UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

AN ANALYSIS OF THE DUTY OF CARE CONCEPT FROM A PRAGMATIC MEDICAL MALPRACTICE PERSPECTIVE

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Submitted in partial fulfilment of the requirements for the degree

Magister Philosophiae

(Medical Law and Ethics)

in the

Faculty of Law, University of Pretoria

9 January 2017

Supervisor:

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DECLARATION OF ORIGINALITY

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DR ELIZABETH MEYER

ACKNOWLEDGEMENTS

I would like to acknowledge and thank Prof PA Carstens for his guidance and mentorship during the past two years.

I would further like to thank all my friends and next-of-kin who have supported and encouraged me over the last month as I was completing this mini-dissertation.

SUMMARY

The focus in the mini-dissertation is the concept of the duty of care which is analysed from a pragmatic medical malpractice perspective. South Africa has experienced a sharp increase in medical malpractice litigation in recent years and, although there is anecdotal evidence that many of these cases are without merit, this trend causes great concern in both public and private health sectors.

The South African medical malpractice liability system is replete with contradictions – why is it that not all patients who suffer negligent injuries institute action against health care professionals, and why do other patients who suffered no negligent injury, litigate? Theories that good communication may be a factor and that physicians who communicate well with their patients are less likely to be sued are supported in the dissertation.

The duty of care, although a legal concept, lies at the heart of good medical practice. Physicians owe their patients a duty of care, both in contract and in delict. Codes of ethics further influence the standard of behaviour of the physician. Concerns have been expressed that there is a decline in professionalism and that the standard of care offered has decreased. Physicians are not infallible and to err is human. As South Africa is a country with limited resources it may be necessary to opt for a utilitarian standard of care that in many instances is below that which is expected in the developed world, but there is no ethical or legal reason why patients should be denied the duty of care.

The foundations in contract and delict of the duty of care are laid down and the relevance of standards of care in this context is outlined. Actions constituting negligence are examined and the responsibilities of the health professional in relation to the duty of care are discussed and applied in the context of South African medical malpractice. Recommendations are proposed for consideration to curb the South African medical malpractice storm.

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INTRODUCTION

'I am also satisfied that a person who has a duty of care may be guilty of murder by omitting to fulfil that duty, as much as by committing any positive act.'

This quotation by Lord Havers in a British High Court Judgement[1] was the reason why I initially decided on the topic and title for my dissertation- 'An analysis of the duty of care concept from a pragmatic medical malpractice perspective'. I was attracted to the topic as it straddles the legal and the medical professions. It has a strong ethical component and, as a medical professional, I have always considered the duty of care to be the ethical foundation on which the medical profession should be based.

There can be no doubt that South Africa is facing a '… medical malpractice storm'.[2] Unfortunately, there are no reliable statistics available to gauge the extent of the crisis. The only recent data available reflects the crisis in the public sector. It is extremely unlikely that the situation facing the private sector is of the same magnitude. Unfortunately, the Medical Protection Society - the major indemnifier of the medical profession in South Africa – has not released data since 2012. My hypothesis is that if members of the medical profession carried out their duty of care with integrity and dedication, this crisis could be obviated or at least stabilised and, consequently, this is my argument in the dissertation.

Initially I proposed to study the situation in both the public and private health sectors for my dissertation (as may be seen from my research proposal submitted in May 2016). This was far too bold and over-ambitious, and rather more suited to further, post-Master's degree studies. The dissertation, therefore, focusses on the duty of care as it pertains to the physician in the private sector, referring to the public sector only where, in my opinion, it is germane to my argument to show up the contrast and differences between the two sectors.

The first three chapters are an attempt by me, with a medical – rather than a legal - background, to achieve a rudimentary understanding of the basic applicable legal tenets on which I could construct a dissertation which would span both professions and include the necessary ethical component. These chapters, therefore, lay the legal basis for the arguments and analyses in subsequent chapters on the concept of duty of care.

Chapter 4 is a discussion on medical negligence and the relevance of the standard of care, while chapter 5 lays the foundation for the nature of the physician's duty of care. Chapter 6 elaborates the physician's duties resulting from the contractual and delictual principles introduced and discussed in the first three chapters. Chapter 7 analyses and applies the concept of a duty of care from a South African medical malpractice perspective. Finally, in

[1] McDonald *The Oxford Dictionary of Medical Quotations* (1984) 43. The comment was made in the case of *R v Arthur (Judgment)* (1981) 12 *BMLR* 1 at 18 and was repeated by the Attorney-General of the United Kingdom of Britain in response to questions in the Commons (Parliament). See *HC Deb* 08 March 1982 vol 19 cc 348-9W.
[2] Pepper & Slabbert 'Is South Africa on the verge of a medical malpractice storm?' 2011 *SAJBL* 29-35.

chapter 8, I draw my conclusions on my findings in the study and offer recommendations for consideration to curb the South African medical malpractice storm.

As offering a solution to the malpractice storm is not the primary focus of the dissertation, these are discussed in a sketchy manner only, with the exception of the possibilities offered by paying close attention to the implications of the concept of the duty of care, as this concept is central to the dissertation.

The dissertation far exceeds the word count prescribed for a short dissertation of this nature. However, this is a consequence of the fact that, as a non-legal practitioner, I had to establish the foundations in law for the duty of care, and also had to establish these principles clearly in my own mind. The reader's indulgence in this regard is called for.

CHAPTER 1

A BRIEF OVERVIEW OF THE ROLE OF THE LAW OF OBLIGATIONS IN HEALTH SERVICES DELIVERY

1.1 Introduction

The law of obligations, which is concerned with rights and duties *in personam*, is the point of departure in analysing the duty of care *vis-à-vis* health services delivery.[3] An obligation is:

> A legal or juridical bond (juridical tie)[4] between two legal subjects[5] in terms of which the one, the creditor, has the right[6] to a particular performance against the other, the debtor, while the debtor has a corresponding duty to render the performance.[7]

The main sources (juridical ties) of obligations are contract, delict, unjustified enrichment, *negotiorum gestio*,[8] the exercising of a statutory administrative or official authority (duty),[9] wills and family relations.[10]

Juridical ties in health services delivery are predominantly created by contract, delict, *negotiorum gestio* and the exercising of a statutory administrative or official authority.[11]

The legal components and prerequisites of each of these juridical sources will be examined briefly below with specific emphasis on where the duty of care fits in.

1.2 Contract

1.2.1 General

A contract is:

> An agreement (based on consensus between legal subjects who have contractual capacity to do so, and which is lawful, physically possible and complies with the prescribed formalities) reached with the intention of creating a legal obligation with resulting rights and duties.[12]

The requirements for a valid and binding contract are:[13]

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[3] Hahlo & Kahn *The South African Legal System and its Background* (1985) 120; Zimmermann *The Law of Obligations: Roman Foundations of the Civil Tradition* (2013) 1-6; Harms *LAWSA* (ed Joubert) 19 (2016) par 218; Hutchison *et al The Law of Contract in South Africa* (2012) 7-8.

[4] This legal tie must be recognised by law and is created because of certain legal facts; De Wet & Van Wyk *Die Suid-Afrikaanse kontrakte en Handelsreg* (1992) 4.

[5] A legal subject is an entity which may have rights and duties such as a human being or company. Otto in Nagel *et al Commercial Law* (2015) 9; Hahlo & Kahn 4-20.

[6] This right is classified as a subjective right and is divided into real rights (ownership), immaterial rights (intellectual creations), personality rights (dignity) and personal rights (the right to performance ito an obligation); Otto 10; Hahlo & Kahn 4-20.

[7] Harms par 219; *D* 44 7 3 *et seq*.

[8] Ie an unauthorised agency where a person without being instructed to do so, manages the affairs of another at the former person's expense; Joubert & Van Zyl *LAWSA* (ed Joubert) 17 (1999) par 17; Otto 23.

[9] *Ibid*.

[10] Hutchison 8; Midgley & Van der Walt *LAWSA* (ed Joubert) 8 (2005) par 1.

[11] *Ibid*.

[12] Otto 40; Hutchison; Christie *The Law of Contract* (2011) 12; Kahn *Contract and Mercantile Law through the Cases* (1971) 2; Van Rensburg *et al LAWSA* (ed Joubert) 9 (2015) par 295; De Wet & Van Wyk 4; Lee *An Introduction to Roman-Dutch Law*' 1953 208.

- Consensus - the minds of the parties must meet (really or ostensibly) on all relevant aspects of their agreement. Thus, the parties must have matching intentions with the serious-minded purpose of concluding a specific contract with its associated consequences.[14]
- Capacity - the parties must have the necessary ability to be able to form a legally recognised intent for the purpose of concluding a contract.[15]
- Formalities – these are the external visible form of the contract. As a general rule no formalities are required, unless prescribed by statute or agreed by the parties themselves. Formalities usually consist of writing and/or the signatures of the parties.[16]
- Legality - the agreement must be legal in so far as it must not be contrary to the common law, any statutory rule, public policy or good morals.[17]
- Physical possibility - the obligations agreed to must objectively be capable of performance at the time the contract is concluded.[18]
- Certainty - the agreement must have a determined or determinable content, so that the obligations can be established and implemented.[19]

A health services delivery contract must, with the exception of the formality requirement, comply with all of the above prerequisites.

The nature of a health services delivery contracts will next be explored briefly.

1.2.2 Nature of the Health Services Delivery Contract

The nature of a contract is determined by the *essentialia* incorporated into the consensus reached between the parties.[20] *Essentialia* are those distinctive terms used to classify a contract as one of the specific contracts recognised by the common law.[21] Each such classification of specific contracts also has tacit standard terms automatically included in

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[13] Hutchison 6; Otto 41; Van Rensburg *et al* pars 296 and 328-351.
[14] Consensus is reached when an offer (*ie* a declaration of intention in which the offeror's proposals regarding the proposed contract is fully set out) is unequivocally assented to by the offeree; Van Rensburg *et al* paras 300-307; Hutchison 47-79; Otto 50-73.
[15] Davel & Jordaan *The Law of Persons* (2005) 65-75; Van Heerden, Cockrell & Keightly *Boberg's The law of Persons and the Family* (1999) 71.
[16] *Neethling v Klopper* 1967 4 SA 459 (A); *Johnston v Leal* 1980 3 SA 927 (A); *Ferreira v SAPDC (Trading) Ltd* 1983 1 SA 235 (A); *Philmatt (Pty) Ltd v Mosselbank Developments Corporation* 1996 2 SA 15 (A).
[17] Van Der Merwe *Contract: General Principles* (2012) 191-210; *De Jager v Absa Bank Bpk* 2001 3 SA 537 (SCA); Hutchison 175-203.
[18] *Wilson v Smith* 1956 1 SA 398 (A); Hutchinson 206-210.
[19] *Burroughs Machines Ltd v Chenville Corporations of SA (Pty) Ltd* 1964 1 SA 669 (W); *De Beer v Keyser* 2002 1 SA 827 (SCA); Hutchinson 210-216.
[20] Hutchison 237; Van Rensburg *et al* par 353; *Treasurer-General v Lippert* (1881) 1 SC 291; *Vasco Dry Cleaners v Twycross* 1979 1 SA 603 (A); *BC Plant Hire CC t/a BC Carriers v Grenco (SA) (Pty) Ltd* 2004 4 SA 550 (C).
[21] *Ibid*.

the consensus by operation of law, known as *naturalia*,[22] unless modified by an *incidentale*, which is a specific term integrated by the parties into their contract by explicit agreement.[23]

The nature of a health services contract is a contract of mandate, that is:

> A consensual contract between one party, the mandatory (patient), and another, the mandatary (health care worker), in terms of which the mandatary undertakes to perform a mandate … for the mandatory.[24]

Some authors classify the contract between patient and health care worker as one of letting and hiring of work (*locatio conductio operis*).[25] The latter requires, as an *essentialia*, that a contractor (mandatary) must complete a specific piece of work or deliver a specified service to a *corporeal thing belonging to the client* (patient).[26] In other words, a *corporeal thing*, to be created or repaired, belonging to the patient, is the subject matter of such an agreement and not the services delivered by the mandatary *per se*.[27] Consequently, I am of the view that nature of a health services contract is one of mandate as defined above.[28]

This assessment is substantiated by the general duties of a mandatary,[29] which is to personally[30] carry out the mandate[31] within the scope of the mandate,[32] to act with reasonable care[33] and in good faith,[34] to render accounts[35] and be accountable,[36] which duties are also in line with the general duties of a health care worker.

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[22] Van Rensburg *et al* par 354; Hutchison 237-238; Van der Merwe *et al* 283; *Botha v Swanepoel* 2002 4 SA 577 (T).

[23] Van Rensburg *et al* par 355; Hutchison 238; Lubbe & Murry *Farlam & Hathaway Contract: Cases, Materials and Commentary* (1988) 417; Van der Merwe *et al* 284.

[24] Joubert & Van Zyl par 2; *D* 17 1 1*pr*; *I* 4 6 28; Grotius *Inleiding* 3 12 2. In Roman Law the contract of *mandadum* was one of the *contractus consensus* and was based on good faith; Joubert & Van Zyl par 2 fn 1.

[25] Slabbert *Medical Law in South Africa* (2011) 70; Strauss *Doctor, Patient and the Law: A Selection of Practical Issues* (1991) 69.

[26] Prozesky-Kuschke in Nagel *et al Commercial Law* (2015) 699-670.

[27] Van der Merwe *et al* 288; Nienaber *LAWSA* (ed Joubert) 9 (2015) par 9; *Alfred McAlpine & Son (Pty) Ltd v Tvl Provincial Administration* 1974 3 SA 506 (T).

[28] In exceptional cases the nature of a health services contract may be one of letting and hiring of services (*locatio conductio operarum*): Slabbert 70; *Myers v Abramson* 1952 3 SA 121 (C).

[29] Nienaber paras 7-13.

[30] *Belonje v African Electric Co (Pty) Ltd* 1949 1 SA 529 (EDL). The fundamental rationalisation for this rule is that the mandatory select the mandatory because of his or skill and expertise: *Voet* 17 1 5; *Van der Keessel* 3 12 5; Nienaber par 9.

[31] *Blatt v Swakopmunder Bankverein GmbH* 1929 SWA 90; *Bloom's Woollens (Pty) Ltd v Taylor* 1962 2 SA 532 (A).

[32] *Poppe Russouw & Co v Kitching* (1888) 2 SC; *Venter v New Clare Smelting Works Ltd* 1928 GWL 78.

[33] *I* 4 6 28; *D* 17 1 10*pr*; *Knoble v Murry* (1854) 2 Searle 75; *Colonial Government v Green* (1870) 3 Buch; *Thomas v Benning* (1878) 8 Buch 16; *Scamia & Co v Table Bay Harbour Board* (1900) 17 SC 121; *Mead v Clark* 1922 EDL 49; *Mouton v Die Mynwerkersunie* 1977 1 SA 119 (A).

[34] This duty goes hand in hand with the duty to act reasonably: *D* 17 1 8 10; *D* 17 1 22 11; *D* 17 1 26 8; *D* 17 1 29 pr; *Leites v Contemporary Refrigeration (Pty) Ltd & Sonpoll Investments (Pty) Ltd* 1968 1 SA 58 (A); *SA Fabrics Ltd v Milliman* 1972 4 SA 529 (A).

[35] *Robert P McNair v Charles Hitchens* (1889) 10 NLR 189; *Curtis-Setchell, Lloyd and Mathews v Koeppen* 1948 3 SA 1024 (W).

[36] *Jeffery v Pollak and Freemantle* 1938 AD 1; *Street v Regina Manufacturers (Pty) Ltd* 1960 2 SA 646 (T).

The duty of a mandatary to act with reasonable care and in good faith is of distinct significance concerning the '*duty of care*' required from a health care worker, when considering and subsequently for this topic.

For a mandatary (health care worker) to act with reasonable care *vis-à-vis* his or her mandate in order to comply with the 'duty of care' requirement, involves the following:[37]

- The mandatary is obligated to execute his or her mandate with reasonable care, skill and diligence, which, in my view, characterises a 'duty of care.'[38]
- Should the mandatary (health care worker) fail to apply the necessary reasonable care, skill and diligence ('duty of care') he or she will be negligent and liable for damage or injury caused to the mandatory (patient).[39]
- If the mandatary is also given a discretion, he or she is compelled to exercise such discretion with the appropriate care and acquaint him or herself with all the key prerequisites of the mandate and surrounding circumstances.[40]

The mandatary must also act in good faith which, additionally, requires him or her to notify the mandator timeously of new or unforeseen circumstances which may influence the outcome of the mandate or be harmful to the mandator.[41] The negligent failure to do so may cause the mandatary to be liable.[42]

The extent of care expected of the mandatary developed from Roman times, when the mandatary was liable for the absence of ordinary or reasonable care, skill and diligence.[43] However, in the medieval period three core classifications were eventually recognised, namely: *Culpa lata* (gross negligence), *culpa levis* (ordinary negligence) and *culpa levissima* (the slightest negligence). It was common convention that a mandatary was constrained to maintain the highest degree of care, skill and diligence and the slightest negligence (*culpa levissima)* would lead to him or her being liable to the mandator. This benchmark, in my view, is a clear indication of the standard of care, skill and diligence which may be expected from a mandatary.[44]

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[37] Nienaber par 10.
[38] *Kennedy v Loynes* (1909) 26 SC 271; *Steenkamp v Du Toit* 1910 TPD 171; *McAlpine v Anderson's Executors* 1926 NPD 377; *Gardner's Estate v Arthur Meikle & Co Ltd* 1946 WLD 286; *Bloom's Woollens (Pty) Ltd v Taylor* above.
[39] Nienaber par 10.
[40] *Ibid.*
[41] *Ibid.*
[42] *Ibid.*
[43] *Ibid*.
[44] *Knoble v Murray* above; *Van der Spuy v Pillans* (1875) 5 Buch 133; *Thomas v Benning* above; *Rogers v Forder and Co* (1882) 3 NLR 8; *Natal Trust and Insurance Co v CC Griffin and Henry Griffin* (1887) 8 NLR 109; *Smit v Tonkin* 1888 *CLJ* 45; *De Villiers v De Villiers* (1887) 5 SC 369; *Pama v Freemantle* (1905) 19 EDC 141; *Larter v Daly* 1914 EDL 23; *Ferreira v Gingell, Ayliff and Co* 1921 EDL 374; *Thomson Watson and Co v Poverty Bay Fanners' Meat Co Ltd* 1924 CPD 380; *McAlpine v Anderson's Executors'* above; *Peffers v Attorneys, Notaries and Conveyancers Fidelity Guarantee Fund Board of Control* 1965 2 SA 53 (C); *Bloom's Woollens (Pty) Ltd v Taylor* above.

Should the execution of the mandate necessitate special knowledge, skill, competence or expertise, the mandatary warrants, by his or her acceptance of the mandate, that he or she is properly skilled.[45] If the mandatary is inadequately skilled, he or she will be liable for damages occurring therefrom.[46]

The 'good faith' prerequisite also directs the mandatary to act honestly and appropriately and in the interest of the mandator.[47] Thus, the mandatary must act with integrity, transparently and honestly in order to apply his or her skill, knowledge and expertise to the mandator's benefit.[48]

Accordingly, a health care worker, as mandatary in terms of his or her contract of mandate, has a contractual 'duty of care' to act with the necessary care, skill and diligence.

1.3 Delict

1.3.1 General

A delict, in general terms, is a wrongful and blameworthy (culpable) civil act which causes harm to a person.[49]

The fundamental requirements for delictual liability are:

> [H]arm sustained by the plaintiff; conduct on the part of the defendant which is wrongful; a causal connection between conduct and the plaintiff's harm; and fault or blameworthiness on the part of the defendant.[50]

The following elements must be present before a person can be held liable in delict, namely: Conduct; wrongfulness; fault; causation; and patrimonial loss or impairment of personality.[51] Each of these components will be considered briefly below.

1.3.2 Conduct

A person's conduct is controlled by his or her will.[52] The transgressor has to make a wilful decision to act willingly.[53] If a person acts in a state of automatism his or her conduct is not wilful and thus he or she will be not be accountable for their actions[54].

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[45] *Sciama and Co v Table Bay Harbour Board* above; *Honey and Blackenberg v Law* 1966 2 SA 43 (R); *Mouton v Die Mynwerkersunie* above.
[46] Nienaber par 10.
[47] *D* 17 1 10*pr*; *D* 17 1 22 4; *D* 44 7 5 *pr*.
[48] *Leites v Contemporary Refrigeration (Pty) Ltd and Sonpoll Investments (Pty) Ltd* 1968 1 SA 58 (A); *SA Fabrics Ltd v Millman* 1972 4 SA 592 (A).
[49] De Groot *Inleiding* 3 32 3-6; Midgley & Van der Walt 2; Boberg *Law of Delict Vol 1 Aquilian Liability* (1984) 1; *Cape of Good Hope Bank v Fischer* (1886) 4 SC 368; *Whittaker v Ross & Bateman, Morant v Ross & Bateman* 1912 AD 92; *Bredell v Pienaar* 1924 CPD 203; *Perlman v Zoutendyk* 1934 CPD 151; *Minister of Justice v Hofmeyr* 1993 3 SA 131 (A).
[50] Midgley & Van der Walt 2; *Evans v Shield Insurance Co Ltd* 1980 2 SA 815 (A); *HL and H Timber Products (Pty) Ltd v Sappi Manufacturing (Pty) Ltd* 2001 4 SA 814 (SCA).
[51] Neethling, Potgieter & Visser *Law of Delict* (2015) 25-263.
[52] Burchell *Principles of Delict* (1993) 36-37.
[53] Loubser, Midgley, Mukheiber, Niesing & Perumel *The Law of Delict in South Africa* (2012) 64; Neethling 26; *S v Jonson* 1969 1 SA 201 (A).

Conduct is categorised as a positive act (*commissio*), or a negative act (*omissio*).[55] A person can only be held liable in delict for his or her *omissio* if there is a legal duty to act.[56] The following scenarios are currently recognised in law as paradigms where an *omissio* not to act, triggering harm to another person, may lead to delictual liability:[57]

- If a person creates a potentially dangerous situation and fails to remove the danger, known as an *omissio per commissionem*;[58]
- If a person had the know-how and insight to realise that his or her *omissio* might cause damage and nevertheless neglects to act in accordance with what the legal convictions of the community expect of him or her;[59]
- If a person manages a dangerous object and fails to apply appropriate control over it;[60]
- Where either the common or statutory law has a stipulation demanding that a person acts in a prescribe manner and he or she refuses to comply;[61]
- If a public officer (such as a medical registrar) has to act in a specified modus operandi and fails to do so;[62]
- It is expected from a person to act in a particular manner where an extraordinary relationship exists (such as the liaison between a medical care worker and a patient);[63]

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[54] *S v Shivute 1*991 (1) SACR 656 (Nm)

[55] Loubser 67; Neethling 30; Boberg *The Law of Delict: Vol 1 Aquilian Liability* (1984) 211; *Premier, Western Cape v Faircape Property Developers (Pty) Ltd* 2003 6 SA 13 (SCA).

[56] *Carmichele v Minister of Safety and Security* 2001 (4) SA 938 (CC) 962.

[57] Neethling 58-79; Loubser 219-223; Burchell 39; *Cape Town Municipality v Bakkerud* 2000 3 SA 1049 (SCA).

[58] *Halliwell v Johanesburg Municipal* Council 1912 AD 659; *Silva's Fishing Corporation (Pty) Ltd v Maweza* 1957 2 SA 256 (A); *Regal v African Superslate (Pty) Ltd* 1963 1 SA 102 (A); *Minister van Polisie v Ewels* 1975 3 SA 590 (A); Neethling 60-62.

[59] Loubser 223; Neethling 65-66; *Langley Fox Building Partnership (Pty) Ltd v De Valence* 1991 1 SA 1 (A); *Minister of Community Development v Koch* 1991 3 SA 751 (A).

[60] Loubser 221-222; Boberg 212; *Cape Town Municipality v Bakkerud* above; *Minister of Water Affairs v Durr* [2007] 1 All SA 337 (SCA).

[61] Loubser 222; Neethling 66-69; *Minister van Polisie v Ewels* above; *Olitzky Property Holdings v State Tender Board* 2001 3 SA 1247 (SCA); *Premier, Western Cape v Faircape Property Developers (Pty) Ltd* above.

[62] Neethling 71; Loubser 223; Burchell 44; *Macadamia Finance Ltd v De Wet* 1991 4 SA 273 (T); *Carmichele v Minister of Safety and Security* above.

[63] Loubser 222; Neethling 69-71; Chürr 'Delictual Claim Based on 'Wrongful Life': Is it Possible' 2009 *THRHR* 168; *Premier, KwaZulu-Natal v Sonny* 2011 3 SA 424 (SCA); *Steward v Botha* 2008 6 SA 310 (SCA); *Bayer South Africa (Pty) Ltd v Frost* 1991 4 SA 559 (A); *Minister van Polisie v Ewels* above. Davel '*Greenfields Engineering Works (Pty) Ltd v NRK Construction (Pty) Ltd* 1978 4 SA 901(N)' 1979 *THRHR* 214 expressed her disbelief that it was held in the *Greenfield*-case, which was decided after *Minister van Polisie v Ewels*[63], that liability for an omission may rightly be considered exceptional. However, in the *Ewels*-case Rumpff JA[63] explicitly indicated that as a general rule liability does not emanate from an omission and there is no general legal duty of care on a person to prevent someone else from suffering damage, even though such person could effortlessly avert the harm, or even if it could have been assumed that he or she, on a moral foundation, could have thwarted the loss.

- Where a person is contractually compelled to protect another from harm and breaches his or her contractual obligation;[64]
- Where a person creates the impression that he or she will protect the interests of a third party but fails to comply with the false impression;[65] and
- Where the state has a common law or constitutional duty to act but fails to act accordingly.[66]

The duty of care is debated in detail in chapters 3, 5 and 6 below.

1.3.3 Wrongfulness

Wrongfulness is primarily linked to the infringement of subjective rights.[67] The following subjective rights are acknowledged in law; real rights, (for example ownership); personal rights (for example contractual claims); personality rights (for example the violation of a person's *dignitas*); and intellectual property rights (for example patents).[68] Any infringement upon a person's subjective rights is *prima facie* wrongful and there is a general legal duty not to breach another person's subjective rights.[69]

The *boni mores* of the general public, which is subject to an objective test founded on reasonableness[70] in view of all the facts of each particular scenario, may also determine whether a person acted wrongful or not.[71]

The role of a duty of care in ascertaining wrongfulness is discussed in chapters 3, 4 and 6 below.

The following grounds of justification are defences to findings of wrongfulness:[72]

- Private or self-defence - that is where a person defends his or a third party's interests by warding off an unlawful attack or imminent unlawful attack.[73]

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[64] Neethling 71-72; *Chartaprops 16 (Pty) Ltd v Silberman* 2009 1 SA 265 (SCA); *Viv's Tippers (Edms) Bpk v Pha Phama Staff Services (Edms) Bpk h/a Pha Phama Security* 2010 4 SA 455 (SCA).
[65] Neethling 71-73; Loubser 222; *Compass Motors Industries (Pty) Ltd v Callguard (Pty) Ltd* 1990 2 SA 520 (W).
[66] *Rail Commuters Action Group v Transnet Ltd t/a Metrorail* 2005 2 SA 359 (CC).
[67] *Clarke v Hurst* 1992 4 SA 630 (D); *Premier, Western Cape v Faircape Property Developers (Pty) Ltd* above; Loubser 18-21; Neethling 33, 51-55.
[68] *Universiteit van Pretoria v Tommie Meyer Films (Edms) Bpk* 1977 4 SA 376 (T); Neethling, Potgieter & Visser *Neethling's Law of Personality* (2005) 52-54.
[69] Neethling 45-47; Brand 'Reflections on Wrongfulness in the Law of Delict' 2007 *SALJ* 76.
[70] Reasonableness, as an open-ended benchmark, is connected to the evaluation the rights, by taking into account the nature and extent of the harm caused, the value of the loss to the victim, preventative measures, the nature of the relationship between the parties, the motive and education of the wrongdoer. The Constitution (chap 2, the Bill of Rights) compels that the *boni mores* must encompass and safeguard constitutional ideals and standards. Loubser 32; *Steenkamp NO v Provincial Tender Board Eastern Cape* 2007 3 SA 121 (CC); *Carmichele v Minister of Safety and Security (Centre for Applied Legal Studies Intervening)* 2001 4 SA 938 (CC); *SM Goldsstein and Co v Cathkin Park Hotel (Pty) Ltd* 2000 4 SA 1019 (SCA); *McMurray* v *HLandH (Pty) Ltd* 2000 4 SA 887 (N).
[71] Neethling 36-50; *Steenkamp NO v The Provincial Tender Board, Eastern Cape* above; *Universiteit van Pretoria v Tommie Meyer Films (Edms) Bpk* above; *Phumelala Gaming and Leisure Ltd v Gründeling* 2007 6 SA 350 (CC); *Hatting v Roux NO* 2011 5 SA 135 (WCC); *Lee v Minister for Correctional Services* 2013 2 SA 144 (CC).
[72] Neethling 87-128; *Malahe v Minister of Safety and Security* 1999 1 SA 528 (SCA).

- Necessity – this is where any other state of necessity or superior force, excluding a wrongful human attack, compels a person to act in a manner that results in harm to an innocent third party.[74]
- Consent to injury and voluntary assumption of the risk of injury - this is where a person waives his or her rights to bodily integrity and consents to an injury being done to him or her, or to the risk of such injury.[75]
- Unauthorised agency - this is where a person acts in order to safeguard the interest of another, but without the latter's consent (*negotiorum gestor*).[76]
- Statutory authority - this is where a statutory proviso sanctions a person to act in a specific way.[77]
- Official capacity – this is where a person's official position authorises him or her act in a certain manner.[78]
- Power to discipline - this relates to persons acting *in loco parentis* who may oversee lawful punishment for correction and education.[79]
- Provocation - this is where a person is provoked by the words or actions of another and acts in revenge.[80]
- Doctrine of the abuse of rights, nuisance and neighbour law - this is where a person abuses any of his or her rights for his or her own benefit, and resultantly causes another person, e.g. his neighbour some form of prejudice.[81]

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[73] Loubser 175; Burchell 67; *Muugwena v Minister of Safety and Security* 2006 4 SA 150 (SCA); *Feni v Kondzani* [2007] 4 All SA 762 (EC); *Ex parte Minister van Justisie: In re S v Van Wyk* 1967 1 SA 488 (A).

[74] Neethling 97-104; Loubser 171-175; *Maimela v Makhado Municipality* 2011 6 SA 533 (SCA); *S v Goliath* 1972 3 SA 1 (A).

[75] Neethling 108-114; Van Oosten *The Doctrine of Informed Concent in Medical Law* (1989) 127; *Santam Insurance Co Ltd v Voster* 1973 4 SA 764 (A); *Lampert v Heever* 1955 2 SA 507 (A). This justification ground is of vital significance to medical care worker and will be discussed in more detail in chap 6. However the gist of the requirements to succeed with this defence is that lawful consent in line with the *boni mores*, as a unilateral act, must be given freely or voluntarily in a serious and intentional manner, either expressly or tacitly, before the injuring conduct starts, with the complete understanding that rights will be waived, proved that the medical worker needs to act within the boundaries of the given consent.

[76] This aspect as a source of a legal obligation will be discussed in more detail below.

[77] Neethling 114-118; Loubser 181-183; *Premier, Western Cape v Faircape Property Developers (Pty) Ltd* above; *Govender v Minister of Safety and Security* 2001 4 SA 273 (SCA).

[78] Neethling 119-120; Loubser 183; *Telematrix (Pty) Ltd t/a Matrix Vehicle Tracking v Advertising Standards Authority* 2006 1 SA 461 (SCA).

[79] Neethling 121-123; Loubser 184-185; Burchell 78-79; *Christian Education of South Africa v Minister of Education* 1999 4 SA 1092 (SE).

[80] Neethling 104-108; Loubser 179-181; *Bester v Calitz* 1982 3 SA 864 (A).

[81] Neethling 123-128; *Gien v Gien* 1979 2 SA 1113 (T); *PGB Boerdery Beleggings (Edms) Bpk v Somerville 62 (Edms) Bpk and another* 2008 2 SA 428 (SCA).

1.3.4 Fault

Fault, in general terms, as a subjective element of delict, entails that the wrongdoer must be blameworthy (culpable) for his or her wrongful conduct and consist of either intent or negligence.[82]

Only a wrongdoer with the mental capacity to distinguish between right and wrong and to act accordingly with an understanding of the possible consequences of his or her actions (accountability) at the time of his or her conduct, may be considered legally blameworthy.[83]

Intent is present when a wrongdoer intentionally directs his or her will to accomplish a specific outcome, while being aware that it is wrongful[84] and can be classified as: Direct intention (*dolus directus*);[85] indirect intention (*dolus indirectus*);[86] and *dolus eventualis*.[87]

Negligence is where a person acts unintentionally, nonetheless his or her conduct does not abide to the criterion of conduct which could legally be expected of him or her in those particular circumstances.[88] The conduct is assessed according to the objective standard of the reasonable person.[89] Conduct can only be negligent if it is evident that the reasonable person would have acted differently in similar circumstances,[90] in so far as he or she would reasonably have foreseen the consequences of their actions and foiled it from occurring.[91]

Professional persons, such as health care workers, are required to act within a more significant degree of care and caution within their sphere of expertise, which degree of skill is not demanded from the reasonable person.[92]

The function of a duty of care to ascertain negligence is evaluated in chapters 3, 4 and 6.

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[82] Neethling 129-158; Loubser 102; Burchell 85; *First National Bank of South Africa v Duvenhage* 2006 5 SA 319 (SCA).
[83] Neethling 131-132; *Minister of Safety and Security v Carmichele* above.
[84] Neethling 132; *Dantex Investment Holdings (Pty) Ltd v Brenner* 1989 1 SA 390 (A); *Black v Joffe* 2007 3 SA 171 (C).
[85] *Ie* where a wrongdoer focuses his will at wanting and accomplishing a precise result. Neethling 133.
[86] *Ie* where the wrongdoer directly anticipates one consequence and proceeds to act, notwithstanding being certain that another consequence will be inevitable. Neethling 133; *Nationale Pers Bpkt v Long* 1930 AD 87
[87] *Ie* where the wrongdoer foresees the probability that a particular result might develop, but continues to act, notwithstanding this possibility. Neethling 133-135; *Minister of Justise and Constitutional Development v Moleko* [2008] 3 All SA 47 (SCA); *Frankel Polllak Vinderine Inc v Stanton* 2000 1 SA 425 (W); *Country Cloud Trading CC v MEC, Department of Infrastructure Development, Gauteng* [2014] ZACC 28.
[88] Neethling 137-158; Loubser 117.
[89] *Ie* the conduct that is not in accordance with that of the reasonable person who finds himself or herself in the same circumstances: *Kruger v Coetzee* 1966 2 SA 428 (A); *SATAWU v Garvas* 2013 1 SA 83 (CC); *Herschel v Mrupe* 1954 3 SA 464 (A).
[90] *Moubary v Syfret* 1935 AD 199; *Cape Town Municipality v Butters* 1996 1 SA 473 (C).
[91] Loubser 120; *Premier, Western Cape v Faircape Property Developers (Pty) Ltd* above; *Shabalala v Metrorail* 2008 3 SA 142 (SCA); *Administrateur Natal v Trust Bank van Afrika Bpk* 1979 3 SA 824 (A); *Kruger v Coetzee* above*; Jones NO v Santam Bpk* 1965 2 SA 542 (A).
[92] Neethling 145-147; *McDonald v Wroe* 2006 3 All SA 656 (C); *Steward v Botha* 2008 6 SA 310 (SCA); *Buthelezi v Ndaba* 2013 5 SA 437 (SCA).

1.3.5 Causation

Causation, which hinges on a factual enquiry, is the nexus between the act (*commissio* or *omissio*) and the damage suffered.[93] If this link is absent, the wrongdoer is not liable in delict.[94]

A distinction is made between a factual[95] and legal causation.[96] Factual causation is usually verified by the *conditio sine qua non* or 'but for' test.[97] That is, will the consequences of the unlawful conduct fall away if the unlawful conduct is eliminated from the equation.[98] Thus, the act must be a *sine qua non* to the consequence thereof.[99] However, the remoteness of the consequence is narrowed by the implementation of legal causation which is based on policy considerations such as reasonableness, fairness and justice, reasonable foreseeability, as well as adequate causation[100] and fault.[101]

Nevertheless, a *novus actus interveniens* may result that the factual causation is interrupted.[102] If not, legal causation should then limit the wrongdoer's liability in such circumstances.[103] [104]

1.3.6 Damage

Damage in a delictual sense can be described as the harmful impact upon any patrimonial or personality interest considered worthy of protection by the law.[105] A person can only be held liable in delict for actual damage initiated by his or her behaviour.[106] Damage can comprise patrimonial loss or the impairment of personality.[107] The latter is irrelevant for

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[93] Neethling 183-220; *First National Bank of South Africa Ltd v Duvenhage* 2006 5 SA 319 (SCA); *mCubed International (Pty) Ltd v Stinger* 2009 4 SA 471 (SCA).
[94] *Ibid.*
[95] Neethling 184-197; Loubser 71; *Lee* v *Minister of Correctional Services* above; *International Shipping Co (Pty) Ltd v Bentley* 1990 1 SA 680 (A); *Protea Assurance Co Ltd v LTA Building SWA Ltd* 1988 1 SA 303 (A).
[96] Neethling 197-203; Loubser 89; *First National Bank of South Africa Ltd v Duvenhage* above *Napier v Collett* 1995 3 SA 140 (A).
[97] *International Shipping Co (Pty) Ltd v Bentley* above.
[98] *Ibid.*
[99] *Ibid.*
[100] Loubser 96-97; Neethling 203- 204; *Smith v Abrahams* 1992 3 SA 158 (C).
[101] Neethling 207- 208; *Cape Empowerment Trust Limited v Fisher Hoffman Sithole* 2013 5 SA 183 (SCA); *Minister of Safety and Security v Van Duivenboden* 2002 6 SA 431 (SCA); *Standard Bank of South Africa v Coetsee* 1981 1 SA 1131 (A).
[102] *S v Tembani* 1999 (1) SACR 192 (W): it was ruled that the medical negligence was not so overwhelming as to make the original wound merely part of the history behind the patient's presence in the hospital; Carstens & Pearmain 843.
[103] Neethling 216-219; *Cape Empowerment Trust v Fisher Hoffman Sithole* above; *OK Bazaars (1929) Ltd v Standard Bank of South Africa Ltd* 2002 3 SA 688 (SCA) 697; *Road Accident Fund v Russell* 2001 2 SA 34 (SCA).
[104] *S v Tembani* above.
[105] Neethling 221-267; *First National Bank of South Africa Ltd v Duvenage* 2006 5 SA 319 (SCA).
[106] *Hentiq 1320 (Pty) Ltd v Mediterranean Shipping* Co 2012 6 SA 88 (SCA); Jowell *v Bramwell-Jones* 2000 3 SA 274 (SCA).
[107] Neethling 228 and 246-250.

purposes of this study. The objective of an award of damages is to compensate a person in money for loss that was caused by the delict.[108]

The *quantum* of delictual patrimonial loss (damage) is computed by the sum-formula approach in terms of which the aggrieved party is placed hypothetically in the same patrimonial position that he or she was immediately prior to the occurrence of the delict.[109]

1.4 *Negotiorum Gestio*

1.4.1 General

Unlike a contractual juridical tie, *negotiorum gestio* is not based on consensus, but involves the voluntary one-sided supervision by one person (*the negotiorum gestor)* of the affairs of another (*the dominus negotii*).[110] In the health services environment it is known as a 'Good Samaritan' act.

Although *negotiorum gestio* in some circumstances may seem to be *prima facie* wrongful, it qualifies as a ground of justification that negates delictual wrongfulness.[111] Almost any act of managing another person's affairs, including that of a mandatary who exceeds the limits of his or her mandate,[112] may be established as *negotiorum gestio*.[113]

1.4.2 Essentials Establishing *Negotiorum Gestio*

The following requirements must be met before *negotiorum gestio* is established:

- Affairs of another - The affairs of another (*dominus negotiorum*) must be managed by the *negotiorum gestor* without being authorised to do so.[114]
- *Dominus* unaware of management of affairs - The *dominus negotiorum* must be unaware that his or her affairs are being managed by another.[115]
- *Animus negotia aliena gerendi* - the *gestor* needs to act with the intention of managing the affairs of another and to recover all expenditures from the *dominus*.[116]
- *Utiliter coeptum* - The *gestor's* management must be objectively useful (*utiliter).*[117]

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[108] Potgieter, Steynberg & Floyd *Visser & Potgieter Law of Damages* (2012) 189.
[109] Potgieter 149-151; Neethling 221-265; *Fulane v Road Accident Fund* 2003 SA 461 (W); *Transnet Ltd v Sechaba Photoscan (Pty) Ltd* 2005 1 SA 299 (SCA).
[110] Watson *The Law of Obligations in the Later Roman Republic* (1965) 193-207; Joubert & Van Zyl par 17.
[111] See 69 above; Voet 3 5 1.
[112] *D* 3 5 31; *L Ferera (Pty) Ltd v Vos* 1953 3 SA 450 (A); *Kehnnan v Stewart* 1905 TS 677; Joubert & Van Zyl par 19.
[113] *Standard Bank Financial Services Ltd v Taylam (Pty) Ltd* 1979 2 SA 383 (C); *Lawrie v Union Government (Minister of Justice)* 1930 TPD 402-408; *Chainowitz v Balgowan Trading Co* 1927 NPD 36; *Jacobs v Maree Outeniqua Produce Agency v Machanick* 1924 CPD 315; *Amod Salie v Ragoon* 1903 TS 100; *Colonial Government v Smith and Co* (1901) 18 SC 380; *Grant's Fanning Co Ltd v Attwell* (1901) 9 HCG 91; Joubert & Van Zyl par 19.
[114] Joubert & Van Zyl par 21.
[115] *De Hart v De Jongh* 1903 TS 260; *William's Estate v Molenschoot and Shep (Pty) Ltd* 1939 CPD 360; *Mohamed v Kamaludien* 1938 CPD; *Turkstra v Massyn* 1959 1 SA 40 (T); Joubert & Van Zyl par 22.
[116] *Odendaal v Van Oudtshoorn* 1968 3 SA 433 (T); *Molife v Barker* (1910) 27 SC 9; Joubert & Van Zyl par 23

The *gestor* must conclude what he or she has commenced with,[118] render an administration or management account to the *dominus*,[119] deliver everything to the *dominus* which may accrue as a result of the *negotiorum gestio*[120] and reimburse the *dominus* for damage caused to him or her.[121]

The standard of care required from the *gestor* be that of the typically cautious person.[122] It was held in *Amod Salie v Ragoon*[123] that the normal test for negligence should be appropriate to ascertain whether the *gestor* acted with the necessary degree of diligence.

The *gestor* is entitled to be reimbursed by the *dominus* for necessary and useful expenses and loss of earnings.[124] However, the *gestor* may not claim any salary or other remuneration for the work done.[125]

1.5 Statutory, Administrative or Official Authority

Numerous statutory provisions regulate medical health services in South Africa, such as the National Health Act,[126] Medicines and Related Substances Act,[127] Allied Health Professions Act,[128] Nursing Act,[129] Pharmacy Act,[130] Dental Technicians Act,[131] Mental Health Care Act,[132] Medical Research Council Act,[133] Health Professions Act[134] and Traditional Health Practitioners Act.[135]

Due to the limited extent of this dissertation, the juridical ties and accompanied duty of care created by statutory, administrative or official authority are not examined.

In the next chapter I turn my attention to the duty of care in the context of wrongfulness.

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[117] *D* 3 5 2; *D* 3 5 8; *D* 3 5 44 *pr*; Joubert & Van Zyl par 24.
[118] *D* 3 5 5 14; *D* 3 5 15; Joubert & Van Zyl par 26.
[119] *D* 3 5 2; 1 3 27 1; Grotius *Inleidinge* 3 27 3; *McEwen v Khader* 1969 4 SA 559 (N); Joubert & Van Zyl par 27.
[120] Grotius *Inleidinge* 3 27 2; Joubert & Van Zyl par 28.
[121] *D* 3 5 2; *D* 3 5 11; *Joubert* & Van Zyl par 28.
[122] *Joubert* & Van Zyl par 29.
[123] 1903 TS 100 103; *Lawrie v Union Government (Minister of Justice)* 1930 TPD 402; *Minister of Justice v Lawrie* 1930 TPD 877; *Mohamed v Kamaludien* 1938 CPD 140; *Boyce v Bloem* 1960 3 SA 855 (T).
[124] *D* 3 5 2; Grotius *Inleidinge* 3 27 5; *D* 3 5 18 4; *New Club Garage v Millborrow and Son* 1931 GWL 86; *Klug and Klug v Penkin* 1932 CPD 401; *Joubert* & Van Zyl paras 30-33.
[125] *Grant's Farming Co Ltd v Attwell* (1901) 9 HCG 91; *Lewis Bros v East London Municipality* (1904) 21 SC 156; *William's Estate v Molenschoot and Schep (Pty) Ltd* 1939 CPD 360.
[126] Act 61 of 2003.
[127] Act 101 of 1965.
[128] Act 63 of 1982.
[129] Act 33 of 2005.
[130] Act 53 of 1974.
[131] Act 19 of 1979.
[132] Act 17 of 2002.
[133] Act 58 of 1991.
[134] Act 56 of 1974 as amended by Act 89 of 1997.
[135] Act 35 of 2004.

CHAPTER 2

THE DUTY OF CARE IN THE CONTEXT OF WRONGFULNESS

2.1 General

Wrongfulness, as explained above,[136] mainly is related to the infringement of subjective rights. But in certain circumstances wrongfulness is more effectively verified by considering whether a duty of care has been breached.[137] In *Trustees, Two Oceans Aquarium Trust v Kantey and Templer (Pty) Ltd,*[138] however, Brand JA criticised the view that the breach of a legal duty of care be interrelated to wrongfulness and identified this construction rather as an evaluation affecting the preventability prerequisite of negligence.[139]

2.2 Test to Establish a Breach of Duty of Care

The preferred test to establish a breach of a duty of care, *vis-à-vis* wrongfulness, is not by inquiring whether a person's subjective right has been violated, but rather by analysing whether, in the context of the *boni mores* or reasonableness norm, the transgressor had a legal duty of care to thwart harm.[140] Vivier ADP held in *Van Eeden v Minister of Safety Security (Women's Legal Centre Trust,* as *amicus curiae)* that:[141]

> The appropriate test for determining wrongfulness [of an omission] has been settled in a long line of decisions of this Court. An omission is wrongful if the defendant is under a legal duty to act positively to prevent the harm suffered by the plaintiff. The test is one of reasonableness. A defendant is under a legal duty to act positively to prevent harm to the plaintiff if it is reasonable to expect of the defendant to have taken positive measures to prevent the harm.

Given that damage to a legal object is not *per se* wrongful and the *boni mores* benchmark does not create a general duty of care to prevent harm or pure economic loss to third parties, Neethling[142] favours the 'duty of care' test to establish wrongfulness, as such requirement would probably place a too demanding a responsibility on the community.[143]

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[136] Par 1.3.3.6.
[137] Neethling 55.
[138] 2006 3 SA 3 138 (SCA).
[139] Brand 'Reflections on Wrongfulness in the Law of Delict 2007 *SALJ* 76; Contra Neethling 55 fn 122 who is in favour of this development since it was first recognised by the Supreme Court of Appeal in *Minister of Police v Ewels* above.
[140] *F v Minister of Safety and Security CC t/a Harvey World Travel* 2012 6 SA 551 (GNP); *Lee v Minister for Correctional Services* above; *Jacobs v Chairman, Governing Body, Rhodes High School* 2011 1 SA 160 (WCC) 165; *Harrington Transnet Ltd t/a Metrorail* 2010 2 SA 479 (SCA); *Holm v Sonland Ontwikkeling (Mpumalanga) (Edms) Bpk* 2010 6 SA (GNP); *Swinburne v Newbee Investments (Pty) Ltd* 2010 5 SA 296 (KZD); *Minister of Safety and Security v Rudman* 2005 2 SA 16 (SCA); *Minister of Safety and Security v Hamilton* 2004 2 SA 221 (SCA); *Minister van Polisie v* Ewels above; Neethling & Potgieter 'Wrongfulness and Negligence in the Law of Delict' 2007 *THRHR* 120; Neethling 56.
[141] 2003 1 SA 389 (SCA) at 395.
[142] Neethling 55-56.
[143] *Minister for Safety and Security v Scott* [2014] 2 All SA 489 (SCA); *Stewart v Botha* 2008 6 SA 310 (SCA); *Telematrix (Pty) Ltd t/a Matrix Vehicle Tracking v Advertising Standards Authority SA* above; *Trustees, Two*

Van der Walt and Midgley[144] submit that liability for an *omissio* usually is more limited than liability for a *commissio* which requires additional policy evaluations. Thus public policy, which does not compel one to love your neighbour, but only restrains one from harming your neighbour, is hesitant to adopt the existence of a general duty of care *vis-à-vis* an *omissio*.[145] Accordingly, wrongfulness in cases of an *omissio* is more effectively ascertained by the breach of a duty of care than an infringement of a subjective right.[146]

Thus, in the absence of a justification ground,[147] a breach of a duty of care, when unreasonable and *contra bonos mores*, will probably be subsequently wrongful.[148] Nevertheless, establishing wrongfulness by applying a breach of a legal duty of care does not involve a new test, as the latter in principle is the same as the question whether a subjective right has been encroached upon, which question, in both instances, is linked to the *boni mores* or general legal convictions of the community.[149]

Boberg approves the aforesaid assessment and endorses the submission that the above does not create two distinct tests for wrongfulness in so far as:[150]

> [T]he difference is only one of emphasis or approach. For right and duty and correlative concepts; the one necessarily implies the other. It follows that breach of a duty and infringement of a right are not alternative foundations for a finding of wrongfulness. Rather, they are alternative *paths* to the policy conclusion that the wrongfulness requirement compels the one or the other seeming more comfortable in the circumstances.

According to this perspective, some judgments, unfortunately, labelled the legal duty of care when determining wrongfulness as 'a legal duty not to act negligently'.[151] This creates the notion that the legal duty test deals with the quest for negligence, applying the negligence test to determine wrongfulness, which methodology echoes the classic duty of care approach of English law, conflating) the elements of wrongfulness and negligence.[152] This viewpoint was expressly rejected by the Supreme Court of Appeal.[153] Still, it is

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Oceans Aquarium Trust v Kantey and Templer (Pty) Ltd above; *Gouda Boerdery BK v Transnet* 2005 5 SA 490 (SCA); *Local Transitional Council of Delmas v Boshoff* 2005 5 SA 514 (SCA) 522.

[144] *Principles of Delict* (2005) 65.

[145] *Ibid.*

[146] Neethling 56.

[147] See 1.3.3 above.

[148] Neethling 56.

[149] Neethling 57.

[150] *The Law of Delict: Vol 1 Aquilian Liability* (1984) 32.

[151] *Stewart v Botha* 2008 6 SA 310 (SCA); *Shabalala v Metrorail* 2008 3 SA 142 (SCA); *McIntosh v Premier, KwaZulu-Natal* 2008 6 SA I (SCA); *Du Preez v Swiegers* 2008 4 SA 627 (SCA); *Van der Eecken v Salvation Army Property Co* 2008 4 SA 28 (T); *Harrington NO v Transnet (Ltd)* 2007 2 SA 228 (C); *Kantey and Templer (Pty) Ltd v Van Zyl NO* 2007 I SA 610 (C); *Minister of Water Affairs v Durr* [2007] 1 All SA 337 (SCA); *Montel Holdings (Pty) Ltd v Premier of Limpopo Province* [2007] 3 All SA 410 (T); *Trustees, Two Oceans Aquarium Trust v Kantey and Templer (Pty) Ltd* above; *Mediterranean Shipping Co (Pty) Ltd v Tebe Trading (Pty) Ltd* [2007] 2 All SA 489 (SCA); *Hirschowitz Flionis v Barlett* 2006 3 SA 575 (SCA); *Gouda Boerdery BK v Transnet* above; *Minister of Correctional Services v Lee* above; *Indac Electronics (Pty) Ltd v Volkskas Bank Ltd* 1992 I SA 783 (A).

[152] Neethling 57; *Trustees, Two Oceans Aquarium Trust v Kantey and Templer (Pty) Ltd* above.

[153] *Local Transitional Council of Delmas v Boshoff* above; *Telematrix (Pty) Ltd t/a Matrix Vehicle Tracking v Advertising Standards Authority* above*; Steenkamp NO v Provincial Tender Board, Eastern Cape* 2006 3 SA 151 (SCA).

problematic that the Supreme Court of Appeal persists in suggesting that the legal duty is a legal duty not to act negligently.[154] As Neethling and Potgieter put it:[155]

> Under the influence of the classic English doctrine of 'duty to take care', courts have customarily described the duty as a duty to take reasonable care, or to conform to a certain standard of conduct. However, such an approach is not tenable in terms of a theoretical structure of delict which requires a distinction between the elements of wrongfulness and fault. The duty to take care, or to act reasonably, or not to act negligently, is a separate and independent duty, concerned with establishing whether or not the defendant was at fault, and which only arises after it has been established that the defendant was in breach of a legal duty not to harm the plaintiff … It is therefore incorrect to express the legal duty in terms of a standard of care.

I agree with Neethling and Potgieter's reasoning.

2.3 Duty of Care and the Rule of Law

A delictual claim, and by implication a common law legal duty of care, may also be created by a statutory stipulation or provision.[156] Generally, in this instance the wrongdoer's behaviour will be wrongful, not because of non-compliance with a statutory legal duty of care *per se*, but rather for the reason that it is reasonable in such a situation to compensate the victim for violating his or her rights.[157] Thus, a breach of a statutory provision is only a pointer that the wrongdoer's conduct is wrongful and compliance with all the other elements of a delict must be present.[158] *Lascon Properties (Pty) Ltd v Wadeville Investments Co (Pty) Ltd*[159] misguidedly gives the idea that the non-compliance with a statutory duty of care *ipso facto* amounts to a delict.[160]

McKerron[161] concludes from case law that in order to establish wrongfulness and subsequently a delict in the above scenario, the claimant is obliged to prove that:[162]

- The relevant statutory provision offers the claimant a private law remedy;[163]
- The victim is a person for whose benefit and protection the statutory duty of care was promulgated;[164]

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[154] Neethling 58; Van der Walt & Midgley 78-79.
[155] 2007 *THRHR* 124.
[156] *Faircape Property Developers (Pty) Ltd v Premier, Western Cape* 2002 6 SA 180 (C); *Premier, Western Cape v Faircape Property Developers (Pty) Ltd* above; *Olitzki Property Holdings v State Tender Board* 2001 3 SA 1247 (SCA); *Knop v Johannesburg City Council* 1995 2 SA I (A); Neethling 66.
[157] *Olitzki Property Holdings v State Tender Board* above; Neethling 66.
[158] Neethling 78.
[159] 1997 4 SA 587 (W).
[160] Badenhorst & Mukheiber 'Liability for Escape of Polluted Water from a Mine' 1998 *De Jure* 169; Neethling 78 fn 289.
[161] *The Law of Delict* (1971) 257.
[162] See also *Pats v Green and Co* 1907 TS 427; Van der Walt & Midgley 104; *Da Silva v Coutinho* 1971 3 SA 123 (A); *Knop v Johannesburg City Council* above.
[163] *Steenkamp NO v Provincial Tender Board, Eastern Cape* above; *Knop v Johannesburg City Council* above; *Lascon Properties (Pty) Ltd v Wadeville Investment Co (Pty) Ltd* above.

- The nature of the impairment and the *modus operandi* in which it occurred are consistent with the objective of the statutory provision;[165]
- The wrongdoer actually disobeyed the statutory obligation;[166] and
- A causal nexus exists between the transgression of the statutory stipulation and the harm.[167]

Reasonableness, *vis-à-vis* a duty of care, in the above scenario is also regulated by the legal convictions of the community and legal policy.[168]

Statutory provisions are of vital importance to resolve whether government institutions, like state hospitals, have a legal duty of care to foil harm.[169]

2.4 Duty of Care and the Existence of Special Relationships

The existence of a special contractual relationship between parties, for instance a health care worker and patient, may subsequently create a legal duty of care to avert harm. It was held in *Cathkin Park Hotel v JD Makesch Architects*[170] that: 'The duty … arose in relation to obligations assumed by the defendants pursuant to a contractual relationship'.[171]

Examples of a duty of care and the existence of special relationships are, *inter alia*, between policeman and a citizen;[172] warden and a prisoner;[173] employer and an employee;[174] parent and a child;[175] municipality and a member of the public;[176] doctor and patient.[177]

However, the court held in *Stewart v Botha*[178] that a claim for wrongful life was not actionable since there was no legal duty of care and therefore no wrongfulness on the part

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[164] *Laskey v Showzone CC* 2007 2 SA 48 (C); *Bedfordview Town Council v Mansyn Seven (Pty) Ltd* 1989 4 SA 599 (W).
[165] Van der Walt & Midgley 105 as demonstrated in the English case of *Gorris v Scott* (1874) LR 9.
[166] *Da Silva v Courtinho* 1971 3 SA 123 (A).
[167] *Jordaan v Smith* 1915 EDL 166; *Da Silva v Coutinho* above.
[168] *Faircape Property Developers (Pty) Ltd v Premier, Western Cape* 2002 6 SA 180 (C); *Premier, Western Cape v Faircape Property Developers (Pty) Ltd* above; *Olitzki Property Holdings v State Tender Board* 2001 3 SA 1247 (SCA); *Knop v Johannesburg City Council* above; Neethling 66.
[169] *Cape Town Municipality v Bakkerud* above; *Beurain h/a Toptrans Transport v Regering van die Republiek van Suid-Afrika* 2001 4 SA 921 (O); Neethling 67.
[170] 1993 2 SA 98 (W) at 100.
[171] *Joubert v Impala Platimum Ltd* 1998 I SA 463 (B); *Greenfields Engineering Works (Pty) Ltd v NKR construction (Pty) Ltd* 1978 4 SA 901 (N); *Bayer South Africa (Pty) Ltd v Frost* above; Neethling & Potgieter 'Deliktuele Aanspreeklikheid by die Lasgewer-lashebber-Verhouding' 1992 *THRHR* 313; Davel '*Greenfields Engineering Works (Pty) Ltd v NKR construction (Pty) Ltd* 1978 4 SA 901 (N)' 1979 *THRHR* 214.
[172] *Minister of Safety and Security v Carmichele* above; Neethling 'Die *Carmichele*-Sage kom tot 'n Gelukkige Einde' 2005 TSAR 402.
[173] *Lee v Minister of Correctional Services* above; *Minister van Veiligheid en Sekuriteit v Geldenhuys* 2004 1 SA 515 (SCA); *Minister of Safety and Security v Craig* [2010] 1 All SA 126 (SCA).
[174] *Standard Bank of South Africa Ltd v OK Bazaars (1929) Ltd* 2000 4 SA 382 (W).
[175] *De Beer v Sergeant* 1976 1 SA246 (T).
[176] *Butise v City of Johannesburg* 2011 6 SA 196 (GSJ).
[177] *Judd v Nelson Mandela Bay Municipality* 2010 CA 149 the court had to consider the delictual liability of municipalities based on the failure *(omissio)* to take preventative action after the plaintiff sustained severe injuries after catching her foot on a raised pavement block. The omission was labelled as wrongful.

of the doctor to inform the parents that the child might be disabled. According to Snyders AJA the acknowledging of such a legal duty of care would be *contra bonos mores* and:[179]

> At the core of cases of the kind that is now before us is a different and deeply existential question: was it preferable – from the perspective of the child – not have been born at all? If the claim of the child is to succeed it will require a court to evaluate the existence of the child against his or her non- existence and find that the latter was preferable… [and] this question goes so deeply to the heart of what it is to be human that it should not even be asked by the law.

Neethling[180] disagrees with this viewpoint and considers that the conduct of a doctor who negligently causes a child to be born with serious disabilities, should be regarded as wrongful and that the comparison of a child's existence or non-existence is beside the point. It is in child's best interest to have access to the best medical care for his or her condition and the *bonos mores* necessitate doctors to act accordingly to avoid wrongfulness.[181]

Britz[182] pointed out that it is not the child's life that is wrongful, but his or her suffering. It was held that 'wrongful life' was an inappropriate term which should be replaced by the action for 'wrongful suffering through disability.' Prior to *H v Foetal Assessment Centre* [183] actions for 'wrongful life' were dismissed by the High Courts as well the Supreme Court of Appeal, but the Constitutional Court has now held that the claim may potentially be found to exist.[184] I agree with Neethling that justice mandates that a child should not have a life of pain, distress and financial need that could have been avoided by a doctor's interception.[185]

A special relationship is not an absolute prerequisite for the creation of a legal duty of care,[186] and each incident must be assessed *vis-à-vis* the *boni mores* benchmark taking into account the relevant circumstances, including the existence of a special relationship between the parties.[187]

If a person contractually undertakes to ensure the safety of another person, such person has a legal duty of care and any harm caused in such contractual situation will be *prima facie* a breach of a duty of care and wrongful.[188] The breach of the duty of care paradigm, itself, is

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[178] 2008 6 SA 310 (SCA).
[179] At 316.
[180] At 70 fn 229.
[181] *Ibid*.
[182] Britz 'Wrongful suffering: A life that should never have been'2015 *THRHR* 577.
[183] 2015 2 SA 193 (CC).
[184] Neethling 'The Constitutional Court affirms the potential existence of an action for wrongful suffering through disability (wrongful life) in South African Law' 2016 *THRHR* 1.
[185] See also *Premier, Kwa-Zulu-Natal v Sonny* 2011 3 SA 424 (SCA) 433; *Friedman v Glickman* 1996 1 SA 1134 (W); Giesen 'Of Wrongful Birth, Wrongful Life, Comparative Law and the Politics of Tort Law System' 2009 *THRHR* 257; Chürr 2009 *THRHR* 168; Human & Mills 'The Immeasurable Wrongfulness of Being: The Denial of a Claim for Wrongful Life 2010 *Stell LR* 67; Van Niekerk 'Wrongful Life Claims: a Failure to Develop the Common Law?' 2012 *Stell* LR 527.
[186] *Van Eeden v Minister of Safety and Security (Women's Legal Centre Trust,* as *amicus curiae)* 2003 1 SA 389 (SCA).
[187] Neethling 71.
[188] *S v Chipinge Rural Council* 1989 2 SA 342 (ZS); *SAR and H v Estate Saunders* 1931 AD 276.

not *per se* wrongful, and the violation of the other person's rights is the actual foundation for wrongfulness in these circumstances.[189]

2.5 Duty of Care *vis-à-vis* Consent

2.5.1 General[190]

Proper consent to injury or harm will negate unlawfulness in terms of the *volenti non fit iniuria* doctrine.[191] Consent is categorised as consent to injury and acceptance of the risk of injury.[192] However, the same principles apply to both forms of consent.[193]

2.5.2 Elements of Consent as a Justification Ground

The following are elements of consent as a ground of justification:

- *Volenti non fit iniuria* is a unilateral act which can unilaterally be rescinded before the wrongful act;[194]
- Consent is a legal act that limits the harmed person's rights;[195]
- Consent may be given expressly or tacitly;[196]
- Consent must precede the harmful act;[197]
- The harmed person, as a general rule, must personally consent to the unlawful act.[198]

By the same token as v*olenti non fit iniuria*, a person does not act wrongfully if he or she executes an act, which should otherwise have been wrongful, while acting in accordance with statutory authority.[199]

The *volenti non fit iniuria* doctrine, in my view, may also have an influence on a health care worker's contractual mandate to execute his or her mandate with reasonable care, skill and diligence ('duty of care').[200] Should the mandatory (health care worker) fail to apply the

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[189] *Lascon Properties (Pty) Ltd v Wadeville Investment Co (Pty) Ltd* above).
[190] Also see chap 1 above.
[191] *D* 47 10 1 5; *De Groot* 3 35 8; *Voet* 47 10 4; Van der Walt & Midgley 140; Neethling 108.
[192] Van Der Walt & Midgley 140; Boberg 724; Van Oosten *The Doctrine of Informed Consent in Medical Law* (1989) 14-15.
[193] *Ibid*.
[194] Van der Walt & Midgley 141; Neethling, Potgieter & Visser 98-101; Neethling 109; *Jooste v National Media Ltd* 1994 2 SA 634 (C).
[195] Boberg 731; Neethling 110; Neethling, Potgieter & Visser 98-99.
[196] *Waring and Gillow Ltd v Sherborne* 1904 TS 340; *Union Government (Minister of Railways and Harbours) v Matthee* 1917 AD 688; *Stoffberg v Elliot* 1923 CPD 148.
[197] Neethling 110 & 114.
[198] *Ibid.*
[199] *East London Western District Farmer's Association V Minister of Education and Development Aid* 1989 2 SA 63 (A); *Government of the Republic of South Africa v Basdeo* 1996 1 SA 366 (A); *Premier, Western Cape v Faircape Property Developers (Pty) Ltd* above.
[200] *Kennedy v Loynes* (1909) 26 SC 271; *Steenkamp v Du Toit* 1910 TPD 171; *McAlpine v Anderson's Executors* 1926 NPD 377; *Gardner's Esate v Arthur Meikle and Co Ltd* 1946 WLD 286; *Bloom's Woollens (Pty) Ltd v Taylor* above.

necessary reasonable care, skill and diligence ('duty of care'), he or she will be negligent and liable for damage or injury caused to the mandatory (patient), unless the latter had consented to the injury or accepted the risk of the injury.[201]

In chapter 3 the duty of care concept is examined more closely, specifically its relation to fault in the form of negligence.

[201] Nienaber par 10. Also see chap 2.5.2 above.

CHAPTER 3

NEGLIGENCE AND THE DUTY OF CARE

3.1 General

The duty of care approach is unrelated to the principles of the Roman-Dutch law of delict.[202] Negligence is usually ascertained by the reasonable person test.[203] Nonetheless, our courts have occasionally ignored this test and have, as a substitute, apparently applied the English law 'duty of care' doctrine.[204] In terms of this methodology, one must first establish whether the wrongdoer owed the victim a duty of care (the 'duty issue') and, subsequently, whether there was a breach of this duty (the 'negligence issue').[205] If the response to both inquiries is positive the wrongdoer will have acted negligently.[206]

3.2 Determining a Duty of Care

In establishing if a duty of care was present, the benchmark was conventionally whether the reasonable person in the situation of the wrongdoer would have anticipated that his or her conduct might cause harm to the victim.[207] However, it is presently accepted that the 'duty of care' question is based on a value judgement, in which foreseeability is irrelevant.[208]

In *Administrateur, Natal v Trust Bank van Afrika Bpk*[209] the court emphasised that the 'duty of care issue' is not concerned with reasonable foresight, but rather the scope of interests which the law is willing and able to safeguard against negligent harm.[210] In determining the latter issue *vis-à-vis* a *breach* of the duty of care, the court[211] deliberates whether the wrongdoer applied the accepted standard of care that the reasonable person would have employed in order to avert damage.[212]

The duty of care is not an all-inclusive duty, but a duty concerning particular individuals or categories of people towards other particular individuals or categories.[213] Unless a victim can prove that he or she is entitled to a duty of care, he or she has no recourse.[214] Thus, a duty of care is owed only to the foreseeable victim.[215]

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[202] Neethling 158.
[203] See chap 4.
[204] Loubser *and* Midgley 148-151; Boberg 274; McKerron 26; Neethling 158.
[205] *Ibid*.
[206] *Ibid*.
[207] *Cape Town Municipality v Paine* 1923 AD 207; Neethling 158.
[208] Neethling 158.
[209] 1979 3 SA 824 (A) at 833.
[210] See also *Knop v Johannesburg City Council* above; *Saaiman v Minister of Safety and Security* 2003 3 SA 496 (O); Van der Walt & Midgley 81-82.
[211] *Administrateur, Natal v Trust Bank van Afrika Bpk* above.
[212] Neethling 158; Van der Walt & Midgley 82.
[213] Neethling 158.
[214] *Workmen's Compensation Commissioner v De Villiers* 1949 1 SA 474 (C).
[215] Van der Walt & Midgley 82; Neethling 158.

3.3 Relevance of the 'Duty of Care' Approach

From a historical point of view, the application of the 'duty of care' principles should be abolished since it is, in its conventional form, a pointless and indirect method to determine negligence, which may simply be established directly in terms of the reasonable person test.[216] The 'duty of care' doctrine may also be mistaken for the test for wrongfulness (breach of a legal duty).[217]

Brand JA, in no uncertain terms condemned the 'duty of care' concept in *Hawekwa Youth Camp v Byrne* and correctly declared that:[218]

> As I see it, the quoted contentions are indicative of confusion between the delictual elements of wrongfulness and negligence. This confusion in turn, so it seems, originated from a further confusion between the concept of 'a legal duty', which is associated in our law with the element of wrongfulness, and the concept of a 'duty of care' in English law, which is usually associated in that legal system with the element of negligence. … Warnings against this confusion, and the fact that it may lead the unwary astray had been sounded by this court on more than one occasion.

Neethling[219] emphasised that the 'duty of care' concept is not synonymous with the legal duty employed to determine wrongfulness. To prevent confusion, Neethling suggested that it would be better to describe the duty concerning the test for wrongfulness as a 'legal duty'.[220] In *McIntosh v Premier, KwaZulu-Natal*[221] Scott JA echoes this principle as follows:

> The word 'duty' and sometimes even the expression 'legal duty' [in respect of the second leg of the negligence test as formulated by Holmes JA in *Kruger V Coetzee*[222]], must not be confused with the concept of 'legal duty' in the context of wrongfulness which. … is distinct from the issue of negligence. I mention this because this confusion was not only apparent in the arguments presented to us in this case but is frequently encountered in reported cases. The use of the expression 'duty of care' is similarly a source of confusion. In English law 'duty of care' is used to denote both what in South African law would be the second leg of the inquiry into negligence and legal duty in the context of wrongfulness. As Brand JA observed in. … [*Trustees, Two Oceans Aquarium Trust v Kantey and Templer (Pty) Ltd*[223]] … 'duty of care' in English law' straddles both elements of wrongfulness and negligence.[224]

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[216] *Ie* whether the reasonable person would have foreseen and guarded against damage; Neethling 158-159.
[217] *Local Traditional Council of Delmas v Boshoff* 2005 5 SA 515 (SCA); *Saayman v Visser* 2008 5 SA 312 (SCA); *Chartaprops 16 (Pty) Ltd v Silberman* 2009 1 SA 265 (SCA); *Bowley Steels (Pty) ltd v Dalian Engineering (Pty) Ltd* 1996 2 SA 393 (T).
[218] 2010 6 SA 83 (SCA) at 90.
[219] At 159.
[220] *Ibid*.
[221] 2008 6 SA 1 (SCA) at 8-9. See further *Chartaprops 16 (Pty) Ltd v Silberman* 2009 1 SA 265 (SCA).
[222] Above.
[223] Above.
[224] The similar criticism of the use of the 'duty-of-care' concept of English law in our law was highlighted in *Knop v Johannesburg City Council* above at 27 where it was held that the duty hypothesis in negligence functioned on two levels, namely fact based and policy-based. The fact-based duty of care investigates, *via* the foreseeability test, if the wrongdoer's behaviour was negligent in the circumstances. However, the 'duty of care' in this scenario is a convenient, but redundant mode. In the terminology for the South African law, the 'policy-based duty of care' is more correctly conveyed as a 'legal duty' to verify the delictual element of wrongfulness. See also *Transitional Council of Delmas v Boshoff* above where Brand JA held the 'legal duty of

Consequently, there is no convincing reason why the duty of care methodology should be applied to establish negligence, since, currently, the reasonable person test is predominantly applied by our courts.[225] However, although the courts sometimes pay lip-service to the difference between wrongfulness and negligence, negligence is essentially considered as co-determinant for wrongfulness.[226]

The *modus operandi* in our law to differentiate between negligence and wrongfulness is inconsistent.[227] As a result the academic fundamentals of our law of delict are sabotaged causing legal ambiguity, which could have been avoided. It is important that the courts resolve this confusion regarding the two approaches to the 'duty of care' concept.[228]

In my view the distinction in terminology in respect of 'legal duty' and a 'duty of care' is essentially semantic and superfluous. Either term should be correctly contextualised in the relevant circumstances.

3.4 Distinction between Wrongfulness and Negligence

Wrongfulness is based on an objective reasonableness criterion, *contra* negligence that hinges on the objective reasonable-person-test.[229] Thus, an objective standard of reasonableness is used in determining both wrongfulness and negligence.[230] However, the fundamental differences between the test for wrongfulness and negligence are the following:[231]

- Wrongfulness's focal point is the reasonableness of the defendant's actions which is defined by the *boni mores*, whereas negligence is identified by the reasonable-person forseeability-test;[232]

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care has no bearing on negligence and should not be mistaken with the 'duty of care' in English law which is usually linked to negligence. See further *Country Cloud Trading CC v MEC, Department of Infrastructure Development* 2014 2 SA 214 (SCA); *Hawekwa Youth Camp v Byrne* above; *Steenkamp NO v Provincial Tender Board, Eastern Cape* above ;*Telematrix (Pty) Ltd t/a Matrix Vehicle Tracking v Advertising Standards Authority* above; Neethling & Potgieter 2007 *THRHR* 124; Neethling 159.

[225] *Kruger v Coetzee* above. Inappropriately some judgements of the Supreme Court of Appeal added to this misperception by an erroneous approach to the 'duty of care' doctrine. See *Government of the Republic of South Africa v Basdeo*; above; *Premier Western Cape v Faircape Property Developers (Pty) Ltd* above; *Road Accident Fund v Mtati* above.

[226] Neethling 160 above.

[227] *Ibid*.

[228] *Ibid.* See *inter alia Masureik (t/a Lotus Corporation v Welkom Municipality* 1995 4 SA 745 (O) and *Faiga v Body Corporate of Dumbarton Oaks* 1997 2 SA 651 for a combination of the two approaches to wrongfulness and negligence caused by the reliance on the 'duty of care' test.

[229] Neethling 163: Neethling & Potgieter 'Statutêre Bevoegdheid: Die Rol van Redelike Voorsienbaarheid by Onregmatigheid en Nalatigheid' 2004 *Obiter* 477. Negligence is also a form of the delictual element of fault.

[230] *Ibid.*

[231] Neethling 163.

[232] *Hirschowithz Flionis v Bartlett* 2006 3 SA 575 (SCA); *Telematrix (Pty) Ltd t/a Matrix Vehicle Tracking v Advertising Standards Authority* above; *Imvula Quality Protection (Pty) Ltd v Loureiro* 2013 3 SA 407 (SCA); *Steenkamp NO v Provincial Tender Board, Eastern Cape* 2006 3 SA 151 (SCA); *Gouda Boerdery BK v Transnet* above; *Ngubane v South African Transport Services* 1991 1 SA 765 (A); *Eskom Holdings Ltd v Hendricks* 2005 5

- Wrongfulness relates to the legal reprehensibility of the wrongdoer's behaviour, whereas negligence, as a form of the delictual element of fault, focuses on the legal blameworthiness of the wrongdoer's wrongful conduct;[233]
- As wrongfulness is involved with the legal reprehensibility of an individual's demeanour, such conduct is established *ex post facto* considering the relevant background, ensued consequences and facts.[234] In contrast, negligence is linked to the legal blameworthiness of the wrongdoer and it is verified *ex ante* taking into account the situation in which the wrongdoer found himself.[235] The latter is managed by placing the reasonable person in the shoes of the wrongdoer at the time of the act, taking into account, within the reasonable persons test framework, only the facts and circumstances of which the wrongdoer had been aware of and whether such outcome could reasonably have been thwarted.[236] Thus, wrongfulness is controlled by concrete facts and negligence by probabilities.[237]
- Conventionally and for reasons of efficiency and logic, wrongfulness should be established before negligence. Currently the courts support a more practical methodology and reason that either wrongfulness or negligence, depending on the circumstances of each case, may be clarified first.[238]
- Wrongfulness and negligence should not be incorporated into one test when considering the reasonableness of the defendant's behaviour as this will negate the function of wrongfulness as a benchmark for control.[239]
- The postulation that the reasonableness of the wrongdoer's actions influences both the delictual elements of wrongfulness and fault (negligence) does not imply that these two elements are automatically consolidated into one element, which would muddy the position of wrongfulness and negligence.[240]

Below I turn my attention to an examination of professional medical negligence in the context of the standard of care.

SA 503 (SCA); *Minister of Safety and Security v Mohofe* 2007 4 SA 215 (SCA); *Local Transitional Council of Delmas v Boshoff* above.

[233] Neethling 164.

[234] *NM v Smith (Freedom of Expression Institute* as *amicus curiae*) 2007 5 SA 250 (CC); Neethling 164.

[235] *Ibid.*

[236] *Ibid.*

[237] Ibid; 'The Right to Privacy, HIV-AIDS and Media Defendants' 2008 *SALJ* 36.

[238] *Administrateur, Transvaal v Van Der Merwe* 1994 4 SA 347 (A); *Cape Town Municipality v Bakkerud* above; *First National Bank of South Africa Ltd v Duvenhage* above.

[239] *Roux v Hattingh* 2012 6 SA 428 (SCA); *Cape Empowerment Trust Limited v Fisher Hoffman Sithole* above; *Cape Town Municipality v Bakkerud above*; Brand 'The Contribution of Louis Harms in the Sphere of Aquilian Liability for Pure Economic Loss' 2013 *THRHR* 65-67; *contra* Neethling & Potgieter 'Wrongfulness in Delict: A Response to Brand JA' 2014 *THRHR* 121-122; Neethling & Potgieter 'Wrongfulness and Delictual Liability for Rugby Injuries: *Roux v Hatting* (SCA)' 2014 *SALJ* 251.

[240] Brand 2013 *THRHR* 65-67; Neethling & Potgieter 2014 *THRHR* 121-122; Neethling & Potgieter 2014 *SALJ* 251; Neethling 165.

CHAPTER 4

PROFESSIONAL MEDICAL NEGLIGENCE AND THE STANDARD OF CARE

4.1 Nature of (Medical) Negligence

The term 'professional medical negligence' is incorporated into the term 'medical malpractice'; the latter embracing all forms of professional misconduct, committed either intentionally or negligently, including breaches of confidentiality and fiduciary doctor-patient relationships.[241]

Before a person may be held liable in delict, it must first be determined whether the conduct was blameworthy (culpable).[242] Faulty or blameworthy conduct may take two forms,that is intent or negligence. Negligence is the most common form of fault in the context of health service provision. The test for negligence in the South African law is an objective test. In *R v Meiring* it was decided that:[243]

> In civil actions we have adopted as the simple test that standard of care and skill which would be observed by the reasonable man. And it seems right as well as convenient to apply the same test in criminal trials … the test of liability should be the same in both.

4.2 The Test for Negligence in Private v Criminal Law

In *S v Van As*[244] the court did not deviate from the *Meiring* decision, but pointed out the difference which exists with regard to the nature and required foreseeability of the test for negligence in private law is in contrast to that in criminal law: In private law a person needs only to have foreseen the general possibility of harm whilst in criminal law it is required that the accused must have foreseen the harm which is alleged to have been caused. No specific percentage of negligence is required to constitute liability in either instance.

As far as private law (law of delict) is concerned, the test for negligence was laid down in the decision of the Appeal Court in *Kruger v Coetzee*:[245]

For the purpose of liability *culpa* arises if –

a) A *diligens paterfamilias*[246] in the position of the defendant –

(i) Would foresee the reasonable possibility of his conduct injuring another in his person or property and causing him patrimonial loss; and

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[241] Marjoribanks *et al* 'Physicians' Discourses on Malpractice and the meaning of Medical Malpractice' 1996 *JHSB* 163 – 178; Carstens & Pearmain (2007) 599. See also 1.3.4 above & chap 3 above.

[242] *First National Bank of South Africa Ltd v Duvenhage* above; 1.3.1 to 1.3.6 above.

[243] Claassen & Verschoor '*Medical Negligence in South Africa* (1992)6; *R v Meiring* above: 'Negligence can never be disentangled from the facts, but the existence is best ascertained by applying the facts of each case to the standard of conduct which the law requires.'

[244] *S v Van As* 1976 (2) SA 921 A 929.

[245] In *S v As* above, Holmes J stated: 'This has been constantly stated for the last 50 years. Requirement (a) (ii) is sometimes overlooked. Whether a *diligens paterfamilias* in the position of the person concerned would take any guarding steps at all and, if so, what steps would be reasonable, must always depend on the particular circumstances of each case.'

[246] Used as a synonym for a reasonable man or person.

ii) Would take reasonable steps to guard against such occurrence; and

b) the defendant failed to take such steps.

Boberg[247] contends that the law requires that the plaintiff's patrimonial loss must be foreseeable because the care that the reasonable man would exercise in a given situation would depend on the person with whom or he or she deals.[248] This relative theory of negligence seems to have been favoured by the Supreme Court of Appeal in *Mukheiber v Raath*[249] where it was stated that the reasonable person would have foreseen harm of the general kind that actually occurred, would have foreseen the general kind of causal sequence by which the harm occurred, would have taken steps to guard against it, and the defendant failed to do so.

In his judgement in *Sea Harvest Corporation (Pty) Ltd v Duncan Dock Cold Storage (Pty) Ltd*,[250] Scott JA comments that the former test involves a narrower test for foreseeability, relating it to the consequences which the conduct in question produces, and serves to conflate the test for negligence and for what has been called 'legal causation.'[251]

In *Mkhat*swa *v Minister of Defence*[252] the court confirmed that to satisfy a test for negligence foresight of the reasonable possibility of harm is necessary.[253] Foresight of a mere possibility of harm will not suffice.[254]

Negligence is not inherently unlawful.[255] It is unlawful and actionable if it occurs in circumstances that the law recognises as making it unlawful.[256] This is unlike a positive act causing physical harm which is presumed to be unlawful.[257]

Although the test for negligence is primarily an objective one, a measure of subjectivity is reached as a result of the following qualifications in respect of the test[258] in criminal matters:

- Cognisance of the particular circumstances surrounding the accused: Because negligence is constituted by the failure to act as the reasonable man would have done in similar circumstances, the reasonable man must be placed in the same.

[247] Boberg 309.
[248] Claassen & Verschoor 11. See also Burchell 1983 211 where it is submitted that in a charge of culpable homicide the death of the specific deceased need not have been reasonably foreseeable, but the deceased must have been one of a class of persons whose death was so foreseeable. See also 3.1 to 3.4 above.
[249] 1999 3 SA 1065 (SCA) 31. The decision in this matter is of importance, not only in terms of wrongful conception liability, but also in the elements of causation and damages; Carstens & Pearmain 728.
[250] 2000 1 SA 827 (SCA).
[251] Carstens & Pearmain 522. See also 1.3.5 above.
[252] 2000 1 SA 1104 (SCA); Carstens & Pearmain.
[253] See 1.3.4 and 3.2 above.
[254] See 3.2 above.
[255] See 3.4 above.
[256] *Ibid.*
[257] Carstens & Pearmain 523; *Van Duivenboden v Minister of Safety and Security* 2002 (6) SA 431 (SCA).
[258] Claassen & Verschoor 8; 3.4 above.

- Cognisance of the specific expertise of the accused. The objective standard is relaxed 'upwards'.[259]
- Cognisance of the youthfulness of the accused.

4.3 Medical Negligence

4.3.1 Reasonable Care and Skill

As far as the private law is concerned, the test for negligence of medical practitioners is described as follows in the matter *Van Wyk v Lewis:*[260]

> [A] medical practitioner is not to bring to bear upon the case entrusted to him the highest possible degree of professional skill, but he is bound to employ reasonable skill and care. And in deciding what is reasonable the Court will have regard 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.

An important exception to the rule that negligence is judged objectively applies where a person presents himself as an expert in a specific field.[261] The traditional standard of the reasonable man is then raised to the standard of the 'reasonable expert'.[262] The test for negligence of an expert was stated in *R v van Schoor*.[263]

When someone enters into a profession or vocation which requires special knowledge or skill, the law demands such degree of capability as can reasonably be expected from a practitioner of such profession or vocation.[264] In 1838 the test for medical negligence was formulated by Chief Justice Tindall in the English decision *Lanphier v Phipos*.[265] The general principle that a physician's negligence should be assessed with reference to the 'reasonable expert' was confirmed and applied in later case law dealing with professional medical negligence.[266]

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[259] *S v Mahlalela* 1966 (1) SA226 (A). The accused, an herbalist was charged with murder. He had given a child a mixture of herbs and beer to drink. The child was consequently poisoned and died. The accused was convicted of murder. The appellant, as an expert on herbs, should have foreseen that the herbs could possibly be poisonous. He was found guilty of culpable homicide.

[260] 1924 AD 438 444.

[261] *S v Mahlalela* above.

[262] *Ibid.*

[263] 1948 4 SA 349 (C) 350: 'Coming to the case of a man required to do the work of an expert, as e.g. a doctor dealing with the life and death of his patient, he too must conform to the acts of a reasonable man, but the reasonable man is now viewed in the light of an expert; and even such expert doctor, in the treatment of his patients would be required to exercise in certain circumstances a greater deal of care and caution than in other circumstances.'

[264] Claassen & Verschoor 13; Strauss & Strydom *Die Suid Afrikaanse Geneeskundige Reg* (1967) 266.

[265] (1938) 8 C&P 81: 'Every person who enters into a learned profession undertakes to bring to exercise of it a reasonable degree of care and skill. He does not undertake if he is an attorney, that at all events you shall gain your case, nor does a surgeon undertake that he will perform a cure; nor does he undertake to use the highest possible degree of skill. There may be persons who have higher education and greater advantage than he has, but he undertakes to bring a fair, reasonable and competent degree of skill, and you will say whether, in this case, the injury was occasioned by the want of such skill in the defendant.'

[266] Carstens & Pearmain 619ff; *Coppen v Impey* 1916 CPA 309, 314; *Esterhuizen v Administrator, Transvaal* 1957 3 SA 710 (T) 723 - 724; *S v Mkwetshana* 1965 2 SA 493 (N) 496.

In South Africa the test for medical negligence concerning cases of incompetent medical diagnosis or treatment was formulated by Innes ACJ in the case of *Mitchell v Dixon.*[267] If the physician is a general medical practitioner the test is therefore that of the reasonable general practitioner and if the physician is a specialist, the test is that of the reasonable specialist with reference to the specific field of specialisation.[268] This principle is of particular significance in a developing country such as South Africa. Due to shortages of qualified physicians and compromised medical services, especially in the rural areas, physicians are frequently called upon to perform medical procedures for which they are not qualified to undertake. The question arises – by which yardstick must they be judged in cases of alleged negligence? The locality of practice and the *imperitae culpae adnumerator* – rule are also extremely relevant in answering this question.[269] The mentioned principle is rooted in case law,[270] but Carstens[271] opines that it is the case of *R v Van der Merwe*[272] which sets the tone to this question.

In this case, as in *Van Schoor*,[273] the court stated that the test for negligence is exactly the same in civil as in criminal law. The burden of proof in criminal cases is, however, heavier than in civil cases (negligence beyond reasonable doubt *versus* on a balance of probabilities). The other point is that the same standard of care is not required by a general practitioner as of a specialist.[274]

4.3.2 *Imperitae Culpae Adnumerator*

The maxim means that ignorance or lack of skill is deemed to be negligence.[275] This maxim is regarded by Neethling[276] as misleading because our law does not accept that mere ignorance constitutes negligence.[277]

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[267] 1914 AD 519 525: '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'. Later decisions approved this formulation e.g. *Coppen v Impey* 314 above; *Esterhuizen v Administrator, Transvaal* above 723; *Pringle v Administrator, Transvaal* 1990 2 SA 379 (W).

[268] Carstens & Pearmain 623; Strauss & Strydom 268; Van Oosten *International Encyclopaedia of Laws* (ed Blanpain) (1996) 158; Carstens *Die Strafregtelike en Deliktuele Aanspreeklikheid van die Geneesheer op Grond van Nalatigheid* (LLD thesis 1996 UP) 137.

[269] Carstens & Pearmain 623; The locality rule and the *imperitae culpae adnumeratur* –rule is discussed *infra.*

[270] *Van Wyk v Lewis* above 9; *Esterhuizen v Administrator, Transvaal* above 9; *S v Mkwetshana* above.

[271] Carstens & Pearmain 623.

[272] 1953 (2) PH H 124(W). The deceased was a general practitioner who was accused of culpable homicide after the deceased was overdosed with dicumarol. Roper J said that in deciding what reasonable, regards must be had to the general level of skill and diligence possessed and exercised by the branch of the profession to which the practitioner belongs. The standard is the reasonable care and skill ordinarily exercised by that branch of the profession. Roper J continued that this did not mean that a practitioner can hide behind the defence that he did not know enough or was not sufficiently skilled. He said that before a practitioner used an unfamiliar drug he must satisfy himself as to the properties of the drug. He cannot, when called to account, say that he did not know. It was his duty to know.

[273] Above.

[274] Neethling *Law of Delict* (2001)136.

[275] See 1.2.2 above where such neglect good lead to breach of contract.

[276] *Ibid.*

The *imperitia* rule is applied in the Ethical Rules of Conduct for Practitioners Registered under the Health Professions Act.[278] Said Rules pertaining specifically to the medical profession state the following in terms of Annexure 6 of section 1:

> A medical practitioner or medical specialist – (a) shall perform acts only in the field of medicine in which he or she was educated and trained and in which he or she has gained experience, regards being had to both the extent and the limits of his or her professional expertise.

4.3.3 The Locality Rule

In the South African administration of justice there are conflicting opinions on whether a doctor's locality of practice is a determining factor in deciding what a reasonable practitioner would have done in similar circumstances.[279] In the case of *Van Wyk v Lewis,*[280] Innes CJ observed:[281]

> The ordinary medical practitioner should, as it seems to me, exercise the same degree of skill and care, whether he carries on his work in the town or the country, in one place or another. The fact that several incompetent or careless practitioners happen to settle at the same place cannot affect the standard of diligence and skill which local patients have the right to expect.

In the same case, Wessels AJ came to the opposite conclusion:[282]

> It seems to me however that you cannot expect the same skill and care of a practitioner in a country town in the Union as you can expect of one in a large hospital in Cape Town or Johannesburg. In the same way you find with leading hospitals in London, Paris and Berlin . . . it seems to me, therefore, that the locality where an operation is performed is an element in judging whether or not reasonable skill, care and judgement have been exercised.

Although the applicability of the 'locality rule' has not yet been revisited and the view of Wessels has never been rejected by the courts, Carstens[283] opines that the viewpoint of Innes CJ is to be preferred, specifically in view of vastly improved medical facilities, present information technology and the universal training of medical practitioners. However, there are certain considerations within the context of the realities of the South African situation which should have a deciding influence on the question whether the locality of medical practice must be considered as a factor when assessing negligence. It is the opinion of

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[277] Boberg *Delict: Principles and Cases Vol 1: Aquilian Liability* (1984) 346. Lack of skill can never amount to negligence for no-one can be skilful at everything. It may be negligent to undertake work requiring a certain expertise without possessing the necessary degree of competence.
[278] 56 of 1974. In terms of GN R717 dated 4 August 2006.
[279] Claasen & Verschoor 18: According to the locality rule provision should be made for the nature of the community served by the doctor. According to this view a practitioner in a rural area cannot be measured against the same standard as that of his urban colleague. In the South African context the rural practitioner's lack of supporting medical facilities and infrastructure when compared to the well-equipped urban practices should surely be a consideration in the assessment of medical negligence.
[280] Above at 438.
[281] Above at 444.
[282] Above 457.
[283] Carstens & Pearmain 637.

Carstens that a distinction should be drawn between the subjective competence and ability of a physician and the objective circumstances of the particular locality where the physician practises or is employed.[284] As Gordon succinctly stated:[285] [286]

> The point is that a practitioner, wherever he may be, cannot be expected to perform miracles or to make bricks without straw.

4.3.4 Medical Mishaps and Errors of Clinical Judgment

Whether error of clinical judgement will constitute negligence depends on the particular circumstances of the specific incident.[287]

In the *Whitehouse v Jordan*[288] matter, the English court of Appeal upheld the defendant's appeal by setting aside the finding of negligence but stated that even if the defendant had pulled at the baby's head too long and too hard: [289] [290]

> [W]e must say, and say firmly, that in a professional man, an error of judgement is not negligence.

The House of Lords confirmed the Appeal Court decision but was critical of the above statement:[291]

> Merely to describe something as an error of judgement tells us nothing about whether it is negligent or not. . . . an error of judgement may, or may not, be negligent; it depends on the nature of the error; if it is one that would not have been made by a reasonably competent professional man professing to have the standard and the type of skill that the defendant held himself out as having and acting with reasonable care, then it is negligent. If, on the other hand, it is an error that a man, acting with ordinary care might have made, then it was not negligent.

The law does not require that a practitioner be infallible and an error of judgement will not constitute negligence where the proper standard of care has been followed.[292]

In a South African case of *Pringle v Administrator, Transvaal*,[293] the patient (plaintiff) underwent a medianoscopy for a lymph node on the trachea. While removing the node, the superior vena cava was perforated as a result of the surgeon, as he admitted in retrospect, 'tugg[ing] too hard'. It was subsequently found that: [294]

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[284] Above 638.
[285] Gordon *Medical Jurisprudence* (1953) 113.
[286] Carstens 'The Locality Rule in Cases of Medical Malpractice' 1990 *De Rebus* 421.
[287] See 4.2 above.
[288] 1981 1 All ER 267. The plaintiff was born brain damaged after a problematic pregnancy was followed by a long labour with failure to progress. The registrar failed to deliver the child vaginally after six failed forceps attempts. The child was subsequently delivered by emergency Caesarian section. The judge reasoned that the decision to initially apply forceps was reasonable under the circumstances but that the registrar was negligent in that he pulled for too long and too hard.
[289] Above at 650 & 658.
[290] Claassen 20.
[291] *Whitehouse v Jordan and another* WLR 246, 263.
[292] Claassen & Verschoor 20.
[293] 1990 2 SA 379 (W); Carstens & Pearmain 702
[294] Above at 395B-D.

> [T]here is no suggestion that any act or omission by [the surgeon] was so glaringly below proper standards as to make a finding of negligence inevitable,

but:[295]

> [B]y using excessive force . . . he did not apply that skill and diligence possessed and exercised by the members of the branch of the profession to which he belonged.

4.3.5 Different Schools of Opinion

It is recognised that differences of opinion and practice exist and a practitioner does not act improperly where or she makes use of a method favoured by a respectable minority.[296] Negligence will be established by the failure to exercise the ordinary skill of a physician.[297]

4.3.6 Customary Practice

Following customary practice is but one of the factors taken into consideration to determine whether the physician's conduct measured up to the required standard of care and skill: it is not conclusive proof thereof.[298] Where a medical practice is ostensibly dangerous, the courts may condemn it and hold a practitioner liable for any prejudice resulting therefrom.

In *Van Wyk v Lewis* the following comment was made on customary practice:[299]

> The court can only refuse to admit such an universal practice if, in its opinion, it is so unreasonable and so dangerous that it would be contrary to public policy to admit it.

Giesen opines that:[300]

> [E]vidence as to some sort of 'standard practice' is not necessarily to be taken as conclusive on an issue of negligence. A 'common practice 'may not be good enough to fulfil the standard required by the law.

4.3.7 Resources and the Duty of Care

Insufficient resources, incompetent staff or inappropriate staff supervision is not a defence for poor care.[301] If the physician was aware, or might reasonably have been expected to be aware of the unavailability of resources, he or she should have brought his concerns to the attention of the appropriate person.[302] The physician must ensure that what can be done is

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[295] Above at 396H-I.
[296] Giesen *International Medical Malpractice Law: A Comparative Law Study arising from Medical Care* (1988) 103.
[297] Above.
[298] Claasen & Verschoor 22.
[299] Above at 460.
[300] Giesen 109.
[301] See also 1.2.2 above.
[302] Carstens & Pearmain 638 hold that: '[A] distinction is to be drawn between the subjective competence and ability of a physician (ability with regard to training, experience and skill), and the objective circumstances of the particular locality where the physician practises or is employed.'; And 'the mere factor that a medical practitioner practises in a remote area does not imply that he/she is, as it were,' licensed' to be negligent and then to blame poor or compromised facilities, . . .The doctor is still legally required to maintain the standard of the 'reasonable skilful and competent doctor in the same circumstances.' See also above.

done safely and appropriately, explain to the patient what cannot be done safely and ensure that the patient is treated appropriately.[303]

Now that the principles applicable to professional medical negligence in the context of standard of care have been established, I am able to turn my attention in the next chapter to an examination of the exact nature of a physician's duty of care.

[303] Kline 8.

CHAPTER 5

THE NATURE OF THE PHYSICIAN'S DUTY OF CARE

5.1 Introduction

The bond of trust between the patient and the physician is vital to the diagnostic and therapeutic process and forms the basis of the doctor–patient relationship.[304] Because of a physician's knowledge and the highly confidential nature of his or her services, a physician is said to find him- or herself in a relationship[305] of particular trust.[306] This trust position is referred to as being of a fiduciary nature.[307] This entails that physicians have an obligation to act with the utmost good faith and loyalty.[308] They must never allow their personal interests to conflict with their professional duty.[309]

The principle of 'duty of care' was established in *Donoghue v Stevenson* [310] in 1932 where Lord Atkin identified that there was a general duty to take reasonable care to avoid foreseeable injury to a neighbour. Physicians owe their patients a duty in contract as well as in delict.[311] Giesen[312] is of the view that there is really only one duty generating alternative (or concurrent) remedies or causes of action.[313] There is therefore no essential distinction,

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[304] Ludwig 'Physician-patient relationship' 2014. https://dept.washington.edu/bioethx/topics/physpt.html (accessed 2016-09-12). See also 1.2.2 & 1.4.2 above.

[305] Lerm 210; Claassen & Verschoor 116; Strauss & Strydom 111.

[306] See 1.2.2 & 1.4.2 above.

[307] Carstens & Pearmain 321: 'Black's Law Dictionary defines 'fiduciary as a person having duty, created by his undertaking, to act primarily for another's benefit in matters connected with such undertaking. A fiduciary invokes a higher level of trust that is born out of dependency.' A fiduciary duty is defined by Black's as 'a duty to act for someone else's benefit while subordinating one's personal interests to that of the other person. It is the highest standard of duty implied by law.'' They continue: '[A]and trust the knowledge, professionalism and skill patients generally depend upon of physicians for their health needs, thus creating a fiduciary responsibility on the part of physicians.'

[308] See 1.2.2 & 1.4.2 above.

[309] See 1.2.2 above.

[310] 1932 AC 562 UKHL 100. See also *Administrator Natal v Trust Bank of Africa Ltd* 1979 (3) SA 824 (A); *Bayer South Africa (Pty) Ltd v Frost* above 568B-C; *Knop v Johannesburg City Council* above at 24 D-E; *Sea Harvest Corporation (Pty) Ltd v Duncan Dock Cold Storage (Pty) Ltd* above at 837G; *Minister of Safety and Security v Van Duivenboden* above at 12 & 22; *Gouda Boerdery BK v Transnet* above para 12; *Telematrix (Pty) Ltd t/a Matrix Vehicle Tracking v ASASA* above paras 13 & 14; *Trustees, Two Oceans Aquarium Trust v Kantey and Temper (Pty) Ltd* above paras 10-12; *Doug Parsons Property Investments (Pty) Ltd v Erasmus De Klerk Inc* 2015 (5) SA 244 (GJ); Neethling & Potgieter *Law of Delict* (2015) 158.

[311] See 1.2.1 & 1.2.2 above.

[312] Giesen 73.

[313] Claassen & Verschoor 118. The authors use the example of a surgeon who performs an operation in an improper manner is, firstly guilty of breach of contract because he does not perform the operation correctly in term of the contract. Secondly, the commission of an unlawful act is also present because the surgeon injures the patient's rights of personality regarding the integrity of his person. See also *Van Wyk and Lewis* 438; *Correira v Berwind* 1986 (4) (1) ZLR 192 (H) where the court found that surgery had been performed negligently. It was ruled that medical staff owe a duty of care to their patients whether or not a contract exists between them. With regard to concurrence of remedies, see Claassen & Verschoor 123 who opine 'One of the same acts may lead to different claims for which different remedies are available'.

in the field of medical practice, between the duty of care and skill owed by the physician to his or her patient in contract and in delict.[314]

This duty of care, although founded in normative ethics, various ethical codes, regulations and the Hippocratic Oath itself,[315] is imposed on the practitioner by law.[316]

In terms of the ethics of the profession,[317] a physician is under a general duty to act and treat a patient. Although he or she may refuse to treat a patient, he or she is ethically obliged to treat a patient in an emergency situation. Traditionally it was held that a person could not be held liable by virtue of a mere omission.[318] Today it is accepted that a mere omission can, in fact, lead to delictual as well as criminal liability where the circumstances are such that the physician concerned could personally be expected to intervene:[319]

> A court may now well hold a doctor liable for harm suffered by an injured or ailing person, where the doctor was aware of his condition and unreasonably refused or failed to attend.

This principle is illustrated by Constitutional Court judgements concerning the delictual element of wrongfulness in cases of negligent omission.[320] In the matter of *Minister of Safety and Security v Van Duivenboden*[321] Nugent *inter alia* expressed himself as follows:

> In applying the test … formulated in [Ewels][322] the 'convictions of the community' must necessarily now be informed by the norms and values of our society as they have been

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[314] See 1.2.1 & 1.2.2 & chaps 2 & 3 above.

[315] Lerm *'A Critical Analysis of Exclusionary Clauses in Medical Contracts'* (LLD Dissertation 2008 UP) 225.

[316] Carstens & Pearmain 249; Health Professions Act 56 of 1974 as amended by Act 89 of 1997 in terms of which the Health Professions Council of South Africa was established; National Health Act of 61 of 2003.

[317] Health Professions Council of South Africa *Guidelines for Good Practice in the Health Care Professions. General Ethical Guidelines for the Healthcare Professions* Ed Human Rights, Ethics and Professional Practise(sic) Booklet 1 2008.

[318] Lerm 226; Voet Commentaries ad Pandectas 9.2.3 as translated by Gane. *The Selective Voet being the Commentary on the Pandectas* 1955 – 1958). The eminent Roman-jurist by the turn of the 17th century wrote, although 'it would suit the duty of the good man to come to help the imperilled fortunes of his neighbour, if he can do it without hurt to himself.' Nevertheless, wrote the writer, 'A doctor who refuses to attend a patient cannot be held liable under the Aquillian law.' See also Strauss Doctor, Patient and The Law (1991) 23 who states the traditional view of our law was that 'failure on the part of someone to act 'positively' to ward off danger from another or to protect the latter's interest otherwise generally could not lead to any liability on the part of the former.' It is for that reason that Strauss op cit 24 states that: 'In our law the doctor's right of refusal was traditionally 'mere omission'.' The author however places a *caveat* in that 'in certain instances liability for an omission can be incurred for example where the defendant has by a positive act created a potentially dangerous situation and refrains from taking steps to avoid the danger; where the defendant has assumed control over a dangerous object and then neglects to exercise proper care over it; where the defendant is under a statutory duty to act and neglects to do so; where the defendant has by contract assumed certain duties and fails to carry them out.' See also Van Oosten (1996) 59 – 61; See Strauss & Strydom (1967) 185; Gordon (1953) 123; McQuoid-Mason & Strauss (1983) 190; Claassen & Verschoor (1992) 38 – 39 117. See also 1.3.2 above.

[319] Lerm *ibid*; Strauss 24; 1.3.2 above.

[320] See 2.2; 2.3; 2,4 & 2.5 above.

[321] 2002 (6) SA 431 (SCA) 17.

[322] Brand 'Influence of the Constitution on the law of delict'2014 *Advocate; Minister v Polisie v Ewels* 1975 (3) SA 590 (A): 'A negligent omission is wrongful only in circumstances where there exists a legal duty to act positively to avoid the materialisation of the harm.' Whether or not such a duty exists, so it was said in Ewels, is in turn tested against the flexible standard of 'the legal conviction of the community.'

embodied in the 1996 Constitution. The Constitution is the supreme law, and no norms or values that are inconsistent with it can have legal validity …'.

5.2 Professional Duty to Heal or to Cure?[323]

Relevant to the duty of care of physicians and to medical negligence is the question as to whether there is a duty or obligation on them to heal or cure their patients?[324] In the matter of *Behrmann v Klugmann*[325] a doctor was sued after the birth of a normal child following a failed vasectomy. The plaintiffs testified that statements made by the defendant had caused them to believe that the operation was irreversible and that Mr B would be sterile after 10 weeks. The defendant testified that it was his or her practice to warn post-vasectomy patients that it could take up to nine months to achieve two negative sperm counts and that therefor she would first have to declare Mr B sterile. The court agreed with the view expressed by the English Court of Appeal in *Eyre v Measday*[326] that in the absence of an express warranty, the court would be slow to imply that a medical man gives an unqualified warranty as to the results of an intended operation.[327] In the case of *Buls v Tsatsarolakis* Nicholas J observed:[328]

> 'Generally speaking every man has a right that others shall not injure him in his person and that involves a duty to exercise proper care. Every man has a legal right not to be harmed; but is there apart from a contract, a legal right to be healed? It is no doubt the professional duty of a medical practitioner to treat his patient with due care and skill, but does he, merely by undertaking a case, become subject to a legal duty, a breach of which founds and action for damages, to take due and proper steps to heal the patient? It is an interesting question, but because it was not argued and discuss it further.

In the cases of *Kovalsky v Krige,*[329] *Coppen v Impey*[330] and *Van Wyk v Lewis,*[331] the court reiterated that the reasonable care, skill and experience which are legally required of medical practitioners do not imply that a medical practitioner, in any sense, grants a guarantee to any patient that the patient would indeed be healed or cured.

Strauss[332] is of the opinion that where a patient consults with a medical practitioner, no more is required of the practitioner than to treat the patient with reasonable care, skill and

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[323] Carstens & Pearmain 642.
[324] See also 2.4 above.
[325] 1988 (W) as discussed by Strauss 1984 176.
[326] [1986] 1 All ER 488 (CA).
[327] See 1.2.2 above.
[328] 1976 2 SA 891 (T).
[329] 1910 20 CTR 822. A physician tried to stop bleeding using ferric chloride. Although other practitioners testified that they would have preferred other methods, he was not held liable.
[330] *Coppen v Impey* above 314 'A medical man, while he does not in law undertake to perform a cure, or treat his patient with the utmost skill and competency, is liable for negligence or unskilfulness in his treatment for, holding himself out as a professional man, he undertakes to perform the service required of him with reasonable skill and ability.'
[331] Above at 456.
[332] Strauss 40; it is to be noted that the duty to heal is not of a contractual nature.

experience legally required, unless the practitioner explicitly guarantees that the patient will be healed or cured – an undertaking that no prudent practitioner will subscribe to.[333]

It is to be noted that the right of a patient not to be harmed or injured accords with the provisions of sections 11 and 12(2)(b) of the Constitution of the Republic of South Africa, 1996 (the Constitution). These sections entrench the right to life and bodily integrity.[334] Carstens[335] submits that:

> [T]he Constitution does not impose any professional duty on physicians to heal or cure their patients, other than to act with reasonable skill, care experience and diligence. Every medical intervention is fraught with potential risks, including bodily/mental injuries or even death. To interpret any right in the Constitution to impose a duty on medical practitioners to heal or cure their patients, would imply that medical practitioners are now responsible for man's mortality – this stance will never be sustained by any constitutional justification or limitation.

I fully endorse Carstens' assessment.

Next, I examine the duties and obligations of a health care provider flowing from the contractual and delictual relationships that were the topic of the first three chapters of the dissertation.

[333] See 1.2.2 above.
[334] The Constitution, 1996.
[335] Carstens & Pearmain 643.

CHAPTER 6

THE DUTIES AND OBLIGATIONS OF A HEALTH CARE PROVIDER FLOWING FROM THE CONTRACTUAL AND DELICTUAL RELATIONSHIPS

6.1 General

The *essentialia* in a contract between a physician and a patient is said to include, unless otherwise agreed, not to cure the patient or guarantee a specific outcome,[336] but an undertaking to examine, diagnose and treat the patient against payment in the usual manner with the necessary reasonable skill and diligence.[337] To achieve this, the physician is to act with the degree of skill and care that can reasonably be expected from an average practitioner in the field.[338] By acting in a careless and/or negligent manner, the physician not only commits a breach of contract, but is also liable in delict for loss suffered by the patient in consequence of the negligent conduct.[339]

6.2 The Physician's Duty to Treat

The answer to this question depends on whether the physician is in private practice or in the fulltime employ of a health services provider in the public sector. Where a physician is in private practice or she enters into a contractual relationship with the patient after consensus is reached.[340] However, where the patient presents for treatment in the public service, and enters a public hospital, owned by provincial governments, in which health service delivery takes place, the situation is more problematic.[341]

In the public sector, from a constitutional perspective, the state cannot refuse access to healthcare services to any person.[342] In terms of sections 27(1) and 27(3) of the Constitution:[343]

> Everyone has the right to have access to – (a) healthcare services, including reproductive health care; ... No one may be refused emergency medical treatment.

Private healthcare providers, unlike the state, are not tasked by the Constitution with the realisation of the right of universal access to healthcare services.[344] Private healthcare

[336] McQuoid-Mason & Strauss 114; Strauss 40; Carstens & Pearmain above; *Buls v Tsatsarolakis* above; *Kovalsky v Krige* above 822; *Van Wyk v Lewis* above 438 at 458.
[337] See 1.2.2 above.
[338] Chap 4 above.
[339] McQuoid-Mason & Strauss 114; Carstens & Pearmain 619; Dada & McQuoid Mason (2001) *Introduction to Medico-Legal Practice* 22; Strauss 243; Claassen & Verschoor 13.
[340] Strauss 3; Claassen & Verschoor 116.
[341] Carstens & Pearmain 382 discuss the objections made against the notion that a contractual relationship does exist in this situation. One of the objections against the notion that there exists a contractual relationship between the patient and public provider is that it 'would promote the notion that the state is 'selling' healthcare goods and patients are 'purchasing' them ...' However a contractual agreement does not necessarily imply a commercial objective. In the case of *Shields v Minister of Health* 1976 (1) SA 891 (T) as in the case of *Administrator, Natal v Eduardo* 1990 (3) SA 581 (A) it was accepted that the relationship was a contractual one.
[342] *Contra* the common law position: see 1.3.2 & 1.4.1 to 1.4.2 above.
[343] The Constitution above.

providers, legally speaking, may generally accept or refuse patients as they wish and there is no duty on them to treat people who are not existing patients.[345] An exception is in an emergency situation where the private healthcare provider is ethically obliged to act.[346]

However, once the private physician has been consulted and he or she has agreed to accept the person as a patient, or she has the duty to complete treatment.[347]

In terms of section 5 of the National Health Act:

> Emergency treatment: A healthcare provider, health worker or health establishment may not refuse a person medical treatment.[348]'

State doctors may not refuse to treat patients whom they are bound to treat in terms of their contracts of employment, or under a statutory duty, or under the terms of the Constitution.

6.3 The Duty to Complete Treatment

> Once the physician has accepted a patient and has embarked upon a specific course of treatment, he may not unilaterally abandon the patient . . . (unless the patient makes it impossible to continue treating him).[349]

The physician who accepted and started treatment must therefore complete it unless:

- The initial physician can leave it in the hands of another competent practitioner;
- The treating physician issues sufficient instructions to a competent person for further treatment;
- The patient is cured and does not require further treatment;
- A patient who is mentally competent, refuses further treatment or insists on being discharged from hospital;
- The treating physician gives the patient reasonable notice that or she intends to discontinue his or her practice. Or she must ensure that other facilities are available. The doctor should issue full instructions for proposed further treatment and indicate his or her willingness to consult with the second practitioner who takes over.[350]

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[344] Carstens & Pearmain 380.
[345] Dada & McQuoid-Mason 6 'This is because in law there is usually no liability for a mere omission – unless there is a duty to act or the circumstances are such that society would regard the failure to act as unlawful.' *Magwere v Minister of Health NO* 1981 (4) SA 472 (Z): Strauss 3 'There being no legal duty in general upon a doctor to accept a patient, it is also true that the doctor has no general right to treat any person.'
[346] HPCSA Ethical Rules of Conduct for Practitioners Registered under the Health Professions Act, 1974.
[347] See 1.2.2 & 1.4.1 to 1.4.2 above.
[348] 61 of 2003
[349] Strauss 3.
[350] Dada & MacQuoid-Mason 6; Gordon 1953 *Medical Jurisprudence* 123.

6.4 The Duty to Obtain the Patient's Consent

A physician generally has no right to treat a patient unless the patient consents to treatment.[351]

6.5 The Duty to Inform the Patient

To be legally valid, consent must be based on sufficient knowledge concerning the nature and effect of the procedure or act consented to.[352] The implications of consenting to or alternatively refusing consent must also be explained and understood by the patient.[353] The rationale for the doctrine of informed consent is the endorsement of patient autonomy as a fundamental right and the rejection of medical paternalism and the promotion of scientific, informed rational decision-making.[354] Van Oosten[355] describes the purpose of informed consent as follows:

(a) To ensure the patient's right to self-determination and freedom of choice;
(b) To encourage rational decision-making by enabling the patient to weigh and balance the benefits and disadvantages of the proposed intervention in order to come to an enlightened choice either to undergo or refuse it.

The question remains, what information must be disclosed to the patient? The requirements for the disclosure of information are regulated by the National Health Care Act.[356] The nature and scope of the information which must be disclosed must be considered in the context of legislative requirements as provided in sections 6 to 8 of the Act:[357] The doctor is, in terms of the National Health Act,[358] obliged to give the patient an

[351] Dada & MacQuoid-Mason 6; Strauss 3 'Legally the doctor's right to operate or treat is based entirely on the patient's consent – apart from emergency cases where a patient is brought to a doctor in an unconscious or semi-conscious state, and apart from where a patient is under a statutory duty to submit ...'; Carstens & Pearmain 877ff; Van Oosten 1996 *Encyclopaedia* 63: '[T]the patient's effective consent is fundamental to lawful medical intervention. And further '[T]he doctor may incur liability for breach of contract, civil or criminal assault or negligence as the case may be.' See also 1.3.3 & 2.4.1 to 2.4.2 above; 6.3 & 6.4 below.
[352] See 1.3.3; 2.4 & 2.4.2 above.
[353] See 1.3.3; 2.4 & 2.4.2 above.
[354] Carstens & Pearmain 877 refers to: *Stoffberg v Elliot* above: 'A man by entering a hospital does not submit himself to such surgical treatment as the doctor in attendance upon him mat think necessary ... [B]y going into hospital he does not waive or give up his right to say what operation he will submit to, and unless his consent to an operation is expressly obtained, any operation performed upon him without his consent is an unlawful interference with his right of security and control of his own body.'; also *Esterhuizen v Adminstrator, Transvaal* above ; *Castell v De Greeff* 1994 (4) SA 408 C.
[355] Van Oosten 68 – 69.
[356] 61 of 2003.
[357] '6. User to have full knowledge: (1) Every health care provider must inform a user of – (a)the user's health status except in circumstances where there is substantial evidence that the disclosure of the user's health status would be contrary to the best interests of the user; (b) the range of diagnostic procedures and treatment options generally available to the user; (c) the benefits, risks, costs and consequences generally associated with each option; and (d) the user's right to refuse health services and explain the implications, risks, obligations of such refusal. (2) The health care provider concerned must, where possible, inform the user as contemplated in subsection (1) in a language that the user understands and in a manner which takes into account the user's level of literacy. 7 Consent of user: (1)Subject to section 8, a health service may not be provided to a user without the user's informed consent, unless – (a) the user is unable to give informed consent and such consent is given by a person - (i) mandated by the user in writing to grant consent on his or

idea, in general terms, understandable to a layman, of the nature, scope,[359] consequences,[360] risks, dangers, complications,[361] benefits, disadvantages, and prognosis[362] and of possible alternatives[363] to the proposed procedure. A doctor must also warn a patient about the meaning of certain symptoms.[364]

The South African courts rejected paternalistic approaches to patient autonomy as illustrated in the case of *Castell v De Greeff*.[365]

6.6 The Duty to Exercise Due Care and Skill[366]

The physician's duty to exercise reasonable care and skill ranks foremost amongst the doctor's legal obligations.[367] This duty may take the form of an express term of the

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her behalf; or (ii) authorized to give such consent in terms of any law or court order; (b) the user is unable to give informed consent and no person is mandated or authorized to give such consent, and the consent is given by the spouse or partner of the user or, in the absence of such spouse or partner, a parent, grandparent, an adult child or a brother or a sister of the user, in the specific order as listed; (c) the provision of a health service without informed consent is authorized in terms of any law or a court order; (d) failure to treat the user, or group of people which includes the user, will result in a serious risk to public health; or (e) any delay in the provision of the health service to the user might result in his or her death or irreversible damage to his or her health and the user has not expressly, impliedly or by conduct refused that service. (2) A health care provider must take all reasonable steps to obtain the user's informed consent. (3) For the purposes of this section 'informed consent' means consent for the provision of a specified health service given by a person with legal capacity to do so and who has been informed as contemplated in section 6; 8. Participation in decisions: (1) A user has the right to participate in any decision affecting his or her personal health and treatment. (2) (a) If the informed consent required by section 7 is given by a person other than the user, such person must, if possible, consult the user before giving the required consent. (b) A user who is capable of understanding must be informed as contemplated in section 6 even if he or she lacks the legal capacity to give the informed consent required by section 7: (3) If a user is unable to participate in a decision affecting his or her personal health and treatment, he or she must be informed as contemplated in section 6 after the provision of the health service in question unless the disclosure of such information would be contrary to the user's best interest.'

[358] National Health Act 61 of 2003, section 6.

[359] *Esterhuizen v Administrator Transvaal* above 720. The doctor failed to disclose that the proposed treatment, unlike the previous treatments involved radical radiotherapy. It was held that such treatment constituted an assault on the patient arising from an absence of consent.

[360] Of both undergoing or of refusing to undergo the procedure.

[361] *Castell v De Greeff* above.

[362] *Ibid.*

[363] The alternative may be no treatment.

[364] *Dube v Administrator Transvaal* 1963 4 SA 260 (W).

[365] Van Oosten 'The doctrine of informed consent: Medical paternalism ousted in favour of patient autonomy' (1995) *de Jure 170.* The court had to determine whether the patient had, *inter alia* been properly informed of the risks involved in a particular procedure. Prior to this case, the test had been that of the *reasonable doctor.* No consideration was given to the possibility that a particular patient may have considered a particular risk as significant. In this case the court moved away from the doctrine of the reasonable doctor towards a doctrine of informed consent. The test had to be applied in two parts: A risk would be material if 'the reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it, and secondly, a risk would be material if the doctor is or reasonably should have been aware, that the particular patient, if warned of the risk, would be likely to attach significance to it.'

[366] See 1.2.2; 1.3.2; 1.3.3; 1.4.2; chaps 2 & 3 above.

[367] Lerm 203; Strauss & Strydom 266; Carstens *Prophylaxis against medical negligence: A practical approach.* (1988) *De Rebus* 345; Dada & McQuoid-Mason 22; Carstens & Pearmain 364: *Mitchell v Dixon* above; *S v Mahalela* above 4.1.4; *van Wyk v Lewis* above 4.2.2 & 4.2.1 above.

agreement between the physician provider and the patient, or it may never even have been discussed.[368] Even in the absence of an express agreement, an implied term to exercise due care comes into being as soon as the contract between the two parties is concluded.[369]

From previous discussion in chapter 4 it is clear that the degree of skill and care that can be expected is largely a question of evidence and may include factors such as the prevailing, universal, customary or usual practice of the profession, the location where the medical intervention or treatment is performed or given, the facilities available, the nature of the procedure and the different conditions or possible emergency situation in which the procedure or intervention is performed.[370] It must be emphasised that a clear distinction is drawn in South African case law between the degree of knowledge, experience, care and skill expected of a specialist as opposed to that of a general practitioner.[371] In certain instances the courts may depart from the general rule of measuring the conduct of a physician in terms of the branch of the profession to which or she belongs.[372]

Where the court applies the principle *impurities culpae adnumerateur*, a general practitioner would be negligent if he or she undertook work requiring a certain degree of training, knowledge, skill, competence or experience associated with a specialist and which the general practitioner lacks and where the general practitioner is aware or should be aware that or she lacks these qualities.[373] Furthermore, a general practitioner will be criticised for a reprehensible error of judgement if or she refuses to call in a specialist to assist in a problem case and a specialist is indeed available.[374]

6.7 The Physician's Duty to Execute the Patient's Instructions Honestly, Faithfully and with Care

As was discussed in chapters 1, and 2 and 3, the relationship between the physician and patient is a private law matter and is governed by the law of obligations. A further duty

[368] Lerm 204.
[369] Claassen & Verschoor 13 – 14; Carstens & Pearmain 362.
[370] Claassen & Verschoor 14 -15; Strauss & Strydom 266 – 268; *Van Wyk v Lewis* above 457; Carstens & Pearmain above.
[371] *R v Van der Merwe* above in which Roper J drew the distinction as follows: 'When a medical practitioner is tried, the test is not what a specialist would or would not have done in the circumstances, because a general practitioner is not expected to have the same degree of knowledge and skill and experience as a specialist. ... But the question is what is the common knowledge in the branch of the profession to which the accused belongs?' This dictum was endorsed by Bakker J in *Esterhuizen v Administrator Transvaal* above 723 & 724: Also *Buls v Tsarolakis* above 893; *Pringle v Administrator, Transvaal* above 384.
[372] *Ibid.*
[373] Lerm 209; *Coppen v Impey* above: 'Unskilfulness on his part is equivalent to negligence and renders him liable to a plaintiff, who sustained injury there from, the maxim of the law being *imperitae culpae adnumerateur*.' *S v Mkwetshana* above 497: 'Either the appellant had insufficient knowledge and experience of the drug, in which case it was negligence on his part to administer it; if he knew little, if anything, about it he was subjecting his patient to a considerable risk. For him to have done that in the light of his experience, and particularly his inexperience of the drug and its usages, marks him as being negligent.'
[374] *S v Nel* 1987 TPD (unreported).

which arises is that the physician must execute the patient's instructions with honesty, faithfully and with care.[375]

6.8 The Physician's Duty of Confidentiality

Because of the nature of the doctor patient relationship, the patient has a fundamental need for and right to privacy.[376] This need must be respected so that the patient can freely disclose his or her symptoms and conditions to the physician,[377] as health matters are of the most sensitive areas of privacy.[378] This right is also protected by the Constitution:

> Everyone has the right to privacy, which includes the right not to have –
> (a) their person or their home searched.[379]

The physical examination of a patient is very much an invasion of his or her privacy and such examination can only be lawfully conducted if the patient waives his or her right to privacy for the purpose thereof.[380] Information as to a patient's health status is also bound to issues of privacy – it is confidential and personal information that if disclosed without permission could adversely affect the patient's bodily or psychological integrity. The right to psychological and bodily integrity is also protected by the Constitution.[381] Besides the patient's rights to privacy and confidentiality being protected by the common law, such rights are also protected by legislation.[382]

In Chapter 7, the penultimate chapter of the dissertation, the duty of care is examined closely in the context of the South African medical malpractice environment.

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[375] Carstens & Pearmain 947: 'If a patient does not trust a healthcare professional, he/she is unlikely to take the latter's advice concerning treatment or believe a diagnosis.'
[376] Lerm 215; Carstens & Pearmain 943; sec 14 of the Constitution, 1996.
[377] *Ibid.*
[378] *Ibid*.
[379] Sec 14 of the Constitution of South Africa, 1996.
[380] Carstens & Pearmain 944.
[381] Sec 12.
[382] Act 2 of 2000 which prohibits the disclosure of personal information in the absence of prior consent ito s 34 & s 67. It also deals specifically with health records ito s 30 & s 61. The National Health Act, 61 of 2003 also contains extensive provisions that support and uphold the patient's right to privacy. With regard to confidentiality this Act stipulates that all information concerning a user, including information relating to his or her health status, treatment or stay in a health establishment is confidential. It goes on to provide that no person may disclose any such information unless: the user consents to that disclosure in writing or a court order or any law requires that disclosure; or non-disclosure of the information represents a serious threat to public health. 14(2). The Health Provisions Council in its published guidelines referred to above deals specifically with an accused right of privacy and confidentiality when requiring that practitioners *inter alia:* '[Recognize] the right of patients to expect that they will not pass on any personal and confidential information they acquire in the course of their professional duties, unless they agree to disclosure, or unless there is a good and overriding reason for doing so, (Examples of such reasons may be any probable and serious harm to an identifiable third party, a public health emergency, or any overriding and ethically justified legal requirements.) Do not breach confidentiality without sound reason and without the knowledge of the patient… '

CHAPTER 7

APPLICATION OF THE DUTY OF CARE FROM A MEDICAL MALPRACTICE PERSPECTIVE

7.1 Medical Malpractice: The South African Scenario

Medical malpractice claims have increased significantly over the last number of years.[383] The rising number of claims affects both the private and public sectors.[384] The risk of facing a medical malpractice lawsuit should arguably ensure a higher standard of care by the physician,[385] but it appears that physicians are practicing more defensive medicine.[386]

Claims costs depend on the number of claims, the value of the claims paid out and legal costs. In South Africa, all have increased in recent years.[387]

Various reasons have been advanced for the increase in both the number and the value of claims and both will be canvassed briefly.

7.1.1 The Rise in the Value of Claims

7.1.1.1 Advances in Medicine and Technology.[388]

The rise in the value of medical claims could perhaps in part be ascribed to advances in medicine and technology.[389] Improved but expensive and sophisticated care has considerably extended life-expectancy for severely compromised patients.[390] Furthermore, technological advances are pushing up the prices of assistive devices such as wheelchairs.[391]

7.1.2 Causes of Increased Malpractice Litigation.[392]

7.1.2.1 Healthcare System

Many adverse events result from systemic factors rather than individual negligence and errors occur despite the best intentions of medical personnel.[393] The institutional weaknesses within the public health system may contribute to the increase in litigation since the quality of care is compromised. Whilst doctors have to perform their duties in accordance with the degree of skill expected from them, this is often made impossible by

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[383] Pienaar 'Investigating the Reasons behind the Increase in Medical Negligence Claims' 2016 *PER/PELJ* 1; Pepper & Slabbert 'Is South Africa on the verge of a Malpractice Litigation Storm?' 2011 *SAJBL* 29; Oosthuizen & Carstens 'Medical Malpractice: The Extent, Consequences and Causes of the Problem' 2015 *THRHR* 273; Malherbe 'Counting the Cost: The Consequences of Increased Medical Malpractice Litigation in South Africa' 2013 *SA MEDICAL J* 83.
[384] Oosthuizen & Carstens 2015 *THRHR* 275.
[385] Pepper & Slabbert 30; Pienaar 2016 *PER/PERLJ* 3.
[386] Oosthuizen & Carstens 2015 *THRHR* 278.
[387] Pienaar 2016 *PER/PERLJ* 2.
[388] Bateman 'Public Somnambulism: A General lack of Awareness of the Consequences of Increasing Medical Negligence Litigation' 2014 *SA Medical J* 216.
[389] Pienaar 2016 *PER/PERLJ* 5.
[390] Bateman 2014 *SA Medical J* 216.
[391] Pienaar 2016 *PER/PERLJ* 5.
[392] Oosthuizen & Carstens 2015 *THRHR* 280.
[393] Reason 'Human Error: Models and Management'2000 *BMJ* 768.

factors beyond their control.[394] Decisions made by administrators have a direct impact on the quality of services practitioners can provide to their patients.[395] Liability can be incurred by these individuals, as well as by health departments and hospital bodies vicariously, if negligent maladministration or mismanagement results in harm being suffered.[396]

7.1.2.2 'Person' Versus 'System Approach

Adverse events are blamed on individuals rather than institutions or organisations.[397] The approach focuses on the unsafe acts of the personnel and the practitioners. Blame is allocated, disciplinary measures instituted and there is a threat of litigation.[398] Error management resources are directed at making individuals less fallible.[399] This personal approach may be inappropriate in the complex healthcare environment. Errors should rather be managed, not by targeting the individual, but by implementing programmes which target several different components of the system, including the person, the team, the task, the workplace and the institution as a whole.[400] However, our current liability system, which is focused on individual accountability, may not be conducive to such an approach as it may deter individual behaviour, but does little to address the systemic factors.[401]

7.1.2.3 Medical Profession

There have been suggestions that the increase in claims has been brought on by a decline in professionalism and the standard of care.[402] The Health Professions Council of South Africa (HPCSA) has also raised concerns about the increased number of complaints they have received.[403]

Lapses in judgement do occur and even the most vigilant physicians make mistakes.[404] Many studies have, however, found that the quality of care provided and the technical expertise of the physician may not be determining factors when it comes to malpractice litigation.[405] Instead it seems that patients' dissatisfaction may be critical.[406] A perceived lack of caring and a breakdown in communication often precede the decision to litigate.[407]

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[394] Oosthuizen & Carstens 2016 *THRHR* 280.
[395] Vincent 'Research into Medical Accidents: A Case of Negligence?' 1989 *BMJ* 1152.
[396] McQuoid-Mason 'Establishing Liability for Harm caused to Patients in a Resource-Deficient Environment' 2010 *SA Medical J* 574.
[397] Oosthuizen & Carstens 2016 *THRHR* 281.
[398] Reason 2000 *BMJ* 768.
[399] Reason 2000 *BMJ* 769.
[400] *Idem.*
[401] Leape 'The nature of adverse event in hospitalized patients: Results of the Harvard Medical Practice Study II' 1991 *NEJM* 383.
[402] 'Patients need educating on rights, responsibilities *Business Day* (2012-08-08).
[403] 'HPCSA responds to campaign criticism' *Medical Chronicle* (2012 – 06 – 04) http://bit.ly/ZFNbit (accessed on 2016-12-19).
[404] Oosthuizen & Carstens 2016 *THRHR* 282
[405] *Ibid*.
[406] *Ibid*.
[407] Moore 'Medical information therapy and medical malpractice litigation in South Africa' 2013 *SAJBL* 60. Also: Commentary 'Reducing Legal Risk by Practicing Patient-Centred Medicine' 2002 *Arch Int Med* 1217; Bell

Oosthuizen summarises:[408]

> Merely obtaining money may not be the only objective of injured patients; the reasons for filing suit may be due to the manner in which the practitioner subsequently managed the situation after the occurrence of the adverse event. Practitioners would thus be wise to adjust their behaviour accordingly. Communication is essential. Practitioners need to build a rapport with their patients and, in the case of an adverse event; they need to manage the situation sympathetically, whilst keeping in mind that patients may be immensely affected by such an unfortunate outcome.

7.1.2.4 The Legal Profession

The Minister of Health has in the past vilified lawyers and accused them of being greedy.[409] Many doctors share his sentiments.[410] Although many lawyers do not act altruistically when taking on malpractice case, patients who have suffered injury as a result of a physician's negligence have a right to be compensated.[411] Lawyers provide the only avenue for financial redress. Previously, before the advent of contingency fees, the threat of an adverse costs order did serve to deter meritless claims.[412] However, legal practices are determined by the liability and compensation systems within which they function.[413]

Certain factors which may well contribute to the increase in malpractice litigation are:

- Medical malpractice attorneys are purposefully targeting the public and encouraging them to seek legal assistance if they have suffered an adverse incident;[414]
- Amendments to the Road Accident Fund legislation may have driven attorneys to other types of personal injury litigation;[415]
- The Contingency Fee Act[416] has placed litigation in the reach of an indigent population that could not previously have afforded to litigate. It may, however, have led to certain questionable practices.[417]

'Unsaid but not forgotten: Patients unvoiced desires in office visits' 2001 *Arch Intern Med 1977;* Hoffmann 'Patterns of unprofessional conduct by medical practitioners in South Africa (2007-2013) http://wwwtandonline.com/doi/full/10.1080/20786190.2016.1186366 (accessed 2016/07/19).

[408] Oosthuizen 2016 *THRHR* 283.

[409] 'Motsoaledi wages war against lawyers' *Medical Chronicle* (2011-10-10). http://wwwmedicalchronicle.co.za/category/news/archives (accessed 16-12-16).

[410] Oosthuizen & Carstens 2016 *THRHR* 282.

[411] *Ibid.*

[412] Strauss 245.

[413] Oosthuizen &Carstens 2016 *THRHR* 283.

[414] Pepper & Slabbert 2011 *SALBL* 30.

[415] Road Accident Amendment Act 19 of 2005; *Law Society of South Africa v Minister for Transport* 2011 1 SA 400 (CC); Malherbe 2013 *SA Medical J* 83.

[416] 66 of 1997.

[417] Oosthuizen & Carstens 2016 *THRHR* 283; Howarth 'The Threat of Litigation: Private Obstetric Care – *quo vadis*?' *SAJBL* 85.

7.1.2.5 Increased Patient Awareness

Certain stakeholders in the medical profession have indicated that the proliferation of complaints and litigation is not owing to a decline in standards and care, but rather that patients have become more aware of their rights.[418]

7.2 Patient-Centred Legislation[419]

Legislative provisions[420] enacted over the last two decades place emphasis on patients' rights, thereby entitling patients to institute claims against medical practitioners.

7.3 Patient-Centred Jurisprudence[421]

The autonomy of a patient (inclusive of a child) is the constant theme in all the latest legislation. The important sub-themes being autonomy, informed consent, confidentiality and the paramountcy of the child's best interest.[422] As the courts have to consider and apply all the above legislative provisions in medical malpractice matters, the increase in successful malpractice claims is to be expected.

7.4 What is the Duty of Care Owed to Patients?[423]

Although the test for medical negligence is an established test in law, the question may well be asked: How does this legal standard find practical application in medical practice? All physicians have a duty of care – not only to patients, but also to colleagues and

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[418] 'HPCSA's 'Report a doc' campaign likely to hike medical costs' *Medical Chronicle* (2012-5-7). http://wwwmedicalchronicle.co.za/category/newa/archives (accessed 16-12-16).

[419] Pienaar 2016 *PEL/PELJ* 8.

[420] The Constitution, 1996, the National Health Act 61 of 2003, and the Consumer Protection Act 68 of 2008 all contain provisions that aim to protect the user of services, including health services. The Children's Act 38 of 2005 empowers children to take independent decisions regarding their health care, provided certain requirements are met. The Mental Health Care Act, 17 of 2002 contains a patient's charter that *inter alia* states that a patient is entitled to be informed of his/her rights. The Protection of Personal Information Act 4 of 2013, once fully in effect, will also impact on the way that health care providers practise.

[421] Pienaar *PEL/PELJ* 12.

[422] *Ibid.*

[423] General Medical Council (2013) www.gmc-uk.org/guidance (accessed 2016-12-19). 'Patients must be able to trust doctors with their lives and health. To justify that trust thy must show respect for human life and make sure their practices meet the standard expected of them in the following domains: 1 Knowledge, skill and performance: Make the care of their patients their first concern; Provide a good standard of practice and care; Keep their professional knowledge up to date; Recognise and work within the limits of their competence. 2 Safety and quality: Take prompt action if they think that patient safety, dignity or comfort is being compromised; protect and promote the health of patients and the public. 3 Communication, partnership and teamwork: Treat patients as individuals and respect their dignity; Treat patients politely and considerately; Work in partnership with patients; Listen to and respond to their concerns and preferences; Give patients the information they want or need in a way that they can understand; Respect patients' right to reach decisions with their healthcare provider about their treatment and care; Support patients' rights in caring for themselves to improve and maintain their health; Work with colleagues in the ways that bet serve patients 'interests. 4 Maintaining trust. Be honest and open and act with integrity; Never discriminate unfairly against patients and colleagues; Never abuse your patients' trust in you or the public's trust in the profession; You are personally accountable for your professional practice and must always be prepared to justify your decisions and actions.'

themselves.[424] The basic tenets of the duty of care have been laid down by the British General Medical Council in their guide for physicians, entitled 'Good Medical Practice:'[425] To practise at the standard of the 'reasonably competent'[426] practitioner, an ordinarily competent skilled physician is expected to further:[427] Keep, contemporaneous and accurate records, neither delegate nor accept delegated work unless it is clear that the person to whom the work is delegated is competent to carry out the work concerned in a safe and appropriately skilled manner, comply with statutory duties such as those around health and safety, equality and human rights and finally, draw to the attention of appropriate persons any concerns if he or she is concerned that they are unable to meet those standards.[428]

Across healthcare practice since the advent of evidence-based medicine a range of policies, protocols, and standards assist compliance with the duty of care and should help to achieve effective practice within each branch of medicine and within each episode of care, treatment, support and advice.[429] Similarly, there are international checklists for the surgical specialities.[430] The biggest challenge, however, is the implementation of such checklists and guidelines.[431]

As an example of what a physician should do to 'measure up' to the legal standard so as to avoid legal liability when consulting a patient for the first time, Carstens provides a list of basic considerations to be observed by the general practitioner.[432]

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[424] See chaps 1 to 6 above.
[425] *Ibid.*
[426] *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.
[427] Kline '*The duty of care for healthcare professionals.'* 2013 7.
[428] *Ibid.*
[429] SA Good Clinical Practice Guidelines Wits Health: www.witshealth.co.za; National Core Standards: www.rhap.org.za/wp-content/uploads; The Primary Healthcare Package for South Africa; Clinical Guidelines and Protocols: www.kznhealth.gov.za.
[430] WHO Surgical Safety Checklist: http:www.who.int/patientsafety/safesurgery/checklist/en/ (accessed 2016-12-20).
[431] Walker 'Surgical checklists: Do they improve outcomes?' 2012 *BJA* 175.
[432] Carstens & Pearmain 622; Samuels 'Negligence by the general practitioner' 2006 *MLJ* 77: '[S]eek to develop a knowledge of the history of the patient and his family; check the existing records and keep appropriate notes; ask the right questions to seek an understanding and appraisal of the patient, whether the patient is educated or not; ascertain whether the patient has been travelling, specifically if the patient has been abroad; examine the patient: Is a full and careful examination called for? Is there proper instrumentation available? Is there any reason to consider a heart attack? If so, what action is called for? Consider the gender, age, appearance and occupation of the patient; particular care needs to be taken with children because of their immaturity and limited capacity, if any to communicate. Child abuse, actual, suspected or alleged, is always a matter of utmost sensitivity; does the presented problem seem to be a common problem or illness, or is there any unusual or uncommon element? Might it be malaria: How confident in diagnosis is one? Is it a condition seen before? Is there any suspicion in one's mind? Could there be any risk of anything serious in the presented case? Is any urgent action called for? Should a tetanus injection be administered to an elderly lady who has scraped her leg, whilst gardening? Are there any risks or adverse side effects from the proposed treatment about which the patient should be warned? is there any illness 'doing the rounds''? Could this be avian flu? Is there local professional concern at anything in particular at this time? Are there any signs, or possible signs of meningitis? For example, body rash, sensitivity to light and touch? Is there any sort of aggregate of factors of a worrying nature? Will it be sufficient to treat and follow up the next day?'

Various classifications or groupings of incidences of medical negligence have been proposed by various writers:[433] The generic listing is as follows: The performance of an illegal operation;[434] the use of defective medical equipment;[435] a wrongful diagnosis;[436] a wrongful blood transfusion;[437] incorrect or incompetent administration of anaesthesia;[438] incorrect or incompetent technique or procedure;[439] a careless or unskilful handling of the patient;[440] careless or unskilful administration of treatment;[441] the administration of an incorrect dosage of drug;[442] excessive radiotherapy; insufficient or incompetent aftercare or follow up treatment;[443] transmission of HIV via a blood transfusion;[444] baby swops by staff;[445] failure to move a patient to a hospital;[446] failure to call a specialist;[447] Failed sterilisations or vasectomies;[448] failed abortion;[449] and a failure to adequately inform or instruct the patient.[450]

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[433] Carstens & Pearmain 646.
[434] *Ibid:* eg an illegal abortion: *Zurnamer v Thielke* 1914 CPD 176.
[435] *Ibid:* eg a hypodermic needle which breaks off and is not removed*: Mitchell v Dixon* above.
[436] *Ibid*: *Mitchell v Dixon* above*; Coppen v Impey* above; *Dube v Administrator, Transvaal* above*.*
[437] *Ibid*: *S v Berman* 1966 (WLD) unreported.
[438] Carstens & Pearmain 646; eg inadequate anaesthetic: *Allott v Paterson and Jackson* 1936 SR 221; incorrectly connecting the oxygen pipe to the gas tank which results in the patient's death : *S v Lombard* 1979 (TPA) unreported; incorrectly inserting the endotracheal tube or failure to ensure that it remains correctly inserted which resulted in the patient's death : *S v Kramer* 1987 1 SA 887 (W); complications arising from and epidural anaesthetic for performing of a caesarean section: *Touyz v Reyneke* 1994 (A) unreported; patient reduced to a permanent vegetative state as a result of suffering a heart attack during anaesthesia: *Michael v Linksfield Park Clinic (Pty) Ltd* 2001 3 SA 1188 (SCA).
[439] Eg shortening of a patient's leg owing to incorrect setting of a leg fracture: *Webb v Isaac* 1915 EDL 273; Volkmann's ischaemia resulting in amputation and loss of function; *Dube v Administrator Transvaal* above; Death resulting from pulling too hard on the umbilical cord: *S v Nel;* above loss of a leg owing to compartment syndrome; *Soumbasis v Administrator, Orange Free State* 1987 (O); brain damage and damage to vision due to tugging a forceps too hard; *Pringle v Administrator, Transvaal* above.
[440] Eg sustaining serious burns as a result of being put into bed with an unprotected hot water bottle while still under anaesthetic: *Lower Umfolosi District War Memorial Hospital v Lowe* 1937 NPD 31.
[441] Eg injury to and loss of a kidney: *Correira v Berwind* above; unpleasant and harmful after- and side-effects of tuberculosis medicine *Mtetwa v Minister of Health* 1989 3 SA 600 (D).
[442] Which results in the patient's death: *R v Van Schoor* above; *R v Van Der Merwe* above*; S v Mkwetshana* above; *S v Bezuidenhout* 1964 2 SA 651 (A); *S v Shivute* above.
[443] Eg. a failure to pay a return visit to the patient after treatment has been administered: *Kovalsky v Kruge* and *Webb v Isaacs* above; leaving the patient before it was safe to do so; *Pearce v Fine* 1986 (D) unreported; failure to administer proper post-operative care *Soumbasis v Administrator*; *Lower Umfolosi District War Memorial Hospital v Lowe*; *Touyz v Reyneke*; premature discharge of the patient from hospital *Soumbasis v Administrator* above*.*
[444] *X v SA Blood Transfusion Service* 1991 (T) unreported.
[445] *Clinton-Parker v Administrator, Transvaal*, *Dawkins v Administrator* 1996 2 SA 37 (W). This case is also relevant in context of the element of causation underlying delictual liability. See also *Silver v Premier, Gauteng Provincial Government* above*.*
[446] *Webb v Isaac* above.
[447] *S v Nel* above; *McDonald v Wroe* Unreported case no 7975/03 (CPD).
[448] *Behrmann v Klugman* above; *Edouard v Administrator of Natal* above*; Administrator Natal v Edouard above.*
[449] *Chalk v Fassler* 1995 (WLD) unreported.
[450] *Prowse v Kaplan* 1933 EDL 25; *Dube v Administrator*, *Transvaa* above; *Lymbery v Jefferies* 1925 AD 236; *Allott v Jackson and PatersonI* above; *Layton and Layton v Wilcox and Higginson* 1944 SR 48, 50; *Richter v Estate Hammann* above; *Behrmann v Klugman* above; *Soumbasis v Administrator, Orange Free State* above*;*

The following classification or grouping of specific incidences of medical negligence is as proposed by Carstens[451] and is comparable to that of Claassen and Verchoor:[452]

- Medical negligence in context of general medical practice: Autonomy, lack of consent failure to inform; failure to refer; insufficient skill, experience and communication;
- Medical negligence in context of misdiagnosis, professional errors of judgement, Volkmann cases, negligent diagnosis of child abuse, failure to communicate the diagnosis and loss of chance;
- Medical negligence in context of specialisation: Surgery (general, orthopaedic and plastics) obstetrics and gynaecology (inclusive of wrongful life/birth/conception), psychiatry;
- Medical negligence in the context of injuries or deaths caused by therapeutic agents, anaesthesia, medication, retained instruments and objects, radiology, blood transfusions and hospital acquired infections; and
- Medical negligence in context of tele- and cyber-medicine.

Castell v De Greeff above*; Friedman v Glicksman* above*; Broude v Mcintosh* above*; Oldwage v Louwrens* [2004] 1 All SA 532 (C) ; *Louwrens v Oldwage* 2006 2 SA 161 (SCA).

[451] Carstens LLD thesis 401 and Carstens & Pearmain 648.

[452] Claasen & Verschoor 31 – 54.

CHAPTER 8

DISCUSSION AND CONCLUSION

8.1 Overview

It is important in the context of medical malpractice to be aware of the fundamental difference in mind-set between the medical and legal professions.[453] Giesen attributes this difference as originating in different processes of education, 'role-modelling' and training.

The physician[454]

> [S]ees his duty first and foremost in harmonious co-operation with his colleagues, the aim being to promote the good health of the patient. It is for this reason that the obligation to maintain an unconditional *esprit de corps* has an importance the equal of which is probably not to be found in any other professional body. This duty has been a constant, nay, the eternal theme in medical history, and can be traced from the Hippocratic Oath throughout the history of medical ethical codes right up to current professional regulations. Wherever possible, differences of opinion are arbitrated and settled without recourse to external intervention. There is nothing so liable to undermine the patient's confidence and trust – such highly important factor in the treatment relations between patient and physician – as the witnessing of a conflict before his very eyes. For this reason the atmosphere which surrounds the physician in practice and the clinic is created with the intention of stressing his status, authority and, it is perhaps true to say, infallibility.

However, the law cannot allow physicians to play God; even physicians have to earn and merit the confidence and trust they expect their patients to have in them.[455] Unfortunately, as a result of both training and role-modelling, physicians are generally poorly equipped to deal with criticism and disapproval. The fear of legal liability lies heavily on the minds of physicians and may colour their understanding of professional integrity.[456]

The reaction of almost any physician to being sued is more than anything else the feeling that the patient is showing him or her gross ingratitude.[457] But he or she also experiences a severe humiliation which makes all future practice of his or her profession intolerable or more difficult. If or she is at the same time involved in criminal proceedings, he or she is then all the more handicapped.[458] Studies suggest errors can have a significant emotional impact that can last for years.[459] The fear of liability and the consequent practise of defensive medicine and, unfamiliar with the medical malpractice system, they engage in

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[453] Giesen 721:
'From the very first day of his professional training, the young lawyer is reared on dialectics, controversy, and doubt. His entire professional life consists of differences of opinion and criticism, whether against opposing lawyers, colleagues on the bench, the Supreme Court jurisdiction and judicature, or the alternative hypotheses. What allows him to experience the feeling of success for which he has been aiming, and makes him feel that he is now established and capable of fulfilling his professional duties, is the discovery of an error which a colleague has committed.'

[454] Giesen 721.

[455] Giesen 722.

[456] *Ibid.*

[457] Giesen 722: '[*W*]*illcox v Sing* [1985} 2 QdR 66 (FC) was heavily influenced by such considerations …'.

[458] Giesen 721.

[459] Shanafelt 'Burnout and medical errors among American surgeons' 2009 *Annals Surg* 690.

behaviours that, ironically, make themselves more vulnerable to lawsuits.[460] [461] Instead, physicians concerned with threats of malpractice litigation should focus on demonstrating the knowledge, skills and attitudes that result in a patient maintaining respect for the physician in the face of a bad outcome.[462]

On the other hand, the physician must recognize the fact that, according to the principles of the law of delict, even a slight carelessness in the exercising of his or her profession may lead to civil or even criminal liability. But he or she should also recognize that a charge of negligence or malpractice is no death sentence, and neither will it necessarily lead to a loss of professional reputation.[463] As was aptly remarked by Donaldson LJ in *Whitehouse v Jordan*:[464]

> There are a very few professional men who will assert that they have never fallen below the high standards rightly expected of them. That they have never been negligent. If they do, it is unlikely that they should be believed. And this is true of lawyers as of medical men. If the judge's conclusion is right, what distinguishes Mr Jordan (the defendant doctor) from his professional colleagues is not that on one isolated occasion his acknowledged skill partially deserted him, but that damage resulted. Whether or not damage results from a negligent act is almost always a matter of chance and it ill becomes anyone to adopt an attitude of superiority.[465]

This sentiment was emphasised by Peter Pain J in *Clark v MacLachlan*,[466] where he expressed the hope, with reference to the 'Olympian reputation' of one of the medical professionals involved in the case before him, that the professor of medicine referred to 'will take comfort in the thought that even Apollo, the god of healing, and the father of Aesculapius, had his moments of weakness'.

It is only when a physician realises this or can accept what has occurred does it enable him or her to co-operate towards finding an explanation for what has occurred, answer for his or her conduct and methods, and regard the trial or malpractice action not as an affair in which prestige is at stake, but rather as the risk inherent in the profession and against which he or she as a rule will have insured themselves.[467]

It could, however, be argued that the joint effect of patient-centred legislation and jurisprudence as discussed in chapter 7 has tipped the scales ever so slightly in favour of the patient and has made it increasingly difficult for a medical practitioner to defend a medical negligence claim brought against him or her. The law of delict is now rendered subject to the objective normative value system contained in the Bill of Rights, by section 8(1) of the Constitution. Moreover, the influence of this normative value system on the common law is

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[460] Commentary: 'Reducing legal risk by practicing patient- centred medicine' 2002 *Arch Int Med* 1217.
[461] Studdert 'Defensive medicine and tort reform: A wide view'2010 *J Gen Intern Med* 380.
[462] Commentary 2002 *Arch Int Med* 1217.
[463] Giesen 723.
[464] *Ibid*.
[465] *Ibid.*
[466] Ibid; also *Clark v MacLennan* [1983] 1 All ER 416 *(Peter Pain J* at 433g).
[467] Giesen 724.

mandated by section 39(2) of the Constitution.[468] [469] It is with reference to the matrix of this value system that the principles of the common law must be adapted or changed and, if necessary, discarded.[470] Brand opines:[471]

> [A]lthough the overt purpose of the law of delict is to compensate, it also plays a covert role which it prescribes a set of ethical rules for social interaction. As a natural consequence, the law of delict is underpinned by a sense of morality and fairness. In the light it seems logical that constitutional values would have a dramatic effect on delict, but that the impact would be through the application rather than the amendment of established principles.

If there was no malpractice, there would be no claims.[472] Ideally, one would want to prevent claims and costs by reducing malpractice. For this to happen the quality of care must improve and patient safety must be promoted.[473]

In the latter half of the 20th century there was a major change in the attitude of the public towards the medical profession.[474] Certainly, there is an appreciation amongst many members of the profession that they no longer are appreciated as they had been previously.[475] Coupled with this was a great increase in what was expected from the profession and medical services.[476] The public is mostly aware of the huge advances in medical technology and this awareness has led to unrealistic expectations.[477] Possibly because health issues tend to attract media interest and wide publicity, medicine is a victim of its own success in this respect and patients are led to expect the latest techniques and perfect outcomes on each occasion.[478] Undoubtedly, patients and the public are more informed and discerning – all possibly resulting or amplified by the rise of patient autonomy, the decline of medical paternalism and, of course, the availability of 'Dr Google.'

Few physicians think this is wrong. However, alongside this change in public attitude has appeared an ever-increasing number of lawsuits. Much research has been done as to why patients are so ready to sue doctors – merely obtaining financial compensation is certainly not the only objective.[479] The suit may rather in some instances result from the manner in which the physician subsequently managed the adverse incident.[480] Amongst the other

[468] Carstens & Pearmain 21ff.
[469] Brand *Advocate* 2014 40.
[470] *Ibid.*
[471] *Ibid.*
[472] Coetzee 2010 *Obstetrics and Gynaecology Forum* 111.
[473] Oosthuizen 2015 *THRHR* 284.
[474] Corcoran 'What is negligence?' *BJU International* 2000 280.
[475] *Ibid.*
[476] *Ibid.*
[477] *Ibid.*
[478] *Ibid.*
[479] Oosthuizen 2016 *THRHR* 282.
[480] Hickson 'Factors that prompted families to file medical malpractice claims following perinatal injuries' 1992 *JAMA* 1359; See also Corcoran 2000 *BJU International* 280.

common reasons given are to prevent the same thing happening to others and to establish the true facts.[481]

8.2 How can this increase in medical malpractice be avoided?

This question cannot be answered easily, if at all. In the end patients will have to contend with the effects of malpractice and increased litigation.[482] Litigation has a damaging emotional impact on the doctor-patient relationship and the detrimental effects of such damage should not be under-estimated.[483] There is, however, one avoidable risk factor in many cases – a lack of communication.[484] This may be manifested by a paucity of written records, it may be a lack of oral communication between doctor and nurse, doctor and patient, doctor and next-of-kin, senior and junior colleague. Frequently it is a combination of all of these, but a lack of communication, in whatever form, is unacceptable. It is vital for all the clinical professions, but in particular doctors, who remain the worst offenders, to address this problem.[485]

8.3 Recommendations to curb the South African malpractice storm

1. Settlements

Owing to the financial benefit victims derive from compensation for medical negligence, patients or plaintiffs may develop compensation neurosis.[486] This unfortunately opens the litigation system to abuse. There is much anecdotal evidence that this may well have contributed to the increase in litigation.

The massive increase in indemnity settlements is of concern.[487] It has recently been proposed by an insurance company newly entering the South African medical malpractice market[488] that they rather would offer an annuity-based settlement model to plaintiffs where the merits of the case indicate that fair reparation is warranted. An immediate offer to implement the annuity model will be made once the merits of the claim have been evaluated. Should increased funding be needed (mainly due to higher than expected inflation, or ultimately much improved longevity), such funds will be callable from the insurer in terms of a guarantee issued by the insurer to the financial institution. However, if the affected third party should die earlier than initially estimated, the surplus funds will be

[481] Corcoran 2000 *BJU Intn* 280.
[482] Oosthuizen 2015 *THRHR* 284; Malherbe *SAMJ* 83.
[483] Malherbe 2013 *SA Medical J* 83.
[484] Corcoran 2000 *BJU Intn* 285.
[485] *Ibid.*
[486] Weighill 'Compensation neurosis: A review of the literature' 1983 *Jnl Psycho Res* 97: 'Compensation neurosis is regarded as an unconscious attempt by a victim to retain physical or psychological symptoms in order to profit from financial compensation. Although victims may legitimately be injured or impaired due to medical negligence they may perpetuate the symptoms. See also Herbert 'Compensation neurosis' 1986 *Am Acad Psychiatry Law* 143.
[487] Oosthuizen 2015 *THRHR* 284; Pepper 2011 *SAJBL* 32.
[488] Constantia Insurance Company Ltd launched 'EthiQal, Medical Risk Protection' in November 2016: 'Annuity Claims Settlement Model'.

returned to the insurer. Similarly, should the third party make a substantive recovery or not require the full scope of remediation as initially planned, a revised present value calculation will be performed and validated with reference to external experts, and the surplus funds in the trust accounts will be returned. This model is expected to alleviate the medical rehabilitation and lifestyle needs of the affected 3rd party, instead of incurring further consequences of delayed medical response while long and complex litigation is pursued.

2. Capping of medical negligence claims (delictual reform)

Conventional reforms in the apportionment of damages, such as caps on non-economic damages, seek merely to limit non-patrimonial damages.[489] Studdert[490] is of the opinion that although capping may be necessary, it is not a sufficient measure to 'bend the healthcare curve'. He makes the point that tort reforms:

> Should be evaluated not only for their potential to avoid over-deterrence, but also for their potential to achieve appropriate, true deterrence – that is to reduce the incidence of injury due to substandard care.[491]

3. Compulsory mediation or alternative dispute resolution

It would appear that compulsory mediation or other alternative dispute resolution methods are set to play a role in the medical malpractice scenario in the future. In the latest newsletter of the South African Society of Obstetricians mention is made of the formation of a mediation committee.[492] The Society of Obstetricians has also recommended that physicians add a compulsory mediation clause to the physician-patient contract in event of any adverse incident or threatened litigation.[493]

4. Contingency Act amended

The purpose of the Contingency Fee Act[494] was to enable a poor indigent population to claim just compensation if they should have suffered personal injury. It has, however, led to some questionable practices in some instances.[495]

The amendment of the Act to allow for a means test and an evaluation of the matter before proceeding with the adversarial procedure may contribute to offloading the massive backload of matters.

[489] Baltic 'Who benefits from tort reform?' http://medicaleconomics.modernmedicine (accessed 21017-01-04).
[490] Studdert 2010 *J Gen Intern Med* 380.
[491] *Ibid.*
[492] SASOG 'Better Obs Newsletter'2016-12-12 3
[493] *Ibid.*
[494] 66 of 1997.
[495] Oosthuizen *THRHR* 2015.

5. Avoidance of defensive medicine

The fear of litigation has an effect on how medicine is practised – physicians practice defensively to avoid claims.[496] Compassion-centred care should not be substituted with defensive medicine.[497]

6. Adapting the standard of care

Kindness, respect, compassion and good communication make a real contribution to patient care and experience. So do personal hygiene for patients, adequate food and drink and appropriate nursing care. In a resource-deficient environment, patients cannot expect first world standards of care, but they are entitled to the highest standard of caring.

Utilitarianism as a standard may be the basis on which access to healthcare services is rationed, but:[498]

> [T]he (moral) rule that you are to love your neighbour becomes in law, you must not injure your neighbour; and the layer's question, 'who is my neighbour?' receives a restricted reply. You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour. Who, then, in law is my neighbour? The answer seems to be – persons who are so closely and directly affected by my act that I ought to have them in contemplation as being so affected when I am directing my mind to the acts or omissions which are called in question.

I conclude my dissertation with a precept that has stood me in good stead in the many years that I have practiced medicine:

> **'The best prevention for malpractice is rapport with the patient and complete honesty.'**[499]

'

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[496] Oosthuizen 2016 *THRHR* 278; Whitehouse 'Counting the cost of GP claims' 2013 *Practice Matters* 8.
[497] Pepper 2011 *SAJBL* 32.
[498] Lord Atkin delivering his landmark speech in *Donoghue v Stevenson* above 5.1.
[499] Meador *A Little Book of Doctors' Rules* (1992) 371.

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