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Admissions and apologies

When things go wrong, appropriate communication by medical practitioners with a patient and their relatives is a skill perfected over time. When and how to communicate sympathy or an apology are not considerations which should be lightly dismissed. While a general message of condolence or sympathy is unlikely to be problematic, an apology, for example, may hold negative consequences for the practitioner involved.

South Africa has no apology statute or provisions in its rules of evidence dealing with the admissibility of apologies in court.

An apology may be explainable in evidence but not after much anxiety and cost. Medical practitioners must be careful in how they convey expressions of commiseration following an unexpected medical outcome. That doesn't mean one should not act compassionately or communicate as needed with a patient or relatives.

An admission may not only expose the practitioner to liability in a claim but may also give cause for the professional indemnity insurer to deny coverage because of breach of the "no admissions" obligations placed on the professional in terms of their medical malpractice policy.

It is important to notify the circumstances to the medical negligence insurer and obtain their consent and guidance (and the guidance of legal counsel appointed by those insurers) before communicating substantively. Do not make any admissions without the consent of the insurer.

When mediating a medical malpractice dispute a full and frank exchange of views is very useful in obtaining a resolution. The rules of mediation usually provide that what is said in the course of mediation cannot be used in subsequent litigation or arbitration if the mediation is unsuccessful (although of course what is said cannot be unheard, it cannot be used in evidence in later proceedings).

So, it is useful to include in a medical negligence mediation a wording to prevent apologies from being used in evidence. Apologies may be useful in mediation, because it may be all the patient seeks and could go a considerable way to achieving a swift and cost-effective resolution. It also allows for practitioners to be able to express sympathy and commiseration, contextualised in the mediation process, without concern that it may be misinterpreted as an admission or used against the practitioner in subsequent proceedings.

It is important for doctors to step back and seek independent advice, because in the midst of the emotion of a matter a doctor may have an initial belief that they made an error, which may not be the case, as seen in our case study below.

CASE STUDY:

Buthelezi v Ndaba [2013] SCA



FACTS:

A specialist gynaecologist and obstetrician performed a total abdominal hysterectomy on his patient. She then began to suffer from urinary incontinence, which it was found was caused by a vesico-vaginal fistula (a hole in the wall of her bladder). The patient alleged that the fistula was caused by negligence in performing the hysterectomy operation. Whether the doctor was negligent hinged on competing evidence presented by two expert witnesses.

The determination of negligence rests with the court, not expert witnesses. But a court is bound to be informed by expert opinions. When the experts disagree (as often happens in court cases) the court must analyse the underlying reasoning which led each expert to their opinion.

The trial court did not properly analyse the expert opinions because it was swayed in favour of the patient's case by a supposed admission of negligence by the doctor during the hearing. The doctor admitted to the court that "the injury to the [patient's] bladder should not have happened unless something went wrong during the hysterectomy". However, on appeal, the appeal court said that this statement does not amount to an admission of negligence. A doctor cannot be held negligent "simply because something went wrong". The test is always "whether the practitioner exercised reasonable skill and care or, in other words, whether or not his conduct fell below the standard of a reasonably competent practitioner in his field."

In this case, the doctor did not make any formal legal admission of guilt or negligence. Admitting that something "went wrong" is not the same as admitting that the doctor caused the injury or that he was negligent or wrongful. Even with the best will in the world and exercising proper care and skill, things can go wrong in the operating theatre.

By analysing the expert evidence, the appeal court found that the doctor was not negligent (and they therefore reversed the decision of the trial court).

However, this case highlights the danger of a seemingly innocent admission of negligence: when the doctor admitted to the first court that the injury should not have happened unless something went wrong during his surgery, the court was swayed and found against him. It was only on appeal that he won the case, after showing that the expert evidence was not correctly considered. Therefore the doctor had to go through two lengthy and costly court cases to vindicate his position.



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MEDICAL DEFENCE REVIEW - FIRST EDITION

Wrongful birth and wrongful life claims

A wrongful birth claim is a claim by a parent against a healthcare provider for negligently failing to advise them that their child might be born with a congenital disability or a severe health condition. The financial claim is made on behalf of the parent and relates to the additional financial burden he or she has to endure as a result of caring for a child with a disability.

South African law recognises the right of a woman to choose to terminate her pregnancy under certain circumstances. The law on termination of pregnancy is set out in the Choice on Termination of Pregnancy Act 1996. One of the recognised reasons for abortion includes a finding by a medical practitioner that there is a substantial risk that the fetus would suffer from a severe physical or mental abnormality.

Wrongful birth claims have been recognised in South African law for some time.

A wrongful life claim is more controversial because it is a claim by the child (or made on behalf of the child) against a healthcare provider and would include a claim for damages for past and future medical expenses and general damages for disability and loss of amenities of life.

A wrongful life claim poses more difficult questions than a wrongful birth claim, because, as the courts have put it, these cases pose a “deeply existential question: was it preferable – from the perspective of the child – not to have been born at all?”

It also potentially lengthens the time period in which the claim can be brought. Generally, claims expire (“prescribe”) within 3 years of the harm arising. That would be the case for wrongful birth claims. However, if the claimant is a minor child, the time period in which to claim is extended to one year after the child reaches the age of adulthood. Therefore, the time period for the claim could be extended to 19 years after the birth of the child. The time period could potentially be extended even further if the child is mentally impaired and only realises later that they have a claim.

A Constitutional Court case from 2015 now allows for the possibility of wrongful life claims.

- The claim will be allowed in the alternative to the wrongful birth claim (therefore the claims cannot be cumulative). This means that if a wrongful birth claim is successful, the child cannot launch a separate wrongful life claim. However, if for example a parent fails to pursue a wrongful birth claim, the child will have the option to launch a wrongful life claim in his or her own name.
- The child claimant will also have to ensure that they satisfy all the legal requirements to prove the case (including meeting the legal tests for negligence and wrongfulness, for example). Since this case allowing for the possibility of such claims is relatively new, how this is proved in practice is yet to be worked out by the courts, as and when these cases start to arise.

CASE STUDY:

H v Fetal Assessment Centre [2015] CC



FACTS:

The case was brought on behalf of a boy who was born with Down syndrome (i.e. the case was brought in the child's name, and not on behalf of the parents).

It was alleged that the Fetal Assessment Centre negligently failed to warn the mother that there was a high risk of the child being born with Down syndrome. The mother alleged that had she been warned, she would have chosen to undergo an abortion. The child claimed special damages for past and future medical expenses and general damages for disability and loss of amenities of life.

The Fetal Assessment Centre argued that the child's claim did not exist in law. However, the court developed the law to allow for the possibility for a child to claim in their own right for "wrongful life".

Previous courts did not allow such claims because the courts did not find it appropriate to answer the question whether the particular child should have been born at all. "That is a question that goes so deeply to the heart of what it is to be human that it should not even be asked of the law."

The Constitutional Court, in developing the law and allowing for the possibility of such a claim, commented on the unfortunate naming of such cases as "wrongful life" issues, and said that the "legal issue is not the 'wrongful life' of the child, but whether the law should allow a child to claim compensation for a life with disability". By framing the issue as one of "wrongful life", it becomes almost impossible for a court to decide the case. Courts cannot evaluate the existence of children against their non-existence.

But by reframing the issue, to allow a claim for compensation for a life with disability, the claim becomes conceivable.

The court also noted that recognising a child's claim in such a case would not infringe upon his or her dignity, because recognising a claim for damages does not imply that life with a disability is worth less than life without one. Allowing the claim helps a child to cope with a condition of life he or she was born with and makes it possible for that child to live as comfortably as possible in the circumstances.

Healthcare practitioners should be aware of the possibility of wrongful life claims, because it means that even if a claim does not emanate from the parents of a child with a disability that could have been foreseen, the child may bring their own claim years later.



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Understanding Medical Malpractice Insurance

Do I have cover at retirement?

Whether you have insurance cover at retirement depends on the wording of your insurance policy.

Some claims-made policies provide cover upon your retirement for an initial period of, for example, three years (subject to terms and conditions) and can be extended annually (by application) to cater for age of majority claims (subject to prevailing underwriting criteria and, if required, payment of additional premiums to the insurer), and also extends to cover your estate.

Age of majority claims may become relevant, for example, in the case of a wrongful life claim, as discussed in the case study above.

Risk Management for Medical Professionals

Medical malpractice cases are on the rise. To mitigate against this alarming trend, medical practitioners should use every tool in their arsenal to avoid mistakes where possible. Doctors and hospitals have a range of research to draw from in helping them to manage their practices better, schedule surgeries for optimal outcomes and create a better working environment to avoid burnout.

Employing careful risk management strategies, healthcare practitioners can aim to be proactive in avoiding mistakes and errors, as opposed to reacting to crises after they occur.

Beware defensive medicine practices

Healthcare practitioners who fail to consider a range of options when deciding on a risk management plan may fall into the trap of practicing defensive medicine, which occurs when the aim is to avoid exposure to malpractice litigation – working from a reactive place of fear of litigation instead of from a proactive and healthy approach of maximising patient benefit.

Defensive medicine can take many forms, for example avoiding procedures that could help a patient but that are deemed risky, or ordering unnecessary tests, prescribing unnecessary medication and needless hospitalisation.

The dangers of defensive medicine include increased health care costs and pose risks to the patient. The relationship between the doctor and patient may be compromised as well. “Defensive medicine is not just expensive and wasteful. It could increase your risk of litigation if practices result in harm.” For example, studies have shown that over-diagnosis and overtreatment of patients following a routine mammogram may lead to more harm than benefit for patients who are asymptomatic and at average risk of breast cancer.

Proper communication with patients, a deep knowledge of how to obtain informed consent and thorough patient contracts could also help mitigate against the tendency towards practicing defensive medicine. Having adequate medical malpractice coverage may also go some way toward avoiding the excessive practice of defensive medicine.



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Consider using a checklist

Another interesting tool for risk management in a medical setting looks deceptively simple: a checklist. With healthcare becoming more specialised, healthcare practitioners have to keep track of a vast amount of information. Mistakes and complications could arise in a multitude of ways, and therefore risk management is vital.

Dr Atul Gawande, renowned surgeon and public health leader details the usefulness of a checklist in his bestselling book *The Checklist Manifesto*. Tasked by the World Health Organisation to come up with a program to improve the rate of avoidable deaths and harm from surgery, Dr Gawande and his team developed the WHO Surgical Safety Checklist.

Healthcare practitioners already make use of a type of checklist when assessing the vital signs recorded by most hospitals (body temperature, pulse, blood pressure and respiratory rate). This is nothing if not a checklist to get a basic picture of how sick a patient is.

With increasing complexity and the vast volume of knowledge now available to healthcare practitioners, knowledge has both saved and burdened us. We now have thousands of medical procedures, each with different risks and requirements. Dr Gawande notes that the greatest difficulties and stresses in medical practice are not just “money or government or the threat of malpractice lawsuits or insurance company hassles – although they all play their role. It is the complexity that science has dropped upon us and the enormous strains we are encountering in making good on its promise.”

Checklists in surgery, for example, generally consist of three pause points:

1. Before the patient is given anaesthesia;
2. After anaesthesia but before an incision is made; and
3. At the end of the procedure before the patient is wheeled out of the operating theatre.

Each section is meant to take one minute or less.

Checklists must be tested in the real world to confirm its practicality in the specific setting in which it is meant to be used. Each checklist can then be tweaked for optimal performance in its given setting.

The WHO's Surgical Safety Checklist could be used as a starting point, since it has been developed through countless hours of research and testing. Bad checklists are too long and vague. Good checklists are precise, practical and easy to use, even in dire situations. They do not spell out everything, but provide reminders of the most critical steps only, things that even highly skilled professionals could miss under pressure.

Checklists also help to create a communicative team out of virtual strangers.

One of the steps in the surgery checklist requires everyone in the operating theatre to stop and introduce themselves by name before surgery begins. This may seem silly or trivial, but this one step has been found to foster teamwork and better group performance. There is also an increased likelihood that any member of the team will raise concerns and offer solutions, especially among the more junior members of the team. Psychology studies back up the fact that people who know each other's names work together better.

When the performance of nurses was studied at John Hopkins Hospital, it was found that they increased participation, responsibility and willingness to speak up if issues arose – the researchers called it an “activation phenomenon”. Saying something as simple as one's name at the start of the procedure “activated” each person's willingness to speak up later if need be.

Therefore checklists can establish a higher standard of baseline performance.

The study at John Hopkins looked at the implementation of a checklist relating to inserting central lines. After implementation, infection rates and death rates decreased, and the hospital saved millions of dollars in costs.

There has been debate around whether the WHO's Surgical Safety Checklist really affects surgical morbidity and mortality in all hospital settings. While the results from around the world vary, a study conducted in Kwazulu Natal, focused on using a modified checklist to improve maternal outcomes in caesarean deliveries provides promising results.

At the time the study was done, Kwazulu Natal had the highest rate of caesarean deliveries (in the public sector) in South Africa. After implementation of the checklist, it was recorded that postoperative sepsis and unscheduled return to the operating theatre were significantly improved. There were also greater reductions in postoperative deaths in hospitals that were good implementers of the modified checklist.

The study found that factors hindering implementation of the modified checklist included lack of support from upper management and poor teamwork between doctors and nurses (with doctors sometimes arriving in theatre after the anaesthetic had been administered). Good implementation was related to personal motivation of self-appointed "checklist champions" and support from management.

Taking just three minutes to run through a checklist could save lives and lead to better outcomes. Every medical practice would do well to create and use a checklist.

Be aware of the timing of medical procedures

After studying countless academic papers, author Daniel Pink found that afternoons are particularly bad times for health care work.

For example:

- Errors in anaesthesia are three times more likely to occur for afternoon procedures (around 3pm) than morning surgery (between 9am and noon).
- Unnecessary antibiotics are prescribed more often in the afternoon.
- Handwashing for both nurses and doctors plummets in the afternoon.
- Colonoscopies are less thorough when done in the afternoon.

There are a number of measures that a healthcare practitioner can take to mitigate against the effects of the afternoon slump. For example, taking systematic, regular breaks can help. These breaks have to be meaningful, allowing for complete detachment from work. Frequent breaks that involve movement or nature are good options. Social breaks are also good for mental rejuvenation.

Chronotherapy is another interesting area of research promoting the theory that the timing of surgery and other medical interventions matter. Chronotherapy is the idea that the body reacts to medical interventions differently based on the time of day and the body's natural circadian rhythms. Wounds that occur during the day tend to heal faster than wounds that occur at night. Studies have also found that surgeries performed earlier in the week have better outcomes than those performed on the weekend.

With medical malpractice cases alarmingly on the rise, medical practitioners should use every tool in their arsenal to avoid mistakes where possible. The use of checklists, guarding against unnecessary practice of defensive medicine and being wary of the timing of medical procedures are some of the methods that can be employed to ensure the best possible outcomes for patients.

When does the duty of care arise for a covering doctor?

When a doctor covers for another that does not mean that the covering doctor is merely on standby for any emergency that could arise during the absence of the patients' regular doctor, nor that the covering doctor does not assume normal responsibility for the patient.

The covering doctor's duty of care to the patient arises immediately when the covering doctor accepts the request to cover and, for example, positively responds to a call that the patient has been admitted to the hospital. If that were not the case it would mean that during the patient's regular doctor's temporary period of absence the patient was practically without a doctor or specialist taking care of them.

CASE STUDY:

Life Healthcare Group (Pty) Ltd v Dr Suliman [2018] SCA

FACTS:

The parents of a child diagnosed with cerebral palsy sued the hospital and the doctor, a specialist obstetrician and gynaecologist, for damages due to a birth injury sustained by their child.

The hospital admitted its nursing staff were negligent but contended that the doctor was contributorily negligent and should contribute to the settlement (of R20 million).

The patient was admitted to the hospital at 10h00 but the first and only time she was seen by the covering doctor was over eleven hours later at 21h20 that evening. The covering doctor contended that his duty to the patient only arose when he saw the patient for the first time that evening.

The nursing staff's duties were, among other things, to observe, monitor and record the developments of the patient. A cardiotocography (CTG) was used to monitor the foetal heart rate. The doctor was telephoned shortly after the mother's admission to the hospital and informed of her admission. The doctor then instructed the nurse to allow the labour to proceed and to sedate the patient if necessary. The doctor also prescribed medicine for managing pain and nausea.

The sister telephoned the doctor at about 18h35 to report certain observations including a deceleration of the foetal heart rate and added that the heart rate had recovered quickly. The doctor instructed the mother to be transferred to the labour ward, her membranes to be ruptured and an epidural to be arranged. At this time the doctor had not been to see the patient.

At 18h40 the foetal heartrate decreased to 90 heartbeats per minute but this was not brought to the attention of the doctor as it ought to have been. The recording showed that the contractions had been strong at approximately 3 per minute. The doctor was made aware of this at 19h30. Another deceleration was recorded at 19h40 and not reported to the doctor. At 21h00 the doctor was informed that the patient was fully dilated.

He arrived at the hospital at 21h20 to see the patient for the first time since her admission at 10h00.

He looked at the CTG and realized that the foetus had been in distress for some time and that urgent delivery was required. The equipment needed to assist in the delivery was not available and when found, the sister could not use it, resulting in a further delay of the birth of the baby who was born at 22h10.

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

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

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

The court said that a reasonable obstetrician would have met with the patient at her time of admittance to create the doctor-patient relationship and to assure her that in the absence of her own doctor he would be standing in and would take good care of her.

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

On the evidence it was found that the doctor's negligence was also causative of the cerebral palsy. The correct question to be asked was: "Was it more probable than not that the birth injuries suffered by the baby could be avoided, if (the doctor) had attended the hospital earlier, after the 18h35 phone call?" The court found that had he done so he would have noticed the non-reassuring tracings on the CTG and would have seen the early signs of foetal distress and according to his own evidence, would have conducted an emergency caesarean that would have avoided the birth injury to the baby. That was also the view of the other medical experts, who agreed that the brain damage probably occurred after 20h00 and especially after 21h00. There was time enough to intervene successfully.

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

Good news for doctors - The facts don't always speak for themselves in medical malpractice cases (Res Ipsa Loquitor)

When a plaintiff brings a claim for damages against a defendant who has allegedly caused harm or a loss, the legal elements of the case must all be proved. For example, it must be shown that a loss or harm was suffered, that the action or omission causing the harm was wrongful and that there was intention to cause harm or negligence that resulted in the harm.

Even though each element of the case must be proven for legal liability to ensue, the courts do operate on certain presumptions, and may draw certain inferences.

Some examples are:

- Everyone is innocent until proven guilty;
- Generally it is the plaintiff (the person bringing the claim) who bears the burden of proof; and
- Res ipsa loquitor (which literally means "the thing speaks for itself"). This principle is used to infer negligence from the very nature of the accident or event, in a case where the mere occurrence of a certain type of accident is sufficient to imply negligence. But res ipsa loquitor does not usually apply in medical negligence cases.

The principle of res ipsa loquitor poses very specific problems to cases of medical negligence, because if it were used in such cases, negligence might almost always be inferred. For example, if a patient gets injured during surgery, the principle would mean that the mere fact that the patient was injured while being operated on is sufficient to prove negligence. However, this is not always the case, because a number of things could go wrong in surgery that may have nothing to do with a doctor's negligence (for example, a patient may have had an unknown underlying disease).

Therefore, at least for medical negligence cases, the courts will generally not use the principle of res ipsa loquitor to infer negligence, and evidence will have to be led to prove negligence. Remember that while the courts will rarely use res ipsa loquitor in medical negligence cases, it is not impossible for the maxim to be applied, in certain circumstances.

CASE STUDY:

Goliath v Member of the Executive Council for Health, Eastern Cape [2014] SCA

FACTS:

A patient brought a claim against the hospital in which she had undergone a routine hysterectomy for a fibroid uterus. A surgical swab had been left inside the patient and after developing complications including severe pain and a wound abscess, she had to undergo a further operation to remove the swab.

The question that the court had to consider was whether negligence had been established.

The court said that res ipsa loquitor could rarely be applied in medical negligence cases. This is not to say that it could never find application in a case based on medical negligence. The courts are reluctant to apply the maxim because, "with the best will in the world things sometimes went amiss in surgical operations or medical treatment. A doctor was not to be held negligent simply because something went wrong."

The court said that res ipsa loquitor "is not a presumption of law, but merely a permissible inference which the court may employ if upon all the facts it appears to be justified" and it "is usually invoked in circumstances when the only known facts, relating to negligence, consist of the occurrence itself."

In this case there was no way for a swab to have been left in the patient's body except that it was overlooked during surgery. Liability depended on whether the injury sustained was due to negligence on the part of the hospital staff in allowing the swab to be left inside the patient.

The patient testified and called an expert witness to testify for her case, providing sufficient evidence to give rise to an inference of negligence. No witnesses were called on behalf of the defendant.

In a civil case it is not necessary for a plaintiff to prove that the inference that she asks the court to draw is the only reasonable inference – it is sufficient if she convinces the court that the inference is the most readily acceptable of a number of possible inferences. When an inference of negligence would be justified and to what extent expert evidence would be necessary depends on the facts of the particular case.

The defendant, in failing to provide any evidence whatsoever, took the risk of a judgment being given against him. The defendant could have tried to provide evidence to show that whilst the patient was undergoing surgery, reasonable care had indeed been exercised, but he did not do this. No explanation was given as to why the medical staff who attended to the patient were not called as witnesses. Therefore, on all the evidence, negligence had been established.

CASE STUDY:

MEC for Health, Western Cape v Q [2018] SCA



FACTS:

A baby girl was born presenting with clinical features of spastic quadriplegic cerebral palsy caused by damage to her brain. The baby's mother claimed alleging negligent medical treatment to herself and the baby by the various health practitioners, nurses and doctors, employed at the various state facilities she attended during her pregnancy and at the time of her child's birth.

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

The court accepted the MEC's expert evidence that the extensive brain damage evidenced could only have developed over 4-5 weeks and it was unlikely that it was a result of an occurrence during delivery or a week before then. Among other things the baby's blood pH at birth was inconsistent with intrapartum brain injury and there was evidence of previous bleeding in the baby's brain. There was no trigger event during birth. The improvement of the Apgar score was uncharacteristic of intrapartum brain injury.

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

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

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

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

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

The court referred with approval to the earlier judgment of *Goliath v Member of the Executive Council for Health, Eastern Cape* (discussed above).

Our courts have also previously referred with approval to English Judgments cautioning against the natural human tendency to find fault where an innocent patient is injured. "... we should be doing a disservice to the community at large if we were to impose liability on hospitals and doctors for everything that happens to go wrong...We must insist on due care for the patient at every point, but we must not condemn as negligence that which is only a misadventure".



List of relevant legislation and regulations

The healthcare profession is regulated not only by the obvious healthcare legislation such as the Health Professions Act, but also by a wide range of other legislation that could affect a medical practice. Some of the relevant legislation and regulations that affect medical practitioners are listed below.

Compensation for Occupational Injuries and Diseases Act, 1993

Consumer Protection Act, 2008

Financial Advisory and Intermediary Services Act, 2002

Health Professions Act, 1974

Regulations Relating to the Conduct of Inquiries into Alleged Unprofessional Conduct Under the Health Professional Act, 1974

These are the regulations that set out the process for inquiries by the Health Professions Council of South Africa.

Insurance Act, 2017

Medical Schemes Act, 1998

Medicines and Related Substances Act, 1965

Mental Health Care Act, 2002

National Health Act, 2003

Promotion of Access to Information Act, 2000

Protection of Personal Information Act, 2013

Road Accident Fund Act, 1996

Therefore healthcare practitioners need to be aware that apart from the fact that the provision of health care services is a regulated field, there are also other regulations and laws that impact on the more administrative side of their practices. For example, collecting patient information must comply with the Protection of Personal Information Act. The request for patient documents may be impacted by the Promotion of Access to Information Act. Dealing with medical schemes is affected by the Medical Schemes Act, which regulates the medical schemes industry. The Consumer Protection Act may be implicated when issues arise relating to defective medical equipment.



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Doctors, take our online CPD quiz for 2 Ethics CPD points.

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CPD QUIZ

1. When does the duty of care arise for a covering doctor?

- a. Immediately when the covering doctor accepts the request to cover and, for example, positively responds to a call related to the patient
- b. Never
- c. When the doctor decides that he or she is ready to accept responsibility for the patient
- d. When the hospital calls the doctor in relation to the patient's care

2. If you apologise to a patient, can that be used as proof of negligence?

- a. Yes, an apology is always an admission of negligence
- b. It depends on whether the apology was made as part of a formal admission of negligence, in which case it can help in proving negligence
- c. No, apologies are not admissible in court
- d. It depends on the judge hearing the case

3. What is defensive medicine?

- a. Defending a medical malpractice case
- b. Practicing medicine well
- c. Risk management and practice management
- d. Practicing medicine with the aim of avoiding exposure to malpractice litigation

4. Generally, who has to prove a claim for damages for harm or loss?

- a. The person bringing the claim (the plaintiff)
- b. The person defending the claim (the defendant)
- c. The court
- d. Expert witnesses

5. The courts don't often use the principle of res ipsa loquitor ("the facts speak for themselves") in medical malpractice cases:

- a. True
- b. False

6. When there are conflicting expert witness opinions, the courts will consider:

- a. The underlying reasoning which led to the expert opinion
- b. Which expert has more experience
- c. Which side has more experts
- d. The conflicting opinions cancel each other out

7. When will a claim for "wrongful birth" usually prescribe/expire?

- a. Twenty one years
- b. Eighteen years
- c. Three years
- d. One year

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8. When will a child be able to pursue a claim for “wrongful life”?

- a. After a parent successfully sues on the basis of wrongful birth
- b. The claim for wrongful life does not exist in our law
- c. Cumulatively (together with) a wrongful birth claim
- d. When a parent fails to pursue a wrongful birth claim, or in the alternative to a wrongful birth claim

9. An example of practising defensive medicine is

- a. Ordering unnecessary tests
- b. Scheduling surgery at an optimal time of day
- c. Using a checklist to reduce the possibility of making a mistake
- d. Hiring a lawyer to defend a medical malpractice suit

10. Which act governs the collection of patient information?

- a. Protection of Personal Information Act
- b. Consumer Protection Act
- c. Medical Schemes Act
- d. Promotion of Access to Information Act



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