2018 Medico-Legal Year in Review

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The healthcare industry is still in a state of flux and there remains much uncertainty because of significant proposed changes to the regulatory and legislative landscape. 2018 has set the stage for 2019 to be a challenging healthcare year.

All of the proposals so far are in Bill form and none of the laws have yet been finalised. This includes the draft National Health Insurance Bill and draft changes to the Medical Schemes Act. Most of the changes are aimed at addressing, as the Health Minister puts it, the “terrible twins of the healthcare system” – the high costs of private healthcare and the poor quality of public health services. Once the draft Bills have been tabled in Parliament and are passed, the industry, though it will probably be massively disrupted, will at least have clarity and certainty as to the future. It seems doubtful, however, that much progress will be made in 2019 in what is an election year; and where it appears there have been recent significant amendments to the NHI draft (not seen or considered in any broader or parliamentary consultative process) and the battle of ideologies regarding a national healthcare system continue both internally at a governing party level and industry level. To add to that, there has now been ministerial acknowledgement that financially the country is not in a position to implement the NHI as contemplated (certainly not on the timing as initially proposed).

Progress on the National Health Insurance system is set to proceed simultaneously with changes to the Medical Schemes industry. The legislative reforms to the medical scheme landscape aim to regulate medical schemes more heavily and attempt to bring them in line with the principle that medical schemes are not meant to be profit-making enterprises.

The amendments to the Medical Schemes Act will also heavily affect the medical scheme brokerage market, with some statements from the Minister of Health indicating that broking services in relation to medical aids will be abolished completely, or at least modified. There will likely be pushback from the industry, and this may affect the final changes. Brokers may have to explicitly justify the fees that they charge in relation to value provided, or at least somehow show that they actually contact their clients periodically.

The healthcare industry lives in an interconnected web of various pieces of legislation that do not always get dealt with holistically – in order to create the NHI, the Health Minister has identified at least 12 pieces of legislation that need to be amended, the Medical Schemes Act being only one of them. The draft NHI Bill seems to be moving forward, notwithstanding the latest unpublicised amendments (National Treasury has confirmed that the Bill will soon be tabled in Parliament) along with the amendments to the Medical Schemes Act.

The health market inquiry, conducted by the Competition Commission, will also have an impact on the medical scheme industry and on the private healthcare sector. The inquiry has been ongoing for over four and a half years and a preliminary report was only produced in July 2018, after the draft NHI Bill and draft changes to the Medical Schemes Act were put forward.

Those Bills may need to be re-looked at in order to align the drafts with the recommendations of the health market inquiry – otherwise what would have been the point of this years-long enquiry?

The inquiry broadly found that the private healthcare industry in South Africa is characterised by lack of competition, rising prices, minimal transparency and disempowered users of the healthcare system due to asymmetry of information.

They recommend changing medical scheme benefit options, in order to “increase comparability between schemes and increase competition” in the market. Increasing market transparency and improving competition through a supply side regulator are also recommended. How these recommendations will tie in to the NHI Bill and the Medical Schemes Act amendments are yet to be seen.

The inquiry report, coupled with the NHI and Medical Scheme drafts have done little to reassure an already skittish private healthcare industry, whose relationship with government has not been comfortable for years. Although having recently shown signs of improvement, this relationship is likely to remain challenging due to ideological differences and different views on funding. Everyone is agreed on the desirability of quality universal healthcare and accessibility of affordable healthcare for all. It is in how that is to be achieved where the differences arise.

We also have the Law Reform Commission inquiry into medical negligence and related litigation, ordered by the Health Minister, but recommendations from the commission are still awaited. The commission said in its discussion document that this is the "first step in the investigation into medico-legal claims against the state" and therefore it does "not contain clearly defined recommendations for law reform." That inquiry highlights the significant medico-legal challenges faced by the public health sector, and enormous contingent liabilities amongst all the provinces for medical malpractice claims. The private sector has its own challenges in dealing with increased costs and values of medical malpractice claims and professional indemnity insurance. Amendments to the State Liability Act were proposed this year to allow for (under certain conditions) payments of damages awarded against the State in instalments. That has been met by substantial opposition in submissions made to Parliament on the draft legislation. The objections are largely based on the alleged flaws in the financial benefits which would flow from such orders. As a matter of principle, whatever the economics may be, there is no reason not to legislate to also allow periodic payments in medico-legal damages awarded against private healthcare practitioners and facilities as well. An attempt this year to have the court develop the common law to allow for periodic payments of such damages was unsuccessful, essentially on the facts of the case raised, so it remains open for the appropriate case supported by the necessary evidence to convince the court to allow for such payments in the future.

Even assuming there are funds to implement NHI as envisaged, the scheme will be stillborn if the huge historical medico-legal exposure of public healthcare institutions is not resolved urgently together with the quality of healthcare provided. Starting with a clean slate (or at least a substantially clean slate) is necessary to avoid the situation where billions of Rands are taken from the health budget annually to resolved a large historical list, and current list of medico-legal claims, and which means that money is not spent on delivering and improving healthcare quality and facilities, creating a spiral of ongoing claims which the public healthcare sector will have difficulty in escaping. That requires the large number of historic claims to be dealt with innovatively, aggressively and urgently.

Every month delay makes it more and more difficult to resolve existing and new claims cost-effectively because with the passing of time records are lost, witnesses disappear or memories fade, expectations of the claimants harden, and the costs of medical interventions which may be needed to assist deserving claimants increase significantly.

In the courts, the highly litigious environment in the healthcare sector is also spurred on by huge awards – the appeal court in *Khoza v MEC for Health* in 2018 increased an award of general damages related to brain damage of a child, from R200 000 to R1.8 million.

NK obo ZK v Member of the Executive Council for Health of the Gauteng Provincial Government **(Supreme Court of Appeal)**

Summary

Date of judgment: 15 March 2018

Date of incident causing alleged harm: 25 May 2008

The patient was successful in her case against a public health institution. She claimed on behalf of her minor child, who suffered a brain injury during birth which resulted in the child being diagnosed with cerebral palsy. The injury could have been avoided but for negligent treatment during labour and delivery of the baby.

This case was an appeal against the amount (quantum) of damages awarded by the court. The appeal court substantially increased the amount of damages awarded to the patient.

The patient's claim was successful.

Judgment

A mother was successful in proving that the staff of a public health institution were negligent in treating her during labour and birth of her minor child. The negligent treatment led to the child's brain injury and diagnosis of cerebral palsy. This case involved the determination of the amount (quantum) of damages to be awarded to the mother and her child.

The lower court awarded general damages in the amount of R200 000, as well as damages for past and future medical expenses. The mother appealed this award, arguing that the amount for general damages should be increased. General damages are awarded for pain and suffering and loss of amenities of life.

Evidence was led to justify an increase in the award, including the fact that the child will be incontinent for his entire life. This will result in the perpetual use of nappies. The wet and soiled nappies will have to be changed by caregivers. Moreover, the experts said that the child experiences pain and discomfort as well as unhappiness and frustration with his situation. He will have to undergo physiotherapy, requiring the regular use of a hoist in later years. He dislikes being moved by others. He will lose his entire mobility when he is about 37 years old. He has difficulty eating and, at least to some extent, he is force-fed. This evidence was not disputed. The child is not in a state of "unconscious suffering".

The child's awareness of his suffering, albeit diminished by his reduced mental faculties, puts him in the "twilight" situation discussed in the oft-quoted case of *Marine & Trade Insurance Co Ltd v Katz NO [1979] AD*. That case held that in awards arising from brain injuries, although a person may not have "full insight into her dire plight and full appreciation of her grievous loss", there may be a "twilight" situation in which she is not a so-called "cabbage" and accordingly an award for general

damages would be appropriate. This case has been followed in numerous instances and confirms that the child is entitled to an award for general damages.

The court had regard to what the lower court considered in coming to its decision - in coming to its conclusions on the appropriate amount to award as general damages, the lower court said that the figure agreed between the parties relating to past, future and related medical and hospital expenses took the child's loss of amenities of life into consideration. Accordingly, the lower court held that a further award in that regard would be a duplication of compensation.

However, the appeal court said that compensation for pain and suffering – to the extent that one can ever "compensate" for it – is neither a duplication of the amount awarded for past and future medical and hospital expenses, nor for loss of amenities of life. Therefore, the appeal court held that the lower court was clearly wrong in regard to the "duplication" issue and, accordingly, its award must be interfered with. There is, moreover, a striking disparity between what the lower court had ordered and what the appeal court thinks should have been awarded.

Based on the evidence and with the use of comparative judgments, the court increased the award for general damages from R200 000 to R1.8 million.

Legal principles

The courts adopt a flexible approach to general damages, determined by the broadest general considerations, depending on what is fair in all the circumstances of the case. The court does not have to determine what the award will be used for (its purpose or function). They must consider the child's loss of amenities of life and his pain and suffering. With regard to compensation the court said that while money cannot compensate for everything lost, it does have the power to enable those caring for the child to try things which may alleviate his pain and suffering.

The courts generally look to past awards in cases with similar facts, in order to determine what a fair award could be. Past awards are merely a guide and are not to be slavishly followed, but they remain a guide nevertheless. The court noted that it is important that court awards, where the sequelae of an accident are substantially similar, should be consonant with one another, similar across the land. Consistency and predictability are important to the rule of law. This also facilitates the settlement of disputes as to quantum.

With regard to the percentage contingency deduction that should be applied to the award for medical expenses, even though the discount rate often cannot be assessed on any logical basis, the court said that nevertheless, in context, something more reasoned is required, not only if a court is to depart from the normal range of between 15 and 20 per cent, but also simply to take the median of what the respective parties asked for. Conjecture may be required in making a contingency deduction, but it should not be done whimsically.

Apart from the grand scale changes to the healthcare landscape, medical law continues to develop, with the courts grappling with issues ranging from the best interests of children (when it comes to the refusal by parents of medical treatment for their child, for instance) to the legality of euthanasia, for example. The courts did not satisfactorily resolve the question of the lawfulness of euthanasia when that last came before them. The law reform commission long ago proposed appropriate legislation to allow for euthanasia in certain circumstances. No health minister has had the political appetite to push for those suggested legislative reforms (neither did the Constitutional Court have any equivalent judicial appetite when it was seized of the matter). The recent charges against Professor Davidson for murder may bring the debate to a head and conclusion in the new year.

Looking at the medical negligence cases heard in the latter part of the year by the Supreme Court of Appeal, it is striking that most related to injuries to babies during birth. This is in keeping with the trend of obstetricians and gynaecologists being the most litigated against area of the medical profession. Notably, recent judgments (echoing earlier and other jurisdiction's judgments) recognise that an adverse health outcome does not in itself necessarily mean causative negligent conduct on the part of the relevant health professional – the courts are cautious to simply infer fault in those circumstances. Therefore, it has not been a one-way street of successful medical malpractice claims. In the past year the Courts dealt with a number of cases involving absent or incomplete records, with varying outcomes for the parties:

M obo M v Member of the Executive Council for Health of the Gauteng Provincial Government

(Gauteng HC)

Summary

Date of judgment: 20 April 2018

Date of incident causing alleged harm: 17 May 2010

The patient brought this claim in her representative capacity as the mother and guardian of a minor child, who allegedly suffered harm during birth due to the negligence of staff at a public health institution, which resulted in the child suffering from cerebral palsy.

The patient's claim was successful.

Judgment

The patient was the only witness regarding what happened to her on 17 May 2010, as well as her interaction with the nursing staff. The hospital and its staff did not provide any oral evidence at all.

The patient's evidence was that she suffered prolonged labour in a case where a caesarean section was indicated. She eventually gave birth via vaginal delivery, and the baby was stained with meconium. The baby suffers from cerebral palsy due to a birth injury (lack of oxygen to the brain during birth).

Apart from lack of monitoring of the foetus and lack of proper medical care, medical records were not available (they were either not kept or were lost), the nursing staff also treated the patient unprofessionally in telling her that her baby had died when in fact she had not. Further, the nurses were allegedly watching television when they should have been attending to the patient and told the patient to stop making a noise.

According to the Civil Proceedings Evidence Act 25 of 1965 "judgment may be given in any civil proceedings on the evidence of any single competent and credible witness." The patient's version was not countered by any other evidence and stood as the only version. The patient presented as a truthful, credible and reliable witness throughout.

In addition, the patient's version was corroborated extensively by the expert opinion of an obstetrician and gynaecologist, which was accepted as satisfactory in all material respects (and which evidence also remained unchallenged).

The patient succeeded in her claim.

Legal principles

The court commented on the undesirable conduct of the hospital's staff members relating to the absence of the relevant hospital records of the patient's pregnancy and delivery of her baby. No acceptable explanation was provided for the absence of such records.

Medical records are crucial and completely indispensable in the adjudication of cases such as this. The absence of records makes the adjudication of such cases extremely difficult. This deficiency may result in certain consequences (such as an inference drawn against the hospital).

The National Health Act 51 of 2003 obliges medical institutions to create and preserve medical records.

The hospital and its employees had both a constitutional and statutory obligation to make and keep meticulous clinical and hospital notes and records relating to the patient's treatment. The applicable provisions of the Health Act are peremptory.

Medical practitioners are also obliged to keep patients' medical records in terms of the Health Professions Council's Ethical Professional Guidelines. The guidelines also emphasise the importance and crucial nature of patients' records, particularly in the case of minor children, such as this case. With regard to the midwives and nursing staff who attended to the patient, their conduct would additionally be subject to the Guide for Maternity Care in South Africa, and the Rules of the South African Nursing Council issued under the Nursing Act 50 of 1978.

***HN v MEC for Health, KZN* (KZN HC)**

Summary

Date of judgment: 4 April 2018

Date of incident causing alleged harm: August 2012

The patient sued a public health institution for medical negligence in her personal capacity and on behalf of her minor son, who she alleged suffered a brain injury during birth which resulted in the minor child being diagnosed with cerebral palsy. The patient alleged that the injury could have been avoided but for negligent treatment during labour and delivery of the baby.

The patient's claim was successful.

Judgment

The court found that the most probable cause of the brain injury was due to a prolonged hypoxic ischaemic injury (lack of oxygen to the brain) due to distress caused by a prolonged active labour.

The other possible causes of the injury were discussed and discounted, with foetal distress and its consequences being the most probable cause of the child's condition.

The medical staff were negligent in failing to adequately monitor the patient and address the need for an urgent caesarean section to be performed, which could have avoided the injury. It seemed that there was no monitoring during the last few hours of labour (or alternatively no records were kept of those hours). The probabilities suggest that adequate monitoring would have made the foetal distress apparent. The fact that the medical staff knew that the patient was HIV positive meant that she was more susceptible to hypoxic ischaemic injuries and, therefore, the lack of monitoring was more serious.

Having clearly identified the urgent need for a caesarean section, the fact that it took an hour and a half for that procedure to be performed was outside acceptable time limits. This delay also represented substandard care.

The patient's claim was successful.

Legal principles

Regarding causation, the court noted that it is not necessary to determine conclusively as a matter of medical causation, that foetal distress was actually the cause of the harm. It is sufficient if it is the most probable cause that presents itself, since the burden of proof in civil cases is a balance of probabilities.

The court discussed the evidentiary value of hospital records in some detail.

At the start of the trial the parties had agreed that the medical records are what they purport to be, without being proof of the truth thereof. The question of admissibility and the evidentiary value to be given to these records was considered. The court also noted that records relating to crucial times during the labour process were incomplete or missing.

The defendant hospital kept the medical records. The court said that statements in the records favourable to the hospital are hearsay if the author of the records is not called to testify and, therefore, those records are not admissible. No application was made for the admission of that part of the records.

However, recordings favourable to the patient's case in establishing liability, made as part of the records kept by the hospital, are on a different footing. They constitute admissions made by the hospital and its employees in the ordinary course of discharging their duties and are binding against the hospital. The hospital's staff are obliged to record the medical position as it unfolded. They have an obligation to speak on behalf of the hospital and dispute what is recorded if it is incorrect. The hospital's legal counsel did not dispute this interpretation.

***Member of the Executive Council: Health and Social Development, Gauteng Province v M obo M* (Gauteng High Court)**

Summary

Date of judgement: 21 May 2018

Date of incident causing alleged harm: unclear on the judgment

The patient sued a public health institution for medical negligence. She alleged that the hospital's negligence caused her child's cerebral palsy. The patient was successful.

However, this case is an application by the MEC for Health and Social Development, Gauteng, to be allowed to appeal the judgment. The original judgment was delivered on 19 April 2017. One of the issues is that the court's approach to record keeping was "strange". This case also involves missing records.

The court allowed the appeal to proceed.

Therefore, the case will go to the Supreme Court of Appeal to be heard (on a date yet to be determined).

Judgment

The court said that the law on missing medical records must be determined.

The court emphasised that hospital records of the patient and her child in cases such as this are pivotal to the determination of the case. The MEC argued that the court conflated the failure to keep records with causal negligence, and this was incorrect. The court found that sufficient records were available to make the findings in respect of negligence and causation – but the court also found it appropriate to remind health institutions of their statutory duty to keep records. The court said the question whether missing records should bear on a finding of causation and negligence, is important and must be considered and clarified by the Supreme Court of Appeal. While the court was careful not to admit that it had drawn a negative inference against the MEC due to the missing records, the court implied that the missing records did bear weight in the judgment.

Because of the prospects of success and the legal questions around missing records that have not been settled, the court allowed the appeal.

The court noted that the number of medical negligence cases involving incomplete or absent records is on the rise. The public has an interest in the correctness and fairness of the outcome of these cases.

On a separate issue, the MEC's court papers were filed late. Condonation for late filing of the appeal application and leave to appeal was granted after considering the prospects of success of an appeal. However, granting condonation in this case does not imply that the suboptimal functioning of the State Attorney's office should be a general justification for delay in all cases. Each case should be assessed on its own facts.

Legal principles

The court considered the issue of incomplete or missing records. The hospital and the MEC contends that if records or documents are missing, they are simply missing. They argue that if something was not written down, it does not mean that it was not done. The MEC's argument was that due to the incomplete records, "we simply don't know" what happened.

A witness for the hospital (a nurse on duty on the day of the birth) conceded that if something which should have been recorded, was not recorded, it means it was not done. However, the MEC argued that as a matter of law, if something is not recorded, no adverse inference can be drawn.

The MEC therefore argued that leave to the SCA should be granted "to express definitive views on professional negligence, causation and, in that context, the role of incomplete recordkeeping. It cannot be law that, as has been prevalent in many provincial decisions, inadequate recordkeeping plays a role (albeit subjectively) in the conclusions of the fact-finder."

The MEC's position was that even though the loss of records amounts to a contravention of rules, regulations and legislation, it is irrelevant to the determination of causation and negligence.

The court found enough merit in the arguments raised by the MEC about recordkeeping to justify consideration by a higher court, particularly in respect of any weight the court may have attached to the missing or incomplete records in the determination of causation and negligence. In respect of the expert evidence also, there was sufficient merit in the MEC's arguments relating to the method employed by the experts and their reliance, if any, on the incomplete or missing records, to warrant a higher court's consideration.

No absolute certainty of success is required for leave to appeal to be granted. Furthermore, the number of medical negligence cases involving incomplete or absent records is on the rise. The public has an interest in the correctness and fairness of the outcome of these cases.

A number of judgments also dealt with the matters of negligence, causation, or the application or not of the *res ipsa loquitor*:

Clarke v MEC for Health Western Cape and Another **(Western Cape High Court)**

Summary

Date of judgement: 8 March 2018

Date of incident causing alleged harm: 30 November 2011

The patient sued a public health institution for injuries allegedly sustained by her when she underwent surgery to remove her gallbladder (cholecystectomy). The surgery was meant to be laparoscopic but was converted into an open cholecystectomy. The patient claimed that the doctors negligently caused an injury to her colon during the gallbladder surgery.

The patient could not prove that the doctors were negligent in any aspect of the surgery.

The patient's claim failed.

Judgment

The patient alleged that an injury to her colon was sustained, either caused by the surgeons during her gallbladder surgery, or that it was an injury the surgeons failed to notice and repair. It was alleged by the doctors that the type of injury sustained is an acceptable consequence of that type of surgery. Furthermore, they did not see any tears or injuries while operating. The patient had a lot of adhesions from prior surgeries, so it may have been possible to miss an injury.

The factual and expert evidence supported the view that the type of injury the patient sustained was not of such a nature that it would have been seen at the time of surgery. If it had been identified, it was more likely that the doctors would have repaired the injury. The expert witnesses could do no more than speculate as to what had happened during surgery. One of the factual witnesses was also an expert in his field and had assisted with a part of the surgery – his evidence was accepted as clear, concise and uncontroverted.

Negligence could not be proven and therefore the patient's claim failed.

Legal principles

With regard to expert evidence, the court noted that the evidence of eye witnesses (direct evidence) should be examined first. If that evidence is not credible or otherwise unacceptable, then the court is bound to decide which opinions of the various experts is preferable. The evidence provided by an expert is based on reconstruction and cannot bear the same weight as credible direct eyewitness testimony. This is important in medical negligence cases because the human body and its reaction to medical and surgical intervention is far too complex to recreate/reconstruct with certainty what could have occurred if the witness had not been present.

Therefore, in medical negligence cases, courts are very careful not to assume negligence just because there was a complication due to surgery or other medical intervention.

Furthermore, when expert witnesses hold diametrically opposed views, both based on logical reasoning, the court cannot merely express a preference for one over the other, and on that basis find that a medical practitioner has acted negligently. If a doctor acts in accordance with a reasonable and respectable body of medical opinion, they cannot be found negligent merely because another equally reasonable and respectable body of medical opinion would have acted differently.

As a side issue, the court noted that the patient also sought to take issue with lack of consent relating to the change in method of operation. However, the question of informed consent is part of the requirement of wrongfulness in delictual claims. The court said that since negligence is also a requirement, where no negligence has been proven, the question of wrongfulness does not arise.

***MEC for Health, Western Cape v Q* (Supreme Court of Appeal)**

Summary

Date of judgement: 28 September 2018

Date of incident causing alleged harm: 7 December 2011

The patient sued a public health facility for medical negligence on behalf of her minor child, who she alleged suffered a brain injury during birth, which resulted in the child being diagnosed with cerebral palsy. The patient alleged that the injury could have been avoided but for negligent treatment during labour and delivery of the baby.

The patient could not prove that there was a causal connection between the alleged negligent conduct of the nursing staff and the baby's cerebral palsy. The court found on the established facts and on logical and well-reasoned expert evidence that the baby had suffered an ante-natal injury

some weeks before labour was induced. Therefore, there was no causal link between the alleged negligence and the harm suffered.

The patient's claim failed.

Judgment

A baby girl was born presenting with clinical features of spastic quadriplegic cerebral palsy caused by damage to her brain. The baby's mother alleged negligent medical treatment to herself and the baby by the various public health practitioners, during her pregnancy and at the time of her child's birth.

The court considered the expert evidence presented on behalf of the parties and concessions made in evidence. The court cautioned against finding fault by relying on an expert opinion which is not based on logic simply because a patient suffered harm.

The court accepted the hospital's expert evidence that the extensive brain damage evidenced could only have developed over 4-5 weeks and it was unlikely that it was a result of an occurrence during delivery or a week before then. Among other things there was evidence of previous bleeding in the baby's brain. There was no trigger event during birth.

It is a firm principle of our law that a person who asserts a damage causing event must prove it. The legal duty owed by the medical staff treating the patient and her baby require that they adhere to the general level of skill and diligence possessed at the time by the members of the profession to which they belong. Only reasonable care and skill is required. The patient had to prove through credible and persuasive evidence, on a balance of probabilities that the doctors and nurses failed to adhere to the required standards.

The court found that the hospital's expert opinion evidence was founded on clearly established facts, logical and well-reasoned and that on all the evidence, the baby had suffered an ante-natal injury 34 weeks into the pregnancy or at least some weeks before labour was induced. The patient's expert conceded that the foetus was probably already compromised by these dates.

Consequently, there was no causal link between the alleged failure to intervene or any other alleged negligence and the damage suffered. Ultimately, not only the cause of the damage remained unidentified but also, it's timing.

Therefore, the mere fact that harm has been occasioned to a patient is not on its own proof that the medical staff had caused it or that they had done so negligently.

Legal principles

The expert evidence presented was central to determining the required level of care and whether that had been breached. Expert witnesses need to support their opinion with valid reasons. It is not the mere opinion of the witness that is decisive but their ability to satisfy the court because of their special skill, training and experience that their reasons for the opinion which they express are acceptable. The court must be satisfied that the opinion has a logical basis.

The court referred with approval to the earlier judgment of *Goliath v Member of the Executive Council for Health, Eastern Cape* and English judgments cautioning against the natural human tendency to find fault where an innocent patient is injured. *". . . we should be doing a disservice to the community at large if we were to impose liability on hospitals and doctors for everything that happens to go wrong…We must insist on due care for the patient at every point, but we must not condemn as negligence that which is only a misadventure".*

The Constitutional Court has also provided further clarity regarding prescription of medical malpractice claims:

***Loni v Member of the Executive Council, Department of Health, Eastern Cape, Bhisho* (CC)**

Summary

Date of judgment: 22 February 2018

Date of incident causing alleged harm: 10 August 1999

This case involved the question of whether a claim related to medical negligence in treating a gunshot wound had prescribed (expired). The claim was against a public health facility and its medical staff.

The patient had waited an unreasonably long time to launch his claim.

The patient's claim failed.

Judgment

The patient was treated for a gunshot wound by staff at a public health facility. He continued to suffer pain and eventually discovered that his leg was disabled. He sued the hospital for negligence in treating his wound, which he alleged led to his disability. However, his claim was only launched 7 years after the injury, because the patient claimed that he was unaware of his potential claim until he had consulted with another doctor some years after his injury.

The focus by the patient on his lack of knowledge of the development of osteitis (inflammation of the bone) was not the correct focus. The patient, on his own evidence, had received sub-standard care and treatment, had suffered harm as a result and this was plainly apparent to him long before the issue of osteitis arose.

The courts have said that it is not necessary for the extent of the harm to be known, the debt arises once harm has been suffered.

Objectively, a reasonable person in the position of the patient would have realised that the treatment and care which he had received was sub-standard and was not in accordance with what he could have expected from medical practitioners and staff acting carefully, reasonably and professionally. On an assessment of the patient's evidence, it is clear that by December 2000, he had already suffered significant harm (leaving aside the question of osteitis), and it would have been apparent from a reasonable assessment that the pain and suffering which he had endured was a direct result of the sub-standard care which he had received.

Legal principles

A patient usually has three years after suffering harm or loss to launch a claim, otherwise the claim expires (prescribes). However, there is an exception, if the patient did not know about the harm suffered or the identity of the person who caused the harm – the three-year period then starts to run only when they should reasonably have become aware of the harm or loss and the identity of the person causing the harm.

The correct interpretation of the relevant provisions of the Prescription Act were dealt with by the Constitutional Court in *Links v Member of the Executive Council, Department of Health, Northern Cape Province* [2016] CC.

In the *Links* case, the court found that for a party to successfully rely on a prescription claim in terms of section 12(3) of the Prescription Act, they must first prove "what the facts are that the applicant is required to know before prescription could commence running" and secondly, that the patient had knowledge of those facts. Therefore, in cases involving professional negligence, the facts from which the debt arises are those facts which would cause a patient, on reasonable grounds, to suspect that there was fault on the part of the medical staff and that caused him or her to "seek further advice". It would be unrealistic to expect someone, with no knowledge of medicine, to have knowledge of the facts of his condition, without seeking professional medical advice.

Until there are reasonable grounds for suspecting fault to cause the patient to seek further advice, the patient cannot be said to have knowledge of the facts from which the debt arises.

However, the facts in *Links* are distinguishable from the facts of this matter. In *Links*, the claimant plainly required expert medical opinion, firstly, in order to establish that the treatment that he had received had been negligent, and secondly, in order to draw the causative link between the harm suffered and the negligent treatment. It was in this context that the court in *Links* stated that it would be unrealistic to expect a litigant who has no knowledge of medicine to have knowledge of what caused his condition without having first had an opportunity of consulting a relevant medical professional or specialist for advice.

When the principle in *Links* is applied to the present facts, the patient should have, over time, suspected fault on the part of the hospital staff. There were enough indicators that the medical staff had failed to provide him with proper care and treatment, as he still experienced pain and the wound was infected and oozing pus. With that experience, he could not have thought or believed that he had received adequate medical treatment. Furthermore, since he had been given his medical file, he could have sought advice at that stage. There was no basis for him to wait more than seven years

to do so. His explanation that he could not take action as he did not have access to independent medical practitioners, who could explain to him why he was limping or why he continued to experience pain in his leg, did not help him either.

It is clear that long before the patient's discharge from hospital in 2001 and certainly thereafter, he had knowledge of the facts upon which his claim was based. He had knowledge of his treatment and the quality (or lack thereof) from his first day in hospital and had suffered pain continuously after that. This is the same information which caused him to ultimately seek further advice in 2011. The fact that he was not aware that he was disabled or had developed osteitis is not the relevant consideration.

The Supreme Court of Appeal in Suliman dealt with the very important issue of the duty of care of covering doctors:

Life Healthcare Group (Pty) Ltd v Suliman **(Supreme Court of Appeal)**

Summary

Date of judgment: 20 September 2018

Date of incident causing alleged harm: 12 July 2008

The patient sued a private hospital for medical negligence in her personal capacity and on behalf of her minor child, who she alleged suffered a brain injury during birth which resulted in the minor child being diagnosed with cerebral palsy. The patient alleged that the injury could have been avoided but for negligent treatment during labour and delivery of the baby. The hospital settled the patient's claim in the amount of R20 million and then sought a contribution in paying the claim, from the doctor who attended the patient's delivery.

The hospital was successful in proving that the doctor was contributorily negligent and therefore partially liable to settle the claim.

Judgment

The patient had contracted with an obstetrician and gynaecologist in private practice to attend to her during her labour and subsequent delivery of the baby.

After going into labour, she arrived at the hospital, but her doctor was unavailable. Her doctor had, however, planned with another doctor to cover for her (this covering doctor is the defendant in this case).

The covering doctor was called when the patient was admitted to hospital. He instructed the nurses telephonically to allow labour to proceed and to sedate the patient, if necessary. He also prescribed medication for managing pain and nausea.

A nurse phoned the doctor later to report a deceleration of the foetal heart rate but added that it recovered quickly. The doctor instructed the nurse to transfer the patient to the labour ward, that her membranes be ruptured and that an epidural be arranged. Further deceleration of the foetal heart rate occurred but was not reported to the doctor. He still had not arrived at the hospital to examine and attend to the patient.

The doctor eventually arrived 20 minutes after being informed that the patient was fully dilated.

On his arrival, he looked at the CTG and realised that the foetus had been in distress for some time and that delivery was a matter of urgency. Time was now of the essence. He needed a vacuum extractor which is used to assist in the delivery. The nurse on duty could not find it, and when she did eventually find it, it became clear that she could not use it. The doctor then asked for forceps but, once again, the nurse was unable to find them. The birth of the baby was delayed by another 20 to

25 minutes. The baby was born after an episiotomy was performed. On delivery the baby was born “flat”, in the language of the medical community, meaning that he was not breathing and barely had a heartbeat. Clearly, he had suffered birth hypoxia, the deprivation of oxygen. He was resuscitated and oxygen was administered, but a little later it was discovered that he had developed cerebral palsy.

The hospital settled the claim with the patient but then argued in court that the attending covering doctor must contribute to the damages awarded, since his negligence had contributed to the harm suffered.

In determining whether the doctor was liable the court said that the real issue between the doctor and the hospital was not whether his earlier attendance upon the patient would have prevented the harm, but whether he was under an obligation to attend earlier. All the evidence shows that it is more probable than not that had the doctor attended the hospital earlier the injuries would have been avoided. For that reason, the hospital succeeded in proving factual causation on a balance of probabilities.

Further, the court said that the attitude of the doctor that he had no doctor-patient relationship with the patient (since he was merely covering for a colleague) was too lackadaisical and legally and morally indefensible.

The court found that the doctor’s duty of care to the patient arose when the patient was admitted to the hospital and the doctor responded positively to that notification.

The doctor manifested his responsibility by giving instructions to the nurse. His conduct of getting involved in the treatment of the patient placed him in a position to be responsible for her and the baby.

The court also found the doctor negligent because a reasonable obstetrician would have visited the patient shortly after admission and conducted his own observations.

The court found the suggestion that the patient was not visited earlier because the covering doctor did not want to interfere with the personal relationship she had with her doctor as it would cause anxiety on her part and that he did not regard her as his patient to be unacceptable: “If this is not gross negligence, then it is difficult to imagine what would be.”

On the evidence it was found that the doctor’s negligence was also causative of the cerebral palsy. The correct question to be asked was: “Was it more probable than not that the birth injuries suffered by the baby could be avoided, if (the doctor) had attended the hospital earlier, after the 18h35 phone call?” The court found that had he done so he would have noticed the non-reassuring tracings on the CTG and would have seen the early signs of foetal distress and according to his own evidence, would have conducted an emergency caesarean that would have avoided the birth injury to the baby. That was also the view of the other medical experts, who agreed on when the brain damage probably occurred and found that there was time enough to intervene successfully.

Therefore, the court found that there was contributory negligence on the part of the doctor and that the doctor’s negligence was greater than that of the nursing staff. The doctor was the specialist who abdicated his duties especially after receiving the phone call at 18h35 and had adopted a hands-off approach. A 40-60 apportionment in favour of the hospital was made.

Legal principles

The court found that the doctor's duty of care to the patient arose when the patient was admitted to the hospital and the doctor responded positively to that notification. The fact that he was a covering doctor did not alter this duty. His conduct of getting involved in the treatment of the patient placed him in a position to be responsible for her and the baby.

The court found that a reasonable obstetrician would have visited the patient shortly after admission and conducted his own observations. He would have met with the patient at her time of admittance to create the doctor-patient relationship and to assure her that in the absence of her own doctor he would be standing in and would take good care of her.

The NHI Bill, the amendments to the Medical Schemes Act, the Competition Commission inquiry into the private health market and the Law Reform Commission investigation into public health medico-legal claims are some of the big issues that need to be finalised. Together they signal huge changes to and challenges for the healthcare industry. For now, these strands are not being woven together properly – they must all be brought together in order to coherently and practically reform the healthcare industry.

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