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medical defence

Natmed Medical Defence Review

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Dear Reader

Natmed's Medical Defence Review is part of our contribution to the medical and medical malpractice insurance industries, along with our **What if? series, Top Ten Takeaways** and Annual Survey of Medical Malpractice Judgments of 2018.

The Review contains case studies linked to legal issues relevant to the medical industry.

For definitions of medical malpractice and insurance terms, see our **Natmedipedia**.

My thanks to our CEO Donald Dinnie, who is steeped in years of experience and expertise in South African health and medical malpractice law, head of legal Aneesa Bodiat and the Natmed legal team, for their excellent work in producing this Review.

Enjoy your read.

Stephen Kellerman
Natmed Founder

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Duty of care is also for non-medically qualified administrative staff

It is not only medical practitioners but also administrative staff who owe a duty of care to their patients, in conducting themselves with reasonable skill and care.

This could include, for example, a receptionist. If a receptionist employed by a doctor or a hospital negligently provides inaccurate information to a patient, and this causes the patient harm, the doctor or hospital may be vicariously liable for that negligent act. This is due to the principle of vicarious liability, under which an employer is found to be liable for the actions of their employees, performed during the course and scope of their employment.

Case Study:

Darnley v Croydon Health Services NHS Trust [2018]

Facts:

The patient went to the emergency department after being assaulted and struck over the back of his head. He told the unit's receptionist he was feeling unwell and his head was hurting. The receptionist told him he would need to sit down, and wait four to five hours before somebody looked at him.

The patient sat down, as instructed, but left after 19 minutes without informing anyone of that fact. His condition subsequently deteriorated and he was consequently admitted to another emergency unit late that evening. His diagnosis included a large extra-dural haematoma, with a marked midline shift.

He underwent an emergency evacuation of the haematoma, but was left with permanent brain damage. In his claim, the patient alleged that a breach of duty had been committed by the non-clinical reception staff concerning the length of time he would have to wait. The **English Supreme Court therefore** had to consider whether the hospital operating the emergency unit owed a duty of care when providing, via its receptionists, information as to the period of time within which medical attention was likely to be available.

The court held that it has long been established that a duty of care is owed to patients by those who run and provide casualty departments, and to those presenting themselves and complaining of illness or injury, and before they are received and treated in the hospital's wards. There is a clear duty not to cause physical injury (which was the nature of this injury).

The duty is owed by the hospital, and it is not appropriate to distinguish in that regard between medical and non-medical staff. The hospital had charged its reception staff with the responsibility of first point of contact, in order that patients would be provided with accurate information from the outset as to the availability of medical assistance.

The court referred to an earlier judgment involving the **London Ambulance Service**, which also founded its liability judgment on the basis that a call handler had given misleading assurances of an ambulance arriving shortly.

Non-medical staff do not have to give medical, or wider general advice to patients. But there is a duty inherent in their role not to provide misinformation to patients.

The position in **South African** law would be the same. Staff at hospitals, emergency units and doctors' rooms should all take heed and conduct themselves accordingly.

Is assisted suicide ever legal?

In terms of current South African law, you cannot assist a patient in ending his or her life (known as "assisted suicide"). Suicide itself is not a crime but when a health care practitioner assists a patient in ending his or her life, the healthcare practitioner is exposed to criminal sanction for murder or culpable homicide.

Consent of a patient is **not** a defence to assisted suicide, which may be seen as murder or culpable homicide.

Assisting a patient, even if they are of sound mind, in planning or facilitating their death is controversial, ethically and legally. Ethically, doctors may feel a duty to assist suffering patients while balancing their duty to preserve life. But euthanasia is **not legal** in South Africa.

What can a patient do?

- A person of sound mind may refuse treatment that would otherwise prolong life. This is not regarded as suicide but is seen as an aspect of personal autonomy. A patient is always entitled to refuse medical treatment (medical treatment without the patient's consent may be regarded as an assault).
- If a person has no capacity to make any decisions regarding their treatment, for example they are braindead or in what is known as "a persistent vegetative state" and are being kept alive artificially by means of a respirator, for example, then the healthcare practitioner and the family of the patient, together with any other person having a responsibility for the patient, may decide to cease treatment. If there is uncertainty, or a difference of views, the parties should approach a court to decide the issue.
- It is allowable to prescribe drugs by way of palliative treatment for pain that may have the effect of hastening the patient's death. This is in cases where the restoration of health is no longer possible but pain relief is still effective for making the patient comfortable. If there is any doubt whether the line towards assisted suicide is being crossed, a healthcare practitioner should prudently seek legal advice.

Case study:

Minister of Justice and Correctional Services and Others v Estate Late James Stransham-Ford and Others [2016]

Facts:

Mr Stransham-Ford had terminal stage 4 cancer and had only a few weeks left to live when he approached a court for an order allowing him to request a registered medical practitioner to end his life or to enable him to end his life by the administration or provision of some or other lethal agent. He also asked the court to confirm that the medical practitioner be free from any civil, criminal or disciplinary liability that may otherwise have arisen from assisting him in ending his life.

The court emphasised that assisted suicide is not allowed in South African law and highlighted that there were sufficient other means to alleviate the suffering that would otherwise be present in the final stages of terminal illnesses (such as hospice care and other forms of palliative care).

If the law on assisted suicide were to change, it would most likely be through legislation drafted by Parliament.

Takeaway: A healthcare practitioner **cannot** assist someone in ending their life.

Consent to sterilisation

The necessary consent required to proceed with a sterilisation procedure is set out in the Sterilisation Act 1998. Sterilisation requires *written* consent.

The Sterilisation Act begins by affirming everyone's right to bodily integrity and emphasising the right to make decisions regarding one's reproductive health.

The inability to give consent does not automatically entail the loss of the constitutional rights related to sterilization (for example, for someone who is mentally disabled and unable to give informed consent). Under specific circumstances, these rights can be exercised on behalf of people unable to give consent as well. However, a decision regarding sterilisation for someone who is unable to give informed consent personally will be very carefully considered and will not be taken lightly.

Furthermore, even though minor children may in some circumstances be able to consent to certain medical procedures, sterilisation is not allowed to be performed on a person who is under the age of 18 years old except where a failure to do so would jeopardise the person's life or seriously impair their physical health (section 3 of the Act).

Because sterilisation is such a personal procedure and may in some cases be irreversible, proper information regarding the procedure and its consequences must be provided to patients. Furthermore, oral consent, even if it is informed, is generally not enough – written consent is required (the prescribed consent form must be signed). This is set out in section 4 of the Act.

Consent must be given freely and voluntary and without any inducement. The patient must be given a clear explanation and adequate description of the proposed plan of the procedure and the consequences, risks, and the reversible or irreversible nature of the sterilisation procedure. The patient must be told that they can withdraw their consent at any time before the procedure.

Failure to comply with the Act is a criminal offence and may result in a fine or imprisonment for a period not exceeding five years. From the following two case studies, the importance of consent in a sterilisation procedure will be illustrated.

Depending on the type of sterilisation procedure to be performed, it is important to warn the patient of any chance of a future pregnancy occurring, no matter how slight, in order to avoid future claims related to unplanned pregnancies.

Case Study:

Pandie v Isaacs [2013]

Facts:

The patient sued a gynaecologist and obstetrician for a sterilisation procedure that she alleged she had not consented to. The lower court found in favour of the patient but the doctor appealed that decision. The appeal court found in favour of the doctor.

The sterilisation (a tubal ligation) was carried out along with the patient's caesarean section operation in which her fourth child was delivered.

The patient's main arguments were that she had made it clear to the doctor, in oral discussion, that she did not want to undergo sterilisation and that the doctor had been negligent in not personally checking, before the operation, whether the plaintiff had signed the written consent to sterilisation form required by the Sterilisation Act.

There was a factual dispute between the parties about what happened before the procedure. One of these disputes related to a conversation between the parties the day before the caesarean section, in which the doctor alleged that sterilisation was discussed and explained and the patient expressed a desire to be sterilised; the patient denied this and alleged that she had told the doctor that she did not want to be sterilised. After this consultation, the doctor gave the patient a sealed letter to hand to the hospital on her admission for the caesarean section – the letter informed the hospital that the patient was being admitted for an elective caesarean section and tubal ligation. After assessing the evidence and the probabilities, the court found that the patient probably had consented to the sterilisation during this consultation and this was the most probable reason why the doctor made a note for the caesarean section and the tubal ligation to be done.

However, the patient still had the opportunity to withdraw consent, and therefore what happened next is also relevant.

The patient arrived at the hospital for her caesarean section and was attended to by a nurse. The consent form was prepared by the nurse but at some point the references to sterilisation and tubal ligation were crossed out and initialled. The nurse also recorded in the medical records that no tubal ligation was to be done.

The patient was then taken in to theatre and a different nurse completed the final pre-operative checks. This checklist is on the same page as the sections signed by the previous nurse (who noted that no sterilisation was to be done). This theatre nurse did not inform the doctor that the tubal ligation was not to be done (it seemed that she did not know of the patient's decision not to proceed with the procedure, or did not check the written consent form). Furthermore, this theatre nurse set out the special equipment necessary to perform the sterilisation procedure.

The doctor did not see the patient before she was taken into theatre. The events of what occurred during surgery were disputed. However, what is relevant is that the tubal ligation was done. The doctor alleged that he later found out that the patient had changed her mind about the sterilisation. The doctor and the patient did not discuss the sterilisation after the operation (when the doctor attended to her in the ward prior to discharge).

The patient thereafter consulted a different gynaecologist who confirmed to her that a bilateral tubal ligation had been performed, and that a reversal of the procedure could be attempted.

The appeal court found that the Sterilisation Act does require written consent. However, when examining common gynaecological practice, the court found that while checking the written consent form personally (that is, the doctor him or herself should check the consent form) would be best practice, in general, most doctors rely on the hospital staff to check that written consent is in place. Therefore the doctor's conduct on the day of the operation conformed with what would be seen as reasonable and acceptable by others in the profession. However, just because this is accepted general medical practice does not mean that the doctor

was not negligent – the court said that the matter of consent is distinct from medical practice and is a question of law for the court to decide. Expert evidence may be helpful but is not decisive.

Nevertheless, the onus was on the patient to prove negligence and the court found that negligence was not proven. The court found that the doctor had performed the most significant component of obtaining informed consent the day before the procedure, when the patient at that time consented to the sterilisation procedure.

The completion of the written consent form was found to be a mechanical exercise in this specific case and could therefore be left to others (that is, the hospital staff). There was nothing done by the hospital staff to alert the doctor that anything regarding consent to the sterilisation had changed or that they had not done their job properly. Further, the operating table was prepared for both the caesarean section and the sterilisation and the doctor checked with the nurse before the procedure that they were going ahead with both the caesarean section and the tubal ligation.

Therefore the court found it clear that the *hospital staff* had been negligent in their duties regarding communicating the withdrawal of consent for the sterilisation. The doctor was not found negligent. However the patient had not sued the hospital and furthermore, had not pleaded that the doctor was vicariously liable for the hospital staff in any way. Therefore the patient's claim failed.

Takeaway: Even though there may be some room for disagreement regarding the absolute necessity of a written consent for sterilisation, it is always advisable to obtain proper written consent for sterilisation, and to double check that consent before the procedure is done. This will avoid disagreement later on and can avert lengthy and costly litigation.

Case study:

R and Another v Dhavaraj [2019]

Facts:

This was a claim by the parents of a minor child in their personal capacity and on behalf of their child, against a doctor who failed to perform a sterilisation by tubal ligation, as requested. Failure to perform the sterilisation resulted in the patient's pregnancy and birth of the minor child. The patient claimed damages for maintenance of the minor child as well as general damages for pain and suffering, shock and loss of amenities of life related to the unintended pregnancy and birth.

The patient alleged that the agreement was for the doctor to perform the sterilisation immediately following the birth of her second child by way of caesarean section. She claims that he did not do the sterilisation, that she was not informed of the failure to perform the tubal ligation and further that she was not prescribed any alternative form of contraception.

However, the doctor alleged that even though there had been discussion of sterilisation, the patient was undecided on whether to proceed with the tubal ligation and had agreed that she would consider her decision and let the doctor know whether she wanted to proceed with the sterilisation – if so, she would also sign the relevant form consenting to the procedure. The doctor also alleged that no further discussion regarding the sterilisation was had, and that the consent form was not signed. Following the caesarean section, he claims to have informed the patient that the tubal ligation had not been done and prescribed an oral contraceptive, and advised her to return for a laparoscopic tubal ligation later if she desired.

The patient's third child was subsequently born via caesarean section and the doctor immediately performed a tubal ligation on the plaintiff, as agreed with her.

From the above facts, it is clear that the patient's and the doctor's version of events are contradictory and therefore the court had to decide which version was most probably true. The plaintiff (patient) bears the onus of proof. In weighing the probabilities, the credibility of witnesses is also important.

This was a contractual claim and the court said that for a contract to have been formed, the offer by the doctor to perform a sterilisation must have been properly accepted by the patient (by way of the signed consent form) and furthermore, this acceptance must have actually come to the doctor's attention.

It was common practice in the doctor's office to require patients to bring the signed consent form with them to the hospital on admission, and not to accept the signed forms in the doctor's rooms. Even though the patient disputed this practice and said that she had handed the signed consent to the doctor's receptionist (around the birth of her second child), when she eventually did have the tubal ligation done (around the birth of her third child) she did bring the signed consent form to the hospital because it was found in the hospital file. It was therefore more probable that the consent form was expected to be handed in to the hospital and not to the doctor's staff. Even though the patient may have genuinely believed that she had consented to the sterilisation, the consent had never reached the doctor and therefore the doctor was unaware of that consent.

The patient was billed for a sterilisation after the birth of her second child but this was not conclusive, because it was shown that the doctor's billing process was generally fraught with errors. Furthermore, the doctor showed genuine surprise at this billing error and reversed the charge when he was made aware of it.

The court noted that both parties seemed to genuinely believe in their respective versions, which contradicted each other. However, for a contract to be formed there must be a meeting of the minds, which was not evident here. The probabilities favoured the defendant doctor's version.

Therefore the patient's claim failed.

Takeaway: Keeping proper records and copies of consent forms, as well as detailed contemporaneous notes, are essential for health care practitioners.

Emergency medical intervention without consent

Medical interventions must be performed with the consent of the patient. However, if consent is not present, there are a number of grounds of justification to allow for medical intervention without consent.

These grounds of justification are: emergencies; necessity; statutory authority; court orders; good morals (*boni mores)*; contributory negligence; prescription; and error of professional judgment and medical misadventure.

When a medical intervention without consent is performed in the absence of a ground of justification, it would be unlawful because it violates a patient's Constitutional rights including the right to bodily integrity. Prior to being codified by the Constitution, treatment without consent was already unlawful in terms of common law rights.

If in an emergency situation a medical practitioner cannot obtain consent to intervene, they can rely on the legal principle known as *negotiorum gestio (*which means management of another's business) and entails getting involved in someone else's affairs, without their consent, but for their benefit. This is a useful ground of justification in an emergency setting where, for example, a patient is unconscious and it is impossible to obtain consent, and medical intervention must be performed immediately in order to save the patient's life or preserve his or her health. In those cases, the defence of *negotiorum gestio* will render the medical treatment lawful.

The requirements for this defence are as follows:

1. There must be a situation of emergency.
2. The patient must be incapable of giving consent.
3. The intervention must not be expressly against the patient's will.
4. The intervention must be in the patient's best interests.

This principle only applies when it would be unreasonable to postpone the medical treatment until consent can be obtained, and not just inconvenient to postpone the treatment. Any expenses caused by the emergency medical treatment provided can potentially be recovered from the patient if such treatment was not against the express wishes of the patient regardless of the treatment being successful or not. The National Health Act also makes provision for medical intervention without consent in cases of emergency.

Relatives of the injured patient will not be entitled to "veto" any necessary medical treatment, except potentially in the limited circumstances of the patient having signed an advance directive not to be resuscitated or if the emergency medical treatment will be futile

Case Study:

Stoffberg v Elliot [1923]

Facts:

The patient claimed £10 000 in damages for assault. The patient was admitted to hospital for surgical and medical treatment for cancer of the penis. The doctor who treated the plaintiff was an honorary visiting surgeon who assumed that the administrative procedures, including obtaining the patient's consent, had been followed. He was doing charitable work at the hospital. The patient's penis was surgically removed. The patient maintained that he had not given consent to the operation.

The court said that in the eyes of the law every person has certain absolute rights which the law protects. They are not dependent upon statute or contract but they are rights to be respected and one of them is that of absolute security of the person. No one can interfere in any way with the person of another, except in certain circumstances.

The court said that it may be that there are many cases in which a doctor could perform surgical operations upon another person without that other person's consent, for example a man who is picked up unconscious in the street and whose consent cannot be obtained for treatment necessary to save his life. In such a situation, the operation could be performed without consent. Another example given was the case where a patient is undergoing one abdominal operation and while his body is open the doctor finds there is something else seriously wrong. In order to save his life, it is necessary to fix the second problem as well. In such a case, the doctor would be justified in acting.

The court pointed out that in the present case there was no such emergency and that it was admitted that consent ought to have been obtained and was not obtained owing to some oversight in the hospital so that the operation took place without consent and as such was a wrongful act and an infringement of the plaintiff's rights, not justified by urgency or excused upon any other ground.

You must preserve medical records properly

Keeping and maintaining proper medical records is vitally important for health care practitioners. Failing to keep records, or tampering with or losing records, could result in a fine or imprisonment and is illegal. It could also affect the outcome of a court case – if records have been lost or tampered with, a court may draw a negative inference against the party who lost or tampered with the record (that is, it will reflect badly on their case).

We set out some of the legal obligations relating to preserving medical records below: tips on what to do and what not to do, followed by a case study that illustrates the consequences of failing to maintain proper records.

What should you do with patient information?

- Keep and maintain proper records at all times (and keep a backup too).
- All hospital and medical records must be preserved and maintained in their original state.
- Make sure all staff understand your record-keeping system and are able to comply with it.
- Implement controls so that no-one can tamper with records.
- Make sure staff understand that tampering with records is unacceptable and illegal.

DO NOT:

- Allow unauthorised access to records.
- Gain unauthorised access to records.
- Falsify any record by adding to or deleting or changing any information.
- Provide false information with the intention that it be included in a record.
- Create, change or destroy a record without authority to do so.
- Fail to create or change a record when properly required to do so.
- Copy any part of a record without authority.
- Connect the personal identification elements of a patient's record with any element of that record that concerns the patient's condition, treatment or history without authority.
- Connect any part of a computer or other electronic system on which records are kept to any other computer or electronic system without proper authority to do so.
- Modify or impair the operation of the operating system of a computer or other electronic system or programme on which a patient's records are kept without proper authority to do so.

These prohibitions are found in section 17 of the National Health Act, which deals with protection of records. Failure to comply could result in a fine and/or imprisonment.

Which law creates the obligation to keep and maintain proper records?

Section 13 of the National Health Act obliges the person in charge of a health establishment to ensure that a health record is created and maintained at that health establishment for every user of health services.

Health records must be kept **confidential** (in terms of section 14) unless:

- The patient consents to disclosure of the information;
- Non-disclosure of the information represents a serious threat to public health; **or**
- A court order or any law requires disclosure (for example, the information must be disclosed during court proceedings if they are relevant to the case).

Who else can access health records?

- You can disclose information to other healthcare workers (for example to nurses or anaesthetists that you are working with) during the ordinary course and scope of treating a patient where sharing the information is legitimate and in the interests of the patient and their treatment. This is allowed in terms of section 15 of the Act.
- Section 16 of the Act allows access to records for research, teaching and study purposes with the authorisation of the patient, head of the health establishment concerned **and** the relevant health research ethics committee. (However, you do not need this authorisation if the information does not reflect any information as to the identity of the patient i.e. it is anonymised).

Case study:

Khoza v Member of the Executive Council for Health and Social Development of the Gauteng Provincial Government [2015]

Facts:

The *Khoza* case dealt with a patient who gave birth to a baby with cerebral palsy. It was agreed that the child's condition arose due to lack of sufficient oxygen during labour.

The patient had a difficult labour and was monitored with a cardio-topographic monitoring machine (a CTG). The CTG is used to detect foetal distress.

The patient sued the hospital for medical negligence for failing to properly monitor or review the mother and foetus when there was a duty to do so and for improperly administering a high dose of syntocinon.

The CTG records for the critical period of monitoring could not be found. The file was called for and it contained every document one would expect except for the critical CTG tracings. No proper explanation was offered for their disappearance. It was also clear that some of the hospital records relating to the dose of syntocinon were altered, although whether they were deliberately tampered with or whether a genuine error was immediately corrected could not be determined.

The plaintiff could not rely on the CTG records because they were missing. If a CTG is done, it is usually seen as essential evidence of the monitoring process. The court said that "the CTG is the single most important and reliable monitoring device during the critical phases of labour." Oral evidence provided by a nurse and her notes relating to the CTG data were classified as hearsay evidence because the primary source (the CTG) could not verify this secondary evidence.

Usually the plaintiff has to prove negligence. But in a case such as this, the disappearance of records without any explanation may result in an adverse inference being drawn that the missing records support the plaintiff's case.

The missing CTG and the altered records were a fundamental part of this case and ultimately contributed to a finding in favour of the plaintiff.

Takeaway: This case highlights the importance of maintaining and preserving proper medical records in their original form. For further case studies on medical records, please read our Annual Survey of Medical Malpractice Judgments of 2018.

Minors, blood transfusions and the court

Cases involving the ordering of medical treatment of a minor child (that is, someone younger than 18 years of age) against the wishes of their parents are always challenging.

From time to time our courts are tasked with having to consider (usually under constrained circumstances and on an urgent basis) whether to order the medical treatment of a minor child against the wishes of the child's parents. The cases usually involve the giving of blood transfusions where the parents object on religious grounds.

Invariably in such matters, where the medical evidence is that without the transfusion the child will die, a transfusion is ordered by the court. Treatment will always be ordered where a child's life is in danger and not treating is at odds with the child's best interests.

The High Court is the upper guardian of a minor child and will always act in the best interests of the child. Section 28 of the Constitution provides that a child's best interests are of paramount importance in every matter concerning the child, and that every child has the right to basic healthcare services

In terms of Section 129 of the Children's Act, a High Court or children's court may consent to the medical treatment of – or a surgical operation on – a child in all instances where another person that may give consent under that Act (usually a parent) refuses or is unable to give consent. In terms of that section no parent, guardian or care-giver of a child may withhold consent by reason only of religious or other beliefs, unless that person can show that there is a medically accepted alternative choice to the medical treatment or surgery proposed.

Because applications for ordering medical treatment are usually dealt with in circumstances of urgency, and the treatment is once off and administered immediately following the order, the effect of the order is final and the order is not revisited. However, in relation to chronic conditions and ongoing treatment, the court may make an interim order to allow immediate treatment, and convene a later hearing to decide the matter finally.

If, on the return date, the parents can convince the court that there is a medically accepted alternative treatment which would have the same life-saving results as a blood transfusion, the interim order will be discharged. If not, the order will be made final and the doctors and hospital can continue administering blood transfusions if needed.

Medical malpractice trends from 2018

We conducted a detailed review of the medico-legal judgments handed down in 2018 (see our Annual Survey of Medical Malpractice Judgments of 2018 for the full review) and have uncovered a number of trends in the medical malpractice litigation arena.

There were over twenty judgments in 2018 nationally dealing with medical malpractice cases. A number of trends appear from those cases, including the fact that just because a patient suffers an adverse health event, that does not automatically mean that the medical practitioners are at fault. There was an alarmingly high prevalence of lost and incomplete medical records, and unfortunately, most of the cases related to injuries to minor children (often babies) due to injuries that occurred during labour and birth. The majority of the cases related to the public healthcare sector.

Birth injuries

Of the twenty-two medical malpractice cases, fourteen were related to birth injuries, that is, claims relating to various injuries to new born babies that allegedly occurred during labour or delivery or shortly after birth. Of those fourteen, at least ten related to claims regarding cerebral palsy. In two of those cases the baby had passed away. These cases are usually launched by mothers in their personal capacity and on behalf of the minor child. Most of the birth injury cases are based on allegations of failure to deliver the child timeously resulting in cerebral palsy as a result of lack of oxygen during labour or prolonged labour. Often the allegations relate to the need to have carried out a caesarean section which was not done at all or not done quickly enough. The mothers/patients succeeded in eight of the fourteen cases. Some of those cases failed not on the merits but on the interlocutory issues (that is, technical issues unrelated to the merits of the main claim). For example, two of those judgments related to applications related solely to compelling the production of documents which did not exist. Both failed. In that regard the court held that the defendants could only be compelled to discover or produce documents over which they had control and which they could find. The merits of those claims still need to be determined.

Where the birth injury claims failed on the merits the issue was often the inability of the claimant to prove causation (it could not be established when the brain injury occurred). If it occurred immediately before birth it was too late to do anything. If it had occurred days or weeks before birth nothing could be done by the birthing team. If it occurred during prolonged labour, the patient was generally successful in her claim.

Lost medical records

Eleven of the judgments had to deal with missing or inadequate medical records in some way or the other. In dealing with this the courts sometimes draw an adverse inference but that is not always the case. In many instances, no acceptable explanation was provided for the absence of the records. In all of the cases the courts found that medical records are crucial and indispensable. Hospital employees have both a constitutional and statutory obligation to keep appropriate clinical notes. Medical practitioners are further obliged to do so by the various ethical rules and guidelines of their relevant professions.

While in some judgments the court did not draw any adverse inference against the hospital because of the absence of the records it did find that the absence of records played a role in determining whether the evidence of the patient was acceptable and satisfactory in establishing the alleged negligence on the part of the medical staff. Often the absence of records, or incomplete records means that the patient's version of events goes largely uncontested.

In one of the cerebral palsy case judgments the defendant MEC argued that the court conflated the failure to keep records with causal negligence and that was incorrect. The court did say that the question whether missing records should bear on a finding of causation and negligence is an important one to be considered and clarified by the Supreme Court of Appeal. The court was careful not to say that it had drawn a negative inference against the MEC due to the missing records, but the court did imply that the missing records bore weight in the judgment. Because of the increasing number of medical negligence cases involving the absence of or incomplete records the court allowed leave to appeal to the Supreme Court of Appeal.

It will be interesting to see what that SCA does with the question. It is likely that the impact of absent or incomplete medical records will always be dependent on the facts of the particular case and evidence presented. What is clear is that the absence of or incomplete medical records constitutes a significant ongoing problem for public health facilities in particular in the defence of medical malpractice claims.

Harm does not always lie where it falls

A number of the judgments also considered whether the mere fact that the injury had occurred should lead to an inference of negligence. The judgments dealt with the principle of *res ipsa loquitor*, (which holds that the mere occurrence of the kind of injury is sufficient to imply negligence) and reiterated that this principle is nothing more than a convenient Latin phrase used to describe proof of facts sufficient to support an inference that the defendant was negligent.

All of the judgments emphasised that the onus of proof in medical negligence cases is no different than in any other civil case. The onus is on the plaintiff to prove all the elements of the claim on the balance of probabilities. The judgments consistently held that the courts will not likely assume negligence just because an injury occurred.

The courts have also consistently held that if a doctor acts reasonably they cannot be found negligent merely because another doctor also acting reasonably would have done something different.

Time span for litigation

Litigation is a long road. Most of the cases took about seven to eight years to conclude from the date of harm to the date of the judgment. An outlier was one cerebral palsy case that took fifteen years to conclude. Another judgment took eighteen years to conclude but that was a claim which had actually prescribed (expired due to the running of time).

A few judgments were given about four years after the harm occurred but were interlocutory judgments, for example, dealing with access to documents.

Due to the time and costs involved in litigation, alternative medical dispute resolution (including mediation) of medical malpractice claims is currently much favoured by many of the private practitioner professional bodies, and public health authorities.

We have published a comprehensive Annual Survey of Medical Malpractice Judgments of 2018 detailing the judgments and key takeaways grouped by category, which also includes a tabulated review of those medical malpractice cases for quick reference.

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