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MEDICAL MALPRACTICE AND COMPENSATION IN SOUTH AFRICA

L.C. COETZEE* AND PIETER CARSTENS**

I. THE OVERALL SCHEME FOR PREVENTING AND REDRESSING MEDICAL ERRORS AND ADVERSE EVENTS, INCLUDING REGULATION, CRIMINAL AND CIVIL LIABILITY, AND SOCIAL AND PRIVATE INSURANCE, AND THE RELATIONSHIPS AMONG THESE VARIOUS SYSTEMS

A. *Regulatory Methods*¹

1. Government Licensing Authorities for Doctors and Hospitals

The practice of the medical profession in the Republic of South Africa is primarily regulated by a number of statutory enactments.² The most important statute governing medical practice is the Health Professions Act.³ The Act provides for the establishment of the Health Professions Council of South Africa (HPCSA), 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.”⁴ Briefly, the Act provides for control over the education, training, registration, and practices of a variety of health professionals.⁵

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1. See generally P. CARSTENS & D. PEARMAIN, FOUNDATIONAL PRINCIPLES OF SOUTH AFRICAN MEDICAL LAW 249–81 (2007); Sybrand A. Strauss, *South Africa*, in INTERNATIONAL ENCYCLOPAEDIA OF LAWS 45–58 (Herman Nys ed., 2007).

2. Apart from the provisions of the Constitution of the Republic of South Africa, 1996, and the provisions of the common law.

3. Health Professions Act 56 of 1974.

4. *Id.* §§ 2, 3.

5. *Id.* § 3. The Act can be characterised as the “charter” of the medical practitioner in South Africa. However, it also governs the practice of dentistry, psychology, and a variety of supplementary health services apart from nursing, midwifery, pharmacy, homeopathy, chiropractic, traditional healing and the like. *Id.* § 17. Ministerial regulations governing topics ranging from the registration of students through disciplinary control over professionals have been promulgated from time to time under the Act.

The Health Professions Act provides for the establishment of “a professional board with regard to any profession in respect of which a register is kept in terms of [the] Act,” by the Minister of Health acting on the recommendation of the HPCSA.⁶ Twelve such boards have thus far been established.⁷ Within the context of the present discussion, the Medical and Dental Professional Board (MDPB)—responsible for all registered medical and dental practitioners, and the training of medical and dental students⁸—needs to be mentioned specifically. Legally, the professional boards fall under the overall control of the HPCSA, although, *de facto*, they function largely independently.⁹

No person may practise within the Republic of South Africa as a medical practitioner unless he or she is registered in terms of the Health Professions Act.¹⁰ The Minister of Health may, on the recommendation of the HPCSA and the relevant professional board, “by regulation define the scope of any other health profession registrable in terms of [the Health Professions] Act by specifying the acts which shall for the purposes of the application of [the] Act be deemed to be acts pertaining to that profession.”¹¹ Such regulation may only be made, however, after the relevant professional board “has been given the opportunity of submitting . . . recommendations as to the definition of the scope of the profession in question.”¹²

The Health Professions Act prohibits any person from practising within South Africa any health profession the scope of which has been defined by the Minister, unless he or she is registered in terms of the Act in respect of such profession.¹³ Contravention of this provision amounts to an offence¹⁴ which is punishable by a fine or imprisonment for a period not exceeding twelve months, or both a fine and such imprisonment.¹⁵

The HPCSA is the statutory regulatory body responsible for exercising control over medical practitioners, dentists, psychologists, and certain categories of medical personnel, such as physiotherapists, radiographers, medi-

6. *Id.* § 15.

7. *Professional Boards*, HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA, http://www.hpcsa.co.za/board_overview.php (last visited Apr. 15, 2011).

8. *Professional Boards: Medical & Dental*, HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA, http://www.hpcsa.co.za/board_meddent.php (last visited Apr. 15, 2011).

9. Strauss, *supra* note 1, at 45.

10. Health Professions Act § 17(1)(a).

11. *Id.* § 33(1).

12. *Id.*

13. *Id.* § 34(1). This prohibition is subject to the provisions of sections 32(c) and 39. *Id.*

14. *Id.* § 34(2).

15. *Id.* § 39(2).

cal technologists, optometrists, and emergency care personnel. Our courts have recognised that the HPCSA is in effect the sole repository of the power to decide what is ethical and what is unethical in medical practice.¹⁶ The HPCSA is also acknowledged as:

[T]ruly a statutory *custos morum* of the medical profession, the guardian of the prestige, status and dignity of the profession and the public interest in so far as members of the public are affected by the conduct of members of the profession to whom they had stood in a professional relationship.¹⁷

The HPCSA has wide powers under the Health Professions Act, and may, inter alia, perform the following actions: “render financial assistance to professional boards to enable them to perform their functions”; consider, after consultation with the relevant professional board, “any matter affecting the professions registrable with the [HPCSA]”; consistent with national health policy determined by the Minister, “make representations or take such action in connection therewith as the [HPCSA] deems advisable”; “delegate to any committee or any person such of its powers as it may from time to time determine”; and “make rules on all matters which the [HPCSA] considers necessary or expedient in order that the objects of [the Health Professions] Act may be achieved.”¹⁸ Importantly, the HPCSA is empowered to establish such committees as it may deem necessary,¹⁹ including disciplinary committees, and is obliged to establish ad hoc disciplinary appeal committees.²⁰ It may delegate to any committee such of its powers as it may from time to time determine, but is not divested of any power so delegated.²¹ The HPCSA derives its income from registration, examination, annual, and any other fees, payable in terms of the Health Professions Act.²² The HPCSA is further responsible for recommending to the Minister of Health the establishment of “a professional board with regard to any health profession in respect of which a register is kept in terms of [the Health Professions] Act.”²³

16. *Pretorius v. Suid-Afrikaanse Geneeskundige & Tandheeskundige Raad* 1980 (2) SA 354 (T) at 358–59; cf. *S. African Med. & Dental Council v. Shapiro* 1954 (2) SA 578 (T) at 587; *Groenewald v. S. African Med. Council* 1934 TPD 404 at 410, 416.

17. *Veriava v. President of S. African Med. & Dental Council* 1985 (2) SA 293 (T) at 307; see also *De la Rouviere v. S. African Med. & Dental Council* 1977 (1) SA 85 (N) at 97; *Phathela v. Chairman Disciplinary Comm. S. African Med. & Dental Council* 1995 (3) SA 179 (T) at 182; *Groenewald* 1934 TPD at 410.

18. Health Professions Act § 4(a)–(f).

19. *Id.* § 10(1)(a).

20. *Id.* § 10(2).

21. *Id.* § 10(1)(b).

22. *Id.* § 13.

23. *Id.* § 15(1).

The professional boards also have wide powers under the Act, *inter alia*, the removal and restoration of names to and from a register, and the suspension of a registered person from practising his or her profession pending the institution of a formal inquiry; the appointment of examiners and moderators, the conducting of examinations, and the granting of certificates; the approval of training schools; the considerations of any matter affecting any profession falling within the ambit of the professional board, and the making of representations or the taking of such action in connection therewith as the professional board deems advisable; and the recognition of local and foreign qualifications.²⁴

Professional boards have the “power to institute an inquiry into any complaint, charge or allegation of unprofessional conduct against practitioners registered under [the Health Professions] Act.”²⁵ In practice, professional boards do not conduct such inquiries themselves, but appoint a professional conduct committee to do so.²⁶ The Act defines “unprofessional conduct” essentially as “improper or disgraceful or dishonourable or unworthy conduct.”²⁷ On finding the practitioner guilty of such conduct, the committee may impose one or other of the following penalties:

- (a) a caution or a reprimand or a reprimand and a caution; or
- (b) suspension for a specified period from practising or performing acts specially pertaining to his profession; or
- (c) removal of his or her name from the register;^[28] or
- (d) a fine not exceeding R10 000;^[29] or
- (e) a compulsory period of professional service as may be determined by the professional board; or
- (f) the payment of the costs of the proceedings or a restitution.³⁰

24. *Id.* § 15B.

25. *Id.* § 41.

26. *Id.* Such a committee is appointed by a professional board by virtue of its powers under section 15(5)(f) of the Act read with the regulations published in Government Notice R979 of 13 August 1999. See also section 15(5)(A), which has been inserted into the Act after the promulgation of the regulations.

27. *Id.* § 1.

28. The effect of a suspension or removal from the register is that the person concerned is disqualified from carrying on his or her profession and that his or her registration certificate is deemed to be cancelled until the period of suspension has expired or until his or her name has been restored to the register by the professional board. *Id.* § 44. If an appeal is lodged against a penalty of erasure or suspension from practice, such penalty remains effective until the appeal is heard. *Id.* § 42(1A).

29. If, on reasonable grounds, the professional board is of the opinion, upon investigation of the complaint, charge or allegation of unprofessional conduct against a registered practitioner, that it will impose a fine on conviction after an inquiry, the registered practitioner may be given the option of an admission of guilt and payment of such fine. *Id.* § 42(8), (9).

30. *Id.* § 42(1)(a)–(f).

Any person who is aggrieved by a decision of the HPCSA, a professional board, or a disciplinary appeal committee, may appeal to the appropriate division of the High Court.³¹

2. Medico-Ethical Codes of Conduct

“Although courts of law are clearly not bound by medico-ethical codes of conduct and medical practices when determining liability for medical malpractice, the ethical precepts and prevailing practices of the medical profession will be an important consideration in ascertaining what constitutes medical malpractice.”³² There are several national and international medico-ethical codes of conduct that govern the conduct of doctors and the practice of medicine. In South Africa, the HPCSA must, “in consultation with a professional board, from time to time make rules specifying the acts or omissions in respect of which the professional board may take disciplinary steps.”³³ These rules of conduct—the Ethical Rules of Conduct for Practitioners Registered Under the Health Professions Act³⁴—constitute the most important national medico-ethical code of conduct. It is important to note, however, that the professional board’s power of inquiry is not limited to acts or omissions specified in these rules.³⁵

31. *Id.* § 20(1).

32. Strauss, *supra* note 1, at 40–41; *see also* CARSTENS & PEARMAIN, *supra* note 1, at 264.

33. Health Professions Act § 49(1).

34. Proc R717 in GG29079 of 4 Aug. 2006. We do not intend to discuss in detail the rules of conduct, but merely wish to mention the categories of rules currently pertaining to doctors and dentists in general. These categories are the following: advertising and canvassing or touting; information to be included on professional stationery; the naming of a practice; itinerant practice; fees and commission; partnership and juristic persons; covering; supersession; impeding a patient from obtaining the opinion of another practitioner or from being treated by another practitioner; casting reflections on the professional reputation of colleagues; professional confidentiality; retention of human organs; the signing of official documents; certificates and reports and the information they should contain; issuing of prescriptions; professional appointments; secret remedies; defeating or obstructing the council or board in the performance of its duties; performance of professional acts; exploitation; medicine; financial interest in hospitals; reporting of impairment or of unprofessional, illegal or unethical conduct; research, development and use of chemical, biological and nuclear capabilities; and dual registration. Another medico-ethical code of conduct worth mentioning is the guidelines on ethics for medical research of the South African Medical Research Council (MRC). The MRC guidelines—the last complete edition of which was the third revised edition, published in 1993—are currently being reviewed. The following five booklets have thus far been published: BOOK 1: GUIDELINES ON ETHICS FOR MEDICAL RESEARCH: GENERAL PRINCIPLES (2002); BOOK 2: GUIDELINES ON ETHICS FOR MEDICAL RESEARCH: REPRODUCTIVE BIOLOGY AND GENETIC RESEARCH (2002); BOOK 3: GUIDELINES ON ETHICS FOR MEDICAL RESEARCH: USE OF ANIMALS IN RESEARCH AND TRAINING (2004); BOOK 4: GUIDELINES ON ETHICS FOR MEDICAL RESEARCH: USE OF BIOHAZARDS AND RADIATION (2002); BOOK 5: GUIDELINES ON ETHICS FOR MEDICAL RESEARCH: HIV PREVENTIVE VACCINE RESEARCH (2003).

35. Health Professions Act § 49(1).

3. Reporting of Medical Errors and Adverse Events to the Health Profession Council of South Africa

Under the Ethical Rules of Conduct for Practitioners Registered Under the Health Professions Act,³⁶ a student, intern or practitioner is obliged to “report any unprofessional, illegal or unethical conduct on the part of another student, intern or practitioner.”³⁷ Of course, prevention is better than finding a cure, and, to this end, the Rules provide that a student, intern, or practitioner must “report impairment in another student, intern or practitioner to the board if he or she is convinced that such student, intern or practitioner is impaired,”³⁸ and must:

[R]eport his or her own impairment or suspected impairment to the board concerned if he or she is aware of his or her own impairment or has been publicly informed, or has been seriously advised by a colleague to act appropriately to obtain help in view of an alleged or established impairment.³⁹

“Impairment” is defined in the rules to mean “a mental or physical condition which affects the competence, attitude, judgment or performance of professional acts by a registered practitioner.”⁴⁰

B. Liability Systems

The relationship between doctor or hospital and patient is essentially governed by private law, and, to be more precise, the law of contract and the law of delict (tort).⁴¹ However, public-law considerations are growing in importance in the wake of the introduction of the 1996 Constitution and national legislation. The majority of the South African population depends on the public sector for health care.⁴²

36. Proc R717 in GG29079 of 4 Aug. 2006.

37. *Id.* R. 25(1)(c). Neither “unprofessional conduct” nor “unethical conduct” is defined for the purposes of these rules. It is submitted that, since a practitioner is required under Rule 21 to “perform, except in an emergency, only a professional act (a) for which he or she is adequately educated, trained and sufficiently experienced; or (b) under improper conditions and in appropriate surroundings,” *id.* R. 21, conduct in contravention of Rule 21 will be regarded as unethical conduct that should be reported to the professional board.

38. *Id.* R. 25(1)(a).

39. *Id.* R. 25(1)(b).

40. *Id.* R. 1.

41. Strauss, *supra* note 1, at 59.

42. CARSTENS & PEARMAIN, *supra* note 1, at 283.

1. Contract⁴³

A patient who consults a doctor in private practice enters into a contractual relationship with the doctor, and a patient who presents for medical treatment at a hospital enters into a contractual relationship with the relevant (private or provincial) hospital authority. In the latter instance, both the hospital authority and the staff of the hospital (including the doctors) may incur liability for the negligent conduct of the hospital employees.⁴⁴

No legal formalities are required for the conclusion of the contract between doctor or hospital and patient. The contract comes into being by mere consensus between the parties,⁴⁵ but, in practice, both private and state hospitals usually require their patients to sign an admission form and require written consent for surgery. The contract may be concluded expressly or tacitly, and may be written or oral.⁴⁶ Doctors in private practice normally enter into tacit agreements with their patients.⁴⁷

Express agreements between doctor or hospital and patient are not unusual, especially in cases of specialised procedures. Where no express agreement has been reached, the implied terms of the contract between the parties will depend upon the specific circumstances of the case.⁴⁸ Usually, the implied agreement between doctor and patient entails that the doctor undertakes 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 medical practitioner in the particular branch of the profession possesses, and with the amount of care that may reasonably be expected from such a practitioner.⁴⁹ The doctor ordinarily undertakes to act in accordance with the recognised, accepted, customary, or usual practices of medicine.⁵⁰ Any unusual procedures contemplated by the medical practitioner should first be discussed with the patient.

43. See generally CARSTENS & PEARMAIN, *supra* note 1, at 283–88; N.J.B. CLAASSEN & T. VERSCHOOR, MEDICAL NEGLIGENCE IN SOUTH AFRICA 115–18 (1992); INTRODUCTION TO MEDICO-LEGAL PRACTICE 5 (Mahomed A. Dada & David J. McQuoid-Mason eds., 2001); Strauss, *supra* note 1, at 59–64; S.A. STRAUSS & M.J. STRYDOM, DIE SUID-AFRIKAANSE GENEESKUNDIGE REG [THE SOUTH AFRICAN MEDICAL LAW] 104 (1967).

44. INTRODUCTION TO MEDICO-LEGAL PRACTICE, *supra* note 43, at 5.

45. CLAASSEN & VERSCHOOR, *supra* note 43, at 115.

46. Strauss, *supra* note 1, at 60.

47. *Id.*

48. *Id.*

49. *Id.*

50. *Id.* (citing *Van Wyk v. Lewis* 1924 AD 438 at 448, 469–70; *Allot v. Paterson & Jackson* 1936 SR 221 at 224; cf. *Collins v. Adm'r, Cape* 1995 (4) SA 73 (C) at 81–82; *Coppen v. Impey* 1916 CPD 309 at 314; *Kovalsky v. Krige* (1910) 20 CTR 822 at 823; *Buls v. Tsatsarolakis* 1976 (2) SA 891 (T) at 893; *Clinton-Parker v. Adm'r, Transvaal* 1996 (2) SA 37 (W) at 56, 58; *Applicant v. Adm'r, Transvaal* 1993 (4) SA 733 (W) at 738.) Diagnosis and treatment are not always involved, as the contract may also

Ordinarily, by taking on a case, a doctor or hospital does not guarantee that the patient will be cured or that the intervention will be a success; of course, the possibility of an express or implied warranty to that effect does exist.⁵¹ In the normal course of events, the doctor undertakes no more than to treat or operate upon the patient with due competence, care, and skill—namely, that which may be expected from a medical practitioner in the particular branch of the profession.⁵²

A doctor or hospital that fails to perform in accordance with, or that departs or deviates from, the express or implied terms of the contract, commits a breach of contract.⁵³ Since medical practitioners are expected to exercise reasonable skill and care, it will amount to breach of contract for a medical practitioner to perform his or her duties in a negligent manner.⁵⁴

Breach of contract may result in the doctor or hospital being held liable for patrimonial loss, or in the doctor or hospital being unable to recover a fee for services rendered.⁵⁵ However, non-pecuniary (non-patrimonial) damages cannot be recovered in contract.⁵⁶ Specific performance is not a likely remedy, since the doctor renders a personal service to the patient.⁵⁷

The medical practitioner cannot unilaterally withdraw from the agreement once treatment has commenced.⁵⁸ Once the treatment has been completed, the agreement comes to an end and the doctor can no longer be

involve medical examinations for non-therapeutic interventions (such as cosmetic surgery, experimentation, or prophylactic measures) or medical examinations for other purposes such as employment. *Id.* at 61 n.2.

51. Strauss, *supra* note 1, at 61 (citing *Van Wyk* 1924 AD at 456; *Coppen* 1916 CPD at 314; *Kovalsky* 20 CTR at 823; *Verhoef v. Meyer* 1975 (T), 1976 (A) (unreported); *Chalk v. Fassler* 1995 (W) (unreported); *Behrmann v. Klugman* 1988 (W) (unreported); *cf. Buis* 1976 (2) SA at 893 (question raised but not answered)); *see also* SYBRAND A. STRAUSS, DOCTOR, PATIENT AND THE LAW: A SELECTION OF PRACTICAL ISSUES 35–36, 41, 176–77 (1991).

52. *Id.*; *see also* INTRODUCTION TO MEDICO-LEGAL PRACTICE, *supra* note 43, at 5, 22; STRAUSS, *supra* note 51, at 41.

53. Strauss, *supra* note 1, at 62. Examples of such conduct would include where a doctor other than the one agreed upon performs the medical intervention, or where the medical intervention differs from the one agreed upon. *Id.* at 62 n.2 (citing STRAUSS & STRYDOM, *supra* note 43, at 107; *Burger v. Adm'r, Kaap* 1990 (1) SA 483 (C), *Recsei's Estate v. Meine* 1943 EDL 277).

54. CLAASSEN & VERSCHOOR, *supra* note 43, at 116.

55. Strauss, *supra* note 1, at 62 (citing *Recsei's Estate* 1943 EDL 277; *McCallum v. Hallen* 1916 EDL 74; *Sutherland v. White* 1911 EDL 407; *Hewatt v. Rendel* 1925 TPD 679; *cf. Oates v. Niland* 1914 CPD 976; *Kruger v. Boltman* 1933 (1) PH A 3 (E); *Shiels v. Minister of Health* 1974 (3) SA 276 (RA)).

56. *Id.* (citing *Adm'r, Natal v. Edouard* 1990 (3) SA 581 (A) at 590, 593; *Edouard v. Adm'r, Natal* 1989 (2) SA 368 (D) at 385; *cf. Jansen van Vuuren v. Kruger* 1993 (4) SA 842 (A) at 848–49).

57. *See Myers v. Abramson* 1952 (3) SA 121 (C) at 124.

58. CLAASSEN & VERSCHOOR, *supra* note 43, at 117. Note, however, that in terms of section 20 of the National Health Act, a “health care provider may refuse to treat a [patient or client] who is physically or verbally abusive or who sexually harasses him or her.” National Health Act 61 of 2003 § 20(4).

expected to attend to the patient.⁵⁹ An undertaking on the part of a doctor to examine a patient and to diagnose his or her condition does not amount to an undertaking on the part of the doctor to personally treat the patient.⁶⁰ A doctor may refer the patient to another doctor for treatment without fear of being held liable for breach of contract.⁶¹ In fact, a failure to refer a patient to a specialist when the doctor lacks the necessary knowledge or skill to treat the patient may amount to negligence.⁶²

2. Delict (Tort)⁶³

In terms of the law of delict, doctors and hospitals are expected to exercise reasonable care to prevent harm from occurring to their patients.⁶⁴ Should a patient suffer damage or loss as a result of a doctor or hospital's wrongful failure to take reasonable care, the doctor or hospital may incur liability for negligence.⁶⁵ A doctor or hospital that intentionally violates the patient's physical integrity may be held liable for assault, whilst a doctor or hospital that intentionally violates the patient's privacy may incur liability for *injuria*.⁶⁶

The State Liability Act makes provision for delictual liability of the state.⁶⁷ Vicarious liability of the state is recognised in that a delictual claim against the state shall be cognisable by a court of law if the claim arises out of any wrong committed by any servant of the state acting in his capacity and within the scope of his authority as such.⁶⁸ Both patrimonial loss and non-pecuniary damages are recoverable in delict.⁶⁹

59. Strauss, *supra* note 1, at 63 (citing *Kovalsky v. Krige* (1910) 20 CTR 822 at 822); CLAASSEN & VERSCHOOR, *supra* note 43, at 117.

60. CLAASSEN & VERSCHOOR, *supra* note 43, at 117.

61. *Id.*

62. *Id.*; INTRODUCTION TO MEDICO-LEGAL PRACTICE, *supra* note 43, at 5.

63. See generally CARSTENS & PEARMAIN, *supra* note 1, at 489; CLAASSEN & VERSCHOOR, *supra* note 43, at 118–24; INTRODUCTION TO MEDICO-LEGAL PRACTICE, *supra* note 43, at 22; Strauss, *supra* note 1, at 64–65; STRAUSS & STRYDOM, *supra* note 43, at 159.

64. Strauss, *supra* note 1, at 64–65 (citing *Correia v. Berwind* 1986 (4) SA 60 (Z) at 66; cf. *Michael v. Linksfield Park Clinic (Pty) Ltd.* 2001 (3) SA 1188 (SCA); *Van Wyk v. Lewis* 1924 AD 438 at 443–44, 455–56; *Collins v. Adm'r, Cape* 1995 (4) SA 73 (C) at 81).

65. *Id.* at 64.

66. *Id.* at 64–65.

67. State Liability Act 20 of 1957 § 1.

68. *Id.*

69. Strauss, *supra* note 1, at 63 (citing *Adm'r, Natal v. Edouard* 1990 (3) SA 581 (A) at 590, 595; *Edouard v. Adm'r, Natal* 1989 (2) SA 368 (D) at 389; *Clinton-Parker v. Adm'r, Transvaal* 1996 (2) SA 37 (W); cf. *Jansen van Vuuren v. Kruger* 1993 (4) SA 842 (A) 848–49; *Collins v. Adm'r, Cape* 1995 (4) SA 73 (C) at 83; *Pringle v. Adm'r, Transvaal* 1990 (2) SA 379 (W)).

3. Criminal Law⁷⁰

The relationship between doctor or hospital and patient is not governed directly by criminal law. However, there are various common-law crimes that the doctor may conceivably commit in the course of practising medicine, including murder,⁷¹ culpable homicide,⁷² assault,⁷³ criminal defamation,⁷⁴ *crimen iniuria*,⁷⁵ fraud,⁷⁶ perjury,⁷⁷ and contempt of court.⁷⁸ Culpable homicide—which in South African law is defined as the negligent and unlawful causing of the death of another human being⁷⁹—is by far the most relevant of these. In South African law, the conduct of a doctor who intentionally contributes to, or causes the death of, a patient, amounts to murder. Active euthanasia is therefore regarded as murder.⁸⁰ Because culpable homicide is the only common-law crime for which the proof of negligence (as opposed to intention) is sufficient, it is the only common-law crime for which a professionally negligent practitioner can be held liable.⁸¹ In South African case law, conviction of culpable homicide resulted, for instance, from a negligent over-prescription of medicine,⁸² a blood transfusion performed on the wrong patient,⁸³ an excessive amount of contrast

70. See generally CLAASSEN & VERSCHOOR, *supra* note 43, at 127–28; Strauss, *supra* note 1, at 65; STRAUSS & STRYDOM, *supra* note 43, at 338.

71. C.R. SNYMAN, CRIMINAL LAW 447 (5th ed. 2008) (“Murder is the unlawful and intentional causing of the death of another human being.”).

72. *Id.* at 451 (“Culpable homicide is the unlawful, negligent causing of the death of another human being.”).

73. *Id.* at 455 (“Assault consists in any unlawful and intentional act or omission (a) which results in another person’s bodily integrity being directly or indirectly impaired, or (b) which inspires a belief in another person that such impairment of her bodily integrity is immediately to take place.”).

74. *Id.* at 475 (“Criminal defamation consists in the unlawful and intentional publication of matter concerning another which tends seriously to injure his reputation.”).

75. *Id.* at 469 (“*Crimen iniuria* consists in the unlawful, intentional and serious violation of the dignity or privacy of another.”).

76. *Id.* at 531 (“Fraud is the unlawful and intentional making of a misrepresentation which causes actual prejudice or which is potentially prejudicial to another.”).

77. *Id.* at 343 (“Perjury consists in the unlawful and intentional making of a false statement in the course of a judicial proceeding by a person who has taken the oath or made an affirmation before, or who has been admonished by, somebody competent to administer or accept the oath, affirmation or admonition.”).

78. *Id.* at 325 (“Contempt of court consists in unlawfully and intentionally (a) violating the dignity, repute or authority of a judicial body or a judicial officer in his judicial capacity; or (b) publishing information or comment concerning a pending judicial proceeding which has the tendency to influence the outcome of the proceeding or to interfere with the administration of justice in that proceeding.”).

79. *Id.* at 451.

80. *S v. Hartmann* 1975 (3) SA 532 (C).

81. Ferdinand F.W. van Oosten, *Professional Medical Negligence in Southern African Legal Practice*, 5 MED. & L. 17, 22 (1986).

82. See, e.g., *R v. Van Schoor* 1948 (4) SA 349 (C); *S v. Mkwetshana* 1965 (2) SA 493 (N); *R v. Van der Merwe* 1953 (2) PH 1124 (W).

83. *S v. Berman* 1996 (T) (unreported).

medium administered to a baby,⁸⁴ failure to insert an endotracheal tube correctly and to monitor the patient properly during anaesthesia,⁸⁵ and failure by a general practitioner to call in a specialist obstetrician when complications set in during delivery.⁸⁶

Statutory crimes that may be perpetrated by a doctor in the course of practising medicine include those created under the Inquests Act,⁸⁷ the Human Tissue Act,⁸⁸ the Births and Deaths Registration Act,⁸⁹ the Choice on Termination of Pregnancy Act,⁹⁰ the Sterilisation Act,⁹¹ the Mental Health Care Act,⁹² the National Health Act,⁹³ and the Children's Act.⁹⁴

4. Relationship Between the Liability Systems

The relationship between doctor or hospital and patient is ordinarily of a contractual nature.⁹⁵ Where no contract is formed between the parties,⁹⁶ the relationship between them is governed by the law of delict.⁹⁷ However, the same act or omission by a doctor or hospital may result in both contractual and delictual liability since a breach of a duty of care and negligence may constitute both breach of contract and a delict.⁹⁸

A breach of contract or the commission of a delict by a doctor may, in addition, result in criminal liability where the doctor's wrongful conduct

84. S.A. Strauss, *Oormatige Toediening van Kontrasmiddel: Strafbare Manslag [Excessive Administration of Contrast Medium: Culpable Homicide]*, 8 (1) S. AFR. PRAC. MGMT. 27 (1987) (citing *S v. Bezuidenhout* 1985 (A) (unreported)).

85. *S v. Kramer & Another* 1987 (1) SA 887 (W).

86. S.A. Strauss, *Versuim van Geneesheer om Spesialis-Verloskundige by Probleem-Bevalling in te Roep, Stel Nalatigheid Daar [Failure of General Practitioner to Call in Specialist Obstetrician in Case of Complicated Delivery Constitutes Negligence]*, 9 (1) S. AFR. PRAC. MGMT. 7 (1988) (citing *S v. Nel* 1987 (T) (unreported)).

87. Inquests Act 58 of 1959 § 20.

88. Human Tissue Act 65 of 1983 § 34.

89. Births and Deaths Registration Act 51 of 1992 § 31.

90. Choice on Termination of Pregnancy Act 92 of 1996 § 10.

91. Sterilisation Act 44 of 1998 § 9.

92. Mental Health Care Act 17 of 2002 § 70.

93. National Health Act 61 of 2003 §§ 57(5), 89.

94. Children's Act 38 of 2005 § 305.

95. Strauss, *supra* note 1, at 59.

96. *Id.* at 59 n.2 (providing the example of an emergency where urgent, life-saving treatment is performed on an unconscious patient) (citing *Stoffberg v. Elliott* 1923 CPD 148 at 150).

97. *Id.* at 59. It is still being debated whether a so-called "constitutional delict" exists in our law. See CARSTENS & PEARMAIN, *supra* note 1, at 556–67; Strauss, *supra* note 1, at 59 n.3; Deborah Louise Pearmain, A Critical Analysis of the Law of Health Service Delivery in South Africa 825–37 (Nov. 2004) (unpublished LLD thesis, University of Pretoria).

98. Strauss, *supra* note 1, at 59 (citing *Van Wyk v. Lewis* 1924 AD 438 at 438, 443, 450–51, 455–56; *Adm'r, Natal v. Edouard* 1990 (3) SA 581 (A) at 585; *Castell v. De Greef* 1994 (4) SA 408 (C) at 420, 425; *Edouard v. Adm'r, Natal* 1989 (2) SA 368 (D) at 389; *Correia v. Berwind* 1986 (4) SA 60 (Z) at 63, 66).

satisfies the requirements of the definition of a common-law crime.⁹⁹ Common-law crimes that may overlap with a breach of contract or the commission of a delict by the doctor include murder, culpable homicide, assault, criminal defamation, *crimen injuria*, and fraud.¹⁰⁰

C. Compensation Systems

No social insurance system for medical malpractice or adverse medical events exists in South Africa. There is also no compensation scheme for criminally caused injuries. Those wishing to recover from private practitioners or institutions have no alternative but to institute proceedings either in contract or delict in a court of law. Most of these cases will be settled out of court.¹⁰¹

Those wishing to recover from a state institution, whether in contract or delict, can do so in terms of the State Liability Act.¹⁰² This might be more difficult than one would imagine. In *Nyathi v. MEC for Department of Health, Gauteng*,¹⁰³ the applicant sought confirmation by the Constitutional Court¹⁰⁴ of a declaration by the High Court that the provisions in section 3 of the State Liability Act that “[n]o execution, attachment or like process shall be issued against a defendant or respondent in any such action or proceedings or against the property of the State”¹⁰⁵ was unconstitutional and invalid.¹⁰⁶ The salient facts of this case are indeed very disconcerting. On August 1, 2002, “the applicant suffered 30% second- and third-degree burn wounds after a paraffin stove was thrown at him.”¹⁰⁷ He was admitted to the Pretoria Academic Hospital for treatment on the same day.¹⁰⁸ “[A] central venous line was incorrectly inserted into his right *carotis communis* artery.”¹⁰⁹ On the next day, he was transferred to Kalafong Hospital where the medical staff “failed to timeously diagnose the incorrect insertion of the central venous line.”¹¹⁰ As a result of the conduct of the medical staff at the

99. Strauss, *supra* note 1, at 65.

100. *Id.*; see also *supra* notes 71–79 and accompanying text.

101. See *infra* note 244 and accompanying text.

102. State Liability Act 20 of 1957 § 1.

103. 2008 (5) SA 94 (CC).

104. Under section 172(2)(a) of the Constitution of the Republic of South Africa, 1996.

105. State Liability Act 20 of 1957 § 3.

106. The constitutional validity of the provision was challenged “on the basis that it violated, inter alia, the rights to equality and dignity, enshrined in [sections] 9 and 10 of the Constitution [of the Republic of South Africa, 1996], respectively.” *Nyathi* 2008 (5) SA at 95.

107. *Id.* at 99.

108. *Id.*

109. *Id.*

110. *Id.*

two hospitals, the applicant suffered a stroke and severe left hemiplegia which left him in need of full-time care and medical treatment.¹¹¹ He “used to receive a social grant of R570 per month and his wife’s total monthly income was R1600.”¹¹² The two of them “had to support their four children and provide for their daily living expenses.”¹¹³

On July 25, 2005—almost three years later—the applicant instituted an action in the High Court against the Member of the Executive Council for Department of Health (MEC), “claiming damages in the sum of R1,496,000 for the pain caused by the stroke and disability suffered as a result of the negligent and improper care he received at the two hospitals.”¹¹⁴ After initially resisting the applicant’s claim, the MEC later admitted liability.¹¹⁵ “The only remaining issue was the amount payable to the applicant.”¹¹⁶ More than a year later, on July 27, 2006, “the applicant’s attorneys wrote to the State Attorney stating that the applicant’s health was deteriorating rapidly,” that he “urgently required treatment and medication,” and that he “could not afford to pay the necessary medical and legal costs while the hearing scheduled for [May 23, 2007,] was pending.”¹¹⁷ They requested that an interim payment of R317,700 be made within fourteen days, failing which they would approach the court for relief.¹¹⁸ On August 3, 2006, the State Attorney reported that it had referred the matter to the MEC and that the MEC had asked for one week within which to pay.¹¹⁹ Twenty days later, the State Attorney advised the applicant’s attorneys that the MEC was taking issue with paying the requested amount as an interim payment instead of a final payment.¹²⁰ The MEC “requested that payment be deferred until the trial court had decided the issue of costs.”¹²¹

“In September 2006, having received no further response from the [MEC], the applicant lodged an application in terms of Uniform Rule 34A,” which provides for an application for an interim payment,¹²² “and

111. *Id.*

112. *Id.*

113. *Id.*

114. *Id.*

115. *Id.*

116. *Id.*

117. *Id.*

118. *Id.*

119. *Id.* at 100.

120. *Id.*

121. *Id.*

122. UNIFORM RULES OF COURT, R. 34A(1) (“In an action for damages for personal injuries or the death of a person, the plaintiff may, at any time after the expiry of the period for the delivery of the notice of intention to defend, apply to the court for an order requiring the defendant to make an interim

served it on the State Attorney during October 2006.”¹²³ “The matter was unopposed and the court ordered the [MEC] to make an interim payment to the applicant in the amount of 317,700 and to pay the applicant’s costs on the attorney and client scale.”¹²⁴ On December 1, 2006, “[t]he applicant, having received no payment, sent a copy of the court order together with a letter to the State Attorney,” stating “that should the first respondent fail to comply with the court order within the prescribed 30-day period, the applicant’s attorneys would proceed with an application to compel him to do so.”¹²⁵ The MEC failed to comply with the court order.¹²⁶

The Constitutional Court confirmed the order of constitutional invalidity of the court *a quo* and suspended the declaration of invalidity for a period of twelve months to enable Parliament to pass legislation providing for the effective enforcement of court orders.¹²⁷ The court held that section 3 unjustifiably differentiated between the state and private judgment debtors.¹²⁸ It did not afford a judgment creditor who had secured judgment against the state the same protection and benefit afforded to a judgment creditor who had secured judgment against a private litigant.¹²⁹ Furthermore, section 3 placed the state above the law, as it did not positively oblige the state to comply with court orders.¹³⁰ The Court further held that section 3 violated the constitutional rights to dignity¹³¹ and access to courts.¹³² Having found that the limitation imposed on these rights by section 3 was not reasonable and justifiable as intended in the Constitution’s limitation clause,¹³³ the court proceeded to assess the effectiveness of the existing procedures to secure the satisfaction of judgment debts, which it considered essential in determining whether section 3 was constitutionally compliant.¹³⁴ The existing provisions designed to assist judgment creditors in claiming from the National Revenue Fund and the Provincial Revenue

payment in respect of his claim for medical costs and loss of income arising from his physical disability or the death of a person.”).

123. *Nyathi* 2008 (5) SA at 100.

124. *Id.*

125. *Id.*

126. *Id.*

127. *Id.* at 123.

128. *Id.* at 109.

129. *Id.* at 107.

130. *Id.* This was held to be incompatible with the plain language of sections 8, 34, 165(4), and 165(5) of the Constitution of the Republic of South Africa, 1996. *Id.*

131. *Id.* (citing S. AFR. CONST., 1996, § 10)).

132. *Id.* (citing S. AFR. CONST., 1996, § 34)).

133. *Id.* at 110 (citing S. AFR. CONST., 1996, § 36(1)).

134. *Id.* at 111.

Fund¹³⁵ did not contain sufficiently accessible and simple procedures for the payment of judgment debts. Therefore, they did not constitute a reasonable fulfillment of the state's constitutional obligations and failed to deal with how court orders were to be satisfied.¹³⁶

In his judgment, Justice Madala (for the majority) remarked that "deliberate non-compliance with or disobedience of a court order by the State detracts from the 'dignity, accessibility and effectiveness of the courts.'" ¹³⁷ He also pointed out that "[t]he applicant was made to wait for an extremely long time for money required to pay for his treatment" without which "he stood a very slim chance of survival."¹³⁸ Although "[t]he State was made fully aware of this very desperate situation, [it] provided no relief," which showed a lack of "recognition for his worth and importance as a human being."¹³⁹ "Having waited for many months, the applicant eventually received interim payment" once he approached the Constitutional Court, but he "only lived a short while thereafter."¹⁴⁰ Justice Madala added that "[r]eliance on the State's goodwill and moral standards has in this case proved to be futile."¹⁴¹

In his review of the response of our courts to section 3, Justice Madala made the following pronouncements:

An assessment of the cases that have dealt with the Act and the liability of the State for its negligent actions have revealed that courts have been facing immense challenges in this area of the law. The various High Courts have approached the matter very differently and with disparate consequences. However, the common denominator is that judicial officers have recognised that there is a serious problem caused by the fact that a judgment creditor who obtains an order sounding in money, may find that order unenforceable against the State.

In more recent years, and in particular the period from 2002 onwards, courts have been inundated with situations where court orders have been flouted by State functionaries, who, on being handed such court orders, have given very flimsy excuses which in the end only point to their dilatoriness. The public officials seem not to understand the integral role that they play in our constitutional State, as the right of access

135. *Id.* at 112. The provisions are contained in the Public Finance Management Act 1 of 1999 and the attendant Treasury Regulations. See GN R225 in GG27388 of 15 Mar. 2005.

136. *Nyathi* 2008 (5) SA at 113.

137. *Id.* at 108.

138. *Id.* at 109.

139. *Id.*

140. *Id.*

141. *Id.*

to courts entails a duty not only on the courts to ensure access but on the State to bring about the enforceability of court orders.¹⁴²

He expressed his dissatisfaction with the conduct and attitude of certain state officials in no uncertain terms:

In my view there can be no greater carelessness, dilatoriness or negligence than to ignore a court order sounding in money, even more so when the matter emanates from a destitute person who has no means of pursuing his or her claim in a court of law. But we now have some officials who have become a law unto themselves and openly violate people's rights in a manner that shows disdain for the law, in the belief that as State officials they cannot be held responsible for their actions or inaction. Courts have had to spend too much time in trying to ensure that court orders are enforceable against the State precisely because a straightforward procedure is not available.¹⁴³

1. Sufficient Insurance Cover To Be Required for Private Health Establishments

Once section 46 of the National Health Act comes into operation, it will require every private health establishment to maintain insurance cover sufficient to indemnify a user for damages that he or she might suffer as a consequence of a wrongful act by any member of its staff or by any of its employees.¹⁴⁴ In the terminology of the Act, "user" means a patient or certain other parties such as a minor patient's parent, or in the case of a person who is incapable of taking decisions, his or her spouse or partner, adult siblings, and other specified persons.¹⁴⁵ "Health establishment" is defined in the Act as "the whole or part of a public or private institution, facility, building or place, whether for profit or not, that is operated or designed to provide inpatient or outpatient treatment, diagnostic or therapeutic interventions, nursing, rehabilitative, palliative, convalescent, preventative or other health services."¹⁴⁶ This definition is drafted in such wide terms that it includes also the practice of private practitioners. Although most private hospital networks do have professional indemnity insurance, once section 46 of the Act comes into operation, it will become mandatory, and failure to comply will hold the risk of criminal sanction. Hospitals will therefore be responsible for maintaining sufficient insurance cover for staff, such as nurses, whereas medical practitioners attending to

142. *Id.* at 113 (citations omitted).

143. *Id.* at 114.

144. National Health Act 61 of 2003 § 46.

145. *Id.* § 1.

146. *Id.*

patients at the hospital will be responsible for their own insurance cover as they are independent contractors.

2. Private Indemnity (Medical Protection Society)

More than 26,000 medical practitioners in South Africa belong to the Medical Protection Society (MPS).¹⁴⁷ The organisation has been in South Africa for over fifty years.¹⁴⁸ There are various differences between the medical indemnity offered by an organisation such as the MPS, and that offered by commercial insurers.¹⁴⁹ The MPS is a not-for-profit mutual organisation offering discretionary indemnity to their members (even in unusual circumstances).¹⁵⁰ The MPS offers unlimited cover for legal problems arising from medical practice,¹⁵¹ whereas commercial insurers will usually provide limited cover only. The MPS will not deny cover in respect of activities involving a contravention of the provisions of criminal law,¹⁵² whereas the fine print of a commercial insurance policy may do just that. The MPS provides cover even where the medical practitioner's membership has lapsed, provided the membership dues were paid up at the time of the incidence which led to the claim,¹⁵³ whereas commercial insurers may make cover conditional upon the policy still being valid at the time the medical practitioner issued. The MPS further provides legal advice and representation to members in a wide range of circumstances, including legal representation and advice from specialists in the field of medical litigation, and assist member to resolve specific ethical and medico-legal dilemmas as they arise in their practice.¹⁵⁴

147. *About MPS*, MEDICAL PROTECTION SOCIETY, <http://www.medicalprotection.org/southafrica/guide/about-mps> (last visited Nov. 4, 2010). MPS also claims to have over 270,000 members worldwide. *Id.*

148. *Id.*

149. STRAUSS, *supra* note 51, at 247–48; *About MPS*, MEDICAL PROTECTION SOCIETY, <http://www.medicalprotection.org/southafrica/guide/about-mps> (last visited Nov. 4, 2010).

150. *About MPS*, *supra* note 149.

151. *MPS Indemnity*, MEDICAL PROTECTION SOCIETY, <http://www.medicalprotection.org/southafrica/guide/mps-indemnity> (last visited Nov. 4, 2010).

152. *Unusual Requests for Assistance*, MEDICAL PROTECTION SOCIETY, <http://www.medicalprotection.org/southafrica/guide/unusual-requests-for-assistance> (last visited Nov. 4, 2010). Importantly, medical negligence resulting in the death of a patient would constitute the crime of culpable homicide. In the section on criminal law, a number of offences that doctors may commit in the course of practising medicine have been mentioned. *See supra* Part I.B.3.

153. *MPS Indemnity*, *supra* note 151.

154. *Benefits of Membership*, MEDICAL PROTECTION SOCIETY, <http://www.medicalprotection.org/southafrica/guide/benefits-of-membership> (last visited Nov. 4, 2010).

D. Relationships Among the Compensation Systems, the Liability Systems, and the Regulatory Systems

The Inquests Act provides for all matters pertaining to the holding of an inquest following the death (or suspected death) of a person from what is believed to be a cause other than a natural one.¹⁵⁵ In the medical malpractice context, the Act plays an important role in the initiation of criminal proceedings for culpable homicide or murder against a medical practitioner who has caused the death of a patient in a negligent or intentional manner. The Inquests Act provides that any person who has reason to believe that any other person has died due to other than natural causes must report this to a policeman.¹⁵⁶ The Health Professions Act provides that the death of a person undergoing a therapeutic, diagnostic, or palliative procedure, or the death of a person as a result of such a procedure, shall not be deemed to be a death from natural causes as contemplated in the Inquests Act.¹⁵⁷ The same applies if any aspect of such a procedure has been a contributory cause of the person's death.¹⁵⁸ The effect of this provision is that an inquest must be held following such a death before a death certificate can be issued. A policeman who has reason to believe that any person has died from other than natural causes must investigate or cause to be investigated the circumstances of the death and report the death to the magistrate of the district concerned.¹⁵⁹ The policeman investigating the circumstances of the death must submit a report thereon, together with all relevant statements, documents, and information, to the public prosecutor.¹⁶⁰ If criminal proceedings are not instituted in connection with the death, the public prosecutor must submit those statements, documents, and information submitted to him to the magistrate of the district concerned.¹⁶¹ If on the information submitted to him it appears to the magistrate that the death was not due to natural causes, he must ensure that an inquest as to the circumstances and cause of the death is held by a judicial officer.¹⁶² Importantly, if the judicial

155. Inquests Act 58 of 1959 § 2(1).

156. *Id.* § 2. In view of the focus of this enquiry, no attempt shall be made to set out the relevant sections of the Inquests Act in detail. The provisions of the Act that may have a bearing on inquests to be held following an unnatural death at the hands of a medical practitioner will be set out and only to the extent strictly relevant to the present study.

157. Health Professions Act 56 of 1974 § 56.

158. *Id.*

159. Inquests Act § 3(1)(a)–(b).

160. *Id.* § 4. The public prosecutor may, if he deems it necessary, call for any additional information regarding the death. *Id.*

161. *Id.* § 5(1).

162. *Id.* § 5(2). The judicial officer responsible for holding such an inquest is stipulated in section 6. *Id.* § 6.

officer who held the inquest finds that the death was brought about by any act or omission prima facie involving or amounting to an offence on the part of any person, he must cause the record of the proceedings to be submitted to the Director of Public Prosecutions within whose area of jurisdiction the inquest was held.¹⁶³ When the record of any inquest that has been submitted¹⁶⁴ to an Director of Public Prosecutions is no longer required by such Director of Public Prosecutions, it must be returned to the magistrate of the district in which the inquest was held.¹⁶⁵ In terms of section 19(2) of the Inquests Act, such record is deemed to form part of the records of the magistrate's court of the district wherein the inquest was held.¹⁶⁶ The provisions of the Inquests Act do not prevent the institution of criminal proceedings against any person in connection with any death, whether or not an inquest has commenced in respect of such death.¹⁶⁷

Where a registered practitioner has, either before or after registration, been convicted of any offence by a court of law, the professional board is empowered to institute an inquiry if it is of the opinion that such offence constitutes unprofessional conduct.¹⁶⁸ Such practitioner is liable upon conviction of one or other of the penalties mentioned in section 42 of the Health Professions Act.¹⁶⁹ In terms of section 45(1), however, before the imposition of any penalty, such practitioner must be afforded the opportunity of tendering an explanation to the council in extenuation of the conduct in question.¹⁷⁰ The court that has convicted a registered practitioner of an offence must, where there appears to be prima facie proof of unprofessional conduct, direct that a copy of the record of its proceedings be transmitted to the professional board.¹⁷¹

In *Suid-Afrikaanse Geneeskundige & Tandheelkundige Raad v. Strauss*, it was held that, notwithstanding the use of the words "before the imposition of any penalty" in the proviso of section 45(1), the accused doctor should, after proof of his or her conviction in a court of law, be afforded the opportunity to put his or her defence to the charge of unprofessional conduct.¹⁷² The court reasoned that "a strictly literal interpretation of

163. *Id.* § 17(1)(b).

164. *Id.* § 17.

165. *Id.* § 19(1).

166. *Id.* § 19(2).

167. *Id.* § 21(1).

168. Health Professions Act 56 of 1974 § 45(1).

169. *Id.*

170. *Id.*

171. *Id.* § 45(2).

172. 1991 (3) SA 203 (A) at 212.

section 45(1) would lead to a disciplinary inquiry being eroded to the point where it amounted to a farce wherein the disciplinary committee merely fulfilled the function of a rubber stamp," which would offend the principles of natural justice and fairness and would be "diametrically opposed to and incompatible with the obvious intention of the Legislature."¹⁷³

The obligation to direct that a copy of the record of its proceedings be transmitted to the relevant professional board is not restricted to a court that has convicted a registered practitioner of an offence. In fact, "[w]henever in the course of any proceedings before any court of law it appears to the court that there is *prima facie* proof of unprofessional conduct on the part of a registered person," or of conduct which, when regard is had to such person's profession, is unprofessional, the court is bound to "direct that a copy of the record of such proceedings, or such portion thereof as is material to the issue, be transmitted to the [relevant] professional board."¹⁷⁴ It appears, therefore, that any civil and criminal proceeding is covered.

II. THE DETAILS OF THE APPLICABLE LIABILITY AND COMPENSATION SYSTEMS

A. *Criteria Defining Qualification for Compensation*

1. Liability Based on Fault

In South Africa, liability for professional medical negligence, in its civil law context, is primarily rooted in the Law of Obligations (translating into the Law of Contract and the Law of Delict (Tort)). As a result, it is trite law that all compensation for medical negligence (inclusive of medical error and any adverse event) is based on fault (in the form of *culpa*). Thus, generally speaking, a physician's negligence is legally assessed with reference to the yardstick of the "reasonable expert in the same circumstances." In any given context, negligence means that the defendant or the accused failed to foresee the possibility of harm (bodily or mental injury or death) occurring to another in circumstances where the reasonable person (*diligens paterfamilias*) in the defendant's or accused's position would have foreseen the possibility of harm occurring to another and would have taken steps to avoid or prevent it. The generic test for negligence is thus one of foreseeability and preventability.¹⁷⁵ Although the test for negligence is fundamentally objective, it does contain subjective elements when the neg-

173. *Id.* at 205.

174. Health Professions Act § 45(2).

175. See generally CARSTENS & PEARMAIN, *supra* note 1, ch. 9.

ligence of an expert is assessed. "Where the defendant or the accused is an expert, the standard of negligence is upgraded from the reasonable layperson to the reasonable expert. Where the expert is a [medical practitioner], the standard is that of the reasonable [medical practitioner] in the same circumstances."¹⁷⁶

The test for medical negligence was enunciated in the case of *Mitchell v. Dixon*,¹⁷⁷ where Acting Chief Justice Innes observed, "A medical practitioner is not expected to bring to bear upon the case entrusted to him the highest possible degree of professional skill and care, he is bound to employ reasonable skill and care; and he is liable for the consequences if he does not."¹⁷⁸

In *Van Wyk v. Lewis*,¹⁷⁹ reference is made to "the general level of skill and diligence possessed and exercised at the time by the members of the branch of the profession to which the practitioner belongs."¹⁸⁰ What is required, however, is not the highest possible degree of professional care and skill, but reasonable knowledge, ability, experience, care, skill, and diligence.¹⁸¹ Van Oosten correctly states that the standard that is required:

[I]s thus based not on what can be expected of the exceptionally able doctor, but on what can be expected of the ordinary or average doctor in view of the general level of knowledge, ability, experience, skill and diligence possessed and exercised by the profession, bearing in mind that a

176. Ferdinand F.W. van Oosten, *South Africa*, in INTERNATIONAL ENCYCLOPAEDIA OF LAWS 81–82 (R. Blanpain ed., 1996); see also CLAASSEN & VERSCHOOR, *supra* note 43, at 13–26; INTRODUCTION TO MEDICO-LEGAL PRACTICE, *supra* note 43, at 22; STRAUSS, *supra* note 51, at 243; F.F.W. van Oosten & S.A. Strauss, *Legal Liability*, in CLINICAL FORENSIC MEDICINE AND MEDICAL JURISPRUDENCE 40 (P.A. Carstens & P.W.W. Coetzer eds., 2002); P.A. Carstens, *Die Straftreftelike en Deliktuele Aanspreeklikheid van die Geneesheer op grond van Nalatigheid* [The Criminal and Delictual Liability of the Doctor for Negligence] 144 (2006) (unpublished LLD thesis, University of Pretoria); *Blyth v. Van den Heever* 1980 (1) SA 191 (A) at 221; *Magware v. Minister of Health* 1981 (4) SA 472 (Z) at 476–77; cf. CARSTENS & PEARMAIN, *supra* note 1, at 619.

177. 1914 AD 519.

178. *Id.* at 525; see also *Coppen v. Impey* 1916 CPD 309 at 314; *Kovalsky v. Krige* (1910) 20 CTR 822 at 823.

179. *Van Wyk v. Lewis* 1924 AD 438 at 438.

180. *Id.* at 444.

181. *Id.* at 470–71; *Mitchell v. Dixon* 1914 AD 519 at 525; *Blyth* 1980 (1) SA at 221; *Lee v. Schönberg* (1877) 7 Buch 136; *Collins v. Adm'r, Cape* 1995 (4) SA 73 (C) at 81; *Castell v. De Greef* 1993 (3) SA 501 (C) at 509; *R v. Van Schoor* 1948 (4) SA 349 (C) at 350, 352; *Coppen* 1916 CPD at 314; *Kovalsky* 20 CTR at 823; *R v. Van der Merwe* 1950 (4) SA 124 (O); *Allott v. Paterson & Jackson* 1936 SR 221 at 224; *Buls v. Tsatsarolakis* 1976 (2) SA 891 (T) at 893; *Esterhuizen v. Administrator Transvaal* 1957 (3) SA 710 (T) at 723–24; *Pringle v. Adm'r, Transvaal* 1990 (2) SA 379 (W); *S v. Kramer*, 1987 (1) SA 887 (W) at 893; *Dube v. Adm'r, Transvaal* 1963 (4) SA 260 (W) at 266; *Dale v. Hamilton* 1924 WLD 184 at 200; *Magware* 1981 (4) SA at 476–77; cf. *Michael v. Linksfield Park Clinic (Pty) Ltd.* 2001 (3) SA 1188 (SCA) at 1192; *Ex parte Rautenbach* 1938 SR 150 at 151; *S v. Van Almenkerk*, 2006 (T) (unreported); *Clinton-Parker v. Adm'r, Transvaal* 1996 (2) SA 37 (W) at 39–40, 69–70.

doctor is a human being and not a machine and that no human being is infallible.¹⁸²

In essence, "the standard of medical negligence is the recognized and accepted practices of the medical profession, provided these are not unreasonable and dangerous."¹⁸³ The test of medical negligence is the same in civil cases as in criminal cases.¹⁸⁴ Medical practice is affected by many statutory provisions, as well as the common law, and many actions of a doctor that may result in civil liability or a disciplinary inquiry may also involve a contravention of criminal law. A prime example is medical negligence that results in the death of a patient and would constitute the criminal offence of culpable homicide.

The standard of care and skill, in context of medical negligence, required of a general practitioner is to be distinguished from the standard of care and skill required of a medical specialist. Simply stated, if the physician is a *general* medical practitioner, the test is that of the reasonable general practitioner.¹⁸⁵ If the physician is a *specialist*, the test is that of the reasonable specialist with reference to the specific field of medical specialization.¹⁸⁶

2. The Role of the South African Constitution, 1996

The common law pertaining to medical negligence is now subject to the supremacy of the South African Constitution of 1996. The Constitution, with its strong socio-economic rights base in terms of which everyone has access to health care services (including reproductive health care¹⁸⁷), has catapulted health care into the public arena.¹⁸⁸ Traditionally, South African medical law focused primarily, although not exclusively, on private health care emanating from a strongly developed private law application with

182. Van Oosten, *supra* note 176, at 82 (citations omitted).

183. *Id.* at 83; CLAASSEN & VERSCHOOR, *supra* note 43, at 22; Van Oosten & Strauss, *supra* note 176, at 42.

184. *Van Schoor* 1948 (4) SA 349 (C); *Van der Merwe* 1950 (4) SA 124 (O); *cf.* Van Oosten, *supra* note 81, at 22.

185. STRAUSS & STRYDOM, *supra* note 43, at 268; Van Oosten, *supra* note 176, at 83; Van Oosten & Strauss, *supra* note 176, at 45; Carstens, *supra* note 176, at 137.

186. STRAUSS & STRYDOM, *supra* note 43, at 268; Van Oosten, *supra* note 176, at 83; Van Oosten & Strauss, *supra* note 176, at 45; Carstens, *supra* note 176, at 137.

187. S. AFR. CONST., 1996, § 27.

188. See D. Brand, *Introduction to Socio-Economic Rights in the South African Constitution*, in SOCIO-ECONOMIC RIGHTS IN SOUTH AFRICA 1 (D. Brand & C.H. Heyns eds., 2005); C. Ngweni & R. Cook, *Rights Concerning Health*, in SOCIO-ECONOMIC RIGHTS IN SOUTH AFRICA 107 (D. Brand & C.H. Heyns eds., 2005); see also A. CLAPHAM & M. ROBINSON, *REALIZING THE RIGHT TO HEALTH* 11 (Chair of Political Philosophy of the University of Zurich ed., 2009); I. CURRIE & J. DE WAAL, *THE BILL OF RIGHTS HANDBOOK* 566 (2005).

specific reference to the law of contract and delict. Universal access to health care and the notion of the public good, in context of the values, spirit, and purpose of the Constitution, as well as the reality that the majority of South African citizens are dependent on public health care, in the absence of a national health insurance system, have now had the effect that public health care has, to a certain extent, usurped private health care. This effect would also influence the understanding and application of the law pertaining to medical negligence and in some instances calls for a development or “reconfiguration” of the common law in step with the provisions of the Constitution.¹⁸⁹

3. Nature of Damages and Compensation

In terms of the Law of Obligations (Contract and Delict) the same medical negligence (negligent act or omission) may constitute both a breach of contract and delict. In such a case of concurrence of actions, the patient-plaintiff can rely on the breach of contract or alternatively on delict. If he or she establishes both claims, damages should be awarded on the basis of the most advantageous claim. The patient-plaintiff may rely on both a breach of contract and delict in the same proceeding. In the case of such cumulative pleading, it is understood that the patient-plaintiff cannot recover more than the actual loss he or she has suffered. At the same time, if both claims are proved, the patient-plaintiff should be awarded damages on the basis of the cause of action most advantageous to him or her. Only pecuniary (patrimonial damages) may be recovered in contract, while pecuniary and non-pecuniary (non-patrimonial) damages can be recovered in delict. Recoverable pecuniary damages include medical costs (past as well as future), loss of income (past and future earnings), maintenance, etc. The ambit for recoverable non-pecuniary damages include not only compensation for actual physical pain, but also shock, discomfort and mental suffering, disfigurement, loss of amenities of life and disability, and loss of expectation of life—conveniently called loss for “pain and suffering which embraces all these non-pecuniary misfortunes, past and future.”¹⁹⁰ It is possible to claim for detectable psychiatric injury, provided that there was actual psychological injury caused by medical negligence and the psychological harm is significant.¹⁹¹ Pecuniary loss and non-pecuniary loss is

189. In pursuance of section 39(2) of the Constitution. See also *Carmichele v. Minister of Safety and Sec.* 2002 (1) SACR 79 (CC); see generally CARSTENS & PEARMAIN, *supra* note 1, ch. 2.

190. P.Q.R. BOBERG, *THE LAW OF DELICT* 516 (1984).

191. See *Rd. Accident Fund v. Sauls* 2002 (2) SA 55 (SCA); *Barnard v. Santam Ltd.* 1999 (1) SA 202 (SCA); *Clinton-Parker v. Adm'r, Transvaal* 1996 (2) SA 37 (W).

simply a matter of proof on a preponderance of probabilities and in most instances the services of actuaries are called in to quantify/calculate the pecuniary loss suffered by the patient-plaintiff, taking into account the inflation rate (in terms of loss of future earnings), depreciation, life expectancy, retirement age, etc. The calculation of non-pecuniary damages is more complex and controversial and in this regard courts are in principle guided by policy considerations and comparable precedent.¹⁹²

Patient-plaintiffs usually recover damages jointly and severally in the event of medical negligence claims against more than one defendant doctor or hospital, and provision is made in the Apportionment of Damages Act for instances of contributory negligence.¹⁹³ There has also developed a tendency for defendants (doctors/hospitals) against whom a medical negligence claim was successfully instituted by a patient-plaintiff to institute action against one another for a re-apportionment of damages in terms of the Act,¹⁹⁴ specifically if the doctor/hospital-defendants are aggrieved by the apportionment of damages and the amount awarded to the patient-plaintiff.

The most powerful deterrent against medical negligence litigation in South Africa is the risk that the patient-plaintiff runs of an order of costs being made against him if his case fails. The general rule in our system is that the loser pays the costs—his own legal costs as well as the taxed costs of his opponent on the so-called “party and party” scale.¹⁹⁵ The cost factor

192. See generally M.M. CORBETT & D.P. HONEY, 6 THE QUANTUM OF DAMAGES IN BODILY AND FATAL INJURY CASES (2010) (discussing damages awarded in the context of specific injuries to specific body parts); M.M. CORBETT, J.L. BUCHANAN & J.J. GAUNTLETT, THE QUANTUM OF DAMAGES IN BODILY AND FATAL INJURY CASES (3d ed. 1985).

193. Apportionment of Damages Act 34 of 1956 § 1.

194. See *id.* § 2(1); cf. *Wright v. Medi-Clinic Ltd.* 2007 (2) All SA 513 (C).

195. In South Africa a so-called “contingency fee” is conditionally allowed since 1999 in terms of section 2 of the Contingency Fees Act, which reads as follows:

(1) Notwithstanding anything to the contrary in any law or the common law, a legal practitioner may, if in his or her opinion there are reasonable prospects that his or her client may be successful in any proceedings, enter into an agreement with such client in which it is agreed—

(a) that the legal practitioner shall not be entitled to any fees for services rendered in respect of such proceedings unless such client is successful in such proceedings to the extent set out in such agreement;

(b) that the legal practitioner shall be entitled to fees equal to or, subject to subsection (2), higher than his or her normal fees, set out in such agreement, for any such services rendered, if such client is successful in such proceedings to the extent set out in such agreement.

(2) Any fees referred to in subsection (1) (b) which are higher than the normal fees of the legal practitioner concerned (hereinafter referred to as the ‘success fee’), shall not exceed such normal fees by more than 100 per cent: Provided that, in the case of claims sounding in money, the total of any such success fee payable by the client to the legal practitioner, shall not exceed 25 percent of the total amount awarded or any amount obtained by the client in consequence of the proceedings concerned, which amount shall not, for purposes of calculating such excess, include any costs.

therefore constitutes a powerful incentive for settlement of cases out of court, depending on the merit and quantum of the case. Punitive damages (as known in the United States) are not awarded in cases of medical negligence in South Africa.¹⁹⁶

B. Causation and "Loss of Chance"

1. General Rules on Causation

In *Muller v. Mutual and Federal Insurance Co. Ltd.*, the court observed:

[T]he problem of causation in delict involves two distinct enquiries. The first is whether the defendant's wrongful act was a cause of the plaintiff's loss ("factual causation"); the second is whether the wrongful act is linked sufficiently closely to the loss for legal liability to ensue ("legal causation" or remoteness).¹⁹⁷

In *Minister of Police v. Skosana*, the court observed that:

Causation in the law of delict gives rise to two . . . distinct problems. The first is a factual one and 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. If it did not, then no legal liability can arise and *caedit quaestio*. If it did, then the second problem becomes relevant, viz. whether the negligent act or omission is linked to the harm sufficiently closely or directly for legal liability to ensue or whether, as it is said, the harm is too remote. This is basically a juridical problem in which considerations of legal policy may play a part.¹⁹⁸

Contingency Fees Act 66 of 1997 § 2. It should, however, be noted that it is a practice rule with the General Council of the Bar of South Africa, that member advocates are only allowed to enter into contingency fee agreements with clients claiming for personal injury with prior permission from the Bar Council.

196. *Cf. Collins v. Adm'r, Cape* 1995 (4) SA 73 (C).

197. 1994 (2) SA 425 (C) at 449F–449G; *see also S v. Mokgethi En Andere* 1990 (1) SA 32 (A); *Int'l Shipping Co. (Pty) Ltd. v. Bentley* 1990 (1) SA 680 (A) at 700E–701F; *Siman & Co. (Pty) Ltd. v. Barclays Nat'l Bank Ltd.* 1984 (2) SA 888 (A) at 914F–915A; *Minister of Police v. Skosana* 1977 (1) SA 31 (A) at 34E–35D.

198. *Skosana* 1997 (1) SA at 34–35 (citing *Silva's Fishing Corp. (Pty) Ltd. v. Maweza* 1957 (2) SA 256 (A) at 264; *Kakamas Bestuursraad v. Louw* 1960 (2) SA 202 (A) at 222). Acting Judge Farlam then quoted W.L. Prosser, who stated:

A cause is a necessary antecedent: in a very real and practical sense, the term embraces all things which have so far contributed to the result that without them it would not have occurred. It covers not only positive acts and active physical forces, but also pre-existing passive conditions which have played a material part in bringing about the event. In particular it covers the defendant's omissions as well as his acts.

Id. at 35 (quoting W.L. PROSSER, LAW OF TORTS 237 (1971)). The judge then observed:

The test is thus whether but for the negligent act or omission of the defendant the event giving rise to the harm in question would have occurred. This test is otherwise known as that of the *causa (conditio) sine qua non* and I agree with my Brother VILJOEN that generally speaking

Therefore the test for factual causation is, except in the most unusual of circumstances, the *causa (conditio) sine qua non*. The plaintiff must show that the harm would not have arisen but for the actions or omissions of the defendant. The courts decide the question of legal causation on the basis of a number of factors that relate essentially to public policy. The importance of public policy in the constitutional legal order prevails in South Africa. Public policy is informed by the values and principles of the Constitution. Thus decisions as to legal causation must also be informed by constitutional values and principles.¹⁹⁹

The potential for convergence of the principles of the law of contract and of delict is evident from the judgment in *Silver v. Premier, Gauteng Provincial Government*, where the court refused to distinguish between the test for causation in considering the contractual as opposed to the delictual claim of the patient.²⁰⁰ This is particularly relevant in the context of claims involving health care services since the facts upon which the claim is based, whether in contract or in delict, are likely to be the same in many instances.

(there may be exceptions) no act, condition or omission can be regarded as a cause in fact unless it passes this test.

Id. (citing *Portwood v. Svamvur*, 1970 (4) SA 8 (RA) at 14; *Da Silva & Another v. Coutinho*, 1971 (3) SA 123 (A) at 147).

199. *Cf.* CARSTENS & PEARMAIN, *supra* note 1, at 509.

200. *Silver v. Premier, Gauteng Provincial Gov't* 1998 (4) SA 569 (W); *see also* CARSTENS & PEARMAIN, *supra* note 1, at 509. On the subject of the *sine qua non* test the court observed that:

I am aware that the plaintiff's claim is founded in contract and, in the alternative, in delict. But I see no reason why the *sine qua non* test should not apply equally to the contractual claim in *casu*. The loss sustained by the plaintiff is said to have been caused by the breach of an implied term of an agreement that the hospital through its staff and employees would exercise due care, skill and diligence in providing nursing care. Precisely the same facts are relied upon as constituting a breach of the implied term as are relied upon as constituting a breach of the duty of care owed to the plaintiff. It would be anomalous if the same result did not follow irrespective of the cause of action. Furthermore, although the question of remoteness of damage for breach of contract is approached (in the absence of a contractual stipulation as to the basis on which compensation is to be made) by determining whether the damage flowed naturally and directly from the defendant's breach or is such a loss as the parties contemplated might occur as a result of such breach, it must, in my view, follow as a matter of logic that as a general rule, the test for factual causation would first have to be satisfied. There will, of course, be exceptions, such as that cited by [P.J.] Visser and [J.M.] Potgieter in *Law of Damages* (1993) para 6.3.2 at 80-1:

'(W)here a building contractor X is not able to build because Y, who has to deliver cement, and Z, who has to supply bricks, both fail to honour their contractual obligations on the same day and thus cause damage to X (eg he loses profit). According to the *conditio sine qua non* 'test,' neither Y nor Z has caused damage since, if the breach of contract of each is notionally eliminated, the damage does not fall away!'

The learned authors express the view that common sense must be employed in such cases—an approach emphasised by Corbett JA in [*Siman & Co. (Pty) Ltd. v. Barclays Nat'l Bank Ltd.*, 1984 (2) SA 888 (A) at 917, 918A] and employed by Lord Wright in [*Yorkshire Dale Steamship Co. Ltd. v. Minister of War Transport* [1942] 2 All ER 6] and by Beadle CJ in [*Portwood v. Svamvur* 1970 (4) SA 8 (RA) at 15F-G].

Silver 1998 (4) SA 599 (W) at 574-75.

2. "Loss of a Chance"

Apart from an excellent monograph written by Van den Heever on the application of the doctrine of a loss of chance in medical negligence cases,²⁰¹ there is presently no reported judgments on the subject (in context of medical negligence actions) in South Africa, and the positive law position therefore remains uncertain.²⁰² An assessment of the application of the doctrine of loss of a chance in medical negligence underscores the difficulties often encountered by courts when adjudicating on causation in medical negligence in the face of multiple causation theories. Although reasons for and against the application of the doctrine have been persuasively argued and canvassed,²⁰³ in general it seems as though factors militating against the application of the doctrine in medical law include the possibility of opening the floodgates for speculative claims, the idea of "playing god" by placing a value to human life, and the danger of an increase of the incidence of the practice of defensive medicine. On the other hand, factors or considerations that substantiate the application of the doctrine in medical law include the recognition of "a chance" having calculable value, the erosion of a patient-plaintiff's autonomy, considerations of fairness to a patient-plaintiff who is saddled with a difficult burden of proof, and general deterrence.²⁰⁴ Whether South African courts, in context of medical negligence, will be prepared to apply the doctrine of a loss of a chance is doubtful, but at least a moot point, specifically if reliance is placed on comparable English law. In all probability resistance by the courts to apply the doctrine will ultimately emanate from policy considerations.²⁰⁵

201. P. VAN DEN HEEVER, *THE APPLICATION OF THE DOCTRINE OF A LOSS OF A CHANCE TO RECOVER IN MEDICAL LAW* (2006).

202. In *Oldwage v. Louwrens* [2004] 1 All SA 532 (C) at 105–15, the doctrine was referred to, but not discussed; similarly in *McDonald v. Wroe* [2006] 3 All SA 565 (C) at para. 37, reference was made to the Australian case of *Chapel v. Hart* (1998) 195 CLR 232 at para. 17, but no discussion in this regard was entertained.

203. Cf. Helen Reece, *Losses of Chances in the Law*, 59 MOD. L. REV. 188 (1996); Niels Jansen, *The Idea of Lost Chance*, 19 OXFORD J. LEGAL STUD. 271 (1999); Marc Stauch, *Causation, Risk and Loss of a Chance in Medical Negligence*, 17 OXFORD J. LEGAL STUD. 205 (1997); see also VAN DEN HEEVER, *supra* note 201, at 78.

204. See VAN DEN HEEVER, *supra* note 201, at 115.

205. See CARSTENS & PEARMAIN, *supra* note 1, at 833.

C. Liability for Failure to Obtain Informed Consent

Van Oosten has extensively discussed the legal liability that may be incurred for no disclosure of information at all, for insufficient disclosure, and for excessive disclosure.²⁰⁶ In this regard he states that:

The legal consequences of a medical intervention performed without the patient's effective consent are that the doctor/hospital may incur liability for breach of contract,^[207] civil or criminal assault (a violation of bodily integrity),^[208] civil or criminal *injuria* (a violation of *dignitas/privacy*),^[209] or negligence,^[210] as the case may be.²¹¹

In addition the medical practitioner or hospital may be unable to recover a professional fee.²¹² Van Oosten and Strauss state that "[t]his applies irrespective of whether or not the intervention was administered with due care and skill and eventually proves to have been beneficial to the patient."²¹³ Van Oosten further opines that the violation perpetrated by a doctor who performs the wrongful or unlawful operation is one against the patient's physical integrity or dignity/privacy rather than one against his or her health.²¹⁴ This view accords with the applicable provisions of the Constitution. As proposed elsewhere, the absence of informed consent should be

206. FERNINAND F.W. VAN OOSTEN, THE DOCTRINE OF INFORMED CONSENT IN MEDICAL LAW 455 (1991); cf. INTRODUCTION TO MEDICO-LEGAL PRACTICE, *supra* note 43, at 8; Strauss, *supra* note 1, at 70.

207. Cf. *Castell v. De Greef* 1994 (4) SA 408 (C) at 425.

208. Cf. *Louwrens v. Oldwage*, 2006 (2) SA 161 (SCA) at 174; *Broude v. McIntosh* 1998 (3) SA 60 (SCA) at 61 (questioning, but not overturning, this construction of assault); *Lampert v. Hefer* 1955 (2) SA 507 (A); *Castell v. De Greef* 1993 (3) SA 501 (C) at 425; *S v. Binta* 1993 (2) SACR 553 (C) at 561; *Burger v. Adm'r, Kaap* 1990 (1) SA 483 (C) at 489 ("Dit is heeltemal duidelik dat dit die regsposisie is dat as 'n dokter . . . sonder toestemming van die pasiënt opereer dit aanranding is [The legal position is crystal clear: it amounts to assault if a doctor operates without the patient's consent]"); *Richter v. Estate Hammann* 1976 (3) SA 226 (C) at 232; *Stoffberg v. Elliot*, 1923 CPD 148; *S v. Kiti* 1994 (1) SACR 14 (E) at 18; *S v. Sikunyana* 1961 (3) SA 549 (E) (stating that a medical practitioner who performs a dangerous operation with his patient's consent incurs no criminal liability (for assault) if just cause for the operation exists, for the law does not regard his conduct as improper); *Fowlie v. Wilson* 1993 (N) (unreported); *Layton & Layton v. Wilcox & Higginson* 1944 SR 48; *Esterhuizen v. Adm'r, Transvaal* 1957 (3) SA 710 (T) at 718; *Pop v. Revelas* 1999 (W) (unreported); see also *Oldwage v. Louwrens* [2004] 1 All SA 532 (C); *McDonald v. Wroe* [2006] 3 All SA 565 (C) at para. 39 (holding that absence of consent was a violation of the patient's constitutional right in terms of section 12(2)(b)).

209. See *Stoffberg* 1923 CPD at 152.

210. *Louwrens* 2006 (2) SA at 174; *Lymbery v. Jefferies* 1925 AD 236; *Richter v. Estate Hammann*, 1976 (3) SA 226 (C) at 232; *Prowse v. Kaplan* 1933 EDL 257; *Allott v. Patterson & Jackson* 1936 SR 221 at 221–22, 224; *Layton & Layton v. Wilcox & Higginson* 1944 SR 48 at 50; *Dube v. Adm'r Transvaal* 1963 (4) SA 260 (W) at 269.

211. Van Oosten, *supra* note 176, at 63.

212. *Id.* (citing *Recsei's Estate v. Meine* 1943 EDL 277).

213. Strauss, *supra* note 1, at 70; Van Oosten, *supra* note 176, at 69.

214. *Id.* at 64 n.6 (citing VAN OOSTEN, *supra* note 206, at 31, 452).

seen in context of the Constitution as an infringement of one's right to bodily integrity as contemplated in terms of section 12(2)(b).²¹⁵

The onus of proving non-disclosure liability rests with the patient or the state, depending upon whether it is a civil action or a criminal prosecution.²¹⁶ Once a *prima facie* case of non-disclosure has been established, the doctor will have to refute the allegation of non-disclosure by adducing evidence that the requisite disclosure has indeed taken place.²¹⁷ Van Oosten opines in this regard that since disclosure documents and consent forms cannot serve as a meaningful substitute for a disclosure conversation, the former should be afforded evidential value, but should not be considered as conclusive evidence that the requisite disclosure in fact occurred.²¹⁸

D. *Matters of Proof and Gathering of Evidence*

1. *Matters of Proof*

a. *General*

The onus of establishing civil liability for medical negligence on the doctor's part lies with the patient in a civil case and the prosecution in a criminal case. In a civil case liability must be established on a preponderance of probabilities. In a criminal case the guilt of the accused must be proved beyond reasonable doubt.²¹⁹

215. See CARSTENS & PEARMAIN, *supra* note 1, at 676.

216. In this regard Van Oosten states that, in the unlikely event of a doctor being charged with culpable homicide or sued for damages for causing the death of the patient by non-disclosure, it will not only have to be proved that the non-disclosure unlawfully or wrongly caused the patient's death, but also that it was reasonably foreseeable in the circumstances. VAN OOSTEN, *supra* note 206, at 455 n.83.

217. See STRAUSS, *supra* note 51, at 281.

218. VAN OOSTEN, *supra* note 206, at 455–56.

219. Strauss, *supra* note 1, at 100 (citing *Van Wyk v. Lewis* 1924 AD 438; *Mitchell v. Dixon* 1914 AD 519; *Touyz v. Reyneke* 1994 (A) (unreported); *Blyth v. Van den Heever* 1980 (1) SA 191 (A) at 207; *Lee v. Schönberg* (1877) 7 Buch 136; *Castell v. De Greef* 1994 (4) SA 408 (C) at 420, 425; *R v. Van Schoor* 1948 (4) SA 349 (C) at 349–50; *Coppen v. Impey* 1916 CPD 309; *St Augustine Hosp. (Pty) Ltd. v. Le Breton* 1975 (2) SA 530 (D); *Webb v. Isaac* 1915 EDL 273; *Allott v. Paterson & Jackson* 1936 SR 221; *Buls v. Tsatsarolakis* 1976 (2) SA 891 (T) at 893; *Esterhuizen v. Adm'r Transvaal* 1957 (3) SA 710 (T); *Pringle v. Adm'r, Transvaal* 1990 (2) SA 379 (W); *S v. Kramer* 1987 (1) SA 887 (W) at 897; *Dale v. Hamilton* 1924 WLD 184); see also CLAASSEN & VERSCHOOR, *supra* note 43, at 26; L.H. HOFFMANN & D.T. ZEFFERTT, *THE SOUTH AFRICAN LAW OF EVIDENCE* 26 (4th ed. 1988); C.W.H. SCHMIDT, BEWYSREG [LAW OF EVIDENCE] 23 (2000); STRAUSS & STRYDOM, *supra* note 43, at 274; P.J. SWIKKARD & S.E. VAN DER MERWE, BEGINSELS VAN DIE BEWYSREG [PRINCIPLES OF THE LAW OF EVIDENCE] 546–58 (2005); S.A. Strauss, *Geneesheer, Pasiënt en die Reg: 'n Delikate Driehoek [Doctor, Patient and the Law: a Delicate Triangle]*, TYDSKRIF VIR DIE SUID-AFRIKAANSE REG [J. S. AFR. L.] 1 (1987); *Broude v. McIntosh* 1998 (3) SA 60 (SCA) at 61; *Oldwage v. Louwrens* [2004] 1 All SA 532 (C). Note that, should the plaintiff be unable to prove his/her case on a preponderance of probabilities, judgment will be given in favour of the defendant; a court may, however, also order absolution from the instance. In delict, the plaintiff bears the onus to prove a wrongful act/omission on the part of the physician, as well as the element of fault (in the form of negligence) and that the act or omission caused him to suffer damages or personal injury. See HOFFMANN & ZEFFERTT, *supra*, at 496; SCHMIDT,

In proceedings before an Inquest Court, the presiding magistrate has to make a finding on a preponderance of probabilities,²²⁰ and in disciplinary proceedings before a disciplinary committee of the HPCSA, the *pro forma*-

supra, at 39; *Matthews v. Young* 1922 AD 492; *Botha v. Van Niekerk* 1947 (1) SA 699 (T). Where a defendant raises a special defence such as consent, contributory negligence, or prescription, the onus of proof will be on the defendant. See *HOFFMANN & ZEFFERTT, supra*, at 530; *SCHMIDT, supra*, at 41, 132; *Mabaso v. Felix* 1981 (3) SA 865 (A); *Joubert v. Combrinck* 1980 (3) SA 680 (T); see also *SWIKKARD & VAN DER MERWE, supra*, at 546. The state has to prove all the elements of the crime (in this case culpable homicide, where it is alleged that the medical practitioner negligently caused the death of the patient) beyond reasonable doubt, i.e., an act or omission which unlawfully and negligently caused the death of the patient.

220. Cf. Inquests Act 58 of 1959, § 16(2) (with reference to the phrase "*prima facie*"); cf. *Claasens v. Landdros Bloemfontein* 1964 (4) SA 4 (O). The proof of medical negligence is important in context of judicial inquests, specifically where a patient died due to unnatural causes (e.g., the anaesthetic death) and the possible negligence of the attending physician has to be investigated (mention can be made of the form GW 7/24 to be completed in terms of § 56 of the Health Professions Act, as amended, in context of anaesthetic deaths); the judicial inquest is often the "front runner" of a later criminal prosecution on a charge of culpable homicide against a physician. It is to be noted that a judicial inquest is not a criminal trial but an inquisitorial inquiry aimed at transparency for the administration of justice and to install confidence. See *Timol v. Magistrate Johannesburg* 1972 (2) SA 281 (T) at 278H–288A; see also *Wessels v. Additional Magistrate Johannesburg* 1983 (1) SA 530 (T) at 532E–532G; *S v. Ramaligela* 1983 (2) SA 424 (V) at 430D.

At the inquest, conducted by a magistrate or a judge, the presiding officer will have before him/her the *post mortem* report and other documentation relevant to the death of the patient. Normally the pathologist/doctor who conducted the *post mortem* examination will be subpoenaed to testify at the inquest. In terms of § 16(2) of the Inquests Act, the presiding officer has the duty to make the following findings: a) the identity of the deceased; b) the cause or likely cause of death; c) the date of death; d) whether the death has been caused by an act or omission on the part of someone that *prima facie* constitutes an offence—the only relevant offence here in context of medical negligence is culpable homicide. At the end of the inquest an assessment has to be made whether on the evidence as a whole, all the elements for this crime, on a preponderance of probabilities are present. Clearly the findings in terms of the said section 16(2)(b) and (d) are paramount with reference to a possible criminal prosecution against a doctor. In this respect the *post mortem* examination and the report of the pathologist are vital. If the presiding officer makes a positive finding in respect of section 16(2)(d) he or she is obliged to submit the inquest record to the Director of Public Prosecutions who will then as a matter of course normally decide to institute criminal prosecution. In addition, a copy of the inquest record is submitted to the Registrar of the HPCSA to assess whether disciplinary proceedings on account of unprofessional conduct should be instituted against the doctor. See Health Professions Act § 45(2); *Suid-Afrikaanse Geneeskundige & Tandheelkundige Raad v. Strauss* 1980 (2) SA 354 (T) at 212. A doctor, subpoenaed to testify at an inquest, is not obliged to answer self-incriminating questions. See *Magmoed v. Janse Van Rensburg* 1991 SACR 185 (C); *In re Mjoli*, 1994 (2) SA 815 (T); see generally *STRAUSS, supra* note 51, at 437; *Strauss, supra* note 1, at 156 n.1 (pointing out that a "person" for purposes of the Inquests Act, does not include a stillborn baby); *Van Heerden v. Joubert* (1994) (4) SA 793(A) (in which *Van Heerden v. Joubert* 1992 (T) (unreported) was overruled); see also I. GORDON, R. TURNER & T.W. PRICE, *MEDICAL JURISPRUDENCE* 333–34 (3d ed. 1953); cf. *Carstens, supra* note 176, at 313–18; T.G. SCHWÄR, J.A. LOUBSER & J.D. OLIVIER, *DIE ABC VAN GEREGTELIKE GENEESKUNDE [THE ABC OF FORENSIC MEDICINE]* 412 (1984). As to the role of assessors and forensic pathologists at inquests, see *R v. Solomons* 1959 (2) SA 352 (A); T.T. Noguchi & L. Sathyavavgiswaran, *The Role of Forensic Pathologists in the Quality Assurance and Safety of the Patient Care*, in PUBLISHED CONFERENCE PROCEEDINGS OF 15TH WORLD CONGRESS ON MEDICAL LAW SYDNEY AUSTRALIA 26 (2004); T.T. Noguchi, *Medical Malpractice Claims and Quality Improvement as Viewed by a Forensic Pathologist*, 56 JAPANESE J. LEGAL MED. 205 (2002); see also K. Müller & G. Saayman, *Forensic Science in Medicine: What a Doctor Should Know*, 45 S. AFR. FAM. PRAC. 41 (2003); G. Saayman & F.F.W. van Oosten, *Forensic Medicine in South Africa—Time for Change?*, 13 MED. & L. 129 (1994).

complainant has to prove the charges of unprofessional conduct against the respondent-medical practitioner on a preponderance of probabilities.²²¹

It is to be noted, by way of a summary, that generally the application of the maxim of *res ipsa loquitur* is treated by the courts as a particular form of inferential reasoning, requiring careful scrutiny and giving rise to an inference of negligence rather than a presumption of negligence.²²² The South African courts thus far have been reluctant to apply the maxim to cases of medical negligence. Recent case law, however, suggests that the maxim could only be invoked where the medical negligence alleged depends on absolutes and the evidence shows that a particular result would not have followed but for the alleged negligence.²²³ Persuasive arguments have been put forward that the maxim should be applied in specific circum-

221. The nature of the proceeding before a disciplinary committee of the Professional Board for Medical and Dental Practitioners of the HPCSA has been discussed in some detail in case law. See *De La Rouviere v. S. Africa. Med. & Dental Council* 1977 (1) SA 85 (N) at 97; *De Beer v. Health Professions Council of S. Africa* 2005 (1) SA 332 (T); *VRM v. Health Professions Council of S. Africa* 2003 JOL 11944 (T); *Thuketana v. Health Professions Council of S. Africa* 2002 4 All SA 493 (T); *Veriava v. President S. African Med. & Dental Council* 1985 (2) SA 293 (T) at 307; *Pretorius v. S. Africa Geneeskundige & Tandheelkundige Raad* 1980 (2) SA 354 (T) at 358–59; see also STRAUSS, *supra* note 51, at 369; Carstens, *supra* note 176, at 318–24; J. Taitz, *The Disciplinary Powers of the South African Medical and Dental Council*, in 1 ACTA JURIDICA 56 (1988); J. Taitz, *Review of the Disciplinary Proceedings of the Medical and Dental Council*, 105 S. AFR. L. J. 25 (1988). Note that the HPCSA is not an organ of state. *Korf v. Health Professions Council of S. Africa* 2000 (1) SA 1171 (T); *Mistry v. Interim Nat'l Med. and Dental Council of S. Africa* [1997] 3 All SA 519 (D). Disciplinary committees of the Professional Board for Medical and Dental Practitioners function as quasi-judicial administrative tribunals and are bound by the constitutional provisions as articulated in section 33 of the Bill of Rights and the provisions of the Promotion of Administrative Justice Act 3 of 2000. See M. Beukes, *The Constitutional Foundation of the Implementation and Interpretation of the Promotion of Administrative Justice Act*, in THE RIGHT TO KNOW: SOUTH AFRICA'S PROMOTION OF ADMINISTRATIVE JUSTICE AND ACCESS TO INFORMATION ACTS 1 (C. Lange & J. Wessels eds., 2004). Disciplinary committees are thus legally bound to conduct hearings against medical practitioners with procedural fairness, which includes reasonableness, and to provide adequate reasons for their decisions. See C. Hoexter, *Unreasonableness in the Administrative Justice Act*, in THE RIGHT TO KNOW, *supra*, at 148; J. Wessels, 'Adequate reasons' in *Terms of the Promotion of Administrative Justice Act*, in THE RIGHT TO KNOW, *supra*, at 116–32. Decisions of a disciplinary committee of a Professional Board for Medical and Dental Practitioners of the HPCSA may be taken on review to the High Court. See J.R. DE VILLE, JUDICIAL REVIEW OF ADMINISTRATIVE ACTION IN SOUTH AFRICA 384–85 (2003). In context of the nature and scope of evidence to be led at a disciplinary hearing against a medical practitioner, it is significant to note what was stated by Judge Ramsbottom in *McLoughlin v. South African Medical & Dental Council* 1947 (2) SA 377 (W) at 395:

The [Medical] Council and the Disciplinary Committee are bodies of a different kind. They are entrusted with the most important duties; they have the power to compel the attendance of witnesses; evidence is given on oath and any person who gives false evidence on oath before the Council or the committee or who refuses to answer commits and offence; the parties have the right to counsel and witnesses are examined and cross-examined; a legal assessor may be appointed 'to advise on matters of law procedure and evidence' In my opinion a body of this kind [the Medical Council] should be held much more strictly to the rules of procedure and evidence than a body such as [the council of clubs, trade unions, and the like.]"

Id. (emphasis added).

222. See Strauss, *supra* note 1, at 100.

223. *Pringle v. Adm'r, Transvaal* 1990 (2) SA 379 (W).

stances with regard to the proof of medical negligence.²²⁴ In this respect, general principles for the effective application of the maxim in cases of medical negligence are advanced, inter alia, that principles of procedural equality and constitutional considerations dictate that the maxim be applied in cases of medical negligence.

As a general rule of evidence, a plaintiff in a medical negligence action is required to present expert medical evidence in support of allegations thereof. In this regard, expert medical evidence is pivotal in support or defence of medical negligence.²²⁵ The South African Supreme Court of Appeal in the case of *Michael v. Linksfield Park Clinic (Pty) Ltd.* had the opportunity to enunciate the general applicable considerations in assessing expert medical evidence.²²⁶

b. Gathering of Evidence

For the purpose of gathering evidence pertaining to medical negligence, there are different rules which may be invoked to obtain such evidence, depending on the forum in which the doctor's or hospital's negligence is adjudicated. In a criminal trial and in inquest proceedings, the doctor may request certain sections (documents like sworn statements) from the police docket and may also request further particulars for purposes of trial.²²⁷ At disciplinary hearings against a doctor before the Professional Board of the Health Professions Council of South Africa on a charge of professional misconduct (inclusive of alleged medical negligence), the defendant-doctor (respondent) is also entitled to further particulars to the

224. Patrick van den Heever, *The Application of the Doctrine of Res Ipsa Loquitur to Medical Negligence Cases: A Comparative Survey* 63, 329–32 (Jan. 2002) (unpublished LLD thesis, University of Pretoria), available at <http://upetd.up.ac.za/thesis/available/etd-08062007-165205/>.

225. Plaintiffs often find it difficult to obtain medical experts who are prepared to testify against their colleagues. This resistance is described in the literature as a “conspiracy of silence,” a term coined in the United States. See D. GIESEN, *INTERNATIONAL MEDICAL MALPRACTICE LAW* 513 n.7 (1988) (“It is a matter of common knowledge, often mentioned in judicial opinion and other authorities, that the plaintiff in a medical malpractice case is often unable to find a medical expert willing to testify against a fellow physician. . . . It goes without saying that the plaintiff’s inability to obtain favourable expert testimony poses the possibility of great miscarriage of justice.”); cf. STRAUSS, *supra* note 51, at 245; Melvin M. Belli, *An Ancient Therapy Still Applied: The Silent Medical Treatment*, 1 VILL. L. REV. 250 (1956); L. Norton, *Ethics in Medicine and Law: Standards and Conflicts*, LEGAL MED. ANN. 206 (1977); see also Melvin M. Belli, “Ready for the Plaintiff,” 30 TEMP. L.Q. 408, 434 (1957) (warning the medical profession “for Hippocrates’ sake . . . [i]n your own enlightened self-interest, break this conspiracy before the public does it for you!”). Although there is a greater willingness amongst medical practitioners to testify against fellow practitioners, specifically in cases of gross negligence, it seems that it is still problematic for plaintiffs to readily acquire the services of medical experts in this regard.

226. 2001 (3) SA 1188 (SCA) at 1200A–1201F; see CARSTENS & PEARMAIN, *supra* note 1, at 861 (discussing this case).

227. Criminal Procedure Act 55 of 1977 § 87; see also *Shabalala & Five Others v. Attorney-Gen. of the Transvaal* 1996 (1) SA 725 (CC); *S v. Shiburi* 2004 (2) SACR 314 (W).

charge, as well as the initial letter of complaint of the patient originally lodged with the Registrar, and the findings of the prelim committee who assessed the *prima facie* merits of the case against the doctor.²²⁸ In the context of civil litigation, patient-plaintiffs may invoke the Promotion of Access to Information Act, to obtain access to medical records and other related information.²²⁹ The Act was introduced “[t]o give effect to the constitutional right of access to any information held by the State and any information held by another person and that is required for the exercise or protection of any rights.”²³⁰ It should, however, be noted that the Act does not apply to medical records and related medical information requested for civil proceedings after the commencement of the proceedings.²³¹ Where legal proceedings in a medical negligence action have commenced, there is a strict discovery procedure to be followed for the production and discovery of expert medical reports, and similar documents (inclusive of a pre-trial conference) as prescribed, *inter alia*, by the Rules of the Supreme Court Act.²³²

III. AVAILABLE EMPIRICAL DATA ON MEDICAL ERRORS AND ADVERSE EVENTS, THE OPERATION OF THE SYSTEMS DESIGNED TO PREVENT AND/OR REDRESS SUCH ERRORS AND EVENTS, AND THE PREVALENCE AND IMPACT OF MEASURES DESIGNED TO REDUCE MEDICAL ERRORS AND ADVERSE EVENTS, IMPROVE SYSTEM PERFORMANCE, OR REDUCE SYSTEM COSTS

Obtaining empirical data on medical negligence in South Africa has proved very difficult. Despite numerous phone calls and e-mails to officials in the National Department of Health, the various Provincial Departments of Health, the National Department of Justice, the Health Professions Council of South Africa, and the Medical Protection Society, not a single piece of empirical data was provided by any of these parties. Web-sites for the most part do not provide up-to-date, detailed information. This left the authors out in the cold, turning to media reports for answers. It has been reported, for instance, that “[n]early 2,000 doctors in public and private

228. Cf. CARSTENS & PEARMAIN, *supra* note 1, at 269.

229. Promotion of Access to Information Act 2 of 2000.

230. *Id.* pmbl. The Act was introduced to give effect to the provisions of section 32 of the Constitution of the Republic of South Africa, 1996, which governs access to information.

231. *Id.* § 7; see THE RIGHT TO KNOW, *supra* note 221 (discussing and analyzing the Act); see also *Unitas Hospital v. Van Wyk* [2006] SCA 32 (RSA).

232. Rules of the Supreme Court Act 59 of 1959 R. 35–37; see also E. MORRIS, *TECHNIQUE IN LITIGATION* 114 (J. Mullins & C. Da Silva eds., 2010).

healthcare in South Africa are facing claims of negligence.”²³³ According to one media report, “[a]bout 80% of the claims stem from incidents in the public health sector.”²³⁴ It has been claimed that over a two year period doctors in South Africa’s “public hospitals have cost taxpayers more than R1 billion in lawsuits because of botched operations.”²³⁵

The KwaZulu-Natal Health Department apparently spent R376m in 2008/2009, and R547m in 2009/2010 on lawsuits.²³⁶ Three weeks into the new financial year, the provincial department had paid out R87m in medical legal bills and had 294 cases pending.²³⁷ The province of Mpumalanga spent R666,643 in 2008/2009, and R19m in 2009/2010 on medically related legal bills.²³⁸ Gauteng spent R2.8m in 2008/2009, and R10m in 2009/2010 on medical legal fees.²³⁹ The Western Cape spent R4m in 2008/2009, and R6m in 2009/2010.²⁴⁰ The North West Province spent R11.5m in 2008/2009, and R1.7m in 2009/2010.²⁴¹ The Free State Health Department paid out R916,000 in 2008/2009, and R577,000 in 2009/2010.²⁴² The Eastern Cape spent more than R8m on legal fees in 2009/2010.²⁴³

Many cases are settled out of court—perhaps as much as 70% of all claims.²⁴⁴ It has been reported, for instance, that in May 2010 four cases of medical negligence were settled in Johannesburg, with payouts of up to R7m.²⁴⁵

According to figures claimed in media reports to have been obtained from the Medical Protection Society, more than 800 of its members ($\pm 3.08\%$) are facing active claims of alleged negligence, with another 1,000 complaints still to be assessed.²⁴⁶ In his report for 2009, the Chief Executive of the MPS—a membership organisation with more than 270,000 members in over forty countries—reported “poor claims experience” for

233. Subashni Naidoo, *Thousands of Doctors 'Negligent,'* SUNDAY TIMES, June 6, 2010, <http://www.timeslive.co.za/sundaytimes/article489475.ece/Thousands-of-doctors-negligent>.

234. *Id.*

235. Edwin Naidu, *Botched Operations Blight SA,* THE SUNDAY INDEPENDENT, May 2, 2010, <http://www.iol.co.za/news/south-africa/botched-operations-blight-sa-1.482422>.

236. *Id.*

237. *Id.*

238. *Id.*

239. *Id.*

240. *Id.*

241. *Id.*

242. *Id.*

243. *Id.*

244. Naidoo, *supra* note 233.

245. *Id.*

246. *Id.*

the organisation as a whole, and remarked that “[t]he worst of the adverse claims experience has been in the UK and South Africa, although we are beginning to see a rise in both the frequency and average size of claims in most countries in which we operate around the world.”²⁴⁷ He expressed major concern about the “quite startling increase in the value of high claims in the UK, where some settlements have leapt by 40% or more as compared with similar claims settled in the recent past,” and remarked that “a similar worrying trend is also beginning to emerge in South Africa.”²⁴⁸ The MPS promotes safer practice by running risk management and education programmes to reduce avoidable harms.²⁴⁹ A confidential counselling service for members was introduced in South Africa in 2009, and has reportedly been very favourably received by members.²⁵⁰ Medico-legal consultants are available round-the-clock to help members with legal and ethical dilemmas arising from their professional practice, clinical negligence claims, complaints, disciplinary procedures, police investigations, regulatory inquiries, inquests, and the like.

“Most claims relate to botched cosmetic surgery, children born with brain damage, birth defects not diagnosed timeously and Caesarean sections not done when needed.”²⁵¹ It should be noted that South African law recognises actions for wrongful pregnancy and wrongful birth, but not wrongful life. Not surprisingly, the subscription rate for specialists doing obstetrics and gynaecology tops the list at R130,540 for the year January 1, 2010, through December 31, 2010.²⁵² Plastic and reconstructive surgeons fall in the “very high risk” category with a corresponding subscription rate.

Claims worth more than R1m account for over 18% of the total number.²⁵³ This amounts to an increase of nearly 550% in ten years. Claims for amounts above R5m have increased nine fold in the past decade.²⁵⁴ Several claims have been brought for amounts in excess of R30m.²⁵⁵

247. MEDICAL PROTECTION SOCIETY, FINANCIAL STABILITY IN CHALLENGING TIMES: ANNUAL REPORT AND ACCOUNTS FOR THE YEAR ENDED 31 DECEMBER 2009, 2 (2010), *available at* <http://www.medicalprotection.org/Default.aspx?DN=609d6af5-5421-49a4-baeb-f5fa0cb2b3bf>.

248. *Id.* He indicated that this worrying trend will inevitably mean higher subscriptions for all UK members. *Id.*

249. *Id.* at 3.

250. *Id.*

251. Naidoo, *supra* note 233.

252. *Subscription Rates*, MEDICAL PROTECTION SOCIETY, <http://www.medicalprotection.org/southafrica/membership/subscription> (last visited Nov. 4, 2010).

253. Naidoo, *supra* note 233.

254. *Id.*

255. *Id.*

According to media reports, statistics from the Health Professions Council of South Africa show that the names of forty-four medical practitioners have been removed from the register since 2005 as a result of having been found guilty of unprofessional conduct.²⁵⁶

Between April 2008 and March 2009, approximately ninety medical practitioners were found guilty of unprofessional conduct.²⁵⁷ The conduct complained of included insufficient care, refusing to treat patients, misdiagnosis, practising outside the particular practitioner's scope of competence, overcharging, and charging for services not rendered.²⁵⁸ Between January 2008 and October 2008, forty-seven practitioners were found guilty of unprofessional conduct relating to substandard service or inadequate treatment.²⁵⁹

IV. ATTITUDES AND CONCERNS ABOUT THE LIABILITY AND COMPENSATION SYSTEMS

The medical malpractice and compensation scenario in South Africa cannot be properly understood without an insight into the broader socio-economic and, specifically, healthcare situation in the country. South Africa is a developing nation, with pockets of highly developed infrastructure and highly trained and skilled people. "Health care varies from the most basic primary services provided by the State for free" to the indigent, "to highly specialised hi-tech services available in both the public and private sectors."²⁶⁰ The total population in South Africa is in the order of 49 million. "The private sector spends about R66-billion to service 7-million people" through private medical insurance.²⁶¹ This sector also provides services "to foreigners looking for top-quality surgical procedures at relatively affordable prices."²⁶² The public sector spends about R59 billion on the rest of the population.²⁶³ This amounts to 3.05% of the GDP.²⁶⁴ In April 2006, there were 33,220 doctors registered with the HPCSA in pri-

256. *Id.*

257. *Id.*

258. *Id.*

259. *Categorisation of Finalised Professional Conduct Inquiries (January 2008–October 2008)*, HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA, http://www.hpcs.co.za/downloads/conduct_ethics/conduct_inquiries_2008.pdf (last visited Nov. 4, 2010).

260. *Healthcare in South Africa*, MEDIA CLUB SOUTH AFRICA, http://www.medioclubsouthafrica.com/index.php?option=com_content&view=article&id=102:healthcare&catid=34:developmentbg (last visited Apr. 15, 2011).

261. *Id.*

262. *Id.*

263. *Id.*

264. *Id.*

vate and public practice combined.²⁶⁵ Two thousand Tunisian doctors and 450 Cuban doctors are deployed in rural areas.²⁶⁶ Transforming measures (encompassing legislation, health care policies and public-private partnerships) for the health sector are envisioned.²⁶⁷ Poverty and other poverty-related diseases like tuberculosis and cholera place a huge strain on the health system, but HIV/AIDS poses the biggest threat.²⁶⁸ South Africa has the fifth highest number of notified tuberculosis cases in the world.²⁶⁹

Over five million South Africans live with HIV. At this moment, half-a-million are sick with AIDS and require antiretroviral treatment. The majority still struggle to access it. More than two years ago the Department of Health committed to placing 380,000 people on treatment . . . (in the Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa, published 19 November 2003). Yet only 36% of this target has been met. . . . [M]illions more are at risk [S]uffering is being hidden behind a veil of state-supported AIDS denialism.²⁷⁰

We are still reaping the consequences thereof. Currently, there is a National Strategic Plan in place to address challenges posed by HIV/AIDS with increased expenditure.

One of the biggest challenges facing the South African system of liability and compensation for medical malpractice is the shortage of qualified health care practitioners. "Doctors and nurses carry a very heavy workload because of vacancies, an increase in the number of patients coming for treatment and lack of resources."²⁷¹ The chairman of the South African Medical Association, Norman Mabasa, said that the current incidence of medical malpractice is the result of "the skills shortage in the public health system."²⁷² Exhaustion is common.²⁷³ Mabasa has said that "[j]unior doctors are forced to work without supervisions and there is serious neglect in terms of nursing care."²⁷⁴ The ombudsman of the Health Professions Council of South Africa, Abdul Barday, also acknowledged

265. *Id.*

266. *Id.*

267. *Id.*

268. *Id.*

269. *Id.*

270. *Memorandum Handed over to UN and SA Government in Pretoria on 30 May*, TREATMENT ACTION CAMPAIGN (May 30, 2006), <http://www.tac.org.za/community/node/2206>.

271. Naidu, *supra* note 235.

272. *Id.*; Naidoo, *supra* note 233.

273. Naidu, *supra* note 235; Naidoo, *supra* note 233.

274. Naidoo, *supra* note 233.

that “doctors in provincial hospitals worked under trying conditions.”²⁷⁵ “Analysis of figures for registered doctors in relation to the general population and international standards,” based on 2004 figures, “indicates that South Africa is substantially better supplied with doctors than its immediate neighbors, but grossly undersupplied when compared to many developed countries.”²⁷⁶ South Africa had a rate of 7.7 medical practitioners per 10,000 population, whilst Austria, for instance, had a rate of thirty-five, and Canada a rate of twenty-one.²⁷⁷ Vast amounts of money are spent to educate health care workers who are lost to developed nations as a result of recruitment. In 2001, there were almost 1,500 South African doctors in Canada; 17% of all doctors in Saskatchewan earned their first medical degree in South Africa.²⁷⁸

The president of the South African Association of Personal Injury Lawyers, Ronald Bobroff, attributes the high number of negligence cases in the private and state sectors to a lack of accountability and poor management.²⁷⁹ Ambulance services, for instance, do not always respond timeously, resulting in lawsuits.²⁸⁰ This is attributed to poor management and the use of unsuitable vehicles.²⁸¹

Health Minister Dr. Aaron Motsoaledi is reported to have said that the amount paid out in lawsuits was unacceptable.²⁸² Motsoaledi has told Parliament’s portfolio committee on health that he planned to commission an investigation into the reasons for the increase in litigation and the state of care in public hospitals.²⁸³ The *Nyathi* case illustrates how difficult it can be, especially for the indigent, to successfully claim damages from, and enforce judgment against, the state.²⁸⁴ Poorer members of the community not only face the higher risks associated with an understaffed and under-resourced public health sector, but also the hurdle of high legal costs.

275. Naidu, *supra* note 235.

276. *The Shortage of Medical Doctors in South Africa: Scarce and Critical Skills Research Project*, DEP’T OF LABOUR 12 (March 2008), http://www.labour.gov.za/downloads/documents/research-documents/Medical_Doctors_DoL_Report.pdf.

277. *Id.* at 12, 15.

278. Amy Jo Ehman & Patrick Sullivan, *South Africa Appeals to Canada to Stop Recruiting Its MDs*, 164 (3) CAN. MED. ASS’N J. 387 (2001), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC80740/pdf/20010206s00029p387.pdf>.

279. Naidoo, *supra* note 233.

280. Naidu, *supra* note 235.

281. *Id.*

282. *Id.*

283. *Id.*

284. See *Nyathi v. MEC for Dep’t of Health, Gauteng* 2008 (5) SA 94 (CC).

Another concern is the fact that “the conspiracy of silence” is still a reality. Reported medical negligence actions where judgment is given against the medical practitioner remain relatively scarce.

The rise in litigation can perhaps not be attributed purely to a rise in the incidence of negligence. As a result of a greater actualisation of constitutional rights, there has been an increase in access to information, transparency, and accountability through the recently enacted legislation. It is submitted that this, together with greater consumer awareness, may have led to an increase in medical litigation. Greater specialisation in medicine and the less personal nature of the relationship between specialists and patients is another possible contributing factor.