breach of the rule of law and code of good practice if the medical records are not available when they are supposed to be available. The medical records must be kept for at least six years from the date such records are created.¹⁶⁶

Insufficiency of medical records is one of the issues that was tackled in *Madida obo M v MEC for Health for the Province of Kwazulu Natal*¹⁶⁷ where the plaintiff gave birth to a baby with a number of birth defects. The plaintiff instituted an action for damages arising allegedly from medical negligence of employees of the defendant. The defendant however applied for the adjournment of the trial because they did not have the complete medical records of the plaintiff. The court declined the application on the ground that the keeping of the medical records is the obligation of the defendant's employees and they are actually the custodians of such medical records. In fact, the medical records are the defendant's own records. The plaintiff's case was established from the incomplete medical records, suggesting a causal link between the medical service rendered by the employees of the defendant and the injuries sustained by the baby. Expert evidence showed that the hospital staff failed to employ the right procedure on the night the baby was delivered.

2.5.2. Sub-standard medical care

Deaths during or after a surgical procedure or care may be considered medico-legal issue and be subjected to medico-legal autopsy and inquest.¹⁶⁸ Patients who undergo anesthesia and medical procedures may die as a result thereof.¹⁶⁹ The South African law requires any death considered unnatural to be reported for medico-legal investigation.¹⁷⁰ Before surgery or treatment is performed; it is a standard procedure that the patient's consent must be obtained. It is obligatory for

¹⁶⁶ Guidelines on the keeping of patients records (note 163 above).

¹⁶⁷ (14275/2014) [2016] ZAKZPHC 27 (14 March 2016).

¹⁶⁸ TE Madiba, P, P Naidoo & SR Naidoo 'The Amended legislation in procedure related death-An advance in patient care' (2011) 101(4) *South African Medical Journal* 234.

¹⁶⁹ Ibid.

¹⁷⁰ Ibid.

the healthcare providers to recognize the need for the protection of the patients under their care and authority. To avoid substandard medical treatment, the healthcare providers must employ the highest degree of skill and care. The healthcare providers are required to follow strict guidelines in making sure that the patients receive the best possible treatment regardless of where the patient is being treated.

Sub-standard medical care covers a variety of possible malpractices, each of which is important on its own. When sub-standard care occurs, the results can be catastrophic and fatal. Medical negligence is rampant and not often reported but this should not be confused with a patient's expectations. It should be borne in mind that when a healthcare provider does not spend much time with the patient, it does not constitute medical negligence; the same is also true if the patient does not get the results that he or she expected. Medical negligence occurs in instances where the healthcare providers disregard medical ethics that they swore to uphold as medical professionals and provide less than the best possible care to their patients.

In *MEC Health, Eastern Cape v Mkhitha*,¹⁷¹ the court found that sub-standard medical care constituted *novus actus interveniens*. The MEC for health appealed the initial findings of the court a quo, where the plaintiff sued both the MEC and the Road Accident Fund (RAF) for the injuries sustained in a motor collision. Because the injuries sustained were severe, the plaintiff was transferred from Nelson Mandela Academic Hospital to Bedford Orthopedic Hospital (BOH) to undergo surgery. The staff at BOH failed to take necessary X-rays of the plaintiff's leg which would have indicated that there was a mal-alignment of her right leg. As a result, the leg healed with a 15-degree angulation, which she alleged was because of the hospital's negligence.

The court found that the sub-standard medical care did constitute a *novus actus interveniens* and that the RAF could not be held liable for the plaintiff's *sequelae* even though the injuries were initially caused by the negligence of the RAF's insured driver. It was further held that although the plaintiff would not have been hospitalized but for the collision, the negligent treatment of the plaintiff by the staff of BOH had significantly contributed to the consequences of the injuries sustained by the plaintiff.

¹⁷¹ [2016] ZASCA 176.

The negligent treatment further broke the causal chain between the collision and the severity of the injuries sustained by the plaintiff. It is important to ensure that there are no *novus actus interveniens* that could break the causal chain in respect of liability when assessing claims of delictual damages.¹⁷²

There is also the recent case of mentally ill patients who died after being moved from Life Esidimeni facilities into the care of unlicensed non-governmental organisations (NGOs) across Gauteng. In many instances, Most of the patient's families were not notified that their relatives were being relocated.¹⁷³ This happened after the then minister of health announced that her department's contract with Life Esidimeni was being terminated.¹⁷⁴ It was alleged that patients were moved in order to save money and was in line with the government policy to deinstitutionalize certain patients.¹⁷⁵

It was established that the department officials were negligent when they wrongfully transferred the patients from one healthcare institution to another. The transfer violated the constitutional rights of the patients to healthcare and the National Health Act and Mental Health Act.¹⁷⁶ The main issue in this case is that the patients were moved from the structured and non-stop caring environment of Life Esidimeni into an unstructured, unpredictable, sub-standard caring environment of the NGOs.¹⁷⁷ The decision was not only negligent and a violation of the rights of the mentally ill patients but also goes totally against the principle of healthcare which is the preservation of life.¹⁷⁸

2.5.3. Lack of reasonable degree of care and skill

¹⁷² Hogan (note 91 above).

¹⁷³ 'Life Esidimeni' available at <http://www.ewn.co.za/Topic/Life/Esidimeni> (accessed 24 October 2017).

¹⁷⁴ Ibid.

¹⁷⁵ 'Health Minister Aaron Motsoaledi ordered that the office of the Health Ombud investigate' available at <http://www.ewn.co.za/2016/09/14/motsoaledi-order-health-ombudsman-to-probe-psychiatric-patients-deaths> (accessed 24 October 2017).

¹⁷⁶ 'Circumstances surrounding the death of mentally ill patients: Gauteng province' available at <https://www.scribd.com/document/338105573/The-report-into-the-circumstances-surrounding-the-death-of-mentally-illpatients-Gauteng-province> (accessed 24 October 2017).

¹⁷⁷ SA News.gov.za 'Life Esidimeni: Independent tribunal appointed' available at <http://www.sanews.gov.za/south-africa/life-esidimeni-independent-tribunal-appointed> (accessed 29 October 2017).

¹⁷⁸ Politics web 'The Life Esidimeni disaster: The Makgoba report' available at <http://www.politicsweb.co.za/documents/the-life-esidimeni-disaster-the-makgoba-report> (accessed 29 October 2017).

The lack of skill or knowledge to voluntarily engage in a potentially dangerous activity by the healthcare provider indicates negligence. The healthcare providers that do not have areas of specialization and those that are beginners are always the subject of such negligence cases. The act of the healthcare provider to perform an operation or treatment on the patient, knowing very well that he/she does not have knowledge or skill puts the patient at risk. The healthcare provider will be held negligent when he embarks on a treatment or operation when he knows that he does not possess the necessary skills. A beginners' lack of skill exposes the public to a risk of harm.¹⁷⁹ For a practitioner to administer treatment to a patient, he must have certain knowledge or skill usually associated with the proper discharge of the duties connected with that treatment.

In *S v Mkhetsana*,¹⁸⁰ a junior doctor administered a wrong dosage of drug to a patient who was suffering from bronchial asthma, thereby causing the death of the patient. A beginners' lack of skill exposes the public to a risk of harm. In court, it was submitted that the doctor had not been negligent because (a) he was still an intern who was (b) still comparatively inexperienced; (c) he was the only doctor on duty and (d) he had acted in emergency. Caney J held that:

Either the appellant had insufficient knowledge and experience of the drug, in which case it was negligence on his part to administer it in a manner that he did administer it; if he knew little, if anything, about it, he was subjecting his patient to a very considerable risk.

Failure to turn the patient regularly leading to infected bedsores may fall under failure to employ reasonable degree of care. Bedsores or pressure sores are ulcers of the skin caused by unrelieved pressure.¹⁸¹ This condition can result from lying or sitting in one position for too long, such as when a person is bedridden or confined to a wheelchair. Pressure sores that develop while patients are in the care of the healthcare provider are usually caused by the negligent conduct of the healthcare provider who fails to change the lying position of the patient.

¹⁷⁹ G. Van der Merwe & J. E. Du Plessis, *Introduction to the law of South Africa* (Netherlands: Kluwer Law International, 2004) at 310.

¹⁸⁰ 1965 (2) SA 493 (N).

¹⁸¹ Don du Toit, News24 'Bedsores' 21 May 2015 available at <http://www.health24.com/Medical/Diseases/Bedsores-Client-20120721> (accessed 28 August 2017)

Sometimes the healthcare providers may surgically remove the wrong part of the body of a patient. That situation goes hand in hand with a conduct of performing surgery on a wrong patient. A few years ago it was reported that an old woman in Kimberly who was hospitalized with a respiratory problem, ended up in theatre having a heart surgery. The surgeon confused the surnames of the patients. As a result, a wrong patient ended up having a wrong surgery.¹⁸² In instances where the patient suffers because of the surgical removal of a wrong part of the body, the healthcare provider is liable. The patient will however need the medical records to prove that such event occurred and the harm suffered is the result of such event.

In 2006/2007, the Joint Commission on Accreditation of Health Care Organizations introduced the Universal protocol for preventing wrong site, wrong procedure and wrong person surgery.¹⁸³ The simple principles of the protocol included verification process. The healthcare providers are under a duty to verify the identity of the patient, which include the names and the procedure that needs to be done. The second principle requires marking the operative site.¹⁸⁴ It is the duty of a nurse and a surgeon to ensure that a correct area is marked for surgery. It is advisable to use a permanent marker so that the marking does not come off during the preparation for a surgery. The last principle is simply taking time out. The aim of this is to ensure that the practitioners are about to perform the correct procedure, on the correct site, on the correct patient.¹⁸⁵

2.5.4. Medical misdiagnosis

Records show that the Health Professions Council of South Africa (HPCSA) received 2 403 (two thousand four hundred and three) complaints between April 2011 and March 2012. Many of these related to claims of misdiagnosis, practicing outside the scope of practice, and refusal to treat patients.¹⁸⁶ The law expects the healthcare provider to exercise the same standard of skill and care when making a diagnosis as

¹⁸² Marika Sboros, BIZNews 'SA doctors perform heart surgery on wrong patient' 20 August 2014 available at <https://www.biznews.com/health/2014/08/20/sa-doctors-perform-heart-surgery-wrong-patient/> (accessed 23 September 2017).

¹⁸³ Joint Commission on Accreditation of Health Care Organizations 'Universal protocol for preventing wrong site, wrong procedure and wrong person surgery' available at http://www.jointcommision.org/NR/rdonlyres/E3c600EB043B4E86B04ECA4A89AD5433/0/universal_protocol.pdf (accessed 29 August 2017).

¹⁸⁴ Ibid.

¹⁸⁵ Ibid.

¹⁸⁶ J Malherbe 'Counting the cost: The consequences of increased medical malpractice litigation in South Africa' (2013) 103 (2) *South African Medical Journal* 83-84.

is required in all dealings with patients.¹⁸⁷ A wrong diagnosis can lead to holding the healthcare provider liable for negligence.

The healthcare provider who fails to comply with the standard of reasonable medical practitioner in diagnosing a patient will be negligent.¹⁸⁸ A misdiagnosis itself is not evidence of negligence. The key is determining whether the healthcare provider acted competently involves an evaluation of what the healthcare provider did and did not do in arriving at the diagnosis. The plaintiff in seeking to establish liability based on a misdiagnosis must not only prove that the diagnosis was wrong, but that the diagnosis was negligently made in that the degree of skill and diligence, which is expected from a reasonable health care provider was lacking.

A patient is entitled to a thorough and careful examination of the patient's ailment with such diligence and methods as are usually practiced under similar circumstances by members of the branch of the profession to which the attending healthcare provider belongs. In *Topham v Member of Executive Committee for the Department of Health*,¹⁸⁹ the claim arose from the alleged failure of the doctor to diagnose a hip dislocation. The patient was involved in a motor vehicle collision in which she dislocated her hip. She was taken to the hospital where the doctor failed to diagnose her hip dislocation. The court held that a patient who is admitted after a motor vehicle accident should receive a complete clinical examination once a complete history of the patient had been obtained. The patient should be asked where the pain is experienced.¹⁹⁰ In the case of a hip injury or suspected hip injury, a proper examination also entails asking the patient whether he or she can stand up and to flex or bend his or her hip: a patient with a hip dislocation cannot stand up or bend or flex his or her upper leg, because it is too painful.¹⁹¹ The doctor's conduct in the examination and diagnosis of the appellant manifestly fell short of the degree of professional skill and diligence expected of an average general practitioner in similar circumstances. He failed to notice the obvious clinical signs which a patient suffering from a hip dislocation presents.

¹⁸⁷ Dutton (note 156 above) 103.

¹⁸⁸ Ibid 104.

¹⁸⁹ [2013] ZASCA 65 (27 May 2013) para 20.

¹⁹⁰ Ibid.

¹⁹¹ Ibid.

In *Qamba v Minister of Health*,¹⁹² the appellant (in his capacity as the father and guardian of his minor child) alleged that the staff members of Motherwell Health Center failed to diagnose that the child had suffered a fracture to his index finger. It was only established after eight weeks that the child sustained a fracture. Due to the delay in diagnosis, the finger did not heal. The court held that if it were not for the misdiagnosis, the fracture might have healed without the need for surgery. Negligence in this case took the form of an omission in the sense of failing to act positively to prevent harm.

2.5.5. Failure to refer a patient to a specialist

Failure to refer a patient to a specialist or practitioner with particular skill, training or experience may constitute negligence.¹⁹³ Where a healthcare provider is doubtful about a patient's diagnosis, it is good practice to refer the patient to a specialist. Failure to do so falls short of the standard expected from a reasonable healthcare provider.¹⁹⁴ Failure to refer a patient in certain circumstances could invoke the principle of *imperitia culpa adnumeratur* (meaning ignorance or lack of skill is deemed negligence).¹⁹⁵ Failing to refer a patient to the healthcare provider for a service or procedure that is effective and appropriate constitutes underservicing.¹⁹⁶ However, the healthcare provider is not under any obligation to refer the patient to a specialist where the healthcare provider possesses the requisite skill to treat the patient's ailment.

In *McDonald v Wroe*,¹⁹⁷ the plaintiff's action was based on alleged defendant's failure to refer the plaintiff to a specialist maxilla-facial and oral surgeon for the removal of her wisdom teeth. This emerged after the defendant extracted three of the plaintiff's wisdom teeth. The plaintiff suffered trauma on the left side of her face, which resulted in a feeling of numbness and 'pins and needles'. The decision of the court a quo was in favour of the defendant. The court stated that the defendant had the necessary skills to perform the surgery correctly and had in fact done so, and had not performed the surgery negligently. The case was later taken to the appeal

¹⁹² [2010] ZAECGHC 50 (23 June 2010).

¹⁹³ Dutton (note 184 above) 106.

¹⁹⁴ Ibid.

¹⁹⁵ Ibid 107.

¹⁹⁶ David Jan McQuoid-Mason 'Over-servicing', 'underservicing' and 'abandonment': What is the law?' (2015) 105 (3) *South African Medical Journal* 181-182.

¹⁹⁷ [2011] JOL 29733 (C).

court, the decision of the court a quo was upheld and the court stated that the defendant was not under any duty to refer the plaintiff to a specialist because he had the necessary skills to perform the procedure.

2.5.6. Negligent or inappropriate administration of medication

Medication errors causing harm to patients are an important problem in the South African healthcare services.¹⁹⁸ Medication error is defined as any incorrect or wrongful administration of medication, such as a mistake in dosage or route of administration.¹⁹⁹ It also includes failure to prescribe or administer the correct drug or formulation for a particular disease or condition, use of outdated drugs, failure to observe the correct time for administration of the drug, or lack of awareness of adverse effects of certain drug combinations.²⁰⁰

According to research conducted and recorded in the *South African Journal of Child Health*, pharmacists spent 16 weeks in four paediatric wards and detected 633 medication errors – an average of 2.9 per patient.²⁰¹ Many errors involved incorrect dosing, followed by omission of medication and medicine being given at the wrong time.²⁰² Medication error is an event that occurs as a result of actions taken by a healthcare provider in prescribing, dispensing or administration of a drug, irrespective of whether such errors lead to adverse consequences or not.²⁰³

Medication administration error refers to any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional. Such events may be related to professional practice, healthcare products, procedures, and systems, including prescribing; product labeling, packaging, administration; education; monitoring; and use. Wrongful medication administration poses threat to a patient's life. Some healthcare

¹⁹⁸ PC Gordon, RL Llewellyn & MFM James 'Drug administration errors by South African anaesthetists –A survey' (2006) 96 (7) *South African Medical Journal* 630.

¹⁹⁹ Medical Dictionary 'medication error' available at <https://medical-dictionary.thefreedictionary.com/medication+error> (accessed 29 October 2017).

²⁰⁰ The Free Dictionary, Medical Dictionary 'Medication error' available at <http://medical-dictionary.thefreedictionary.com/medication+error> (accessed 23 July 2017).

²⁰¹ R Kgosana, 'Medication errors detected in Pretoria hospital's paediatric wards' *The Citizen*, 17 May 2017 available at <http://citizen.co.za/news/south-africa/1516197/medication-errors-detected-in-pretoria-hospitals-paediatric-wards/> (accessed 23 July 2017).

²⁰² Ibid.

²⁰³ Dennis Chamisa 'The potential of alternative dispute resolution mechanisms in tackling the increase of lawsuits due to medical negligence in public hospitals' Published LLM Dissertation by the University of Cape-Town 2013 at 41-42.

providers blame the look-alike of the medication labels or packaging, the sound-alike of the medication names and incorrect labelling of medicines.

Administration of anesthetic drugs or sedative to patients also forms part of medication administration. An anesthetist may administer a quarter of a million drugs during his or her professional career.²⁰⁴ There has been a number of cases reported, wherein the administration of anesthetic drugs was found to be the legal causation of the harm. In *Napier v Collett*,²⁰⁵ the court dealt with a factual causal link between an accident and the later death of the racehorse. The final judgment reached by the court was that the horse died as a result of the administration of anesthetic during the operation.

In instances where the healthcare provider does not employ the recently developed and widely accepted treatment and his action results in his patient being prejudiced by the outdated treatment, he may be found liable for negligence. It is the duty of a healthcare provider to keep up to date with the new developments in his profession. Healthcare providers should maintain and improve the standard of their performance by keeping their professional knowledge and skills up to date throughout their working life.²⁰⁶ In particular, they should regularly take part in educational activities that would enhance their provision of health services.²⁰⁷ It is a duty that healthcare providers owe to themselves, to always be part of the educational activities that relate to their branch of medicine.

2.5.7. Wrongful conception, birth and life

The actions for wrongful conception, wrongful birth and wrongful life have troubled courts not only in South Africa but in foreign jurisdictions as well. The parents of healthy and normal but unwanted child may institute an action for wrongful conception. Wrongful conception constitutes an action brought by the parents of a normal, healthy child born because of a failed sterilisation or abortion performed by a healthcare provider.²⁰⁸ Parents on similar grounds, but where a child is born

²⁰⁴ AF Merry A& AM Smith *Errors, Medicine and the Law* (Midlands: Cambridge University Press, 2001) 46.

²⁰⁵ 1995 (3) SA 140 (A).

²⁰⁶ Health Professions Council of South Africa 'General Ethical Guidelines for the Healthcare Professions' May 2008 Pretoria at 9.

²⁰⁷ Ibid.

²⁰⁸ *Mukheiber v Raath and others* 1999 (3) SA 1065 2.

handicapped, may bring an action for wrongful birth,²⁰⁹ and a deformed child, who was born because of the negligent diagnosis or other negligent conduct by the healthcare provider, may bring an action for wrongful life.²¹⁰ Wrongful birth and wrongful life claims are slightly different; the difference is that, in wrongful life actions, it is the child that seeks damages from the healthcare provider for allowing the child to be born into a life of disability.²¹¹ In most cases, the cause of such wrongful pregnancy, birth or wrongful life are defective contraceptives or unsuccessful sterilization operations.

Claims for wrongful pregnancy and birth actions can be based on either contract or delict.²¹² The Choice on Termination of Pregnancy Act²¹³ recognizes a woman's right to terminate pregnancy. There is currently no specific statutory recognition of wrongful pregnancy, birth or life actions in South Africa. However, the absence in South Africa of legislation that specifically recognizes and regulates actions of wrongful pregnancy and wrongful birth should not be an obstruction to a person that wishes to institute a claim for wrongful pregnancy or wrongful birth. Recourse could be had to the Constitution and the Choice on Termination of Pregnancy Act. However, any action in respect of these claims will be informed by common law principles.

Failure to monitor the unborn baby during birth may lead to birth defects. The cases of birth defects because of a failure to monitor the birth process and birth complications have been flooding South African courts. According to Lebesse and Aldous,²¹⁴ birth defects are defined as abnormalities of structure or function, including metabolism that are present from birth. Some are clinically obvious at birth,

²⁰⁹ Ibid.

²¹⁰ Ibid.

²¹¹ Norton Rose Fulbright 'Wrongful Pregnancy, Birth and Life Claims' 17 November 2010 available at <http://www.nortonrosefulbright.com/knowledge/publications/44118/wrongful-pregnancy-birth-life-claims> (accessed 24 July 2017)

²¹² Ibid.

²¹³ Act 92 of 1996.

²¹⁴ V Lebesse, C Aldous & H L Malherbe 'South African congenital disorders data, 2006 – 2014' *South African Medical Journal*, Available at <https://www.ajol.info/index.php/samj/article/viewFile/146665/136191> (accessed 28 August 2017). The World Health Organization describes a birth defect as an abnormality in structure or function of a person that is present from birth. The majority of birth defects are genetic or genetic in cause and occur before conception. The remainder are caused by abnormalities of the foetal environment (alcohol, recreational drugs, maternal illness, etc.) that occur after conception. See Living and loving '1 in 15 babies are affected by a birth defect in South Africa' available at <https://www.livingandloving.co.za/baby-blog/1-15-babies-affected-birth-defect-south-africa> (accessed 29 October 2017).

while others manifest later in life. Birth defects are also known as congenital disorders. Birth defects are now the leading cause of infant death. Brain injury is one of the common birth injuries that are usually under litigation. Statistics show that one in fifteen babies are affected by birth defects.

The case of *MPP obo KNM v MEC for Health*²¹⁵ illustrates an issue of defective birth resulting from medical negligence. The plaintiff was left unattended and gave birth to her son K. She was unassisted by any of the medical staff that was available at the hospital. Plaintiff further alleged that because of having been left unattended when she was admitted to the labour ward of the hospital, the nursing staff allowed the newborn infant to fall to the floor after the plaintiff had given birth. Because of having allowed the baby to be born whilst the head and neck of the baby were unsupported, the baby suffered a permanent and total impairment in the form of a dense hemiplegic "Presumed Perinatal Ischaemic Stroke" resulting in cerebral palsy.

The court in coming to its judgment relied on the evidence of the expert witnesses. The court found that the plaintiff established on a balance of probabilities that the defendant acted negligently in failing to treat the plaintiff, K, with the required level of care and skill required of them during the delivery, and that this negligence resulted in the damage to K. The court further noted that had the nurses been present and not negligently in breach of their duty of care, they would have assisted the plaintiff in the delivery process and would have prevented K. from falling.

2.6. Reporting of medical negligence cases

A patient who perceives that the healthcare provider acted negligently or unethically may opt for one of the following ways to report such act.²¹⁶ Institutions where healthcare providers can be reported differ depending on what that practitioner does. If the complaint is about the public hospital, the first person to report the conduct to is the hospital manager.²¹⁷ The patient has a right to complain about any healthcare service that violates his/her right to good health and to have that matter

²¹⁵ [2015] ZAGPPHC 1139 (2 March 2015).

²¹⁶ Health Professions Council of South Africa 'complaints' available at [http://www.hpcsa.co.za/Conduct/Complaints_\(accessed 29 October 2017\)](http://www.hpcsa.co.za/Conduct/Complaints_(accessed%2029%20October%202017).).

²¹⁷ Ibid.

investigated.²¹⁸ After the matter is reported to the hospital manager, the patient must ensure that the matter is investigated and the complainant is furnished with a full report of the findings. If the complainant is not satisfied, he may report that negligence to the provincial Department of Health. There are at present complaints managers in all public health facilities whose responsibilities are to improve the quality of service and perception of public health facilities.²¹⁹

If the complaint is about a private hospital, the report is made to the Hospital Association of South Africa.²²⁰ The Association does not have statutory powers but only has jurisdiction over member hospitals through its Code of Ethics.²²¹ Nurses' unethical conduct may be reported to the South African Nursing Council.²²² The Council has the power to investigate the complaint and obtain the relevant information needed. Once the report is fully compiled, it is submitted to the Preliminary Investigation Committee which may impose a fine or refer the complaint to the Professional Conduct Committee for a professional conduct inquiry.²²³ The latter committee may impose one of the following penalties: removal from the register of practitioners/students,²²⁴ suspension from practicing/training,²²⁵ a caution, a reprimand,²²⁶ a fine or payment of the costs of the proceedings.²²⁷

If the complaint is about any healthcare provider of a certain specialization, the complaint will be brought to the Health Professions Council. After the registrar has

2.7. Chapter Conclusion

²¹⁸ 'Patients' Rights Charter' available at <https://www.idealclinic.org.za/docs/Posters/PATIENTS%20RIGHTS%20CHARTER%20-%20Eng.pdf> (accessed 29 October 2017).

²¹⁹ 'Complaints managers to improve health services' March 2010 available at <http://www.sanews.gov.za/south-africa/complaints-managers-improve-health-services> (accessed 12 September 2017).

²²⁰ Ibid.

²²¹ 'Hospital Association of South Africa' available at http://ombudsman.ombudsmen.co.za/find-an-ombudsman/index.php?option=com_content&view=article&id=101:hospital-association-of-south-africa&catid=35:ombudsman-professional-organisations&Itemid=65 9 (accessed 12 September 2017).

²²² SA Nursing Council 'complains about unprofessional practice' available at <http://www.sanc.co.za/complain.htm> (accessed 30 October 2017).

²²³ Ibid.

²²⁴ 'Guidelines for reporting a case of Professional Misconduct' available at http://www.sanc.co.za/complain_misconduct.htm (accessed 15 September 2017).

²²⁵ Ibid.

²²⁶ Ibid.

²²⁷ Ibid.

The convergence of medicine, ethics and law may seem difficult for the healthcare providers to handle. However, full observance will save many lives and help to reduce the reported number of medical negligence cases. The practice of medicine is in jeopardy as medical negligence claims continue to increase in number and value.²²⁸ patients are aware of their rights thus prefer to seek legal advice when they are treated negligently. Medical negligence victims have been able to prove that the healthcare providers have breached a duty that they owe to their patients in court.

To reduce cases of medical negligence, the healthcare providers must inter alia regularly attend professional development activities to ensure that they are up to date with current developments in the field. This should include adequate training in any procedure that they might wish to perform. Patients should be informed of the level of the practitioner's personal skills, and should be given the choice to obtain alternative expert opinion if there is any doubt about any treatment. The next chapter discusses the statutory provisions about medical negligence.

²²⁸ L.Pienaar (note 61 above).

CHAPTER THREE

STATUTORY PROVISIONS ON MEDICAL NEGLIGENCE

The high occurrence of medical negligence related incidents is part of a broader crisis in the health sector which needs to be addressed as a matter of urgency. The 1996 Constitution and some patient-centred legislation contain specific rights that patients can enforce. This chapter discusses the statutory provisions that can be applied by the courts when adjudicating on medical negligence claims in that medical negligence starts when healthcare providers fail to uphold the patient's rights. The chapter outlines the patients' right charter. The lack of guidelines for the interpretation of medical negligence legislation in South Africa has led to difficulties in applying the law to individual cases. The chapter commences with the discussion of common law position in that area of law and further focuses on patient-centred legislation and pronouncement by courts that strengthen patient autonomy and place patients in an ever stronger position to enforce their rights.

3.1 Introduction

The South African law on healthcare appears to be related to the requirement for healthcare professionals to recognise the need for greater protection for the vulnerable patient under their authority and care.²²⁹ Medical negligence claims are founded either on the law of contract or on the law of delict but all claims for damages, irrespective of which principles of law they are based upon, follow the common law. Unlike the Road Accident Fund claims, the legislature makes no provision for medical negligence claims. The courts rely on precedents and common law principles. The courts can only deviate from the common law principles by means of patient-centred legislation. The Health Department is calling for a change as well as the development of laws that specifically deal with medical negligence claims.

Common law allows any victim of medical negligence to institute a claim against a healthcare provider if he suffers any harm due to the healthcare provider's conduct. The healthcare providers may incur liability if they do not properly exercise their legal

²²⁹ Section 3 (j) of the Health Professions Amendment Act.

duty towards the healthcare user and harm ensues.²³⁰ The negligent conduct of the healthcare provider gives rise to liability if all the elements of delict are met.²³¹ A steep rise in medical negligence litigation is a new trend that is haunting the Health Department. Deterioration of service by overburdened and under staffed medical personnel and equipment causes unnecessary adverse outcomes, giving rise to claims.²³² If there is a settled law that determines what constitutes medical negligence and the extent of the harm suffered, the number of medical negligence claims would have been less.

The violation of the patient's rights in most cases forms the basis of the medical negligence claims. In South Africa, a number of people have either experienced the denial or violation of their constitutional right to healthcare services.²³³ The Department of Health has developed the Patients' Rights Charter as a common standard to achieve the right of access to healthcare services.²³⁴ While not legally binding, the Charter is a useful guide to healthcare users' rights and duties.²³⁵ There are legislative provisions that place emphasis on the patient's rights hence entitling the patients to institute claims against the healthcare providers to protect those rights. Those instruments that are considered relevant to this research are discussed below.

3.2 Patients' Rights Charter

The Department of Health is committed to upholding, promoting and protecting the patients' rights. It proclaimed the Patients' Right Charter as a common standard for achieving the realisation of those rights. This charter is subject to the provisions of any law operating within the Republic of South Africa.²³⁶ The charter lists twelve rights that patients have, whether they go to the public or private sector facilities for

²³⁰ L.C. Cotzee & P. Casterns 'Medical Malpractice and Compensation in South Africa' (2011) 86 (3) *Chicago-Kent law Review* 1263.

²³¹ *Goliath v MEC for Health in the Province of Eastern Cape* [2013] ZAECGHC 72 (14 June 2013) Para 32.

²³² N Classen 'Mediation as an alternative solution to medical malpractice court claims' (2016) 9 (1) *South African Journal of Bioethics and Law* 7.

²³³ HospiceWits 'Patient Bill of Rights' Available at <http://hospicewits.co.za/appendix/> (accessed 23 February 2018).

²³⁴ 'The rights and duties of users of the health care system' available at <https://section27.org.za/wp-content/uploads/2010/04/Chapter8.pdf> (accessed 25 October 2017).

²³⁵ Ibid.

²³⁶ 'National Patients health charter' South African Medical Association available at <https://www.samedical.org/links/charter> (accessed 24 February 2018).

healthcare. None of these rights stand alone, they reinforce rights that are identified in the policies and laws of the country. The Bill of Rights, which is part of the Constitution, gives all people resident in the country access to health care. The problem arises when it comes to the enforcement of such rights.

Under the charter, every patient has a right to a healthy and safe environment, access to safe healthcare, emergency care in life-threatening situations, confidentiality and privacy, to be treated with courtesy and consideration by all staff, be informed about his/her illness/condition and treatment, so as to be in a position to give informed consent, exercise choice in healthcare services, participate in decision-making that affects his/her health, be referred for a second opinion, continuity of care, complain about health services, be treated by a named healthcare provider and refuse treatment or information about his/her illness. These rights are discussed in detail below.

3.3 Legislation that impact on the healthcare system in South Africa

To ensure the professional development and fostering compliance with healthcare standards, a number of statutes are enacted to regulate the healthcare provider duties and responsibilities. The Constitution has included in the Bill of Rights the right to access to healthcare.²³⁷ It is trite that healthcare in South Africa is highly regulated by a number of statutes. This study predominantly focuses on the content of the healthcare legislation that confer enforceable status on the rights outlined in the charter.

3.3.1 Constitution Act 108 of 1996

It is pertinent to start with the Constitution. The Constitution has a significant effect on healthcare. Section 27(1) (a) (2) & (3) states:

- 1) Everyone has the right to have access to:
 - (a) health care services, including reproductive health care;
 - (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.
 - (3) No one may be refused emergency medical treatment.

²³⁷ Section 27 of Act 108 of 1996

Although of central importance to a collection of rights that deal directly and indirectly with health, this section does not operate alone.²³⁸ The Constitution expressly protects the right to bodily integrity,²³⁹ dignity,²⁴⁰ privacy²⁴¹ and access to healthcare.²⁴² These rights are very important in the medical context as it is often the infringement or denial of these rights that forms the basis of a medical negligence claim.²⁴³ In addition to protecting people's rights to bodily integrity, dignity and privacy, the Constitution further stipulates that the government has a duty to respect, protect, promote and fulfill people's rights.²⁴⁴

The rights listed in the Constitution are justiciable if there is any infringement. For instance, the right to privacy may be violated if the patient's confidential information is disclosed to a third party without the consent of the patient. The constitutional right to healthcare is provided for in three sections in the Constitution. They include access to healthcare services,²⁴⁵ emergency service,²⁴⁶ and basic healthcare for children²⁴⁷ and medical services for detained persons and prisoners.²⁴⁸

Section 7(2) of the Constitution obliges the state to respect, protect, promote and fulfil all the rights in the Bill of Rights. In the case of the right to health care, these four fold obligations include the following: the obligation to respect the right. The state is obliged to refrain from denying or limiting access to healthcare to anyone.²⁴⁹ The right to healthcare should be accessible to all in a non-discriminatory basis. In other words, the state must respect the right to access to healthcare by not unfairly and unreasonably getting in the way of people accessing existing health services, whether in the public or private sector.

²³⁸ 'The Constitution and public health policy - Section 27' available at <https://section27.org.za/wp-content/uploads/2010/04/Chapter2.pdf> (accessed 24 february 2018)

²³⁹ Section 12 of the Act.

²⁴⁰ Section 10 of the Act.

²⁴¹ Section 14 of the Act.

²⁴² Ibid.

²⁴³ *Jansen van Vuuren v Kruger* 1993 2 All SA 619 (A).

²⁴⁴ Section 7(2) of the Act.

²⁴⁵ S 27(1) of the Constitution.

²⁴⁶ S 27(3) of the Constitution

²⁴⁷ S28(c) of the Constitution

²⁴⁸ 'Medical treatment and hospitalisation of a person in Custody' available at www.khayelitshacommission.org.za/.../123-4-standing-orders-301-392.html?...6 (accessed 12 February 2018).

²⁴⁹ 'Chapter 4 Right to healthcare' available at https://www.sahrc.org.za/home/21/files/Reports/4th_esr_chap_4.pdf (accessed 13 March 2018).

The obligation to protect include, inter-alia, adopting legislation and other measures to ensure equal access to healthcare facilities provided by third parties. It also has to ensure that privatisation does not constitute a threat to the availability, acceptability and quality of service provided, and to control the marketing of medicines by third parties. This right will be protected if comprehensive legal frameworks are developed to stop people from getting in the way of accessing healthcare.

The third obligation to promote all the rights in the Bill of Rights requires the state to widely spread appropriate information, foster research and support people to make informed choices. This enables the individuals to realise their rights on their own. Lastly, the obligation to fulfil requires the state to facilitate and implement legislative and other measures in recognition of the right to healthcare. It also adopts a national health policy with detailed plans on how to realise the right and create the necessary conditions for people to access healthcare by providing positive assistance, benefits and actual healthcare.

3.3.2 National Health Act 61 of 2003

This Act aims to realise the rights set out in the Constitution by providing a framework for a structured, quality and uniformed healthcare system in South Africa.²⁵⁰ It outlines the provisions that govern national, provincial and local government with regard to health services.²⁵¹ The Act clarifies the state's duty to do what it can to realise the right to have access to healthcare services. It recognises that no person may be refused emergency medical treatment and that everyone has the right to an environment that is not harmful to his or her health.

It further ensures that everyone has access to equal health services by building a national health system that governs both public and private health services.²⁵² It sets out the rights and duties of all health practitioners, and protects the right of children to basic nutrition and healthcare, as well as the rights of vulnerable groups (e.g. women, older persons, and people with disabilities).

²⁵⁰ 'Summary of the National Health Act no 61 of 2003-ESST-OSS AFRICA' available at https://ossafrica.com/esst/index.php?title=Summary_of_the_National_Health_Act%2C_no._61 (accessed 18 March 2018).

²⁵¹ Ibid.

²⁵² Ibid.

After the enactment of the National Health Act, the patient is put in a much stronger position to litigate against a health care practitioner than before, since the Act sets out express rights of the patient which the patient can enforce through litigation.²⁵³ A patient may, for example, decide to institute action where she or he is denied the opportunity to participate in decisions regarding his/her health and may rely on the specific provision in the Act to that effect. Previously, such a patient could rely on the more general protection of the right to bodily integrity as provided for in the Constitution.

3.3.3 Consumer Protection Act 68 of 2008

Patients can now be viewed as consumers from a legal perspective.²⁵⁴ The Act is designed exclusively to promote the rights of South African consumers.²⁵⁵ Its focus is on various types and classes of consumers. The Act is arguably designed to protect the rights of the consumer in all instances where there is a transaction as this term is defined. The provision of healthcare services to a patient in exchange for remuneration with an expected positive outcome would fall within the scope and ambit of the definition of the term “transaction”²⁵⁶ in the Act.²⁵⁷ Therefore, on the face of it, the Act applies to healthcare related transactions. Accordingly, this brings into sharp focus the manner in which one would apply the Act in instances where a healthcare related transaction occurs.

Healthcare related transactions include the provision of hospital service, an emergency service,²⁵⁸ and an ambulance service or a consultation or a related healthcare service that has as its desired outcome the improvement of the health of the patient.²⁵⁹ In each of these instances, the transactions are primarily controlled by healthcare legislation on the basis that the healthcare service is to be provided by a

²⁵³ Ibid.

²⁵⁴ R Kistern & K Moodley ‘Patients as consumers of health care in South Africa: the ethical and legal implications’ (2013) vol 14 *BioMED Central Medical Ethics* 1.

²⁵⁵ Republic of South Africa, Department of Health. National Health Amendment Bill 24 of 2011. Pretoria: Government Printer; 2011. (Government Gazette No. 34739 of 8 November 2011).

²⁵⁶ “transaction” means—

(a) in respect of a person acting in the ordinary course of business—

(i) an agreement between or among that person and one or more other persons for the supply or potential supply of any goods or services in exchange for consideration; or

(ii) the supply by that person of any goods to or at the direction of a Consumer for consideration.

²⁵⁷ Van Rensburg HCJ, *Health and health care in South Africa* (Pretoria: Van Schaik, 2004) 23.

²⁵⁸ Neil Kirby ‘Consumerism and Healthcare’ available at <https://www.werksmans.com/legal-briefs-view/consumerism-and-healthcare/> (accessed 23 February 2018).

²⁵⁹ Ibid.

duly qualified healthcare provider and in accordance with the obligations imposed upon the healthcare provider, both ethically and legally, to provide the service correctly and without harming the patient.

3.3.4 Children's Act 38 of 2005

In South Africa, the Minister of Health through the Department of Social Development, is responsible for the protection and care of children and is therefore the primary subject of the Children's Act.²⁶⁰ However, there are a number of key areas in the Children's Act which require that the department work closely with other departments such as Health, Education, Justice and Safety and Security.²⁶¹ In principle, the Act is intended to fundamentally shift the way in which children are perceived and the way child welfare services are rendered.

The primary objectives of the Act are to give effect to children's constitutional rights to family and parental care, or as a last resort, to alternative care when removed from the family environment, to protect them from maltreatment, neglect, abuse and degradation, and to promote the best interests of the child. Every child has the right to have access to information on health promotion and the prevention and treatment of ill-health and disease, sexuality and reproduction.

3.3.5 Mental Health Care Act 17 of 2002

The Act is all encompassing. It provides for the care, treatment and rehabilitation of the mentally ill.²⁶² Procedures are set out in the Act that covers admission of such individuals and establishment of review boards and their powers in every health establishment. The care and administration of the property of the mentally ill also falls under the scope of this Act. This piece of legislation featured prominently lately in the light of the alleged inadequate quality of care at psychiatric institutions.²⁶³

This Act was seemingly violated together with the National Health Act when the Department of Health hastily and irresponsibly moved many mental health patients

²⁶⁰ P Proudlock, *Progress report on The Children's Bill* (Cape Town: Children's Institute, 2003) p 16.

²⁶¹ Roseline September 'A new children's Act for South Africa: Making it work for children and families' available at <http://socialwork.journals.ac.za/pub/article/viewFile/247/229> (accessed 12 March 2018).

²⁶² M Spamers 'A critical analysis of South Africa mental health law: A selection of human rights and criminal justice issues' Unpublished MA dissertation, University of Pretoria, 2016.

²⁶³ Government must pay R1, 2-million to Life Esidimeni families available at <https://www.timeslive.co.za/news/south-africa/2018-03-19-government-must-pay-r12m-to-life-esidimeni-families> (accessed 24 March 2018)

out of institutional care into often grossly sub-standard community-based care run by various non-government organisations. The Department showed a total disregard of the rights of the mental healthcare users. As a result of the Department's conduct, 143 mental health patients died because of malnutrition and dehydration. The issue was addressed by the commission of enquiry and it was agreed that each claimant will be compensated.²⁶⁴

3.3.6 Health Professions Act 56 of 1974

This Act governs all the activities of the Healthcare providers.²⁶⁵ The Act established the Health Professions Council of South Africa (HPCSA) as a statutory body. The Council regulates the health professions in the country in aspects pertaining to registration, education and training, professional conduct and ethical behaviour, ensuring continuing professional development, and fostering compliance with healthcare standards.²⁶⁶

The Act defines the scope of medical profession and mandates members to register with the Council. It further regulates health professionals in South Africa and is set up to protect members of the public that may have dealings with the healthcare providers. Healthcare providers are registered to ensure that they meet the standards set by their training, professional skills and conduct.

The Council thus has the power to institute disciplinary proceedings regarding any complaint, charge or investigate any allegation of unprofessional conduct against any person registered with it. If a registered practitioner transgresses the rules as laid down by the Council, the practitioner will be subjected to a disciplinary process in terms of the regulations. This means that registered professionals are expected to be sincere and meet national standards in their relationship with the public.

3.3.7 Nursing Act 33 of 2005

This Act established the South African Nursing Council. The Council registers persons entitled to practice nursing, ensures that persons registered in terms of the Act behave towards health service users in a manner that respects their

²⁶⁴ Ibid.

²⁶⁵ Health Professions Act 56 of 1974.

²⁶⁶ HPCSA available at <http://www.hpcsa.co.za/Public> (accessed 23 February 2018).

constitutional rights and initiates disciplinary action against those who fail to do so.²⁶⁷ The Council conducts inspections and investigations of nursing education institutions, nursing education programs and health establishments, in order to ensure compliance with the Act and to report on non-compliance.²⁶⁸

The Act empowers the patients and any other member of the public to bring any case of misconduct against a registered nurse to the attention of the Council.²⁶⁹ The ethical problems always arise when the conduct of the nurse negatively affects the patient or a healthcare user. This could be the result when the nurse or healthcare provider fails to adhere to the fundamental responsibility of their profession. About three years ago, the Nursing Council was reported to have struck off the roll the names of two nurses in Cape Town due to unprofessional conduct.²⁷⁰ The two nurses allegedly neglected and abused a patient. The patient was admitted to a private hospital for the treatment of septic bedsores, malnutrition and dehydration.²⁷¹ A doctor's report confirmed that the patient died as a result of septic bedsores and starvation.²⁷²

3.4 The Patients' Right Charter in South Africa's Health Legislation

This section examines the extent to which the provisions contained in the Patients' Right Charter are enforceable under the existing legislation in South Africa.

3.4.1 Access to healthcare

The Patients' Right Charter states that everyone has the right of access to health care services that include receiving timely emergency care at any health care facility that is open, regardless of one's ability to pay, treatment and rehabilitation that must be made known to the patient to enable the patient to understand such treatment or rehabilitation and the consequences thereof. Provision for special needs in the case of newborn infants, children, pregnant women, the aged, disabled persons, patients

²⁶⁷ Nursing Act 33 of 2005.

²⁶⁸ Ibid.

²⁶⁹ Ibid.

²⁷⁰ Giovanna Gerbi, Eye Witness News 'Two Cape Town nurses fired for unprofessional conduct' 01 October 2014 available at <http://ewn.co.za/2014/10/01/Two-nurses-fired-for-unprofessional-conduct> (accessed 23 February 2018).

²⁷¹ Ibid.

²⁷² Ibid.

in pain, persons living with HIV or AIDS, counseling without discrimination, coercion or violence on matters such as reproductive health, cancer or HIV/AIDS.

*In Oppelt v Head: Health, Department of Health Provincial Administration*²⁷³ the court was faced with a delictual claim arising from delayed medical treatment after the applicant sustained spinal cord injuries that left him paralysed. The applicant was representing his community rugby club in a rugby match. He struck his head against an opponent's shoulder in a scrum collapse and sustained spinal cord injuries that left him paralysed below his neck. The applicant was medically classified as quadriplegic.

The applicant received treatment from three hospitals which were under the respondent's control. He arrived at Wesfleur and was attended to by a nurse and Dr Venter, a junior doctor at Wesfleur at the time. At 16h00, Dr Venter phoned Dr Rothemeyer, a training neurosurgical registrar at the second hospital. Dr Rothemeyer suggested that the applicant be transported by helicopter to the second hospital, a transfer that would have taken 12 minutes, had it materialised. The applicant was instead transported by ambulance. The ambulance took 45 minutes to get to the second hospital.

The applicant was examined by Dr Rothemeyer at 18h00 at Groote Schuur. A note from the ambulance records shows that Dr Civitanich, an orthopaedic surgery registrar, made a call for an ambulance at 20h22 for the applicant's urgent transfer to the specialised spinal cord injury unit at Conradie Hospital. The ambulance was dispatched only on the morning of 24 March 2002 at 00h25. It departed from Groote Schuur at 01h08 and arrived at Conradie at 01h23. There, the applicant's spinal cord injury was treated by a closed reduction procedure at about 03h50. The object was to relieve the pressure on the spinal cord by re-aligning the vertebrae, thereby restoring blood supply to the nerve cells in the spinal cord.

The applicant instituted an action against the respondent in the High Court for the failure of the three hospitals to provide him with prompt and appropriate medical

²⁷³ [2015] ZACC 33.

treatment. The applicant claimed damages for negligence arising from the injury. He averred that the respondent owed him a legal duty to ensure that low velocity spinal cord injuries were treated at Conradie with the greatest possible urgency, and where possible within four hours of the injury.

Failure on the part of the healthcare provider to give the patient emergency treatment timeously resulted in the patient's disability. It was found by the court that there was unreasonable delay on the part of the respondent's employees in providing the applicant with emergency medical treatment as provided for in Section 27(3) of the Constitution. The court held that the respondent is liable to the applicant in damages.

3.4.2 The right to a healthy and safe environment

The right to a clean environment and sustainable development is fundamental and closely connected to the right to health and well-being.²⁷⁴ It is of fundamental importance to note that there is a strong connection between the quality of the environment and the health of the people living and exposed to those environments.²⁷⁵ Everyone has the right to a healthy and safe environment that will ensure his or her physical and mental health or wellbeing, including adequate water supply, sanitation and waste disposal as well as protection from all forms of environmental danger, such as pollution, ecological degradation or infection.²⁷⁶

The physical environment or infrastructure with regard to the health care facilities refers to the state of maintenance of the buildings, the availability of basic services (such as water and electricity), the availability of and access to the necessary technology and the availability of functional medical and non-medical equipment.²⁷⁷ A fully functional, well-equipped and adequately staffed health care facility is of little

²⁷⁴ 'Chapter 8 Environmental rights' available at https://www.sahrc.org.za/home/21/files/Reports/4th_esr_chap_8.pdf (accessed 13 March 2018) page 336.

²⁷⁵ Ibid.

²⁷⁶ Patient rights Charter available at www.kznhealth.gov.za/Patientcharter.htm (accessed 14 March 2018).

²⁷⁷ K Cullinan 'Health services in South Africa: A basic introduction' available at https://www.health-e.org.za/wp-content/uploads/2013/04/Health_services_briefing_doc.pdf (accessed 23 February 2018).

use if it is inaccessible to those in need of health care.²⁷⁸ The responsibility for the provision of a safe and healthy environment is outlined in a range of legislation and different sections of the Constitution. Section 24 of the Constitution states:

Everyone has a right to an environment that is not harmful to their health and well-being and to have the environment protected for the benefit of present and future generations, through reasonable legislative and other measures that prevent pollution and ecological degradation; promote conservation; and secure ecologically sustainable development and use of natural resources while promoting justifiable economic and social development.

In terms of the Mental Health Care Act, every mental health care user must be provided with care, treatment and rehabilitation services that improve the mental capacity of the user to develop to full potential and to facilitate his or her integration into community life.²⁷⁹ One of the reports on the Life Esidimeni tragedy stated:²⁸⁰

Some patients were transferred directly from 'sick bays' to NGOs, others were transferred with co-morbid medical conditions that required highly specialized medical care ('bedsores and puss oozing out of sores' or medical conditions such as epilepsy and hypertension) into NGOs where such care was not available, and yet other frail, disabled and incapacitated patients were transported in inappropriate and inhumane modes of transport.

This conduct by the Department of Health constitutes act of negligence and a total lack of respect for human dignity, care and human life.²⁸¹ The way in which mental health care users were discharged from Life Esidimeni was in breach of their rights under the Constitution and the Mental Health Care Act.²⁸² The places they were moved to were not appropriate environments for patients of their status to be protected and cared for. The patients were not only unable to receive the care that they required, but the discharge of these patients resulted in a poorer level of health care than what they received at Life Esidimeni.

²⁷⁸ YA Vawda & F Variawa 'Challenges confronting health care workers in government's are rollout: rights and responsibilities' 2012 (2) 15 *Potchefstromse Elektroniese Regsblad* 08.

²⁷⁹ S8 (2) of the Mental Health Act 17 of 2002.

²⁸⁰ Professor Malegapuru W Makgoba 'The report into the circumstances surrounding the death of mentally ill patients' available at <https://www.sahrc.org.za/home/21/files/Esidimeni%20full%20report.pdf> (accessed 21 March 2018).

²⁸¹ Ibid.

²⁸² 'The Life Esidimeni case' available at <file:///E:/Life-Esidimeni-Fact-Sheet-1.pdf> (accessed 21 March 2018).

3.4.3 The right to medical Informed Consent and participation in decision making

The patient has the right to participate in the decision regarding his health. The belief that the healthcare provider can do anything on the patient as long as the principles of beneficence (best interests) and non-maleficence (no harm) were upheld has been considerably transformed.²⁸³ A rational healthcare provider will always uphold the ethical standards of medicine and law. It is ethically, legally and at a human level, imperative that patients are accorded their rights to self-determination. Effective communication and trust are central to a healthy practitioner-patient relationship.

Informed consent means that sufficient information is provided to the patient to make a decision and that the patient actually understands the information and the implications of acting on that information.²⁸⁴ Informed consent relates to a person's right to human dignity and autonomy. The idea behind informed consent is that it facilitates the performance of professional tasks in a morally defensible way by bringing the patient's informed preferences into the health care practitioner's plans.²⁸⁵ Being well informed on entering the decision-making process protects the patient's dignity in the healthcare environment.

There are different layers of law that are applied in disputes about informed consent. The Patients' Charter provides for the right to participate in decision making regarding the patient's health. The healthcare provider has a duty to provide the patient with full and accurate information regarding the nature of his or her affliction, its treatment and prognosis. The patient must be informed in a language that he/she understands. If there is a need of an interpreter, arrangements should be made to assist the process of understanding. The patient's informed consent must be obtained before any medical procedure is administered. The consent must be voluntary and the patient must give such consent personally except in special cases such as where the patient is incapacitated either by age or health condition. The healthcare provider has a duty to obtain that consent from the patient.

²⁸³ A Dhai 'Informed consent' (2008) 1 (1) *South African Journal of Bioethics and Law* 27.

²⁸⁴ South African Medical Association 'Guidelines Informed Consent' available at <https://www.samedical.org/images/attachments/guideline-on-informed-consent-jul012.pdf> (accessed 18 November 2017).

²⁸⁵ Dhai (note 281 above).

Informed consent is a prerequisite for any medical treatment. The doctrine of informed consent is founded on the Latin maxim *volenti non fit injuria* (to a willing person, injury is not done).²⁸⁶ The doctrine of informed consent holds that a patient's consent to medical treatment is vitiated if he is given inadequate information concerning the proposed treatment.²⁸⁷ It entails a process of information sharing and decision making based on mutual respect and participation. The doctrine is about patient autonomy or self-determination.²⁸⁸ Patient's autonomy or self-determination implies that the patient has the right and ability to make his or her own choices and decisions about medical care and treatment he or she receives, as long as those decisions are within the boundaries of the law.

In *Castell v De Greef*,²⁸⁹ the doctrine was secured in South African Medical and Health jurisprudence. In that case, the patient sued her plastic surgeon after her double mastectomy, it was held that the plastic surgeon had not disclosed the risks involved with the mastectomy. It was submitted that had the patient known of the inherent risks of the procedure, she would not have undergone the procedure.

The right to be informed flows from the Bill of Rights as enshrined in the South African Constitution, National Health Act, the Health Professions Act and the Health Professions Council of South Africa Ethical Rules and Guidelines. In terms of the Constitution, the right to informed consent flows from the Bill of Rights. Section 12 (2)(a)(b)(c) that deals with the freedom and security of a person, provides as follows:

2. Everyone has the right to bodily and psychological integrity, which includes the right;
 - (a) to make decisions concerning reproduction;
 - (b) to security in and control over their body; and
 - (c) not to be subjected to medical or scientific experiments without their informed consent.

The conduct of the healthcare provider that may infringe on those rights will only be justifiable if a valid consent was obtained. The healthcare providers are expected to be aware of the law in this regard. Before a patient can give consent, the healthcare

²⁸⁶ A Barit 'The doctrine of informed consent in South African Medical Law' Unpublished MA dissertation, University of Pretoria, 2017.

²⁸⁷ Dutton (note 190 above) 51.

²⁸⁸ R. Britz & A. Le Roux-Kemp 'Voluntary informed consent and good clinical practice for clinical research in South Africa: Ethical and legal perspectives' (2012) 102 (9) *The South African Medical Journal* 748.

²⁸⁹ 1994 (4) SA 408 (C) 11.

provider informs the patient about the treatment and the benefits and risks involved. The patient must have the mental capacity to appreciate the information given to him or her. *In Christian Lawyers v National Minister of Health and Others*,²⁹⁰ the court stated:

The concept of informed consent is not alien to our common law. It forms the basis of the doctrine of *volenti non fit injuria* conduct that would otherwise have constituted a delict if it took place without the victim's informed consent.

The healthcare provider must build a strong relationship with the patient based on trust. In that way the two parties will be open with each other and respect each other's decision. The healthcare provider must respect the autonomy of patients. Ethically, for an action to be autonomous, it must be fully understood. There is a legal presumption that patients are fit and proper to make those decisions until the court determines otherwise.²⁹¹

The National Health Act²⁹² codifies the doctrine of informed consent in sections 6, 7 and 8. The Act sets out the nature and scope of the information that should be disclosed to the patient, that it should be done in a language that the patient understands, and that the patient's level of literacy should be taken into account.²⁹³

Section 6 states:

- (1) Every healthcare provider must inform a user of-
 - (a) the user's health status except in circumstances where there is substantial evidence that the disclosure of the user's health status would be contrary to the best interests of the user;
 - (b) the range of diagnostic procedures and treatment options generally available to the user;
 - (c) the benefits, risks, costs and consequences generally associated with each option; and
 - (d) the user's right to refuse health services and explain the implications, risks, obligations of such refusal.
 - (2) The health care provider concerned must, where possible, inform the user as contemplated in subsection (1) in a language that the user understands and in a manner which takes into account the user's level of literacy.
9. Consent to care, treatment and rehabilitation services and admission to health establishments (1) A health care provider or a health establishment

²⁹⁰ 2005 (1) SA 509 T.

²⁹¹ H.K Nevhutalu 'Patient's rights in South Africa's public health system: moral-critical perspectives' unpublished PhD dissertation, University of Stellenbosch, 2016 at 93.

²⁹² Act 61 Of 2003.

²⁹³ R Britz & A. Le Roux-Kemp (note 286 above) 748.

may provide care, treatment and rehabilitation services to or admit a mental health care user only if:
(a) the user has consented to the care, treatment and rehabilitation services or to admission.²⁹⁴

In a nutshell, the prerequisites for an informed consent include disclosure, understanding, capacity and voluntariness. The healthcare provider must disclose all information to the patient in a manner and language that the patient will understand. The patient must be capable of making a decision regarding the treatment. This section explicitly details all the information that the healthcare provider needs to give to the patient so that the patient either gives consent or refuses treatment.

In *Castell v De Greef*²⁹⁵ the court discussed and explained in detail the doctrine of informed consent in medical law in South Africa. The court stated:

Accordingly, in our law, for a patient's consent to constitute a justification that excludes the wrongfulness of medical treatment and its consequences, the doctor is obliged to warn a patient so consenting of a material risk inherent in the proposed treatment.

In that case, the plaintiff's claim was based on the defendant's negligence in performing a surgical operation on the plaintiff's breasts. Complications occurred as a result of the operation and the plaintiff claims that she was not properly informed of the operation to be done, its risks and harm that may flow from such an operation. In deciding whether a medical practitioner has incurred liability for negligence as a result of his failure to warn his patient of the material risks and complications which might flow from a surgical operation or other medical treatment, the issue of consent to medical treatment and the question of whether emphasis should be placed on the autonomy and right of self-determination of the patient, on the one hand, or on the right of the medical profession to determine the meaning of reasonable disclosure, on the other, come to the fore.

Sections 7 and 8 of the National Health Act stipulate that the patient has the right to participate in making any decisions regarding what treatment the patient wants and that the patient must consent before any treatment is given to him/her, unless it is an

²⁹⁴Section 9 of Mental Health Act 17 of 2002.

²⁹⁵ 1994 (4) SA 408 (C).

emergency and a consent cannot be obtained.²⁹⁶ In most situations, obtaining a patient's valid consent to a procedure or treatment is a simple matter of following straightforward guidelines, but circumstances can occasionally develop in which conflicting principles must be resolved and this can pose a dilemma for the healthcare providers. These sections stipulate the following:

Consent of user

7. (1) Subject to section 8, a health service may not be provided to a user without the user's informed consent. Unless-

(a) the user is unable to give informed consent and such consent is given by a person-

(i) mandated by the user in writing to grant consent on his or her behalf; or

(ii) authorised to give such consent in terms of any law or court order;

(b) the user is unable to give informed consent and no person is mandated or authorised to give such consent, and the consent is given by the spouse or partner of the user or, in the absence of such spouse or partner, a parent, grandparent, an adult child or a brother or a sister of the user, in the specific order as listed;

(c) the provision of a health service without informed consent is authorised in terms any law or a Court

(d) failure to treat the user, or group of people which includes the user, will result in a serious risk to public health; or

(e) any delay in the provision of the health service to the user might result in his or her death or irreversible damage to his or her health and the user has not expressly, impliedly or by conduct refused that service

(2) A health care provider must take all reasonable steps to obtain the user's informed consent.

(3) For the purposes of this section "informed consent" means consent for the provision of a specified health service given by a person with legal capacity to do so and who has been informed as contemplated in section 6.

Participation in decisions

8. (1) A user has the right to participate in any decision affecting his or her personal health and treatment.

(2) (a) If the informed consent required by section 7 is given by a person other than the user: such person must, if possible, consult the user before giving the required consent

(b) A user who is capable of understanding must be informed as contemplated in section 6 even if he or she lacks the legal capacity to give the informed consent required by section 7.

(3) If a user is unable to participate in a decision affecting his or her personal health and treatment, he or she must be informed as contemplated in section 6 after the provision of the health service in question unless the disclosure of such information would be contrary to the user's best interest.

²⁹⁶ The National Health Act Guide available at [file:///C:/Users/National%20Health%20Act%20Booklet_Summary%202013%20\(1\).pdf](file:///C:/Users/National%20Health%20Act%20Booklet_Summary%202013%20(1).pdf) (accessed 20 November 2017).

In an emergency where consent cannot be obtained from the patient, the healthcare provider may dispense medical treatment, provided that the treatment is immediately necessary to save life or avoid significant deterioration in the patient's life.²⁹⁷ After the emergency treatment the healthcare provider should apprise the patient of what has been done and the reason why it was done as soon as the patient has sufficiently recovered to understand. It is important to establish the capacity of a patient to make decisions. The healthcare provider can do so by consulting the guidelines issued by the relevant professional bodies.²⁹⁸

Ethical rules of conduct for practitioners registered under the Health Professions Act²⁹⁹ also provide the healthcare provider with a duty to avail the patients all information about the patient's diagnosis, treatment and costs. Ethical Rule 27(a)(d) states:

A practitioner shall at all times provide adequate information about the patient's diagnosis, treatment options and alternatives, costs associated with each such alternative and any other pertinent information to enable the patient to exercise a choice in terms of treatment and informed decision-making pertaining to his or her health and that of others.

According to the Patients' Rights Charter, everyone has a right to be given full information about the nature of one's illness, diagnostic, procedures, the proposed treatment and risks associated therewith and the costs involved.³⁰⁰ The Department of Health is using this legislative framework to ensure that everyone has access to basic healthcare and to uphold, promote and protect every one's right to effective health services.

3.4.4 The Right to confidentiality and privacy

The Patients' Charter states that information concerning one's health, including information concerning treatment may only be disclosed with informed consent,

²⁹⁷ 'Good medical practice in seeking informed consent to treatment' Available at <https://www.medicalcouncil.ie/News-and-Publications/Publications/Information-for-Doctors/Good-Medical-Practice-in-Seeking-Informed-Consent-to-Treatment-pdf.pdf> (accessed 28 February 2018).

²⁹⁸ Guidelines for good practice in the healthcare professions 'Seeking patients' informed consent' Booklet 9 Available at http://www.hpcsa.co.za/downloads/conduct_ethics/rules/generic_ethical_rules/booklet_9_informed_consent.pdf (accessed 23 February 2018).

²⁹⁹ 56 of 1974.

³⁰⁰ 'Informed Consent' available at <http://www.hpcsa-blogs.co.za/what-is-informed-consent/> (accessed 23 February 2018).

except when required in terms of any law or an order of the court³⁰¹ It is of paramount importance to keep the patient's information safe. The Constitution of the country gives everyone the right to privacy, including the privacy of their communications. The healthcare provider must not disclose the patient's information to a third party without the consent of the patient.

Confidentiality is a fundamental right of all patients but access to their medical records can be granted for appropriate reasons. The Constitution provides that everyone has a right to privacy, which includes the right not to have their person or home searched, their property searched, their possessions seized, or the privacy of their communications infringed.³⁰²

This right to confidentiality means more than simply refraining from divulging information, the healthcare providers are also responsible for ensuring that all records containing patients' information are kept securely.³⁰³ Notably, section 14 of the National Health Act provides as follows with regard to the patient's confidentiality:

- (1) All information concerning a user, including information relating to his or her health status, treatment or stay in a health establishment, is confidential
- (2) Subject to section 15, no person may disclose any information contemplated in Subsection (1) unless-
 - (a) The user consents to that disclosure in writing;
 - (b) A court order or any law requires that disclosure; or
 - (c) Non-disclosure of the information represents a serious threat to public health.

Similarly, the Mental Healthcare Act provides that the person, human dignity and privacy of every mental health care user must be respected.³⁰⁴ While all mental health care users have the same rights to confidentiality as any other user, the Act deals expressly with a number of confidentiality issues that are specific to mental health.³⁰⁵ In addition, a mental health care user can also temporarily be denied access to medical information if disclosure is likely to seriously prejudice him or her,

³⁰¹ 'Patient Rights Charter' Available at https://www.google.co.za/search?q=patient+rights+charter&rlz=1C1NHXL_enZA715ZA715&oq=patient+rig&aqs=chrome.5.69i57j0j69i60l2j69i61j0.7638j0j7&sourceid=chrome&ie=UTF-8 (accessed 23 February 2018).

³⁰² Section 14 of the Constitution.

³⁰³ Patient Rights Charter (note 299 above).

³⁰⁴ Section 8 of the Mental Health Care Act 17 of 2002.

³⁰⁵ 'The rights of vulnerable groups to health care Health and Democracy' available <https://section27.org.za/wp-content/uploads/2010/04/Chapter9.pdf> (accessed 23 March 2018).

or cause him or her to act in a way that may prejudice others. These rights may have little meaning if mental health care users have no access to courts or other bodies where allegations of violations of their rights may be adjudicated.

In addition, the Act further states that a person or health establishment may not disclose any information which a mental health care user is entitled to keep confidential in terms of any other law.³⁰⁶ This means that mental health care users have the right to confidentiality.

The healthcare provider is only authorised to disclose the patient's information under three circumstances. Firstly, where the patient consents to the disclosure in writing. Seeking consent of patients to disclosure is part of good communication between healthcare providers and patients and is an essential part of respect for the autonomy and privacy of patients. Information about patients may be required for a wide variety of purposes including education, research, monitoring and epidemiology, public health surveillance, clinical audit, administration and planning, insurance and employment.

Healthcare providers have a duty to protect the privacy of patients and respect their autonomy. When asked to provide information health care practitioners should seek the consent of patients to disclosure of information wherever possible, whether or not the patients can be identified from the disclosure.³⁰⁷ The need to ensure privacy and maintain confidentiality of any information given to the healthcare provider in their professional capacity is very important. In *Jansen van Vuuren v Kruger*,³⁰⁸ the healthcare provider disclosed the patient's HIV status without the patient's consent, in fact against the express wishes of the patient. The court found that this behaviour by the medical practitioner constituted an unauthorised disclosure of the medical facts of the patient and a breach of rules of professional conduct.

Secondly, the healthcare provider is authorised to disclose the patient's information where the law requires the healthcare provider to disclose a patient's medical record, regardless of whether or not the patient has consented. The healthcare provider may disclose the patient's information if there is a court order that requires that

³⁰⁶ S13 (1) Mental Healthcare act 17 of 2002.

³⁰⁷ S Naidoo 'Privacy and disclosure in the consulting room' available at 2014 (69) 10 *South African Dental Journal* 472.

³⁰⁸ 1993 2 All SA 619 (A),

disclosure. Compliance with a court order should be considered mandatory, but this only occurs in exceptional circumstances.

Thirdly, the healthcare provider may be required to disclose medical information where non-disclosure of the information represents a serious threat to public health. In cases where healthcare provider has considered all the available means of obtaining consent, but is satisfied that it is not practicable to do so, or that the patient is not competent to give consent, or exceptionally, in cases where the patient withholds consent, personal information may be disclosed in the public interest where the benefits to an individual or to society of the disclosure outweigh the patient's interest in keeping the information confidential.

Rule 13 of the Ethical Rules of the HPCSA states that a practitioner may divulge information regarding a patient only if this is done in terms of a statutory provision, at the instruction of a court, in the public interest and/or with the express consent of the patient. This is morally and legally important because it respects a patient's rights, respects their autonomy, maintains trust between the parties, increases patient satisfaction, is an HPCSA requirement and it respects the Protection of Personal Information Act. This Act gives everyone the right of access to records held by either public or private bodies for legitimate purposes. In the latter case, people should be allowed access to "any information that is held by another person and that is required for the exercise or protection of any rights". This includes access to health records.

The interplay between the constitutional right to privacy and the right to access to information constitutes the parameters within which the issue of access to a child's medical records is explored.³⁰⁹ The Children's Act and the National Health Act provide for confidentiality pertaining to medical records and encourages participation in decisions affecting an individual's health. The Children's Act now empowers a child to take independent decisions regarding various aspects of his/her health

³⁰⁹ L Pienaar 'Access to the medical records of a child: legislative review required' 2014 (30) 3 *South African Journal on Human Rights* available at https://journals.co.za/content/ju_sajhr/30/3/EJC165119 (accessed 24 February 2018).

care.³¹⁰ Closely linked to this right, is the issue of access to the medical records relating to the medical treatment to which the child consented.³¹¹

The Promotion of Access to Information Act 02 of 2000 (PAIA) provides that access to records of a third party must be refused if the granting of such access will result in the unreasonable disclosure of personal information about the person to whom the records pertain.³¹² Personal information includes information about a person's pregnancy, age, physical or mental health, well-being, disability, a person's medical history or blood type.³¹³ This confirms the underlying goal of the PAIA to protect the privacy of the person to whom the information pertains.³¹⁴ Privacy protection mechanisms are introduced into the PAIA to establish if disclosure would amount to unreasonable disclosure in which case disclosure must be refused.³¹⁵

3.4.5 The right to be referred for a second opinion

Everyone has the right to be referred for a second opinion on request to a health provider of one's choice.³¹⁶ The healthcare provider shall not impede a patient, or in the case of a minor, the parent or guardian of such minor, from obtaining the opinion of another practitioner or from being treated by another practitioner.³¹⁷ It has become a routine part of the medical process for patients to get a medical diagnosis or treatment plan and then seek a second opinion.³¹⁸

In this regard, referral of a patient to a medical specialist by a general healthcare provider is a standard practice in instances where specialist's diagnosis, treatment and care in a specific field is required. It must also be taken into account that referral of a patient can also be for the purpose of obtaining a second opinion on a diagnosis

³¹⁰ Section 129(2) of the Children's Act, enables a child of 12 years of age to consent independently to medical treatment, read with section 130 and section 134.

³¹¹ 'Requests for access' available at <https://www.medicalprotection.org/southafrica/advice-booklets/medical-records-in-south-africa-an-mps-guide/requests-for-access> (accessed 26 February 2018).

³¹² 34(1) relates to public bodies and s 63(1) pertains to private bodies.

³¹³ S 1(a) of the PAIA.

³¹⁴ S 1 (b) PAIA.

³¹⁵ S 1 (d) PAIA.

³¹⁶ Patient Rights Charter (note 301 above).

³¹⁷ HPCSA Guidelines for Good Practice in the Health Care Professions: Booklet 2 – Ethical and Professional rules of the Health Professions Council as Promulgated in Government Gazette R717/2006.

³¹⁸ S Reddy 'New Ways for Patients to Get Second Opinions' available at <http://www.wsj.com/articles/new-ways-to-get-a-second-opinion-1440437584> (accessed 23 February 2018)

made or proposed treatment plan. This is to be encouraged in light of the duties placed on healthcare providers where it relates to patient care in terms of the ethics guiding the medical profession.

3.4.6 The right to refuse treatment

In terms of Section 27(3) of the Constitution, a person may refuse treatment and such refusal shall be verbal or in writing provided that such refusal does not endanger the health of others.³¹⁹ In South Africa, the common law is clear on the legal status of a contemporaneous decision. People with decisional capacity may refuse life-sustaining medical treatment with regard to an illness or injury from which they may be suffering even though such a refusal may hasten their death.³²⁰ Forcing an unwilling patient to submit to medical treatment represents the ultimate limitation of that person's physical integrity.³²¹ However, there are several possible situations which may result in the limitation of a person's physical integrity.

Decisions to refuse medical treatment relate to certain fundamental human rights issues which should be balanced against the interests of the community. Clearly, the right to bodily integrity and the right to dignity provide the basis for arguing that the patient has a right to refuse medical treatment. Forced treatment as opposed to the right to physical integrity captures an age old conflict for healthcare providers to treat the patient or to respect their wishes regardless of the negative consequences that their choice may have on their health.³²² Control by the healthcare providers, family or others should be allowed only in the most limited of circumstances. It should be the norm that patients' decisions to refuse treatment stand, unless the interests of justice or the community permit otherwise.

In South Africa, some aspects of this complex ethical and legal debate were revisited on 30 April 2015 when judgment was handed down in the North Gauteng High Court in *Stransham-Ford v Minister of Justice and Correctional Services*.³²³ The court declared it legal for Robert Stransham Ford to ask a medical practitioner to help him

³¹⁹ Patient Rights Charter (note 314 above).

³²⁰ L Jordaan 'The legal validity of an advance refusal of medical treatment in South African law' 2011 (3) *De Jure Law Journal* 35.

³²¹ A Nienaber & K N Bailey 'The right to physical integrity and informed refusal: Just how far does a patient's right to refuse medical treatment go?' 2016 (9) 2 *South African Journal of Bioethics Law* 74.

³²² A Nienaber & K N Bailey (note 319 above) 75.

³²³ 2015 (4) SA 50 (GP).

end his life and, in doing so, upholding Robert Stransham-Ford's rights to dignity, physical integrity and his autonomy.³²⁴ Stransham-Ford refused medical treatment in the form of strong sedatives because he wanted to die while aware of his surroundings. The judgment is a victory, not only for those who advocate the right of competent adult persons to seek active euthanasia in specific circumstances,³²⁵ but also for claims of patient autonomy and patients' right to reach their own decisions regarding their medical treatment, including their right to refuse treatment.³²⁶

3.4.7 The right to continuity of care

No one shall be abandoned by a healthcare provider or a health facility which initially took responsibility for one's health.³²⁷ The patient, however, has a responsibility to respect the rights of other patients and health care providers.³²⁸ They further have the responsibility to utilise the health care system properly and not to abuse it.³²⁹ To ensure accessibility of quality care to all South Africans, the role of the government, healthcare professionals and civil society must be clearly outlined.

It is important that patients keep their records safely to ensure seamless care, and more importantly that they do not abuse the health system. These responsibilities will go a long way in ensuring quality of care. The effect of patients practising these responsibilities is often not visible, but has a huge impact on the efficacy and quality of healthcare provided. To ensure such accessibility and continuity of care, the government implemented a mobile clinics project in most rural areas. It is also allowed in South Africa for one to receive treatment in any area that one has access to.

3.4.8 The right to complain about health services

³²⁴ *Stransham-Ford case (note 321 above).*

³²⁵ J Herring, *Medical Law and Ethics* (Oxford: Oxford University Press, 2010)21.

³²⁶ P Carstens 'The involuntary detention and isolation of patients infected with extreme resistant tuberculosis: Implications for public health, human rights and informed consent' 2009 (30) 2 *Obiter*, P420-427.

³²⁷ Patient Rights Charter (note 314 above).

³²⁸ Guidelines for good practice in the healthcare profession 'general ethical guidelines for the healthcare professions' Booklet 1 available at http://www.hpcsa.co.za/downloads/conduct_ethics/rules/generic_ethical_rules/booklet_1_guidelines_good_prac.pdf (accessed 24 February 2018).

³²⁹ News24 'Know your rights and responsibilities' available at <https://www.health24.com/Medical/Cancer/Campaigning-for-cancer/Know-your-rights-and-responsibilities-20120721> (accessed 24 February 2018).

Everyone has the right to complain about health care services and to have such complaints investigated and to receive a full response on such investigation.³³⁰ The clinic has a formal, clear, structured complaint procedure and illiterate patients and those with disabilities are assisted in laying complaints. All complaints or suggestions are forwarded to the appropriate authority if they cannot be dealt with in the clinic. A register of complaints and how they were addressed is maintained.

The National Health Act 61 of 2003 provides that any person may lay a complaint about the manner in which he or she was treated at a health establishment and have the complaint investigated. It further states:

- (2) The relevant member of the Executive Council and every municipal council must establish a procedure for the laying of complaints within those areas of the national health system for which they are responsible.
- (3) The procedures for laying complaints must
 - (a) Be displayed by all health establishments in a manner that is visible for any person entering the establishment and the procedure must be communicated to users on a regular basis;
 - (h) In the case of a private health establishment, allow for the laying of complaints with the head of the relevant establishment.

The patient also has the right to complain about healthcare services that either violates the patient's rights to good health or breaches ethical standards, to have the patient's complaint investigated and to receive a full response thereafter.³³¹ The procedure for laying a complaint has been discussed in the previous chapter in Section 2.6.

3.4.9 The right to be treated by a named healthcare provider

Every patient has the right to know the person that is providing health care and therefore must be attended to by a clearly identified health care provider.³³² The underlying reason for being treated by a named healthcare provider is to enable the patient to be able to identify the person who treated him/her. The details of the healthcare provider who treated the patient are required when a complaint is laid.

3.5 Chapter conclusion

³³⁰ Patients' Rights Charter (note 325 above).

³³¹ 'How to lodge a complaint against a healthcare practitioner' available at http://www.hpcsa.co.za/downloads/inquiries/brochures/lodging_a_complaint.pdf (accessed 23 February 2018).

³³² Patient Rights Charter (note 328 above).

The existing legislation does not spell out all legal aspects that have a bearing on the health of the individual. The continuing stream of amendments of both Acts and Regulations show that much still needs to be achieved in health legislation. South Africa also needs to establish the best and fairest healthcare system possible with the available resources.

A comprehensive covering of all possible aspects can be achieved by enacting a new legislation that will specifically deal with medical negligence claims. This would be a fundamental piece of health legislation that would shape the future of the South African health system. The legislation is created for the common good of all persons who are injured and sustained damages as a result of medical negligence. It is understandable that for the good of the public and in the public interest, the common law must be interfered with, so that deviation from the common law would be possible.

CHAPTER FOUR

REASONS BEHIND THE INCREASE IN MEDICAL NEGLIGENCE CLAIMS

This chapter discusses the reasons behind the increase in both claims and the extent of medical negligence litigation to lend credence to the suggestion that the medical law has become undoubtedly the fastest growing field of law. In South Africa, it is not only the number of claims which continue to rise but also the size of the claims and pay-outs. The amount of dreadful claims, such as those for birth defects and brain injuries, have risen drastically as the cost of caring for patients has increased due to technological advancements which improve life expectancy and quality of life.

4.1 Introduction

In South Africa, an increase in both the size and amount of medical malpractice claims has resulted in a move towards the so-called defensive medicine,³³³ and have had devastating emotional effects of malpractice lawsuits on healthcare professionals.³³⁴ It is apparent that the quality of healthcare will affect the outcomes of medical and legal interventions.³³⁵ Poor-quality healthcare inevitably leads to adverse but otherwise avoidable medical outcomes that, in turn, sponsor legal interventions and encourage medico-legal litigation.³³⁶

The patient expects more for less and, when they receive less for more, they quite rightly turn to the legal system for help. Mistakes can be made in all areas of one's professional life, and following medical mishaps, debates related to these misfortunes, both internally and externally, can be damaging to a healthcare provider's career, reputation, and psychological well-being.³³⁷ These misfortunes arise out of negligence and have legal and financial consequences.

³³³ W Moore & M Nöthling-Slabbert 'Medical information therapy and medical malpractice Litigation in South Africa' (2013) 6 (2) *South African Journal of Bioethics and Law* 60. Defensive medicine is defined as the practice of diagnostic or therapeutic measures that are conducted primarily as a safeguard against possible malpractice liability, rather than to ensure the health of the patient. See G.A Ogunbanjo & D. Knapp van Bogaert 'Ethics in health care: the practice of defensive medicine' (2014)56 (1) *South African Family Practice* 6.

³³⁴ Ibid.

³³⁵ Neil Kirby Bizcommunity, 'SA lawyers: Motsoaledi, we're not the reason gynaes won't deliver babies' available at <http://www.bizcommunity.com/Article/196/158/163413.html> (accessed 26 April 2018).

³³⁶ Ibid.

³³⁷ HK Nevhutalu (note 289) 57.

When a healthcare provider fails to provide proper medical care to a patient, the patient is in a good position to seek relief in court. For such medical care to constitute negligence, it must not have measured up to the appropriate standard of care that is required in the profession. Patients will enforce their rights by whatever legal means available to them, especially where they are the recipients of inadequate medical services or treatment, which is the genesis of the harm that is legally actionable.

Medical malpractice litigation remains a source of serious concern to the healthcare industry globally. The increasing number of medical malpractice litigation claims in South Africa has been described as an "explosion" by the Health Minister Dr Aaron Motsoaledi, who warns that the compassion-based practice of medicine is being replaced by defensive medicine and mistrust.³³⁸ The Health Department is struggling with its obligation to provide healthcare services, while still having to pay out billions in medical claims against it.³³⁹ In the private sector, medical specialists are battling with exorbitant medical protection insurance premiums, causing healthcare costs to rise and impacting on practices.

The Department of Health becomes liable due to the principle of vicarious liability. Vicarious liability means that a person is liable for another person's act or omission even though the first person is not at fault.³⁴⁰ It is trite in law that an employer is vicariously liable for the wrongful conduct of an employee if such wrong was committed by the employee in the course and scope of his or her employment or while engaged in any activity incidental thereto.³⁴¹ For instance, if the Health Department employs a healthcare provider to assist it, and he/she negligently or intentionally injures patients while acting in the course and scope of his or her employment, the Department will be held liable for its employee's wrongful conduct.

³³⁸ G Gifford, Health24 'Medical malpractice litigation: Undermining South Africa's health system' 17 April 2018 available at <https://www.health24.com/News/Public-Health/medical-malpractice-litigation-undermining-south-africas-health-system-20180417> (accessed 24 April 2018).

³³⁹ S Hlatshaneni, The Citizen 'Gauteng health is on life support' available at <https://citizen.co.za/news/south-africa/1944017/gauteng-health-is-on-life-support/> (accessed 12 May 2018).

³⁴⁰ Law Teacher 'What is vicarious liability' available at <https://www.lawteacher.net/free-law-essays/contract-law/what-is-vicarious-liability-contract-law-essay.php> (accessed 12 May 2018).

³⁴¹ Vicarious liability was also defined in the case of *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T) 719. Vicarious liability may in general terms be defined as the strict liability of one person for the delict of another.

Nevertheless, injured patients usually sue the department concerned instead of the healthcare providers because government departments have access to more resources than the healthcare providers to meet the patients' claims. The rising number of medical negligence claims affects both the private and public sector.³⁴² This chapter examines factors that are contributing to the rise in medical negligence claims and their impacts on the government health departments.

4.2. medical negligence claims in the Gauteng Province as a an example

Court-ordered payments for medical negligence continue to rise every year. In 2015, Gauteng state hospitals recorded a total of 503 serious adverse events.³⁴³ The Gauteng Health Department paid out more than R1bn to settle 185 medical negligence cases in 2015.³⁴⁴ Brain-damaged babies made up 76% of the claims, which amounted to R769m for 50 claimants.³⁴⁵ According to the 2016/ 17 Gauteng Health Department's Annual Report, the total potential medico-legal liability from claims is now an astounding R13, 452 billion.³⁴⁶ Reasons for the rising claims for medical negligence are examined below.

4.2.1 Deteriorating conditions in state hospitals

South Africa is a developing country that has continued to battle with ways to improve state-owned facilities so that the best services may be provided to its citizens.³⁴⁷ Numerous complaints have been presented regarding the poor service delivery in public hospitals. The increasingly stressful environment in which healthcare professionals are working is one of the major factors leading to the rise in

³⁴² L Pienaar (note 226 above).

³⁴³ Dsc Attorneys 'Medical Malpractice Litigation in S.A.: Response to Criticism of Attorneys' available at <https://www.dsclaw.co.za/news/article/medical-malpractice-litigation-sa-response-criticism-attorneys> (accessed 04/07/2018). Serious Adverse Events (SAE's) is a term used to describe untoward medical acts or omissions that result in significant harm to patients.

³⁴⁴ Mpho Raborife, News24 'More than R1bn paid in medical negligence payouts by Gauteng Health – DA' available at <https://www.news24.com/SouthAfrica/News/more-than-r1bn-paid-in-medical-negligence-payouts-by-gauteng-health-da-20170523> (accessed 05/07/2018).

³⁴⁵ All for Women 'Shocking: Medical negligence in Gauteng costs the country over R1bn' 24 May 2017 available at <https://www.all4women.co.za/1099387/news/south-african-news/shocking-medical-negligence-gauteng-costs-country-r1bn> (accessed 05 July 2018).

³⁴⁶ R Van Zyl 'Shocking stats released of negligence claims against state hospitals' 26 May 2017 available at <https://roodepoortrecord.co.za/2017/05/26/shocking-stats-released-of-negligence-claims-against-state-hospitals/> accessed (05 July 2018).

³⁴⁷ J.B. Spector, Daily Maverick 'South Africa, a developmental state? Five years later, still no chance' 28 November 2017 available at <https://www.dailymaverick.co.za/article/2017-11-28-south-africa-a-developmental-state-five-years-later-still-no-chance/#.WzI8PVUzaUk> (accessed 23 May 2018).

medical negligence. Many of the public healthcare infrastructure is in poor condition and non-operational as a result of underfunding, mismanagement and neglect.³⁴⁸

Generally, public health facilities tend to be underfunded, bureaucratic, inefficient and hopelessly over-subscribed, whereas many private facilities are excellent, as good as any found in developed countries.³⁴⁹ Government hospitals cater for the majority of the population but these hospitals are poorly funded, ill-equipped and often do not have skilled staff.³⁵⁰ In a resource-deficient environment, liability for medical malpractice depends on whether there was intentional or negligent wrongful conduct by the parties concerned, or whether they were vicariously liable for the wrongful acts or omissions of others.³⁵¹

Possible life-saving techniques and equipment may be malfunctioning or unavailable particularly in emergency situations. Resuscitation trollies are often not properly equipped, staff members are not trained to use these and there is sometimes a shortage of oxygen equipment.³⁵² Poor management at every level of the health department and a lack of proper guidelines for different levels of government (including norms and standards for all levels of hospitals) are exacerbating problems in the health facilities.³⁵³

Reports in the media indicate that public hospitals in the Eastern Cape Province are on the brink of collapse, with many patients being treated in hospitals which lack pipe-borne water, electricity and essential medical equipment.³⁵⁴ Receiving quality care, and principally patient-centered care, in the face of such challenges is

³⁴⁸ L.A. Amado 'National Health Insurance: A lofty ideal in need of cautious, planned implementation' (2012) 5 (1) *South African Journal of Bioethics and Law* 7.

³⁴⁹ Just Landed 'Public Healthcare South Africa's health system' available at <https://www.justlanded.com/english/South-Africa/South-Africa-Guide/Health/Public-Healthcare> (accessed 15 April 2018).

³⁵⁰ S Soogun, M Naidoo & K Naidoo 'An evaluation of the use of the South African Triage Scale in an urban district hospital in Durban, South Africa' (2017) 1 (1) *South African Family Practice* 3.

³⁵¹ D McQuoid-Mason 'Establishing liability for harm caused to patients in a resource-deficient environment' (2010) 100 (9) *South African Medical Journal* 573.

³⁵² Health-e-News Service K. Cullinan 'Health services in South Africa: A basic introduction' January 2006 available at https://www.health-e.org.za/wp-content/uploads/2013/04/Health_services_briefing_doc.pdf (accessed 17 May 2018).

³⁵³ Dr. M. Jobson 'Structure of the health system in South Africa' October 2015 available at file:///C:/Users/RMMatumba/Downloads/M_Jobson_Khulumani_Health_paper_-_Structure_of_the_health_system_in_South_Africa_-_Oct_2015.pdf (accessed 13 June 2018).

³⁵⁴ S. Jardine-Baboo, D. Van Rooyen, E. Ricks & P Jordan 'Perceptions of patient-centered care at public hospitals in Nelson Mandela Bay' *Health SA gesondheid* 21 (2016) available at https://ac.els-cdn.com/S1025984816300114/1-s2.0-S1025984816300114-main.pdf?_tid=427899a7-4395-441a-91bd-aab2e6e238a4&acdnat=1530020274_069465995de0c5f2763af81e10920529 (accessed 23 April 2018) 398.

unlikely.³⁵⁵ Experiencing a shortage of basic necessities such as soap, hand paper towels, and functioning equipment, have been cited by healthcare users as factors which impede the rendering of patient-centered care and quality care.³⁵⁶

Though South Africa has many dedicated health professionals in the public sector, standards of care are often poor.³⁵⁷ Reasons range from a shortage of doctors and nurses to bad management of public hospitals, persistent shortages of medicines and other consumables and a widespread failure to comply with basic norms and standards in public hospitals and clinics.³⁵⁸

The health sector is currently in a crisis in respect of human resources and it has been described as the most pressing issue affecting healthcare globally.³⁵⁹ The World Health Organization (WHO) has estimated that there is a global shortage of approximately 4.3 million nurses, doctors, midwives, and other members of the multidisciplinary healthcare professionals.³⁶⁰ The WHO report show an average of eight physicians and forty-one midwifery and nursing personnel per 10 000 population in South Africa.³⁶¹ The global shortage threatens the sustainability and quality of health.³⁶² The shortage of nursing staff and practitioners in South Africa has resulted in an over-burdened healthcare system and may potentially be the reason for the increased number of medical negligence claims as over-worked personnel is bound to fall into errors.

³⁵⁵ Ibid.

³⁵⁶ Ibid at 403.

³⁵⁷ Ibid at 575.

³⁵⁸ PoliticsWeb 'The Gauteng health system in crisis - SECTION27' 05 March 2013 available at <http://www.politicsweb.co.za/documents/the-gauteng-health-system-in-crisis--section27> (accessed 02 June 2018).

³⁵⁹ A. Williams 'Investigation into the factors contributing to malpractice litigation in nursing practice within the private healthcare sector of Gauteng' unpublished MA dissertation, University of Stellenbosch, 2018. P. 1.

³⁶⁰ World Health Organisation 'Global health workforce shortage to reach 12.9 million in coming decades' available at <http://www.who.int/mediacentre/news/releases/2013/health-workforce-shortage/en/> (accessed 23 April 2018).

³⁶¹ Research Consortium 'The shortage of medical doctors in South Africa' March 2008 available at http://www.labour.gov.za/DOL/downloads/documents/research-documents/Medical%20Doctors_DoL_Report.pdf (accessed 12 June 2018).

³⁶² C. Aluttis1, T Bishaw & M.W. Frank 'The workforce for health in a globalized context global shortages and international migration' (2014) 1 available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3926986/pdf/GHA-7-23611.pdf> (accessed 26 March 2018).

The increased workload demand on healthcare provider may also account for the poor standard of medical care delivery.³⁶³ The shortage of healthcare personnel in South Africa has forced both the private and public sectors to make use of international healthcare providers to fill the vacancies. The majority of hospitals instituted the twelve-hour shifts during the 1980s in order to increase recruitment and ease the scheduling of healthcare providers' duties.³⁶⁴ The idea of working three twelve-hour days within the week appealed more to healthcare providers than five, eight-hour days weekly.³⁶⁵ This has significance as healthcare providers are taking a second job at other hospitals or are being asked to work extra shifts if the hospital units are short staffed,³⁶⁶ leading to consequences that stem from prolonged hours and worker fatigue.³⁶⁷

The challenges of having a shortage of medical staff and too many patients are exacerbated by the lack of skills needed to treat serious ailments, mainly due to the locum doctors who do not have adequate expertise to address an emergency.³⁶⁸ The nurse-midwives are obliged to act independently when identifying an obstetric problem and have to search for the medical officers, who are often not present, in order to secure the necessary care for their patients.³⁶⁹ The 260 student doctors who have just returned from studying medicine in Cuba³⁷⁰ are expected to bring some change in the health service departments of the nation.

The transformation of the South African healthcare system is largely dependent on the effective utilization of the country's human resources, yet this remains a critical

³⁶³ R. G. Hughes 'Chapter 2 Nurses at the "Sharp End" of Patient Care' Patient Safety and Quality: An Evidence-Based Handbook for Nurses: Vol. 1 available at https://www.ncbi.nlm.nih.gov/books/NBK2672/pdf/Bookshelf_NBK2672.pdf (accessed 12 June 2018).

³⁶⁴ C.A. Estabrooks, G.C. Cummings, S. Armijo et al 'Effects of shift length on quality of patient care and health provider outcomes: Systematic review' (2009) 18 (3) *Quality and Safety Health Care* 185.

³⁶⁵ Ibid.

³⁶⁶ A.W. Stimpfel, D. M. Sloane & L .H. Aiken 'The Longer The Shifts For Hospital Nurses, The Higher The Levels Of Burnout And Patient Dissatisfaction' 2013 available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3608421/pdf/nihms448267.pdf> (accessed 03 June 2018).

³⁶⁷ Ibid.

³⁶⁸ M. McCoy, A. Sekeitto & Z. Gwebityala 'Understanding South African Public Healthcare Challenges & Technology Opportunities for ConnectMed' available at <http://skollcentreblog.org/wp-content/uploads/2017/07/AwaP-ConnectMed-Report.pdf> (accessed 14 June 2018).

³⁶⁹ 'Guidelines for Maternity care in South Africa' 2007 available at http://www.kznhealth.gov.za/family/Maternity_care_guidelines_2007.pdf (accessed 12 June 2018).

³⁷⁰ News24 '260 soon-to-be-doctors return to SA from Cuba' 28 July 2018 available at <https://www.news24.com/SouthAfrica/News/260-soon-to-be-doctors-return-to-sa-from-cuba-20180708> (accessed 13 July 2018).

constraint in the delivery of quality healthcare.³⁷¹ The shortage of registered healthcare providers in South Africa has been attributed partly to the more affluent countries offering the healthcare practitioners better working conditions³⁷² and increased rewards and incentives.³⁷³

4.2.2 Lack of professionalism and failure to adhere to basics

The reason for failing to adhere to the basics by the healthcare providers goes hand in hand with a lack of equipment in healthcare facilities. A professional person is expected to have a particular set of skills in his or her chosen field, at a level that can be considered an expert.³⁷⁴ This is acquired through learning, knowledge, training, and practice of the relevant skills and, in most cases, demonstrated by qualifications or accreditation of some kind.³⁷⁵ Professional persons are expected to have the ability and dedication to achieve a set of standards in their duties that their peers find acceptable.³⁷⁶

Lack of professionalism or unprofessional conduct, within the focus of this dissertation, can be seen as a conduct of a healthcare provider which is in contravention of the standards of the medical profession. As a collective body, healthcare providers are regarded as “professionals” both by the public and by their peers. They remain the most trusted profession among the public, which has been the case for many years.³⁷⁷ With the advancing complexities in medical knowledge and skills and in providing healthcare, maintaining high professional standards is an increasingly recognized challenge in every society.³⁷⁸

³⁷¹ M. Lagarde, D. Blaauw & J. Cairns ‘Cost-effectiveness analysis of human resources policy interventions to address the shortage of nurses in rural South Africa (2012) 75 (801-806) *Social Science and Medicine* 801.

³⁷² E. Mokoka, M.J. Oosthuizen & V.J. Ehlers ‘Retaining professional nurses in South Africa: Nurse managers’ perspectives’ (2010) 15 (1) *Health SA Gesondheid* 487.

³⁷³ Ibid.

³⁷⁴ Chapter 1: Medical Professionalism - What do we mean? Available at <http://www.medicalprotection.org/uk/advice-booklets/professionalism-an-mps-guide/chapter-1-medical-professionalism-what-do-we-mean> (accessed 17 May 2018).

³⁷⁵ Ibid.

³⁷⁶ ‘Developing specific skills, competencies, and points of view needed by professionals in the field most closely related to this course’ available at <http://www.ideaedu.org/Resources-Events/Teaching-Learning-Resources/Developing-specific-skills-competencies-and-points-of-view-needed-by-professionals-in-the-field-most-closely-related-to-this-course> (accessed 25 May 2018).

³⁷⁷ ‘Chapter 1: Medical Professionalism (note 345).

³⁷⁸ S Benatar ‘Professional competence and professional misconduct in South Africa’ (2014) 104 (77) *South African Medical Journal* 480.

Complaints regarding professional competence and misconduct are among the serious and deeply worrying problems about medical professionals in South Africa. Others include poorly qualified healthcare personnel being allowed to enter practice.³⁷⁹ Healthcare professionals are granted the social privilege of self-governance and internal maintenance of high professional standards, factors that galvanize public trust in the health professionals.³⁸⁰

The foregoing considerations, which impose an additional obligation on health professionals, differentiate healthcare from other occupations: the power differential between the vulnerable,³⁸¹ ill patient and the health professional; the knowledge and learning acquired from research and clinical training performed on ill people;³⁸² and the traditional oath was taken at graduation, in which the graduating health professional acknowledges the service aspect of the profession.³⁸³

It is suggested that medical negligence litigation is increasing because the standard of healthcare provided by medical practitioners is dropping due to deficiencies in skills acquisition.³⁸⁴ The Health Professions Council of South Africa attributed the decline in professionalism among healthcare practitioners as the motivation for launching a campaign in 2012 to educate patients on their rights.³⁸⁵ The decline in the level of professionalism among healthcare practitioners³⁸⁶ is not, however, the only reason for the increase in medical negligence claims.³⁸⁷ Other reasons like lack of facilities in the public healthcare institutions, shortage of qualified personnel, training and retraining of healthcare providers are also contributing factors.

³⁷⁹ Ibid.

³⁸⁰ S. Kling 'Health Professionalism and ethics – is there a difference' (2017) 30 (1) *Current Allergy & Clinical Immunology* 26.

³⁸¹ Ibid.

³⁸² Ibid.

³⁸³ A Dhai & J Moodley 'Ethical challenges to the health profession-patient relationship. Transactions' (2001) 45 (2) *Journal of the Colleges of Medicine of South Africa* 42.

³⁸⁴ E.C. Meyer 'An analysis of the duty of care concept from a Pragmatic Medical Malpractice Perspective' unpublished MA Dissertation University of Pretoria 9 January 2017 p. 28.

³⁸⁵ HPCSA the Bulletin 2017 'Efficient and Effectiveness-Our Five year Endeavours' available at http://www.hpcsa.co.za/Uploads/editor/UserFiles/downloads/publications/bulletin/HPCSA_Bulletin_LR_2017.pdf (accessed 15 June 2018) 37.

³⁸⁶ Health care practitioners may sometimes find themselves having to perform their duties in less than favorable circumstances that are beyond their control. See W.T. Oosthuizen and P.A. Carstens PA 'Medical Malpractice: The Extent, Consequences, and Causes of the Problem' (2015) 78 *THRHR* 281.

³⁸⁷ M.S Pepper & M.N. Slabbert 'Is South Africa on the verge of a medical malpractice litigation storm?' 2011 (4) 1 *South African Journal of Bioethics and Law* 30.

It is a misconception to suggest that every malpractice claim is motivated by monetary reward. Although financial considerations are very important motivators, patients often have many other reasons for suing the health service providers.³⁸⁸ Providing future care to someone can be expensive and exceed resources.³⁸⁹ As a result, patients turn to the courts for survival, even though doing so might not be their natural inclination, but a number of non-economic reasons are often involved. A suit may arise when another healthcare provider suggests that the care given by the patient's healthcare provider is below standard and might have been responsible for the adverse outcome suffered by the patient.

Patients often file claims to obtain information. Statistics show that nearly 20% of plaintiffs indicate that they sued because they were frustrated with their attempts to find out what actually happened and became suspicious that the physician and hospital were engaged in a cover-up.³⁹⁰ The information is likely to come out so it is in the best interests of the physician to provide comprehensive information in an understandable manner promptly after the incident.

Some participants in a healthcare study acknowledged that there are some healthcare providers who are rude to patients.³⁹¹ This constitutes not only unprofessional behavior, but also a lack of professional ethos.³⁹² The harsh manner in which some healthcare providers communicate with patients causes patients to feel upset and afraid and ultimately, they are less likely to communicate their needs.

Some healthcare related suits are based on the fact that the healthcare provider did not listen to the patient or answer questions, or failed to warn them about the risks involved in a particular medical procedure.³⁹³ It is important that facts be properly documented when conversations take place. It is also important to realize that the

³⁸⁸ 'Medical Malpractice: The Basics' available at <http://care-ins.com/wp-content/uploads/2015/09/Medical-Malpractice-book.pdf> (accessed 23 June 2018). p. 4.

³⁸⁹ Ibid.

³⁹⁰ 'Medical Malpractice: The Basics' available at <http://care-ins.com/wp-content/uploads/2015/09/Medical-Malpractice-book.pdf> (accessed 14 April 2018) at 18.

³⁹¹ S. Jardine-Babooa, D. Van Rooyen, E. Ricks & P. Jordana 'Perceptions of patient-centred care at public hospitals in Nelson Mandela Bay' Health SA Gesondheid (2016) 21 398 available at <https://www.sciencedirect.com/science/article/pii/S1025984816300114#!> (accessed 14 April 2018).

³⁹² S.N. Magopeni 'Professional behaviour among nursing students at a college in the Eastern Cape' unpublished MA Dissertation University of Fort Hare, 2013 at 29.

³⁹³ See *Louwrens v Oldwage 2006(2) SA 161 (SCA)*, the plaintiff was successful in his action for damage for the negligent performance upon him of the surgical procedure. The plaintiff's case was that he had not given his informed consent to the surgery and that the defendant had not warned him of the risks inherent in the surgery, specifically of the harm which allegedly manifested.

patient and the family may be under stress, which may make them less able to understand the consequences of the medical procedure. They may need to be told of the dangers several times. Some patients sue because they consider the healthcare provider to be incompetent. Anger can motivate them to seek to protect other patients or seek revenge.

The healthcare provider has a crucial role in a patient's care and failure to carry out his or her duty may result in being liable for his or her acts and omissions.³⁹⁴ Therefore, empowering the healthcare provider with the relevant legal knowledge from foundational levels is a vital and essential component in preventing incidents of medical negligence.³⁹⁵ If the healthcare provider is not knowledgeable of the laws governing his or her practice, the rights and laws protecting the patient, and that which govern the healthcare institution, there is the likelihood of execution of undesirable medical care delivery that may result in harmful consequences to the patient.³⁹⁶

Basic principles in the treatment of patients such as testing the unborn foetus for Downs Syndrome,³⁹⁷ implementing spinal precautions when moving a patient following a high impact accident to prevent paraplegia or referring the patient for a radiological study and diagnosis,³⁹⁸ are not always adhered to.

In the case of *Goliath v MEC of Health in Province of Eastern Cape*,³⁹⁹ the Supreme Court of Appeal upheld the appeal with costs for damages to the plaintiff where a swab was left in the plaintiff's abdomen post-surgery resulting in sepsis. In that case, both the doctor and the nurse were sued, though the failure to ensure the duty of care in this instance lies with the nurse who is in charge of the theatre and is responsible for a swab count.

³⁹⁴ M Mathuray 'A critical evaluation of the nurse's legal knowledge and its impact in preventing nursing malpractice in South Africa' an unpublished MA dissertation University of KwaZulu-Natal 2017 at 7.

³⁹⁵ Ibid.

³⁹⁶ Ibid.

³⁹⁷ Josephs Incorporated Attorneys 'Case studies: Medical Malpractice' available at <http://www.josephs.co.za/case-studies/> (accessed 16 May 2018).

³⁹⁸ Ibid.

³⁹⁹ [2014] ZASCA 182.

A similar outcome was witnessed in *Van Wyk v Lewis*,⁴⁰⁰ where the surgeon had left a swab in the plaintiff's abdominal cavity following surgery. Although the court found that the defendant was not negligent, the court held that it was the general practice that the attending nursing sister carried the responsibility to ensure that all swabs were accounted for.

The healthcare provider's failure to adhere to basic acts was again highlighted in *Micheal v Linksfield*,⁴⁰¹ where the patient suffered cardiac arrest resulting in cerebral anoxia which left him in a vegetative state whilst under general anesthetic during a surgical procedure. Negligence was alleged during the resuscitation procedure due to the failure of the nursing sister to operate the resuscitation equipment correctly, a responsibility she should have been familiar with as the person responsible for checking its functioning.

As a healthcare provider, competency in operating emergency equipment is a vital and basic requirement for safe practice. Failure to operate or possess knowledge thereof is like going to war without an army. It is inexcusable that a registered healthcare provider is ignorant of operating emergency equipment in his or her immediate work environment.⁴⁰² The above incidents illustrate a healthcare provider's negligence and failure to execute responsibilities as required by the standard of care policy under these circumstances. Healthcare providers working in such an environment must know that it is their responsibility for the swab count and the implications of failure could result in legal action for negligence.⁴⁰³

Healthcare providers should follow simple guidelines, such as monitoring the heartbeat of the foetus and looking after the overall health of the mother.⁴⁰⁴ A key cause of maternal deaths is bleeding before or after labour.⁴⁰⁵ The underlying reasons are lack of surgical skills in rural hospitals, lack of emergency blood supplies, and delays in calling for help.

⁴⁰⁰ 1924 AD 438.

⁴⁰¹ 2001 (3) SA 1188 (SCA).

⁴⁰² N. Van Huyssteen 'A Legal Analysis of the Emergency Medical Services in South Africa' Unpublished MA Dissertation University of Pretoria 2015/2016 at 132.

⁴⁰³ R.D. Beuks 'Knowledge of surgical counting practices of the operating room in provincial hospitals in the Cape metropole' Unpublished MA dissertation, University of Stellenbosch 2016 at 53.

⁴⁰⁴ 'Monitoring the condition of the fetus during the first stage of labour' available at <https://bettercare.co.za/learn/maternal-care/text/07.html> (accessed 19 May 2018).

⁴⁰⁵ World Health Organization 'Maternal Mortality' available at <http://www.who.int/news-room/factsheets/detail/maternal-mortality> (accessed 23 May 2018).

In many instances, babies have survived poor care at birth but have been left badly brain damaged. An increasing number of medical negligence cases, many of them involving children harmed in this way, have shown that standards of public health care have declined, and avoidable deaths are on the increase.⁴⁰⁶ In May 2015, a report found that more than 80 000 babies had died at some 590 public healthcare facilities over a two-year period.⁴⁰⁷

In *MEC for Health and Social Development of the Gauteng Provincial Government v Mathebula and Others*,⁴⁰⁸ the Pretoria High Court awarded R23m in compensation to four-year-old Ntsako Mathebula⁴⁰⁹ who was left with cerebral palsy, mental retardation, epilepsy, and other severe medical and developmental problems when medical staff at Tembisa Hospital in the East Rand failed to perform an emergency caesarean on his mother in November 2010.⁴¹⁰

Another botched birth in 2015 resulted in the awarding of R5m in damages against the Gauteng MEC for health. In this instance, Kamogelo Kau suffered a low blood sugar induced brain injury when his mother Christinah gave birth to him at the Pholosong Hospital in Tsakane in 2006.⁴¹¹ His brain injury was aggravated by lack of oxygen after birth and by poorly treated convulsions, which left him with severe cerebral palsy.⁴¹² He suffers from spasticity and quadriparesis and cannot walk, run, or sit for long periods.⁴¹³ His speech has been severely affected, he is incontinent, and he moves by performing a kind of bunny hop.⁴¹⁴ An occupational therapist

⁴⁰⁶ A. Jeffery, PoliticsWeb 'The NHI: Risking lives for no good reason – IRR' available at <http://www.politicsweb.co.za/documents/the-nhi--risking-lives-for-no-good-reason--irr> (accessed 12 May 2018).

⁴⁰⁷ Statistics South Africa 'Prenatal deaths in South Africa 2014' available at <http://www.statssa.gov.za/publications/P03094/P030942014.pdf> (accessed 22 May 2018) page 11.

⁴⁰⁸ [2016] ZAGPJHC 187.

⁴⁰⁹ Ibid.

⁴¹⁰ 'Full Submission on NHI White Paper' 25 May 2016 available at <https://irr.org.za/reports/submissions-on-proposed-legislation/full-submission-on-nhi-white-paper-2013-31-may-2016> (accessed 12 May 2018) p. 26.

⁴¹¹ A. Jeffery, PoliticsWeb 'The NHI: Risking lives for no good reason – IRR' 11 December 2016 available at <http://www.politicsweb.co.za/opinion/the-nhi--risking-lives-for-no-good-reason--irr>

⁴¹² I. De Lange, The Citizen 'Botched Birth Cost MEC 5 Million' 21 September 2015 available at <https://www.pressreader.com/south-africa/the-citizen-kzn/20150921/281672548739980> (accessed 23 May 2018).

⁴¹³ Ibid.

⁴¹⁴ Ibid.

described the loss he had suffered as devastating not only for him but also his mother and family as he would never be able to live independently.⁴¹⁵

4.2.3 Legislation and case law development

In the ancient Greek period, a medical practitioner was sentenced to death if a patient died under his care as a result of the use of unorthodox medical practices.⁴¹⁶

If a patient loses the use of a limb after an operation, the medical practitioner's hands were often cut off as a reciprocal punishment for negligence.⁴¹⁷ In Roman times, where a citizen suffered injury due to medical malpractice,⁴¹⁸ the *paterfamilias* could institute an action against the medical practitioner under the *actio lex aquiliae* for the citizen's loss of the ability to work and the medical expenses incurred.⁴¹⁹

During the Roman-Dutch era, medical negligence was governed by legislation that provided for a medical practitioner who caused the death of a patient to be handed to the family of the patient to do with him as they pleased.⁴²⁰ Where the patient survived but suffered injury, the medical practitioner had to pay a fine to the family.⁴²¹

The common law system is the only available and most appropriate response to dealing with medical negligence in the contemporary times.⁴²² Today, where a patient suffers injury due to medical negligence, the patient or his/her family may choose to institute a civil claim to recover damages,⁴²³ and may file a criminal charge against the healthcare provider and could go further to lodge a complaint with the Health Professions Council against the healthcare provider involved for

⁴¹⁵ Ibid.

⁴¹⁶ M Swanepoel 'The development of the interface between law, medicine and psychiatry: Medico-legal perspective in history' (2009) 12 (4) *Potchefstroom Electronic Law Journal* 127.

⁴¹⁷ L Pienaar (note 340 above) 3.

⁴¹⁸ Ibid.

⁴¹⁹ D. Millard 'Loss of earning capacity: its nature and its place in the South African Law' unpublished MA dissertation, University of Johannesburg, 2005.

⁴²⁰ L. Pienaar (note 415 above).

⁴²¹ Ibid.

⁴²² 'Opportunity to comment on medico-legal claims system' *De Rebus* September 2017 (Sept) DR 3 available at <http://www.derebus.org.za/opportunity-comment-medico-legal-claims-system/> (accessed 21 May 2018).

⁴²³ Dsc Attorneys 'Suing a Doctor or Hospital in South Africa: What Are Your Rights?' available at <https://www.dsclaw.co.za/news/article/suing-doctor-or-hospital-south-africa-what-are-your-rights> (accessed 15 May 2018). The claim can be based on contract or delict depending on the type of damages that is sought to be recovered. Since non-patrimonial damages cannot be recovered in contract, a delictual claim will have to be instituted to recover non-patrimonial damages.

unprofessional conduct.⁴²⁴ The result of a finding of unprofessional conduct by the Health Professions Council may lead to the healthcare provider's name being removed from the register by the Health Professions Council.⁴²⁵ It is evident that a medical mishap or a mere allegation of such could lead to enormous consequences for a medical practitioner.⁴²⁶

The evolution of medical negligence law in South Africa would require progressive change, but this has not been evident in South African law.⁴²⁷ That is why there is a need for legislative intervention in South Africa because there is only an increase in medical negligence claims and not on the measures to reduce such claims. Recent data indicate that the country may be on the verge of a medical malpractice litigation storm. In 2009 – 2010, the Gauteng Department of Health and Social Development faced malpractice claims totalling R573 million.⁴²⁸ Some changes have related to an emphasis on informed consent, thereby moving away from the paternalistic approach, where the patient had to make a choice based on what the doctor decided to tell him, to the current position⁴²⁹ where the patient is autonomous and decides on the choice of treatment on the basis of being fully informed.⁴³⁰

Amendments to South African legislation, such as the Road Accident Fund (RAF) legislation, are also to blame. Claims for damages for personal injury resulting from a

⁴²⁴ Health Professions Council of South Africa 'Ethical and professional rules of the health professions council of South Africa as promulgated in government gazette R717/2006 – guidelines for good practice in the healthcare professions (Booklet 2) Pretoria' 2008 available at http://www.hpcsa.co.za/downloads/conduct_ethics/rules/generic_ethical_rules/booklet_2_generic_ethical_rules_with_anexures.pdf (accessed 13 June 2018).

⁴²⁵ A. Dhai & B. Mkhize 'The Health Professions Council of South Africa and the medical practitioner' (2006) 24 (1) *Clinical Medicine* available at <http://www.cmej.org.za/index.php/cmej/article/viewFile/281/170> (accessed 23 June 2018). The consequence of the removal of a medical practitioner's name from the register at the Health Professions Council, is that such medical practitioner will not be allowed to practice medicine.

⁴²⁶ 'Concept of medical negligence: an overview' available at <http://shodhganga.inflibnet.ac.in/bitstream/10603/145463/3/chapter%202.pdf> (accessed 23 June 2018). The negative emotional effect of medical negligence claims on medical practitioners. See also by Moore and Slabbert 2013 *SAJBL* 60.

⁴²⁷ N. Van Dokkum 'The evolution of medical malpractice law in South Africa' (1997) 41 (2) *Journal of African Law* 182.

⁴²⁸ MS MS Pepper, MN Slabbert, Is South Africa on the verge of a medical malpractice litigation storm? (2011) 4(1) *SAJBL* 29. Pepper, MN Slabbert, Is South Africa on the verge of a medical malpractice litigation storm? (2011) 4(1) *SAJBL* 29.

⁴²⁹ S.C. Chima 'Evaluating the quality of informed consent and contemporary clinical practices by medical doctors in South Africa: An empirical study' (2013) 1 (14) *BioMed Central Medical Ethics* 4 available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3878312/pdf/1472-6939-14-S1-S3.pdf> (accessed 08 June 2018).

See also P Carstens & D Pearmain *Foundational Principles of South African Medical Law* (2007) 156.
⁴³⁰ Ibid.

motor vehicle accident are now less profitable for lawyers,⁴³¹ causing some to turn to other forms of personal injury litigation like medical malpractice.⁴³² The high level of lawsuits in South Africa is partly due to the legal framework which governs and protects patients and healthcare providers.⁴³³

The current healthcare system relies on 'righting a wrong' through the courts, which by its nature is expensive and adversarial. The system should make provision for compensation without necessarily involving the courts.⁴³⁴ If it would not be possible to deal with such matters without the court, then having a specialized court would be a good idea.

Currently, there is no legislation that specifically deals with medical negligence cases. When approaching medical negligence cases, the courts rely on precedents. A number of cases have dealt with medical negligence and many principles have been outlined in such cases. The court reviews past cases to determine reasonable compensation and rulings, in addition to reviewing the evidence, circumstances, and the testimonies given.⁴³⁵ The only way in which the current state of the law can be modified is by means of enacting a new legislation regulating the.⁴³⁶

4.2.4 The Role of Lawyers

The role of the legal profession is mostly misunderstood and vilified.⁴³⁷ A human rights and consumer protection driven society aims to protect the civil liberties of its citizens, including the right to healthcare and the right to have a medical malpractice lawsuit decided by a court of law.⁴³⁸ Contingency fee litigation is the end-game in this quagmire but provides the checks and balances to realize these rights in society.⁴³⁹

⁴³¹ Money Marketing 'Medical malpractice litigation undermining SA's health system' 24 April 2018 available at <https://www.moneymarketing.co.za/medical-malpractice-litigation-undermining-sas-health-system/> (accessed 05 June 2018).

⁴³² Ibid.

⁴³³ Chima, (note 426 above).

⁴³⁴ Ibid.

⁴³⁵ Adele van der Walt Inc 'South African Medical Negligence Cases' available at <http://www.medicallaw.co.za/articles/south-African-medical-negligence-cases-012017.html> (accessed 12 June 2018).

⁴³⁶ 'Opportunity to comment on medico-legal claims system' De Rebus in 2017 (Sept) DR 3 available at <http://www.derebus.org.za/opportunity-comment-medico-legal-claims-system/> (accessed 21 May 2018).

⁴³⁷ Joseph's Incorporated 'Case studies Medical Malpractice: Liberty exists in proportion to wholesome restraint' available at <http://www.josephs.co.za/case-studies/> (accessed 17 June 2018).

⁴³⁸ Ibid.

⁴³⁹ Ibid.

Legal practitioners have been gravitating towards medical malpractice claims as a source of revenue after changes in compensation offered by the Road Accident Fund. The reasons for such changes are the unethical practices that were being engaged in by the legal practitioners.

The present researcher does not share the sentiment suggesting that the legal practitioners are one of the factors contributing to an increase in the number of medical negligence claims. Rather, they contribute to educating patients about their rights and how they can seek redress if their rights are infringed. The legal practitioners are able to prove negligence where it occurred, that is why the courts are awarding large amounts in damages to injured patients.⁴⁴⁰

4.2.5. Patients' awareness of their rights

Over the past decade, there has been a steady increase in the number of malpractice litigations brought against healthcare providers.⁴⁴¹ This has been attributed to an increase in the patients' awareness with regard to their rights in a setting of an overburdened health system with limited resources resulting in legitimate claims for compensation due to negligence.⁴⁴²

Now, there is an increased awareness amongst patients of their rights, and an encouragement to exercise them.⁴⁴³ This is partly due to the Health Professions Council of South Africa's (HPCSA) launch of a national campaign to raise awareness on patients' rights.⁴⁴⁴ Nobody could disagree with the need for patients to be better educated about their rights and responsibilities. But what can be challenged as Dr Kgosi Letlape, former acting head of the HPCSA, said; is an assumption that an

⁴⁴⁰ A. Jeffrey 'The NHI Proposal Risking Lives for No Good Reason' available at https://irr.org.za/reports/atLiberty/files/liberty_2014_issue-29_2014_the-nhi-proposal-2014-risking-lives-for-no-good-reaso....pdf (accessed 04 May 2018).

⁴⁴¹ T.A Brennan, L.L. Leape *et al* 'Incidence of adverse events and negligence in hospitalized patients: results of the Harvard Medical Practice Study' available at <https://qualitysafety.bmj.com/content/qhc/13/2/145.full.pdf> (accessed 21 April 2018)

⁴⁴² K. Cullinan 'Health services in South Africa: A basic introduction' available at https://www.health-e.org.za/wp-content/uploads/2013/04/Health_services_briefing_doc.pdf (accessed 12 May 2018)

⁴⁴³ D. Spence 'What happened to the doctor-patient relationship?' (2012) *British Medical Journal* 344 available at <https://www.bmj.com/content/344/bmj.e4349> (accessed 05 June 2018).

⁴⁴⁴ Health Professions Council of South Africa 'HPCSA embarks on health and human rights awareness campaign' 19 March 2012. http://www.hpcsa.co.za/downloads/press_releases/press-release-2012/health_and_human_rights_awareness_campaign_march.pdf (accessed 24 May 2013).

increase in complaints and claims is a direct result of a decline in professionalism.⁴⁴⁵ The increase in the cost of negligence claims stems from heightened patient awareness,⁴⁴⁶ and claimant lawyer's attention,⁴⁴⁷ as well as a deterioration in the quality of patient care provided by healthcare providers.⁴⁴⁸ The level of compensation awarded relates to the harm suffered and to the degree of negligence. The cost of patient care packages is also increasing as technology improves, which is affecting the size of awards in claims founded on negligence .

Action needs to be taken to address the costs and causes of negligence. To kick-start the campaign for change, the Department of Health has met with a number of organizations including insurers and indemnifiers to discuss working together to control these rising costs. The South African Law Reform Commission (SALRC) is also investigating the rise in medical negligence claims.⁴⁴⁹ The change will not be immediate, in the meantime, it is important for all healthcare professionals to ensure that their indemnity or insurance arrangements are robust enough to accommodate escalating costs and flexible enough to adjust to the new and unusual demands with which they are currently faced.

Awareness of patients of their rights can bring about a lot of advantages such as increased quality of health care services, decreased costs, more prompt recovery,⁴⁵⁰ decreased length of stay in hospitals, lower risk of irreversible physical and mental damages,⁴⁵¹ and more importantly, the increased dignity of patients through

⁴⁴⁵ News24 'Report medical malpractice – council'19 March 2012 <http://www.news24.com/SouthAfrica/News/Report-medical-malpractice-council-20120319> (accessed 24 May 2013).

⁴⁴⁶ G.R. Howarth 'The importance of comprehensive protection in today's healthcare environment' (2013) 7 (103) The South African Medical Journal available at <http://www.samj.org.za/index.php/samj/article/view/7106/5211> (accessed 15 June 2018),

⁴⁴⁷ Ibid.

⁴⁴⁸ Ibid.

⁴⁴⁹ The South African Law Reform Commission 'Medico-Legal Claims' 33 projects 141 20 MAY 2017 available at http://www.issa.org.za/upload/SALRC%20ip33_prj141_Medico-legal.pdf (accessed 13 May 2018)

⁴⁵⁰ R. Kieft, Brigitte BMJ de Brouwer et al 'How nurses and their work environment affect patient experiences of the quality of care: a qualitative study' available at <https://bmchealthservres.biomedcentral.com/track/pdf/10.1186/1472-6963-14-249> (accessed 12 May 2018).

⁴⁵¹ S.C. Slade, D. L Carey et al 'Effects of falls prevention interventions on falls outcomes for hospitalized adults: protocol for a systematic review with meta-analysis' available at <http://bmjopen.bmj.com/content/bmjopen/7/11/e017864.full.pdf> (accessed 16 June 2018).

informing them about their rights to participate in decision making.⁴⁵² On the other hand, lack of respect for patients' rights may lead to hazards and insecurity to the health situation of patients.⁴⁵³ Besides, it may ruin the relationship between the healthcare providers and patients that consequently decreases efficiency, effectiveness, and suitable care of the patient.⁴⁵⁴

One of the principles of medical governance that leads to quality of health services improvement is the patients' participation in the treatment process. This can be achieved only when patients are reasonably aware of their rights. However, with ever-increasing complexity in the health systems and fast growing medical technologies and methods, the awareness of patients of their rights is yet to spread to every patient in the country.

4.3. Chapter conclusion

This chapter discussed the reasons for the increasing medical negligence claims. The reasons expressed above are, no doubt, important to be looked at when considering putting in place mechanisms that can reduce the number of claims. The implementation of a mechanism must aim at promoting quality health care by ensuring patient safety.

The public healthcare system suffers from a range of systemic weaknesses that have an effect on the quality of care provided and has made it vulnerable to litigation. These weaknesses include the absence of legislation applicable to the medico-legal claims, a court system suitable for such claims and legal practitioners that are experts in the medical field. The next chapter presents the conclusion and recommendations of the study.

⁴⁵² Z. Mastaneh & L. Mouseli 'Patients' Awareness of Their Rights: Insight from a Developing Country' (2013) 1 (2) *International Journal of Health Policy and Management* 144.

⁴⁵³ Health Professions Council of South Africa 'Confidentiality: protecting and providing information' booklet 10 Pretoria May 2008 Available at http://www.hpcsa.co.za/Uploads/editor/UserFiles/downloads/conduct_ethics/rules/generic_ethical_rules/booklet_10_confidentiality_protecting_and_providing_information.pdf (accessed 23 June 2018).

⁴⁵⁴ Mastaneh & Mouseli (note 450 above).

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

The issue of medico-legal negligence and liability of the healthcare providers for injuries to the patients in South Africa set the framework of this research. The discussion focussed on the examination and analysis of the sources and effects of medical negligence in the healthcare system and patients' rights. Although some of the aspects in this research have already been researched on, this specific research area is still in its infancy and more research is still needed to address issues of negligence in the healthcare system.

5.1 Overview of the preceding chapters

Chapter one stated the problem, methodology and the purpose of the research that was undertaken. The problem outlined in that chapter is that there are many civil and disciplinary cases flowing from the negligent conduct of the medical personnel. At first, victims of medical negligence were failing to sue the healthcare system or practitioners due to high costs of litigation, however, that has now changed because of the contingency fees agreements that are concluded by the victims and their legal representatives. Since the inception of such agreements, the courts have been inundated with medical negligence cases and the value of such cases have continued to rise exponentially. This has badly affected the South African healthcare system.

The purpose of this study, as outlined in the first chapter, was to determine the extent to which the victims of medical negligence are protected under the law of the country. To actualise the above purpose, the researcher had to identify and examine factors causing the increase in medical negligence litigation.

Chapter Two discussed the concept of medical negligence and the elements that must be proved to establish the alleged negligence. The concept of medical negligence is discussed in detail. Instances where healthcare providers may be negligent are outlined and supported by case laws. The burden of proof in medical negligence cases lies with the plaintiff wherein all elements of a delict must be fully proved on preponderance of evidence. It is however a huge task to prove negligence in a court of law.

Forms of medical negligence were also part of the discussion in this chapter. These forms vary and they are grounds that victims of medical negligence rely on to bring their cases to the court of law. It was further stated that most healthcare providers fail to uphold their professional ethics and values. Most of these misconducts are as a result of the healthcare provider's lack of critical thinking and decision making skills.

Chapter Three outlined the patients' rights and statutes that are used when adjudicating on medical negligence cases. In this chapter, it became clear that the absence of a statute that specifically deals with medical negligence is a gap that must be filled. Having such legislation can help to reduce challenges that are being faced in the healthcare system. The transformation of Patients' Rights Charter into legislation must be prioritised. In this way, healthcare providers are likely to give more attention to such rights.

Furthermore, the challenge in the work environment is that healthcare providers do not notify or read out the rights to patients. In some healthcare institutions, such rights are pasted on the walls but illiterate people can neither read nor understand them. It is the duty of a healthcare provider to educate such people about their rights.

This research discovered that there are serious challenges associated with finding medical records to use in court as evidence of negligence against healthcare providers. The healthcare providers usually fail to properly keep patient's records. Another challenge is that hand written records may be hard to read and understand due to bad handwriting. Good quality medical records are essential components of safe and effective healthcare. Insufficient evidence becomes inadequate for evidential purposes in a court of law.

It also transpired from the research that failure to comply with medical ethics seems common among healthcare providers. This is so because all forms of medical negligence emanate from failing to follow the necessary steps and procedures when treating patients. Lack of professionalism or failure to adhere to medical ethics is commonly used by patients as ground for their cases before the court.

Chapter Four's central point was the discussion of factors that contribute to the rise in the number of medical negligence claims and values. It is clear from that chapter that for the healthcare system to tackle its problems, it must first examine the

causes. Again, it became clear that birth defects and brain injuries have risen drastically. Claims based on those incidents have attracted substantial compensation from the courts against healthcare providers and health institutions.

5.2 Recommendations

After scrutinizing various factors that are contributing to the increase in medical negligence claims and values, several recommendations are made here that can assist in minimizing incidences that give rise to such claims.

The first step should be to establish a task team to look into this matter in depth and make recommendations aimed at preventing, not only the number of medico-legal claims, but also the factors that give rise to such claims in the health sector. The task team should examine the reports of institutions such as HPCSA to find out the most common causes of these claims and their effects. After identifying the causes, it will be easier to come up with solutions.

South Africa is one of the countries that do not have special rules and procedures for medical negligence claims. The health sector must consider taking a similar approach to that followed in the Road Accident Fund claims. There should be law reforms for medical negligence claims. Legislation should be enacted to cover all aspects of medical negligence claims. This will be the only way in which a deviation from the common law would be possible through legislative intervention.⁴⁵⁵ The present state of this area of the law is unsatisfactory. It is clear from issues such as the inaccessibility of the law for the very people who need it most, the delays in finalising cases, the limits imposed by the nature of legal processes conducted in terms of the common law.⁴⁵⁶

There must be limit on amount that can be claimed for non-economic damages as a result of medical negligence even though it is difficult to place a value on the claim for pain and suffering. The Health Department pays different amounts for cases based on similar cause of action. Compensation should be calculated based on the healthcare provider's failure to uphold the standard of care required. Liability rules should be changed to reduce the size of payments through capping the damage

⁴⁵⁵ South African Law Reform Commission Issue paper 33 project 141 Medico-Legal Claims 20 May 2017 46.

⁴⁵⁶ Ibid.

awards. A law should be formulated which prohibit victims of medical negligence who have received compensation from also receiving disability grants.

Potential value of medical negligence cases come from the non-economic claims. The reasons for this are that lawyers work billable hours in cases of non-economic claims and such cases take time to be finalised, therefore, generating more fees than a case that is settled out of court. Capping will reduce a billable hour for lawyers and time period for trial will reduce. Health insurance premiums will also reduce because the healthcare providers will no longer be too risky to insure.

In California, the legislature introduced the Medical Injury Compensation Reform Act of 1975, or MICRA which tried to address a malpractice crisis. The law has destroyed the ability of large segments of California patients to file malpractice lawsuits.⁴⁵⁷ So the goal of its original supporters, which was to make malpractice cases harder to bring and cheaper to defend, has been gloriously realized.⁴⁵⁸ It will be useful to take a closer look at measures adopted by other countries.

Restoring good practice in the Health Department should also be considered when addressing this problem. The starting point would be implementing better self-monitoring strategies and peer review aimed at reporting challenges and errors not only to reduce the rate of inappropriate care and negligent injuries but also to establish a pattern of challenges that they encounter on daily basis.

Parliament should provide rules relating to alternative dispute resolutions such as settlement conference or mediation. Mediation has the advantage of shortening the period that it takes before a case is finalized on litigation. For example, the medical negligence case involving Nicholaas van Niekerk, at the Charlotte Maxeke Academic Hospital dragged from 2005 to 2012 in the South Gauteng High Court.⁴⁵⁹ The time spent in medical litigation is emotionally draining and unsympathetic to the parties to the dispute.

⁴⁵⁷ M.Hiltzik 'It's time to fix California's outdated medical malpractice law' available at <http://articles.latimes.com/2013/jul/09/business/la-fi-hiltzik-20130710> (accessed 23 November 2018).

⁴⁵⁸ Ibid.

⁴⁵⁹ Don Makatile, Gauteng's medical negligence shame available at <https://www.iol.co.za/news/gautengs-medical-negligence-shame-1911421> (accessed 23 January 2019).

The mediator should have basic knowledge about the field so as to facilitate the mediation process in a speedy manner. Alternatively, the mediation could be constituted by an accredited mediator, healthcare practitioner, interpreter and legal practitioner. This will allow the process to be effective leading to the satisfaction of all parties involved.

A specialized court that would sit regularly to deal with medical negligence cases should be instituted. Matters involving medical negligence should be adjudicated by judges who are experts or have obtained specific qualifications in medical and legal field. The judges in that court must be able to answer scientific questions involved in medical negligence cases in order to avoid judgements that will be clouded by sympathy and emotions due to failure to understand the underlying medical issues. The purpose of this court will be to deter frivolous litigation and prevent miscarriages of justice. The aim of this study was also to determine how best the victims of medical negligence can be protected under the law by holding healthcare providers delictually accountable for their negligent conduct that causes harm to patients.

Public education is also necessary to inform patients about their rights under such legislation. The regulating body of the healthcare providers should step up its regulatory responsibilities. There is a need to be proactive and not merely reactive. Those with inadequate qualifications and experience must be identified and be removed from the profession. Punishments by the HPCSA, caution, reprimand, and suspension for a certain period of time or a fine of a certain amount that are usually imposed by the HPCSA are simply inadequate to curb the numerous incidents of medical negligence. Continuous medical education for health service providers is advocated to assist the practitioners in updating their knowledge on the disease dynamics and modes of treatment.

5.3 Areas for future research

This work focussed on medical negligence and the considerations were directed at minimising, if not eradicating, such incidents in the medical field with particular attention to the protection of the interests of the patient. Future research could be directed at discovering the best way to make the healthcare providers more efficient

in the discharge of their responsibilities to patients. Focus should be on the government's role in providing healthcare education and equipping healthcare facilities since this is necessary to the attainment of a high level efficiency in the healthcare delivery.

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