The incommensurability of the archaic perceptions of the maxim *res ipsa loquitur* in medical negligence litigation

by

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PREFACE

The delict of medical negligence is based on the process of identifying fault on the part of a medical professional or medical institution for the harm caused to a patient. The medical professional or hospital is criticised for the alleged substandard care that resulted in injury to the patient. Unfortunately, medical professionals sometimes perceive a claim for compensation based on liability as a personal attack on their character that suggests that they are inefficient or incompetent, whereas it should be seen as a way of correcting a wrong. Furthermore, cases like *Michael v Linksfield Park Clinic*[1]contribute to public cynicism about a prejudiced judicial system that seems to favour the medical profession. *Michael v Linksfield Park Clinic*[2]embodies this perceived injustice, as it is a case where uncomplicated surgery for the repair of a broken nose in a healthy young man resulted in permanent brain damage. The facts in the causal chain of events were that the anaesthetist, in administering certain anaesthetic solutions, caused a hypertensive crisis that he failed to control. This caused the patient to go into cardiac arrest, which was not adequately managed. The patient suffered a hypoxic incident with insufficient oxygen to the brain and, ultimately, permanent brain damage. The medical professionals failed to explain the medical clinical course of an anaesthetic-induced error to the court and thus the court did not appreciate the medical reality. 'Medical reality', in this sense means the true interpretation of the medical facts. Because liability cannot arise before causation has been established, the focus of the thesis is on the medical interpretation of the injury in order to determine factual and legal causation.

Perhaps the need to understand such 'unfairness' or injustice is the motive behind the legal appeals for the reintroduction of the *res ipsa loquitur* maxim in medical negligence cases in South Africa. Maybe it is a plea for the introduction of an all-encompassing phrase to confer a reverse onus on the defendant based on the complexity of the science of medicine – or indeed in all complex technical cases. Perhaps it is simply an appeal for greater equality in the doctor-patient relationship thereby advancing patient's rights. The South African Constitution[3] as the supreme law of the country includes a Bill of Rights for a society based on 'social justice and fundamental human rights'[4] with equal rights and equal opportunities to

[1]2001 (3) SA 1188 (SCA). Cf CE Pienaar *An analysis of evidence-based medicine in context of medical negligence litigation* (unpublished LLM dissertation, University of Pretoria 2011), available at http://upetd.up.ac.za/thesis/available/etd-09212011-130356/unrestricted/dissertation.pdf (accessed 3 February 2012). Pienaar describes the anaesthetic chaos that occurred during the operation in detail.
[2]*Michael* (n 1). The plaintiff failed to discharge his onus of proof from the available medical evidence and the court dismissed the plaintiff's case. See chapter 1 para 3.1
[3]The Constitution of the Republic of South Africa, 1996 (the Constitution).
[4]Preamble to the Constitution.

all.[5] It stipulates that 'everyone has the right to have access to health care services' and the right to make decisions over your own body ie the 'right to bodily integrity'.[6] The Constitution places a positive obligation on the state to promote the rights of all South Africans taking into consideration the wrongs of the past, socio- and economic injustices and the right to equality and human dignity; this is referred to as a substantive approach to adapt the common law so that it fulfils the constitutional needs of the country. It should provide more substance to the concept of equality with a purpose to rectify wrongs and eliminate past racial discrimination.[7] The Constitutional Court has linked the notion of equality with human dignity. Any violation of a human right affects a person's dignity and should be interpreted as a form of discrimination.[8] This strong constitutional influence resulted in the court leaning towards a wider interpretation of legal principles.[9] This is in line with the global movement towards bending the rules of causation in certain cases, motivated by the desire to remedy breach of human dignity and to safeguard physical and bodily integrity.[10]

South Africa currently has a compromised health system. A finding of fault in medical negligence cases is directed at an individual health professional or institution and such claims rarely highlight organisational errors or badly managed systems. However, statistical evidence[11]that shows an increase in medical negligence litigation in the last five years may well indicate systemic failures. South Africa is fighting crime, corruption and systemic failures. Although it seems inadequate to promote human dignity to the homeless in South Africa where people are starving, it should remain our constitutional vision and goal to strive for and promote human dignity as a human value worthy of protection. It is certainly

[5]Preamble to the Constitution.
[6]Section 27(1)*(a)*and section 12(2) of the Constitution respectively.
[7]*City Council of Pretoria v Walker* 1998 (3) BCLR 257 (CC). The court held that it is the duty of the municipality to eliminate all disparities in the community. The aim is substantive equality and not formal equality so the previously disadvantaged community was treated with a 'softer hand'.
[8]*Oppelt v Head: Health, Department of Health Provincial Administration: Western Cape* [2015] ZACC 33.The human worth (dignity) refers to a situation where all human beings are treated equally for purposes of section 9(2) of the Constitution and in respect whereof they may not be unfairly discriminated against in terms of section (3). See chapter 2 para 7.
[9]*Oppelt* (n 8). The majority ruled in favour of the plaintiff based on inadequate policy and system structures.
[10]*Chester v Afshar* (2004) All ER (HL) 24, where the English court developed the English common law on causation to protect patient rights and the 'right of autonomy and dignity can and ought to be vindicated by a narrow and modest departure from traditional causation principles'.
[11]See article written by Prof M Pepper (University of Pretoria, Department Immunology) http://www.news24.com/Archives/City-Press/Doctors-lose-patience-as-suites-spike-20150429 (accessed 14 March 2013). The author describes a case in point, the death of Rita Nel (45) of Carolina, Mpumalanga. On 2 April she was admitted to the Steve Biko Academic Hospital in Pretoria with a lung condition, and had to undergo a diagnostic CT scan. However, the scanner was broken and, because the Gauteng health department had failed to pay their suppliers, the latter refused to repair the machine. For three weeks, Nel lay untreated in the hospital, waiting in vain for the scan. She died untreated on 23 April. Cf Bulletin of the World Health Organization: Bridging the gap in South Africa, http://www.who.int/bulletin/volumes/88/11/10-021110/en/

worthy of being developed by means of the substantive constitutional approach for a better South Africa.[12]One sees activists, like the group *Know Your Constitution*, [13]campaigning for the Constitution to be made available to the people in all South African languages. From this, it is natural to see the public developing a growing interest in, for example, patients' rights and awareness regarding the expected standard of health care delivery. Because the function of the Bill of Rights is to enable rights to be vindicated and to provide remedies when duties have been breached, it is not surprising to find claims based on the fallacy that any medical accident or 'any medical injury' or negative medical outcome is or should be seen as a breach of a legal duty by a medical professional.

The global increase in litigation in the field of medical negligence is perhaps as a result of a heightened general awareness of patients' rights. However, from a medical perspective, the increase in litigation may be based on unrealistic expectations from the public regarding treatment options and surgical outcomes. An additional cause for the increase in litigation may be the consequence of the rapid development in the field of technical-medicine (such as laparoscopic surgery) and its higher risk of injury.[14] It is in this technical field where the incidence of injury decreases with the experience of the surgeon and where the unaware jurist might be tempted to make use of the *res ipsa loquitur* maxim. Another silent, yet fundamental, cause of the increased number of court cases is the shift in focus of managed health care systems to cutting costs rather than delivering effective health care. This has a marked influence on medical insurance systems. Such a notional shift in managed health care is cause for concern in respect of the expected standard of care, as cost-reducing principles increase the risk of compromising the golden standard of care delivery in health care. One can only be astounded at the lack of ethical considerations and the failure of integrity and respect for human life exhibited in *Sibisi NO v Maitin*, [15]where a larger-than-normal baby was born with severe shoulder paralysis. When asked why he had not considered performing a caesarean section when dealing with this large baby (4.5 kg) of an

[12]*City Council of Pretoria v Walker* (n 7). See chapter 2 para 1, for a discussion where a substantive constitutional revolution is described as the achievement of the goal of equality in a community by correcting wrongs of the past. It will sometimes come at a price for those who were previously advantaged in favour of the previously disadvantaged. It describes the action needed to be taken to advance the position of those who suffered unfair discrimination in the past. It considers the community as a whole and it includes socio-economic disadvantages and it promotes human dignity.
[13]T Hodgson 'Towards an active citizenry' *Daily Maverick* 30 October 2013, available at http://www.dailymaverick.co.za/article/2013-10-30-towards-an-active-citizenry-bringing-the-constitution-to-the-people (accessed 3 February 2014).
[14]See chapter 4 para 10 regarding the risks and complications of this procedure.
[15][2014] ZASCA 156 para 35.

African woman – African women are known for their smaller pelvic frames – the defendant-doctor testified that, in accordance with the American Family Physician guidelines,[16] these risk factors (of the case) were not a reason for performing a caesarean section. He observed that, if an unnecessary caesarean section was performed, it would entail a huge cost factor: performing about 2 000 caesarean sections to prevent one shoulder dystocia. Perhaps similar managed health care guidelines[17] were the cause of an obstetrician's reluctance to perform a caesarean section in England in *Pearce v United Bristol Healthcare NHS Trust*,[18] where a baby went 14 days beyond term and the failure to perform a caesarean section caused the death of the unborn baby. In another English case, *Montgomery v Lanarkshire*, [19]a large baby was born during normal delivery with cerebral palsy (brain damage) to a mother of small build. When asked why a caesarean section was not considered, the defence of the obstetrician in this 2015 case was that she did not warn the mother of the high risk of shoulder dystocia because most women would then elect to have a caesarean section as opposed to natural birth.

The interaction between law and medicine is challenging and complex because of the intricacies of diseases and the function of the human body and its reaction to injuries and pathology. Concepts such as cause and effect in medicine, or why certain things happen to the body or what causes it are found in medical science, and not easily understood. Medical science focuses primarily on the cause of a disease or injury in order to treat or prevent it, and seeks medical solutions by examining the relationship between medical conditions and their occurrence. It does not focus on the causal chain to attribute liability in order to compensate a claimant for a wrongdoing. The legal focus is on holding a wrongdoer legally accountable in a fair and just manner. The clinical course in medicine is seldom one occurrence but is often

[16]In a guideline issued in December 2012 by the Royal College of Obstetricians and Gynaecologists, dealing with shoulder dystocia a caesarean section was not indicated; https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_42.pdf (accessed 8 July 2016). However, see MA Zamorski & WS Biggs 'Management of suspected fetal macrosomia' (2001) 63(2) *Am Fam. Physician* 302–307: 'Elective caesarean section is not recommended for suspected fetal macrosomia (estimated fetal weight over 4.5 kg) without diabetes. Estimation of fetal weight is unreliable and the large majority of macrosomic infants do not experience shoulder dystocia. In the USA, a decision analysis model estimated that an additional 2 345 caesarean deliveries would be required, at a cost of US$4.9 million, to prevent one permanent injury from shoulder dystocia.' In other words the cost of an unnecessary caesarean section is weighed against the prevention of a permanent disability like brachial plexus injury (Erb's palsy); DJ Rouse et al 'The effectiveness and costs of elective caesarean delivery for fetal macrosomia diagnosed by ultrasound' (1996) 276(18) *JAMA* 1480–1486.

[17]See Guidelines (n 16).

[18][1999] ECC 167; [1999] PIQR P53; (1999) 48 BMLR 118 CA (Civ Div). This case is discussed in detail in chapter 3 para 9.4.

[19][2015] UKSC11; [2013] CSIH 3; [2010] CSIH 104. Fortunately the court found in favour of the plaintiff. This case is discussed in detail in chapter 3 para 9.5.

seen as a chain of events leading to optimal medical health. This 'medical reality' means understanding and appreciating the medical facts. Every single part of the chain (the clinical course) causes or has an effect on, or even a cumulative effect on, the subsequent part. The cumulative causal chain of events is explained by the medical expert in context with the expected or desired standard of care, which is then weighed against the care that was delivered. The court, against the set standard then evaluates the nature of the care delivered as it forms the basis of factual causation in delict. The required standard of care means more than simply skill and care of a doctor. It includes referring to the acceptable standard of the practice of medicine. For example, in *Michael v Linksfield Park Clinic*[20]the medical chain consisted of (i) a hypertensive crisis; (ii) leading to cardiac arrest; (iii) leading to hypoxia that ultimately led to brain damage. All these events form part of the clinical course and are pure medical science. In other words, the law makes an assessment according to medical standards and policies from the facts of the injury and construes (in the above example) that the *insufficiently* managed hypertensive crisis led to *insufficiently* managed cardiac arrest that resulted in *irreversible* hypoxia and *ultimate* brain damage. Furthermore, every change in the clinical course of the patient should be evaluated to ensure that it forms part of the main causal chain that led to the injury. If this is not done, the defendant cannot be found liable for the undesired outcome, based on a failure to establish legal causation.[21]

Without satisfying all the elements in delict, namely (a) a commission or omission (*actus reus*), (b) that is unlawful or wrongful (wrongfulness), (c) that was committed negligently or with particular intent (*culpa* or fault), (d) that results in or causes the harm (causation) and (e) the existence of injury, loss or damage (harm),[22] the plaintiff would be unable to convince the court to attribute liability to the defendant. The elements of delict test whether the defendant's conduct should be seen as the breach of a legal duty in law and whether the defendant's conduct falls short of the expected standard of care.[23] Negligence (*culpa*) is established only when it becomes evident from the defendant's testimony that he failed to act reasonably in the circumstances.[24]

[20]*Michael* (n 1).
[21]*Lee v Minister of Correctional Services* [2012] ZACC 30; 2013 (2) SA 144 (CC); 2013 (2) BCLR 129 (CC) para 39.
[22]*Judd v Mandela Bay Municipality* 2011 ZAECPEHC 4 para 8.
[23]*Sea Harvest Corporation (Pty) Ltd v Duncan Dock Cold Storage (Pty) Ltd* [1999] ZASCA 87; 2000 (1) SA 827 paras 21–22.
[24]*Kruger v Coetzee* 1966 (2) SA 428 (A).

The thesis argues that in medical cases the law in South Africa as it stands contains no easy solution or catch-all phrase encapsulated by the *res ipsa loquitur* maxim. More particularly, in medical negligence cases one has to appreciate the medical causes and effects to be able to say 'the facts speak for themselves' or '*res ipsa loquitur*', which would rarely be the case considering the difficult science of medicine. In determining liability based on the breach of a legal duty in a medical case, there is ultimately only one question, and that is whether the plaintiff, having regard to all the evidence in the case, has discharged the onus of proof on a balance of probability.[25]Such a judgment is possible only with a proper appreciation of the medical reality. In South African law, even the unintentional leaving of a swab in a patient's body is not evidence of negligence (*culpa* and liability) or even a presumption of negligence, if all the delictual elements are not satisfied or cannot be inferred from the facts.[26]If an investigation into the circumstantial evidence is necessary to evaluate the medical professional's conduct at the time of the injury it would conflict with the design of the *res ipsa loquitur* maxim in a medical negligence case and the possible opportunity to make use of the maxim falls away. The fact of the injury is not an ordinary occurrence that is known to the non-medical person. To argue in South African context that, the maxim attracts a presumption of negligent conduct (*culpa*) based on the fact of the injury because of the extraordinary nature of the injury in a situation under the control of the defendant-doctor will not discharge the onus of proof resting on the plaintiff. Such an allegation lacks substance in terms of delictual principles. It is vague and does not provide sufficient information for a court to arrive at a decision that inadequate care caused the injury, because there are too many alternative explanations that are not negligent in nature. In South Africa, to get a medical professional to explain why he failed to guard against leaving a swab behind, requires at least sufficient circumstantial evidence to show, for example, that the doctor neglected his legal duty to the patient by ignoring the swab-count of the theatre nurse. The thesis ultimately argues that the application of the maxim is not the solution to the problem of assisting plaintiffs in medical negligence cases in South Africa. As the law stands, the plaintiff's case will be better served by preparing a medical case based on medical expert evidence than to allege lack of care without considering the other delictual principles.

[25]*Sardi v Standard and General Insurance Co Ltd* 1977 (3) SA 776 (A) 780C–H *per* Holmes J.
[26]*Minister of Safety and Security v Van Duivenboden* (2002) (6) SA 431 (SCA) 441E–442B (para 12), where Nugent JA said that '[w]here the negligence manifests itself in a positive act that causes physical harm it is presumed to be unlawful, but that is not so in the case of a negligent omission. A negligent omission is unlawful only if it occurs in circumstances that the law regards as sufficient to give rise to a legal duty to avoid negligently causing harm'.

The author had a career in the medical profession before becoming involved in the legal profession, which gave her insight into the nature of the medical merits of a case supported by expert medical interpretation. She found that medical negligence cases are often dismissed on the ground that insufficient medical information is presented to the court. In addition, unfortunately, she found that some medical professionals are determined to mislead the court into believing unjustifiable alternative causes of harm.[27]Once the plaintiff's case is mired in such an inaccurate interpretation of the medical facts, any legal inference or factual inference made will be flawed. This influenced the author's decision to take on the daunting task of explaining the methodology of medicine and the legal principles applicable to claims for medical negligence. It follows that one can hardly draw a factual presumption, ie the function of the *res ipsa loquitur* maxim, from complex medical facts that are not clearly appreciated. This led to the statement of the thesis, namely, that the *res ipsa loquitur* maxim is incommensurable with the medical reality.

The author trusts that this thesis may provide a guide for novice legal practitioners in the interesting field of medical negligence litigation, with its proud roots in Roman law. The author does not favour the use of the *res ipsa loquitur* maxim in medical negligence cases in South Africa, based on the argument that the maxim does not satisfy all the elements in delict. In summary, it is the author's view that it is fundamental that the South African plaintiff should make use of medical expert evidence that sets the desired standard of care for the court. This standard is then contrasted against the standard that was delivered. Furthermore, the plaintiff should rely on remedial equality principles that ensure that the basic right to be treated with dignity, predominantly in context of bodily integrity, is promoted and has been respected. Managed health care studies that are based on cost and not based on optimum health care, should be investigated to monitor any disregard for bodily integrity. The common law should be development on a continuous basis in accordance with constitutional principles. In this context, the relaxation of causal principles should include a South African court moving to a more inquisitorial approach with more judicial involvement in medical cases, as it may assist with the elimination of possible medical expert bias.

[27]*Sibisi* (n 15).

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Contents

SUMMARY

The thesis' objective is to explain why there are good grounds to support the approach of the South African court, as stated by Brand JA in *Buthelezi v Ndaba*:[1]the *res ipsa loquitur* maxim can 'rarely, if ever, find application in cases based on alleged medical negligence' in South Africa. Although it has been held[2] that, each case must be decided on its own merits and that 'the question of negligence or no negligence must be ascertained from a consideration of all the facts viewed as a whole', the court concluded that it 'cannot determine in the abstract whether a surgeon has or has not exhibited reasonable skill and care'. The thesis sets out to clarify that the word 'abstract', by implication, means that, without an appreciation and understanding of the concrete factual evidence regarding the defendant's conduct and frame of mind at the time of the incident and the cause of the injury, the court is unable to address the question of negligence or (in terms of the maxim) infer negligence. Determining liability in a medical case is a value judgment based on understanding the cause of the injury (based on the medical reality) and the material facts setting out what the doctor ought to have known about the risk of a potential injury at the time and whether he took reasonable steps to prevent such an injury (*culpa*). Unquestionably, this means understanding that the actual injury and the dreaded occurrence are one and the same thing.[3] The thesis argues that a non-medical person may understand medical facts different from a medical professional and the true medical facts is the medical reality of each case. Without a proper understanding of the medical reality, which is most likely abstruse for the non-medical person, the causal link between the action of the defendant and the harm is not obvious. It should be clear that the subject matter of the action or omission is the very subject matter of the damage. Consequently, presenting further evidence to establish the element of negligence (*culpa*) *ipso facto* excludes the application of the *res ipsa loquitur* maxim. Although the court in more recent times[4]has suggested in an *obiter* remark that the time may well have come to jettison the maxim and replace it with *prima facie* evidence, the court appears to have agreed with the standing precedent.[5] It was reaffirmed that all the evidence must be viewed as a whole and assessed to discharge the onus of proof on a preponderance of probability, which again by implication means the maxim is excluded.

[1]ZASCA 72; 2013 (5) SA 437 (SCA) para 16. See the explanation in chapter 2 para 8.
[2]*Van Wyk v Lewis* 1923 E 37; 1924 AD 438 at 445, 453 and 461–462.
[3]*Kruger v Coetzee* 1966 (2) SA 428 (A) 430E–F.
[4]*Goliath v MEC for Health, Eastern Cape* 2014 ZASCA 182 para 12, referring to *Ratcliffe v Plymouth and Torbay Health Authority* [1998] EWCA Civ 2000.
[5]*Van Wyk* (n 2) 453 and 461–462, where the court stated that the maxim will 'rarely, if ever, find application in cases based on alleged medical negligence'.

Before the latest dictum in *Goliath v MEC for Health, Eastern Cape*,[6] suggesting that 'the time may well have come … to jettison [the maxim] from our legal lexicon', academic writers[7] had argued that the *res ipsa loquitur* maxim should be applied not only in medical negligence cases but also in related legal procedures in medical law, like medical accidents, medical inquests, criminal procedures, and disciplinary inquiries instituted by the Health Professions Council of South Africa. This triggered this thesis's examination of the prerequisites for delictual liability and the criteria for the application of the *res ipsa loquitur* maxim in South Africa. To make its case, the thesis considers the historical and present use of the maxim in England and Wales in medical negligence litigation.[8]Finally, the thesis discusses multiple medical clinical scenarios as examples in order to appreciate the required standard of care against which the delivered standard of care of the defendant-doctor is weighed. The role of the maxim is discussed in these contexts to demonstrate that sometimes the answers of the defendants in rebuttal of the maxim lack justification in medical context. Several more plausible explanations might have been overlooked if the medical facts and legal principles are oversimplified. Although this is no different from any other action that is brought in delict, the complexity of the medical reality is often the cause of confusion. The thesis reinforces the statement that a profound appreciation of medical principles is necessary before drawing factual presumptions, which is contrary to the design of the *res ipsa loquitur* maxim.

In extreme or 'blatant-blunder' cases, for example if the wrong limb is amputated, fault and breach of legal duty are obvious, as all the elements in delict are found from the facts, ie *wrongfulness, causation* and *negligence (culpa).* Although this is perceived to be a perfect example of the application of the *res ipsa loquitur* maxim, it conflicts with a distinctive feature of the maxim, ie that a factual presumption is permissible only when the key facts are available but the cause of the injury remains unknown (it has to be inferred from the occurrence).[9] For this reason, the maxim is also not applicable to blatant-blunder cases. These obvious-error cases differ from retained-swab cases. In the latter, there is a lack of information to draw a factual presumption of negligence. If multiple alternatives (that do not involve negligence) are available that may show that the patient indeed received the expected

[6]*Goliath* (n 4) para 12, citing *Ratcliff* (n 4).
[7]P van den Heever & P Carstens *Res Ipsa Loquitur and Medical Negligence* (2011) 36.
[8]*Ratcliffe* (n 4), which is discussed in chapter 3 para 7.
[9]Chapter 2 para 8. In *Administrator Natal v Stanley Motors Ltd* 1960 (1) SA 690 (A) 700 the court referred to the English case *Barkway v South Wales Transport Co Ltd* [1950] 1 All ER, where Lord Porter stated that if the facts are known the question ceases to be one where the facts speak for themselves.

standard of care (for example, the surgery was interrupted because the patient's condition became critical and unstable), the maxim cannot apply. Such information will only become known if the court is fully informed of the medical reality of the situation. The South African court does not accept the maxim in a general way (the mere fact of the injury), which means that if the plaintiff relied solely on the maxim, the end result will be that the plaintiff did not discharge his onus of proof. The thesis found foremost that the maxim compares unfavourably with conventional delictual principles in South Africa. The purpose of the *res ipsa loquitur* maxim is to draw a factual inference from the available evidence because no direct evidence is available.[10] The court was faced in Van Wyk v Lewis with this problem.[11] It is argued that the incorrect application of the maxim as a rebuttable presumption rather than a factual presumption may well be the reason why the maxim is excluded in medical negligence cases in South Africa.

The thesis reviewed the use of the maxim in the context of constitutional rights and patients' rights as it may be of general public importance to determine whether the application of the maxim addresses any perceived imbalance in the doctor-patient relationship.[12] The South African legal system is moving towards a substantive approach, which means that the court evaluates any constitutional right taking into consideration the broader context of the community, like previous wrongs that should be corrected, equality rights, socio-economic status and human dignity.[13] Should the maxim be included in patients' rights? The right to dignity[14] and bodily integrity is part of the intrinsic worth of human beings and human beings are to be treated as being worthy of respect and concern. Any disregard for bodily integrity is a violation of a human right. In the light of the latter, the

[10]Chapter 2 para 5. *Prima facie* evidence means that there is enough evidence that, if not refuted, will become conclusive evidence and *res ipsa loquitur* means that because the facts are so obvious a party need explain no more. See PJ Schwikkard & SE van der Merwe *Beginsels van die Bewysreg* (2009) 22 for the difference between *prima facie* evidence and *prima facie* proof.

[11]*Van Wyk* (n 2), where the court said that all the facts should be viewed as a whole and concluded that it 'cannot determine in the abstract whether a surgeon has or has not exhibited reasonable skill and care'. The case is discussed in chapter 2 para 3 and chapter 4 para 5.1.

[12]Ibid at 151. Van den Heever and Carstens argue that everyone is equal before the law and has the right to equal protection and benefit, and that a victim of a medical accident is at a procedural disadvantage because such a patient does not understand what happened from a medical perspective.

[13]*Oppelt v Head: Health, Department of Health Provincial Administration: Western Cape* [2015] ZACC 33, where the majority widely applied the principles of causation, highlighted the reasonableness concept in the element of wrongfulness, and concentrated on the relaxed principles of negligence. See chapter 2 para 7.

[14]*S v Makwanyane and Another* 1995 (6) BCLR 665 (CC); 1995 (3) SA 391 (CC) at para 328. The Judge said: "The importance of dignity as a founding value of the new Constitution cannot be overemphasised. Recognising a right to dignity is an acknowledgement of the intrinsic worth of human beings: human beings are entitled to be treated as worthy of respect and concern. This right therefore is the foundation of many of the other rights that are specifically entrenched in Chapter 3."

thesis investigated whether the maxim might assist the patient with his medical case from a constitutional point of view.

Several medical negligence cases illustrate in both South Africa and England that the use of the maxim attracts medical explanations that are not always consistent with the injury and that there are more plausible alternatives as medical reality that were not identified and tested. It was clear that in some cases insufficient medical evidence was presented to the court. In the South African law of delict there can be no liability if the delictual elements are not all identified. The act complained of must have caused the injury; 'but for' the act the plaintiff would not have been injured. The 'but for' test is important, even if the test does not provide a comprehensive test of causation.[15] The central reason why the design of the maxim is not suitable to medical cases in South Africa is that medical reality has to be discerned. This is done by weighing up the expected standard of care against the standard received. From this factual causation and negligence (*culpa*) are determined. As with any other case in delict, if, at the close of a case, not all the elements in delict have been proved, the plaintiff's case will fail. If a South African plaintiff alleges a broad inference of negligence (based on the fact of the injury) he will be unsuccessful.[16] This explains why the application of the maxim is more problematic in South Africa than in England.

Turning then to the English court the thesis found several similarities. The English court weighs the comparative risks and benefits of a case and then reaches a defensible conclusion on the matter[17] and that negligent conduct means failing to do what a reasonable man would do, or to do something that a prudent and reasonable man would not do.[18] The English court then considers the balance between due care and negligence. English law requires a professional to perform his services with reasonable care and skill[19] and any failure in this regard is deemed to be substandard care classified as a lack of care. The issue will usually be whether the defendant breached a duty of care (ie displayed lack of care) in a situation under his control and whether such a breach caused harm to the patient.[20] An unusual injury in these circumstances will be sufficient to allege lack of care and to require an

[15]Chapter 2 para 4.3.
[16]Chapter 2 para 8.
[17]Chapter 3 para 2; *Bolitho v City and Hackney Health Authority* [1998] AC 232 at 241–242.
[18]Chapter 3 para 2; *Blyth v Birmingham Waterworks Co.* (1856) 11 Exch 781 at 784.
[19]Chapter 3 para 2; *Greaves and Co. Ltd v Baynham Meikle & Partners* [1975] 3 All ER 99 at 103–104, where Lord Denning MR said that the law does not usually imply a warranty that a professional will achieve the desired result, but only a term that he will use reasonable care and skill.
[20]Chapter 3 para 2; *Lochgelly Iron and Coal Co. v McMullan* [1934] AC 1 at 25. The duty of care, as a matter of policy, determines whether that particular damage suffered by the claimant in that particular manner can ever be actionable.

explanation from the defendant-doctor (the design of the maxim). The duty of care is found in the doctor-patient relationship and is easily determined, as the doctor undertakes the task of providing advice, a diagnosis or treatment[21] to the patient. The scope of the doctor's duty is not limited to a duty not to harm the patient, but also a duty to inform the patient about risks and to provide proper and adequate advice to a patient.[22] An English claimant can take a defendant-doctor to court simply based on an allegation of a failure to warn about a material risk. Furthermore, if a surgeon performs an operation without the consent of the patient he commits a battery, even though his intention was to benefit the patient.[23]

In comparison, the South African delictual law differs substantially from its English counterpart. In South Africa, if the elements of negligence, causation and wrongfulness are not proved as part of the delict, then the plaintiff's case will fail.[24] The South African court interprets the element of negligence as subjective in the sense that the court puts itself in the shoes of a particular defendant to determine, under the circumstances, whether he has foreseen that harm and has taken steps to prevent it. In England a case may be brought on any one of (i) insufficient advice ie failure to warn against risks; or (ii) failure to diagnose; or (iii) failure to treat a patient. In South Africa the duty of the doctor to provide proper advice and information about risks and complications is included in the patient's consent to the operation or treatment and forms part of the element of wrongfulness. In England, the failure to obtain proper consent from the patient can be a cause of action that stands on its own. Significant to this investigation, is the fact that the English court allows for a broad inference of lack of care, (based on the injury) when things go wrong under the direct control of the doctor. The claimant is allowed to call for an explanation. The inference (design of the maxim) is thus elevated to a rebuttable presumption that needs an answer from the defendant. It differs substantially from South African legal principles. The fact of the injury is not enough evidence to presume lack of care of the defendant-doctor (even if the situation was completely under his control). It simply lacks substantive proof to aver negligence and causation. Lastly, the element of causation is established as part of the delictual principles in South Africa and equally important in England when the harm must be linked to the action of the defendant. The principles underlying causation are uniform in both the English and South

[21]Chapter 3 para 2; *Cassidy v Minister of Health* [1951] 2 KB 348 at 359, where Denning LJ said that if a man goes to a doctor, no one doubts that the doctor must exercise reasonable care and skill in his treatment, whether the doctor is paid for his services or not.
[22]Chapter 3 para 2; *South Australia Asset Management Corp. v York Montague Ltd* [1997] AC 191 at 213–214.
[23]Chapter 3 para 2; *Appleton v Garrett* [1996] PIQR P1 para 6-049.
[24]Chapter 2 para 4.

African courts except for the use of procedural tools like the *res ipsa loquitur* maxim in England.

There are various significant points to be made. First, binding case law in South Africa has established that the *res ipsa loquitur* maxim is not part of medical negligence law because the court found that liability should be ascertained from reviewing all the facts of a case and this cannot be done in the abstract[25] (or in a general way). Second, the *obiter dictum* of the court in *Goliath v MEC for Health Eastern Cape*[26] should be heeded: the *res ipsa loquitur* maxim should be replaced with *prima facie* evidence with the support of medical expert evidence, as the maxim tends to oversimplify complex medical realities and thus increases the risk that the court may decide cases for reasons that cannot be justified from a medical perspective. Third, recent English case law held that medical expert evidence has to be used in addition to the use of the maxim, which most likely may have the effect that the maxim may also have lost its appeal in medical law in England.[27] Fourth, not only have the legal principles been misunderstood in South Africa, but basic medical realities have been conceptually misunderstood, which may have contributed to the disagreement between scholars concerning the use of the *res ipsa loquitur* maxim.[28] The design of the *res ipsa loquitur* maxim, ie to be in a position to infer negligence (*culpa* or liability) from an occurrence,[29] is of no use in medical negligence cases because the standard against which the defendant should be measured (the medical reality) is unclear. Fifth, if a decision was made to depart from established principles for constitutional and policy considerations and a genuine reverse onus or even a rebuttable presumption was imposed on the defendant to prove that he acted without negligence, this may infringe on the constitutional rights to equality and just administrative fairness of the defendant. It would allow plaintiffs to court with claims based on unrealistic expectations, as undesired outcomes in medicine do not necessarily flow from negligence. Sixth, in the light of the aim of the South African court to favour a more substantive approach over the old formal and textual approach, thereby departing from established legal principles, a relaxation in the usual approach to a medical case could be justified based on equality, dignity and respect for mental and bodily integrity. However, this does not support an argument to allow the maxim for all the reasons given above. South Africa should learn from the experience of the English court to bring a case

[25] *Van Wyk* (n 2) 445, 453 and 461–462.
[26] *Goliath* (n 4).
[27] *Ratcliffe* (n 4), which is discussed in chapter 3 para 7.
[28] Chapter 2 para 3 and 8.
[29] *Groenewald v Conradie* 1965 (1) SA 184 (A).

with medical expert opinion and to guard against a possible additional burden of proof on the plaintiff to rebut the maxim, which is discussed later.[30] The court should exercise caution and should promote and protect the rights of equality and seek to reinforce basic rights by not holding a defendant liable for the payment of damages when the violation of a right is not shown to have worsened the plaintiff's physical condition.

In conclusion, the maxim remains a notional idea without substance in law in medical negligence cases in South Africa. If the maxim is used for no other reason than to assist a plaintiff to get to court, legal experience from England reveals that the use of the maxim seems unhelpful at most, without the support of medical expert evidence. Indeed, in the South African context it is clear that use of the maxim may lead to plaintiffs advancing insufficiently-prepared evidence, which in turn is vulnerable to rebuttal by defendants introducing alternative explanations that are most unlikely from a medical perspective. Such an unlikely explanation may well place a further burden on the plaintiff ie that of the alternative explanations offered in defence, but also that of his case.[31]

[30]Chapter 3 para 10, where the claimant must disprove the defendant's argument in rebuttal in addition to proving his case in court.
[31]Chapter 3 para 10 and chapter 5 para 3.2.

General notes

1. The e-medicine medical search engine was used as a first search and easy reference. The individual authors were then researched.

2. The thesis has a legal component and medical component. The references in the bibliography are split accordingly. Of fundamental importance is to note that, in South African law no question of liability arises before it has been established that the negligent act complained of was the cause of the damage ie *causa sine qua non*. Therefore, the focus of the thesis is on the medical interpretation of the injury in order to be in a position to determine factual and legal causation.

3. The complete medical reports were unavailable for some court cases, so it is possible that some of the medical facts presented in court will not appear in this thesis. This was not seen as a limiting factor, as the science of medicine is globally recognised: the interpretation of the medical facts in the cases is fact-sensitive in the context of accepted international medical standards. The importance of fact-sensitive cases is relevant and crucial for purposes of establishing the expected medical standard of care to be weighed against the standard delivered by the defendant in proving a delictual case in South Africa. The medical standard means the skill and care assumed by the doctor, but also the accepted standard of practice of the profession. Thus, the thesis relied on the correct interpretation of medical facts before undertaking the legal analyses. The purpose of the analysis of English law principles in chapter 3 was to investigate how the medical standard is determined or how the English court deals with the medical standard, causation and negligence. Thus, an in-depth understanding of the medical reality of each case was necessary. The acceptable medical standard was obtained from published medical literature that sets the standard of the profession. Using this as basis, the legal arguments were analysed. In following this structure and method, the thesis discovered that the English court allows for a general allegation of negligence based on lack of skill and care of the defendant-doctor in an unusual situation under his direct control; it is significantly different in South Africa.

4. For consistency the thesis refers to ‘plaintiff’ in the South African context and ‘claimant’ in the English and Welsh context (as was the use after the Civil Procedure Rules 1998 came into force on 26 April 1999), however, the thesis was also led by the preferred use of each court.

5. The thesis avoids complicated medical arguments and uses only sufficient medical information to support alternative arguments based on scientific and medical standards to determine the expected standard of care and to identify the elements of negligence and causation.

6. This thesis does not undertake a complete comparison of the South African and English approach to the *res ipsa loquitur* maxim and medical negligence cases in general. The purpose of contrasting South African law with the English legal experience is to seek guidance from selected cases in English law regarding its perspective on legal principles in medical law. Thus, English case law is analysed from a South African legal perspective for assistance.

7. The thesis deals with the general principles of delictual liability and the breach of a legal duty and looks at specific cases from different perspectives, which inevitably resulted in some repeated discussion of these cases.

8. Where relevant, the thesis refers to the medical knowledge available at the time of the case under discussion, but also includes more recent medical research studies on the same topic where this allows for a better understanding of the medical issues. Of course, whether a given medical professional was negligent in particular circumstances turns on the state of medical knowledge at the time he or she acted.

CHAPTER 1: INTRODUCTION

1 General introduction

The Universal Declaration of Human Rights (UDHR) marks a milestone in the history of human rights.[1] The UDHR provides an internationally agreed set of standards to guide and assess the conduct of governments across a wide range of sectors, and has a direct bearing on medicine, public health, and the strengthening of health systems.[2]

Two important documents stemming from the UDHR are the International Covenant on Economic, Social, and Cultural Rights (ICESCR)[3] and the Convention on the Rights of the Child (CRC).[4] These human rights treaties are legally binding on those countries that have ratified them. With regard to health, the main objective is to establish the right to enjoy the highest attainable standard of physical and mental health; this objective forms an integral part of the treaties. All countries have ratified a binding treaty that is related to health, for example, the Constitution of WHO,[5] the Declaration of Alma-Ata,[6] the Ottawa Charter for Health Promotion,[7] the Bangkok Charter for Health Promotion in a Globalized World.[8]

In 1997, the final Constitution of South Africa was adopted. It includes a Bill of Rights[9] based on some of the international treaties. In particular, the preamble provides for a Constitution based on democratic values, social justice and fundamental human rights.

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[1]The Universal Declaration of Human Rights was proclaimed by the United Nations General Assembly in Paris on 10 December 1948; http://www.ohchr.org/EN/UDHR/Pages/Introduction.aspx? LangID=eng (accessed 14 December 2015).

[2] S Marks *Health and Human Rights: Basic International Documents* 2 ed (2006).

[3]United Nations (UN) 'International Covenant on Economic, Social and Cultural Rights (ICESCR) (1966); see discussion by O de Schutter 'Economic, social and cultural rights as human rights: An introduction' (2013), available athttp://cridho.uclouvain.be/documents/Working.Papers/CRIDHO-WP2013-2-ODeSchutterESCRights.pdf (accessed 14 December 2015).

[4]UN Convention on the Rights of the Child (CRC) (1989), available at http://www.ohchr.org/en/professionalinterest/pages/crc.aspx (accessed 14 December 2015).

[5]World Health Organization (WHO) Constitution of the World Health Organization (1946) http://www.who.int/governance/eb/whoconstitution en.pdf (accessed 14 December 2015; also see discussion by G Backman 'Health systems and the right to health: An assessment of 194 countries' (2008) 372 *Lancet*, available at http://www.who.int/medicines/areas/human_rights/Health_System_HR_194_countries.pdf (accessed 14 December 2015).

[6]WHO Declaration of Alma-Ata, international conference on primary health care, Alma-Ata, USSR, 6–12 September, 1978, available at http://www.who.int/publications/almaata_declaration_en.pdf, also see http://www.searo.who.int/entity/primary_health_care/documents/sea_hsd_338.pdf (accessed 14 December 2015).

[7]WHO Ottawa charter for health promotion (1986), available at http://www.mecd.gob.es/dms-static/574eadc8-07b6-450f-b5b2-085ff1e201c8/ottawacharterhp-pdf.pdf (accessed 14 December 2015).

[8]WHO The Bangkok charter for health promotion in a globalized world (2005), available at http://www.who.int/healthpromotion/conferences/6gchp/hpr_050829_%20BCHP.pdf (accessed 14 December 2015).

[9]Chapter 2 of the Constitution of South Africa.

Equality and equal protection before the law are guaranteed,[10] and everyone has a fundamental right to life, dignity, the right to reasonable health care,[11] and to be treated in accordance with specific standards of care that will not cause harm. Carstens and Kok[12] describe the role of medical ethics as a 'protective measure of human rights' that seeks to 'act in the best interest of the patient'. Section 8 of the South African Constitution operates vertically, thus affording protection to the individual against the state, but also horizontally, whereby it affords protection between subjects themselves. This is relevant as one foresees tension between the exercising of these respective rights ie between civil rights and the constitutional rights of equality and non-discrimination.

Furthermore, s 8(3) places a general obligation on the court to develop the common law of the country by promoting the values enshrined in the Constitution, exemplified in the decision of the Constitutional Court in *Carmichele v Minister of Safety and Security*.[13] In addition, the courts and other tribunals must, when interpreting legislation and when developing the common law, 'promote the spirit, purport and objects of the Bill of Rights.'[14] Noteworthy is the role that human dignity plays in the transformation process in an attempt to eliminate the negative influences of the past and to advance core values. Human dignity is the human value of a person with a body, mind and soul. A right to have their privacy respected protection of mental and bodily integrity, reputation, feeling and identity.[15] The South African court has since recognised the principle of a substantive constitutional approach – better known as transformative constitutionalism – to accept that a need exists to correct the wrongs of the past and to address and protect human rights. With the substantive approach the court applies restitutionary measures, by changing the way the law applies. The law is applied in an interconnected manner weighing up the means and the ends and its impact on human dignity.

[10]Sections 9, 11 and 10 of the Constitution. Section 9, among other things, describes 17 grounds on which discrimination is forbidden. The notion of human dignity plays a significant role in the concept of equality. Section 10 reads 'Everyone has inherent dignity and the right to have their dignity respected and protected'. Section 7(2) provides that the 'state must respect, protect promote and fulfil the rights in the Bill of Rights'; also see *Glenister v President of the RSA; Helen Suzman Foundation as Amicus Curiae* 2011 (3) SA 347 (CC) (2011 (7) BCLR 651) paras 189–91.

[11]The available resources of the state influence the rights of all South African citizens. See *Soobramoney v Minister of Health (Kwazulu-Natal)* 1997 ZACC 17; 1998 (1) SA 765 (CC); 1997 (12) BCLR 1696; *Government of the Republic of South Africa v Grootboom* [2000] ZACC 19, 2001 (1) SA 46 (CC), 2000 (11) BCLR 1169 (CC).

[12]PA Carstens & A Kok 'An assessment of the use of disclaimers by South African hospitals in view of constitutional demand, foreign law and medico-legal considerations'(2003) 18 *SAPR/PL* 430.

[13]*Carmichele v Minister of Safety and Security* 2001 (4) SA 938 (CC), where the court also establishes an objective normative value system which acts as a principle to guide the legislature, executive and judiciary.

[14]Section 39(2) of the Constitution.

[15]*Van der Merwe v Road Accident Fund* [2006] ZACC 4; 2006 (4) SA 230 (CC); 2006 (6) BCLR 682 (CC) para 40.

The court takes into consideration socio-economic conditions, any inequality and discriminatory factors and tests whether it is rational, reasonable and proportionally correct to arrive at the end result. It brought about a change from a strict formal approach to a broader approach which has the purpose of enforcing recognised human rights.[16] The substantive approach also allows for a wider application of legal principles which was seen in medical law in South Africa. Such a broader application of legal principles was also noted in England (and Wales).[17] It is effectively a judicial relaxation of some of the strict rules governing the law of delict in South Africa to protect the weak and vulnerable. It is a leaning towards allowing for a lighter burden of proof for plaintiffs in medical negligence cases.

Medical ethics and duties are developed to protect patient rights and originate from measures contained in the *Lex Aquilia*.[18] Medical ethics form the basis of the relationship between a doctor and patient and are part of defining the required standard of care in medicine. Any care that falls below the expected standard comprises a breach of a legal duty and an infringement of the patients' rights.[19] One act or omission may constitute a breach in both delict and contract, as the two legal concepts are integrated in the doctor-patient relationship.[20] A surgeon may be liable in contract because he did not perform according to the contract and therefore breached the terms of the contract or in delict because he failed in his legal duty to the patient not to cause harm. Moreover, the *boni mores* or legal convictions of the community[21] influence South African common law and therefore dictate what the expected and lawful role of the medical professional is in our society. In other words, public

[16]Regarding inequality and discrimination, see *President of the Republic of SA and Another v Hugo* [1997] ZACC 4; regarding appropriate respect for diversity, see *MEC for Education, KZN v Pillay* [2007] ZACC 21; regarding religious or gender inequality, see *National Coalition for Gay and Lesbian Equality v Minister of Justice* [1998] ZACC 15; regarding the development of a notion of substantive equality that goes beyond liberal notions of formal equality, see C Albertyn & B Goldblatt 'Equality' in S Woolman & M Bishop *Constitutional Law of South Africa* 2 ed (2007) chapter 35.

[17]In South Africa, in *Oppelt v Head: Health, Department of Health Provincial Administration: Western Cape* [2015] ZACC 33, the court widely applied the principles of causation and highlighted the reasonableness concept in the element of wrongfulness, and relaxed the principles of negligence: see chapter 2 para 7. In England, in *Chester v Afshar* (2004) All ER (HL) 24, the court was in favour of developing the English common law and departing from traditional causation principles.

[18]A Mason 'The standards of care and the Lex Aquilia' (2002), available at http://www.roman-empire.net/articles/article-021.html (accessed 14 June 2014).See chapter 2 para 2 for a discussion.

[19]J Neethling, JM Potgieter & PJ Visser *Law of Delict* (2010) 6 at 50 and 54. See chapter 2 for a detailed discussion.

[20]FFW van Oosten 'Patient rights: A status report on the Republic of South Africa' *Law in Motion. International Encyclopaedia of Laws* – World Conference (1996) 53; SA Strauss & MJ Strydom *Die Suid-Afrikaanse Geneeskundige Reg* (1967) 104ff.

[21]*Telematrix (Pty) Ltd t/a Matrix Vehicle Tracking v Advertising Standards Authority SA* 2006 (1) SA 461 (SCA) para 13; *Two Oceans Aquarium Trust v Kantey & Templer (Pty) Ltd* 2007 1 All SA 240 (SCA) para 12. A detailed discussion follows in chapter 2.

opinion plays a role in determining delictual liability.[22] The legal duty imposed on the medical professional as a matter of policy determines whether the harm suffered by the plaintiff in the particular manner that it occurred can ever be actionable. This legal duty of a medical professional is independent of the will of the party, as it takes place in accordance with the legal duty owed to the patient, which is imposed by law.

In the South African delictual context, one will be liable when a legal duty is owed and a person is expected to act and an 'act of a person [that] in a wrongful and culpable way causes harm to another'.[23]All the elements in delict, ie wrongfulness, negligence (*culpa*), causation and damage have to be established to attribute liability to a defendant. These are separate and distinct components of the same delict, each having its own requirements and tests. A legal duty is owed to the patient in a doctor-patient relationship and any failure to act in accordance with accepted medical standards - specified by the legal duty - will be wrongful. In South Africa,[24] wrongfulness is only one of the elements required to prove delictual liability. A further element is *culpa*,[25] which in the broader context is indicative of fault,[26] but in its narrow context means negligence (*culpa*). In addition to the component of *culpa*, a medical professional will be measured against the yardstick of *imperitia culpae adnumeratur*[27] translated as *want of skill is reckoned as culpa.* It means that a reasonable medical professional ought to know that a patient might be injured when treated by an inexperienced and unskilful medical professional. The requirement of the element of negligence (*culpa*), as part of delict, is established when one has proved that the defendant's conduct (to foresee harm and guard against it) was unreasonable. It would be unreasonable if it fell short of the standard of conduct of a hypothetical reasonable doctor in the same circumstances. The standard of this hypothetic *reasonable* doctor is found in acceptable international medical principles which are published and that are peer-reviewed.

[22]Hugo de Groot *Inleidinge tot die Hollandsche Rechts-Geleerdheid,* 3 33 5. More recent cases are *Telematrix* (n 21) para 13; *Two Oceans Aquarium Trust* (n 21) para 12; *Cape Town Municipality v Bakkerud* 2000 (3) SA 1049 (SCA) 1057B–C. The *boni mores* test comprises the actual prevailing legal convictions and does not depend on personal views.
[23]Neethling et al (2010) (n 19) 4.
[24]The English court does not distinguish between the elements of wrongfulness and negligence. See A Fagan 'A duty without distinction' 2000 *Acta Juridica* 49. The author provides a clear explanation of the difference between the English 'duty of care' and the legal duty referred to in South Africa.
[25]Paul in *Digesta* 9 2 31: '*Culpa* is not to foresee what a reasonable man would have foreseen'.
[26]PA Carstens & DL Pearmain *Foundational Principles of South African Medical Law* (2007) 613ff.
[27]*Digesta* 50 17 32: Gaius 7 *ad edictuum provincial*: including ignorant conduct and *Inst Just* 4 3 7: defining *imperitia* as a lack of professional skill, capacity, knowledge and incompetence. A medical professional is a specialist in the field of medicine and if he lacks capacity he would be found in breach of his legal duty to the patient and liable.

However, before a defendant can be held liable it has to be established that the act complained of caused the injury. The element of factual causation is the *causa sine qua non*; in other words, had it not been for the act the plaintiff would not have suffered the damage. But the defendant cannot be liable for all the consequences and if the consequences are too remote (legal causation) he will not be liable. Factual causation, as the term describes, is fact-sensitive and can only be determined by connecting the action with the injury. It is argued that, to be in a position to establish factual causation one has to understand the medical chain of events that led to the injury. The thesis investigates the elements of negligence (*culpa*) and factual causation in a medical context because these elements are often controversial.[28] In South Africa, as in other common-law countries, the plaintiff bears the difficult burden of proving that the defendant-doctor breached his legal duty and caused the harm.[29] It is also often seen that when an unexpected injury occurs in a medical case, evidence to determine liability is not easily available to the plaintiff and it is most likely known to the defendant.[30] This is one reason why the use of the maxim *res ipsa loquitur* appeals to plaintiffs who feel the need for assistance to lighten the burden of proof.

Van den Heever and Carstens[31] state that the imbalance of power in the doctor-patient relationship is a primary reason why the *res ipsa loquitur* maxim should be reintroduced in medical cases in South Africa. The thesis argues that the maxim may not be relied on in South African courts. It undermines the basis for establishing the elements of a delict. No factual inference can justifiably be made if the key facts are unavailable to support an inference of negligence on a balance of probability, and no such inference of negligence can be made if the medical facts are not properly appreciated and understood. The court cannot draw a presumption of fact from the fact of the injury, as the elements of factual causation and negligence (*culpa*) are fact-sensitive and based on the medical reality. The interpretation of medical facts for the medical professional is very different from the interpretation of a non-medical person. Under these conditions, the maxim should not be applied to medical cases.

[28]Chapter 2 para 4 for a detailed discussion.
[29]D Giesen *International Medical Malpractice Law: A Comparative Study of Civil Responsibility arising from Medical Care* (1988) 513; NJB Claassen & T Verschoor *Medical Negligence in South Africa* (1992) 26; Carstens & Pearmain (n 26) 855.
[30]Giesen (n 29) 515; D Hirsh et al '*Res Ipsa Loquitur* and medical malpractice – Does it really speak for the patient?' 1984 *Med Trial Tech Q* 410–12.
[31]P van den Heever & P Carstens *Res Ipsa Loquitur and Medical Negligence* (2011) 150–75.They argue (among other things) that it amounts to unfair discrimination to bar a patient (in law) from relying on the maxim and that it imposes a burden or disadvantage on a patient.

An argument may perhaps be made for the introduction of the maxim based on constitutional grounds,[32] but before considering this, it should be established whether the maxim contributes or has any value in a medical case. Against this background, the thesis sets out to investigate the reasons why the South African courts[33] have rejected the maxim and, in addition, to investigate whether a more lenient approach for a wider application of the maxim, similar to the English system, may be justified in the South African law. The South African Constitution[34] directs that the common law must be developed; therefore, the function of the law may well be to redress the perceived imbalance of power in the doctor-patient relationship by easing the burden of proof for the patient. Nonetheless, the thesis argues that a plaintiff is not entitled to be compensated and a defendant is not bound to compensate the plaintiff where the alleged breach of duty is not shown to have caused or worsened the condition of the plaintiff. Any suggested judicial interference or departure from legal principles should be justified, rational and reasonable and in accordance with delictual principles.[35]

1.1 Background to the *res ipsa loquitur* maxim

The earliest use[36] of the phrase *res ipsa loquitur* in legal matters was by Cicero when he addressed the court in defence of his friend Milo, who was accused of murdering Clodius.

[32]Chapter 2 paras 1 and 9 for a discussion of the constitutional aspects of medical cases.
[33]*Van Wyk v Lewis* 1923, E 37; 1924 AD 438.
[34]Section 39 of the Constitution directs that when interpreting the Bill of Rights a court must promote the values enshrined in the Bill of Rights that underlie an open and democratic society based on human dignity, equality and freedom. Section 27(1)(a) states that everyone has the right to have access to health care services which is discussed in the chapter 2 para 4.1.1.See *Soobramoney* (n 11) above.
[35]See discussion of South African cases in chapter 2 paras 1; 7; 9 and the English cases in chapter 3 paras 2; 6.3; 9.
[36]See the translation of the Pro Milone speech, 'Asconius on Cicero's Pro Milone' John Paul Adams (1996), available at http://www.csun.edu/~hcfll004/asconius.htm (accessed 3 February 2012). Marcus Tullius Cicero wrote the speech in 52 BC in defence of Titus Annius Milo, who was accused of murdering his political enemy Publius Clodius Pulcher. Milo was a *praetor* who aspired to the post of *consul*. He and Clodius were rivals who had been involved in several violent altercations. Clodius was a leader of the people's party, and was popular among the plebs. Milo, as tribune of the plebs in 57 BC, had been instrumental in engineering Cicero's recall from exile. Cicero's speech in defence of Milo was criticised because the absence of a summary of the cause of events did not rebut incriminating evidence against Milo. Cicero's strongest argument was that the assault took place in close proximity to Clodius' house when Milo was leaving Rome on official matters. Milo was in a coach with his wife and a retinue of slaves and Clodius was on horseback with his usual entourage of armed brigands and slaves. The incident occurred during the late Roman Republic, when there was an unstable political scene and corruption was rife. Cicero implied that the events following the death of Clodius, when his supporters burnt down the Senate House and attacked the house of the *interrex*, invoked greater indignation and uproar than the murder itself. Due to the violent nature of the crime and the revolutionary implications, several armed guards were stationed around the courts to placate the mobs. The jury convicted Milo because they felt that, even taking into consideration that Milo may not have been aware of an initial injury to Clodius, the subsequent butchering of Clodius should be punished. Cicero presented a case of self-defence. His intention in

Circumstantial evidence was presented by Cicero to support an argument of self-defence. As a final argument, Cicero summed up the evidence and stated that the body of facts (*res*) spoke for itself – '*res ipsa loquitur*' – despite the vagueness of his argument.

Subsequently, about 2000 years later, the maxim was introduced in England, where the first benchmark cases in which the maxim of *res ipsa loquitur* was implicitly applied were *Byrne v Boadle* in 1863 and *Scott v London & St Katherine Docks Company* in 1865.[37]In the former, a barrel that fell from a window injured a passer-by and, in the latter, a bag of sugar fell from the second storey of a building, injuring a person passing by. The maxim was not discussed, but the occurrence was adequate to infer lack of care. It seemed that it was inferred that, had the proper care been exercised, the harm would have been prevented. In 1935, an Australian court cautioned against the use of the maxim. Dixon J in *Fitzpatrick v Walter E Cooper Pty Ltd*[38] remarked that the phrase *res ipsa loquitur* 'does no more than furnish a presumption of fact'. The court referred to the English case of *Ballard v North British Railway Co*,[39] where it was held that the maxim does not discharging the plaintiff from carrying the burden of proof. It was held that if an alternative explanation (without negligence) was provided by the defendant, then the defendant had refuted the factual presumption created by the maxim and the plaintiff still had to prove his case. At the time, the presumption drawn from such descriptive facts were neither conclusive evidence of liability nor a rebuttable presumption, only an inference from the fact of the occurrence. Only if the defendant failed to provide the remainder of the factual evidence with his explanation, devoid of negligence, would the plaintiff have proved his case.

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using the phrase *res ipsa loquitur* is unclear: it is not certain whether he meant that the thing (*res*) that speaks for itself was the frequent skirmishes between the two rivals or that Clodius was so close to his own home when ambushing Milo or that it was the constant widespread state of unrest at the time. It seems that only Cicero knew which facts had bespoken the incident when he used the phrase, and judging by the outcome, the facts (referred to) carried no weight in his argument. In the end, the thing notably did not speak for itself.

[37]*Byrne v Boadle* [1863] 159 ER 299; [1863] 2 Hurl. & Colt 722, 159; and *Scott v London & St Katherine Docks Co* [1865] 3 Hurl. & Colt. 596. See a discussion in chapter 3 para 3.

[38][1935] 54 CLR. 218. In this case a man was working on the ground when a bag of plaster fell on him from the slip of a crane of a ship and he died. There was a dispute about whether worker's compensation was relevant, but the jury found against the plaintiff. Dixon J referred to *Ballard v North British Railway Co* (1923) 14 Lloyd's LR 68, where it was explained that the thing (*res*) tells a story that might not be the whole story, and the remainder of the story is then told by the defendant. If the defendant presents an alternative cause of the accident the plaintiff is still left with the burden of proving his case. If the defendant fails to present an alternative explanation the plaintiff has proved his case.

[39]*Ballard v North British Railway Co* (n 38) 68.

In South Africa,[40] in the leading case of *Van Wyk v Lewis* reported in 1924, the *res ipsa loquitur* maxim was considered and rejected in the context of medical negligence. The minority relied on the English decision of *Hillyer v The Governors of St Bartholomew's Hospital*[41] and concluded that the mere fact that a foreign substance is sewn closed in the body of a patient constitutes a case of negligence (*culpa*). The majority, unconvinced that negligence in the form of *culpa* had been shown from all the relevant facts, rejected the maxim for any future medical negligence case.[42]The majority explained that the court must place itself as nearly as possible in the exact position in which the surgeon had found himself when conducting that particular operation, and then determine from all the circumstances available whether the surgeon acted with reasonable care or negligently. It is argued that, to make use of a presumption of negligence (the maxim) without key factual information (relevant to the element of *culpa* and causation), it is not possible for a court to place itself as near as possible in the exact position in which the defendant-doctor has found himself. Nevertheless, based on the *stare decisis* doctrine, this 'celebrated ruling by a three-judge appellate bench has functioned as protective shield as far as the doctor is concerned'[43] by preventing a plaintiff to ask for an explanation early in litigation. Ever since, this case has provided authority that the *res ipsa loquitur* maxim does not apply to medical negligence cases in South Africa.[44] Subsequent cases in South Africa attempted to reintroduce the maxim, the more important being *Cecilia Goliath v MEC for Health, Eastern*

[40]*Van Wyk* (n 33). A swab was evacuated some time after the operation and the plaintiff relied on the maxim, averring that the facts speak of negligence. See chapter 2 para 8.

[41]1909 2 KB 828. In this case the plaintiff brought an action against the governors of a hospital for damages for injuries that had allegedly been caused to him during an operation due to the negligence of a member of the hospital staff. The action was not maintainable. At the time, the only duty undertaken by the governors of a public hospital towards a patient was to use due care and skill in selecting their medical staff. The relationship of master and servant, at the time, did not exist between governors and the physicians and surgeons who gave their services, and the nurses and other attendants at an operation ceased for the time being to be the servants of the governors, because for the duration of the operation they take their orders from the operating surgeon alone and not the hospital authorities.

[42]*Van Wyk* (n 33). Wessel AJ said that 'we cannot determine in the abstract whether a surgeon has or has not exhibited reasonable skill and care', implying that more information is needed to establish culpable conduct.

[43]SA Strauss 'The physician's liability for medical malpractice: A fair solution to the problem of proof?'1967 *SALJ* 244.

[44]The case is identified as a 'protective shield' because it protects the medical profession against floodgates of medical negligence litigation simply based on an unqualified assertion that the 'the facts' of an undesired outcome 'speak for itself' as being in breach of a legal duty. In England the consequences of not answering a claim where sufficient facts are available and where the maxim has been accepted are that the plaintiff has proved his case. The English system allows for a generalised inference of negligence based on lack of care in circumstances under the control of the doctor. See the English case of *Lloyde v West Midlands Gas Board* (1971) 2 All ER (CA) 1242–6, where the court found that, if the plaintiff is unable to explain the cause of the accident, fault will be imposed on the defendant in the absence of an explanation. The maxim is discussed in detail in chapter 2 para 8 and the English application in chapter 2 paras 2 and 3.

Cape.[45]Unfortunately, the court avoided going into the reasons for abandoning the *res ipsa loquitur* maxim but it correctly decided the case on all the facts as a whole. It seemed obvious that we had seen the last of the maxim in South African medical law, but plaintiffs have nevertheless persisted in trying to make use of the maxim.

1.2 Legal argument

Notably, the ruling in *Van Wyk v Lewis* was contrary to the precedent in English law[46] and other legal systems[47] and, in this regard, attracted strong criticism. Authors were divided in their approach to the purpose of the maxim in medical law.[48] As mentioned previously, Van den Heever and Carstens[49] argued that the court in *Van Wyk v Lewis*[50]erred in directing that the occurrence of a retained swab is an uncertainty. It should not be interpreted as 'relative' or inconclusive evidence. Such an occurrence - leaving the swab in the patient - is conclusive evidence of breach of a legal duty. It should be seen as 'absolute' evidence of such a breach; it is not dependent on surrounding circumstances.[51] It is not clear whether these authors interpreted the term 'absolute' as conclusive evidence of negligence or as a rebuttable presumption. Either way, the authors' viewpoint is not correct; a presumption of fact on key facts (which is the effect of the maxim) is not a rebuttable presumption of law, it is, at best, a weak possibility of negligent conduct without any circumstantial evidence to support an allegation of negligence except for the fact of the injury. The authors stated that the decision of the court cannot be supported, as it is based on a 'fundamental misdirection' ie a left-behind swab is sufficient evidence of breach of a legal duty and so the case should not be regarded as uncontested authority. For obvious reasons, the authors agreed with the minority

[45]2014 ZASCA 182 at para 11, referring to Holmes JA in *Sardi v Standard and General Insurance Co Ltd* 1977 (3) SA 776 (A) 780C–H; see also *Nzimande v MEC for Health Gauteng* 2015 (6) SA 192 (GP). These cases are discussed in chapter 2 para 8.
[46]*Byrne v Boadle* (n 37); *Scott v London & St Katherine Docks Co* (n 37). A discussion of the *res ipsa loquitur* maxim is undertaken in chapter 3.
[47]For example, the United States, which followed *Byrne v Boadle* (n 37) and *Scott v London & St Katherine Docks Co* (n 37). Despite severe criticism it is applied in most of the states.
[48]Strauss & Strydom (n 20) 279; TB Barlow 'Medical negligence resulting in death' 1948 *THRHR* 173 and 177; P Carstens 'Die toepassing van *res ipsa loquitur* in gevalle van mediese nalatigheid' 1999 *De Jure* 19 (for the maxim); I Gordon, R Turner & TW Price *Medical Jurisprudence* (1953) 116 (against the maxim). The list is not complete.
[49]Van den Heever & Carstens (n 31) 31.
[50]*Van Wyk* (n 33).
[51]Van den Heever & Carstens (n 31) 31, where 'relative' evidence is seemingly interpreted as inconclusive evidence and 'absolute' evidence is sufficient evidence in terms of the maxim. See discussion chapter 2 para 3.

decision in *Van Wyk v Lewis*.[52] Strauss and Strydom[53] first argued for the application of the maxim in medical negligence cases. Recently Strauss[54] has advised that an adverse event should be seen as a presumption of negligence: 'mere proof by a plaintiff of an injurious result caused by an instrumentality which was in the exclusive control of the defendant or following on the happening of an occurrence solely under the defendant's control, gives rise to a presumption of negligence'. Yet again, it is not clear if the author is referring to the design of the maxim as a factual presumption; however, Strauss now seems to regard as correct the *Van Wyk v Lewis*[55]dictum. Although this may seem to be the function and design of the maxim in ordinary cases involving falling barrels or falling bags of sugar, it cannot be the same in medical cases. Bags do not fall from windows and, as a presumption of fact, it implies that the other key facts are sufficient to ascertain *prima facie* fault. It is not so in a medical negligence case, as sometimes swabs can be left in wounds for reasons not known to the uninformed person and further investigation is needed to complete the picture. Notably, a difference between two concepts may well be the reason for the divided legal opinion. The function of the maxim allows a permissible factual inference[56] to be drawn based on other available facts; it is not a presumption of negligence (rebuttable presumption of fault). The factual inference leads the court to draw certain inferences or conclusions from known facts.[57] In other words, from certain known facts, in the ordinary course of everyday life, other facts can be inferred based on logical reasoning.

International authors also have different opinions about the function of the maxim. Fleming[58] explained that when analysing the cases related to the *res ipsa loquitur* maxim it is not possible to categorise the type of case where the maxim would apply as the types of accidents differ and are unique. Giesen[59] remarked that the use of the *res ipsa loquitur* maxim is 'a type of circumstantial evidence based on logical reasoning whereby certain facts may be inferred from the existence of or ordinary occurrence of other facts'.

[52]Kotze JA stated that the mere fact that a swab was retained is an inference of negligence that should be answered in rebuttal.
[53]Strauss & Strydom (n 20) 279.
[54]Strauss (n 43) 419.
[55]*Van Wyk* (n 33).
[56]Van den Heever & Carstens (n 31) 34, referring to *Van Wyk* (n 33); *Arthur v Bezuidenhout and Mieny* 1962 (2) SA 566 (A) 574 (factual inference is ''n blote afleiding wat 'n weerleggingslas plaas op die teenkant...en affekteer nie die bewyslas nie'); *Sardi* (n 45) 780.
[57]CWH Schmidt *Bewysreg* 3 ed (1989) 133.
[58]J Fleming *The Law of Torts* (1998) 353 (from Australia).
[59]Giesen (n 29) 515 (from Germany).

To this end, certain questions are raised regarding the nature of *ordinary facts.* More particularly, 'ordinary facts' in the medical context or any other specialised context cannot be the same as 'ordinary facts' in layman's terms. The stage is set to argue that an *ordinary occurrence* of everyday life cannot include specialist spheres. The interpretation of medical facts by medical experts is the basis of a medical case. It sets the desired standard of care against which the delivered standard will be measured; it is the telling of the medical story of what should have occurred and what indeed occurred. The explanatory facts form part of the chain of events and describe the medical reality. If the medical reality in the medical context - or reality in any other specialised context for that matter - is not understood, how can the elements of delict be tested on a preponderance of probability? Each and every element must be satisfied to assign liability to the defendant.[60] For example, when the signs and symptoms of a disease or illness are observed, the medical professional will rule out certain forms of disease-patterns by elimination. This is called the diagnostic process with its cause-and-effect approach. A blood pressure of 180 over 110 (fact) is meaningless to many non-medical persons, but one medical interpretation (medical reality) in accordance with medical principles will reveal a person suffering from hypertension, with a higher than normal risk of thrombosis (inference based on facts). Certain medical interventions may seem blameworthy to the layperson, but fall well within standard conduct for the medical professional. For instance, if the common bile duct is cut without explanation (justification) it cannot be concluded that it was done in a culpable manner. If such a bile duct was trapped in a cancerous growth and even with carefully dissection was torn, the conduct (action of tearing the bile duct) would not be negligent and would be justified given the circumstances. Therefore, this thesis argues that the fact of the injury is not sufficient evidence to render an act *prima facie* negligent (*culpa*) or attracts a presumption of fact – the *res ipsa loquitur* maxim - based on key facts. An inaccurate understanding of the medical reality would result in an incorrect legal inference. The fact of the injury creates a mere possibility of negligent conduct that should be investigated to further a plaintiff's case. The medical reality is based on accepted international medical standards analysing the underlying medical and not the assumed inferences of the legal mind. The onus is on the plaintiff to prove the existence of a causal relation between the wrongful, culpable act and the loss suffered that is sufficiently close to determine legal causation. For this reason, a proper appreciation of the medical reality tested against the standard and general medical norm is critical. Legal causation hinges

[60]Chapter 2 para 4.1 and footnotes for an opposing viewpoint regarding the sequence of the elements in delict.

on excluding other factors or influences that may have broken the causal chain and that are too remote to have caused the damage. Furthermore, it seems that the fact of the injury only has a bearing on the element of wrongfulness in delict and not on the element of negligence (*culpa*).[61] Put differently, it is clear that leaving a swab in the body of a plaintiff is wrongful - based on the duty not to cause harm - if it is not justifiable. However, there is no evidence that the action was negligent (culpable conduct) if further evidence in explanation from the defendant is not provided, because of the subjective nature of the element of *culpa*. But, in the South African court, a defendant is only obliged to explain his actions when a *prima facie* case has been brought in evidence. Thus, the plaintiff's case will fall because the mere fact of the injury is not *prima facie* evidence of negligent conduct. It confirms the potential confusion between the interpretation of a factual presumption as opposed to a legal presumption and that this may be the underlying cause of the lack of consensus among academic writers.

Moving the emphasis to the legal duty not to harm because it is an infringement of patient rights to bodily integrity, and so forth, other academic commentary was examined. Hirsh *et al*[62] also believed that the 'underlying premise of *res ipsa* is the result bespeaks negligence' or, put differently, one of the requirements in a *res ipsa loquitur* case is that the facts must be such that no other conclusion but that of negligent conduct (*culpa* and liability) can be drawn from them. These authors based their statement on a presumption drawn from the action of the defendant. They were of the opinion that in a medical negligence case it is assumed that the defendant knew what occurred, or at least is more likely than the plaintiff to have known what occurred. They explained that in some jurisdictions the maxim might shift the burden of proof to the defendant to show conduct free from negligence, while in others it merely puts an obligation on the defendant to answer in reply to the maxim; it does not request from a defendant to disprove negligence only to show that his conduct was careful. If the latter is done, the plaintiff is then obliged to continue to prove that a *prima facie* case was made out. They argued for fairness to all parties, as in a medical negligence case the plaintiff is injured by something that he cannot control, and the defendant is in a better position to explain what happened.

[61]Chapter 2 para 4.2.
[62]Hirsh et al (n 30) 410–12.

This thesis argues that from insufficient key facts[63] (only the fact of the injury) one cannot infer negligence (*culpa*) or the element of causation. The court has to be in a position to be put in the position of the defendant and weigh the standard of care delivered against the set standard of care. Notwithstanding this premise, the thesis additionally considers, in constitutional context, whether the use of the maxim should not be made available to plaintiffs based on patients' rights and the so-called imbalance of power between the doctor and the patient. But the question remains: does the maxim actually assist a plaintiff with his case? Considering the fact that the *res ipsa loquitur* maxim is an evidential presumption[64] based on facts from which further inferences may be drawn; if the maxim is applied the maxim calls for an answer but it is not a legal presumption from which legal conclusions can be drawn. This alerts one to the problem that limited facts - an incomplete picture - might lead to an unsupported inference of negligence (culpable conduct) without key facts being available. This may lead to distorted legal outcomes in South African law and a court deciding cases for reasons that are unjustifiable from a medical perspective. In South Africa the mere fact of the injury is speculation that the injury might have occurred as a result of substandard conduct by the defendant-doctor because of many alternative explanations that may not be negligent in nature. The legal effect of the incorrect use of a factual presumption may have bearing on how the case is decided.[65] To use the facts of *Van Wyk v Lewis*[66]as an example, the plaintiff failed to convince the court that the facts that speak, ie *res ipsa loquitur*, were sufficient evidence to prove negligence (both *culpa* and legal liability). If the res (body of facts) is obscured, the inconclusive and unfortunate occurrence suffered by the plaintiff provides no information but that of a wrongful harm – the element of wrongfulness. It does not provide information regarding the conduct of the defendant. A factual inference made from the fact of the injury is insufficient to sustain an allegation of negligence (culpa or liability). Van den Heever and Carstens may have overlooked this criterion.[67] Subjective evidence from the defendant to determine the element of negligence (*culpa*) has to be heard

[63]*Easson v L & N E Ry* [1944] KB 421 at 425; [1944] 2 All ER 425 at 430. The plaintiff was injured when he fell out of a door on the defendant's train. The doors were operated manually by the passengers. It could not be established that the defendant was in control of closing the doors.
[64]Chapter 2 para 5; see also *Administrator, Natal v Stanley Motors Ltd* 1960 1 SA 690 (A) 700 (occurrences should be such that they would not have had occurred without negligence). See *Sardi* (n 45) 780D; *Dalion Materials (Pty) Ltd v Cintrust (Pty) Ltd* 1978 (3) SA 599 (W) 605D.
[65]Chapter 2 para 5 on legal presumptions.
[66]*Van Wyk* (n 33).
[67]Van den Heever & Carstens (n 31) 171, stating that an operation on the right knee instead of the left knee would be a good example based on the *res ipsa loquitur* maxim. See chapter 2 para 8.

and tested.[68] Even if one should aver that the fact of the injury is enough evidence to infer 'careless conduct' or breach of legal duty it would be interpreted as conjecture in the South African court based on the uncertainty that perhaps there may be circumstances where swabs are retained in medical cases. The plaintiff's case would not even be heard as no cause of action has been established. When further investigation into the delictual elements and therefore the conduct of the wrongdoer is required (*culpa*)[69] the maxim would be inappropriate in any event and besides, the court process would have advanced past its use.

With the correct application of the maxim (in delict), all the elements of Aquilian liability should be satisfied, even though inferred from other facts.[70] The *res ipsa loquitur* maxim, as factual inference, should indicate that the fact of the occurrence shows certain facts have occurred that possibly should not have occurred. For example, driving on the wrong side of the road caused an accident. The element of negligent conduct (*culpa*) is a value judgment that is superimposed on the primary descriptive facts of what happened. But no value judgment can be made if the primary facts are incorrectly understood. A court must decide, from the fact that the vehicle that caused the accident was unlawfully on the wrong side of the road, whether to infer that the conduct of the defendant was careless and therefore negligent (liable). Even with an ordinary everyday life experience like a road accident it is not necessarily a simple argument. Therefore, where things go wrong during surgery in a medical negligence case, it is not possible for the court to make a value judgment without satisfactory evidence. The descriptive facts have a certain meaning for the non-medical person and another meaning for the medical professional. This illustrates the argument of the thesis that, at best (without the medical reality setting the expected standard of care), the fact of the injury is simply a possibility that substandard care was delivered.

Van den Heever and Carstens[71] stated further that, to ensure that the correct inference is drawn, two essential rules of logic should apply: the first is that the inference (of negligence) must be consistent with the proved facts, and the second is that the proved facts should be such that they exclude every other reasonable inference (of non-negligence) that

[68]Chapter 2 para 4.2.
[69]Ibid.
[70]PQR Boberg *The Law of Delict* (1984) 24.
[71]Van den Heever & Carstens (n 31) 13, where they refer to Cooper et al *Cases and Materials on Evidence* (1997) 483; *R v De Blom* 1939 AD 188 at 202–3; Schmidt & Rademeyer *The Law of Evidence* (2009) 83, who refers to Gerke, who draws a distinction between civil and criminal matters in this regard: Gerke *A Logical Philosophical Analysis of Certain Legal Concepts* (unpublished doctoral thesis Unisa 1966) 167–9. The party bearing the onus in a civil case needs only to demonstrate that one proposition is more probable than another, whereas the exclusion of a reasonable alternative hypothesis is mandatory in a criminal trial.

can be drawn. Thus, if an alternative inference can be drawn, devoid of negligent conduct, then the design of the maxim would fail, as there would be doubt whether the inference sought to be drawn, is correct. This confirms the argument of the thesis, albeit in different concept. The authors interpret the fact of the injury similar to the English court as 'lack of care' which required an investigation into the principles of the law of tort in the English law. The thesis maintains that in South African law, in a medical case the plaintiff (without medical expert evidence) will almost always remain uncertain of whether there was another non-negligent explanation. If the case advances to court a plaintiff will always be surprised in a case based only on the maxim. The latter premise agrees with the minority dictum of Wessels AJ in *Van Wyk v Lewis*[72] and supports the notions of the study.

In summary, the general discourse in legal opinion indicates either an incorrect interpretation of legal concepts, like the rebuttable presumption as opposed to the factual presumption[73] of the *res ipsa loquitur* maxim; or is confusing South African principles with English legal principles; or has a misperception of the medical realities of the case.[74] In addition, it seems that those favouring the application of the maxim do not apply its requirements meticulously. The requirements dictate that it must be shown, foremost, that the injury was caused by a body of facts or a thing (*res*) solely under the control of the defendant and also that the nature of the occurrence must be such as to justify an inference of negligence.[75] At this point, it became clear that to request from the court in a difficult case like *Van Wyk v Lewis*[76] to draw an inference of negligence simply based on the fact of a 'retained swab' may be a form of false syllogism[77] because of an oversimplification of the medical realities. As said before, an unqualified act of leaving a swab behind may establish a wrongful act against the convictions of society, ie 'not to harm',[78] or infringe a constitutional right, in which case the facts of the case call for more information and justification based on the norms and values of society. It raises a possibility that the defendant-doctor failed to exercise proper skill and care by not ensuring that the swab was not retained.[79] Such a

[72]*Van Wyk* (n 33), where Wessels A J said that 'we cannot determine in the abstract whether a surgeon has or has not exhibited reasonable skill and care'.
[73]See previous para and the incorrect assumption that all undesired surgical injuries are perceived as negligent (blameworthy).
[74]See previous para and the true facts that the removal of the cancerous growth caused the surgical injury.
[75]RG McKerron *The Law of Delict* (1971) 42. See Van den Heever & Carstens (n 31) 34 for a detailed list. The requirements are discussed in chapter 2 para 8 and chapter 3 para 3, 4.
[76]*Van Wyk* (n 33). See a detailed discussion of this case in chapter 4 para 5.
[77]*Macleod v Rens* 1997 (3) SA 1039 (E) 1048.
[78]Chapter 2 para 4.1 below.
[79]Chapter 4 para 5.1 for a detailed discussion of the surgical aspects of *Van Wyk* (n 33).

scenario, although *prima facie* wrongful, is not *prima facie* negligent, as the court has to test the subjective actions of the defendant at the time that the swab was left behind.[80] Such an argument has the effect that the requirements of the *res ipsa loquitur* maxim almost seem too imprecise to be met in a medical case in South Africa. This point will not be advanced any further as it is sufficiently addressed under the discussion of the elements in delict in general.

The final confirmation for the rationale of this thesis is based on the judgment in *Macleod v Rens*.[81]This decision was made in respect of a road accident case but it epitomises the approach of this thesis to medical negligence cases and the *res ipsa loquitur* maxim in South Africa. The court held that the maxim–

> pithily states a method of reasoning for the particular circumstances where the only available evidence is that of the accident. It boils down to the notion that in a proper case it can be self-evident that the accident was caused by the negligence of the person in control of the object involved in the accident. As such it is not a magic formula. It does not permit the Court to side-step or gloss over a deficiency in the plaintiff's evidence; it is no short cut to a finding of negligence: these are real dangers in the application of the expression. It seems to tempt courts into speculation. Expressions such as 'in ordinary human experience', 'common sense dictates' and 'obviously' which are regularly employed in reasoning along the lines of the maxim, sometimes only serve to disguise conjecture. Moreover, there is a risk of false syllogism inherent in reasoning that, as the accident would ordinarily not have occurred without negligence on the part of the driver of the vehicle, the defendant, having been the driver, was therefore negligent. Finally, reasoning along the lines of *res ipsa loquitur* leads to the somewhat unsatisfactory finding that the defendant was negligent in some general or unspecified manner.[82]

This dictum accords with the reasoning of this thesis, in that the court cannot justify a decision based on a cursory explanation regarding descriptive medical facts that might be inconsistent with the medical reality; the court cannot arrive at a conclusion of negligence

[80]The key point is that negligence must be evaluated in light of all the circumstances. See Carstens & Pearmain (n 26) at 621, where the authors state that the test is defendant-specific: in other words, would a reasonable medical professional have foreseen the damage and taken steps to prevent it? See note 74 above.
[81]*Macleod* (n 77) 1048.
[82]*Macleod* (n 77).This quotation is the foundation and rationale of the study.

(*culpa* or liability) without sufficient evidence regarding the conduct of the defendant-doctor, purely based on the fact that a swab was retained. The medical clinical course is too complicated to rely on a maxim that is general and unspecific regarding the cause of injury and conduct (*culpa*) to ascribe blame to a defendant-doctor (liability). If a court has heard all the evidence, including what caused a swab to be retained (factual causation), and there was no justification for the retention of the swab (wrongful and culpable conduct), only *then* would a court be in a position to say *res ipsa loquitur*. However, by then, the use of the maxim would be worthless.

The recent judgment in *Goliath v MEC for Health, Eastern Cape*[83] criticised the *res ipsa loquitur* maxim, stating that the maxim's effect is that it allows for a piecemeal approach that fails to consider all the facts as a whole. This case too confirms the stance that unsubstantiated inferences without key facts cannot be made without a proper appreciation of the relevant medical facts; and, more importantly, that a defendant cannot be found 'negligent in some general or unspecified manner' without satisfying all the elements of Aquilian liability.[84]Furthermore, it seems unlikely that the *res ipsa loquitur* maxim may be adapted to assist a claimant in medical negligence cases as the design of the maxim is not consistent with delictual principles in medical cases; however, based on previous Constitutional Court decisions,[85] it may well be that future decisions will take cognisance of the vulnerability of patients in trying to achieve a caring, sharing and empathetic society and the courts may expand some of the criteria when applying the elements of delict. Whether such changes will include the wider application of the maxim remains to be seen but should be disallowed. The use of the maxim will increase the risk of plaintiffs continuing to construct insufficiently prepared cases. Not only is the maxim unaccommodating, but it is also potentially detrimental to a plaintiff's case in medical negligence litigation in South Africa.[86] Because of

[83]*Goliath* (SCA) (n 45) para 12, referring to Lord Justice Hobhouse in *Ratcliffe v Plymouth and Torbay Health Authority* [1988] EWCA Civ. 2000 (11 February 1998), who stated that it is time to drop the maxim from the litigator's vocabulary and replace it with the phrase '*prima facie* evidence'.
[84]*Macleod* (n 77) 1048. The elements of wrongfulness, fault (*culpa*), with the two-tier test of foreseeability and preventability, the causal chain, factual causation and non-remoteness should reveal the cause of the loss. See also JM Burchell *Principle of Delict* (1993) 23ff and Strauss & Strydom (n 20) 275, who state that the maxim might unjustifiably have the result that the elements in delict evolve into a 'magic formula whereby the medical practitioner can be held liable for any unexpected or untoward result'.
[85]*Lee v Minister of Correctional Services* [2012] ZACC 30; 2013 (2) SA 144 (CC); *Oppelt v Head: Health, Department of Health Provincial Administration: Western Cape* [2015] ZACC 33. These cases are discussed in detail in chapter 2 paras 1; 7; 9.
[86]Chapter 3 on the evolution of *res ipsa loquitur* in England. In *Ratcliffe v Plymouth & Torbay Health Authority* (n 83) 172 it was shown that the defendant does not have to prove that his explanation is more probable than that of the plaintiff, but only that he exercised his duty with reasonable care. The use of the maxim resulted in 'exotic' explanations by the defendant–doctors, which did not assist a court in finding the truth.

the English influence on South African law and evident from incorrect interpretations by scholars, it is perceived that the maxim assists individuals who are pursuing a claim for compensation by easing the difficulty of proving that a doctor was negligent and caused their loss. This, in turn, is thought to promote the patient's right to vindicate his or her right to bodily integrity by easing the burden of establishing that he or she has been a victim of medical negligence. The thesis argues otherwise: in the South African context the maxim is potentially harmful to plaintiffs *and defendants* in medical negligence cases as it tends to generalise complex medical realities; it increases the risk that courts may decide cases for reasons that are not consistent in both legal and medical context which may lead to unreasonable prejudice and injustice. Against this background, the argument of this thesis was formulated.

2 Explanatory notes on the descriptive title

The descriptive title refers to a fundamental dissimilarity between the medical interpretation of medical facts and the legal interpretation of medical facts: '*The incommensurability of the archaic perceptions of the maxim res ipsa loquitur in medical negligence litigation*'. The maxim *res ipsa loquitur* may be a useful procedural aid for plaintiffs, but its use in medical negligence cases is discouraged. This stance accords with the decision in *Van Wyk v Lewis*[87]but not with some academic writers, who described the dictum of the court in *Van Wyk v Lewis*' as untenable and out of touch with modern approaches adopted by other Common law countries'.[88]Although the court in a recent judgment, *Cecilia Goliath v MEC for Health, Eastern Cape*,[89] argued against using *res ipsa loquitur* in future medical cases, the reasoning for the decision was not explained. It is argued that the *res ipsa loquitur* maxim may rarely, if ever, be useful to a plaintiff in a medical negligence case.

Several preconceived notions[90] are linked with the application and the use of the maxim in South Africa. The most important one is that any undesired outcome of a medical intervention is perceived to be evidence of negligent conduct.[91] This misconception arises

[87]*Van Wyk* (n 33), where a swab was left in the body of the patient after an operation. See chapter 2 para 3 and 8.
[88]Van den Heever & Carstens (n 31) 36.
[89]*Goliath* (SCA) (n 45) para 12. See chapter 2 para 8.
[90]The concept of insufficient facts is not the same as an absence of explanation from the defendant; ordinary facts are not the same as medical facts and interpretation; even a *res ipsa loquitur* case must meet the prerequisites of a delictual claim; any medical accident is not *prima facie* evidence of lack of care and skill, etc. The list is not complete.
[91]D Hirsh et al (n 30) 410–12.

from legal interpretations of medical facts that may be inconsistent with the medical interpretation of medical facts. In this regard, the writer faced a dilemma when translating medical scientific realities into legal arguments. The following analogy[92]is useful in describing the predicament. If one has the perfect tool, eg a screwdriver, and the task is to remove a nail from a piece of wood, one's perception that the nail is a screw would most probably be the source of endless frustration. However, when analysing the cause of the problem, two elements would be discerned: the design and the use of the tool. An uninformed user of the wrong tool may invest futile effort because the nail and the screwdriver are incommensurable. However, an analyst or designer would appreciate the cause-and-effect relationship between the screwdriver and the screw and would simply replace the tool with a more effective one. The simplest solution sometimes is found to the most complex problems if the designer and the user reflect an intrinsic understanding of the same things. Thus, when two concepts are so different that they could never exist together or agree with one another, they are found to be incommensurable.

The term 'incommensurability' is used by scientists to capture methodological, observational and conceptual inconsistencies between successive scientific paradigms,[93] and therefore its use in a legal context may be criticised. However, the justification for its use is found in the successive and contemporaneous involvement of the disciplines of law and medicine in the field of medical negligence. In essence, it is a practical expression to describe the central underlying argument of the thesis, ie that a substantial conceptual difference exists between legal conclusions from legal interpretation of medical facts and medical conclusions based on medical facts. Clinical medicine is described as an ongoing medical diagnostic process that gives rise to the medical interpretation and explanation of facts, viz medical conclusions. As explained before, the expected medical standard must be in agreement with the values and norms of our society as embodied in the South African Constitution. For example, it is regarded as good and safe medical practice to remove as much affected tissue as possible from a cancerous growth, even if this results in damage to the bile duct. If these medical realities are not investigated and clarified, unsustainable decisions and uncertainty in judicial reasoning may result. The premise for the thesis was thus established: the *res ipsa loquitur* maxim is incommensurable with the medical clinical process in medical negligence litigation.

[92]EM Goldratt *The Choice* (2008) 8.
[93]T Kuhn *The Structure of Scientific Revolutions* (1962) 148–50.

As Feyerabend[94] so aptly remarked,

> [p]aradigms can be based on different assumptions regarding the structure of their domain, which makes it impossible to compare them in a meaningful way. The adoption of a new theory includes and is dependent upon the adoption of new terms. Thus, scientists are using different terms when talking about different theories. Those who hold different, competing theories to be true will be talking over one another, in the sense that they cannot a priori arrive at agreement, given two different discourses with two different theoretical languages and dictates.

Oberheim,[95] in support of Feyerabend, explains that the notion of incommensurability means that two theories are conceptually incompatible. He maintains that meanings, even of observational terms, are determined by the theories to which they belong. When there is a theory change there are meaning changes that could result in a new conception of reality. A misunderstanding of medical reality goes to the heart of the argument of this thesis, viz that misconceptions of medical reality in legal reasoning lead to the inappropriate use and application of the *res ipsa loquitur* maxim.

3 The background to the thesis

3.1 Rationale

The rationale behind the title is that in a medical case the court weighs the expected standard of care against the delivered standard of care to determine substandard care. Therefore, it is important to understand medical realities before drawing juristic inferences or conclusions, and this *ipso facto* excludes the *res ipsa loquitur* maxim from being applied in any medical negligence case. The focus of the thesis is on the medical facts of several cases to determine the set medical standard. From the set standard the reasoning of the court is followed in determining the elements in delict, more particularly those of factual causation and negligence. The thesis clarifies, independent of the *stare decisis* rule, why the *res ipsa loquitur* maxim would not be applicable to the majority of medical negligence cases in South

[94]E Oberheim 'On the historical origins of the contemporary notion of incommensurability: Paul Feyerabend's assault on conceptual conservatism' (2005) 36 *Stud. Hist. Phil. Sci.* 363–90, available at http://edoc.hu-berlin.de/oa/articles/re DSIYTe3E6e/PDF/25gdEOvNBFnQg.pdf(accessed 1 May 2013).
[95]Oberheim (n 94).

African law. The thesis also seeks to qualify the conceptual differences that exist between the context of medicine and law in medical negligence cases in the presence of similar terminology, eg the term 'causation'. The problem arises when more causes of action are found in any complex case, medical cases being cases in point. It is usually found that there may be several factors in the causal chain that significantly contributed to the undesired medical event. As explained before, in *Michael v Linksfield Park Clinic*[96] a young healthy man underwent nose surgery that resulted in permanent brain damage. Only if this process - the medical reality - is understood and appreciated can factual causation and negligence (*culpa*) be determined. The medical reality is obtained from the set standard of care based on accepted international medical principles. The cause-and-effect medical chain provides medical facts that support the causal link between the occurrence and the harm. It is from this medical reality that factual causation is determined which, in turn is the legal nexus between the wrongful conduct and the injury. This approach harmonises with the argument that, if the *res ipsa loquitur* maxim is correctly applied to determine whether there has been negligent conduct, inferential reasoning based on medical facts should support all elements in delict, and in particularly the elements of negligence and factual causation, which falls outside of the scope of the maxim. Even if the assumption is that, usually, uncomplicated nose surgery does not lead to brain damage, this syllogism will lead to false inferences, which are not based on sound delictual legal principles ie causation and negligent conduct. It will increase the risk that courts may decide cases for reasons inconsistent with the true medical perspectives.

Because of the major influence of constitutional rights mentioned before, the thesis considered possible changes in the law of delict in South Africa. It is understandable that tension may develop between patient rights and the conventional common law of South Africa. The substantive approach moved away from the conservative approach. Thus, it is unsurprising that the courts engage directly with correcting the wrongs of the past[97] and even require the executive powers of the country to give effect to the socio-economic claims of the poor and the vulnerable. The court promotes the values that underpin an open and democratic

[96]2001 (3) SA 1188 (SCA). The medical aetiology is recognized from the clinical course. A nose injury was the initial diagnosis. The surgical complication changed the diagnosis. The anaesthetist caused the hypertensive crisis. The inadequate management of the hypertensive crisis and the cardiac arrest caused the brain damage.
[97]*Van der Merwe v Road Accident Fund and Others* (n 15). Human dignity comprises mental integrity, bodily integrity, reputation, privacy, feeling and identity. See detailed discussion in chapter 2 para 1; 7 and 9 regarding the horizontal application of the Bill of Rights indicating that not only is the complainant's rights at issue but invariably also the rights of the defendant and any limitation of the defendant's rights will be seen as unfair discrimination; also see *Oppelt v Head: Health, Department of Health Provincial Administration: Western Cape* [2015] ZACC 33, the court widely applied the principles of causation and highlighted the reasonableness concept in the element of wrongfulness and relaxed principles of negligence; See chapter 2 para 7.

society and is determined to relax some of the established legal principles when such departure is justified. The right to bodily integrity is interpreted to include to be treated with dignity. This is also seen in England and Wales where the courts are now more willing to challenge medical expert opinion and, where a claimant has established a breach of a human right, in circumstances where the law of tort has not previously assisted, the courts seem to be willing to reconsider the common-law position and balance the claimant's rights and the defendant's interests more carefully.[98] This thesis examines the benefits of such a development in the South African context.

3.2 The maxim of *res ipsa loquitur* as part of the rationale

The court in *Van Wyk v Lewis*[99] held that 'no doubt it is sometimes said that in cases where the maxim applies the happening of the occurrence is in itself *prima facie* evidence of negligence'. The thesis focuses on the premise created by the design of the *res ipsa loquitur* maxim in medical cases. If, in certain instances, this evidentiary principle should allow the court to draw a presumption of fact from a particular fact or cluster of facts regarding an unsatisfactory outcome of a medical intervention, it means that the cause of the injury has to be known or the cause of the injury at least has to carry a highly probability of being the correct cause. In addition, the subjective conduct of the defendant has to be known from the available facts, for example, that the defendant was reckless or omitted or neglected to act under specific circumstances. Furthermore, since this evidentiary inference from the facts is not a presumption of law, it is only a reasoning process deduced from the facts. Now, if the *res ipsa loquitur* maxim is applied to medical cases, the medical reality should be evident before negligence can be inferred from any facts, and if not, it cannot lead to a change in judicial reasoning to confer liability. In other words, if cutting a bile duct during surgery is not factual evidence of negligence (*culpa*), it cannot even be presumed as careless conduct from the key facts, because the element of negligence (*culpa*) has not been satisfied. The court has to be provided with the set medical standard of care and only then will the court be in a position to monitor whether the defendant took the required steps to prevent such an injury. Against the medical reality the court will be able to find this required standard of care to measure all the evidence.

[98] *Chester v Afshar* (n 17). See chapter 2 para 6.3 and 9.5.
[99] *Van Wyk* (n 33). See chapter 2 para 3 and 8.

The thesis seeks clarity about the use of the maxim, since the interpretation and function of the *res ipsa loquitur* maxim have been quite controversial. Concisely, the maxim is described by some as a type of logical reasoning that does not depend upon any rule of law, as it 'propounds no principle'[100] and should not even be called a maxim. Some commentators argue that the *res ipsa loquitur* maxim is merely a 'presumption of fact' and a way to indicate that, within certain circumstances, inferential reasoning is permissible.[101] Therefore, the maxim may be applied in circumstances where accidents do not ordinarily happen without negligence. Often – as expressed by the minority decision in *Van Wyk v Lewis*[102] – a plaintiff may produce evidence of certain facts that, unless rebutted, reasonably indicate insufficient care leading to a conclusion of negligent conduct (*culpa*); in such cases the maxim *res ipsa loquitur* is often held to apply.[103] The functioning of the maxim is described in the English case *Ballard v Northern British Railway Co*[104]by Lord Shaw: '[The maxim] has its place in that scheme of and search for causation upon which the mind sets itself working.' This once again leads to the realisation that the approach of the English court differs from that of the South African court. In England, the presumption of the maxim based on the fact of the injury is sufficient to aver lack of care in a situation completely under the control of the defendant that is unexpected in nature. This realisation is discussed in chapter three and also led the writer to examine whether the early appreciation of the medical reality plays the same role in England than in South Africa. The general presumption - the design of the maxim - which is accepted in England, does not affect the medical reality as any dispute in the medical reality only arises after the defendant's explanation in rebutting the maxim was heard. In South Africa, any conceptual confusion in respect of the true medical reality will lead to incorrect assumptions and failure to show a proper cause of injury and negligence. What seems to be a simple situation of lack of care because a swab was retained, from the ordinary person's point of view, may be completely different for a medical professional experiencing a surgical emergency. It is true that the function of presenting medical evidence is to set the record straight regarding the chain of events. If a healthy young man underwent uncomplicated nose surgery[105] and sustained permanent brain damage the ordinary person may want to assume

[100]*Macleod v Rens* (n 77) 1048.
[101]PJ Schwikkard & SE van der Merwe *Principles of Evidence* (2002).
[102]*Van Wyk* (n 33) 452.
[103]*Mitchell v Maison Lisbon* [1937] TPD 13, where the plaintiff sustained a burn from a permanent waving instrument.
[104]*Ballard v North British Railway Co* (n 38) 68 with reference to *Parfitt v Lawless* [1872] LR 2 P. & D. 462 at 472, where it was established that if the thing was under the control of the defendant and injury occurs the lack of care could be inferred from the fact of the injury. See chapter 3 para 3.
[105]*Michael* (n 96).

that negligence must have occurred. Whereas the medical chain of events is that of a complicated medical mechanism explained before, namely, a hypertensive crisis which was caused by the anaesthetist. The crisis was not managed well and caused cardiac arrest. The arrest was not managed well and caused hypoxia. The hypoxia was not reversed in time and caused irreversible brain damage. These were the medical facts that should have been presented to the court by way of medical expert evidence. The maxim was not pleaded in this case, but even if the maxim had been pleaded and accepted, it would not have made a difference in the South African legal context as the causal link was not explained by medical experts to set the expected standard of care for the court to contrast the delivered standard of care. The defendant-doctors indeed would have answered in rebuttal a case of *prima facie* evidence of negligence by simply stating evidence of careful conduct.[106] They had no obligation to disprove the plaintiff's case (there was no reverse onus on the defendant). Thus, had the plaintiff relied on the maxim (without proper expert evidence) it would still have led to an unsuccessful case for the plaintiff. Had the maxim been accepted on the general basis that, in the ordinary course of things, uncomplicated nose surgery does not lead to brain damage, therefore *res ipsa loquitur*, the underestimation of the medical chain of facts (set out above) would not have been sufficiently encapsulated in the maxim and the maxim would not have assisted the plaintiff in any event, as the defendant would have given the same reply of careful conduct and causation would not have been established.

To proceed to court with insufficiently prepared evidence (based solely on the maxim) would make the plaintiff vulnerable to rebuttal by medical defendants on 'exotic' grounds as will be illustrated later[107] and the South African plaintiff would not have shown a causal link - factual causation - or the element of negligence (*culpa*). In addition, the plaintiff would have to disprove any explanation offered by the defendant in rebutting the maxim. This is another hurdle for the plaintiff to overcome and it is an increased burden of proof for a South African plaintiff. According to a patient's right to dignity and bodily integrity a 'victim' of a medical injury should have a remedial measure to claim an infringement of this right. As argued before, in South African context, if the medical reality remained obscured then justice will not be done even if the maxim is applied. The maxim is inappropriate in medical cases in

[106]The defendants did not present evidence to show that they foresaw the incident and guarded against it. Unfortunately, in this case, the medical expert of the plaintiff should have been the second defendant. As expert he concentrated more on acquitting the defendant than on explaining the medical reality to the court.
[107]Chapter 3 para 4.1, remarks on 'exotic' explanations by the defendant doctors, where explanations were offered not realistic in context of the medical facts. Any explanation without negligence is acceptable.

South Africa because the plaintiff has to prove all the delictual elements when advancing his case.

3.3 Legal principles underlying the *res ipsa loquitur* maxim and the rationale of the study

The thesis uses the practical realities of medicine to demonstrate the set standard of care against which the standard of care of the defendant-doctor is weighed. The underlying principles of the law of delict and the law of evidence that govern the maxim *res ipsa loquitur* in analysed in medical negligence cases. To briefly summarise, in the law of medical negligence, it is trite that the intentional or negligent causing of bodily harm to another without lawful justification is an actionable wrong.[108] It is accepted[109] that wrongfulness in the context of breach of a legal duty is one of the essential elements to show liability. It is also accepted that the legal duty of care owed to the patient can arise independently of contract,[110] namely, in delict. It is implicitly linked to the fact that the patient has submitted himself to the care of the doctor because of the skill and knowledge of the professional. It is the writer's argument that any adverse event, in the medical context, can at best only be presumed to satisfy the element of wrongfulness, based on the duty of the doctor not to cause harm.[111] In this regard a judicial enquiry into wrongfulness is determined by weighing competing norms and interests, in order to focus on whether it would be 'reasonable' to impose liability. In this regard the writer explored aspects that may rebut the presumption of wrongfulness in delict. In South African law, the consent given by the plaintiff justifies the action of the defendant and the law then accepts it as lawful. Inadequate disclosure or an absence of informed consent (in South Africa) forms part of the delictual element of wrongfulness. If proper and sufficient consent has not been given the court will find a defendant liable based on a breach of his duty (only with regard to the element of wrongfulness) but the other elements in delict still have to be satisfied. It should be noted that without the consent of the patient the doctor cannot justify his actions. It is also questionable if a doctor will be successful with a defence based on the maxim *volenti non fit* - iniuria translated as 'to a willing person injury is not

[108]*Stoffberg v Elliot* 1923 CPD 148, where the court stated that in the eyes of the law every person has certain absolute rights which the law protects, one of which is the security of the person. Any bodily interference with or restraint of a man's person that is not justified in law, or excused in law or consented to is a wrong, and for this wrong the plaintiff has a right to claim damages.
[109]*Lillicrap, Wassenaar and Partners v Pilkington Brothers SA (Pty) Ltd* 1985 1 SA 475 (A) 496ff.
[110]SA Strauss 'Duty of care of doctor may rise independent of contract' (1988) 9 *S A Practice Man.* 155.2.
[111]*Lillicrap* (n 109); *Loureiro and others v Imvula Quality Protections (Pty) Ltd* ZACC 4 at para 53.

done' - as the defendant-doctor is required to show that the plaintiff had knowledge of the risk that the plaintiff appreciated the nature and extent of the risk and, notwithstanding such risk, freely and voluntarily assumed the risk.[112]

In England this is not the same as lack of disclosure alone may be a sufficient ground to prove a breach of the duty of care. In *Chester v Afshar*[113]the English court explicitly referred to a need, based on patient's rights, to bend the rules on causation and thus protect patient's rights and autonomy. The decision of the court was made on policy and/or moral grounds. The court's stance was that every adult individual of sound mind has a right to decide what may or may not be done with his body (the right of autonomy) and also has the right to make important medical decisions affecting his life. In this regard, the English court found that the duty of the doctor[114] is sufficiently similar in the practice of medicine to that of law but significantly different in its legal application. In England the duty of care of the medical professional is imposed by law when a doctor undertakes to diagnose, to advise and treat the patient. Since consent to medical treatment is essentially concerned with the right of autonomy of the patient to be informed and to be allowed to make a choice of whether to accept the risk of the operation or not, encroaching on such a right is sufficient to prove liability where a claimant approaches the court alleging lack of disclosure, as seen in *Chester v Afshar*.[115]

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[112]SA Strauss *Toestemming tot Benadeling as Verweer in die Strafreg en Deliktereg* (1961) 48ff. See *Sibisi NO v Maitin* [2014] ZASCA 156, where the court addressed informed consent. It was argued that the test should be based on the right to self-determination entrenched in the Constitution and should be about the 'reasonable patient'. The 'reasonable patient' test was discussed in *Castell v De Greef* 1994 (4) SA 408 (C).

[113]*Chester v Afshar* (n 17), before Lord Bingham of Cornhill, Lord Steyn, Lord Hoffmann, Lord Hope and Lord Walker of Gestingthorpe. The claimant underwent surgery performed by the defendant, who negligently failed to warn her about the small risk of *cauda equina* damage. See discussion chapter 2 para 6.3 and 9.5.

[114]*Cassidy v Minister of Health* [1951] 2 KB 348 at 359, per Lord Denning: 'no one doubts that the doctor must exercise reasonable care and skill'; in *Donoghue v Stevenson* [1932] AC 562, the court stated that you must take reasonable care to avoid acts or omissions which you reasonably can foresee would likely injure your neighbour; in *Hunter v Hanley* [1955] SC 200 at 204-205, the court indicated that the true test for establishing negligence in diagnosis or treatment is whether the doctor has proved to be guilty of such failure as no doctor of ordinary skill would be guilty of; in *Eckersley v Binnie & Partners* [1988] 18 Con. LR 1 at 80, it was held that a professional man should have the expected knowledge, should not lag behind in new developments in the field and should be alert to the hazards and risks inherent in the profession. There are several cases on the failure to provide proper advice and communication: cf. *Stamos v Davies* [1985] 21 DLR (4th) 507 at 519 where the judge said that the underlying cause for the misadventure and for the litigation was the failure of the doctor to take his patient into his confidence. Also see *Lee v South West Thames Regional Health Authority* [1985] 2 All ER 385 and *Sidaway v Bethlem Royal Hospital Governors* [1985] AC 871.

[115]*Chester* (n 17); In *Glass v United Kingdom* [2004] 1 FCR 553; (2004) 77 BMLR 120 where the Court of Appeal held that where doctors and parents disagree regarding the treatment of the child the conflict should be taken to court. The hospital administered morphine and reported that the child should not be resuscitated against the mother's wishes. The hospital had a duty to involve the parents in the decision. The hospital interfered with the right to respect life.

Furthermore, with regard to the element of negligence: determining negligent conduct is subjective[116] because the court investigates the conduct of the wrongdoer and determine whether the defendant could have foreseen the harm and guarded against it. The case of *Van Wyk v Lewis* is discussed throughout the thesis, because it demonstrates the stance taken by the South African court on the *res ipsa loquitur* maxim. The discussion of the *Van Wyk* case also involves the actual practice of medicine. In this case, the surgeon or hospital subcontracts the counting of swabs to the theatre personnel and this led to many uncertainties. Does this mean a swab that was left behind is still under the indirect control of the surgeon, as it is obviously no longer under his direct control? Some commentators were of the view that the plaintiff's case was dismissed because the court was unwilling to hold a surgeon, who transfers the task of counting swabs to a competent sister, liable for negligent conduct[117] and not necessarily because the requirements of the *res ipsa loquitur* maxim had not been satisfied. Several questions were raised about how this impacts on the use of the maxim. According to the requirements of the maxim, the medical facts should point to a high probability of negligence before the *res ipsa loquitur* maxim can be relied upon. It follows that it seems that a thorough understanding of the medical facts might be a prerequisite before the maxim can be applied, which is certainly not the function of the maxim. The purpose of the maxim (as factual presumption) is to complete the picture, so to speak, when direct evidence is not available. If one cannot complete the picture, surely no presumption can be made. The thesis argues that the latter scenario is exactly where the confusion arises for the South African plaintiff. The completion of the picture rests with the medical expert to explain the expected and internationally accepted standard of care to the court in order that the court can measure the standard of care that was delivered. For obvious reasons, this differs substantially from the non-medical person's opinion regarding what is described as a high probability of negligence.

As explained before, when a plaintiff relies on *res ipsa loquitur* exclusively, it will have the effect that the interpretation of the medical facts is limited to how the plaintiff understands those facts. The defendant, in refuting the presumption of fact - the maxim - may now present any explanation, not necessarily plausible, causing the court not to be in a

[116] Whether the determination is objective or subjective may be controversial. Paul, in Digesta 9 2 31 interpret it as subjective: '*Culpa* is not to foresee what a reasonable man would have foreseen'. In *Farmer v Robinson G M Co Ltd* 1917 AD 501 at 521ff the expected standard is that of a *diligens paterfamilias*. Or it may be objective, where conduct is described as 'free from an unreasonable risk of harm to another' in *Stern v Podbrey* 1947 (1) SA 350 (C) 364.

[117] *Van Wyk* (n 33) 449. See chapter 2 para 3 and 8.

position to decide the real issue of causation or negligence (*culpa*). For example, if the defendant offers a plausible explanation, that the operation was terminated due to equipment failure, this would justify leaving a swab behind. Such an explanation would clear the defendant of not acting in accordance with his duty, but it would not clear the hospital, as they should have foreseen such an event and should have taken precautions to prevent the equipment failure. But what if the defendant showed diligent care in counting the swabs and one was still left behind? Would he still be liable? This thesis argues that, according to the South African law of delict, the court will then look at the circumstances in order to complete the question of causation and negligence. Was there a reason or justification for missing the swab? This will effectively make the use of the maxim inappropriate. The thesis argues that the use of the maxim is accepted in England because of its design ie that the defendant can be called to answer. On the other hand, the South African plaintiff is misguided in the use of the maxim; its application often results in a plaintiff advancing to court on insufficient medical evidence leaving the court without a yardstick to determine delictual liability or worse, that the plaintiff has not shown a causal link between the action of the defendant and the injury. In addition, it places the defendant in a prime position to direct the trial, as the defendant, in refuting the maxim, need only offer an explanation that shows that he was not negligent eg that an unforeseen allergic reaction caused the harm, and so forth. It does not even have to be the most likely cause of the injury as long as it is an explanation that shows absence of negligence. The plaintiff would be caught unawares by the unexpected explanation from the defendant that cannot be tested against the acceptable standard of care in terms of delictual principles elements. It would not assist the court in its truth-finding mission. In fact, the only medical evidence before the court would be that offered in defence and the plaintiff's case will fail.

Apart from the fact that negligence cannot be seen as 'negligent in some general or unspecified manner',[118] when analysing the element of negligence, the aspects of foreseeability and prevention are very specific in determining negligence. For example, if the patient experiences massive haemorrhaging while the surgeon is dissecting a cancerous growth, which leads to the patient being medically too unstable to remain anaesthetised and the operation being terminated, such an immediate emergency would justify leaving a swab behind and reopening at a later date. Such subjective information in respect of the emergency and the conduct of the surgeon during the emergency has to be tested to determine the

[118] *Macleod* (n 77) 1048.

element of negligence. A defendant facing such a situation will not be judged too critically as the surgeon could not have foreseen the sudden emergency or guarded against it, but his management of the situation will be tested. The medical reality of circumstantial evidence undoubtedly does not support the use of the *res ipsa loquitur* maxim, and might be applicable to all retained-swab cases where more information is needed.

On the other hand, if it is particularly clear from the incident that the occurrence has the appearance of negligence (*culpa* and liability) it becomes *prima facie* evidence of negligence and the need for the application of the maxim falls away. When approaching such a case on a *prima facie* basis, it means that there is enough evidence for the defendant to defend his case and the plaintiff, having obtained medical information from a medical expert, can advance to court prepared to prove his case. But relying on the fact that something went wrong (in general terms), and then relying on *res ipsa loquitur*, have the combined effect that the answer of the defendant in defending the maxim has to be refuted plus the plaintiff has to prove his case. It is a further burden on the plaintiff to overcome. The latter is investigated regardless that the thesis finds some discrepancies in the application of the maxim. The requirements of the maxim prescribe that besides the fact that the manner in which the accident occurred must be unknown,[119] there must be a high probability of negligent conduct, which can be implied from the facts but if the facts are sufficiently known the maxim has no application.[120]The thesis argues that in a medical case the requirements of the maxim are not satisfied, as from a plaintiff's point of view the plaintiff would rarely know what occurred without medical expert evidence only that the outcome was undesired. If the South African plaintiff follows the English example, not realizing the different legal principles, it would have the effect that the plaintiff be 'blindly' going to a court on vague and general grounds of negligent conduct. It does not substantiating a case brought in delict and the defendant will not be obliged to rebut such a case or if the court allows the maxim, will put a defendant in a superior position to defend his case by presenting any non-negligent alternative explanation to escape liability. It is trite that, in any case, if direct evidence is not available, negligence

[119]Van den Heever & Carstens (n 31) 34; *Administrator, Natal v Stanley Motors Ltd* (n 64) 700, for example, it is not known how the other vehicle ended on the wrong side of the road; There is a difference between absence of facts and insufficient evidence of an accident. In *Wagener v Pharmacare* 2003 (4) SA 285 (SCA) and in *Ntsele v MEC for Health Gauteng Provincial Government* 2013 (2) All SA 356 (GSJ) both plaintiffs failed to present proper information in support of their cases and relied on the mistaken belief that the *res ipsa loquitur* maxim can fill in the blank spaces.

[120]*Barkway v South Wales Transport Co Ltd* [1950] 1 All ER 392 at 394–5; *Administrator, Natal v Stanley Motors Ltd* (n 64) 700. Ogilvie Thompson JA stated that where the facts are sufficiently known the question ceases to be one where the facts speak for themselves and the solution is to be found by determining whether, on the facts as established, negligence is to be inferred or not.

may be inferred from the facts, as no court can ever eliminate every conceivable possibility.[121] However, with no other facts before the court to complete the picture, the plaintiff would be unprepared. The facts of a case from which an inference is deduced, if it is a reasonable deduction, may have the validity of legal proof as opposed to conjecture.[122] Such an inference must be evident from the facts ie that the harm was occasioned by the defendant's negligence. The thesis states that this is not possible in a medical negligence case as contrary to proper judicial reasoning, negligence would be inferred in a too-wide sense and in some general or unspecified manner.[123] As stated previously, if all the facts are indeed known, the maxim is not appropriate and the case should simply be based on *prima facie* evidence. One of the requirements of the maxim is that the cause has to be unknown but, with sufficient other fact-sensitive information available to infer a legal breach.[124]

It seems self-evident that, in more complicated medical negligence cases, despite an undesirable event, a general unspecified inference of negligence (liability) cannot be supported by a simple factual presumption in the application of the *res ipsa loquitur* maxim. The medical reality will become clear only when the desired medical standard of care has been stated to the court by means of accepted medical expert evidence and a detailed analysis of the cause and effect of the medical injury. A proper understanding of medical information clarifies the elements in delict to determine, with reference to the factual chain of events, whether negligent conduct (*culpa*) can be proved. A real risk exists that the application of the maxim to a medical negligence case may create a misperception that sufficient information has been presented in order for the court to draw a legal inference of negligence from a mere factual presumption, when in fact that is not the case. If such an erroneous belief is answered by the defendant with *any* explanation of negligence not occurring, even unrealistic or unrelated to the inference on the facts, the plaintiff will lose the case, with a real risk that the defendant's explanation convinced the court.[125]

[121] *Gibby v East Grinstead Gas Co* [1944] 1 All ER 358 (CA) 362.
[122] *Jones v Great Western Railway Co* (1930) 47 TLR 39 at 45.
[123] *Macleod* (n 77) 1048.
[124] Regarding requirements of *res ipsa loquitur* maxim see Van den Heever & Carstens (n 31) 34; *Administrator, Natal v Stanley Motors Ltd* (n 64) 700.
[125] The defendants' use of an 'exotic' explanation occurred in England: see chapter 3 para 4.1.

3.4 Synopsis of some disputed elements for discussion

The thesis argues that the *res ipsa loquitur* maxim ('the thing speaks for itself') is not or should not be part of the South African law of delict regulating compensation claims for medical negligence. The perception that the maxim may assist South African claimants in their claims by easing the difficulty of proving that medical professionals acted negligently and that this negligence caused their loss is incorrect. The thesis argues, on the contrary, that the maxim is harmful to both South African plaintiffs and defendants as it tends to oversimplify medical aspects. It thus increases the risk that the court may decide cases based on incorrect medical information. The design of the maxim allows claimants to advance a case to court without the support of medical expert evidence. This, in turn, allows a defendant to rebut such a case with 'exotic' explanations that are not plausible, but may nonetheless convince a court.

Bearing in mind that, the South African court today seeks to enforce patients' rights - such as autonomy, dignity and bodily integrity - by providing for compensation by a defendant whose violation of such a right is shown to have worsened the physical and psychological condition of the patient. The thesis examines the value of the maxim in such a context. The thesis considers the arguments of Van den Heever and Carstens[126] that (i) the maxim should apply to medical cases because a plaintiff is treated unequally if he is deprived of the right to use the maxim; (ii) the maxim will assist a plaintiff who is at a disadvantage because he has no medical knowledge of what happened; (iii) the maxim is not prejudicial to the defendant as it only calls for an explanation; (iv) if a plaintiff is barred from invoking the maxim this should be regarded as unfair discrimination; and (v) the maxim may be broadly translated into the right to the highest attainable standard of health with reference to processes and outcomes. In contrast, the thesis argues that the maxim is inappropriate for a medical case and of no assistance to a South African plaintiff. The thesis advocates for allegations in a medical case to be based on medical expert evidence indicating *prima facie* evidence of negligence. In addition, the thesis argues that because of constitutional considerations the South African court should be flexible when deciding whether the care that was provided infringed on the bodily integrity and dignity of the plaintiff. Such an approach is based on substantive restitution and a constitutional approach taking into consideration broader aspects like socio-economic conditions, discrimination and fair and just legal principles. This will

[126]Van den Heever & Carstens (n 31) 151ff.

level the playing fields as it would protect patients' rights and ensure treatment that is in the best interest of the patient.

The thesis investigates the following issues and draws on selected case studies of a variety of medical procedures in the medical and legal context:

3.4.1 the presumption of fact as opposed to a presumption of law in cases where the *res ipsa loquitur* maxim applies;

3.4.2 the differences between relative evidence and absolute evidence in a medical negligence context and the impact of these differences on the maxim;

3.4.3 the differences between *ordinary facts* and *medical facts* in the context of the inference of negligence underlying the application of the maxim;

3.4.4 when an inference from the facts is sufficient to establish *prima facie* evidence in the context of the maxim and medical negligence cases;

3.4.5 where the maxim applies, all the delictual elements should be satisfied, even if legal deductions are made from the facts by implication;

3.4.6 the constitutional aspects of patients' rights; and

3.4.7 the possible judicial relaxation of the principles of causation.

4 Legal system and concepts

The thesis consists of three interrelated phases with an underlying theme of protecting patients' rights. The first phase is an examination of the South African substantive and procedural law and the underlying principles of the law of delict and the law of evidence in medical law, as it governs the application of the *res ipsa loquitur* maxim in South Africa. The focus of the thesis is therefore on the law of delict and the law of evidence relevant to the function of the *res ipsa loquitur* maxim, with a view to deciding whether the maxim will ever be appropriate in medical negligence cases and, if so, when it will apply to medical negligence cases. The study investigates why the court in *Cecelia Goliath v MEC for Health Eastern Cape* held that 'the time may well have come … to jettison [the maxim] from our legal lexicon',[127] unlike the academic authors Van den Heever and Carstens,[128] who favour the reintroduction of the maxim in South Africa. A broad overview of the general principles of the law of delict is given, viz aspects of wrongfulness, negligence, factual causation, legal

[127] *Goliath* (SCA) (n 45) para 12, referring to Lord Justice Hobhouse in *Ratcliffe* (n 83), and stating that it is time to drop the maxim from the litigator's vocabulary and replace it with the phrase '*prima facie* evidence'.
[128] Van den Heever & Carstens (n 31) 36.

causation and damage in general, and in respect of the *res ipsa loquitur* maxim in medical negligence cases. The law of evidence regarding presumptions is discussed as part of the function of the *res ipsa loquitur* maxim. The questions raised are investigated to decide if the maxim is consistently applied in accordance with legal principles. The thesis notes the flexibility of the court, in accordance with constitutional values, when relaxing causation principles in the case of *Oppelt v Head: Health, Department of Health Provincial Administration: Western Cape.*[129]

The second phase of the thesis introduces research focusing on the law of tort in England and Wales when applying the maxim *res ipsa loquitur* in medical negligence cases. The purpose is to find answers to understand the discourse of South African jurists when applying the *res ipsa loquitur* maxim in South Africa. The decisions of the English court, with its historical influence on South African law, are explored to find a possible different approach to the use of the maxim, as the maxim is still applied in England. An investigation into the application of the maxim is undertaken to determine whether *res ipsa loquitur* furthers the case of a claimant in England, unlike in South Africa. The case of *Chester v Afshar*[130] is discussed as it impacted on patient's rights and placed a lighter burden of proof on the claimant because of the judicial relaxation of traditional causation principles. The thesis notes how the balance of power shifted in the therapeutic relationship between the doctor and the patient in England and Wales and the impact of this on the development of the English common law.[131] The judiciary in England and Wales is now more willing to challenge medical opinion in medical negligence cases.

With the basic arguments of the thesis in mind, the interconnected third and final phase seeks to determine whether conceptual disparity - for instance, a misguided medical reality or incorrect understanding of what happened - may be the reason for an incorrect legal interpretation of the principles of the *res ipsa loquitur* maxim in South Africa. The medical reality is scrutinised because in South African law it establishes the norm (medical standard) against which the defendant-doctor will be compared. The expected medical standard should be explained by the medical expert in addition to how the delivered treatment deviated from

[129]*Oppelt v Head: Health, Department of Health: Western Cape* (n 85), where the majority judgment found for the plaintiff in respect of whether the plaintiff has proved the element of negligence and the minority found against the plaintiff. This case is discussed in chapter 2 paras 1; 7; 9.
[130]*Chester v Afshar* (n 17). See chapter 2 para 6.3 and 9.5.
[131]Chapter 3 para 9. See also *Pearce v United Bristol Healthcare NHS Trust* [1999] ECC 167; [1999] PIQR P53; (1999) 48 BMLR 118 CA (Civ Div), where the overdue delivery of baby resulted in a stillbirth; and *Montgomery v Lanarkshire* [2015] UKSC 11; [2013] CSIH 3; [2010] CSIH 104, where a baby was born with severe disabilities as a result of birth complications.

this standard ie *what went wrong*. Such a medical chain of events is used to establish legal causation and liability. The established medical reality forms the basis from which factual causation is derived. Factual causation and legal causation (non-remoteness of damage) provide a legal nexus between the medical action or omission and the damage (injury) to the plaintiff. South African law differs from English law in their application of the *res ipsa loquitur* maxim. The core difference was in the management of the factual inference of negligence (*culpa*). The English court allows a general inference of negligence (based on lack of skill and care in a situation under the defendant's control which is unexpected in nature) to prevent a defendant, who most likely knows what occurred, to avoid responsibility simply by not giving evidence.[132] In contrast, the South African court held that a defendant cannot be found negligent in some general unspecified manner[133] and all the facts of the case should be considered as a whole in testing all principles in delict.

5 Substantive law versus procedural law

Throughout the thesis the application of the *res ipsa loquitur* maxim is set against a combination of procedural law and substantive law. The most divergent or conflicting arguments are found within substantive law, which sets down the principles of a delictual action based on Aquilian liability, ie when 'the negligent action of a wrongdoer caused damage to another'.[134] The substantive law states that an action will be actionable only if it is recognised in law to be in breach of a legal duty and as such, wrongful. The element of wrongfulness is further linked to a legal duty owed by the doctor to the patient not to cause harm. The requirements of the element of wrongfulness are developed by the court based on the principles of *boni mores* expectations and on constitutional rights. The added element of negligence deals with the conduct of the defendant and whether he acted reasonably, in accordance with standards set by the medical profession ie the accepted medical standard. The conduct of the defendant will be seen as reasonable if it tests positively against the conduct of a medical professional with similar qualifications, placed in similar circumstances. The test for negligence is whether the defendant's conduct is unreasonable and whether it falls short of the accepted medical standard ie that of a hypothetical reasonable doctor. Such a reasonable doctor is diligently caring for his patient in accordance with the set standards of

[132]Chapter 3 para 3 and chapter 5 para 3.2.
[133]Ibid.
[134]Neethling et al (2010) (n 19) 3.

the profession. He would have foreseen the injury and would have taken preventative steps to avoid the injury. In addition, the elements of factual causation and legal causation are tested to ascertain whether the wrongful negligent conduct was the direct cause of the injury. Against the background of these elements of delictual liability, the function of the maxim *res ipsa loquitur* is investigated. The law of evidence dictates the function of presumptions. The primary role of the maxim *res ipsa loquitur* is that it creates an inference from the facts whereby a legal conclusion may sometimes be drawn from the occurrence. The law of evidence forms part of substantial and procedural law, but it is described as mostly that part of law governing, *inter alia*, legal inferences and presumptions, the onus of proof, the nature and weight of evidence presented in court, and admissible and inadmissible evidence based on the evidentiary rules created by the court. The questions raised by the thesis, listed in paragraph 3.4 above, regarding the functioning of the *res ipsa loquitur* maxim, will be tested against these relevant legal principles.

When contrasting some of the principles of delict in the South African legal system to those of the law of tort in England, in order to gain a better understanding of the use of the maxim, it is acknowledged that the principle of breach of a legal duty in South Africa differs from the principle of a breach of a 'duty of care' in England. One finds marked similarities but also profound differences.[135] For example, the element of *wrongfulness* is not differentiated from the element of *negligence* in the English law of tort, where negligence is described as a lack of care additional to a failure to foresee a certain risk and guarding against it.[136] In contrast, the South African court has defined the elements of delictual liability collectively as a wrongful act performed negligently, that causes non-remote damage to another. Considering only the element of wrongfulness for the argument, the implication for the application of the *res ipsa loquitur* maxim is that the English court allows for a generalised inference of negligence (based on lack of skill and care under specific circumstances and as such incorporating the element of wrongfulness) as long as it seems 'just and reasonable'. In comparison, the South African court has to apply the test for wrongfulness based on the legal duty not to cause harm in addition, to focus on the reasonableness of imposing liability and taking into consideration whether it was justified

[135] *Telematrix* (n 21)para 14 warns that reference to a 'legal duty' as a criterion for wrongfulness should be guarded against and should not be confused with the 'duty of care' in English law, as the latter comprises the elements of both wrongfulness and negligence.

[136] *Caparo v Dickman* [1990] 2 AC 60, where their Lordships concluded that the tripartite test states that the harm must be foreseeable, that a requisite proximity between the defendant and the claimant must exist, and that it will be fair, just and reasonable to impose such a duty on the defendant, taking public policy into consideration.

(justified in the sense of whether the defendant obtained the consent of the plaintiff prior to his actions). The difference between the systems may not have a practical implication for medical negligence cases in general, because of the doctor-patient relationship and based on proper legal arguments supported by medical expert evidence, but of extreme importance is the fact that, when the maxim is applied in South Africa, it tends to overlook the elements of negligence (*culpa*) and factual causation. As it stands, the inference of fact created by the *res ipsa loquitur* maxim in South African law has its equivalent in England. It is merely a measure of circumstantial evidence that creates a rebuttable presumption of fact which, only if a *prima facie* case has been established, may cast an evidential burden on the defendant to refute the facts.

Furthermore, the civil justice system in England (and Wales) has been modified by changes in the Civil Procedural Rules (CPR) and contains a more inquisitorial element and greater judicial involvement in managing a trial. Although the fundamental framework is still largely adversarial in nature,[137] the changes may have a considerable effect on the functioning of the maxim in England, since the courts are allowed to question the medical experts in its truth-finding goal. The legal system in South Africa is strictly adversarial: a plaintiff presents a medical negligence case based on substantial medical expert evidence (setting the standard) from which factual causation is averred and negligence concluded. The nature of such a system means that the parties conceal their cases from each other. The inquisitorial nature of the court in the English civil justice system allows for the medical experts of both parties to be questioned by the court in search of the medical standard of care and the medical truths regarding the occurrence itself.[138]The benefit of such a modern approach in England is more transparency and the approach is open and honest in declaring its resources, intentions, or attitude with the intention of narrowing the issues in dispute or settling the action.

6 Methodology, approach and limitations

The thesis explores the opposing views about the *res ipsa loquitur* maxim in South Africa. The judiciary rejected the application of the maxim in medical cases. However, academic authors appeal for the re-institution of the application of the *res ipsa loquitur* maxim in South

[137]*Pearce v United Bristol Healthcare NHS Trust* (n 131), where carrying a baby beyond the due date caused the death of the baby; *Montgomery v Lanarkshire* (n 131), where a doctor failed to recognised shoulder dystocia and the baby was born with severe disabilities.
[138]Civil Procedure Rules Practice Direction (CPR) Pt r.35.11.4 (1)-(3), in terms of which experts have a duty to the court that overrides any obligation to the person who instructed them.

Africa in medical cases based on legal arguments and constitutional grounds.[139] This prompts an investigation into the use and function of the maxim in limited South African cases.[140] These inadequate resources in South Africa directed the thesis to study the used of the maxim in England and Wales. Influenced by the South African medical law requirements, the thesis focuses on weighing the set medical standard of care against the standard of care supplied by the defendant-doctor. This leads to a discussion and interpretation of the medical aspects of most of the cases in order to understand the reasoning of the court. The purpose of the thesis is not to review the manner in which the English cases were decided rather to be guided regarding the use of the maxim in context of internationally accepted medical standards ie the medical reality. Seen in this light the actual medical reports of each case would not have substantially altered the arguments of the thesis. The English legal system is assessed and the use of the maxim investigated amongst other (i) to determine the procedural function of the maxim and the circumstances when the court accepts the maxim; and (ii) to learn from English experience how the court when applying the maxim interprets notions like negligence and causation. Several English cases demonstrate that the fact of the injury allows the claimant to ask for an explanation from the defendant (the function of the maxim) particularly when a claimant was unexpectedly injured during circumstances under direct control of the defendant-doctor. A factual presumption of negligent conduct is then drawn from the fact of the injury that compels the defendant-doctor to rebut. If he fails to defend this presumption it becomes conclusive evidence of negligence. It creates a rebuttable presumption of negligence which is not the case in South African law. It resulted in futher research regarding the manner in which the English court addresses elements of negligence and causation when applying the maxim. Taking the above into consideration the thesis examines recent English cases like

[139]Chapter 2 para 8.

[140]*Mitchell v Dixon* 1914 AD 519, where a needle broke off during the treatment of a pneumothorax and the court found that it was the result of insufficient care; *Coppen v Impey* 1916 CPD 309, where the plaintiff averred that an x-ray burn was the result of negligence and the court found that lack of skill cannot be inferred from the evidence; *Allot v Paterson and Jackson* 1936 SR 211, where a dental extraction resulted in injury to the shoulder and the court relied on *Van Wyk* (n 33), stating that negligence should be inferred from all the surrounding evidence as 'the mere fact that injuries were sustained is not in itself *prima facie* proof of negligence'; *Mitchell v Maison Lisbon* (n 103) 13, where the plaintiff was burnt with permanent waving apparatus; *Groenewald v Conradie* 1965 (1) SA 184 (A) 187F, where Rumpff JA emphasised that the maxim can be used only 'wanneer dit nodig is om enkel en alleen na die betrokke gebeurtenis te kyk sonder die hulp van enige ander verduidelikende getuienis' translated as '*the maxim can be of use when the occurrence itself provides sufficient information without circumstantial evidence'; Pringle v Administrator Transvaal* 1990 (2) SA 379 (W), where the superior vena cava was perforated during surgery and the court held that 'if the evidence showed that by the mere fact of such a perforation negligence had to be present, then the maxim would have application' (this was not the case); *Goliath v MEC for Health in the Province of Eastern Cape* 2013 ZAECGHC 72 (High Court), where recurring sepsis over a period of time revealed a septic gauze swab from the wound. On appeal, the court avoided the maxim but found for the plaintiff, stating 'that on all of the evidence and the probabilities and the inferences' the plaintiff proved her case. The list is not complete and cases are discussed in chapter 2 para 8.

Lillywhite,[141]*Thomas v Curley*,[142]*Pearce v United Bristol Healthcare NHS Trust*[143]and *Montgomery v Lanarkshire.*[144] The latter cases are also investigated to analyse the approach of the English court towards the *res ipsa loquitur* maxim in modern times as the court now required medical expert evidence to accompany a case based on the maxim. The South African case *Van Wyk v Lewis*[145] is revisited to compare it with more recent cases like *Ntsele*,[146]*Buthelezi v Ndaba*[147]and *Medi-Clinic Limited v Vermeulen*[148] in order to confirm the reasons why *res ipsa loquitur* should not find application in medical negligence cases.

With limited cases arising in South Africa and the repeated attempts[149] to use the maxim in medical negligence cases in South Africa, the thesis examines possible inconsistencies, controversies and defects in the application of the maxim. The thesis argues that the South African law of delict, as it stands, cannot allow for the *res ipsa loquitur* maxim. If the English system is followed it requires changing the function of the maxim from a presumption of fact to a rebuttable presumption of law. Apart from being against delictual principles in South Africa, it effectively creates a reverse onus, which may have a discriminatory effect with constitutional consequences as it will trespass on the rights of the defendant-doctor. The thesis suggests that it would be wiser to improve the medical negligence system by importing other measures, such as (i) to consider a broader substantial constitutional approach in deciding a case, based on the right to bodily integrity and dignity and in so doing, relax the rules of causation if it is rational and just; and ii) reforming South African civil procedure by introducing a greater degree of judicial inquisitorial involvement, or (iii) using mandatory medical court assessors.[150]

The writer selected English cases based on a keyword search of '*res ipsa loquitur'*. The writer chose random cases but was guided to use cases with less complicated medical

[141]*Lillywhite v University College London Hospital's NHS Trust* [2005] EWCA Civ. 1466. See chapter 3 para 9.1.
[142]*Thomas v Curley* [2013] EWCA Civ 117. See chapter 3 para 9.3.
[143]*Pearce v United Bristol Healthcare* (n 131). See chapter 3 para 9.4.
[144]*Montgomery v Lanarkshire* (n 131). See chapter 3 para 9.5.
[145]*Van Wyk* (n 33). See chapter 2 para 3 and 8.
[146]*Ntsele* (n 119). See chapter 4 para 8.1.
[147]ZASCA 72; 2013 (5) SA 437 (SCA). See chapter 4 para 8.2.
[148]2014 ZASCA 150. See chapter 2 para 8.
[149]See eg *Nzimande v MEC for Health Gauteng* 2015 (6) SA 192 (GP), where a baby was born by caesarean section and sustained cuts to her arms. The court erred in allowing the *res ipsa loquitur* maxim and ignoring the *stare decisis* doctrine, but found in favour of the plaintiff based on the fact that the plaintiff 'established a strong *prima facie* case of grave negligence by doctors and nurses alike' (para 19).
[150]H Woolf 'Are the courts excessively deferential to the medical profession?'(2001) 9(1) *Med LR* 1–16. Available at http://www.ncbi.nlm.nih.gov/pubmed/14682323. Lord Woolf was of the opinion that the medical profession could not be relied on to resolve justified complaints justly.

aspects to discern legal patterns from the medical reality.[151]Statistical information regarding the method of selecting English cases is as follows. The writer obtained all data about *res ipsa loquitur* cases from the i-law website. The website yielded 41 cases, which included personal injury cases and slip-and-trip cases which were discarded. The number of cases was reduced to 29 medical negligence cases, of which 18 were finally used. Ten cases were not used because of their intricate medical aspects and disputed facts.[152] The writer avoided using five cases based on legal arguments about the prescription of time periods, except in chapter five[153] where the prescription period may have impacted on constitutional rights. Although some cases were not particularly relevant to the use of the maxim, they were mentioned to show the difference between the English and South African legal systems, for example that lack of informed consent is a cause of action in its own right in England and in South Africa it falls under the element of wrongfulness and is justification for an otherwise wrongful act. Additionally, the writer obtained 82 cases from the Lloyds Report database, of which some overlap but 29 cases were cited because it applied the requirements of the maxim. The writer referred to 39 cases in less detail and discussed 11 in more detail, based on the *res ipsa loquitur* maxim. Several cases were mentioned and the medical reality discussed in which the maxim was not applied in the actual court case. It was done to illustrate the particular argument. In general, minimal reference is made to non-medical cases, as the core of the thesis lies in the misinterpretation of medical clinical facts by the legal profession and judiciary when arriving at a legal conclusion. No reference is made to cases of product liability, as this would introduce a different element to the argument. The *res ipsa loquitur* maxim assumes fault whereas strict liability dispenses with it. As an allowance, the case of *Wagener v Pharmacare* is discussed briefly, as the facts of the case are relevant to medical negligence rather than product liability.

As mentioned before, the purpose of the thesis is to understand the medical reality of each case. The set medical standard is determined from the medical profession in both South African and English cases. The standard delivered by the defendant is then assessed before venturing into an analysis of legal principles and reasoning. This is done because the grounds for liability in medical negligence context in South African delictual law are established against the delictual elements ie wrongfulness, negligence and causation. Although it may

[151]It is not the objective of this study to venture fully and comprehensively into complicated medical facts and inferences, but only to use medical explanations as illustrations that are sufficient to support its arguments.
[152]These included a plastic surgery case about keloid formation after surgery and a case about ineffective anaesthesia that led to a patient being aware of the surgical process during surgery.
[153]Chapter 5 para 3.4

seem to be unnecessary from an English point of view to determine causation and negligence because of the wider application of concepts like lack of skill and care and the assistance of the maxim to extract an answer in rebuttal from the defendant, in South African legal context the medical reality is crucial to understanding the application of all the delictual elements. Therefore, the particular medical information of each case was considered from the summaries of the case but it was investigated in detail against the accepted medical standard at the time of the case which was obtained from internationally published medical literature. This is done to understand the legal arguments and to determine the manner in which the court accepted elements like negligence and causation. Taking the above into consideration a possible limitation of the chapter discussing English cases is that detailed medical expert reports presented to the courts were not available. The writer relied on legal summaries of the cases that included a legal summary of the medical evidence. The writer was assisted by a medical expert in determining the true medical reality of each case. Therefore, there is a possibility that the medical arguments expressed in each court case may differ from the medical reality interpreted by the thesis. All things considered; this did not restrict the legal arguments of the thesis, since the principles in medical science are globally recognised. Furthermore, considering that the primary goal of the thesis is to learn from English experience and not to criticise or review the English cases, the medical reality revealed the difference between the legal systems and that the *res ipsa loquitur* doctrine developed along different lines in England (and Wales) than it did in South Africa. The research findings are consistent with the current stance of the South African court. Therefore, reliability of the results correlates with the reasoning of the South African court regarding the requirements and application of the maxim. The validity and cogency of the research is based on the supportive medical arguments obtained from a panel of international renowned medical experts, so to speak ie medical publications, which highlighted the erroneous legal reasoning in cases where the maxim is applied without the proper support of medical expert evidence in South African medical law.

7 Significance of the study

The maxim *res ipsa loquitur* has been the source of global legal research for centuries and several academic works on the subject have been published. This is, however, the first study that the author is aware of that has as its aim the analysis of the medical clinical aspects and interpretation in the context of the use of the maxim *res ipsa loquitur* in medical negligence

litigation in South Africa. The thesis will contribute to the understanding and appreciation of the medical realities on which factual causation and negligence (both *culpa* and fault) are based, and will explain why the application of the maxim *res ipsa loquitur* is incommensurable with medical negligence cases in South African law. The thesis states that, a failure to establish the medical standard with the assistance of medical expert evidence results in a misinterpretation of medical clinical evidence in general. In accordance with delictual principles in South Africa a plaintiff is not assisted with the burden of proof when relying on the maxim. This differs from the arguments of Van den Heever and Carstens who argue in favour of its use.[154] The argument, namely to use the maxim to uphold patients' rights cannot be sustained as a reverse onus on the defendant would be seen as prejudicial and lacking fair and just administrative justice principles. It is suggested that the South African court should consider a judicial shift to an inquisitorial civil justice approach as regards medical law, similar to developments in the United Kingdom where the changes to civil litigation principles[155] have allowed for greater judicial involvement in managing trials. South Africa can learn from English cases like *Thomas v Curley*[156] where the usefulness of the maxim was disputed and where the adversarial approach was still evident with distinct opposing views and arguments. South Africa has followed in the tracks of the English court where the judicial relaxation of the rules on causation was noticeable in *Chester v Afshar*[157] to protect the patient's right to autonomy. But change in the English system does not come unhindered: the latter stance of the English court was criticised. It was suggested that the decision should be confined to its very specific context, as not only does it cast doubt on the proper approach to causation, but it also appears to undermine the hitherto accepted test in relation to a breach of duty in cases of informed consent.[158] Unlike South Africa, an English claimant may bring a case on aspects of a breach of duty based on a lack of advice or incorrect diagnosis or inadequate treatment based on insufficient warning of risks or lack of skill and care.[159]

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[154]Van den Heever & Carstens (n 31) 150. The authors submit that the maxim should be invoked in the context of a patient's right to the highest attainable standard of health, since it is an effective legal mechanism to understand whether an attending doctor has discharged his legal duty to the patient.

[155]Civil Procedure Rules and Practice Direction.

[156]*Thomas v Curley* (n 142), where the usefulness of the *res ipsa loquitur* maxim was disputed and, in addition, the case was argued on the interpretation of the medical facts to clarify factual causation. See the discussion in chapter 3 para 9.3.

[157]*Chester v Afshar* (n 17), discussed in chapter 2 paras 6.3; 9.5.

[158]Ibid, as reported on by Angus Moon. The court was divided in this case as the decision was based on the claimant's subjective evidence; she stated that had she been warned about the complications, she would have reacted differently.

[159]*Chester v Afshar* (n 17), discussed in chapter 2 paras 6.3; 9.5.

8 Overview of the chapters

Chapter 1

This chapter was a general overview of the legal principles relevant to the function and application of the *res ipsa loquitur* maxim in South Africa. It touches on opposing legal opinions regarding the effectiveness and use of the maxim and also raises questions about the mechanism of the maxim. It also initiates an investigation into the possibility of using the maxim to assist a patient to court based on patient's rights, alternatively, an investigation into how the interests of patients in the doctor-patient relationship can best be served. It sets out to explain the reason for the descriptive title and also explains that medical reality is foremost in making inferences from which legal conclusions can be drawn. This chapter lists inconsistencies in respect of the application of the *res ipsa loquitur* maxim in a medical negligence context and a possible confusion between a presumption of fact and a legal presumption. This leads to the rationale for the thesis and a synopsis of the disputed notions under investigation. The background to the thesis gives the reasons for the choice of legal system and explains some of the substantive and procedural aspects relevant to the *res ipsa loquitur* maxim. The writer explains the method used to obtain the study material, the writer's approach to the aim of the thesis, and certain limitations. Finally, the proposed significance of the thesis is described.

Chapter 2

The purpose of chapter 2 is to provide an overview of the law of delict applicable to medical law, in addition to the different presumptions in the law of evidence that govern the *res ipsa loquitur* maxim. Medical negligence cases and the fundamental legal principles in South African law are discussed. The chapter addresses the historical legal influences on the South African legal system and the background to the development and status of the *res ipsa loquitur* maxim in South Africa. The chapter discusses all the delictual elements required to satisfy a court concerning the liability of a defendant in a medical negligence case. It aims to clarify the confusion between factual presumptions and legal presumptions and what constitutes *prima facie* evidence. It illustrates that it would be unwise to use a presumption of fact presuming it has qualities of a presumption of law when negligent conduct is demonstrated. A summary of the legal principles relevant to medical law is provided as a background to the application of the *res ipsa loquitur* maxim. The medical aspects of several

cases are discussed to illustrate how the South African court determines delictual liability by evaluating whether the standard of care delivered by the defendant was according to the expected medical standard of care. The chapter investigates how patient's rights, based on human dignity and bodily integrity, have influenced recent Constitutional Court decisions.

Chapter 3

Chapter 3 begins with a summary of the principles of the law of tort in England and a brief outline of the difference between the law of tort in England and the law of delict in South Africa. It continues with an analysis of the relevant aspects of the application of the *res ipsa loquitur* maxim in the English court. The chapter discusses several cases and the medical components of the cases. The medical reality is established from the medical literature which sets the acceptable international standard of care for the medical profession. In this context the function of the maxim is analysed. The chapter addresses the extended use of the maxim in *Ratcliffe v Plymouth & Torbay Health Authority*.[160]The chapter ends with a discussion of several cases, for example, *Lillywhite v University College London Hospital's NHS Trust*[161]and an observation that the change in the application of the maxim has brought about more careful and thorough case preparation in English medical cases. The chapter explores human rights jurisprudence and the awareness of patient rights in England and Wales and their influence on judicial perceptions of the scope of the duty of care in medical negligence cases.

Chapter 4

Chapter 4 introduces the medical component of the thesis by discussing the medical clinical diagnostic process that leads to medical interpretation and medical reasoning which specifies the standard of medical service delivery. This chapter creates the legal nexus between the medical interpretation of facts, medical cause and effect, and factual causation. The chapter demonstrates that medical cause and effect (aetiology and pathogenesis) emphasise different aspects to guide the medical professional through the diagnostic process of medicine to arrive at a medical conclusion regarding the cause of the injury or disease. The difference between medical expert opinion and factual causation from which legal conclusions are drawn is

[160]*Ratcliffe* (n 83), discussed in chapter 3 para 7.
[161]*Lillywhite* (n 141), discussed in chapter 3 para 9.1.

investigated. The chapter discusses risks and complications, the learning curve and the medical use of statistics. Several cases are used to demonstrate the difficulty of determining the medical reality from which factual causation is determined. The case of *Van Wyk v Lewis*[162] is reconstructed and discussed in medical and legal context, and cases like *Ntsele*[163] and *Buthelezi v Ndaba* are examined[164] to demonstrate the medical standard of care in relation to the medical reality of the case that is needed to establish factual causation and negligent conduct.

Chapter 5

This chapter summarises the position of the *res ipsa loquitur* maxim in South Africa and England. It gives an overview of the basic findings and conclusions, as well as the differences between the legal systems. The chapter addresses the impact of the state's lack of resources on the element of wrongfulness and how this limits the convictions of the community regarding constitutional rights. The legal questions, highlighted in chapter 1 regarding the burden of proof and the presumption of fact, as opposed to a presumption of law in cases where the *res ipsa loquitur* maxim applies, are explained. The difference between vague words like relative evidence and absolute evidence in medical negligence context is explained. The difference between *ordinary facts* and *medical facts,* in the context of inferring negligence, is demonstrated as it is the design of the *res ipsa loquitur* maxim. The chapter concludes that an occurrence of an adverse kind, in medical negligence cases, does not have meaning for the uninformed person without medical expert evidence that describes the standard of care that can be expected and whether the defendant-doctor acted within that set standard. It is the interpretation and explanation of the medical reality. The chapter closes with a discussion of patient's rights and the right to dignity. It takes a closer look at why the medical and legal systems are not serving the best interests of plaintiffs and offers suggestions on how to balance conflicting interests.

[162]*Van Wyk* (n 33), discussed in chapter 2 para 3 and 8.
[163]*Ntsele* (n 119), discussed in chapter 4 para 8.1.
[164]*Buthelezi* (n 147), discussed in chapter 4 para 8.2.

CHAPTER 2: AN OVERVIEW OF THE LAW OF DELICT RELEVANT TO MEDICAL NEGLIGENCE AND THE RES IPSA LOQUITUR MAXIM IN SOUTH AFRICA

1 Introduction

As indicated before, the thesis proposes that the classic *res ipsa loquitur* maxim is insufficient in design and function to be of any use in medical negligence cases, which are complex by nature. Some explanation is necessary, at the outset, for addressing in this chapter the delictual principles and related jurisprudence in greater detail. It is essential to take into account the elements of the law of delict and the purpose of each element as they are inherent in the application of the *res ipsa loquitur* maxim.

Therefore, this chapter has five aims. First, it seeks to provide a brief background to the law of delict and historic influences on the South African legal system. The jurisprudence of South African medical law originates from Roman-Dutch law[1] and English law, and is based on precedent that expands statutory law[2] and, as such, develops the common law. Common law changes incrementally and every country develops its own over time. South Africa has a 'rule of law', which is a fundamental aspect of any constitutional democracy. If constitutional values and rights are properly interpreted, protected and applied, the South African courts are able to correct previous wrongs and prevent future transgressions.

Second, this chapter explains the place of the maxim in the law of delict. The law of delict and the law of contract in medical law are categorised under private law. The law of evidence regulates the admissibility of certain legal presumptions and inferences and hence influences the *res ipsa loquitur* maxim. The *res ipsa loquitur* maxim, if applied correctly, creates a factual presumption that is not a rule of law but simply an inference from the facts

[1]Voet 47 1 1 and Grotius 3 32 7.

[2]Case law is the law created by the judiciary when deciding individual disputes in cases, and the doctrine of judicial precedent (*stare decisis*) is applicable. Medical law in South Africa is governed by, inter alia, the Constitution of South Africa, 1996, which contains the Bill of Rights; the National Health Act 61 of 2003 and Regulations, which form a framework for a structured uniform health system; the National Core Standards, published in 2011 by the Department of Health; the Health Professions Act 56 of 1974 and Regulations, which control the health professions; the Health Professions Council of South Africa, which provides Ethical Rules and Guidelines (like Undesirable Business Practice); the Pharmacy Act 53 of 1974, which controls the pharmaceutical business; the Medicines and Related Substances Control Act 101 of 1965; the South African Nursing Act 33 of 2005 and Regulations, which control the nursing profession; the Consumer Protection Act 68 of 2008; and the common law.

of the case when no direct evidence is available.[3] Delictual liability is proved when the elements[4] of wrongfulness, negligence, causation and resulting damage have been satisfied.

Third, the elements of delict are discussed in detail but in a particular order, so as to be meaningful in medical negligence cases, as the focus of the thesis is distinctly medical law. The function of civil actions is to compensate plaintiffs for their losses based on a breach of a legal duty owed to the plaintiff. The legal duty of the medical professional is obvious from the doctor–patient relationship and it is an obligation not to cause harm other than what is necessary to treat the patient, provided that the patient gave his consent. From a practical point of view, the investigation into a possible medical negligence case will start with an investigation into the element of wrongfulness. The delictual element of wrongfulness (unlawful conduct) is discussed in the context of the legal duty[5] owed to the plaintiff. The element of fault in the form of negligence (*culpa)* is then discussed to introduce its test and application.[6] In most cases of medical negligence, the standard of care that was delivered is under scrutiny and the conduct of the medical professional is tested against the reasonable conduct expected with reference to the convictions of society and the profession. Medical scientific evidence is presented to the court by medical experts as an explanation of how, in fact, the damage occurred. A successful delictual claim depends on proving the causal link

[3]PJ Schwikkard & SE van der Merwe *Beginsels van die Bewysreg* (2009) 549. The authors explain that factual presumption is not a rule of law but is simply based on common sense: a '*toelaatbare afleiding wat gemaak kan word indien dit met die bewese feite strook*'. The authors refer to *Steenberg v De Kaap Timber (Pty) Ltd* 1992 (2) SA 169 (A). See CWH Schmidt *Bewysreg* 3 ed (1989) 149.

[4]See paras 4.1, 4.2 and 4.3 below for a discussion of the elements in delict.

[5]There is a difference between a legal duty as contemplated in the element of wrongfulness in South Africa and a duty of care as described by English courts. See *Steenkamp NO v Provincial Tender Board Eastern Cape* 2006 (3) SA 151 (SCA). A legal duty does not naturally exist between legal parties and should be established from the relationship between the parties. See A Fagan 'A duty without distinction' *Acta Juridica* (2000) 49. The author provides a clear distinction between the English 'duty of care' and the legal duty referred to in South Africa. He explains the nature of the two duties. In England the duty lies in performing the act carefully, whereas in South Africa the legal duty is simply to refrain from performing an act. A further difference is found in the breach of the duty: while England refers to 'careless conduct' as the breach, in South Africa a legal duty can be breached by innocent conduct. Fagan refers to *Administrateur, Natal v Trust Bank Bpk* 1979 (3) SA 824 (A), where the court acknowledges similarities between a legal duty and a duty of care, and *Bayer South Africa v Frost* 1991 (4) SA 559 (A), where the court stated that there must be a legal duty to take reasonable steps to avoid harm. This was also confirmed in *Mukheiber v Raath* 1999 (3) SA 1065 (SCA). In *Mkhatswa v Minister of Defence* 2000 (1) SA 1104 (SCA) the court stated that negligence is the failure to comply with the standards of a reasonable person and that negligence is the starting point to determine liability. In *Telematrix (Pty) Ltd t/a Matrix Vehicle Tracking v Advertising Standards Authority SA* 2006 (1) SA 461 (SCA) para 14, Harms JA warns that reference to a 'legal duty' as the criterion for wrongfulness should not be confused with the 'duty of care' in English law, as the latter comprises the elements of wrongfulness and negligence. He refers to *Administrateur, Natal v Trust Bank van Africa Bpk* (above in this note) 833D–834A, where Rumpff CJ stated that the 'duty of care' is ''n onding in ons gemenereg', and *Steenkamp NO v Provincial Tender Board, Eastern Cape* (above in this note) 159H–I, where the court states that the 'constant use of the phrase duty of care is unfortunate as it is inherently misleading'.

[6]*Kruger v Coetzee* 1966 (2) SA 428 (A), where it was established that the test for negligence is based on the obligations of the *diligens paterfamilias*.

between a defendant's action and the harm suffered. Proving all the elements of a delict places a heavy burden of proof on an injured plaintiff, as he has to prove that the defendant-doctor was in breach of this legal duty and thus caused harm to the plaintiff. Most of the actions against the medical profession are for compensation based on personal injuries or death. The general principle in delict is that the plaintiff should be restored to the same position that he would have been in had it not been for the negligent act committed by the medical professional. Accordingly, this part of the chapter is concerned with what a plaintiff must prove to establish a *prima facie* case against a defendant. The chapter examines the approach of the academic writers, Van den Heever and Carstens[7] who advocate the use of the maxim in contrast to the decisive ruling of the South African court.

Fourth, this chapter provides an outline of medical negligence as a separate delict as well as a discussion of the *res ipsa loquitur* maxim and its current status in medical negligence law in South Africa. The previous chapter listed several disputed aspects[8] of the interpretation and use of the *res ipsa loquitur* maxim that inspired the decision to investigate the correct use of the maxim. It is important to note that for the application of the *res ipsa loquitur* maxim to be useful the factual presumption raised by the maxim must satisfy all the elements of a delict, even if inferences from the facts are implied.[9]The thesis investigates all the medical principles relevant to a medical negligence case, even if such a case did not rely on the maxim because, from a broader point of view, the fact of the injury or the undesired outcome of medical treatment can be perceived as a *res ipsa loquitur* case. The thesis statement proposes that the *res ipsa loquitur* maxim can function only under ordinary conditions, where the circumstances of the occurrence are part of the knowledge of the general public experiencing everyday life. Hence, from the available facts one can assume that negligence (culpable conduct) caused the harm. However, this is not the case for cases based on complex medical facts that do not form part of everyday life. Put differently, to raise a presumption of fact, which is the design of the maxim, the plaintiff must have sufficient understanding and evidence regarding the occurrence and the conduct of the defendant to claim that the facts speak of negligence ie *res ipsa loquitur*. At best, with sufficient evidence

[7]P van den Heever & P Carstens *Res Ipsa Loquitur and Medical Negligence* (2011).
[8]See chapter 1 para 3.4.
[9]DT Zeffert, AP Paizes & A St Q Skeen *The South African Law of Evidence* (2003) 168, where the authors say that a presumption of fact is nothing other than an 'inference of common sense, based upon what usually happens or is assumed to happen'. This definition was adopted by Bekker J in *Van den Bergh v Parity Insurance Co Ltd* 1966 (2) SA 621 (W) 623F, where the court said that the effect of a presumption of fact is that it does not influence the burden of proof; it forms part of the reasoning by which the court may decide whether the party who bears the onus has discharged it; and it can only affect the evidential burden of proof.

available in a medical negligence case an action based on an adverse event may be brought to court based on *prima facie* evidence that a legal duty not to harm was breached (the element of wrongfulness) but such an occurrence carries only a possibility that the conduct in question failed to comply with the necessary standard of care[10] and needs to be tested (the element of negligence). In the light of this reasoning this chapter investigates whether the maxim should be effectively excluded in medical negligence cases. This chapter aims to illustrate why the South African courts do not follow the example of the English courts, which see the maxim as a tool that enables a claimant who has no knowledge, or insufficient knowledge, of how the accident occurred to rely on the accident itself, thereby preventing a defendant from avoiding responsibility by not giving evidence.[11] A further objective that emerges later is showing that, despite the perceived notion that the maxim is a reliable tool in England the English Court of Appeal confirmed that the maxim has no use when there is evidence of how and why the result occurred in the presence of disagreeing medical experts.[12]

Fifth, this chapter considers whether upholding constitutional and particularly patient's rights may involve a wider application of the *res ipsa loquitur* maxim or a wider application of strict delictual principles[13] based on the substantive legal approach presently found in South Africa.[14]

2 Influences on the South African legal system

Before the time of Justinian, the *actio iniuriarum* had been a general remedy for any wrongful aggression upon the person, dignity or reputation of another.[15] Roman[16] influence

[10]M Loubser et al *The Law of Delict in South Africa* (2012) 133.
[11]*Mahon v Osborne* [1939] 2 KB 14 at 50, per Goddard LJ stating that the surgeon is in command of the operation and the patient knows nothing about it. If a swab is left behind the surgeon must be called to explain: *Barkway v South Wales Transport Co. Ltd* [1950] 1All ER 392.
[12]*Delaney v Southmead Health Authority* (1992), [1995] 6 Med LR 355 and *Thomas v Curley* [2013] EWCA Civ 117.See chapter 3 para 9.3.
[13]*Lee v Minister for Correctional Services* [2012] ZACC 30; 2013 (2) SA 144 (CC), where the Constitutional Court overturned the ruling of the Supreme Court of Appeal and safeguarded the rights of detainees. The implications were that factual causation principles were applied in a wider and more flexible manner. The majority judgment stated that the 'but for' test in factual causation should be developed in accordance with the spirit, purport and objects of the Bill of Rights contained in the Constitution of South Africa, 1996. See also *City Council of Pretoria v Walker* 1998 (3) BCLR 257 (CC), where the aspects of substantive approach was established.
[14]LWH Ackermann 'The legal nature of the South African constitutional revolution' (2004) *NZLR* 633–679. The author describes the change in substantive law (not procedural law); especially regarding the transformation that is taking place in South Africa. The focus of transformation is on equality and on correcting the wrongs of the past by promoting the achievement of equality and to protect and advance persons and categories of persons, previously disadvantaged by unfair discrimination.
[15]Digesta 47 10 1 2.

developed the delict of *damnuminiuris datum*, ie wrongs against the person. The wrongs were corrected with specific monetary penalties that benefited the victim. Although the Romans were under no general obligation to ensure that others did not experience material loss, they were required to 'act with care' in circumstances where their actions may cause damage.[17] The nature of the doctor and patient relationship, in medical law, is based on the *Lex Aquilia* and is tested against negligent medical conduct.[18] The civil obligations even in Roman times were that 'man must bear the damage he suffers' (*res perit domino*).[19] From *res perit domino* developed the delictual liability of modern times, namely, that loss to the owner can be shifted to the party who caused such loss. The Romans believed that one must take reasonable care to avoid acts that one can reasonably foresee will injure one's neighbour.[20] They defined negligence as a wrongful action contrary to one's duty of care that caused harm to another.[21] The duty was always a negative one – to avoid causing injury to others. Furthermore, the Romans required that a person must have been guilty of either *dolus* (wilful conduct) or *culpa* (negligent conduct) to be liable. If the person did not act in accordance with the civil obligations expected of a citizen of Rome he would be held responsible in law. The responsibility would be to compensate the victim for damages sustained in the form of pecuniary loss.[22] The term *dolus,* in Aquilian liability, meant a 'wilful and conscious

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[16]A Mason 'The standards of care and the Lex Aquilia' (2002), availableathttp://www.roman-empire.net/articles/article-021.html (accessed 14 June 2014). The Roman history of the principle of *iniuria* can be traced as far back as the Twelve Tables. The *Lex Aquilia*, which describes *damnum iniuria datum*, dates from 287 BC.

[17]Grotius *Inleidinge tot die Hollandse Rechtsgeleerdheid* 3 32 12; Johannes Voet *Commentarius as Pandectas* 9 2 12; R Zimmerman *The Law of Obligations: Roman Foundations of the Civilian Tradition* (1990) 953 and 393ff (legal remedies in Roman times were founded on negligence and/or contract); FH Lawson *Negligence in the Civil Law* (1950) 4; BW Frier *A Casebook on the Roman Law of Delict* (1989) 11. These remedies can be compared to provisions in the Babylonian Laws of Hammurabi, the Hittite Laws and the Hebrew Laws contained in the Pentateuch: see Lawson (n 17) 5. The relation to earlier legislation, and what preceded the *Lex Aquilia*, remains uncertain, yet literary and juristic texts supply a few references to the Twelve Tables.

[18]Frier (n 17) 39.

[19]C Asser *Handleiding tot de beoefening van het Nederlands Burgerlijk Recht: Verbintenissenrecht* (1994) 9 part III at 12 '*in beginsel moet iederde door hem zelf geleden schade dragen*'. But Aquilian liability provides for an exception to the rule if the plaintiff can prove the damage was caused by an act or omission that was wrongful and negligent.

[20]In the English case of *Donoghue v Stevenson* [1932] AC 562 at 580, Lord Atkins states that it becomes a law that 'you must not injure your neighbour'.

[21]The *Lex Aquilia* itself mentions only special causes of damage, which were further extended to injury to freemen (slaves that were set free). See Digesta 9 2 8 Gaius 7 ad ed. provinc. From the translation of the Digesta, also Ulpianus on the Edict Book XVIII: Ulpianus recognised a contract of service, for example, where a doctor unskilfully operated on a slave.

[22]This was extended to include a loss because of injury to a freeman. Fault was a necessary element of liability on the part of the offender. In order for the defendant to be guilty, the plaintiff has to establish that a right of the plaintiff was invaded and that the loss was attributed to the defendant who failed to exercise reasonable care.

wrongdoing'.[23] It involved three elements: an intentional act, knowledge that the act will cause harm to the plaintiff, and a duty to refrain from committing the act.[24] In an Aquilian action, *culpa*, according to Paul in the Digesta,[25] is 'not to foresee what a reasonable man would have foreseen'.[26] In addition, lack of professional skill, lack of capacity, lack of knowledge and general incompetence relative to the standards that were expected of a person giving a service were incorporated in the rule *imperitia culpae adnumeratur*.[27] This approach accords with the stance in modern times that the ignorance or incompetence of a professional person who presents himself as having a certain level of expertise will be regarded as negligent conduct.[28]

During the seventeenth century, Dutch settlers, who referred to Roman law in Dutch legal writings,[29] introduced Roman-Dutch law to South Africa. The 1580 *Ordonantie op't stuk van de Justitie binnen de steden en ten platte landen van Holland en West Friesland*[30] later determined the civil procedural law in South Africa.[31] In Roman and Roman-Dutch law, where patrimonial damage was caused by an *injuria,* the remedy available to the plaintiff was an action based on the *actio iniuriarum* for the insult inflicted, as well as an action based on the Aquilian action to recover compensation for the patrimonial loss sustained.[32] The plaintiff must prove that the act complained of caused him *damnum,* ie patrimonial loss. This should not be confused with an action for pain and suffering.[33]

[23]RG McKerron *The Law of Delict* (1971) 47, referring to Dernburg.
[24]For a further qualification, see the definition by the American author, OW Holmes, in *Common Law* (1881) 53. He states that foresight is not enough and intent or the wish for the consequences to take place will qualify as a motive for *dolus,* rendering *dolus* not relevant to medical negligence cases, as no reasonable medical professional would intentionally harm his patient.
[25]Digesta 9 2 31.
[26]Lawson (n 17) 36–43. The author distinguishes whether *culpa* is subjective or objective in Roman law.
[27]The phrase is described in Digesta 50 17 32 and Justinian Inst Just 4 3 7; see also PA Carstens & DL Pearmain *Foundational Principles of South African Medical Law* (2007) 613. According to these authors, ignorance or incompetence is regarded as negligence, ie the absence of professional skill and experience that are required and regulated by the medical profession.
[28]Carstens & Pearmain (n 27) 613–614, where it is suggested that a lack of skill and competence in cases where a certain skill is expected would be wrongful, and a person is further expected to foresee that lack of skill and competence will harm a patient, and as such he will be negligent.
[29]Grotius, Johannes Voet, Simon Groenewegen and Johannes van der Linden. De Groot defined the position in Roman-Dutch law that mere ignorance, lack of understanding and weakness are equal to guilt, for which the physician is liable. Also see Carstens & Pearmain (n 25) 616 on the role of the *imperitia* rule; a duty of care exists if the physician agrees to treat the patient.
[30]H R Hahlo & E Kahn *The South African Legal System and its Background* (1968) 477.
[31]Schmidt (1982) (n 3) 12.
[32]Digesta 9 2 5 1; 47 10 7 1; Voet 47 10 18; 2 13 14.
[33]In *Hoffa v S.A. Mutual Fire and General Insurance Co. Ltd.* 1965 (2) SA 944 (C) 951–952, Van Winsen J expressed the view that, although the Roman-Dutch writers favoured a claim for pain and suffering together with patrimonial loss, this does not mean that pain and suffering forms part of an Aquilian action, as it was unknown to Roman law. It was influenced by German and local Netherlandic custom. See McKerron (n 23) 51

In 1860 the Cape was annexed by the British. Although Roman-Dutch law remained in force English procedural law was adopted, which influenced the South African substantive law. The developments were largely based on English legislation and, when interpreting legal arguments, English precedents were used. As such, Roman-Dutch law acquired a distinct British influence.[34] Modern delictual law in South Africa has developed its Aquilian character to comprise, inter alia, damage that flows from unlawful competition and misrepresentation, damage that flows from damage to person and property, and damage indirectly caused to the plaintiff's property or person.[35]

3 The place of the *res ipsa loquitur* maxim in the law of delict

Substantive law, according to Salmond,[36] is that part of law that 'is concerned with the ends which the administration of justice seeks; procedural law deals with the means by which those ends are to be attained'. Schwikkard and Van der Merwe[37] explain that a factual basis is necessary to determine the rights, duties and liabilities that exist in terms of substantive law. Both substantive law and procedural law define rights and duties. Procedural law is the instrument to enforce the substantive law.[38] The law of evidence is aligned with the procedural law as part of 'that branch of the law which governs litigation'.[39] Private law, and more particularly the law of contract and the law of delict, dictates the relationship between the medical professional and his patient or between the hospital and the patient.[40] As the law of evidence is closely affiliated with procedural law, it defines, inter alia, the principles of onus of proof, evidence in general and judicial cognisance. It distinguishes between *prima*

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fn 40. It follows that, except in the case of an injury involving physical injury to a person or property, the plaintiff's only remedy will ordinarily be the *actio iniuriarum*.

[34]There is a clear departure from English law principles in several aspects of South African law not relevant to this study. See *R v Pillay* 1945 AD 653, regarding privilege in disclosure of information; *S v Lwane* 1966 2 SA 433 (A), regarding judges' rules and Rule Board for Rules of Court, in terms of the Supreme Courts Act 59 of 1959 (now the Superior Courts Act 10 of 2013), and regulations as published from time to time in *Government Gazette*.

[35]PJ Visser & JM Potgieter *Law of Damages* (1993) 32; JP Neethling, JM Potgieter & PJ Visser *The Law of Delict* (2006) 37: the *boni mores* or general reasonableness criterion is a juridical yardstick that describes the prevailing convictions of the community regarding right and wrong. It 'enables the court continuously to adapt the law to reflect the changing values of the community': JC van der Walt & JR Midgley *Principles of Delict* (2005) 46; Loubser et al (n 10) 224–233, where the authors refer to pure economic harm.

[36]JW Salmond *On Jurisprudence* (1966) para 128.

[37]PJ Schwikkard & SE van der Merwe *Principles of Evidence* (2002) 2.

[38]Ibid, where the authors explain that a factual basis, as seen from the law of contract, is necessary to establish the rights and obligations of the parties. The authors refer to *S v Thomo* 1969 (1) SA 385 (A) 394C–D.

[39]Salmond (n 36) para 128, referred to by Schmidt (1982) (n 3) 6.

[40]SA Strauss 'Medical Law - South Africa' in *International Encyclopaedia of Laws* (2006) 45–58.

facie evidence and conclusive evidence with its prerequisites. The *res ipsa loquitur* maxim is a presumption that asks the court to draw an inference from the facts. It is categorised under factual presumptions and should be separated from irrebuttable presumptions and rebuttable presumptions of law.[41] The *res ipsa loquitur* maxim merely creates a *presumption of fact*, ie an inference that places an evidential burden on the defendant (to refute the presumed fact). It is argued that, from an incorrect perception that the *res ipsa loquitur* maxim functions as a rebuttable presumption in law and not only as factual presumption, emerges the approach of certain authors that the court was misguided in the application of the maxim in *Van Wyk v Lewis*.[42]

There appears to be four interpretations of the maxim:

(i) the occurrence of the injury automatically denotes negligence, ie there is no chance of any defence, similar to the irrebuttable presumption of law: this is incorrect;

(ii) once the plaintiff shows the fact of the injury, ie an adverse event, the defendant must rebut negligence and has the burden of disproving conflicting evidence, failing which the court is asked to make a legal presumption ie similar to a reversed onus of proof: this is not correct;

(iii)(a) once the plaintiff shows the fact of the injury, ie an adverse event, the defendant must rebut negligence by offering any explanation that negates negligence, but he has no obligation to disprove the plaintiff's case, ie a factual presumption; the court should infer from the facts that the occurrence could not have happened without negligence (if this is not possible, the category changes to (iv) below): this is the version of the English court;

(iii)(b) once the plaintiff shows the fact of the injury with other key facts, the defendant must rebut negligence by offering any explanation that negates negligence, but he has no obligation to disprove the plaintiff's case, ie a factual presumption; the court should infer from the facts that the occurrence could not have happened without negligence and because this cannot be done reliably with a medical case the maxim does not apply: this is the version of the South African court;

[41] See para 5 below.
[42] 1924 AD 438. For a discussion of legal presumptions see para 8 below; for a discussion of presumptions in English law see chapter 3 para 3.

(iv) the fact of injury without other key facts raises the possibility of an implication of negligence, which requires the plaintiff to lead some evidence to prove his case as the formal burden of proof stays with the plaintiff, ie similar to *prima facie* evidence.

It should be noted that the interchangeable use of the phrase *res ipsa loquitur* with the phrase *prima facie* is the cause of some of the confusion. This thesis argues that the *res ipsa loquitur* maxim in South Africa falls under category (iii)(b) above, as it is only an inference drawn from factual evidence based on key facts within the ordinary experience of ordinary persons and not applicable to medical cases.

4 Concepts of delictual liability in general

Neethling et al[43] describe a delict as an 'act of a person that in a wrongful and culpable way causes harm to another'. Five essential elements for liability are identified: an act (*actus reus*),[44] that is unlawful or wrongful[45] (wrongfulness or unlawfulness), that was performed negligently (fault,[46] in particular *culpa*), and that was the direct cause[47] (the nexus between a wrongful act and harm is causation) of harm (damage) to the plaintiff.[48] In South Africa,[49] the elements to prove liability in general and in medical negligence cases are: (1) an act or a failure to act; (2) wrongfulness; (3) negligence; (4) causation; and (5) damage. These elements are of the same delict (wrongful act). Each element has its separate test and prerequisites. The above elements give rise to a delictual action based, for example, on medical negligence. For a plaintiff to prove liability against a defendant, all five elements must be proved. However, there is no onus upon a defendant to disprove the plaintiff's case until the plaintiff has established *prima facie* proof that his legal right has been negligently infringed.[50] A plaintiff's case will fail if a defendant refutes the *prima facie* evidence with an

[43]Neethling, Potgieter & Visser (2006) (n 35) 3; Van der Walt & Midgley (1997) (n 35) para 2.
[44]Neethling, Potgieter & Visser *The Law of Delict* (2010) 34, where they distinguish between a *commissio* (to act) and *omissio* (failure to act). See cases where an *omissio* was recognised: *Two Oceans Aquarium Trust v Kantey & Templer (Pty) Ltd* [2007] 1 All SA 240 (SCA) 244C–245F; *Hawekwa Youth Camp v Byrne* [2010] 2 All SA 312 (SCA) 321E.
[45]See para 4.1 below.
[46]The element of 'fault' is divided into *intent* and *negligence*. The latter is relevant for this study. See Neethling, Potgieter & Visser (2010) (n 44) 123 and Van der Walt & Midgley (1997) (n 35) para 103 for a discussion of the elements.
[47]See para 4.3 below.
[48]*Bredell v Pienaar* 1924 CPD 203, 209; *Judd v Mandela Bay Municipality* 2011 ZAECPEHC 4 at 3.
[49]*Cecilia Goliath v MEC for Health in the Province of Eastern Cape* [2014] ZASCA 182; 2015 (2) SA 97 (SCA).
[50]*Matthews v Young* 1922 AD 492 at 507: De Villiers JA explains that under the *Lex Aquilia* there is only an action for *damnum iniuria datum*, which is for pecuniary loss inflicted through a legal injury, and the defendant is not called to answer the plaintiff's case before the plaintiff has proved both the pecuniary loss and that it

alternative explanation that negates negligence. In medical law, when the plaintiff sustains physical damage, it is assumed that the damage is a wrongful act if there is not sufficient justification for the injury. A patient should be informed of the planned medical intervention and should consent to it. If not, it will be interpreted as a breach of a legal duty not to harm and would be *prima facie* evidence of wrongfulness (an element in delict).[51] The action must infringe a legally recognised right of the plaintiff[52] or constitute the breach of a legal duty owed to the plaintiff. In *Lillicrap, Wassenaar and Partners v Pilkington Brothers SA (Pty) Ltd*[53]the court held that 'the causing of damage to property or injury to the person' contains a general proposition that most delictual actions arising from damage to property and person are *prima facie* unlawful (wrongful). Any medical intervention with an adverse outcome (injury) is *prima facie* wrongful but it is not in itself proof of negligence (*culpa* and liability). The other elements of the delict, ie negligence, causation and damage, still need to be proved. The mere fact that a doctor acted negligently (in a culpable manner) does not mean that his conduct caused the harm. Additionally, the mere fact that the doctor caused the harm does not mean that the action was performed in a negligent manner.

Although personal injury and medical negligence function within the realm of 'damage to property and person', one has to take cognisance of the extended use of Aquilian liability by the court because it introduced further sub-rules to the elements of a delict. The extended use of Aquilian liability was evident from the judgment in *Union Government v National Bank of South Africa*, [54]where it was held that 'in our law Aquilian liability has long outgrown its earlier limitation to damages arising from physical damage or personal injury'.

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directly results from the *iniuria*. See *Country Cloud Trading CC v MEC, Department of Infrastructure Development* 2014 (2) SA 214 (SCA) para 20ff. Brand JA relied on *Santam Insurance Co v Vorster* 1973 (4) SA 764 (A) and *Telematrix (Pty) Ltd t/a Matrix Vehicle Tracking v Advertising Standards Authority SA* (n 5), emphasising that causing physical harm might be *prima facie* wrongful. See TJ Scott 'Aquiliese aanspreeklikheid vir suiwer ekonomiese verlies – die Hoogste Hof van Appel draai die sluise toe' (2014) 4 *TSAR* 681-689, where the author discusses *Country Cloud Trading CC v MEC, Department of Infrastructure Development* (above in this note) 214.

[51]FDJ Brand 'The contribution of Louis Harms in the sphere of Aquilian liability for pure economic loss' 2013 *THRHR* 57 and 60. The author highlights the fact that, when dealing with the negligent causation of pure economic loss, one should remember that the act or omission is not *prima facie* wrongful (as with physical damage to property or person) and that more is needed.

[52]Van der Walt & Midgley (n 35) para 60; see Brand JA in *Two Oceans Aquarium Trust v Kantey & Templer (Pty) Ltd* (n 44)paras 10–11.

[53]1985 (1) SA 475 (A) 497B, 498G–499A; see also *Fourway Haulage SA (Pty) Ltd v SA National Roads Agency Ltd* 2009 (2) SA 150 (SCA) paras 12 and 19, where it was shown that wrongfulness is the infringement of a duty owed to the plaintiff.

[54]1921 AD 121 at 128. This viewpoint accords with *Administrateur, Natal v Trust Bank Bpk* (n 5), where negligence misstatements caused pure economic loss.

This 'extended use' precipitated an academic debate, and a redefining and re-describing of the precise meaning of the element of *wrongfulness*[55]ensued. For practical purposes in medical negligence cases, each of the elements of delictual liability is independent of the others; therefore, the sequence of applying the elements, for example, to elevate negligence before wrongfulness or the other way round, has no bearing on the outcome. A case of a plaintiff will fail if any *one* of the elements was not proved. The fact that an act is negligent does not make it wrongful,[56] but also, the fact that an act is wrongful does not make it negligent. Nevertheless, it merits a proper understanding of the requirements of the different elements in delict.

4.1 Wrongfulness

As briefly discussed before, the element of wrongfulness is one of the key elements to determine delictual liability.[57] The notion of wrongfulness is described in medical negligence as a breach of a legal duty arising from the doctor and patient relationship. The doctor has a professional duty to use his skill, competence and experience to diagnose, treat and care for the patient.[58] The element of wrongfulness is rarely a difficult concept in medical law but the lively academic debate[59] regarding the status of the element of wrongfulness in delict, in cases

[55]*Telematrix (Pty) Ltd t/a Matrix Vehicle Tracking v Advertising Standards Authority SA* (n 5). Harms JA developed a 'new' test for wrongfulness by stating that 'conduct is wrongful if public policy considerations demand that in the circumstances the plaintiff has to be compensated for the loss caused by the negligent act or omission.' This adaptation of the test of wrongfulness caused mixed reaction and criticism. See, in TJ Scott & D Visser *Developing Delict – Essays in Honour of Robert Feenstra* (2000), the following essays: F du Bois 'Getting wrongfulness right: A Ciceronian attempt' 1; A Fagan 'A duty without distinction' (n 5) 49; and J Potgieter 'Gedagtes oor die rol van onregmatigheid'67. See also Neethling, Potgieter & Visser (2010) (n 44) 78; J Neethling & JM Potgieter 'Wrongfulness in delict: A response to Brand JA' 2014 *THRHR* 116; A Fagan 'Rethinking wrongfulness in the law of delict' (2005) 122 *SALJ* 90; J Neethling 'The conflation of wrongfulness and negligence: Is it always such a bad thing for the law of delict? (2006) 123 *SALJ* 204; J Neethling & JM Potgieter 'Wrongfulness and negligence in the law of delict: A Babylonian confusion' (2007) 70 *THRHR* 120; J Neethling and JM Potgieter 'Die toets vir nalatigheid onder die soeklig: *Sea Harvest Corporation (Pty) Ltd v Duncan Dock Cold Storage (Pty) Ltd* 2000 (1) SA 8 (SCA) THRHR 162; *Trustees, Two Oceans Aquarium Trust v Kantey & Templer (Pty) Ltd* (n 44) 144E–F; TJ Scott: in his comments on the cases of *Crown Chickens Pty Ltd t/a Rocklands Poultry v Rieck* 2007 (2) SA 118 (SCA) and *Shabalala v Metrorail* 2008 (3) SA 142 (SCA), the author refers to J Neethling, JM Potgieter & PJ Visser *Law of Delict* (2010) 39–40, 117, 141–144; Van der Walt & Midgley (2005) 67, 71, 155, 166; NJ van der Merwe & PJJ Olivier *Die Onregmatige Daad in die Suid-Afrikaanse Reg* (1989) 51, 73 fn 62, 111 fn 91, 131; PQR Boberg *The Law of Delict I – Aquilian Liability* (1984) 33–34, 268.

[56]*Indac Electronics (Pty) Ltd v Volkskas Bank Ltd* [1991] ZASCA 190, 1992 (1) SA 783 (A) 793I–J; *Minister of Safety and Security v Van Duivenboden* 2002 (6) SA 431 (SCA) para 12.

[57]*Lillicrap* (n 53) 496I–497A.

[58]*Buls v Tsatsarolakis* 1976 (2) SA 891 (T) 893.

[59]Conduct that would not be wrongful if negligent may be wrongful if intentional. See *Roux v Hattingh* 2012 (6) SA 428 (SCA) para 38ff. On this topic see F du Bois (ed) *Wille's Principles of South African Law* (2007) 1187; Fagan (n 55) 90; Scott & Visser (n 55); Neethling, Potgieter & Visser (2010) (n 44) 78; J Neethling & JM Potgieter 'Wrongfulness in delict: A response to Brand JA' (2014) THRHR 116; J Neethling 'The conflation of

of pure economic loss, should be mentioned for the sake of completeness. However, the writer does not intend to enter the debate concerning the priority and sequence of these delictual elements.

4.1.1 Wrongfulness in general

The question of wrongfulness is relevant to the topic of this thesis: if we assume that the medical professional or hospital could have prevented the death of a plaintiff, but negligently failed to do so due to financial constraints, should they as a matter of public and legal policy be held liable for the loss of support that the dependents of the plaintiff suffered because of the harm?[60] Before one answers such a question one has to understand how the court interprets the issue of public policy and wrongfulness. In *Minister van Polisie v Ewels*,[61] Rumpff CJ authoritatively stated that harm is wrongful and actionable in delict only if the legal convictions of the community regard it as such. He defined the legal duty underpinning wrongfulness as the convictions of society, ie *boni mores*, which include a duty not to harm another. This new test for wrongfulness, ie the *boni mores* test, has since been widely accepted.[62] In *Administrateur, Natal v Trust Bank Bpk*[63]the court took a significant step in developing the law when it recognised a claim for recovery of damages for pure economic loss caused by a negligent misstatement. The law has since changed; now a bank may be liable to the true owner of a cheque that was collected negligently.[64] The court, subsequently, recognised other claims for pure economic loss.[65]

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wrongfulness and negligence: Is it always such a bad thing for the law of delict?' (2006) 123 *SALJ* 204; Neethling & Potgieter (2007) (n 55) 120; *Trustees, Two Oceans Aquarium Trust v Kantey & Templer (Pty) Ltd* (n 44) 144E–F; and Scott (n 55), in his comments on the cases of *Crown Chickens Pty Ltd t/a Rocklands Poultry v Rieck* (n 55) and *Shabalala v Metrorail* (n 55).

[60]*Hawekwa Youth Camp v Byrne* (n 44) para 25.

[61]1975 (3) SA 590 (A) 596F–597E.

[62]*Telematrix (Pty) Ltd t/a Matrix Vehicle Tracking v Advertising Standards Authority SA* (n 5). Harms JA refers to *Indac Electronics (Pty) Ltd v Volkskas Bank Ltd* (n 56) 797F–G and *Minister of Safety and Security v Duivenboden* (n 56) para 21: the law recognises the existence of a legal duty in circumstances where public policy considerations require it. See also *Marais v Richard* 1981 (1) SA 1157 (A) 1168; *Schultz v Butt* 1986 (3) SA 667 (A) 679; *Administrateur v Van der Merwe* 1994 ZASCA 83; 1994 (4) SA 347 (A) 358, 361G; *Wingaardt v Grobler* 2010 (6) SA 148 (ECG); *Carmichele v Minister of Safety and Security* 2001 (1) SA 489 (SCA) 494B; and *Van Eeden v Minister of Safety and Security* 2003 (1) SA 389 (SCA) 359H–396B.

[63]*Administrateur, Natal v Trust Bank Bpk* (n 5), where negligent misstatements caused pure economic loss.

[64]In *Indac Electronics (Pty) Ltd v Volkskas Bank Ltd* (n 56) the matter was decided on exception.

[65]*Delphisure Group Insurance Brokers Cape (Pty) Ltd v Dippenaar* 2010 (5) SA 499 (SCA); *Fourway Haulage SA (Pty) Ltd v National Roads Agency Limited* (n 53).

Several phrases describe the nature of the *boni mores* test, including the 'legal convictions of the community' and 'general criteria of reasonableness'. In *Administrateur, Natal v Trust Bank Bpk*, [66]Rumpff AJ stated that a legal duty (in the context of wrongfulness) should be a device of judicial control over the area of actionable negligence on the grounds of policy. The *boni mores* or general reasonableness criterion is a juridical yardstick that describes the prevailing convictions of the community regarding right and wrong. It 'enables the court continuously to adapt the law to reflect the changing values of the community'.[67] Brand JA in *Two Oceans Aquarium Trust v Kantey & Templer (Pty) Ltd*[68]assumed that the element of negligence should be established prior to determining wrongfulness when he said 'negligent conduct giving rise to damages is, however, not actionable per se. It is only actionable if the law recognises it as wrongful'. He confirmed that, where a person performs a positive act and causes physical damage to the property or person of another, such an act would, *prima facie*, be wrongful.[69] From the above it becomes obvious that the element of wrongfulness is not easily accepted with reference to liability for negligent omissions and for negligent cause of pure economic loss.[70] It seems that one cannot ascribe a legal duty to *any person* for purposes of delictual liability; it must be a recognised wrong. In *Telematrix (Pty) Ltd t/a Matrix Vehicle Tracking v Advertising Standards Authority SA*,[71]Harms AJ clarified that, when dealing with the negligent causation of pure economic loss, one should remember that the act or omission is not *prima facie* wrongful, and the breach of a legal duty is needed.[72] He confirmed that policy considerations must show that the plaintiff should be entitled to compensation, unless it is a case of *prima facie* wrongfulness, such as where the loss was due to damage caused to the person or property. It has been shown that negligently causing pure economic loss is generally not wrongful, but some exceptions to this rule have been created.[73] While the material under discussion may be perceived as too arcane, the

[66]*Administrateur, Natal v Trust Bank Bpk* (n 5) 833C–D.
[67]Neethling, Potgieter & Visser (2006) (n 35) 37.
[68]*Two Oceans Aquarium Trust v Kantey & Templer (Pty) Ltd* (n 44) paras 10–11.
[69] Ibid.
[70]*Two Oceans Aquarium Trust v Kantey & Templer (Pty) Ltd* (n 44) para 10. See *Minister of Safety and Security v Van Duivenboden* (n 56) para 12; and *Gouda Boerdery BK v Transnet* 2005 (5) SA 40 (SCA) para 12: these cases aver that wrongfulness depends on a legal duty not to act negligently. The imposition of such a legal duty is a matter of judicial determination involving criteria of public or legal policy consistent with constitutional norms: see *Administrateur, Natal v Trust Bank Bpk* (n 5).
[71]*Telematrix (Pty) Ltd t/a Matrix Vehicle Tracking v Advertising Standards Authority SA* (n 5) para 13. Harms AJ refers with regard to policy consideration to *Lillicrap* (n 53) para 501G–H.
[72]*BOE Bank Ltd v Ries* 2002 (2) SA 39 (SCA) paras 12–13.
[73]*Greenfield Engineering Works (Pty) Ltd v NKR Construction (Pty) Ltd* 1978 (4) SA 901 (N); J Neethling, JM Potgieter & TJ Scott *Casebook on the Law of Delict/Vonnisbundel oor die Deliktereg* (2013) 696–697.See *Minister of Safety and Security v Van Duivenboden* (n 56) para 12, where it is said that wrongfulness depends on the existence of a legal duty not to act negligently. Also see JC Knobel 'Die volgorde waarin die delikselemente

relevance lies in the ensuing discussion below of *Soobramoney v Minister of Health (Kwazulu-Natal).*[74] The discussion shows how the court departed from the norms applicable to the test for wrongfulness. The plaintiff's claim for the right to medical treatment was declined because of a lack of available resources, thus limiting the individual's right to health services. This conflicts with the convictions of the *boni mores.* The thesis stated earlier that to invoke the *res ipsa loquitur* maxim in a medical case would be problematic because of the difficulty of drawing reliable inferences from the mere fact of an adverse medical outcome. The elements of negligence and factual causation are vague for a non-medical person. Furthermore, taking into account the complexities in determining the element of wrongfulness, the thesis further asserts that concluding that an act was wrongful involves the weighing of competing norms and interests, more particularly in a country faced with transformation where constitutional rights are foremost. The latter is too complex to fall within the ambit of the function of the maxim.

The *boni mores* test is an objective test regarding what the 'actual prevailing legal convictions' are and, in South Africa at present, where a court is obliged to enforce constitutional rights. The test does not depend on personal views.[75] The legal convictions should be worthy of legal protection and should be informed by the values and norms of a society, as is embodied in the Bill of Rights.[76] The plaintiff must persuade the court to regard the action of the defendant as wrongful in delict and therefore actionable. The court, in determining wrongfulness, takes heed of the established common law and, if no similar cases exist, decides whether it would be reasonable to determine that the conduct of the defendant was wrongful under the circumstances. In *Loureiro and Others v iMvula Quality Protection (Pty) Ltd*[77] the court held that–

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onregmatigheid en skuld bepaal moet word' 2008 *THRHR* 1. He concedes that sometimes one may test for negligence before wrongfulness, but opines that with a proper understanding of the elements, wrongfulness, in principle, is always a prerequisite of fault. See Scott in his comments on *Shabalala v Metrorail* (n 55) 160.

[74]1997 ZACC 17; 1998 (1) SA 765 (CC); 1997 (12) BCLR 1696.The question that the court faced was whether section 27(1)(a), the right to have access to health care services, was violated. It seems that judicial reasoning about section 27 may influence wrongfulness in delict.

[75]*Cape Town Municipality v Bakkerud* 2000 (3) SA 1049 (SCA) 1057B–C.

[76]See *Loureiro and Other v iMvula Quality Protection (Pty) Ltd* 2014 (3) SA 394 (SCA) 404H–405A regarding the well-established principle that the law of delict and the law of contract give effect to and provide remedies for violations of constitutional rights. See *Steenkamp NO v Provincial Tender Board, Eastern Cape* (n 5) para 19, where it was argued that the fact that the element of wrongfulness is challenged effectively transforms it into a constitutional issue. See Neethling, Potgieter & Visser (2010) (n 44) 21.

[77]*Loureiro and Other v iMvula Quality Protection (Pty) Ltd* (n 76) 410B–D.

> [t]he wrongfulness enquiry focuses on the conduct and goes to whether the policy and legal convictions of the community, constitutionally understood, regard it as acceptable. It is based on the duty not to cause harm – indeed to respect rights – and questions the reasonableness of imposing liability.

The Constitutional Court, in *Le Roux v Dey*,[78] endorsed the following criteria for wrongfulness: (a) a judicial determination of whether, assuming all the other elements of delictual liability to be present, it would be reasonable to impose liability on a defendant for the damages flowing from a specific conduct; (b) the judicial determination of reasonableness would in turn depend on considerations of public and legal policy in accordance with constitutional norms. The court clarified that reasonableness, in the context of wrongfulness, has nothing to do with reasonableness in the context of negligence (the reasonable conduct of a defendant). Reasonableness in the context of wrongfulness is the reasonableness of imposing liability on the defendant for the harm resulting from his conduct.[79] Conduct is wrongful if it infringes a legally recognised right[80] or constitutes the breach of a legal duty to the plaintiff.[81] Since *Minister van Polisie v Ewels*, [82]it was generally accepted that, in delictual cases, an omission (failure to take action) might constitute wrongful conduct in circumstances where the legal convictions of the community impose a legal duty to prevent harm.[83] Prior conduct that creates a situation that is harmful to another, which is then not prevented, will be

[78]2011 (3) SA 274 (CC) 315.
[79]In *Minister van Polisie v Ewels* (n 61) the court introduced a question, viz 'whether it would be reasonable to impose liability of the defendant', as an additional test for wrongfulness, which was reiterated by *Crown Chickens (Pty) Ltd t/a Rocklands Poultry v Rieck* (n 55) 122. The 'reasonableness' consideration in addition to wrongfulness was strongly criticised by Neethling, Potgieter & Visser (2010) (n 44) 83–86. See Scott (n 55) in his comments on the cases of *Crown Chickens Pty Ltd t/a Rocklands Poultry v Rieck* (n 55) and *Shabalala v Metrorail* (n 55).
[80]See Neethling, Potgieter & Visser (2010) (n 44) 50 for different rights.
[81]Van der Walt & Midgley (1997) (n 35) para 60.
[82]*Minister van Polisie v Ewels* (n 61) 596H–597G where the court employed the element of wrongfulness as means of regulating liability in the cases of omission; confirmed in *Butters v Cape Town Municipality* 1993 (3) SA 521 (C) 528; confirmed in *Cape Town Municipality v Bakkerud* (n 75) 1056E–H, where it was held that ethical obligations become legal duties when 'the legal convictions of the community demand that the omission ought to be regarded as unlawful'. The court also confirmed that prior conduct is not a prerequisite for liability for an omission; it is merely a factor that could indicate a legal duty to prevent harm; again affirmed in *Minister of Safety and Security v Van Duivenboden* (n 56).
[83]*Minister of Law and Order v Kadir* 1994 ZASCA 138; 1995 (1) SA 303 (SCA) 317C–318A; *Van Eeden v Minister of Safety and Security* (n 62); *Dudley Lee v The Minister of Correctional Services* (n 13), where the Constitutional Court decided against the Minister of Correctional Services. The plaintiff contracted tuberculosis in prison because of the failure of the state correctional facilities to prevent the spread of the disease. See Van der Walt & Midgley (1997) (n 35) para 74, stating that 'a breach of a statutory duty, or negligent exercise of statutory power, may give rise to a claim for compensation either in terms of the statute itself, or according to general delictual principles'.

interpreted as an omission to act in accordance with a legal duty.[84] It is understandable that the court should test the reasonableness of assigning a legal duty to a defendant under circumstances where unlawful conduct can cause harm. Fagan and Scott[85] have opposite viewpoints regarding whether the element of wrongfulness should be determined prior to the element of negligence. They also alert us to the discourse of academic writers where it is proposed that the reasonableness test for wrongfulness which forms part of the element of wrongfulness (the *boni mores* test) should be executed *ex post facto*, ie 'with hindsight', as opposed to the *ex ante facto* approach of the *diligens paterfamilias* test, ie 'with foresight'.[86] Interestingly, one sees that the 'reasonableness' concept has found its way to the element of non-remoteness of damage (legal causation) as well.[87]

Seen in context, the approach followed in medical negligence is that the legal duty expected of the medical professional is to act with skill and competence, in accordance with accepted standards of care, in the best interests of the patient (*boni mores*), and not to cause harm – other than harm that is justified in terms of information provided to the patient and the consent[88] furnished by the patient in respect of a particular medical procedure. Usually, the element of wrongfulness is determined before the question of fault or negligence, because a medical professional should first obtain 'informed consent'[89] from his patient before

[84]Neethling, Potgieter & Visser (2010) (n 44)58.
[85]Fagan (n 55) 90; Scott & Visser (n 55); Neethling, Potgieter & Visser (2010) (n 44) 78; Neethling & Potgieter (2014) (n 59) 116; Neethling 'The conflation of wrongfulness and negligence' (n 55) 204; Neethling & Potgieter (2010) (n 44) 120; *Trustees, Two Oceans Aquarium Trust v Kantey & Templer (Pty) Ltd* (n 44) 144E–F; Scott (n 55), in his comments on the cases of *Crown Chickens Pty Ltd t/a Rocklands Poultry v Rieck* and *Shabalala v Metrorail* (n 55). Scott refers to Neethling, Potgieter & Visser (n 44)39–40ff; Van der Walt & Midgley (n 35) 67ff; Van der Merwe & Olivier (n 55) 51ff; Boberg (n 55) 33–34ff.
[86]Neethling, Potgieter & Visser (2010) (n 44) 39–40ff; Van der Walt & Midgley (n 35) 67ff; Van der Merwe & Olivier (1989) (n 55) 51ff; Boberg (n 55) 33–34ff.
[87]See para 4.3 below.
[88]Patient autonomy as a fundamental right has been endorsed and medical paternalism rejected. See FFW van Oosten *The doctrine of informed consent in medical law* (unpublished LLD dissertation, Unisa 1989) 12–13, 414. This was confirmed by the decision of Ackermann J in *Castell v De Greeff* 1994 (4) SA 408 p 426 stating that we need to adopt the stance of the Australian court:
It is in accord with the fundamental right of individual autonomy and self-determination to which South African law is moving. The formulation also sets its face against paternalism, from many other species whereof South Africa is now turning away. It is in accord with developments in common law countries like Canada, the United States of America and Australia, as well as judicial views on the continent of Europe.
The court referred to the High Court of Australia decision of *Rogers v Whitaker* (1992) 109 ALR 625; [1993] 4 Med LR 79, where it was accepted that, although accepted medical practice may set the standard, it is for the court to determine whether the defendant's conduct conforms to the standard of reasonable care.
[89]Informed consent is a prerequisite and justification to make an otherwise wrongful act lawful. Informed consent serves as a defence against allegations of assault and unlawful action in context of medical negligence cases. See FFW van Oosten 'Informed consent: A patient's right and the doctor's duty of disclosure in South Africa' in *Medicine and Law* (1989) 443–456; NJB Claassen & T Verschoor *Medical Negligence in South Africa* (1992) 62–63; SA Strauss *Doctor, Patient and the Law: Selection of Practical Issues* (1991) 3, 46, 70ff; Boberg (n 55) 751; Van der Merwe & Olivier (1989) (n 55) 107ff. For justification in the medical context, see FFW van Oosten 'Medical law: South Africa' in *International Encyclopaedia of Laws* (ed R Blanpain) 'Patient

performing a surgical operation or other medical intervention. If the medical professional failed to obtain the necessary consent, an operation would be unjustified and unlawful (wrongful),[90] except in emergency situations. For obvious reasons, 'consent to bodily harm' is relevant only to the medical profession, as in the hands of a non-medical person such an operation would be criminal in nature.

In the course of presenting medical evidence in a medical case, the reasonable test for wrongfulness may pose difficulties where the accepted standard dictated by the medical profession and the *boni mores* are in harmony, but both conflict with the applicable selection criteria of the South African health system and the developed common law. In *Soobramoney v Minister of Health (Kwazulu-Natal),*[91] the selection criteria of the health system, because of insufficient resources, were legal grounds for judicial discretion[92] to interfere with individual legal rights, contrary to the expectations of the *boni mores*. The Constitutional Court was faced with a set of facts where the 'universal' constitutional right to medical treatment was challenged by an under-resourced health care system. The plaintiff suffered from terminal ischaemic heart disease and cerebro-vascular disease. His kidneys failed in 1996 and his condition was diagnosed as irreversible. In order to overcome chronic renal failure he sought regular renal dialysis from the health care system. Because of its limited resources, the health care system had adopted a set of guidelines for dialysis treatment. The guidelines stipulate that only patients who fulfilled the following conditions will be treated: the condition of the prospective patient must be curable within a short period of time, and the patient must be eligible for a kidney transplant. It was common cause that the life of the plaintiff could be

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rights: A status report on the Republic of South Africa' (1996) 997; SA Strauss & MJ Strydom *Die Suid-Afrikaanse Geneeskundige Reg* (1967) 223–224.

[90]Informed consent should not be *contra boni mores*, ie against the legal convictions of the community. Informed consent is obtained if the patient fully understands and appreciates the options, risks, complications and proposed outcome of a procedure. For example, to insert cancerous cells into a person for medical research purposes may be seen as *contra boni mores*, even if medical scientific principles may allow it or even if a person consented to it. At present, euthanasia (the intentional ending of a life) is unlawful in South Africa yet allowed in Belgium. Dutch law, however, does not use the term 'euthanasia' but includes it under the broader definition of 'assisted suicide and termination of life on request'. See http://www.schreeuwomleven.nl/abortus/textofdutcheuthanasialaw.doc (accessed 12 May 2015). See also Euthanasia in the Netherlands:http://www.patientsrightscouncil.org/site/wp-content/uploads/2012/03/Netherlands_Ministry_of_Justice_FAQ_Euthanasia_2010.pdf (accessed 12 May 2015). In addition, to use unregistered medication on people for research purposes without complying with research ethics would be wrongful even if informed consent was obtained.

[91]*Soobramoney v Minister of Health* (n 74).

[92]Ibid.

prolonged but his condition could not be reversed. Furthermore, the plaintiff was not eligible for a kidney transplant because of his heart condition.

The plaintiff based his legal action on s 27(3) (the right 'not to be refused emergency treatment') and s 11 ('everyone has the right to life') of the Constitution.[93] The court found that the medical condition of the plaintiff did not qualify as an emergency, as an emergency was described as a 'sudden catastrophe'. The medical condition of the plaintiff was classified as a chronic condition. The court found that the right to emergency medical treatment was independent of and could not be inferred from the right to life and section 27 of the Constitution deals with health care rights in the context of available health care services. The court found that the criteria used by the hospital to decide 'who shall live when not everyone can' were reasonable and were fairly applied. The court explained that the plaintiff, Mr Soobramoney, had to be given all the benefits that everyone else received and there were several others in his situation. The limited resources of the state cannot deal with the full burden, and therefore he was declined as a patient. In this context the standards were set in accordance with the availability of renal dialysis services and resources, and not the patient's rights. The court cautioned that these executive policies should be challenged, if found to be unreasonable. The jurisprudence of the concept of the *boni mores* of South African society was thus judicially adapted. Any future plaintiff who was refused health care services has to bear in mind that part of the burden of proving wrongfulness would be the available resources of the state.

4.1.2 The element of wrongfulness and informed consent

As previously discussed, the medical professional has to obtain the consent of the patient before performing any medical intervention. The issue of 'informed consent' relates only to the element of wrongfulness. If the medical professional acted without the full consent of his patient, the element of wrongfulness would have been established. However, the other elements in delict must still be established for a plaintiff to be successful with his case. The issue of 'informed consent' as part of the element of wrongfulness in medical law in South Africa warrants a discussion as it differs from the use in England (and Wales). The English court goes one step further and in some instances allows an action in the form of the tort of battery, where a surgeon performs an operation without the consent of the patient even

[93]The Constitution of South Africa, 1996.

though his intention is to benefit the patient.[94] The English court regards non-disclosure of information (lack of consent to medical treatment) as one of the aspects of the law of tort ie failure to provide adequate warning or advice and inadequate communication. Failure to inform is based on the principle of patient autonomy and the right of the patient to decide whether he is prepared to accept the risk of an operation. A claimant may be successful in his case if he alleges that the defendant failed to disclose material information.[95] Informed consent, as an aspect of giving advice, includes a warning about or an explanation of the material risks and complications of the planned medical intervention. In South Africa, informed consent forms part of the element of wrongfulness. The following case is used to illustrate the complexity of alleging lack of informed consent in South Africa. The court avoided addressing the element of wrongfulness (and informed consent) and ascertained that the plaintiff failed to prove the element of negligence; therefore, the court did not have to decide on the element of wrongfulness. The case also shows the difficulty of understanding the medical reality.

In a recent South African case, *Sibisi NO v Maitin*,[96] the High Court dismissed the plaintiff's action but granted her leave to appeal. The Supreme Court of Appeal was asked to exercise its power to extend the common law. It seems that the reasoning of the English court above may have influenced the request of the South African plaintiff to plead her right to informed consent as the only remaining basis for her appeal. The South African Supreme Court of Appeal was asked to determine a case on the basis that the outcome would have been different had the plaintiff been granted her right to self-regulation, ie patient autonomy. The plaintiff's appeal relied principally on her right to have been informed about the risk of a vaginal delivery, given the estimated size and actual weight of the baby. In addition, the plaintiff's appeal asked whether, had a reasonable patient been given the information about the risk of vaginal delivery in such a case, the plaintiff would have agreed to a vaginal

[94]*Collins v Wilcock* [1984] 3 All ER 374 at 377. The tort of battery is any unwanted act. The act is the trespass (the touching). It must be intentional 'the actual infliction of unlawful force on another person' even if the intention is to benefit and not to cause harm. Consent to treatment exculpates the doctor in context of the doctor–patient relationship.

[95]*Afshar v Chester* [2004] All ER (HL) 24. The claimant appealed to the House of Lords and argued that the doctor failed to warn her about a serious risk of nerve injury: *cauda equina* damage. The injury that she sustained became the product of the very risk that she was not warned about. The case was based on a legal and professional duty to exercise reasonable care and skill in examining her, in assessing her case, in warning her of any risks, in operating on her, and in supervising her care after the surgery. The court found that the doctor discharged his duties except for his failure to warn the claimant about the risks of the operation. See the discussion in chapter 3 paras 2; 6.3 and 9.5.

[96][2014] ZASCA 156.

delivery or elected for a caesarean section. This argument is similar to the argument about informed consent in the English court above.

The facts of the case were as follows: Mrs Sibisi, a teacher by profession, sued Dr Maitin, an obstetrician and gynaecologist, for damages. The action was based on the alleged negligent conduct of the defendant that caused young Yandiswa to develop Erb's palsy (paralysis of the shoulder as a result of injury to the brachial plexus, a network of nerve fibres in the shoulder) during birth. The plaintiff had consulted the defendant since the birth of her first child in January 2001. That delivery was normal, although the plaintiff had suffered from hypertension (high blood pressure) during that pregnancy. The weight of her first baby was 2.9 kg. Her second pregnancy, in 2005, ended with a miscarriage. The plaintiff became pregnant for the third time in 2005. The date for the expected delivery was 7 January 2006. On 9 January 2006, the plaintiff consulted with the defendant, who estimated the weight of the infant to be 4 kg. The baby was regarded as a large baby by any standard.

The plaintiff was admitted to hospital at 16h17 the same afternoon, and it was agreed that labour would be induced. At 17h55 Prandin Gel (induction medication) was inserted vaginally to induce labour. At 22h30 a Pethidine injection was administered. A CTG (a cardiotocography which monitors the impact of the maternal contractions on the foetal heartbeat) was performed at 02h00 the following day. At 04h00 the further use of Prandin Gel was advised by the defendant when the cervix of the plaintiff was found to be dilated only 2 cm. At 06h10 the plaintiff was in great pain and an anaesthetist was called to administer an epidural at 06h20. At 07h00 moderate decelerations (a slowdown of the heartbeat of the foetus) were noted on the CTG. The defendant was notified. He advised them to initiate Pitocin (a hormone administered intravenously that stimulates contractions of the uterus) at 08h25. At 08h30 the cervix of the plaintiff was 5 cm dilated and Pitocin was not administered due to the deceleration of the foetal heart rate at 09h00. At 09h25 the defendant ordered a further dose of Pitocin. At 10h00 the midwife administered oxygen to assist the distressed baby. At 11h00 the cervix of the plaintiff was 8 cm dilated with no decelerations in the foetal heartbeat noted. At 11h30 the midwife noticed blood in the amniotic fluid and at 12h30 a pelvic examination revealed that the cervix of the plaintiff was fully dilated. It was noted that the foetal head was 3/5 above the pelvic rim. The defendant was summoned and arrived at hospital at 13h00. At 13h18 the defendant attached a vacuum extractor to the baby's head and performed an episiotomy. The defendant noted that the anterior shoulder of the baby was stuck. The defendant tried the McRoberts manoeuvre (a position to flatten the

maternal sacrum). Finally, the baby was delivered and was bagged with an ambu-bag, as she had an Apgar of 4/10 (a measurement of the appearance, pulse, grimace, activity and respiration of the infant 5 and 10 minutes after birth). The defendant requested the services of a paediatrician, a certain Dr K, who attended the infant.

The pleadings averred that the defendant failed to monitor the plaintiff adequately when she was in labour; failed to perform a clinical examination to estimate the size of the baby; failed to perform an ultrasound for that purpose; failed to notice that the baby was large and that he should have performed a caesarean section; failed to assist the plaintiff in giving birth in a manner that was safe for her and the baby; failed to notice the presence of shoulder dystocia which necessitated the performance of a caesarean section; failed to warn her of the possible consequences of a vaginal delivery of a large baby; induced labour when it was neither safe nor necessary; failed to perform the vacuum extraction procedure properly; and failed to prevent injury to the baby by exercising due skill and care.

The Supreme Court of Appeal dealt with the delictual elements in a preferred sequence by addressing the element of negligence before the element of wrongfulness. With regard to the element of negligence and therefore foreseeability, the plaintiff stated that the defendant should have foreseen the risks of vaginal delivery, given the size of the baby. The criterion of informed consent (wrongfulness) was described in more detail at this late stage; in the court *a quo* it had been only referred to as the defendant had failed to warn the plaintiff about the risk of proceeding with a vaginal delivery. The further allegations followed in the Supreme Court of Appeal, namely, a duty to warn her about the material risks and complications that might result from the vaginal delivery, and a duty to inform her about the specific alternative procedures that might minimise the risks.

The Supreme Court of Appeal *per* Lewis JA noted that the plaintiff did not make an allegation about the fact that she had a right to be informed of any risk that was significant or that she would have regarded as significant. The defendant argued that the risks referred to, assumed to be brachial plexus injury of the infant, were not sufficiently material for him to have been under a duty to warn her. In the court *a quo,* Penzhorn AJ held that there was no need to develop the common law in order to recognise a patient's autonomy and right to bodily integrity in making an informed decision as to whether to proceed with one course of action rather than another, ie in this instance to be advised of the risks of vaginal and caesarean section delivery respectively. The Supreme Court of Appeal avoided addressing the elements of wrongfulness and informed consent and found the defendant not negligent. The

Supreme Court of Appeal concluded that there was no reason why the defendant could have foreseen that the baby would present with shoulder dystocia. The Supreme Court of Appeal found that the reasonable obstetrician would have been in the same position as the defendant and would not have foreseen the possibility of shoulder dystocia. The plaintiff did not discharge the onus of proof and the court stated that if there is no negligence found, then the element of 'wrongfulness does not even arise'.

The plaintiff argued that the common law should be extended to recognise that the test for whether a patient had given informed consent should be whether the reasonable patient, given the information about the risk of vaginal delivery in such a case, would have agreed to it or would have chosen a caesarean section. The court should be guided by medical opinion as to what a reasonable doctor would have told the patient under these circumstances, but the court 'must, of course, make up its own mind'.[97] The 'reasonable doctor' test was challenged in *Sibisi NO v Maitin*[98] on the basis that the 'reasonable doctor' test leaves 'the determination of a legal duty to the judgment of doctors appointed in their own cause'. It was argued that the test should be based on the right to self-determination entrenched in the Constitution and should be about the 'reasonable patient'. The 'reasonable patient' test was previously discussed in *Castell v De Greef*,[99] *per* Ackermann J, who followed the approach of the High Court of Australia in the case of *Rogers v Whitaker*.[100] In *Castell v De Greef* Ackermann J advised that 'for a patient's consent to constitute justification that excludes the wrongfulness of medical treatment and its consequences', the doctor is obliged to warn a patient so consenting of a material risk inherent in the proposed treatment. The court held that a risk would be material if, in the circumstances of the particular case: '(a) a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it; or (b) the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it'. From the above information Lewis JA, in *Sibisi NO v Maitin*[101] concluded that the question of informed consent applies to the wrongfulness element of the Aquilian action. If the patient did not give consent the conduct of the defendant would not be justified and would be wrongful. The court confirmed that negligence is also a requirement, and if no negligence is proved, the test for wrongfulness

[97] *Richter v Estate Hamman* 1976 (3) SA 226 (C) 232G–H.
[98] *Sibisi* (n 96) para 47.
[99] *Castell v De Greeff* (n 88) 426–H.
[100] *Rogers v Whitaker* (n 88), where English and Canadian cases were considered.
[101] *Sibisi* (n 96) para 50.

does not even arise.[102] The court thereby followed the decision in *Le Roux v Dey*[103] that, since the plaintiff failed to prove that the defendant was negligent, the court did not find it necessary to determine which test should be adopted in relation to informed consent (as part of the element of wrongfulness).

To return to *Sibisi NO v Maitin*[104]in context of the thesis, the medical information should have described the medical reality from which factual causation is derived. In a case relying on the *res ipsa loquitur* maxim, the following discussion of the medical facts would have been overlooked. For example, Zamorski et al[105] explain that macrosomia (large baby) is difficult to predict, but it is associated with an increased risk of trauma to the baby or the birth canal of the mother and the need for a caesarean section. The risk of an unnecessary elective caesarean section should be weighed against the serious risk of the delivery of a macrosomic (large) infant with shoulder dystocia and subsequent brachial plexus injury or asphyxia (lack of oxygen) and subsequent brain damage. When considering the patient's obstetric history, the lack of progress during labour, the inadequacy of foetus–pelvic disproportion (the foetal head was 3/5 above the pelvic rim) and the distress of the baby, it would have been unwise for the defendant to proceed with inducing an already slow process and then persist with a vacuum extraction in the presence of a large infant. The plaintiff should have been advised that the vaginal delivery is attempted as a first option and, should the labour not progress as expected, the trial labour has failed and the caesarean section delivery is indicated.

Medical literature indicates that the plaintiff had several risk factors that should have alerted the defendant to possible complications during labour. It was the plaintiff's third pregnancy and she had previously had a normal delivery, which should signify an expected normal labour without any delay. The defendant is not faulted for his decision to attempt a trial labour period. However, he is faulted for not abandoning the trial labour period when it was evident that labour did not proceed as expected. The plaintiff was in labour for 19 hours,

[102]See *Nicola McDonald v Dr Graham Wroe* (2006) 3 All SA 565 (C), where the court held that the onus of proving a lack of informed consent lies with the plaintiff. The full bench accordingly reaffirmed causation as an element deeply entrenched in our law of delict. A patient/plaintiff who intends relying on lack of informed consent bears the onus to prove on a balance of probabilities that (i) the medical practitioner was negligent in that he failed to warn his patient of the particular risk or complication; and (ii) the medical practitioner's negligent omission as such caused the damages suffered.

[103]*Le Roux v Dey* (n 78) 315, where the court held that wrongfulness depends on a judicial determination that it would be reasonable to impose liability on the defendant *assuming all the other elements of delictual liability to be present.*

[104]*Sibisi* (n 96).

[105]MA Zamorski & W Biggs 'Management of suspected fetal macrosomia' (2001) 63(2) *Am Fam. Physician* 302–307.

despite being artificially induced. The defendant acknowledged that he knew that African women tend to have narrow and small pelvises. He should have been aware that the baby revealed foetal distress symptoms, although the symptoms were alleviated when oxygen was administered. The most important sign of an imminent complication was the fact that the head of the foetus remained high in the pelvic rim at a time when the cervix was fully dilated. The foetus–pelvic disproportion[106] was evident as soon as the foetal head was 3/5 above the pelvic rim. This was the last reasonable chance for performing a caesarean section. Despite the disproportionate foetus–pelvic ratio, where the head of the foetus did not advance naturally into the pelvic rim (a clear indication that the trial labour is failing), the defendant still did not consider an alternative course of action, ie a caesarean section. He persisted with a vacuum extraction, deliberately forcing the head of the foetus through the narrow pelvic rim and through the birth canal. By doing so, he lost the window of opportunity to prevent injury to the baby by means of a caesarean section. The defendant created one of the most frightening emergencies in the delivery room, ie shoulder dystocia, by artificially forcing the baby through the canal when all the facts pointed to the contrary action. The result– struggling to release the shoulder –was indeed an emergency. However, the emergency was as a direct consequence of the defendant's actions during the vacuum extraction. The defendant used excessive force to get the head into the pelvic rim and thereby damaged the brachial plexus and caused the shoulder injury. This is a known complication from pulling down on the head of the infant.[107]

As discussed previously, it is widely accepted that any harm caused intentionally or negligently is not necessarily actionable, since it must be wrongful as well.[108]It is not necessary to plead 'unlawfulness' or that an action was wrongful, but the facts pleaded should be a clear indication of wrongfulness.[109] The fact that an action is negligent does not

[106]D Maharaj 'Assessing cephalopelvic disproportion: Back to the basics' CME Review Article (2010) 65(6) *Obstetrical & Gynaecological Survey*.
[107]EG Baxley & RW Gobbo 'Shoulder dystocia' (2004) 69 (7) *Am Fam. Physician* 1707–1714.Similarly, prophylactic caesarean delivery is not recommended as a means of preventing morbidity in pregnancies in which foetal macrosomia is suspected. [SOR evidence level C, expert opinion based on cost-effectiveness analysis.] Analytic decision models have estimated that 2345 caesarean deliveries, at a cost of nearly $5 million annually, would be needed to prevent one permanent brachial plexus injury among babies born to women without diabetes who had foetuses suspected of weighing more than 4000 g. In the subgroup of pregnant women with diabetes, the frequency of shoulder dystocia, brachial plexus palsy and caesarean delivery was higher, leading the authors to conclude that a policy of elective caesarean delivery in this group potentially may have greater merit. [SOR evidence level C, expert opinion based on cost-effectiveness analysis.] Available at http://www.aafp.org/afp/2004/0401/p1707.html (accessed 2 January 2015). It is astonishing that anyone can consider cost-effectiveness as justification for not performing an elective caesarean section.
[108]*Cape Town Municipality v Paine* 1923 AD 207 at 216–217; see Burchell (n 108) 29.
[109]*Mabaso v Felix* 1981 (3) SA 865 (A) 874; see Burchell (n 108) 29.

make it wrongful per se.[110] Negligent conduct may result in damage (harm), however, it is not actionable if it is not recognised by law as wrongful conduct (unlawful conduct).[111]Considering the importance of constitutional rights in South Africa, one would expect that the principle of respect for patient autonomy and patient's rights would be primary in medical cases. Every human being has the right to determine what may be done to him, and his bodily, mental and physical integrity should be protected, as enshrined in the South African Constitution. From the detailed discussion of the above case it is clear that had the mother been informed about the risks and complications she would have opted for a caesarean section as preferred form of delivery. The defence of the medical professional that the patient gave his consent is derived from the Roman law principle *volenti non fit iniuria*[112]as justification for his action, but the consent must relate to the procedure that the doctor performs. It should be performed with reasonable care and skill[113] and should not exceed the consent given by the patient. Consent to the operation should also include consent to the risk of the operation or injury.[114] The duty to disclose information to the patient is widely established.[115] The consent from the patient should be voluntarily given, without undue influence and should display knowledge and understanding, ie informed consent.[116] The legal duty to disclose the necessary information rests with the medical professional, along with the legal duty not to cause harm.

4.2 Negligence

The thesis argues that a proper understanding of the element of negligence is disregarded in a case relying on the *res ipsa loquitur* maxim in medical negligence cases in the South African context. To demonstrate such a statement, the thesis intends to discuss the element of

[110]*Indac Electronics (Pty) Ltd v Volkskas Bank Ltd* (n 56) 793 and *Minister of Safety and Security v Van Duivenboden* (n 56) para 12.
[111]*Trustees, Two Oceans Aquarium Trust* v *Kantey & Templer (Pty) Ltd* (n 44).
[112]*Santam v Vorster* (n 50). See *Seti v South African Rail Commuter Corporation Ltd* [2013] ZAWCHC 109; *Esterhuizen v Administrator Transvaal* 1957 (3) SA 710 (T) 719 C–D; D Giesen 'From paternalism to self-determination to shared decision-making'1988 *Acta Juridica* 107; FFW van Oosten '*Castell v De Greef* and the doctrine of informed consent: Medical paternalism ousted in favour of patient autonomy' (1995) *De Jure* 166; also his Lordship Justice Diplock in *Woolridge v Sumner* 1963 2 QB 43. Originally the maxim stated a principle of estoppel applicable to a Roman citizen who consented to be sold as a slave.
[113]*Van Wyk* (n 42) 444; *Blyth v Van den Heever* 1980 (1) SA 191 (A) 221A; *Pringle v Administrator, Transvaal* 1990 (2) SA 379 (W) 384I–385E.
[114]De Groot 3 35 8 and Voet 27 10 4; see Loubser et al (2010) (n 10) 163.
[115]*S v Kiti* 1994 (1) SACR 14 (E); *Mtetwa v Administrator Natal* 1989 (3) SA 600 (D); *Administrator Natal v Edouard* 1990 (3) SA 581 (A).
[116]*Esterhuizen v Administrator Transvaal* 1957 (3) SA 710 (T) 719.

negligence in greater detail. As mentioned before, *iniuria*[117] implies the presence of either *dolus* or *culpa*; it refers to fault. The objective is to determine whether the defendant wilfully or carelessly caused the injury of the plaintiff and whether blame can be imputed to him if he failed to act according to the test of a reasonable person.[118]*Culpa*, in the form of negligence, means that the loss suffered by the plaintiff must be imputable to the defendant because of the conduct of the defendant. The defendant must have intended to unilaterally accept the risk on behalf of the patient or failed to prevent it by the exercise of reasonable care.[119] The element of negligence does not function in isolation and is one of the elements in delict that should be satisfied before liability can be ascribed to the defendant. A person will not be liable if negligence is proved without establishing the element of wrongfulness and the other elements of a delict.[120] A prerequisite for fault, often overlooked, is accountability. A person must be accountable for his actions, of sound mind, and be able to determine between right and wrong.[121]Accountability is important in medical cases because of its relevance to patient's rights and the right to autonomy, privacy and bodily integrity. An infringement of any of these rights will be actionable in law as it forms part of all the elements in delict and constitutional rights and a medical professional must protect the rights of his patient.

In 1917, in *Farmer v Robinson*,[122] Innes AJ held that *culpa* is a failure to 'exercise reasonable foresight' but not a 'failure to predict the future'.[123] Negligence is the failure to exercise that degree of care demanded by the circumstances.[124] In *Herschel v Mrupe*[125]the court decided that a reasonable person is neither an exceptionally 'gifted, careful or developed person; nor is he underdeveloped, nor is he someone who recklessly takes chances or who has no prudence'. A reasonable person 'serves as the *legal personification* of those qualities which the community expects from its members in their daily contact with another'.

[117]See para 2 above.
[118]See Roman law, Gaius Book III sections 210–211, concerning the careless or negligent action of the wrongdoer. (211) He is understood to have killed unlawfully who killed with malice (*dolus*) or negligence (*culpa*). There is no other law that considers damage without fault (*iniuria*). Consequently, he who damages without negligence and/or malice in a certain case remains unpunished. Available at http://faculty.cua.edu/pennington/law508/roman%20law/ GaiusInstitutesEnglish.htm (accessed 13 September 2014); see *Kruger v Coetzee* (n 9) 430E–F for a 'modern example' as opposed to Roman law.
[119]McKerron (n 23) 13.
[120]*Gouda Boerdery BK v Transnet* (n 70) 506H.
[121]*Weber v Santam* 1983 (1) SA 381 (A); *Eskom v Hendriks* 2005 (5) SA 503 (SCA); *S v Campher*1987 (1) SA 940 (A).
[122]1917 AD 501 at 522.
[123]At the time the English case *Donoghue v Stevenson* (n 20), Lord Atkin, directed that a duty involuntary assumed exists that 'you must not injure your neighbour' and that one should use ordinary skill and care to prevent harm to another
[124]*Cape Town Municipality v Paine* (n 108) 207 and 229ff.
[125]1954 (3) SA 464 (A) 490E–F.

The authoritative negligence test, formulated by Holmes AJ in *Kruger v Coetzee*, [126]had been constantly applied as the prescribed test, ie that which is expected of a *diligens paterfamilias*[127]who (a) would have reasonably foreseen the damage; and, if so, (b) would have taken reasonable precautions to prevent the harm; and (c) if he failed to do so, would be negligent.

Within the element of negligence, in *The Premier of the Western Cape v Loots*,[128] the court was confronted with the fact that the test for negligence seems to have an abstract character rather than a concrete or relative one. This case is about an unsuccessful sterilisation operation that resulted in a pregnancy. The woman experienced complications during the birth process and she was severely disabled. The court took the relative approach or a wider approach interpreting 'pregnancy as a dangerous condition associated with a myriad of potential complications'. In doing so, the court linked the negligent conduct of the doctor (not performing the sterilisation operation successfully) with the undesired outcome of pregnancy and in the end disability during the birth process. It is evident that some of the causal principles were relaxed and described as the relative test. The court followed the approach in *Mukheiber v Raath*[129] where the relative test was used. The court in the latter case indicated that, for the purpose of liability, *culpa* arises if: (a) a reasonable person in the position of the defendant would have foreseen harm of the general kind that actually occurred, would have foreseen the general kind of causal sequence by which that harm occurred, and would have taken steps to guard against it; and (b) the defendant failed to take those steps. In an earlier case, *Sea Harvest Corporation (Pty) Ltd v Duncan Dock Cold Storage (Pty) Ltd,*[130] the court recognised that a completely abstract approach would not always be appropriate and that the court should be flexible, as 'in the ultimate analysis the true criterion for determining negligence is whether in the particular circumstances the conduct complained of falls short of the standard of the reasonable person'.

[126]*Kruger v Coetzee* (n 6) 430E–F. In *Peri-Urban Areas Health Board v Munarin* 1965 (3) SA 367 (A), Holmes JA initially prescribed that a *diligens paterfamilias* would 'foresee the reasonable possibility of his conduct injuring another in his person or property and causing him patrimonial loss' and 'would take reasonable steps to guard against such occurrence' and that, if he failed to take such steps, he would be negligent. See Neethling, Potgieter, & Visser (2010) (n 44)131; Van der Walt & Midgley (n 35) para 116.
[127]Holmes JA, in *Peri-Urban Areas Health Board v Munarin* (n 126) 373, describes the *diligens paterfamilias* as that 'notional epitome of reasonable prudence'.
[128]*The Premier of Western Cape v Loots* [2011] ZASCA 32 para 13, where the court stated that it adopted the relative approach as a broad guideline, which requires that the general nature of the harm is looked at, as well as the general manner in which it was foreseen.
[129]*Mukheiber v Raath* (n 5) 1077.
[130]*Sea Harvest Corporation v Duncan Dock* (n 55).

Although the test may sometimes be applied in an abstract mode,[131] it is suggested that in medical law the test should accord with the relative approach, in order to give substance to patients' rights, ie setting right a perceived injustice to a patient.[132]This medical standard of care required may be abstract in describing the expected 'reasonable degree of skill and care'[133]if compared to the 'reasonable person' in ordinary civil society that has acquired certain skills.[134] However, the approach in medical law is that the standard is that of a reasonable medical professional with the same qualifications as a defendant-doctor placed in those particular circumstances. The degree to which a court will test foreseeability will be the risk that a reasonable medical professional with the same qualifications in the same circumstances would concretely have foreseen and guarded against. A situation may arise where a medical professional may encounter a rare medical condition or circumstances while operating, and because such a rare risk may not have been foreseen (in the eyes of the reasonable medical professional), the defendant-doctor would not be liable.

The determination of foreseeability may go beyond determining the element of *negligence* and may overlap with the element of legal causation (non-remoteness of damage). The nature of the injury that occurred, the remoteness thereof and the kind of risk contemplated and guarded against may have common characteristics,[135] but, in addition, it has to be reasonable[136] (in general) to impose liability on a defendant-doctor. To use an example where negligence impacts on legal causation, one may turn to the unreported case, *Rademeyer NO v Minister of Defence*. In this case, a young man, suffering from severe depression, was misdiagnosed with lymphoma (cancer in the lymph nodes and lymphatic system). He was asked to return to hospital to have the diagnosis confirmed by means of a biopsy within a week's time. When he returned after a week for the follow-up consultation and biopsy, the doctor was not available. No one attended to him. Apparently severely distraught, he overdosed on medication. Later that same day, he was admitted to an emergency clinic with serious breathing problems. The clinic transferred him to 1 Military

[131]*Groenewald v Groenewald* (n 131).
[132]A similar approach in seen in *Lee v Correctional Services* (n 13).
[133]*Mitchell v Dixon* 1914 AD 519, where the plaintiff was burnt by permanent waving appliances.
[134]Loubser et al (2012) (n 10) 133, where the authors state that sometimes a plaintiff cannot produce sufficient evidence of negligence but the matter at hand is in the knowledge of the defendant. In such an instance less evidence is necessary to make a *prima facie* case because, once the plaintiff has put forward all available evidence, the defendant bears an evidentiary burden to indicate that the conduct in question complied with the necessary standard of care.
[135]See para 4.3 below regarding causation and particularly regarding the interfacing of the foreseeability consideration of the element of *negligence* with that of legal causation (non-remoteness of damage).
[136]*Le Roux v Dey* (n 78) 315; see para 4.1 above.

Hospital. During the ensuing 24 hours, the medical condition of the semi-comatose patient was insufficiently managed, with insufficient resuscitation attempts and lack of follow-up medical treatment. He aspirated (breathing a foreign substance such as vomit into the lungs) and died of respiratory collapse.

The factual causation is found in the medical facts ie that the misdiagnosis of fast-spreading cancerous growth, not confirmed, served as a death sentence for a severely depressed patient. Following up with the patient and confirming the diagnosis of a dreaded disease was critical at the time. The overdose on psychiatric medication caused respiratory distress. Despite the patient being admitted in time to alleviate the respiratory emergency, 1 Military Hospital failed to use the window of opportunity to save the patient's life.

The claim was against the Minister of Defence for loss of support, since the Minister was the employer of the deceased at the time and vicariously liable for the medical professionals and personnel at the clinic and at 1 Military Hospital. The lack of proper and sufficient care caused and/or contributed to the death. Of significance is the fact that had the incident occurred in private practice, the same circumstances would have meant that the tests for foreseeability and legal causation (non-remoteness of damage) would have been closely related. The first doctor, with his misdiagnosis of lymphoma, should have foreseen that any patient would be devastated with an unconfirmed diagnosis of cancer and, further, should have foreseen that an untreated, severely depressed patient may become suicidal in the face of such a diagnosis. However, the first doctor could not have foreseen that the treatment at the hospital would fall short of reasonable expected and proper care. The treatment at the hospital that was substandard would have qualified as a *novus actus interveniens*, ie an independent intervening act that breaks the causal link between the cause and the consequences.[137] To this end, even where a defendant's conduct does not break the factual chain, it can still interrupt legal causation.[138]A court would ask the following questions: Was the harm reasonably foreseeable or did it form part of a reasonably foreseeable harm of a

[137]Boberg (n 55) 440–442; Neethling Potgieter & Visser (2010) (n 44) 189ff. See also *Smit v Abrahams* 1994 (4) SA 1 (A) 171; see the English case *Smith v Leech Brain & Co Ltd* 1962 2 QB 405, for the 'thin skull' rule where it is argued that the claim for damage is casted wider than the actual damage; in other words, the frailty of the victim is not a defence to limit the scope of liability for the defendant.

[138]*The Premier of the Western Cape Province v Loots* (n 128) para 19, where the court found that in order for conduct to qualify as a *novus actus interveniens* in the context of legal causation the plaintiff's conduct must be unreasonable. In this case the mother underwent a sterilisation process that failed. She fell pregnant and refused to have an abortion. During the caesarean section the mother developed an amniotic fluid embolism and sustained permanent brain damage. It was argued that the plaintiff's refusal to have the abortion was another factual cause of the same consequence and as such a *novus actus.* The court found that neither reasonable nor unreasonable conduct of the plaintiff can free the defendant from the imputation of liability.

general kind? Is the damage too remote? Such questions constitute a juridical enquiry as the foreseeability criterion in the context of legal causation is not the same as that of negligence. Foreseeability plays a role in determining both negligence and legal causation; however, the role of foreseeability with regard to fault (*culpa*) on the one hand and imputability of harm on the other hand is fundamentally different.[139] Legal convictions and policy considerations would also play a part in determining wrongfulness and the fairness of imposing liability on the defendant.[140] The approach of the court is usually based on a flexible approach,[141] where the court considered reasonableness, fairness and justice.

Although the standard of care expected is part of the *boni mores* and the legal convictions of the community, it is also dictated by the medical profession. A higher degree of care is expected in certain fields of expertise.[142] Lack of skill is seen as fault[143] and a doctor will be found negligent if he performs an operation knowing full well that he is not sufficiently qualified, skilled or experienced to perform such an operation.[144] In *Mitchell v Dixon*[145] it was held that a professional is expected to employ reasonable skill and care. 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'. The standard is not the highest possible degree of professional skill, but reasonable skill and care.[146]

Regarding conditions when precautionary action is significant, the court in *Herschel v Mrupe*[147] held that 'circumstances may be such that the risk of possible harm may be slight and the lack of seriousness may result in a situation where no precautionary action is taken, and then there can be no question of negligence'. In this regard, it is widely argued[148] that preventative action is indicated when there is a high likelihood of serious harm, the magnitude of which outweighs the cost of prevention and utility of conduct. If a medical professional performs an unnecessary delicate operation with a high risk of harm, he would be seen as exercising a lack of care. The seriousness of the operation, with possible risks and complications, should be discussed with the patient to obtain informed consent, as any

[139]*Sea Harvest Corporation v Duncan Dock* (n 55): see judgment paras 22, 23.
[140]*International Shipping Co (Pty) Ltd v Bentley* 1990 (1) SA 680 (A).
[141]See para 4.3 below for a discussion of legal causation.
[142]Neethling, Potgieter & Visser (2010) (n 44)139 fn 110.
[143]See para 2 above for the maxim *imperitia culpae adnumeratur.*
[144]Carstens & Pearmain (n 27) 613ff.
[145]*Mitchell v Dixon* (n 133) 525.
[146]*Mitchell v Dixon* (n 133) 525.
[147]*Herchel v Mrupe* (n 125) 477.
[148]Boberg (n 55) 333ff; Van der Walt & Midgley (n 35) 179.

medical intervention is not without risk (contained in the element of wrongfulness). The 'conduct'[149] of the professional (whether his action was reasonable) forms part of the element of negligence, [150]ie whether the defendant had foreseen and prevented the complication. It has no bearing on factual causation (the answer to the 'but for' question) or whether the defendant caused the harm. The failure to foresee and guard against the harm may be the cause of the harm in certain circumstances. In summary, the test for negligence has two aspects, foreseeability and preventability. Foreseeability is the degree of the risk emerging from the conduct and the gravity of the consequences, while preventability addresses the action and effectiveness of the conduct and the cost of the burden in preventing the harm.

In conclusion, when establishing the element of negligence the test is to determine whether the defendant could have anticipated the harmful event in order to take steps to prevent it, and whether he indeed took reasonable precautionary steps to prevent it. It is a subjective test regarding the conduct of that particular defendant-doctor at the time of the injury in contrast with the expected standard of care stipulated by the medical profession (described as the reasonable medical professional in similar circumstances). This thesis argues that if the fact of the injury is the only fact available, negligence (*culpa*) cannot be inferred from the facts. The *res ipsa loquitur* maxim is insufficient to be of use in a medical negligence case.

4.3 Causation

As seen before, the thesis argues that the application of the *res ipsa loquitur* maxim is insufficient to integrate the complexities of a medical negligence case with regard to the elements of wrongfulness (in respect of public policy), negligence and causation. In order to determine causation, one must show that a direct link exists between the action of the wrongdoer and the occurrence that caused the harm.[151] The element of causation consists of

[149]Regarding the conduct of the defendant see *Groenewald v Groenewald* (n 131) para 19ff; *S v Mokgethi* 1990 (1) SA 33 (A) 44B–47H; *Road Accident Fund v Russell* 2001 (2) SA 34 (SCA); *The Premier of the Western Cape v Loots* (n 125); Boberg (n 55) 440–442; CG van der Merwe & JE du Plessis *Introduction to the Law of South Africa* (2004) chap 8.

[150]Foreseeability should be in respect of actual harm as opposed to general harm. See ADJ van Rensburg 'Normatiewe voorsienbaarheid as aanspreeklikheidsbegrensings maatstaf in die privaatreg' 1972 *THRHR* and *Sea Harvest Corporation (Pty) Ltd v Duncan Dock Cold Storage (Pty) Ltd* (n 55) 847D–G. This also goes back to Roman times; see para 2 above.

[151]*First National Bank of South Africa Ltd v Duvenhage* 2006 (5) SA 319 (SCA) 320F; Neethling, Potgieter & Visser (2010) (n 44)175.

factual causation and legal causation.[152] Factual causation determines, on the relevant facts, whether there is a break in the chain of events that leads to the damage. Legal causation, sometimes described as 'non-remoteness of damage', determines which of the *sequelae* suffered by the plaintiff can reasonably be imputed to the defendant. The thesis argues that the medical reality is fact-sensitive; it explains the difference between the expected standard of care and the standard of care delivered by the defendant-doctor from which factual causation is established.

An accepted method by which factual causation is established is the *conditio sine qua non* test,[153] or the 'but-for' test (cause-in-fact). In *Minister of Police v Skosana*[154]a negligent delay in medical treatment caused the death of a man. The deceased was injured in a motor accident while under the influence of alcohol, and the investigation into a charge of drunken driving took preference over the seriousness of the man's injuries. The court asked the following question: had it not been for the defendant's action (but-for), would the plaintiff still have suffered the damage?[155] The court analysed whether the negligent omission in question (the delay in treatment) caused or materially contributed to the harm suffered by the deceased. The court tested whether the negligent omission was linked to the harm, and whether it was sufficiently close or directly linked for legal liability to ensue. To be recognised as a 'cause in fact', it should pass the 'but-for' test. The primary cause of death was the accident, which caused the perforation of the small bowel and the resulting peritonitis (inflammation of the peritoneum typically caused by the rupture of an internal organ). However, the delay in treatment was the direct cause that led to the severity of the medical condition of the deceased at the time. Had the medical treatment begun about five hours earlier (the expected standard of care), the deceased would have undergone surgery and would have survived. The original cause (the motor vehicle accident) resulted in a treatable injury, but the failure to treat the injury (insufficient care) on the part of the defendant caused

[152]It was described by Corbett CJ in *International Shipping Co* (n 140) 700E–G. For a comprehensive study see R Midgley 'Revisiting factual causation' in GB Glover (ed) *Essays in Honour of AJ Kerr* (2006);Loubser et al (2012) (n 10) – see chapter 5 for factual causation and chapter 6 for legal causation; Neethling & Potgieter 'Wrongfulness' (2014) (n 55) 120.

[153]See *Minister of Police v Skosana* 1977 (1) SA 31 (A) 34–35; *International Shipping* (n 140); Van der Merwe & Olivier (1989) (n 55) 107ff.

[154]*Minister of Police v Skosana* (n 153) 34–35. This case deals with the problems of causation and the *conditio sine qua non* test. The deceased was intoxicated while driving a motor vehicle and was injured after an accident. The deceased was taken to the district surgeon to take an alcohol-level blood sample. Thereafter, he was placed in police custody. The next morning he became very ill and was taken back to the district surgeon, who found him to be very ill and arranged for his immediate admission to hospital. After further delay, he was taken to surgery, where it was discovered that he was suffering from several internal injuries and a perforated small bowel. He died in theatre while under anaesthesia.

[155]See also *mCubed International (Pty) Ltd v Singer NNO* 2009 (4) SA 471 (SCA) 479E–482G.

the death (damage). The plaintiff bore the onus to prove that proper care would have resulted in a better outcome; put differently, if proper care had been exercised, the deceased would have survived.[156] The medical expert evidence was clear indicating that most specialist units would have operated immediately. This was sufficient to establish on the balance of probability that, had the deceased been taken to the hospital soon after the accident, it was highly probable that surgery would have taken place in time, which would have saved his life.

In *Minister of Safety and Security v Van Duivenboden*,[157] the court found that–

> a plaintiff is not required to establish the causal link with certainty but only to establish that the wrongful conduct was probably a cause of the loss, which calls for a sensitive retrospective analysis of what would probably have occurred, based upon the evidence and what can be expected to occur in the ordinary course of human affairs rather than an exercise in metaphysics.

The plaintiff should show that the defendant's wrongful conduct was *one* of the factual causes of the harm, not that it was the only or main cause of the harm.[158] Ultimately, the court must decide whether the harm caused by the wrongful action of the defendant would have been avoided if the action were lawful.[159] Where there is more than one operative cause of the plaintiff's damage, and both conditions could have been the result of the unlawful conduct, the defendant would be liable. If there are conflicting explanations regarding the cause of the medical accident, neither of which is certain, the plaintiff has failed to prove his case on a balance of probability. The defendant does not have to prove that his explanation is the correct or more plausible one.

In *Lee v Minister of Correctional Services*,[160] the Constitutional Court followed in the footsteps of its English counterpart[161] by relaxing the strict but-for test in cases with scientific

[156]The court looked at the hypothetical question whether the deceased would have survived the injuries if he had received proper care in time.
[157]*Minister of Safety and Security v Van Duivenboden* (n 56).
[158]Neethling, Potgieter & Visser (2010) (n 44)187 para 2.5 regarding factual causation and para 3 regarding legal causation.
[159]*Minister of Finance v Gore NO* 2007 (1) SA 111 (SCA) para 33.
[160]*Lee v Minister of Correctional Services* (n 13) para 73ff. The plaintiff contracted tuberculosis while awaiting trial in prison and claimed that the disease was caused by the negligent failure of the Pollsmoor prison to maintain a health system that allowed for the diagnosis, treatment and prevention of the disease.
[161]See the following English cases: *Bonnington Castings Ltd v Wardlaw* [1956] AC 613, where the claimant contracted pneumoconiosis from inhaling air that contained silica dust at his workplace. The court found that the

uncertainty. The plaintiff does not have to prove that he would not have suffered the damage but for the breach of a legal duty. He has to prove only a 'material contribution' to the injuries and he can still recover damages for the whole loss. This was a landmark case and deserves discussion, even though it does not deal with medical negligence, given that South African law follows a generalising approach to the elements of delictual liability. The case also underlines the state's accountability, responsiveness and the rule of law regarding constitutional rights. It confirms the state's responsibility to prisoners, whose right to autonomy has been taken away in terms of their physical welfare, provided that attending to their welfare, is attainable, given the available resources.[162] Although determining the element of causation was difficult in this case (link between insufficient medical service and contracting tuberculosis), notwithstanding the fact that all the facts were admitted, the case is used to demonstrate the degree of legal reasoning and argument necessary to determine causation in a medical case. One cannot simply say 'the facts speak for itself' or *res ipsa loquitur* as it is not obvious to which facts one is referring. The High Court ruled in favour of the plaintiff, the Supreme Court of Appeal reversed the judgment of the court *a quo*, and the plaintiff took his case to the Constitutional Court. The background to this case is that the plaintiff was arrested on certain charges. He was detained in prison for more than four years and contracted tuberculosis. It was common cause that tuberculosis management in the prison system was 'virtually non-existent'. The element of causation was disputed and the Supreme Court of Appeal found that the plaintiff had failed to prove that, had the prison system been more adequate in their management of the disease, he would not have contracted the disease. However, the majority in the Constitutional Court found that a more flexible approach was warranted and that our law does not require evidentiary proof of the alternative, but merely substitution of a notional and hypothetical lawful, non-negligent alternative.[163] If a causal link

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claimant did not have to prove that the harmful dust was the sole or even most substantial cause of the harm; he only had to show that the dust materially contributed to the disease. See the later discussion in chapter 3 paras 2 and 6.3 regarding English cases, and *McGhee v National Coal Board* [1972] 3 All ER 1008; [1973] 1 WLR 1, where the claimant contracted dermatitis as a result of exposure to brick dust. The House of Lords treated both cases as exceptions to the requirement to satisfy the 'but for' test for causation and stated that a material increase in the risk as equivalent to material contribution to the damage. The court stated that a failure to take steps which would bring about a material reduction of the risk involves, in this type of case, a substantial contribution to the injury. Lord Wilberforce, in the latter case, explicitly recognised that this process involves overcoming an 'evidential gap' by drawing an inference of fact, which strictly speaking the evidence does not support.

[162]*Lee* (n 13) para 17.

[163]*Lee* (n 13) para 43 of the majority judgment. The majority referred to *Minister of Finance v Gore* (n 159) and *Minister of Safety and Security v Van Duivenboden* (n 56), where Nugent JA said the plaintiff is not required to establish the causal link with certainty; he need only establish that the wrongful conduct was probably a cause of the loss.

is found, the next enquiry is about legal liability. The Constitutional Court confirmed that the function of the authorities is to execute its duties in accordance with the Constitution, with an emphasis on human dignity and adequate health care services. The court stated that there is a duty on the court to be vigilant and not hesitate to ensure that the common law is developed to reflect the spirit, purport and objects of the Bill of Rights.[164] The court held that the spirit, purport and objects of the Bill of Rights provide additional reasons for finding in favour of the applicant and imposing delictual liability.[165] This approach indicates that the common law, but-for test for causation is an inadequate tool for securing constitutionally tailored justice in cases where prisoners have proved exposure to the disease because of negligence on the part of prison authorities. The court argued consistent with the approach of the English courts that such a stance is justified on simple justice principles, showing that it would be wrong for employers to avoid liability for wrongdoing because the causal link is inadequate. The court held *obiter* that the English courts may have adopted this approach despite the absence of a constitutional imperative, but in South Africa the imperative is compelling. Thus, a case is made for relaxing the over-rigid strictures of but-for factual inferences.[166]

It is worth diverting at this point to mention that taking into consideration the wider approach of the South African court regarding causational principles the court might possibly in future consider amending the function and use of the *res ipsa loquitur* maxim based on patients' rights and the perceived imbalance of the doctor-patient relationship. The right to equality is an essential component of the transformative Constitution, because 'the right to equality encapsulates the aspiration of eventually achieving a society in which all enjoy equal access to resources and amenities of life, and are able to develop their full human potential'.[167] Substantive equality is understood to mean that there are structural or systemic reasons like socio-economic differences, why not all individuals enjoy equal opportunities and thus focuses on remedial actions to balance it. It is in this context that patients' rights and the perceived imbalance between a doctor and his patient have to be observed.[168]It should be

[164]*Lee* (n 13) para 111, referring to *Carmichele v Minister of Safety and Security* (n 62) para 36.
[165]*Lee* (n 13) para 70.
[166]*Lee* (n 13) paras 101 and 102. See *Oppelt v Head, Department of Health Provincial Administration: Western Cape* [2015] ZACC 33, where the principle of causation was relaxed. See the discussion of the latter case in para 7 below.
[167]P de Vos & W Freedman (eds) *South African Constitutional Law in Context* (2014) 421. The authors refer to P Langa 'Transformative constitutionalism' (2006) 17(3) *Stell LR* 351–360 at 352–353.
[168]Ibid. The authors use the following example to illustrate the difference between formal equality and substantive equality. If a guest house stipulates that it accommodates only gay and lesbian couples and denies accommodation to heterosexual couples, the court that adheres to a formal notion of equality has to find in favour of the heterosexual couples because they are treated differently to gay and lesbian couples (unfair discrimination). A court that embraces a substantive notion of equality would look at the larger social context.

observed in accordance with s 9(1) of the Bill of Rights, namely, that everyone has the right to the equal protection and benefit of the law, and that measures should be put into place to protect and advance persons who are disadvantaged in some sort of way.[169]It might mean to put systems in place and amending the function of the maxim so that it can assist a patient in his case, but this is not the argument at present.

Legal causation in medical negligence is concerned with the relation between the medical incident and the harm. The medical reality (clinical course as to what medically happened) has to be understood as the defendant cannot be liable if his conduct did not cause the harm. The function of legal causation or non-remoteness of damage is to qualify which wrongful act, closely or directly linked to the harm, is the legal cause of the consequences suffered by the plaintiff. Legal causation serves to limit liability because the consequences of an act or omission might be too general or extensive to be linked to the action. The court must ensure that the defendant is not (unjustly) required to recompense the total harm suffered by the plaintiff if it is too remote from the damage-causing action. The criterion in law to determine remoteness is a flexible test (sometimes referred to as a supple test) where a direct link is sought with the assistance of aspects of reasonable foreseeability, intervening actions, the presence of a legal policy, and principles of fairness and justice.[170] Previously, the thesis has shown[171] that the determination of foreseeability may go beyond the element of negligence and extend into the notion of legal causation. By way of example: a patient goes into surgery for the removal of gallstones, develops pancreatitis (unrelated to the first medical condition), becomes severely ill, her condition deteriorates and two weeks later she aspirates (inhaling vomit), leading to pneumonia and her death. The initial operation is not sufficiently linked with the pancreatitis that she later developed; the pancreatitis is another disease and the reason for her further stay in hospital and follow-up treatment. The management of the pancreatitis and the medical clinical course that followed should be investigated to test for

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When gay and lesbian couples stay in a guest house open to all they may feel vulnerable and exposed because of the existing stigmas and the judgment of the heterosexuals staying in the same place. The latter court may found that this different treatment is justified.

[169]Section 9 of the Constitution of South Africa makes provision for national legislation to prevent or prohibit unfair discrimination and to promote and advance the equal enjoyment of rights of persons and categories of persons advantaged by discrimination. Thus, patients' rights are protected and will be promoted.

[170]*International Shipping Co* (n 140), where an auditor wrongfully and negligently misstated the financial position of the company which resulted in financial loss. The loss was found too remote because a number of other occurrences separated cause and effect. The judge stated that the auditor could not have foreseen that the finance company would have departed so much from normal business practice; *OK Bazaars (1929) Ltd v Standard Bank of South Africa Ltd* 2002 (3) SA 688 (SCA) at 765.

[171]See 4.2 before.

negligent conduct (*culpa*). If her condition deteriorated because of insufficient treatment the link would be established for negligence. A sufficiently close link must exist between the wrongful action and the damage to impute liability to the defendant.[172] The court must determine the *causa causans* (the nearest cause of the damage) that resulted in the injury.

In *Mafesa v Parity Versekeringsmaatskappy*,[173] the plaintiff sustained a fracture of his leg and, after being discharged, fell on a smooth surface, breaking the leg again. The court found that the causal link was broken between the first occurrence and the second injury and that the fall was an intervening cause. To reiterate, the importance of legal causation is to limit liability and to determine which harmful conduct should be ascribed to the wrongdoer. The wrongdoer cannot be held liable if the damage is too remotely related to the wrongful act.[174]

In *Standard Bank of South Africa Ltd v OK Bazaars*[175]the court took a flexible approach to the test for legal causation. In accordance with the flexible test, the notions of legal causation are ultimately determined by broad policy considerations as to 'whether right minded people, including judges, would regard the imposition of liability on the defendant for the consequences concerned as reasonable and fair'.[176] In establishing non-remoteness of damage, the court looked at concepts like 'reasonable foreseeability, directness, the absence or presence of a *novus actus interveniens* (intervening act),[177] legal policy, reasonability, fairness and justice'.[178] To determine whether it is an intervening act, the court investigates if the intervening act was independent and unforeseen, or if it contributed to the occurrence of

[172]*Siman & Co (Pty) Ltd v Barclays National Bank Ltd* 1984 (2) SA 888 (A) 914ff.
[173]1968 (2) SA 603 (O). Also see *Alston v Marine and Trade Insurance Co* 1964 (4) SA 112 (W).
[174]Neethling, Potgieter & Visser (2010) (n 44) 188; Van der Walt & Midgley (n 35) 132, who state that liability should be limited 'by determining whether or not a factual link between conduct and consequence is recognized in law'.
[175]2000 (4) SA 382 (W); 2002 (3) SA 688 (SCA) 765.
[176]*The Premier of the Western Cape Province v Loots* (n 128) para 8, where a sterilisation operation was unsuccessful. The woman became pregnant, and complications during the birth process resulted in the woman being rendered severely disabled and unable to attend to her child. The court addressed the overlap between negligence and non-remoteness of damages and held that the foreseeability criterion in the context of legal causation must mean foreseeability of the actual harm as opposed to harm of a general kind. The court referred to Van Rensburg (n 150) 56, where the author suggests that, in order to impute harm to the wrongdoer, actual harm must have been foreseeable with '*genoegsame graad van waarskynlikheid'*, ie a sufficient degree of probability.
[177]See *Road Accident v Russell* (n 149), where it was found that the effects of a motor vehicle accident resulted in depression, which led to suicide. The court decided that the chain of causation was not interrupted. The decision of the court must have been based on the medical information and interpretation. In medical negligence cases the determination whether an intervening event qualifies as a *novus actus interveniens* is a medical question, as the medical chain of events of the original action will be interrupted by an alternative event or not.
[178]*Standard Chartered Bank of Canada v Nedperm Bank Ltd* 1994 (4) SA 747 (A). This decision was criticised, but the case does not form part of the focal point of the thesis.

harm after the original harm occurred.[179]The thesis argues that, in a medical case, it is debatable whether any one of the delictual elements as set out above can be inferred from an unfavourable event (the mere fact of the injury) that caused harm to a plaintiff. The purpose of the *res ipsa loquitur* maxim is to infer from the facts certain unavailable facts (to complete the picture), which on occasion is possible in an ordinary everyday occurrence. In cases where a descriptive, facts-sensitive inquiry of how the harm occurred, is principally based on medical and scientific evidence and prescribed delictual principles, such an inference would rarely be justifiable.

5 Legal presumptions

On the basis of the investigation into the above delictual elements, it will be evident that the application of the *res ipsa loquitur* maxim to medical cases renders an unsatisfactory result. As suggested previously, further analysis may be justified to determine whether a more flexible application of the maxim may assist the plaintiff in a complex medical case, based on constitutional arguments appealing to the rights of plaintiffs. Before advancing into such an investigation it is first necessary to have a closer look at the mechanism of the legal use of presumptions in South Africa. Legal presumptions are categorised under the law of evidence. The law of evidence governs the proof of facts and forms part of the procedural mechanism in law. The weight of evidence[180] that will sway the court to find in favour of the plaintiff is based on a balance of probability. The plaintiff may lead direct evidence or may rely on any legitimate inferences drawn from the proven facts. If the defendant fails to provide evidence to rebut that of the plaintiff, and the plaintiff has made out a *prima facie* case against the defendant, the plaintiff may succeed in the action.

In *R v Oakes*[181]the court distinguished between presumptions with basic facts and without basic facts. The latter are conclusions drawn until the contrary is proved. Therefore, an inference is a deduction from evidence, which may be equivalent to legal proof.

[179]*Smit v Abrahams* (n 137) 17–19, where the court decided on the basis of policy considerations whether there existed a close connection between the wrongful act and the damage. The defendant suffered a greater loss than he would otherwise have done because of the poverty of the plaintiff. The parties had a collision. The plaintiff used his bakkie to conduct his business. He was impecunious and could not buy another bakkie. He had been unable to afford insurance. The plaintiff claimed the market value plus the temporary cost of hiring alternative transport in order to continue his business.
[180]Schwikkard & Van der Merwe (2009) *Beginsels* (n 3) 18, where the authors describe *facta probanda* as facts that need to be proved to succeed with an action and *facta probantia* as the facts that are proving or disproving the facts in dispute. The authors provide a detailed discussion of presumptions at 21, 22.
[181]1986 26 DLR 200.

Schwikkard and Van der Merwe[182]discuss presumptions under irrebuttable presumptions of law,[183] rebuttable presumptions of law,[184] and presumptions of fact.[185]Factual inferences[186] are made from evidence based on facts, as no direct evidence is available. However, a factual presumption is not a rule of law. An irrebuttable presumption is dictated by substantive law, ie *praesumptio iuris et de iure*[187] and it is a legal presumption that is irreversible.[188]For example, there is an irreversible presumption that a child under seven years is *doli incapax* (incapable of forming the intent to commit a crime) and *culpae incapax* (not accountable for his or her actions and omissions). Rebuttable presumptions are '[p]resumptions of law [that] are arbitrary consequences expressly annexed by law to particular facts'[189] and the presumption can be disproved by conflicting evidence. A rebuttable presumption, ie *praesumptio iuris tantum*, is a true presumption as legal presumption and leads the court to draw certain inferences. This legal presumption can also be described as a conclusion from the known facts.[190] It is reversible, and if evidence is offered in rebuttal, the inference can no longer be made. An example of a rebuttable presumption would be that the father of a child born in wedlock is the child's natural father.

The *res ipsa loquitur* maxim is simply a factual presumption, and may assist a plaintiff with the evidentiary burden. Its function is to ask the court to infer from the facts that the occurrence could not have happened without negligence.[191] It is important to note that, from the facts alone, the court should be able to conclude that there was a high probability of negligence (*culpa* and liability). Sufficient key facts should be available to draw a conclusion on the facts alone, for example, driving on the wrong side of the road. A factual presumption

[182]Schwikkard & Van der Merwe (2002) *Principles* (n 37) 469.
[183]Ibid. Irrebuttable presumptions of law 'furnish conclusive proof of the fact presumed and cannot be rebutted by evidence to the contrary'.
[184]Ibid. Rebuttable presumptions of law are 'rules of law (within the law of evidence) compelling the provisional assumption of a fact'. They will stand unless destroyed.
[185]Ibid, referring to Elliot & Phipson (1987) *Manual of the Law of Evidence* 12 ed 89: a presumption of fact is 'merely frequently recurring examples of circumstantial evidence'.
[186]See *Arthur v Bezuidenhout and Mieny* 1962 (2) SA 566 (A) 574: '*wat feitlike vermoede betref is dit 'n blote afleiding wat 'n weerleggingslas plaas of die teenkant … en affekteer nie die bewyslas nie*'; Schmidt (1989) (n 3) 149.
[187]See Schwikkard &Van der Merwe (2009) *Beginsels* (n 3) 22ff.
[188]*Silver Garbus and Co (Pty) Ltd v Teichert* 1954 (2) SA 98 (N) 103, where a woman was allegedly unaware of what she was signing and the court declared: 'Hence, even if she had no actual knowledge of what she had done, she is presumed to have known the contents of the documents she signed.'
[189]HM Malek *Phipson on Evidence* (2013) paras 7–17.
[190]Schmidt (1982) (n 3) 133: 'regsvermoede is dan 'n gevolgtrekking wat van regsweë op die regter afgedwing word'.
[191]Zeffert, Paizes & Skeen (n 9) 201, where the authors stated that the *res ipsa loquitur* maxim is applied when an accident 'happens in a manner which is unexplained but which does not ordinarily occur unless there has been negligence'.

simply asks the court to draw an inference from the available and sufficient facts. The difference between a presumption of law and a presumption of fact is fundamental. In a presumption of law (rebuttable presumption), if no evidence is called to rebut the presumption of law a judge should allow the presumption to stand. This is different with a presumption of fact. There may be a presumption of fact (*res ipsa loquitur*), but this does not compel a judge, in the absence of any evidence supporting the presumption of fact, to be satisfied and persuaded by the presumption of fact (*res ipsa loquitur*) that there was negligence.[192] Thus, a presiding judge entertains a presumption of fact (*res ipsa loquitur*) as *prima facie* evidence, which can be persuasive evidence, or even conclusive evidence,[193] until it is refuted. In principle, the design of the *res ipsa loquitur* maxim would function only in circumstances where all the elements of delictual liability are obvious from the facts (even if it is only by drawing an inference), and where no other explanation (from the facts) can be made but that the defendant was negligent. In South Africa, the *res ipsa loquitur* maxim is useful, particularly in motor vehicle accident cases.[194] The *res ipsa loquitur* maxim is used to 'fill in' the complete chain of events by means of a factual inference, as happened in *Administrator, Natal v Stanley Motors Ltd*.[195]However, Thompson AJ decided not to apply the *res ipsa loquitur* maxim because all the evidence was available (one of the requirements of the maxim is that all the evidence should not be available). Instead, the judge confirmed this of the requirements of the maxim. He indicated that 'if facts are sufficiently known, the question ceases to be one where the facts speak for themselves, and the solution is to be found by determining whether, on the facts, as established, negligence is to be inferred or not'. In other words, there is no need for the maxim to complete the picture. On the other hand, insufficient information regarding factual causation has the effect that there may not even be *prima facie* evidence available from the occurrence, as happened in *Groenewald v Auto Protection Insurance Co Ltd*.[196]Rumpff AJ pronounced that, in the circumstances of the case, the first collision was not a *prima facie* case of negligence. The mere fact that the first collision occurred does not create an inference of negligence on the fact of the accident. The

[192]*Tregea v Godart* 1939 AD 16 33. See Schmidt (n 3) 149: the maxim *res ipsa loquitur* is simply a 'versameling van nalatigheids afleiding sonder die spreuk res ipsa loquitur'. Although dependent on a basic fact it has not developed into a presumption of law.
[193]JF Stephen *Digest of Law of Evidence* (1876) a.1: 'a rule of law that courts and judges shall draw a particular inference from a particular fact, or from particular evidence, unless or until the truth of such inference is disproved'.
[194]*Modyosi v SA Eagle Insurance Co Ltd* 1990 (3) SA 442 (A), where the cause of the accident was unknown.
[195]1960 (1) SA 690 (A) 700. Occurrences should be such that it would not have had occurred without negligence: see *Sardi v Standard and General Insurance Co Ltd* 1977 (3) SA 776 (A) 780D; *Dalion Materials (Pty) Ltd v Cintrust (Pty) Ltd* 1978 (3) SA 599 (W) 605D.
[196]1965 (1) SA 184 (A) 187D.

judge indicated that it is neither proper nor logical to infer negligence merely because two motor vehicles collided on the national road, and it is most certainly not enough to invoke the maxim *res ipsa loquitur*. It is not self-evident that because two vehicles collided the person in control of one of them must have been negligent. He referred to the leading case in this regard, *Arthur v Bezuidenhout and Mieny*,[197] where it was held that the *res ipsa loquitur* maxim applies where it is shown that in the collision one vehicle veered to the wrong side of the road into the face of oncoming traffic. The court held that the occurrence would then be sufficiently described to determine negligence from the very nature of the facts. The explanation of the defendant in reply may negate the facts or may bring other information before the court. The court stated that the *res ipsa loquitur* maxim does not transfer the onus of proof to the defendant. It simply creates a rebuttable presumption of fact (not of law). In South Africa the maxim is not a general presumption of negligence and the facts per se should be enough to enable the court to complete the picture and to determine negligence. Holmes JA, in *Sardi v Standard and General Insurance Co Ltd* [198]held that the maxim has no bearing on the onus of proof. It is invoked where the known facts, relating to negligence, consist of the occurrence itself. The important differential fact for a case based on the *res ipsa loquitur* maxim in is that the defendant is required to answer to rebut the inference; he cannot simply remain silent. If he remains silent he would be found liable as there is enough evidence to conclude negligent conduct from the incident. This is essentially the power of the maxim in an ordinary case. However, as shown before, it is not the same in a medical case. If the plaintiff relies on the fact of the injury and the defendant remains silent, the court will simply state that the plaintiff has not proved his case because all the elements in delict were not satisfied. The thesis argues that it is the search for this so-called power that motivates the plea to re-introduce the maxim to the medical field. But to use the maxim in a medical case will mislead the plaintiff into believing that he has done enough to win his case. Yet, it is not rational to base a difficult case, often with an intricate chain of events, on a maxim designed for an ordinary cause of harm in an everyday occurrence. In a medical case the accepted medical standard of care is unknown to the uninformed person or the unassisted court against which the actions of the defendant need to be assessed. Unlike a *prima facie* case, where a plaintiff is aware that he has to support his case with evidence or run the risk of losing the case because the court is unable to decide the case on insufficient facts, the maxim causes a plaintiff to present an unprepared case.

[197] *Arthur v Bezuidenhout and Mieny* (n 186).
[198] *Sardi v Standard and General Insurance Co Ltd* (n 195).

In *Macleod v Rens*[199]Erasmus J stated that generally one assumes that a roadworthy motor vehicle under the control of a skilful and careful driver will behave in accordance with the basic traffic rules to ensure the safety of all road users and that it will not deviate from its path into the line of oncoming traffic. The court, referring to the *res ipsa loquitur* maxim, warned against speculation and of finding a defendant negligent in 'some general or unspecified manner'. Of interest is the fact that factual presumptions such as the *res ipsa loquitur* maxim were applied to criminal cases. Indeed, the court confirmed in *S v Mudoti*[200]that the test for liability is similar in both civil and criminal cases. In a later paragraph[201] the relevance of the *res ipsa loquitur* maxim to medical negligence cases is discussed.

6 *Prima facie* evidence

The previous paragraph dealt with the *res ipsa loquitur* maxim as a presumption of fact in contrast with *prima facie* evidence. In simple terms, *prima facie* evidence is a weaker form of evidence than conclusive evidence and it falls within the ambit of the law of evidence. Evidence can be *prima facie* evidence or conclusive evidence.[202] Also, it is trite that a plaintiff will succeed if a *prima facie* case has been proved against the defendant and the defendant failed to show that the injury was caused by something other than the defendant's negligence. The weight of evidence and the nature of evidence fall under the law of evidence.[203] If a

[199]1997 (3) SA 1039 (E) 1047I–J. See also chapter 1 para 1. 2. The court states that the *res ipsa loquitur* maxim– pithily states a method of reasoning for the particular circumstances where the only available evidence is that of the accident. It boils down to the notion that in a proper case it can be self-evident that the accident was caused by the negligence of the person in control of the object involved in the accident. As such it is not a magic formula. It does not permit the court to side-step or gloss over a deficiency in the plaintiff's evidence; it is no short cut to a finding of negligence: these are real dangers in the application of the expression. It seems to tempt courts into speculation. Expressions such as 'in ordinary human experience', 'common sense dictates' and 'obviously' which are regularly employed in reasoning along the lines of the maxim, sometimes only serve to disguise conjecture. Moreover, there is a risk of false syllogism inherent in reasoning that, as the accident would ordinarily not occurred without negligence on the part of the driver of the vehicle, the defendant, having been the driver, was therefore negligent. Finally, reasoning along the lines of *res ipsa loquitur* leads to the somewhat unsatisfactory finding that the defendant was negligent in some general or unspecified manner.

[200]1986 (4) SA 278 (ZSC) 279H–280. See *S v Skweyiya* 1984 (4) SA 712 (A), where it was found that the goods are presumed to be stolen or received by a person in possession of recently stolen goods.

[201]See para 8 below.

[202]*R v Jacobson and Levy* 1931 AD 466 at 478, where Stratford AR states:
Prima facie evidence, in its more usual sense, means *prima facie* proof of an issue the burden of proving which is upon the party giving that evidence. In the absence of further evidence from the other side, the *prima facie* proof becomes conclusive proof and the party giving it discharges his onus.
See *R v Abel* 1948 (1) SA 654 (A); *R v Ismail* 1952 (1) SA 204 (A) 208H; *S v Veldhuizen* 1982 (3) SA 413 (A) 416; *Terry v Senator Versekeringsmaatskappy Bpk* 1984 (1) SA 693 (A) 699.

[203]Schwikkard & Van der Merwe (2009) *Beginsels* (n 3) 535, where the authors describe the different types of evidence.

prima facie[204]case has been established, it means that there is sufficient evidence that must be defended. In *Ex parte Minister of Justice: In re R v Jacobson and Levy*, [205]the court concluded that–

> if a party on whom lies the burden of proof, goes as far as he reasonably can in producing evidence and that evidence 'calls for an answer' then, in such case, he has produced *prima facie* proof, and, in the absence of an answer from the other side, it becomes conclusive proof.

The court held that *prima facie* evidence need not be conclusive or irrefutable but may become conclusive in the absence of a defence. It should be noted that 'conclusive' in this context simply means that there is sufficient evidence to allow the court to conclude that there was negligence (*culpa* and liability). It is not 'conclusive' in the sense of mathematical proof ie leaving no other possibility open; it is conclusive because of the larger weight of the plaintiff's evidence without any counterweight in rebuttal. In the early stages of a *prima facie* case, evidence rebutting the case is not considered; what is considered is whether the plaintiff's case has enough merit to take it to a full trial. An objective of the doctrine of *prima facie* evidence is to prevent litigants from bringing spurious charges that simply waste all the other parties' time.[206] Although it is accepted that if the factual information of the occurrence is primarily in the knowledge of the defendant, and the plaintiff is unable to furnish evidence, then less evidence will suffice to establish a *prima facie*[207]case. The latter situation was found in *Union Government v Sykes*,[208] where Innes AJ held that, although less evidence will suffice in the above circumstances, it will not alter the onus of proof that rests on the plaintiff. The plaintiff should present all the evidence available and the defendant then rebuts that by completing the factual evidence[209] or chain of events. If the defendant fails to answer in rebuttal, the plaintiff's version may be accepted by the court and the plaintiff will be successful. If the plaintiff, who carries the burden to present the evidence, does not have sufficient evidence to discharge the onus of proof, it would not have been a *prima facie* case

[204]The Latin expression means *on its first encounter*, *at first blush*, or *at first sight*. A *prima facie* case might not stand or fall on its own; if an opposing party introduces other evidence or asserts an affirmative defence it can only be reconciled with a full trial.
[205]*R v Jacobson and Levy* (n 202) 478.
[206]*Molofe v Mahaeng* 1999 (1) SA 562 (SCA) 568H–569B.
[207]*Gericke v Sack* 1978 (1) SA 821 (A).
[208]1913 AD 156 at 173.
[209]See *Marine and Trade Insurance Company Limited v Van der Schyff* 1972 (1) SA 26 (A) 37A; *Rabie v Kimberley Municipality* 1991 (4) SA 243 (NC) 259.

and the plaintiff's case will fail. Although, the terms *prima facie* and *res ipsa loquitur* are sometimes used interchangeably and do not have a fixed usage, *prima facie* evidence should not be confused with the maxim *res ipsa loquitur*. The difference between the two is that *prima facie* is a term meaning there is enough evidence for a case to be answered whereas *res ipsa loquitur* means that, because the facts are so obvious, a party need explain no more. Any *res ipsa loquitur* case should be a *prima facie* case, yet a *prima facie* case is not necessarily a *res ipsa loquitur* case. The stronger the facts of the occurrence (factual causation) the more they can be supplemented with inferences concerning the defendant's negligence.[210]To reiterate, if the facts of the occurrence in an ordinary case indicate that negligence is so obvious that a party need explain no more, the factual presumption (*res ipsa loquitur*) requires that the defendant should answer to rebut the inference. If he remains silent he will lose his case. However, this answer in rebuttal must show an alternative explanation without negligence that will be weighed against the probability of the inference. If the court cannot weigh the defendant's rebuttal against the probability of the inference the court will simply revert to hearing the case on *prima facie* principles and the plaintiff will be unprepared. But this will only be so if a high probability of negligence was inferred with the maxim. As indicated before, if the plaintiff has no evidence but the fact of the injury and the defendant remains silent the plaintiff will lose his case based on the fact that he did not discharge his onus of proving a case on delictual principles and that he failed to show a proper cause of action.

A classic example of a true *res ipsa loquitur* case is when a barrel of flour falls from an open door on the upper floor and injures a passer-by. All the elements in delict can be inferred from the occurrence and there is a high probability of negligence which becomes conclusive if not defended. On the other hand, if the facts of a *prima facie* case are not answered the court will still weigh the evidence of the plaintiff to determine if the plaintiff has proved his case or may even rule against the plaintiff if insufficient evidence is presented. *Prima facie* evidence is not necessarily based on a probability but can be based on several allegations and further evidence is needed to prove that one scenario is more probable than another. With a *prima facie* case, the plaintiff would be aware that, without supporting evidence, his case may be rather weak. If nothing else, he would not have a false sense of security, assuming that he has a fail proof case relying only on the fact of the injury, as would be the case if he relied on the *res ipsa loquitur* maxim.

[210]Zeffert, Paizes & Skeen (n 9) 221.

7 Understanding medical negligence

This paragraph provides an overview of medical negligence as a separate delictual ground and the background to the main topic of this thesis ie the *res ipsa loquitur* maxim. The standard of care and the defendant's failure to meet that standard is usually the core argument in an action for medical negligence. The essential question is whether the alleged negligent action of the defendant was the direct cause of the damage suffered by the plaintiff. If the defendant's conduct was reasonable, he was not negligent, but, if he acted unreasonably under the circumstances, he would be negligent. Medical expert evidence is invariably a pivotal part of an action for medical negligence in providing the accepted standard of care. The medical expert provides the court with medical facts (evidence) to determine, inter alia, whether the defendant failed to keep up to date with changing medical standards, or had taken on a task beyond his competence and skill, or took unjustified risks, or took a risk that was not justified when weighed against the benefit for the patient, or failed to prevent harm that was foreseeable. The basic approach is determining how the defendant ought to have behaved under the circumstances (expected standard). Put differently, the approach determines how the behaviour of the defendant compares with that of the hypothetical reasonable medical professional under the same circumstances.

The legal duty in delict is derived from the relationship between the doctor and the patient.[211] The standard of care required from a medical professional is to achieve the general level of skill and diligence possessed and exercised, at the time, by the members of the branch of the profession to which he belongs.[212] The relevant legislation,[213] prescribed ethical considerations,[214] constitutional rights[215] and patients' rights form part of the standard of care

[211]Carstens & Pearmain (n 27).*Foundational Principles of South African Medical Law* is a comprehensive work that provides details about the law of contract and delict in medical negligence in South Africa. Also see Strauss & Strydom (n 89) 266; Claassen & Verschoor (n 89) 118; FFW van Oosten 'The legal liability of doctors and hospitals for medical malpractice' (1996) 80 *SAMJ* 23ff; SA Strauss 'Duty of care of doctor towards patient may arise independent of contract' (1988) Vol 9 *SAPM* 155, 2; *Carreira v Berwind* 1986 (4) SA 60 66; *Van Wyk* (n 42) 443–444; *Collins v Administrator Cape* 1995 (4) SA 73, 81.

[212]*Mitchell v Dixon* (n 133) 525 *per* Innes ACJ; *Buls v Tsatsarolakis* (n 58) 893.

[213]Medical law in South Africa is governed by, inter alia, the Constitution of South Africa, 1996, which contains the Bill of Rights; the National Health Act 61 of 2003 and Regulations, which form a framework for a structured uniform health system; the National Core Standards, published in 2011 by the Department of Health; the Health Professions Act 56 of 1974 and Regulations, which control the health professions; the Health Professions Council of South Africa, which provides Ethical Rules and Guidelines (like Undesirable Business Practices); the Pharmacy Act 53 of 1974, which controls the pharmaceutical business; the Medicines and Related Substances Control Act 101 of 1965; the South African Nursing Act 33 of 2005 and Regulations which control the nursing profession; the Consumer Protection Act 68 of 2008; and the common law.

[214]Health Professions Council of South Africa, which provides Ethical Rules and Guidelines. Normative ethics include the responsibility of the medical professional to comply with the standards of conduct.

[215]The Constitution.

expected by the existing *boni mores*.[216] Moreover, the prescribed standard is also determined by the medical profession, based on evidence-based medicine principles, scientific clinical trials, international and local guidelines, professional guidelines, professional codes of conduct, ethical rules[217] and so forth.

As indicated earlier, South African law under the influence of Roman and Roman-Dutch law regarded *omissio* (failure to act) as wrongful only when a positive duty to avoid harm existed.[218] The medical professional is burdened with a legal duty[219] to prevent and avoid injury to his patient. Liability for failure to act is universal in medical law. Several cases[220] received the attention of the court based on allegations of a failure by the medical professional to perform a task. In *Kovalsky v Krige*[221]the patient alleged that the doctor left the patient in an unstable condition. In the leading case, *Van Wyk v Lewis*, [222]the surgeon failed to remove a swab from the abdomen of the patient. It is perhaps not a true case of 'omission', but it is central to the ensuing discussion of *res ipsa loquitur* principles.

The medical professional has a legal duty to his patient both in contract and in delict.[223] A medical professional undertakes in contract to perform an operation with skill, competence and due care and in accordance with prescribed medical standards. A further contractual relationship exists between the hospital and the patient, not relevant to the doctor, unless the doctor is employed by the hospital. According to the principles of vicarious liability,[224] the hospital, expressly or tacitly, incurs liability for the negligent conduct of its employees.[225] The terms of the agreement between the parties is based on their relationship

[216]The legal convictions of the community are also embodied in the Bill of Rights in the Constitution.
[217]See chapter 4 below.
[218]See para 4.1 above.
[219]*Minister van Polisie v Ewels* (n 61) 596H–597G, where the Appeal Court recognised wrongfulness in circumstances where the legal convictions of the community required a legal duty to shield others from injury, and not only when there was a negative duty to avoid injury. See *Minister of Law and Order v Kadir* (n 83) 317C–318A; *Van Eeden v Minister of Safety and Security* (n 62).
[220]*Van Wyk* (n 42) 444; *Allot v Paterson and Jackson* 1936 SR 221; *Kovalsky v Krige* 1910 CTR 922; *Buls v Tsatsarolakis* (n 58); *Dube v Administrator Transvaal* 1966 (4) SA 260 (T); *Blyth v Van Heerden* (n 113).
[221]*Kovalsky v Krige* (n 220).
[222]*Van Wyk* (n 42). See *Lee* (n 13), where the specific omission to prevent and manage the spread of tuberculosis caused the harm to the plaintiff.
[223]Strauss & Strydom (n 89)106ff; I Gordon, R Turner & TW Price *Medical Jurisprudence* (1953) 75ff; Van Oosten 'Legal liability' (1991) (n 211) 23ff; *Allot v Paterson and Jackson* (n 220); *Kovalsky v Krige* (n 220); *Coppen v Impey* 1916 CPD 309 at 314; *Buls v Tsatsarolakis* (n 58) 893.
[224]Where an employer–employee relationship exists, the delict will be that of the employer, as the employee committed the wrong while acting within the course and scope of his employment: see *F v Minister of Safety and Security* 2005 (6) SA 419 (CC) para 40 fn 33; *K v Minister of Safety and Security* 2005 (6) SA 419 (CC) para 21.
[225]Carstens & Pearmain (n 27) 283–288; Claassen & Verschoor (n 89)115–118; AD Mahomed & DJ McQuoid-Mason *Introduction to Medico-Legal Practice* (2001) 5; Strauss (2006) (n 40) 59–64; Strauss &Strydom (n 89)104.

and by implication are, that the doctor undertakes to examine the patient, to arrive at a working diagnosis with alternative differential diagnoses, to treat the patient with professional skill, competence and fair judgement, or to refer a patient to another professional who has more skill and experience.[226] Also implied in the agreement between the medical professional and the patient is that the medical professional should act in accordance with recognised and accepted practices of medicine.[227] If a medical professional does not comply with the terms and conditions of the express or implied contract, he will be in breach of the contract, and liable. The rules governing breach of contract[228] are different from the rules of delict and have no bearing on the element of negligence.[229] They deal with a breach in accordance with the terms of the agreement. Breach of a contract, although part of a civil wrong against an injured party, is not classified as a delict.[230]

In delict, such a legal duty arises because of a professionally assumed duty by the medical professional to treat the patient. Such an involuntarily assumed duty is recognised in law,[231] is independent of the will or conviction of the medical professional, and depends on the particular circumstances[232] of each case. The same act or omission may be relevant to a breach in contract or part of a delictual claim of liability,[233] as 'precisely the same facts are

[226]Strauss (1991) (n 89) 25. To establish whether a failure to act was reasonable the court will look at the doctor's actual knowledge of the condition of the patient and his professional ability; the seriousness of the patient's condition; the physical state of the doctor and the availability of other doctors; the doctor's need to attend to other patients; whether attending to the patient will expose the doctor to danger; whether the patient wishes to be treated; and professional ethical considerations.

[227]*Van Wyk* (n 42) 448, 469–470; *Allot v Paterson & Jackson* (n 220) 224; *Collins v Administrator Cape* (n 211) 81–82; *Coppen v Impey* (n 223); *Kovalsky v Krige* (n 220) 823; *Buls v Tsatsarolakis* (n 58) 893; *Clinton-Parker v Administrator Transvaal* 1996 (2) SA 37 (W) 56, 58; *Applicant v Administrator Transvaal* 1993 (4) SA 733 (W) 738.

[228]The focus of this study is on delictual aspects and not on contractual obligations. However, see *Loureiro v iMvula Quality Protection (Pty) Ltd* (n 76) 408G–H: in contract, the rule '*expressum facit cessare tacitum*' ('that which is expressed excludes what is implied') effectively rules out tacit obligations that might imply a 'reasonable standard'.

[229]*Thoroughbred Breeders' Association v Price Waterhouse* 2001 (4) SA 551 (SCA) 66; *Administrator Natal v Edouard* (n 115) 597E–F; *Scoin Trading (Pty) Ltd v Bernstein* 2011 (2) SA 118 (SCA) 122I; see also GE Lubbe et al *Contract: General Principles* (2007) 330–331.

[230]Voet 47. 1. 1. As per *Loureiro v iMvula Quality Protection (Pty) Ltd* (n 76) 407G: 'in absence of a contrary stipulation, the law of contract does not require fault (even in the form of negligence) for breach of [contract]'.

[231]*Minister of Law and Order v Kadir* (n 83) 317, where the police had failed to collect information that would have assisted the plaintiff in a civil claim in a road accident matter. On appeal, the court rejected the idea of holding a police officer personally liable for damages for a relatively insignificant dereliction, and therefore the plaintiff failed to prove the legal duty in this regard.

[232]The elements of wrongfulness related to a 'legal duty' are seldom contentious in medical negligence cases. Also see liability for negligent omissions in other cases: *Trustees, Two Oceans Aquarium Trust v Kantley and Templer (Pty) Ltd* (n 44) 144E–F, referring to *Minister of Safety and Security v Van Duivenboden* (n 56) para 12; *Gouda Boerdery BK v Transnet* (n 70), referring to a 'legal duty not to act negligently'.

[233]*Van Wyk* (n 42) 443; *Donoghue v Stevenson* (n 20) 609–610. See Claassen & Verschoor (n 89) 115–124: the authors believe that the legal duty of a physician entails that the physician is burdened with a duty of care to exercise reasonable skill and care during the treatment of the patient.

relied upon as constituting a breach of the implied term as are relied upon as constituting a breach of the duty of care [legal duty]' owed to the plaintiff.[234]

Van Oosten[235] proposes that the relationship of the doctor and the patient is primarily that of contract and that the doctor enters into a contractual relationship with his patient to provide the necessary skill and care in a competent and professional manner. According to Van Oosten, the medical professional assumes a duty to provide reasonable care to the patient in relation to all treatment. Consequently, the doctor attracts a duty of care (a legal duty) due to his professional knowledge and the reliance of the patient on that knowledge and his skill as a doctor. Van Oosten believes that the medical professional should inform[236] his patient in respect of his skill and competence to perform a certain operation or medical treatment. This information will form the basis of the agreement.[237] It seems that a plaintiff would be wise to entertain the allegations of breach of contract accumulatively to or in the alternative to the allegations made in delict.[238]

The legal duty of the doctor owed to the patient is illustrated by Strauss[239] as a duty of the medical professional to act with the required competent skill and care in accordance with prescribed medical standards, for the comfort, well-being and safety of the patient. The National Health Act[240] oversees the relationship between health care providers and health care

[234]*Per* Cloete J in *Friedman v Glicksman* 1998 (1) SA 569 (W).
[235]Van Oosten 'Legal liability' (1991) (n 211) 23ff.
[236]FFW van Oosten 'Informed consent: A patient's right and the doctor's duty of disclosure in South Africa' (1989) (n 89) 443–456. The author states that the information should be adequate in order for the patient to arrive at an informed decision based on the information provided. Due to his training and qualifications as a medical professional, the doctor would be aware of and able to foresee certain complications and risks and would take all reasonable steps to prevent risks and complications to follow the proposed medical treatment or medical intervention. If the defendant fails to follow the above process he is not acting in accordance with reasonable practice and if the patient suffers harm as a result of the practice that was followed, the medical professional would be found to have lacked the necessary care and would be negligent. It should be noted that the planned medical intervention must be recognised in law, must not be *contra bones mores*, and should conform to the prevailing convictions of the community and general human rights.
[237] Sharing of information has since become a prescription in terms of the National Health Act 61 of 2003, Chapter 2. Earlier, in *Esterhuizen v Administrator, Transvaal* (n 116), the court held that–
if it is to be said that a person consented to bodily harm or to run the risk of such harm, then it presupposes, so it seems to me, knowledge of that harm or risk; accordingly mere consent to undergo X-ray treatment, in the belief that it is harmless or being unaware of the risks it carries, cannot in my view amount to effective consent to undergo the risk or the consequent harm.
See *Louwrens v Oldwage* 2006 (2) SA 161 (SCA), where the court found that a 2 per cent change in a complication is negligible and that it was not unreasonable that the defendant did not mention it when sharing information with the patient.
[238]General damages, such as pain and suffering, are presumed or arise by inference of law, but can be claimed only in delict and not in breach of contract.
[239]Strauss (1991) (n 89) 36–37.
[240]Act 61 of 2003, Chapter 2.

users and lists the primary obligations of the parties.[241] Pienaar[242] summarises the relevant responsibilities of the medical professional: to diagnose, treat, inform and follow up on the patient, in harmony with the best available medical practice principles, or to consult or refer to another professional who is more skilled and experienced in that particular field of interest. In order to treat the patient, the medical professional must make a working diagnosis with differential diagnoses,[243] in accordance with acceptable medical principles. In order to make a diagnosis, he has to examine the patient by means of clinical observations, a physical examination and by recording a proper medical and family history. Further blood tests, radiological examinations, ultrasounds, scans or other imaging may be needed to assist the medical professional in making a diagnosis. Throughout the process, the medical professional should consult with the patient, explain the risks and complications of the proposed medical interventions, and thus obtain informed consent. The medical condition of the patient should constantly be monitored for change and the previous diagnosis adjusted or reaffirmed.[244]

As will become evident later, the issue whether a medical professional was negligent (*culpa* and liability) is resolved via the process of a fact-finding enquiry. The importance of this is relevant to demonstrating how inadequate the use of the *res ipsa loquitur* maxim is in relation to medical cases. Before venturing into a discussion of the *res ipsa loquitur* maxim in more detail with regard to medical cases, it is important to emphasise the difficulties with the notion of, and process of establishing, negligence in medical cases. Although this analysis may seem repetitive, the purpose here is to illustrate that the test for negligence has evolved from what a reasonable man would have foreseen and prevented (in everyday life) to what the public expects from a reasonable doctor in the practice of medicine (the acceptable standard of care). The test measures the behaviour of the doctor against the standard set by his peers in an international arena. It stipulates the medical principles for treatment or medical processes in a particular field, which is evidenced by current medical expertise and international and local medical literature. It is not usually known to the non-medical person.

[241]One of the duties of a health care provider is to share information to help the user make an informed decision. The user is, inter alia, entitled to have knowledge of his health status, the range of diagnostic procedures and treatment options available, and the user's right to refuse health services.

[242]CE Pienaar *An analysis of evidence-based medicine in context of medical negligence litigation* (unpublished LLM dissertation, University of Pretoria 2011), available at http://upetd.up.ac.za/thesis/available/etd-09212011-130356/unrestricted/dissertation.pdf (accessed 3 February 2012).

[243]See chapter 4 below regarding the standard of medical care.

[244]An initial diagnosis of an 'inflamed gall bladder' after a failed operation will be changed to 'complications following a cholecystectomy' (removal of a gall bladder), and will not remain as 'cholecystectomy'.

As mentioned previously, all the elements of delict must be established for a plaintiff to be successful in a case of medical negligence, as well as in a case relying on the *res ipsa loquitur* maxim. Negligent conduct usually manifests itself in the form of a positive act that causes physical damage to the property or person of another and that is *prima facie* wrongful.[245] In *Stoffberg v Eliot*, [246]Watermeyer J held the medical position to be the following:

> Any bodily interference with or restraint of a man's person which is not justified in law, or excused in law, or consented to, is wrong, and for that wrong the person whose body has been interfered with has a right to claim such damages as he can prove he has suffered owing to that interference.

According to Van Oosten,[247] any medical intervention would be wrongful conduct if it were performed without justification or without the patient consenting to the harm.[248] If a patient consents to a medical procedure – for example, to have her uterus removed (hysterectomy) – the consent granted would justify the medical professional removing the uterus. However, if in the process of removing the uterus the surgeon transects the ureter (the tube between the bladder and the kidney), the action becomes wrongful, as it is presumed that in the hands of a skilful surgeon the uterus would be removed without further injury other than the injury consented to (removal of the uterus). If the surgeon encountered a distortion in the normal anatomy of the patient because of previous operations and adhesion formation, in certain instances that would be justification for the injury to the ureter.

A closer look at the previous example will show that, when testing the element of negligence, the court will examine whether the adhesion formation should have been foreseen and prevented. Bearing in mind that negligence 'is the failure in given circumstance to

[245]See para 4 above; *Trustees, Two Oceans Aquarium v Kantley and Templer (Pty) Ltd* (n 44) para 10; *Indac Electronics (Pty) Ltd v Volkskas Bank Ltd* (n 56) 797; *Minister of Safety and Security v Van Duivenboden* (n 56) para 12; *LAWSA* Vol 8 Part 1 para 65. Roman law did not recognise omission as wrongful but Roman-Dutch law recognises omission as wrongful if there is a negative duty to avoid causing injury to others and not a positive duty to shield others from injury.

[246]1923 CPD 148.

[247]Van Oosten 'Legal liability'(1991) (n 211) 23ff. The information should be adequate so that the patient can arrive at an informed decision based on the information provided.

[248]See para 4 above on wrongfulness. 'Informed consent' is a prerequisite in determining the element of wrongfulness and would justify an act that would otherwise have been wrongful. Informed consent serves as a defence against allegations of assault and unlawful action in the context of medical negligence cases. See Van Oosten 'Informed consent' (1989) (n 89) 443ff; Claassen & Verschoor (1992) (n 89) 62–63; Strauss (1991) (n 89) 3, 46, 70ff; Boberg (n 55) 751; Van der Merwe & Olivier (n 55) 107ff. For justification in the medical context, see Van Oosten 'Legal liability' (1991) (n 211) 23ff; Strauss & Strydom (n 89) 223–224.

exercise that degree of care which the circumstances demand',[249] the defendant would be found negligent if he failed to foresee and prevent harm from occurring to his patient.[250] Further to the previous example, if the defendant can show that he had foreseen that an injury to the ureter might occur and took reasonable action to prevent it, but despite this preventative action, the injury still occurred, the defendant would not be negligent. Van Oosten[251] confirms that negligence implies that the defendant-doctor failed to foresee and guard against risk or harm to the plaintiff-patient and that a reasonable doctor would have foreseen that possibility and would have guarded against it by taking steps to prevent it. He writes:

> Fundamentally the test is an objective one in so far as the hypothetical or fictitious 'reasonable man' sets the standard, but it also comprises a subjective element inasmuch as it requires, in addition, that the reasonable man be placed in the same position as the defendant or accused found himself at the time. In turn, the reasonable man is commonly defined not as the perfect man, but the man of average intelligence, knowledge, competence, care, skill and prudence.

The element of negligence is established from comparing the action of the defendant with what a reasonable person would have done under the same circumstances.[252] The standard of care is that which a *diligens paterfamilias*[253] would have exercised in the same circumstances. This was the test concerning a reasonable man in the street in everyday life. In *Van Wyk v Lewis*, [254]the court pronounced, based on *Mitchell v Dixon*, [255]that a medical practitioner is

[249]*Cape Town Municipality v Paine* (n 108) 207 and 229–230; also see *Farmer v Robinson* (n 122) 522; *Herschel v Mrupe* (n 125) 490E–F; *Kruger v Coetzee* (n 6) 430E–G; Neethling, Potgieter & Visser(2010) (n 44) 131; Van der Walt & Midgley (2005) (n 35) para 116.
[250]Claassen & Verschoor (n 89) 117; *R v Meiring* 1927 AD 41 at 46, describing the standard of care and skill that would be expected by the reasonable man in similar circumstances.
[251]Van Oosten 'Legal liability' (1991) (n 211) 23ff.
[252]*Sea Harvest Corporation (Pty) Ltd v Duncan Dock Cold Storage (Pty) Ltd* (n 55) para 21, which referred to *Kruger v Coetzee* (n 6) 430E–F; *Mukheiber v Raath* (n 5) 1077E–F para 32, where it was stated that the relationship between doctors, nurses and patients involves the duty to act with reasonable care and skill. It is a duty imposed by the law of delict. See also *Farmer v Robinson* (n 122) 521–524; *Transvaal Provincial Administration v Coley* 1925 AD 24; *Jameson's Minors v Central South African Railways* 1908 TS 575 at 587: *Cape Town Municipality v Paine* (n 108) 229–230.
[253]*Kruger v Coetzee* (n 6) 430E–G. *S v Burger* 1975 (4) SA 877 (A) confirmed the duty of a 'diligent *paterfamilias'* and enunciated that the diversity of a population would influence the test of a reasonable man. In this case, Holmes J established that one does not expect of a *diligens paterfamilias* any extremes like 'Solomonic wisdom, prophetic foresight, chameleonic caution, headlong haste, nervous timidity or the trained reflexes of a racing driver but only moderation and prudent common sense'. See also Claassen & Verschoor (n 89) 8.
[254]*Van Wyk* (n 42).

bound to employ reasonable skill and care with regard to the 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. Claassen and Verschoor[256] argue that reasonable care[257] should mean that, should the physician fail to employ a recently developed but widely acknowledged method of treatment and his patient is prejudiced by the outdated method used by him, then the physician can be held liable for the consequences. In *R v Van der Merwe*[258] the court held that, in a skilled profession such as the medical profession, negligence has a special application, as the professional practises a profession that requires skill, he holds himself out as possessing the necessary skill, and he undertakes to perform the services required with reasonable skill and ability. The court said further that–

> in deciding what is reasonable regard must be had to the general level of skill and diligence possessed and exercised by the members of the branch of the profession to which the practitioner belongs. The standard is the reasonable care, skill and diligence which are ordinarily exercised in the profession generally.[259]

In *R v Van Schoor*,[260] Steyn J held that the elevated degree of care and skill expected of a doctor is that 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 degree of care and caution than in other circumstances'. Thus, the reasonable man test has been elevated to that which is expected of a reasonable doctor.

To determine the appropriate standard of what constitutes 'reasonable care', the court in *Michael v Linksfield Park Clinic (Pty) Ltd*[261] referred to the English case *Bolitho v City*

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[255]*Mitchell v Dixon* (n 133).
[256]Claassen & Verschoor (n 89)7, 16.
[257]'Reasonable care' has been widely established: see *Van Wyk* (n 42); *Allot v Paterson and Jackson* (n 220); *Kovalsky v Krige* (n 220); *Coppen v Impey* (n 223); *Buls v Tsatsarolakis* (n 58);*Applicant v Administrator Transvaal* (n 227); *Collins v Administrator Cape* (n 211); *Clinton-Parker v Administrator Transvaal* (n 227) 46–47.
[258]1953 (2) PH H 124 (W).
[259]*R v Van der Merwe*(n 258).
[260]1948 (4) SA 349 (C) 350.
[261]2001 (3) SA 1188 (SCA) 784. In this case the plaintiff's son, a healthy and fit 17-year-old-boy, sustained a sports injury to his nose. During surgery to repair the bridge of his nose, several intravenous medications were administered. These resulted in a hypertensive-medicine-induced crisis, which the anaesthetist failed to control. The boy went into cardiac arrest which was insufficiently handled by the medical professionals and the boy sustained brain damage. The court went to great lengths to obtain proper medical information from the medical

&Hackney Health Authority.[262]The court held that it is not bound by expert opinion if there is no logical basis for such opinion. A defendant can be held liable despite professional opinion sanctioning the conduct in issue. The court will have the ultimate say and not the professional expert. It is generally accepted[263] that the standard of care required from the medical professional is no longer that of a fictitious reasonable person, but that of a reasonable doctor in the same position as the individual doctor. The standard of the medical professional will also be tested with reference to the legal convictions of the community and prescribed medical standards.[264] A defence based on lack of resources would succeed, if a vital instrument or equipment, usually available, is not available and the patient sustains avoidable harm. It is argued that a lack of resources should not be confused with mismanagement of resources or maladministration of available funds.

Before turning to a detailed discussion of the application of the maxim in medical cases, it is important to consider the effect of constitutional rights and substantive transformation in South Africa on medical cases. As mentioned before, the right to be treated with dignity and respect is a central value underlying the South African Constitution and can even be seen as the cornerstone of the Constitution and the rights protected by the Constitution.[265] When interpreting and applying the various substantive rights the Constitutional Court bases its approach on the right to human dignity.[266] The court does not relate to these rights in an 'contextual or overtly formalistic manner', but has adopted a substantive approach, taking into consideration the broader social, economic and political

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experts and finally announced strict conditions for the presenting of a medical expert's evidence: the court is not bound by the evidence presented by the experts and will not allow the expert to usurp the function of the court; expert opinion should be based on logical scientific practice and should constitute sound practice. The court warned that medical experts are scientists who are used to assessing the likelihood of events against a scientific certainty that is possibly based on statistical evidence and does not necessarily weigh the balance of probability of the most likely events. For a detailed discussion of this case, see Pienaar (n 242).

[262][1997] 3 WLR 1151. In the initial test in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582, it was determined that 'a doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a *responsible* body of medical men skilled in that particular art'. This judgment of His Lordship McNair was based on *Holmes v Board of Trustees of the City of London* 1977 81 DLR (3d) 67 at 91. However, this test was qualified in *Bolitho v City & Hackney Health Authority* [1997] 3 WLR 1151, when the House of Lords made it clear that the court must be careful to distinguish whether the practice of the medical profession has a logical basis. This includes weighing the risks against benefits. Therefore, it is open to the judge to find negligence without proof of a general standard and despite expert evidence to the contrary.

[263]See Van Oosten 'Legal liability' (1991) (n 211) 23ff; Boberg (n 55) 346; Van der Merwe & Olivier (n 55) 142ff; Carstens & Pearmain (n 27) 619ff.

[264]See para 4.1 above. In *Soobramoney v Minister of Health (Kwazulu-Natal)* (n 74), the selection criteria of the health system, because of insufficient resources, were legal grounds for judicial discretion to interfere with individual legal rights contrary to the *boni mores*.

[265]De Vos et al *Constitutional Law* (n 167) 418.

[266]Ibid.

context, but always remaining mindful of the structure of society and the cultural assumptions deeply embedded in society.[267]

This approach of the Constitutional Court is evident in *The Premier of the Western Cape v Loots*[268] and in *Lee v Minister for Correctional Services.*[269] In a recent case, *Oppelt v Head: Health, Department of Health Provincial Administration: Western Cape*[270]a young man, while playing rugby, sustained spinal cord injuries that rendered him paralysed from the neck down. The plaintiff averred that the defendant had owed him a legal duty to ensure that his low velocity spinal cord injury was treated with the greatest possible urgency to prevent permanent damage to the spinal cord. The essence of the claim was that the said treatment should have occurred within four hours; because it did not, permanent damage resulted. The High Court found in favour of the plaintiff, the Supreme Court of Appeal reversed the decision of the High Court, and the plaintiff approached the Constitutional Court. The plaintiff (now applicant) requested leave to appeal based on constitutional issues as well as an arguable point of law of general public importance. The plaintiff averred that his constitutional right not to be refused emergency treatment was violated; that the defendant acted unreasonably in that he was not transferred to a speciality unit immediately; that the finding of the Supreme Court of Appeal ie that he failed to establish a causal link between the conduct of the hospital employees and the paralysis of the plaintiff was incorrect; and that the latter conclusion regarding factual causation was wrong because of an incorrect approach to the evaluation of the evidence of the plaintiff's medical expert. The majority ruled in favour of the plaintiff based on a more flexible approach to factual causation principles. The court held that the rule is not inflexible, and ultimately it is a matter of common sense whether the facts established a sufficiently close link between the harm and the unreasonable omission. The court stated that the defendant's employees did not give a satisfactory explanation for the unreasonable delay in treatment. The court accepted the more relaxed approach because the plaintiff was unable to show that, if he had been treated in time, the paralysis would not have resulted.

[267]De Vos et al *Constitutional Law* (n 167) 419.
[268]*The Premier of the Western Cape v Loots* (n 128), where causational principles were relaxed. See para 4.2 above.
[269]*Lee v Minister for Correctional* Services (n 13), where factual causation principles were applied in a flexible manner. See para 4.3above.
[270]*Oppelt* (n 166).The stance of the court is consistent with the judicial relaxation of causation in England. See chapter 3 para 2 and 9.

This substantive approach by the court may seem strange against the backdrop of previous formal and contextual legal reasoning, but it should be viewed as an obligation on the state to consider socio-economic aspects in all constitutional rights and a requirement to act rational, just and reasonable.[271] In doing so, the measures must be balanced and flexible, taking into consideration short-, medium- and long-term effects and needs of the community.

8 *Res ipsa loquitur* in medical negligence cases

The thesis intends to discuss several medical cases as if the case relied on the maxim because of the incorrect belief that a plaintiff usually has no knowledge of what occurred and that the fact of the injury may be perceived as a potential *res ipsa loquitur* case.[272] In 1916, in South Africa, a plaintiff sustained an x-ray burn to her hand in *Coppen v Impey.*[273]It was found, without referring to *res ipsa loquitur* principles, that the plaintiff had the onus of proving that the defendant had been unskilful in his application of the x-ray apparatus under his control. The court held that the plaintiff had to show that the defendant was the cause of the harm suffered by the plaintiff. The court stated that no inference of negligence would be entertained without sufficient expert evidence. If such a case was presented today, without medical expert evidence, the outcome would have been the same, because uninformed individuals would not have knowledge of the underlying physical principles of irradiation on human tissue or about the likely harm of the incorrect use of potentially dangerous equipment to prove the cause of the injury. Furthermore, it is unlikely that a South African court would have accepted the case based only on a lack of informed consent (as part of the element of wrongfulness) as the plaintiff undoubtedly consented to the treatment although not to treatment in the hands of an unskilled operator. It is the lack of skill that caused the injury.

[271]De Vos et al (n 167) 723.

[272]It is the argument of the thesis that the maxim is used incorrectly in medical cases for example, it is not correct to use the maxim simply because of incomplete medical evidence or lack of understanding of the evidence when the cause of the injury is known to the medically informed person and evident from the medical literature. The function of the maxim in South Africa is rather that when something ought to have occurred in a certain way (assuming one understands all the aspects of the incident), it gives rise to the presumption that it could not have happened without negligence. See discussion in para 8 below.

[273]*Coppen v Impey* (n 223).The maxim was adopted from an 1874 case, *Gifford v Table Bay Dock and Breakwater Management Commission* [1874] Buch 962 118. The court found sufficient evidence of negligence and the question whether a presumption of negligence was raised was avoided. The court referred to the English case, *Scott v London & St Katherine Docks Co* [1865] 3 Hurl & Colt 596 and accepted the *res ipsa loquitur* maxim. This case is referred to by Van den Heever & Carstens (n 7) 8.

In 1924, in *Van Wyk v Lewis*, [274]South Africa saw the defining moment for the status of the *res ipsa loquitur* maxim. The plaintiff claimed damages from a surgeon who performed a cholecystectomy operation (removal of the gall bladder). Several months later a muslin swab was excreted. The plaintiff presented her own evidence. She did not make use of a medical expert; however, the court commissioned prominent medical experts to assist the court in this matter. The court of first instance ruled that a *prima facie* case was made out without having to rely on the *res ipsa loquitur* maxim.[275] Van der Riet J rejected the maxim by stating:

> [w]hile, therefore, the leaving of a swab may be *prima facie* evidence of negligence on the part of those taking part in the operation I do not think that it could be said that this justifies the contention that it is a matter of *res ipsa loquitur*, that a finding that a swab has been left behind indicates negligence on the part of the operating surgeon. I am not prepared to state to what extent as a general rule negligence is to be presumed for it seems to me that this question depends on the special circumstances of the operation, for the degree of care which the surgeon can devote to this detail of detecting swabs must largely depend upon the nature of the operation and the expedition which had to be used. [276]

The defendant did not apply for absolution from the instance at that stage (an allegation that the plaintiff failed to prove her case), which implies that he did not dispute that the plaintiff may have established a *prima facie* case. Van der Riet J held that a swab was indeed retained; that the defendant adopted the standards system in use at the hospital to count swabs; that the defendant made a careful search before sewing up; that the theatre nurse failed to warn him of a missing swab; that the nurse is not an agent of the surgeon and he could therefore not be held liable for any failure on her part; and that the surgeon was not personally negligent. The court found in favour of the defendant.[277] The plaintiff appealed to the then Appellate Division in Bloemfontein.

[274]*Van Wyk* (n 42). See a detailed analysis of the medical facts and interpretation in chapter 4.
[275]For a quote in the context of the decision of the High Court at the time see Van den Heever & Carstens (n 7) 23, 24 fnn 56, 59, 60.
[276]*Van Wyk* (n 42) 1923 E 304, which was the decision of the High Court.
[277]See Van den Heever & Carstens (n 7) 25 for a detailed discussion.

On appeal, the matter was heard by Innes CJ, Wessels JA and Kotze JA.[278] The majority judges, Innes CJ and Wessels JA, concurred that the maxim should not apply to this case, whereas the minority judge, Kotze JA, dissented and accepted the maxim. Innes CJ (for the majority) held[279] that in certain instances the occurrence speaks for itself, 'where the nature of the occurrence is such that the jury or the court would be justified in inferring negligence from the mere fact that the accident happened … [i]t is really a question of inference'. The judge continued that in cases where the maxim is relevant 'the occurrence is in itself *prima facie* evidence of negligence'; it does not mean that the onus of proof shifts automatically to the defendant. The majority judgment stated that the plaintiff alleged a lack of reasonable care and skill and the correctness of that allegation can only be determined in the presence of all the facts. The majority judgment advised that 'there is no absolute test; it depends upon the circumstances'. Wessels JA (for the majority) was reluctant to apply the maxim and stated that the 'mere fact that a swab is left in a patient is not conclusive of negligence' and that–

> [c]ases may be conceived where it is better for the patient, in case of doubt, to leave the swab in rather than to waste time in accurately exploring whether it is there or not, as for instance where a nurse has a doubt but the doctor after search can find no swab, and it becomes patent that if the patient is not instantly sewn up and removed from the operating table he will assuredly die. In such a case there is no advantage to the patient to make sure that the swab is not there if during the time expended in exploration the patient dies.[280]

The majority judgment per Wessels JA determined that 'the maxim *res ipsa loquitur* has no application in cases of this kind. He held that this does not mean that the plaintiff can stop when he has brought some evidence from which negligence should be inferred and then require the defendant to proceed until the balance has swayed in his favour. The onus of proof lies with the plaintiff who has the duty to discharge it, 'from the beginning of the trial to the very end'.[281] The minority (Kotze JA), dissenting partially, was of the opinion that leaving a swab in the abdomen establishes a case of negligence unless it is rebutted in

[278]*Van Wyk* (n 42) 1924 AD 438, which was the Court of Appeal judgment. Innes CJ and Wessels JA concurred and Kotze JA dissented.
[279]*Van Wyk* (n 42) 444ff.
[280]*Van Wyk* (n 42) 464ff.
[281]*Van Wyk* (n 42) 464ff.

evidence. In the particular circumstances of this case, after hearing the defendant's explanation in repeal, Kotze JA also concluded that the defendant was not negligent. Furthermore, the court stated that swab-counting was not under the control of the surgeon, since he delegated it to the theatre sister. The final dictum suggests at least three possible interpretations of the *res ipsa loquitur* maxim:

(i) the occurrence of the injury automatically denotes negligence ie there is no chance of any defence (irrebuttable presumption): this is not accepted as the design of the maxim in South Africa;

(ii) once the plaintiff shows the fact of the injury the defendant may rebut negligence but bears the burden of proving an explanation that indicates there was no negligence, or faces judgment against him (rebuttable presumption): this is not accepted as the design of the maxim in South Africa;

(iii) the fact of the injury raises an evidential inference on the facts or an even weaker *prima facie* implication of negligence that requires the plaintiff, who carries the formal burden of proof, to lead adequate expert evidence to prove his case or run the risk of not discharging the burden of proof. In the latter situation the defendant would lead some evidence to sway the court in his favour but need not disprove negligence. The analysis of the above case by the majority judgment was in accord with this final viewpoint which is the design of the maxim in South Africa.

The rejection of the maxim was reaffirmed in *Allot v Patterson and Jackson*[282] and in *Pringle v Administrator Natal*.[283] It was evident that the *res ipsa loquitur* principles were categorically jettisoned and the statement in *Van Wyk v Lewis*[284]that 'this maxim cannot be invoked where negligence depends on *something not absolute but relative*' later became the highlight of the academic debate.[285] In *Pringle v Administrator Natal*, Blum AJ confirmed 'that the maxim could only be applied where the negligence depended on absolutes'.[286]Even if this appears to be judicial rhetoric, erroneously based on an extreme interpretation of the *res ipsa loquitur* maxim, and the general approach is that no court would ever apply the maxim

[282]*Allot v Patterson and Jackson* (n 220). In this case the plaintiff sustained an injury to his right arm after a dental extraction procedure under general anaesthesia. The dentist and doctor denied liability. The plaintiff apparently had to be restrained by the defendants. The plaintiff alleged that inadequate anaesthesia was used, which led to pain and struggling. The rough and unskilful handling of the patient resulted in the injured arm.
[283]*Pringle v Administrator Transvaal* (n 113).
[284]*Van Wyk* (n 42). See Strauss &Strydom (n 89) 280 for a discussion.
[285]See same paragraph below.
[286]It is one of the arguments that Van den Heever and Carstens (n 7) 36 use to criticise *Van Wyk* (n 42).

in this way, one would find it difficult to apply the maxim to a medical case in any other way. This supports the point that the maxim is not appropriate in medical cases in South Africa based on principles of legal presumptions and delictual requirements of a wrongful act.

The facts of the *Pringle* case were as follows: the plaintiff had a growth in the mediastinum (chest) that was in close proximity to the *superior vena cava* (large blood vessel), and underwent a mediastinoscopy.[287] During the medical procedure, the *superior vena cava* was perforated and massive bleeding ensued. The surgeons had difficulty repairing the perforation and stopping the bleeding and the patient sustained brain damage. The plaintiff's allegations were that the perforation occurred as a result of the surgeon not having the required skill and expertise, and in the alternative that the procedure had been the incorrect procedure for the plaintiff's medical condition. Blum AJ, clarified the difference between 'absolute' and 'relative' evidence, opposed to the design of the maxim, by stating that had evidence been presented to show that the mere fact of such perforation was negligence, the maxim would have applied. The court held that, since the question of negligence *depended on the surrounding circumstances* of the case, it no longer 'depended on absolutes', thus the maxim was *ipso facto* excluded. The court maintained that the maxim was inapplicable to this case. The court concluded on expert evidence that the surgeon used excessive force, which was the cause of the tear in the *superior vena cava*. It was indicative of a lack of the required skill and care. The surgeon was found liable.

It is argued that the above judgment was correct in rejecting the application of the *res ipsa loquitur* maxim[288] for several reasons. First, it appears that expert medical evidence was presented. Second, the court relied on circumstantial evidence. For example, if the plaintiff had invoked the maxim *res ipsa loquitur* without medical expert evidence and the defendant offered an alternative causal explanation in rebuttal, the court would not be able to weigh and test the interpretation of the medical facts of the defence without medical expert evidence on

[287] A small surgical cut is made in the neck of the patient and a device, a lighted instrument, the mediastinoscope, is inserted into the space in the chest between the lungs, the mediastinum, to remove tissue from growths or lymph nodes. The pulmonary artery *superior vena cava* runs in close proximity to the area where the procedure is performed (see http://www.foundhealth.com/mediastinoscopy/overview (accessed 12 May 2015)). See KL Mattox 'Complications in surgery and trauma' (1990) 212(1) *Ann. Surg.* 114–115. The author explains that the structure on which a biopsy is to be performed should be clearly identified and delineated. Needle aspiration should be performed to rule out a vascular structure. A biopsy of a tumour that has invaded a vascular structure may result in a dramatic vessel tear. A disease process may alter the normal anatomy by fibrosis, invasion or displacement (tissue formation around the blood vessel). Complications like injury to the pulmonary artery or *superior vena cava* or other vessels can occur as a result of the dissection, which can result in massive bleeding. Uncontrolled bleeding would lower the blood pressure substantially and if this is not resolved would result in inadequate blood supply to the brain and subsequent brain damage.

[288] *Pringle v Administrator, Transvaal* (n 113).

the side of the plaintiff. It would have had the effect that the maxim (without the support of medical evidence) resulted in a strong defence from the defendant which stands unopposed because of an inadequately prepared plaintiff. The plaintiff would lose the case. In addition, a case based on expert medical evidence and substantial allegations would have called for a proper and relevant explanation from the defendant to rebut the specific allegations. For the defendant to justify the injury he would have to adduce explanations, eg that the anatomy of the plaintiff was distorted due to adhesions surrounding the major blood vessel and therefore the surgery was complicated, or that, despite exercising exceptional care to dissect the vessel it was torn, and so forth. A reasonable doctor would have foreseen that excessive force might result in a torn blood vessel with massive haemorrhaging. A reasonable doctor would have foreseen that failure to re-establish adequate haemostasis (fluid balance in the body) and insufficient resuscitation would result in hypotension (low blood pressure) which would result in insufficient blood supply to the brain and ultimate brain damage. A prudent doctor would have foreseen such an event and would have guarded against such an injury.

The maxim *res ipsa loquitur* has been applied in South Africa in cases other than medical negligence, where it establishes a presumption[289] of fact. In *Klaassen v Benjamin*,[290] the maxim was merely seen as 'a short way of referring to a body of circumstantial evidence when considered in relation to the question whether enough has been proved by the party bearing the onus to put the other party on his reply'. In other words, the key facts should be such, at least, to establish *prima facie* evidence that needs to be answered by the other party. Although it seemed that the maxim was applied in a moderate way, this was not the case. The facts of the cases in which the maxim was applied, at the time, were such that they were known to the ordinary man. These cases were not as complex and fact-sensitive as are medical cases. Nevertheless, the need to standardise the requirements for the *res ipsa loquitur* maxim was addressed in *Groenewald v Conradie*.[291]The court listed the following requirements for the maxim to apply:

[289]See para 5 above in respect of legal presumptions.
[290] 1941 TPD 80 at 87; *SAR & H v General Motors (SA) Ltd* 1949 1 PH J3 (C), where a care fell from a crane; *Paola v Hughes (Pty) Ltd* 1956 (2) SA 587 (N), where a chandelier fell and broke while lowered to clean; *Arthur v Bezuidenhout* (n 186), where the plaintiff sued for damages for the loss of a motor vehicle that had been wrecked in a collision.
[291]1965 (1) SA 184 (A) 187F. Rumpff JA states that 'dit wenslik [is] om te beklemtoon dat die gebruik van die uitdrukking *res ipsa loquitur* , streng gesproke, alleen dan van pas is wanneer dit nodig is om enkel en alleen na die betrokke gebeurtenis te kyk sonder die hulp van enige ander verduidelikende getuienis. Alleen as die gebeurtenis op sigself en in sy eie lig beskou word, behoort die uitdrukking gebesig te word omdat anders die beperkte betekenis daarvan vertroebel mag word'. See also *Mitchell v Maison Lisbon* [1937] TPD 13, where the plaintiff was burnt by the defendant's defective permanent waver.

(a) the thing (*res*) must be under the management or control of the defendant and if some intervening incident becomes evident then the maxim cannot apply;

(b) the accident does not ordinarily happen without negligence; and

(c) there must be no evidence to explain the occurrence, ie an explanation must be absent.

Rumpff JA stated that many classes of an occurrence exist where the mere occurrence of an accident is not sufficient to infer negligence. He referred to Murray,[292] where the author explained:

> If *res ipsa loquitur*, then the defendant may disprove negligence, either by leading evidence, or by closing his case and showing the Court by argument that it ought not in fact to infer negligence. If he disproves negligence he may obtain judgment in his favour, or the Court may grant absolution from the instance. Indeed, the fact that the court may very well, in a given case, refuse absolution at the close of plaintiff's case because *res ipsa loquitur*, and nevertheless grant it at the close of defendant's case, brings the maxim in its true perspective.

Van den Heever and Carstens[293] advocate for the application of the *res ipsa loquitur* maxim in South Africa in medical negligence cases. They summarise the principles of the maxim as follows:

(1) the occurrence does not ordinarily happen without negligence;

(2) the occurrence should carry a high probability of negligence;

(3) the facts upon which the inference is drawn are derived from the occurrence alone;

(4) the presence or absence of negligence must depend on an 'absolute' and if the court had to look at surrounding circumstances for support for the maxim then the maxim cannot find application; and

(5) an inference of negligence is only permissible while the cause remains unknown.[294]

[292]IB Murray '*Res ipsa loquitur*' 1946 *SALJ* 80–81. Murray says that the *res* (thing) is a piece of real evidence and cannot lie or be mistaken. It is this fact that distinguishes a *res ipsa loquitur* case from the ordinary so-called *prima facie* case of negligence, where the witnesses may err. He argues that it is distinctly disadvantageous to try to merge the principles of *res ipsa loquitur* into a principle of *prima facie*.

[293]Van den Heever & Carstens (n 7) 34. They refer to *Mitchell v Maison Lisbon* (n 291); *Allot v Paterson and Jackson* (n 220); *Pringle v Administrator, Transvaal* (n 113); *Administrator, Natal v Stanley Motors*(n 195).

It appears that to rely on the maxim, it must be more probable than not that the defendant was negligent ie the fact of the harm (fact of the occurrence) itself may be considered as enough evidence that the expected skill or care was not exercised. In such a scenario, the only facts available are the facts of the accident itself and the plaintiff is unable to tell how the accident happened. The question then arises whether, on the available facts, negligence (*culpa* grounding liability) can be inferred. The circumstances themselves must speak of negligence by the defendant without the likelihood of outside interference. If it is possible that other persons or occurrences could have interfered with the incident that caused the harm, then the maxim cannot apply. Finally, the design of the maxim is to complete the picture with inferences from available facts where further facts are not available. Where there is evidence as to why or how the harm occurred, it is not appropriate to draw on an inference of negligence without proving a specific act or omission.

Van den Heever and Carstens appeal for the maxim and its application to be revisited, basing their arguments on the misinterpretation of the court in *Van Wyk v Lewis*[295] regarding certain aspects. They maintain that the judgment was 'based on [a] fundamental misdirection [of the court]'.[296] They express the opinion that failing to notice that a swab is missing and leaving it in the abdomen of a plaintiff is 'absolute' evidence of negligence and not 'relative' evidence of negligence. Therefore they endorse the use of maxim *res ipsa loquitur* in this matter. They advocate[297] that 'absolute' evidence means that the occurrence itself must be of such nature that, if 'the common knowledge or ordinary standard' were applied, the occurrence would not have happened without negligence. It is argued that the authors' statement cannot be seen to suggest that the fact of the injury constitutes proof of negligence, suggesting that the design of the maxim should mirror that of a rebuttable presumption, as then the authors are confusing legal presumptions with factual presumptions. The remaining alternative is that the authors' statement should be interpreted as a plea for the application of

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[294]Van den Heever & Carstens (n 7) 34.
[295]*Van Wyk* (n 42).
[296]Van den Heever & Carstens (n 7) 36 and para 2.5.3.3, where the authors are of the opinion that the retention of a swab is 'absolute' evidence and not 'relative' evidence of negligence.
[297]Van den Heever & Carstens (n 7) 146ff, where they discuss the misdirection of the court with regard to 'absolute' evidence and 'relative' evidence. See also P van den Heever *The Application of the Doctrine of Res Ipsa Loquitur to Medical Negligence Actions: A Comparative Survey* (2000) 136.

the maxim similar to that of the English court,[298] where the maxim allows for a more generalised inference of negligence based on lack of skill and care without the restrictions stipulated by the South African delictual law.

The authors conclude that the judgment should not be regarded as 'incontrovertible authority for the proposition that the doctrine of *res ipsa loquitur* cannot be utilized [in medical cases]' and argue that the court should open the door for the maxim. They aver, inter alia, the following:

(i) the ruling of the court in *Van Wyk v Lewis*[299] created prejudice because a victim of a medical accident is precluded from using the maxim, while a victim of a motor vehicle accident, in certain instances, may apply the maxim;

(ii) the application of the maxim will alleviate the burden of proof borne by the plaintiff in a medical negligence case;

(iii) the refusal of the court to allow the application of the maxim in medical negligence claims provided unjustifiable protection to the defendant; and

(iv) constitutional arguments support the maxim with regard to access to courts and equality.[300]

The view of Van den Heever and Carstens gains no support from the case of *Wagener v Pharmacare*[301] where an attempt was made to re-introduce the maxim. The plaintiff underwent a local anaesthetic injection with an anaesthetic solution, Regibloc, in the shoulder to reduce on going pain. The plaintiff developed severe tissue necrosis and paralysis of the right arm. It was argued during the course of the case that the *res ipsa loquitur* maxim should be used in the context of 'product liability' in a medical context. The case went to court before s 61 of the Consumer Protection Act 68 of 2008 came into force, which establishes strict liability alongside orthodox fault liability in delict at common law. The alleged negligence was based on the negligence of the manufacturer in producing an unsafe product. An inability by the plaintiff to produce other evidence of a defect during the manufacturing process or a defective product during the use of the product or in using the product led to the argument that strict liability should be imposed by the court. The plaintiff based his case on the application of the *res ipsa loquitur* maxim. It should be noted that there is a difference

[298] See chapter 3 para 7.
[299] *Van Wyk* (n 42).
[300] See a discussion that contrasts with these recommendations in chapter 5.
[301] 2003 (4) SA 285 (SCA).

between strict liability and the *res ipsa loquitur* maxim. The maxim is a mechanism to establish fault whereas strict liability dispenses with it. Although the effect may be similar in practice, it is conceptually distinct. The element of negligence could not be proved and the court dismissed the case. The court refused to apply the *res ipsa loquitur* maxim.

Strict product liability in the context of the Consumer Protection Act falls outside the scope of the thesis, but *Wagener v Pharmacare* represents a case that arguably should have been based on medical negligence principles and not product liability. For example, why was the conduct of the anaesthetist not investigated? In accordance with medical literature, the inadvertent vascular injection (ie an injection into the artery or vein) of local anaesthetic solutions or corticosteroids can cause avascular necrosis (the dying of bone cells as a result of compromised blood supply).[302] Alternatively, the intra-articular injection (into the joint) of a large dose of corticosteroid together with local anaesthetic solutions with epinephrine can cause rapid damage to the cartilage in the shoulder joint, which would result in paralysis (chondrolysis) of the shoulder. Strangely, these allegations were not investigated. This medical information obtained from the literature accords with the most likely cause of the injury and should have been presented as medical evidence from which factual causation emanates. The cause of the harm may have been an inadvertent injection into the wrong location ie the shoulder joint. The element of negligence (*culpa*) would then have been argued on the basis that the anaesthetist's lack of skill caused the injury. The doctor ought to have known and foreseen that such an injection into the wrong area would cause harm and he should have taken precautions to prevent it. He should have been aware of the risks of injecting the solution into the joint or vascular structures and should have taken preventative steps to avoid doing so. The court was correct in finding that the maxim cannot apply, as the plaintiff brought his case against the manufacturer and not the anaesthetist. The plaintiff relied only on the maxim and failed to present any evidence of fault on the part of the manufacturer. The court was unable to infer negligence (*culpa* and liability) from the undesired event. Unfortunately, the anaesthetist was not party to the proceedings, hence the liability (blameworthiness) of the anaesthetist was not argued.

[302]See Berjano P, González BG, Olmedo JF, Perez-España LA, and Munilla MG. Complications in arthroscopic shoulder surgery. *Arthroscopy*. 1998; 14(8):785–788; for a better explanation see later literature P J MacMohon et al 'Injectable corticosteroid and local anesthetic preparations: A review for radiologists' (2011), available athttp://pubs.rsna.org/doi/full/10.1148/radiol.2523081929 (accessed 12 May 2015; Houston Methodist Orthopedics & Sport Medicine 'Osteonecrosis of the humeral head', available at http://www.methodistorthopedics.com/osteonecrosis-of-the-humeral-head (accessed 10 October 2014); DS Bailies et al 'Severe chondrolysis after shoulder arthroscopy: A case series' (2009) 18(5)*Journal of Shoulder Elbow Surg.* 742–747.

In *Medi-Clinic v Vermeulen*[303] the plaintiff did not rely on the maxim, but it appears to be a simple case of a patient going into hospital to be treated for cerebral malaria and leaving hospital permanently disabled and dependent on a wheelchair. Any argument that this situation indicates that negligence has occurred is flawed. This case is mentioned in context of an undesired and unexpected outcome. It is used to illustrate the complexity of the medical reality. The plaintiff contracted cerebral malaria and was gravely ill. The nursing personnel could not turn him to prevent bedsores as his blood pressure remained dangerously low and it was too risky to turn such a patient. He developed a bedsore so severe that it damaged both his bilateral sciatic nerves and he became wheelchair bound. The court found for the hospital as the management of the medical condition of the plaintiff under these circumstances cannot be criticised. This case demonstrates that an adverse event is rarely indicative of negligence in medical cases as complications can occur at any time and if it is interpreted correctly will provide the explanation of how the harm occurred without negligence.[304] In the ordinary course, the medical reality will not be obvious to non-medical persons.

In another recent case, *Cecilia Goliath v MEC for Health in the Province of Eastern Cape,*[305] the *res ipsa loquitur* maxim was pleaded based on the argument of Van den Heever and Carstens.[306] In this matter, the plaintiff had a routine hysterectomy to remove a fibroid uterus at an Eastern Cape state hospital. The plaintiff appeared to have recovered and was discharged. About two months later the plaintiff was readmitted suffering from severe pain and a wound abscess. She was scheduled for an operation, which was cancelled, because the abscess opened spontaneously. The plaintiff was discharged again. Two weeks later, the plaintiff was readmitted complaining of hard swelling in the abdominal scar. She was discharged again. Unwilling to return to the same hospital, the plaintiff attended a second hospital that referred her to a consulting surgeon, as she was suffering from recurring sepsis. The surgeon operated and removed a septic gauze swab from the wound. The plaintiff instituted action against the first hospital and was assisted by a medical expert who explained to the court the risks and effect of a retained object in an abdomen.

Several problems with the plaintiff's case were evident, the most important of which was that the medical expert did not address the potential *negligence* in respect of the retained

[303]2014 ZASCA 150.
[304]Argument borrowed from the English case of *O'Malley-Williams v Board of Governors of the National Hospital for Nervous Diseases* (1975) 1 BMJ 635 per Bridge J, where the claimant underwent a process where his arteries were investigated by means of x-ray and sustained serious neurological injuries.
[305]*Goliath* (2013) (n 49), the court of first instance.
[306]Van den Heever & Carstens (n 7) para 2.5.3.3.

swab. Therefore, no evidence was led to address one of the essential elements of delictual liability, namely, negligence. The plaintiff failed to plead that the swab was retained due to lack of care (instead of breach of legal duty and insufficient care), and that the surgeon failed to foresee and prevent such an occurrence. No hospital or medical records regarding the specific operation were presented to the court. The plaintiff's case was that there was sufficient evidence to establish negligence, and that the *res ipsa loquitur* 'doctrine'[307] should apply to this matter. The defendants argued that the element of *wrongfulness* had not been sufficiently established, nor had the test for *negligence* been sufficiently satisfied, and finally that the 'doctrine' of *res ipsa loquitur* was not applicable.

The trial court *per* Lowe J found that it was 'unable to find that the plaintiff has discharged the onus which fell upon her to establish the negligence of either surgeon or nursing staff in theatre relevant to the swab being left behind'.[308]The medical and hospital records were not made available by the plaintiff, except for the report of the plaintiff's treating doctor who was also her medical expert. Based on the *stare decisis* rule and the ruling of a superior court[309] the judge held that he could not allow the maxim. It was obvious that the judge was dissatisfied with the fact that several medical records were missing and with the defendant's failure to take responsibility for the case, and this may have been why the judge considered the maxim, before disallowing it. The judge concluded[310] that–

> had the maxim *res ipsa loquitur* been applicable to this matter and had I been able to rely thereon, the result in this matter may well have been completely different and in those circumstances the absence of an explanation by the defendant may well have been sufficient, by way of inferential reasoning, to establish negligence on the part of the medical staff concerned.

The trial court reaffirmed the elements of wrongfulness and negligence and then discussed the application of the *res ipsa loquitur* maxim. The court criticised the decision of its sister court, *Ntsele v MEC for Health Gauteng Provincial Government*[311] (where the maxim was

[307]Word used by the plaintiff in place of 'maxim'.
[308]*Goliath* (2013) (n 49) paras 4–6.
[309]*Van Wyk* (n 42).
[310]*Goliath* (2013) (n 49) para 121.
[311]2013 (2) All SA 356 (GSJ). The judgment in *Ntsele* is *ipso facto* flawed and the *res ipsa loquitur* maxim incorrectly invoked. It is trite that the lower court is bound by the *stare decisis* legal precedent. See chapter 4 for a discussion of the medical aspects of this case.

successfully applied), stating that in that case Mokgoatlheng J made an error in departing from the doctrine of *stare decisis.* The court held that the *Van Wyk v Lewis* decision was made by a court of appeal and any lower court is bound by it, as no South African authority had overruled the decision. The judge observed that, although Van den Heever and Carstens[312] directed that the *res ipsa loquitur* maxim should be reconsidered, the *stare decisis* precedent precluded him from deciding anything other than to reject the maxim. Although the court confirmed the rejection of the *res ipsa loquitur* maxim based on the decision in *Van Wyk v Lewis,* [313]the court invited an appeal on the basis of its preferred use of the *res ipsa loquitur* maxim.[314] The matter was taken on appeal.

Also of importance in this judgment is the court's reiteration of the presumption of fact with regard to negligence. The *res ipsa loquitur* maxim is a factual presumption, not dependent on any rule of law; it is simply an exercise of common sense and is not a true presumption of law. The maxim merely creates a permissible inference of fact, which the court may employ if, upon reviewing all the facts, this appears to be justified.[315] The judgment of the court *a quo* came before the Supreme Court of Appeal in 2014.[316] The Court of Appeal, *per* Ponnan JA, said that it seemed that the sentiments of the court of first instance were that, had it not been bound by the *stare decisis* precedent created by *Van Wyk v Lewis,*[317] its decision would have been different. The judge said that it seemed that this was the reason for granting leave to appeal. The court warned against wrong terminology in law and clarified the clear distinction between the elements of wrongfulness and negligence.[318] The court stated that the general reluctance of courts in South Africa to apply the maxim stems from the English case *Hucks v Cole,*[319] where Lord Denning MR observed that a doctor was not to be held negligent simply because something went wrong. The Supreme Court of Appeal held that 'to hold a doctor negligent simply because something had gone wrong, would be to

[312]Van den Heever & Carstens (n 7) 36.
[313]*Van Wyk* (n 42).
[314]*Goliath* (2013) (n 49) para 121. See *Buthelezi v Ndaba* 2013 ZASCA 72; 2013 (5) SA 437 (SCA), where the *res ipsa loquitur* maxim was again rejected. See chapter 4 for a discussion of this case.
[315]*Sardi* (n 195); *Osborne Panama SA v Shell and BP South African Petroleum Refineries (Pty) Ltd* 1982 (4) SA 890 (A) 897H–898A, where Wessels JA said: 'it is no doubt correct that in any every case, including where the maxim *res ipsa loquitur* is applicable, the enquiry at the end of the case is whether the plaintiff has discharged the onus resting upon him in connections with the issue of negligence.'
[316]*Goliath* (SCA) (n 49) [2014] ZASCA 182, the decision of the Court of Appeal.
[317]*Van Wyk* (n 42).
[318]*Goliath* (SCA) (n 49) para 7.
[319][1986] 118 New LJ 469; [1993] 4 Med LR 393 where Lord Denning MR stated that 'with the best will in the world things sometimes went amiss in surgical operations or medical treatment'.

impermissibly reason backwards from effect to cause'.[320] The Supreme Court of Appeal held that there is only one enquiry: namely, whether the plaintiff, having regard to all of the evidence in the case, had discharged the onus of proof.[321] The court agreed with Lord Justice Hobhouse[322] that 'the time may well have come to jettison it [the *res ipsa loquitur* maxim] from our legal lexicon'.[323] The court concluded in favour of the plaintiff and stated that 'on all of the evidence and the probabilities and the inferences' the plaintiff had discharged the onus of proof.[324]

It is unfortunate that in *Cecilia Goliath v MEC for Health in the Province of Eastern Cape*[325] the court did not elaborate on the reasons for the rejection of the maxim. The court simply avoided becoming 'enmeshed in the evolved mystique of the maxim'[326] and left the question 'in the realm of inference'. Instead the court decided the case on the preponderant weight of the evidence.

Because the Supreme Court of Appeal did not definitively confirm or reject the maxim in *Cecilia Goliath v MEC for Health in the Province of Eastern Cape,* [327]it seemed that the door was left open for the re-introduction of the maxim. In 2015, in *Nzimande v MEC for Health Gauteng,*[328] another case came before the High Court. The plaintiff's claims arose from the manner and fashion in which the medical staff attended to her baby's birth and the management of the follow-up care. The defendant (a state hospital) failed to participate in all the court proceedings other than to oppose the claims. The defendant failed to call any witnesses in support of their denial of liability. The facts of the case were that the plaintiff was scheduled for a caesarean section because of the diagnosis of a breach presentation. After the performance of the operation the plaintiff discovered that the baby had sustained cuts on her left arm during the caesarean process. The cuts were about four centimetres long and had been made into the muscle. The baby was left in an incubator that was dysfunctional or not

[320]*Goliath* (SCA) (n 49) para 9 referring to *Medi-Clinic v Vermeulen* (n 303) para 27.
[321]*Goliath* (SCA) (n 49) para 11. The court referred to *Sardi v Standard and General Insurance Company Ltd* (n 195) 780H. Holmes J held that 'the remainder of the story' must consist of more than mere 'theories or hypothetical suggestions'; the 'defendant's explanation must be based on fact, not fancy'.
[322] The court referred to *Ratcliffe v Plymouth and Torbay Health Authority* [1998] PIQR P170; [1998] Lloyd's Med LR 162; (1998) 42 BMLR 64 at 176 CA (Civ Div) p 178, where Lord Hobhouse stated that there is 'sufficient guidance to litigators and judges about the proper approach to the drawing of inferences' and suggested that 'the expression *res ipsa loquitur* should be dropped from the litigators' vocabulary and replaced with the phrase *prima facie* case'.
[323]*Goliath*(SCA) (n 49) para 12.
[324]*Goliath*(SCA) (n 49) para 19.
[325]*Goliath*(SCA) (n 49)paras 6ff.
[326]*Goliath*(SCA) (n 49) para 11.
[327]*Goliath*(SCA) (n 49)paras 6ff.
[328]2015 (6) SA 192 (GP) paras 3ff.

switched on. The operation to suture the cuts was performed only on the eighth day of the baby's life. The wounds became infected and took three months to heal. The plaintiff also developed complications as her wound began to bleed three days after the operation and she required a further operation. Eventually, both plaintiff and her baby were discharged and the plaintiff consulted a private medical professional. The plaintiff made use of medical experts ie a plastic surgeon and a clinical psychologist, but unfortunately not a gynaecologist. The plaintiff initially asserted that her evidence was sufficient to establish negligence on the part of the nurses and the doctor. The court held that, whereas the *res ipsa loquitur* maxim 'might not find general application, especially in matters in which conflicting expert evidence is called by all parties to the suit, it may well have to be considered in unusual situations such as the present.'[329] The court stated that the factual allegation regarding the operation performed on the mother did not necessarily establish a *prima facie* case of negligence against the doctor as the bleeding may not have been a result of negligence. However, a failure to attend to the problem expeditiously and 'to subject the plaintiff to days of pain, suffering, worry and disability while being parted from her child does not require expert evidence to establish a strong *prima facie* case of grave negligence by doctors and nurses alike.'[330] The court held erroneously that '[a]gainst the factual backdrop the defendant has only itself to blame that the application of the maxim *res ipsa loquitur* is justified'. This is contrary to the binding *stare decisis* rule. The court held that the 'strong *prima facie* case becomes proof on a balance of probabilities once it remains unanswered.'[331] The court ruled in favour of the plaintiff.

Although the court confirmed the use of the maxim, the court applied factual presumption principles to justify its reasons for the decision. Sufficiently strong circumstantial evidence on a balance of probability assisted the plaintiff's case, together with a complete lack of response from the defendant. This discharged the onus in favour of the plaintiff. Whether the maxim was correctly applied is contentious, as the factual allegation in respect of the negligence of the surgeon was not satisfied. It was not evident from the facts that the surgeon was negligent in performing the caesarean section. However, this presented no difficulty as the doctors were employed by the hospital and were in any event vicariously liable regarding the follow-up treatment and overall management of the patient. Had this been a case against a surgeon in private practice, based on the fact of the operation alone, the

[329] *Nzimande* (n 328) para 19.The court referred to *Buthelezi* (n 314) and *Van Wyk* (n 42).
[330] *Nzimande* (n 328) para 19. The court considered the case of *Soobramoney* (n 74) and found that there is no suggestion in the pleadings that the state did not have the available resources to render effective health care, since only routine care was needed.
[331] *Nzimande* (n 328) para 19.

plaintiff would have lost her case because 'the bleed may not in itself be ascribed to negligence'.[332] The writer submits that sufficient factual information was available to establish a *prima facie* case of negligent conduct with the support of medical evidence and there was no need for the plaintiff to rely on the maxim. If the nature of the maxim should change to a rebuttable presumption of negligence in law, thereby placing a reverse onus on the defendant to disprove negligence, not only would it interfere with the defendant's right to equal treatment and to justice it might open the floodgates for frivolous claims that are not supported with medical expert evidence.

9 Conclusion

When testing whether the essential elements of liability are present in a case where the maxim *res ipsa loquitur* is applicable, each one of the elements of wrongfulness, negligence, causation and damage must be established from the defendant's action (or omission).To use the previous case as an example, the following becomes evident: First, the mere fact that the cuts on the baby's arm occurred is wrongful conduct, as it is in conflict with the legal duty of medical professionals and medical personnel to act with skill and competence and not to cause harm or further harm. In simple terms, it is unusual for babies to be injured in such a manner during uncomplicated caesarean section operations. It is contrary to what is expected from prudent and diligent medical professionals and personnel in performing their duty to the patient, because reckless actions and neglecting a patient will cause harm.[333] Second, with regard to the element of negligence, it is evident from the facts that the medical professionals and personnel should have foreseen that their neglect would cause harm to their patients and it should have been prevented. However, in the above example, there was no input from the hospital or its personnel. Such an inquiry could not take place and therefore there was no explanation for the conduct of the medical professionals regarding the cuts into the baby's arm in theatre or the post-operative bleed of the wound of the mother. This should have been investigated with the assistance of a medical expert to determine substandard care (negligence) by setting the expected standard of care for the court to understand the difference. The study of medicine is a specialised profession, and regardless of the fact that the plaintiff had some medical expert assistance, the expertise needed was that of a gynaecologist. The court was not familiar with the particular procedures leading up to the

[332] *Nzimande* (n 328) para 19.
[333] See the discussion of medical information relevant to *Van Wyk* (n 42) in chapter 4 para 5.2.

surgical cuts of the baby's arm or the post-operative bleed of the mother and the specific manner in which the defendant-gynaecologist managed and prevented these. The court seeks medical information to set the acceptable standard and only then the court is able to weigh the actions of the defendants when performing a caesarean section against the set-standard. It shows how the process is usually managed – so as to decide how far the process is controllable – and 'as soon as such circumstances are to be taken into consideration there is no room for the maxim'.[334] It is argued that in all disciplines of technical expertise, eg engineering and aviation, the courts would have a similar difficulty in determining the element of negligence and causation and be unable to infer that *negligent* conduct caused the loss (the design of the maxim). Lastly, it follows that the design of the maxim allows a plaintiff to proceed to court without medical expert evidence.[335]Therefore, neither the medical information about the risks and complications of a neglected duty (like leaving behind a swab) nor an explanation of whether the wrongful act caused the harm (an explanation of how a swab can migrate from the intestines through the gastric tract to be excreted[336]) nor an explanation why it was not prevented (*culpa*) is available to the court. Furthermore, there is no obligation on the defendant to answer the above questions; he only has to offer his version, which cannot be verified. When relying on the maxim a plaintiff presumes that the incident of a retained swab is sufficient evidence to prove the element of negligence. This is not so, at least not regarding the element of negligence, as the conduct of the defendant can only be tested by hearing his subjective testimony of how the injury occurred under his control. With regard to the element of causation, the writer argues that the manner in which the injury occurred or the cause of the injury can rarely be established without the assistance of a medical expert. Factual causation and negligence cannot be implied from the fact of the injury in South Africa. It differs from England (and Wales) where the fact of the injury can lead to a general inference based on lack of skill and care in circumstances under the control of the defendant which are unexpected in nature.[337] In South Africa factual causation is only established when alternative (non-negligent) causes of the incident or injury are ruled out and one of the most likely direct causes of the damage suffered by the patient[338] has been proved.

[334]*Van Wyk* (n 42) 462–463 *per* Wessels JA.
[335]See *Van Wyk* (n 42), where the plaintiff failed to call any medical experts to assist the court. The court commissioned medical experts to assist it; *Nzimande* (n 328), where the plaintiff failed to call a gynaecology expert to assist the court.
[336]See chapter 4 para 5.2.
[337]See chapter 3 para 3.
[338]In the case of a retained swab, where the plaintiff develops sepsis in the area, the developing and spreading sepsis forms part of the body's reaction to the left-behind swab and are the clinical course of the event. It is not the cause of the harm. The failure to remove the swab is the cause of the harm.

In this light, the application of the *res ipsa loquitur* maxim would rarely be relevant to a specialist field. It certainly is true that the medical field and other specialist fields are separated from other delictual actions when applying the maxim, as is the criticism of the authors, Van den Heever and Carstens,[339] but it is simply because in specialist cases the maxim overlooks all the elements in delict.

At best, in *Van Wyk v Lewis*[340]and *Cecilia Goliath v MEC for Health in the Province of Eastern Cape*,[341] a *prima facie* case was established, indicating a probability of breach of a legal duty. In *Van Wyk v Lewis*[342]the defendant was challenged with a very difficult *emergency* operation (diagnosis changed from routine operation to emergency operation) together with sepsis in the abdomen. This called for immediate action from the medical team to save the patient's life.[343] Under these circumstances, detail regarding the normal way of managing an emergency operation is needed to determine whether the elements of negligence and causation have been met. Considering this, the court was correct not to apply the *res ipsa loquitur* maxim in the presence of indeterminate circumstances, regardless of the retained swab. In *Cecilia Goliath v MEC for Health in the Province of Eastern Cape*,[344]the defendant performed a routine hysterectomy operation in 'a modern surgical theatre in circumstances where there was no suggestion that the plaintiff's life was in danger',[345] without the defendant presenting any information regarding any 'counting of swabs prior to sewing-up the patient'. The judge remarked that 'although the procedure performed on [the plaintiff] was under the control of the [defendant's employees], and what they did or did not do was exclusively within their direct knowledge, none of these employees were called to testify'. The court referred to the English case *Ratcliffe v Plymouth and Torbay Health Authority*, [346]quoting Lord Justice Brook, that 'it is likely to be a very rare medical negligence case in which the defendants take the risk of calling no factual evidence, when such evidence is available to them, of the circumstances surrounding a procedure which led to an unexpected outcome'. The court stated that–

[339]Van den Heever & Carstens (n 7) 149ff.
[340]*Van Wyk* (n 42).
[341]*Goliath* (SCA) (n 49).
[342]*Van Wyk* (n 42).
[343] See chapter 4 para 5.2 for a detailed discussion of the case. If the surgeon presents evidence that the function of the theatre sister was to keep track of all the swabs because other more urgent and pressing aspects of the operation occurred, then the defendant will escape liability. Evidently, if the theatre sister was a party to the legal proceedings and failed to show the steps she took to confirm proper swab-counting action to avoid the retention of swabs she would have been negligent.
[344]*Goliath* (SCA) (n 49) para 16ff.
[345]Ibid.
[346]*Ratcliffe* (n 322) para 48.

> in a civil case it is not necessary for a plaintiff to prove that the inference that she asks the court to draw is the only reasonable inference, it suffices for her to convince the court that the inference that she advocates is the most readily apparent and acceptable inference from a number of inferences.[347]

The defendant failed 'to adduce any evidence, whatsoever, accordingly [taking] the risk of a judgment being given against him'. The success of the plaintiff's case was not based on any general presumption of fact but on insufficient evidence provided by the defendant to rebut the plaintiff's *prima facie* case of negligence. The plaintiff discharged her onus on a preponderance of probability. Of significance, and to be welcomed, is the reluctance of the court to apply the *res ipsa loquitur* maxim and to discourage the use of the maxim in any future medical cases. It can be argued that the plaintiff discharged her onus of proof simply because of the defendant's failure to offer an explanation which then became part of the case against him, but it is more likely that the balance of probability was in the plaintiff's favour. The facts in *Goliath* are similar to the facts of the *Nzimande*[348] case where, *with the assistance of a medical expert*, it was *prima facie* evident from the hospital's disregard for the proper management of the medical condition of the patient that it was negligent conduct (*culpa*).

As it stands, the South African court in *Van Wyk v Lewis*[349] rejected the maxim. However, *Cecilia Goliath v MEC for Health in the Province of Eastern Cape*[350] and even *Nzimande v MEC for Health Gauteng*[351] show that the rejection of the maxim is not accepted by all legal practitioners. As the law stands the perception remains that the *res ipsa loquitur* maxim is an easy way for a plaintiff to get his case to court in South Africa. However, the thesis has been arguing that applying the maxim tends to oversimplify medical realities and increase the risk that a court may decide cases for reasons that are unjustifiable from a medical perspective. It remains significant that the availability of the maxim encourages plaintiffs to advance to court with insufficiently prepared evidence. It is possible that the South African court's continued general reluctance to entertain the *res ipsa loquitur* maxim in medical cases has contributed to the development of medical law where *prima facie* cases are

[347] *Goliath* (SCA) (n 49) para 19ff, quoting *AA Onderlinge Assuransie-Assosiasie Bpk v De Beer* 1982 (2) SA 603 (A); *Cooper and Another NNO v Merchant Trade Finance Ltd* 2000 (3) SA 1009 (SCA).
[348] *Nzimande* (n 328).
[349] *Van Wyk* (n 42).
[350] *Goliath* (SCA) (n 49).
[351] *Nzimande* (n 328).

supported by proper medical expert evidence against defendants, based on evidence-based medical principles.

For these reasons, the writer agrees with Van den Heever and Carstens,[352] albeit in another context:

> Thus, if the aforegoing assessment cannot be made by having regard to the occurrence alone, so that the surrounding circumstances must also be considered in order to arrive at a conclusion, *res ipsa loquitur* does not find application. This appears to be the reason why South African courts decline to apply the doctrine to medical negligence cases, based on the notion that the medical interventions that form the subject of the dispute do not fall within the ordinary experience of mankind, because a court would usually be unable to draw a conclusion without the benefit of expert medical evidence.

These writers state that the use of the maxim in medical law will alleviate the burden of proof for the plaintiff; that the defendant is adequately protected, provided we endorse the principle of 'honest doubt (that even if due care is taken, untoward results do sometimes occur); that constitutional arguments appeal to equality, access to courts, access to health care and information; and that medical ethics, post-constitutional legislation and policy also support the acceptance of the maxim in medical law. This thesis argues that the maxim will not alleviate the plaintiff's burden of proof if the plaintiff bases his or her claim on the fact of the injury alone and relies on the maxim alone. The court will be in the exact same position as was the court in *Van Wyk v Lewis*[353]ie unable to determine causation of fact and whether the conduct of the defendant fell within acceptable standards. Although the writer agrees that the courts, in the spirit of constitutionalism, should address the plight of the plaintiff by, for example, relaxing strict liability principles in exceptional cases, such as the rules of factual causation, this approach does not support the use of the maxim.

The goal of the study is to illustrate that medical facts and medical conclusions, ie the medical realities, are determined from the explanation of the medical experts before making legal inferences; therefore, the reason for the inadequacy of the application of the maxim in medical cases is obvious, as the maxim always depends on an approach that in the ordinary course of events (as understood by non-medical persons), harm does not occur without

[352]Van den Heever & Carstens (n 7) 138ff. See also para 8 above.
[353]*Van Wyk* (n 42).

negligence. In a medical case, to raise a presumption of fact, ie the nature of the *res ipsa loquitur* maxim, the conduct of the defendant needs to be clear from the available facts, which is rarely the case, as the management and control of a medical process is part of medical science and not part of everyday life. A plaintiff who depends only on the maxim runs a high risk of not being able to prove his case, because there is no obligation in law on the doctor-defendant to disprove such a case (or event to complete the picture), but only to explain that his conduct was not negligent. This would require a South African court to accept the fact of the injury as the cause of negligent conduct, which is contrary to delictual principles. Thus the thesis argues that the maxim *res ipsa loquitur* is not, and should not be, part of the South African medical law regulating claims for compensation for medical negligence.

It was also clear, from the above survey of cases that the maxim was not consistently applied and leads to uncertainty. In essence it should allow a factual presumption to be drawn from the key available facts. The court was constantly faced with a situation where the fact of the injury did not explain the conduct of the defendant and therefore failed to satisfy the delictual element of negligence (culpable conduct). In many cases, the maxim was actually used as a means of getting to court based on the injury alone, which should have resulted in an application requesting absolution from the instance as no cause of action was shown, but it was simply rebutted with a doctor-defendant explaining his conduct was not negligent. This is not the correct use of the maxim as it elevates the maxim to a rebuttable presumption and not a presumption of fact. As discussed before, the maxim lends itself to different incorrect interpretations: an irrebuttable presumption of law, a rebuttable presumption, and similar to English law[354], a presumption where the fact of injury may raise an inference of lack of care in circumstances under the direct control of the defendant. In South African law where the maxim allows for a mere factual presumption drawn from other facts, the unwise use of the maxim then puts a plaintiff in a position to prove his case without evidence or it obliges a defendant to defend the unsubstantiated allegation of negligence based on no other facts. It is significant to note that where the fact of the injury does not have key facts to explain the occurrence and where it requires the plaintiff to lead some evidence to prove his case, then the maxim is inappropriate. If the maxim is allowed it places the maxim on a par with the manner in which *prima facie* evidence[355] is addressed in South African law, the presumption

[354]See chapter 3 para 3.
[355]*Ratcliffe* (n 322) para 48.

of fact (the maxim) is then raised to a rebuttable presumption in law which is inconsistent with the law of evidence principles.

In conclusion, the thesis argues against the use of the maxim in medical cases. The argument that the court may consider allowing the maxim in the light of the duty of the South African court to uphold constitutional rights and more particularly patients' rights[356] and because the court has a duty to respect, protect, promote and fulfil human rights, is rejected. The thesis argues that the use of the maxim is contrary to South African delictual principles as well as principles in evidence even if the use of the maxim is done similar to the approach in England, [357]where the maxim is now used with expert medical evidence. The argument in South African law remains that all the elements in delict should be established from the medical expert evidence which leaves no place for the maxim. However, the South African court should be open to relax delictual principles on a case by case basis, such as factual causation, as is already evident from previous cases. The thesis further suggests that the South African court should move towards a more inquisitorial approach in medical cases as this will allow the court to investigate the medical information presented to the court by both plaintiff and defendant. To avoid possible fallacies in reasoning, the thesis now turns for clarification to the English court, because of its wider experience in the application of the maxim.

[356]In the light of the Constitutional Court's approach to determine a case on substantive justice principles and not formal justice principles, a more flexible approach is anticipated. See substantive constitutional revolution arguments under paras 4.2 and 4.3 above.
[357]*Ratcliffe* (n 322) para 48.

CHAPTER 3: THE *RES IPSA LOQUITUR* MAXIM IN ENGLAND

1 Introduction

In the previous chapter the law of delict in South Africa was analysed with reference to medical negligence cases and the application of the *res ipsa loquitur* maxim. It was found that, notwithstanding the rejection of the maxim for medical cases previously,[1] the court was recently requested to re-introduce the maxim to South African medical law.[2] Regrettably, the court avoided being drawn into a discussion of the maxim, only, discouraged its use. The court relied on an English case, *Ratcliffe v Plymouth and Torbay Health Authority*, [3]where the English court suggested that the time had come to drop the maxim from the litigator's vocabulary and replace it with the phrase '*prima facie* evidence'. This approach is the same as that of this thesis: that the *res ipsa loquitur* maxim cannot be applicable in medical negligence cases as an appreciation of the medical facts explained against the acceptable standard of care is indispensable before a legal presumption, '*the facts speak for themselves*' can be entertained. The previous chapter demonstrated that, in South Africa a plaintiff has to prove the elements of wrongfulness, causation, fault (*culpa*) and harm[4] to prove liability. The argument of this thesis is that the South African court cannot determine from the fact of the injury whether a defendant caused the injury of whether the conduct of the defendant –doctor fell below the expected standard of care without medical experts. This argument contrasts with the approach of scholars who support the use of the maxim in England (and Wales), stating that the maxim should be introduced 'in a medical negligence action if the negligence can be derived from a so-called absolute without any dependence on the surrounding circumstances'[5].The thesis argues that determining negligence in such a generalized manner is contrary to delictual principles in South Africa. Against this background that thesis first investigates the acceptable and international standard of care to determine the medical reality of each case before analysing the way the English court addresses legal principles like causation and liability.

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[1] *Van Wyk* 1923 E 37; 1924 AD 438 para 304 of the court *a quo.*
[2] *Goliath v Minister of Health in Province of Eastern Cape* 2014 ZASCA 182 para 12.
[3] [1998] PIQR P170; [1998] Lloyd's Med LR 162; (1998) 42 BMLR 64 at 176 CA (Civ Div).
[4] J Neethling, JM Potgieter & PJ Visser *The Law of Delict* (2010) 4, where they define negligence as the 'act of a person that in a wrongful and culpable way causes harm to another'.
[5] P van den Heever & P Carstens *Res Ipsa Loquitur and Medical Negligence* (2011) 138ff. See chapter 2 para 8 above. The authors argue amongst other things that the use of the maxim in medical law will alleviate the burden of proof for the plaintiff; that constitutional arguments appeal to equality, access to courts, and access to health care and information; and that medical ethics, post-constitutional legislation and policy also support the acceptance of the maxim in medical law.

This chapter analyses the use of *res ipsa loquitur* in English cases[6] because of the historical influence of English law on South African law and its substantially more available data. The appeal for the use of the maxim and to follow the English example and other Commonwealth countries[7] justified the research into English case law. The objective of this chapter is to understand the use[8] of the *res ipsa loquitur* maxim by the English court, as a procedural aid to assist a plaintiff with getting to court in a medical negligence case. The English court, in accepting the maxim, because of the presumption of negligence created by the maxim, also seems to accept that a *prima facie* case has been made out (based on the fact of the injury under the control of the defendant-doctor) and then requests an answer from the defendant. Without medical expert support for a plaintiff in presenting his action, the use of the maxim in its simplest form compels the defendant to explain whether he exercised the necessary care. If the court accepts the defendant's explanation, the plaintiff's case will be defeated. If the plaintiff relies on the maxim in its wider form[9] and produces medical expert evidence in support of lack of care by the defendant, the defendant must rebut the maxim and the plaintiff's expert evidence. The maxim has then run its course and the court will then decide whether the plaintiff has discharged the burden of proving negligence. This differs from the legal principles in the law of delict in South Africa.[10]

If the mere occurrence of an undesirable medical accident is accepted by the English court as *prima facie* evidence of alleged negligence based on insufficient care, then the function of the *res ipsa loquitur* maxim is to compel the defendant to explain the presumed lack of care. Interestingly, it appears that the medical evidence of medical experts describing the nature of the medical error[11] becomes relevant only *after* the maxim has been accepted by the court. In this regard, it seems that an initial understanding of medical facts or factual causation is not needed for the *res ipsa loquitur* maxim to be evoked in England. The fact of the injury or thing (*res*) tells a story, which might not be the whole story, but the presumption

[6]For a comprehensive study of international medical negligence, see D Giesen *International Medical Negligence Law* (1988). For a discussion of the principles of medical negligence in England and Wales, see M Jones *Medical Negligence* (2008). For a comparison between South Africa, England and the Unites States regarding *res ipsa loquitur* principles, see Van den Heever & Carstens (2011) (n 5).
[7]Malaysia and Bangladesh were previously British colonies.
[8]*Ballard v North British Railway Co* (1923) 14 Lloyd's LR 68, where it was explained that the thing (*res*) tells a story that might not be the whole story and the remainder of the story is then told by the defendant. If the defendant provides an alternative explanation the plaintiff is still left with the burden of proving his case. If the defendant fails to present an alternative explanation the plaintiff has proved his case.
[9]As directed by *Ratcliffe* (n 3). The court distinguished between a simpler form of the use of the maxim in ordinary cases and a wider form where the allegation of lack of care has to be supported by medical expert evidence for the court to understand the medical reality. See para 7 below.
[10]Chapter 2 para 8.
[11]Chapter 4.

of lack of care in a situation directly under the control of the defendant where an unexpected injury occurs. It is sufficient to be *prima facie* evidence to get the plaintiff to court. The rest of the story is then told by the defendant in defending the presumption of lack of care created by the maxim. If the defendant presents an explanation that shows proper care without negligence, the plaintiff is still left with the initial burden of proving his case.[12] The evidentiary burden then shifts back to the plaintiff[13] (not the onus of proof), who has to prove, on a balance of probability, that the defendant caused the injury. The thesis intends to investigate these differences, since it is evident that the law of tort in England is different from the law of delict in South Africa. In South Africa, a plaintiff cannot rely on the fact of the injury as a presumption of negligent conduct. As explained in the previous chapter, the element of negligence is only one of the elements in delict that has to be established to prove liability. Determining causation turns upon evaluating the actions of the defendant against the medical standard of care set by the profession. The medical reality has to be clearly understood to decide whether the wrongful act caused the harm (factual causation) or to infer negligence. In other words, proof of causation rest inevitably on the drawing of an inference of fact. In South Africa, in a medical case, the elements of causation and negligence cannot be inferred from the injury alone because the medical reality is not known to an uninformed person. These material differences between the functioning of the law of delict in South Africa and that of the law of tort in England, warrant further investigation. It would be the obvious answer to why the maxim is more successful in England than in South Africa.

2 The principles governing the law of tort in England

Before examining the use of the *res ipsa loquitur* maxim, it is necessary to conceptualise the rules of tort that determine the professional liability of a medical professional in England. In general, in the English law of tort,[14] a person may owe a duty of care[15] to another to ensure

[12] *Ballard v North British Railway Co* (n 8).
[13] *Glass v Cambridge Health Authority* [1995] 6 Med LR 91 (QB) 107.
[14] The English legal system differentiates between personal injury matters and medical negligence matters: see *Civil Procedure* Vol 1 (2008) (*The White Book Service*,2008) C2-001.
[15] *Donoghue v Stevenson* [1932] AC 562 at 580, where the claimant was successful in establishing a duty of care between the consumer and the manufacturer of ginger beer. See chapter 2 regarding South African law, where a legal duty does not naturally exist between legal parties and should be established by the relationship between the parties. See A Fagan 'A duty without distinction' (2000) *Acta Juridica* 49. The author explains the difference between the English 'duty of care' and the legal duty referred to in South African courts. The author refers to *Administrateur, Natal v Trust Bank Bpk* 1979 (3) SA 824 (A) where the court acknowledges similarities between a legal duty and a duty of care. Also see *Bayer South Africa v Frost* 1991 (4) SA 559 (A),

that he does not suffer any unreasonable harm or loss. The claimant[16] must determine that a possible legal duty of care[17] was owed by the defendant. In medical cases, such a duty arises from the doctor–patient relationship.[18] It has been held that whether a doctor is under a duty of contract or a duty in terms of the law of tort, there is no rational basis for a distinction, because the general obligations undertaken and owed to the patient remain the same.[19] The duty imposed by law is an undertaking by the doctor to provide advice, to diagnose, and to treat the patient with reasonable skill and care. The English court held that, where a defendant is in a situation where others would reasonably rely upon his advice and judgment or he has taken it upon himself to give advice or allows it to be passed on, and he knew that a person will rely on this advice, a duty of care will arise.[20] The breach of that duty may be any one of the following: failure to furnish the required advice; failure to warn the patient about material risks and complications; failure to take a full medical history; failure to perform tests and so forth and to arrive at a proper diagnosis; and failure to exercise the necessary skill and care in providing the treatment in accordance with the required standard.[21]

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where the court stated that there must be a legal duty to take reasonable steps to avoid harm, which was also confirmed in *Mukheiber v Raath* 1999 (3) SA 1065 (SCA).

[16]In England and Wales the term 'claimant' replaced the term 'plaintiff' after the Civil Procedure Rules 1998 came into force on 26 April 1999. The writer uses the terms 'claimant' and 'plaintiff' interchangeably as dictated by the case under discussion.

[17]*Fletcher v Rylands* [1866] LR 1 Exch 265, where a legal duty was described as follows: 'those who go personally or bring property where they know that they or it may come into collision with the persons or property of others have by law a duty cast upon them to use reasonable care and skill to avoid such a collision'; *Caparo v Dickman* [1990] 2 AC 60, where Lord Brown-Wilkinson identified several instances of policy considerations relevant to the element of 'duty of care'. The tripartite test states that the harm must be reasonably foreseeable; that a requisite degree of proximity between the claimant and defendant exists; and that it will be fair, just and reasonable to impose such a duty on the defendant, taking public policy into consideration.

[18]*R v Bateman* (1925) 94 LJKB 791 at 794, where Lord Hewart said that if 'a person holds himself out as possessing special skill and knowledge and he is consulted, as possessing such skill and knowledge' he owes a duty to the patient to use due caution, diligence, skill and care.

[19]*Sidaway v Bethlem Royal Hospital Governors* [1985] AC 871 at 904.

[20]*Hedley Byrne & Co. Ltd v Heller & Partners Ltd* [1964] AC 465; *Chester v Afshar* (2004) All ER (HL), where the defendant was found negligent because of his failure to warn the claimant of a material risk of the operation. The court departed from traditional causation principles.

[21]*Sidaway v Bethlem Royal Hospital Governors* (n 19) regarding failure to warn; *Smith v Salford Health Authority* [1994] 5 Med LR 321, QBD, where it was held that the doctor should have sent the patient for a CT scan prior to performing a spinal fusion; *Cassidy v Minister of Health* [1951] 2 KB 343 at 349, where the medical professionals ignored the claimant's complaints of excessive and intense pain; *Dillon v Le Roux* [1994] 6 WWR 280, BCCA where the doctor made a diagnosis of reflux esophagitis instead of myocardial infarction; *Jones v Manchester Corporation* [1952] QB 852, where it was found that the doctor was inexperienced and lacked the necessary skill to perform the procedure.

In order to establish a breach of the duty of care, the claimant has to show that a defendant failed to comply with the standard of care expected from a 'reasonable man'.[22] The standard of 'the reasonable man on the Clapham omnibus' is the general standard of care, while the standard applicable to medical professionals is that of a 'reasonable professional',[23] eg a surgeon. If the doctor did not comply with the expected standard, his care would be regarded as below standard and negligent. Of importance for medical negligence cases is the fact that novices in a particular field of expertise must be of the same standard as the specialist in that field, as no allowance is made for lack of experience.[24] A breach of duty will show that a reasonable person or reasonable professional fell short of the standard expected by the community and the profession. In *Roe v Minister of Health*[25]it was held that the defendant will be liable only if the reasonable person would have foreseen the loss or damage in the circumstances prevailing at the time of the alleged breach. It was shown in *Bolton v Stone*[26] that the greater the risk that serious harm can be incurred, the greater the precautions needed to prevent such harm. In addressing the expected standard of care, the court considers the following questions: What did the defendant know? What was the degree of the risk? How practical were the precautions? Was the standard in conflict with the prevailing legal convictions of the community? It is a question of fact and for the claimant to prove that the defendant's conduct did not meet the requisite standard of care.[27]

Lord Justice Denning, in *Lamb v Camden LBC*,[28] stated that 'duty, remoteness and causation' are all useful devices that the court uses to determine the range of liability for negligence. He continued that 'ultimately it is a question of policy for the judges to decide'. He stated that it is a weighing and evaluation process rather than a rule of law. Causation in

[22]*Blyth v Birmingham Waterworks* (1856) 11 Exch 781. Also see *Hall v Brooklands Auto-Racing Club* (1933) 1 KB 205, where the defendant failed to comply with the standard of a reasonable man; and *MacFarlane v Tayside Health Board* (1999) 3 WLR.

[23]See *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118. The *Bolam* principle is the rule that a medical professional is not negligent if he or she acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion. The rule was changed in *Bolitho v City & Hackney Health Authority* [1997] 3 WLR 1151. A child suffered cardiac arrest and subsequent brain damage as a result of pneumonia and airway obstruction. The doctor indicated that she would not have intubated the child even if she had attended to the child. The court held that the method adopted as the standard of practice of medical professionals must be demonstrated to be a method based on logic; otherwise it will not be defensible. See also n 262 in chapter 2.

[24]*Wilsher v Essex Area Health Authority* (1986) 3 All ER 801, where a junior doctor was expected to perform according to the standard of a competent and skilled doctor working in the same post. This topic is addressed in chapter 4 para 4.2, 'learning curve', below.

[25](1954) 2 QB 80.

[26][1951] AC 850; [1951] 1 All ER 1078.

[27]*Bolitho v City & Hackney Health Authority* (n 23), where the court stated that expert opinion should be used to determine the breach of duty of the defendant but it should be based on logical principles.

[28](1981) QB 625.

the tort of negligence, in English law, addresses the elements of remoteness, causation and foreseeability.[29] The plaintiff has to prove that the occurrence was the direct cause of the harm suffered. A direct link between the defendant's negligence (breach of the duty of care) and the plaintiff's loss or injury is established to prove causation. The basic test for causation is whether, 'but for' the negligence of the defendant, the plaintiff would have suffered the damages. The defendant will not be found negligent if the damage could have occurred in another way.[30]The English court relaxed some of the causation aspects and assisted the claimant with the difficulty of the burden of proof;[31] however, this was not accepted in *Fairchild v Glenhaven Funeral Services.*[32] In *Bonnington* and *Fairchild* the court showed that if the defendant's breach of duty increased the risk or materially contributed to the harm, then the rules relevant to causation should be relaxed. The latter cases contributed to the question: under which circumstances will the court allow an inference of fact (to overcome an evidential gap) based on the claimant's allegation of negligence?

In certain cases it seems obvious that an occurrence could not have taken place but for the defendant's lack of care,[33] even if the claimant does not have direct evidence to prove that the defendant was liable. In such a case, the claimant may want to ask the court to infer a lack of care from the available facts. This is also the design of the *res ipsa loquitur* maxim. Without evidence to the contrary, the claimant may well have sufficiently proved that the required standard of care was not met and the defendant had been careless.

[29]*Robinson v Post Office* [1974] 2 All ER 737, where a doctor did not follow up on a test-dose for an anti-tetanus vaccination and the claimant developed a serious allergic reaction to it.
[30]See *Bolitho v City & Hackney Health Authority* (n 23) for a discussion of two elements of causation ie (i) what would the doctor have done had she attended the claimant? (ii) if she did not do what was expected, was that negligent? The court found that the fact that the defendant did not intubate the child was the focal point of the doctor's negligent conduct.
[31]*Bonnington Castings Ltd v Wardlaw* [1956] AC 613, where the court found that a material contribution to the harm established a breach of duty. The claimant developed pneumoconiosis as a result of inhaling contaminated air at his workplace, Also compare *McGhee v National Coal Board* [1972] 3 All ER 1008; [1973] 1 WLR 1, where the court found that a material contribution to the risk is sufficient evidence to indicate a breach of duty.
[32][2002] UKHL 22; [2003] 1 AC 32, where three consolidated appeals followed because workers developed mesothelioma as a result of negligent exposure to asbestos fibres at work. Unlike pneumoconiosis, mesothelioma is not a 'cumulative' disease. If there has been more than one employer there is no means of identifying the fibres that caused the disease. Therefore there was an evidential gap. The House of Lords relaxed the 'but for' causation principles and concluded as follows: If the conduct of the employer or other agents doing substantially similar operations created an unreasonable risk of harm to the claimant, it would be difficult for the claimant to establish causation from an exact risk. However, the breach of duty of all the agents materially increased the risk of harm to the claimant, and the defendants should be held accountable.
[33]*Bull v Devon Area Health Authority* (1989) [1993] 4 Med LR 117 at 131 CA, where a delay of obtaining a specialist obstetrician at the birth of twins caused injury to the second twin. The court doubted where all the facts that are ever going to be known are before the court, but in the absence of a proven explanation for the 'inordinate' delay, the judge had no choice but to find the defendants liable.

3 A synopsis of the development of the *res ipsa loquitur* maxim in England

The first benchmark case where the maxim of *res ipsa loquitur* was implicitly applied was *Byrne v Boadle* in 1863.[34] Although the maxim was not specifically discussed, the occurrence was sufficient to allow the court to infer negligence from the facts. A barrel of flour fell from a second-storey loft onto the head of the claimant, who was injured. The claimant had no knowledge or direct evidence of the prior whereabouts of the barrel or how it came to fall from the loft. The lower court dismissed the claim on the grounds that the claimant did not prove his case. On appeal, the court held that the facts of the accident provided sufficient evidence to establish a breach of duty of care. The judge found in favour of the claimant and said that, beyond all doubt, such facts are sufficient *prima facie* evidence that a presumption of negligence arose out of the careless management of the barrel. The judge declared that it was clear that the barrel was under the control of the warehouse management, who were responsible for the acts of the servants, and their failure to prevent careless conduct constituted negligence. The maxim was intended to assist a claimant who was harmed through no fault of his own and who was unable to prove how the accident occurred. In *Scott v London & St Katherine Docks Co*, the court found that–

> where the thing is shown to be under the management of the defendant or his servants, and the accident is such as in the ordinary course of things does not happen if those who have the management use proper care, it affords reasonable evidence, in the absence of explanation by the defendants, that the accident arose from want of care.[35]

It is significant that if the thing was under the total control of the defendant and injury occurs, the lack of care could be inferred from the fact of the injury or the very nature of the incident,[36] even if there was no direct evidence of how the accident occurred or how the defendant acted.

The use of the maxim was confirmed and the principles underlying its application were established. At the time, the simple justification for the use of the maxim was that, in the ordinary course of events, bags and barrels do not usually fall onto bystanders without

[34] *Byrne v Boadle* [1863] 159 ER 299; [1863] 2 Hurl & Colt 722 159. See *Scott v London & St Katherine Docks Co* (1865) 2 Hurl & Colt 596.
[35] *Scott v London & St Katherine Docks Co* (n 34) 601.
[36] *Parfitt v Lawless* [1872] LR 2 P. & D. 462 at 472.

someone being negligent. In 1923, in *Ballard v North British Railway Co*,[37] a claimant was injured when a railway wagon struck him. Lord Justice Shaw said that had the phrase not been in Latin, nobody would have given it any thought. If the defendant does provide evidence of an alternative cause of the accident, then the claimant has to adduce positive evidence that the defendant acted carelessly to attribute liability to the defendant. However, it was later established that the facts of the accident must satisfy the presumption that the accident occurred as a result of lack of care; such a reasonable inference made from the proven facts may then have the weight of legal proof.[38] In *Caswell v Powell Duffryn Associated Collieries*[39] the court warned that one must not confuse inference with conjecture or speculation. His Lordship stated that there can be no inference unless there are objective facts from which to infer the other facts that are sought to be established. If there are no positive proven facts from which the inference can be made, the method of inference fails. The prerequisites for such an inference depended on whether the incident occurred in an inexplicable fashion,[40] that the incident would not have occurred in the ordinary course of events, and whether the defendant had control[41] of the incident that caused the injury. The effect of the inference must be that it supported the claimant's claim that negligence had occurred.[42] The accident must, in itself, indicate that the harm was caused carelessly. In a case of a retained swab,[43] the court found that the leaving behind of a swab during surgery indicated that the doctor had been careless and breached his duty of care. However, contrary to the perceived natural flow of the application of the maxim in the latter scenario, the court

[37]*Ballard v North British Railway Co* (n 8) 45–53, where the claimant claimed damages following an injury caused by a runaway railway wagon.
[38]*Jones v Great Western Railway Co* [1930] 47 TLR 39, per Lord Macmillan. Such a deduction from the evidence must show that it is more probable than not that negligence occurred; it cannot be conjecture as this will have no value as in essence it will then be a mere guess.
[39]*Caswell v Powell Duffryn Associated Collieries* [1940] AC 152–169.
[40]*Barkway v South Wales Transport Co. Ltd* (1950) 1 All ER 392, when a vehicle veered to the wrong side of the road. It was known that the accident was caused by a flat tyre. The *res ipsa loquitur* maxim could not apply as all the facts were known. The claimant had to prove that the flat tyre was caused by a failure to maintain the vehicle, using ordinary tort law principles.
[41]*Easson v L & N E RY* [1944] KB 421 at 425; [1944] 2 All ER 425 at 425, 430, where the requirement of *control* was not satisfied in an incident where a child fell off a train. As the train left the station, it was determined that the door of the train was not sufficiently under the sole control of the railway company. It could have been opened by somebody for whom the railway company was not responsible.
[42]*Barkway* (n 40) 392; *Byrne v Boadle* (n 34) 159; also see *Scott v London & St Katherine Docks Co* (n 34) 601; *Ballard v North British Railway Co* (n 8) 45; *Moore v R Fox & Sons* [1956] 1 QB 596; *Caswell v Powell Duffryn Associated Collieries* (n 39) 152–69. The list is not exhaustive.
[43]*James v Dunlop* [1931] 1 BMJ 730 (CA), where the husband of the claimant underwent a gallstone operation during which a swab was retained. The formation of a fistula as a result of the retained swab eventually caused the death of the husband. The court found the doctor to be careless and negligent. Strangely, the court altered its position in later cases like *Mahon v Osborne* (1939) 2 KB 14 at 23. See para 4.2 below n 83.

was inconsistent in holding that the *res ipsa loquitur* maxim applied in all retained-swab cases.[44]

The *locus classicus* with regard to the application of the *res ipsa loquitur* maxim is *Cassidy v Minister of Health*. Denning LJ explained the inference of negligence: if a claimant went into hospital with two stiff fingers and came out of hospital with four stiff fingers and a useless hand, this is a *prima facie* case of negligence. One would generally not expect it to happen if due care was used, and the claimant needs an explanation. However, the hospital failed to explain how this could have happened without negligence. Denning LJ held that the lack of care on the part of the medical personnel rendered the hospital vicariously liable:

> [W]henever they accept a patient for treatment, they must use reasonable care and skill to cure him of his ailment. The hospital authorities cannot, of course, do it by themselves: they have no ears to listen through the stethoscope, and no hands to hold the surgeon's knife. They must do it by the staff which they employ; and if their staff is negligent in giving the treatment, they are just as liable for that negligence as is anyone else who employs others to do his duties for him.[45]

He continued that 'where a person is himself under a duty to use care, he cannot get rid of his responsibility by delegating the performance of it to someone else, no matter whether the delegation be to a servant under a contract of service or to an independent contractor under a contract for services'. Although this approach does not mean that, if a patient came out of hospital in a worse condition than he went in, this constitutes negligence, the approach does confirm that such an incident raises a *prima facie* inference of negligence that should be explained.[46] In *Colevilles Ltd v Devine*[47] it was established that the burden of proof did not shift to the defendant if the maxim was applied. The defendant was not obliged to show that

[44]*Mahon v Osborne* (n 43) 23, where a swab was retained following a complicated operation and the court found that an ordinary reasonable man could not determine what precautionary measures the surgeon would have taken and medical expert evidence was needed; *Cooper v Neville* [1961] UKPC 12, where the plaintiff underwent an emergency operation and a swab was retained.
[45]Cassidy v Minister of Health (n 21) 574, where the claimant was suffering from Dupuytren's contracture of the third and fourth finger of his left hand. It is a defect that occurs when the hand is kept in a splint for too long without physiotherapy. A layer of skin that lies under the skin of the palm of the hand develops knots of skin, forming a thick cord that pulls the fingers into a bent position. The Court of Appeal held that prima facie evidence of negligence was shown in respect of the persons in whose care the claimant was. The defendants were found liable, regardless of which individual was negligent. See discussion in para 4.2 below.
[46]Cf also *Holmes v Board of Hospital Trustees of the City of London* (1977) 81 DLR (3d) 67 at 78; *Girard v Royal Columbian Hospital* (1976) 66 DLR (3d) 676 at 691 BCSC.
[47][1969] 1 WLR 475 at 479.

his explanation was more likely than the inference of negligence created by the maxim. If it was equally probable that the accident could have occurred with careless conduct than with careful conduct, the claim would not be successful. This interpretation was confirmed in1970, in *Lloyde v West Midlands Gas Board*, where Megaw LJ discussed the status of the maxim. He said:

> I doubt whether it is right to describe *res ipsa loquitur* as a 'doctrine'. I think it is no more than an exotic, although convenient, phrase to describe what is in essence no more than a common sense approach, not limited by technical rules, to the assessment of the effect of evidence in certain circumstances.[48]

He maintained that applying the maxim means that a plaintiff *prima facie* establishes negligence where (i) it is not possible to prove exactly what caused the accident; and (ii) on the evidence as it stands, it is more likely than not that the effective cause was an act that constitutes a failure to ensure the plaintiff's safety. The English Court of Appeal confirmed the substantive status of the maxim, ie that it was no more than a convenient phrase that is evidentiary in nature. The successful application of the *res ipsa loquitur* maxim will have the effect that the plaintiff has established a *prima facie* case that needs to be rebutted.[49]

Controversy existed[50] about the procedural advantage of the *res ipsa loquitur* maxim and whether *res ipsa loquitur* had been elevated to a principle of substantive law. Supporters of the maxim argued that the maxim reverses the burden of proof[51] and that the defendant has to establish that the accident was not caused by him.[52] In *Ng Chun Pui v Lee Chuen Tat*, the court *a quo* held that the evidence was insufficient and that the defendant failed to discharge his burden of proof.

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[48](1971) 2 All ER (CA) 1242–1246, where the court found that if the plaintiff is unable to explain the cause of the accident, the fact of the accident is sufficient to establish negligence in the absence of an explanation from the defendant. This stance of the court was followed in Bergin v David Wickes Television [1994] PIQR 167 at 168.

[49]*Moore v Worthing District Health Authority* [1992] 3 Med LR 431–434, where the plaintiff underwent a mastoidecktomy and suffered bilateral nerve injury.

[50]*Henderson v Henry E Jenkins & Sons* [1970] AC 282, where Lord Reid and Lord Donovan stated that, following the *res ipsa loquitur* maxim, the burden of proof turned to the defendants; *Ward v Tesco Stores Ltd* [1976] 1 WLR 810, where there was no evidence as to the carelessness of the defendant regarding the spillage of yoghurt on the floor on which the claimant slipped; and *Mahon v Osborne* (n 43) 50, where the court held that the defendant is required to show that he exercised the required care. Also see *Moore v R Fox & Sons* (n 42) 596, referred to by Van den Heever & Carstens (2011) (n 5) 44.

[51]*Henderson v Henry E Jenkins & Sons* (n 50) 596.

[52]*Moore v R Fox & Sons* (n 42) 596, where the court found that it was not necessary for all the events of the accident to fall under the defendant's control.

The matter went on appeal. The appeal judge, Lord Griffiths, explicitly stated:

> [I]n an appropriate case the plaintiff establishes a *prima facie* case by relying upon the fact of the accident. If the defendant adduces no evidence there is nothing to rebut the inference of negligence and the plaintiff will have proved his case. But if the defendant does adduce evidence that evidence must be evaluated to see if it is still reasonable to draw the inference of negligence from the mere fact of the accident. Loosely speaking this may be referred to as a burden on the defendant to show he was not negligent, but that only means that faced with a *prima facie* case of negligence the defendant will be found negligent unless he produces evidence that is capable of rebutting the *prima facie* case.[53]

The court confirmed that the burden to prove negligence rests throughout the case on the plaintiff. The court warned that it is misleading to talk of the burden of proof shifting to the defendant in a case where the maxim applies, as it is merely an evidentiary burden. The court of appeal set aside the decision of the court of first instance, and stated that there is no legal burden on the defendant to disprove negligence.

In more recent times, the court in *Jacobs v Great Yarmouth and Waveney Health Authority* was of the opinion that an inference of negligence should be drawn from the facts presented and in such instances, *res ipsa loquitur*–

> means no more than that, on the facts that the plaintiff is able to prove, although he may not be able to point to a particular negligent act or omission on the part of the defendants, the fair inference to draw is that there has been negligence of some sort on the part of the defendants; but that is an inference to be drawn upon the facts presented by the plaintiff. If there is further evidence presented by the defendant,

[53]*Ng Chun Pui v Lee Chuen Tat* [1988] RTR 298 (PC) 298–301, where the defendant's vehicle veered to the wrong side of the road. The plaintiffs relied on the maxim, and the defendant explained that he had to swerve away from an unidentified vehicle causing the accident. The court stated, regarding the shifting of the burden of proof, that the res ipsa loquitur maxim is no more than the use of a phrase to describe evidence from which it is proper to draw an inference of negligence.

those facts may be shown in an entirely different light and may be that at the end of the day it is not possible to draw the inference of negligence.[54]

Thus, any substantive importance that was given to the *res ipsa loquitur* maxim has been reduced to the maxim being a mere procedural and evidentiary tool[55] to extract an answer from the defendant.

4 A detailed discussion of the elements of the *res ipsa loquitur* maxim

In the previous paragraph it was evident that the English court has developed the *res ipsa loquitur* maxim since *Scott v London & St Katherine Docks Co*[56] from two elements: that the defendant was in control of the instrument or incident when the occurrence took place; and that the occurrence must have been such that in the ordinary course of events it would not have occurred without negligence. In *Barkway v South Wales Transport Co Ltd*,[57] the court explained that the maxim is intended to assist the plaintiff who suffered damages and is unable to adduce evidence regarding the cause of the accident. The court held that if all the facts of the accident are known the maxim cannot be applied and the plaintiff should then proceed with a trial based on tort law. The effect of the *res ipsa loquitur* maxim is that in some cases, because of the circumstances, it is possible to infer negligence from the fact of the injury.[58] Thus, the maxim calls for a presumption to be made that the defendant caused the injury and was negligent in doing so,[59] ie causation and negligence. Therefore, the requirements for the maxim, before *Ratcliffe v Plymouth & Torbay Health Authority*,[60] were:

(i) the defendant had to be in control of the instrumentality;

(ii) the occurrence should strongly suggest negligence; and

[54]*Jacobs v Great Yarmouth and Waveney Health Authority* [1995] 6 Med LR 192, where the judge rejected the plaintiff's case that she was conscious during an operation. Even if the plaintiff could establish a prima facie case of being conscious during the operation due to negligence, the defendants can answer that all proper steps were taken in inducting and administering the anaesthetic.
[55]This stance was reaffirmed in 1998 in *Ratcliffe* (n 3), where Lord Justice Hobhouse said that the essential role of the doctrine is to enable the plaintiff who is not in possession of all the facts to plead. The defendant can displace the inference by providing an alternative explanation (see p 7 of judgment).
[56]*Scott v London & St Katherine Docks Co* (n 34) 596.
[57]*Barkway v South Wales Transport* (n 40) 118; it was also confirmed in *Hay v Grampian Health Board* [1995] 6 Med LR 128 (SC).
[58]*Ballard v North British railway Co* (n 8).
[59]*Barkway v South Wales Transport* (n 40) 399–400.
[60]These were the listed elements before 1998 and the *Ratcliffe*-case (n 3), where after substantial changes were made to the criteria of the use and function of the maxim. See para 7 below.

(iii) the cause of the occurrence must be unknown.

Notwithstanding the clear requirements of the maxim, it appears that various courts applied the maxim differently. Cases in which swabs or instruments were left behind by surgeons, seemingly 'obvious-mistake' cases or blatant blunders,[61] are not interpreted by the court as constituting a lack of care or negligent conduct.[62] The *res ipsa loquitur* maxim in a medical negligence case is not based on 'objective facts',[63] but only on an inference of negligence derived from the facts. If negligence cannot be inferred from the facts and additional information[64] is called for, the *res ipsa loquitur* maxim cannot be applied. It is the thesis statement that in all medical cases in South Africa negligence cannot be inferred from the facts and additional medical expert evidence is almost always needed to determine liability by showing what precautionary measures the medical professional should have taken in accordance with the standard of care. The latter deduction, namely that it seems that in England the *res ipsa loquitur* maxim can also not apply *if negligence cannot be inferred from the facts and where additional information is necessary to infer negligence*, needs further analysis.

4.1 The instrument should be under the control of the defendant

Although 'control over the instrument' is a prerequisite for the use of the *res ipsa loquitur* maxim, this criterion indicates that the defendant causing the accident must have been in total control of the instrument[65] without the involvement of other role players. The principle is that the damage to the claimant would not have occurred 'but for' the action of the defendant-doctor who was in control of the situation, and it addresses the notion of causation. Control suggests a direct link between the action (negligence) of the doctor and the injury to the claimant. If the claimant cannot determine who caused the injury, but the surgeon was in

[61]Obvious-mistake cases are also referred to as 'blatant blunders': see R Dahlquist 'Common knowledge in medical malpractice litigation: A diagnosis and prescription' (1982) *Pacific LJ* 133 and chap II A.
[62]*Mahon v Osborne* (n 43) 23, at 31 where a swab was retained following a complicated emergency operation performed by the surgeon alone. Scott LJ said: "To fall short of perfection is not the same thing as to be negligent". Also see *James v Dunlop* (n 43) 730, where the court found that the surgeon could not escape liability, even though he had delegated the swab counting to a nurse.
[63]*Caswell v Powell Duffryn Associated Collieries* (n 39) 152–169.
[64]*Mahon v Osborne* (n 43) 14 at 23.The court found that an ordinary reasonable man could not determine what precautionary measures the surgeon would have taken and medical expert evidence was needed. The maxim was not applicable in complicated operations. However, the court accepted that a *prima facie* case was raised.
[65]*James v Dunlop* (n 43), where a swab was retained; *Morris v Winsbury-White* [1937] 4 All ER 494, where a tube was left in the bladder and small perineum area.

control of the operation, then the maxim applies.[66] If more than one person was in control of the treatment of the patient, the maxim cannot apply.[67]

To prove negligence the claimant must show the existence of a duty of care that was breached by the defendant in a situation under his control and that the breach caused the injury to the claimant. The standard of care is determined with the assistance of an objective test of what a reasonable person would have done under similar circumstances. In *Roe v Minister of Health*,[68] the court held that the standard of care required to satisfy the obligation of reasonable care is the same standard as in the tort of negligence. The surgeon contracts to perform an operation with reasonable care. If the instrument or situation is under the control of the defendant and the nature of the occurrence is such that it would not have occurred but for the lack of proper care, then the defendant is presumed to have been negligent. The inference of negligence may be refuted with evidence explaining that the accident occurred without the defendant being negligent. His Lordship Justice Morris said that there is no magic in the phrase *res ipsa loquitur* ('the thing speaks for itself'), as it is simply a submission that the facts have established a *prima facie* case against the defendant. Hence, he accepted the presumption created by the *res ipsa loquitur* maxim ie that it can be inferred that someone had been negligent as the claimant had made out a *prima facie* case.[69] The facts of the case illustrated that regardless that the defendant was in total control of the situation, he cannot be held liable if he could not reasonably have foreseen the danger.

The facts of the case were that during 1947 Mr Roe and another patient underwent surgery in a hospital under the management of the Minister of Health. Before they entered the operating theatre, an anaesthetic agent containing Nupercaine was administered by means of a lumbar puncture or spinal block. It was the usual practice to leave the anaesthetic agent in glass ampoules immersed in a phenol solution in order to reduce the risk of infection. In 1954, seven years later, it was discovered that the glass had micro-cracks that were invisible to the eye; these cracks allowed the phenol to penetrate the glass. The phenol contaminated the anaesthetic agent and the latter, after being injected as a spinal block, caused permanent damage to the nerves of the claimant, which resulted in paraplegia.

[66] *Mahon v Osborne* (n 43) 14.
[67] *Morris v Winsbury-White* (n 65) 494. Summerville LJ disagrees with the standard of Law in *Roe v Minister of Health* (n 25) 80.
[68] *Roe v Minister of Health* (n 25) 66, 80.
[69] *Roe v Minister of Health* (n 25) 66.

The matter was taken on appeal to the court of appeal of England and Wales. On appeal, Lord Justice Denning overruled the decision of the court *a quo* and pronounced that the maxim *res ipsa loquitur* was applicable, as the facts did speak for themselves and the hospital and anaesthetist should provide an answer. He explained that, if a person is admitted for surgery for a minor complaint and is discharged as a paraplegic, this calls for an explanation. The defendant-hospital offered an alternative explanation in defence (in 1954), which was that, although the micro-cracks in the vial had indeed allowed for the contamination of the anaesthetic, it was not foreseeable that such an incident might occur, given the prevailing scientific knowledge in 1947. During 1947, the reasonable anaesthetist would have stored the anaesthetic agent in a similar manner and therefore the hospital management could not be held liable for failing to take precautions. The fact that the profession had changed its practice in the light of experience proved that the profession was responsible in its self-regulation.[70] Denning LJ rejected part of the claimant's arguments that 'we must not look at the 1947 incident with 1954 spectacles', and he accepted that no breach of duty occurred, as the risk was unknown at the time and as such not foreseeable. Of interest is that the court found that the maxim applied, which allowed an inference of negligence because the severe outcome called for an explanation. No other explanation was offered save for the contaminated vial seven years later. Whether this was the true cause of the injury is arguable among medical professionals; a plausible alternative cause of the injury, not presented to the court, was the inadvertent spinal injection[71] into a blood vessel, which most likely was the cause of paraplegia.

Nevertheless, Puxon[72] argues that the maxim remains an important adjunct to justice, where a plaintiff is unable, in the nature of things, to hold either the technique or the operator responsible for an injury. Without the assistance of the maxim to draw an inference of

[70]In 1954, an anaesthetist tested the vials and put a dye in the phenol. The dye contaminated the inside of the vial and indicated that the phenol had penetrated the vial.

[71]See the earlier works of JL Corning 'Pain' (1894) J B Lippincott Co, where it was in the initial years of local anaesthesia. The anaesthetist took pains to avoid penetrating the cord itself: he did this by using depth measurement instruments. In other words, the spinal needle has a gauge that allows the anaesthetist to insert the needle to a certain depth thereby preventing injury. NE Epstein 'The risk of epidural and transforaminal steroid injections in the spine: Commentary and a comprehensive review of the literature' (2013) 4 *Surgical Neurology Int.* Suppl. S2: 74–93. The review found that few clinicians report adverse events due to the risk of medico-legal suits. The study revealed that an inadvertent 'vascular injection' into the transforaminal cavity of the spine may cause quadriplegia and respiratory problems. During a transforaminal cervical injection the patient developed left arm and lower extremity weakness. The deficit was attributed to a vascular event, as the procedure carries a high risk of a vascular infarction. After an inadvertent injection into a cervical radicular artery the patient immediately became quadriplegic. The above is a more likely alternative cause of action.

[72]M Puxon QC commenting on *Delaney v Southmead Health Authority* [1995] 6 Med LR 355, CA (Civ Div). Margaret Puxon had successful careers in both medicine and the law. She was a deputy circuit judge between 1970 and 1986 and a recorder from 1986 to 1993, when she retired.

negligence, the court would be denied the evidence of the defendant and would be powerless to investigate the case fully. Puxon[73] explains that it is clear that two escape routes are usually available for the defendant to avoid liability after the maxim is accepted by the court: first, to furnish an explanation that shows there was no negligence, ie that there was a plausible alternative cause of the injury to the claimant over which the defendant had no control, and second, to show that all reasonable care was exercised during the incident. The author remarks that, due to the profound difficulty of producing an explanation that shows there was no negligence, some 'exotic' explanations have been offered by the defendants. Since there is no obligation on the defendant to disprove negligence; he needs only furnish an explanation to show that he was careful in his actions and that, according to his explanation in rebuttal, his actions were not the cause of the injury. It can be argued that the resourceful answers of the defendants, in rebuttal, focus on disproving negligence rather than concentrating on truth-finding principles that should explain the acceptable standard of care to the court. In furnishing a possible but improbable explanation, not necessarily relevant to the real cause of action in the case, the defendants over-complicate the medical negligence matter, as the court now not only has to entertain the alternative cause of injury presented by the defendant in rebuttal, but also has to determine the sometimes hidden and real cause of the injury. It seems that the maxim puts a further burden on the claimant to refute the defendant's answer in rebutting the maxim, in addition to proving causation.

4.2 Negligence has to be obvious from the facts

The second element of the *res ipsa loquitur* maxim, that negligence has to be deduced from the facts, should be a significant cause of indecision, because of the specialised field of medicine. However as seen before, in contrast to South African law an inference of negligence can simply be derived from the undesired outcome of a medical incident under the control of the defendant which is then attributed to the lack of care exercised by the defendant. If used in its strict sense and in a technically correct manner, it was argued that all medical negligence cases, except for the obvious mistake cases, would be excluded[74] from the

[73]M Puxon QC 'Commentary on the judgment' (1995) 1 *Medical Law Reports* 5. She referred to the court's summary of the position of *res ipsa loquitur* in *Delaney v Southmead Health Authority* (n 72). She referred, as an example, to the explanation offered by the defendant of a paradoxical embolus in *Saunders v Leeds Western Health Authority* [1993] 4 Med LR 355.

[74]Experiences of medical professionals in their fields of proficiency, competence and skill are interpreted among these professionals as an ordinary course but it does not fall within the ordinary experience of a reasonable man in everyday life. In *Mahon v Osborne* (n 43) 14, the court asked how the ordinary judge could have sufficient

maxim, as the facts of a medical negligence case are not easily understood by a non-medical person. In this regard Jones[75] explains that the circumstances and control over the instrument should be such that 'in the ordinary course of things' accidents do not happen unless someone was negligent. The statement is based on ordinary life experiences and on the usual experiences of humans. Barrels[76] and sugar bags[77] do not fall from second storeys, and the amputation of the left leg instead of the right leg is an objective fact from which anyone can infer that a lack of care and negligence were likely. However, not every medical adverse event may constitute negligence – this depends on what information or objective facts are available – but a medical adverse event under the control of the doctor nevertheless may create a legal presumption of negligence in England.

The English court recognises the difficulty it has in drawing an inference of negligence based on the facts in complicated cases. In certain cases there would be equally possible explanations and it would be equally likely for an occurrence to have occurred whether there was negligence or not. In *Jones v Great Western Railway Co*,[78] a certain Murray had to put on the brakes of a railway carriage to control its speed. The brake-handle was defective and Murray was thrown off balance as a result of the defective brake and was killed. The court had to determine whether the facts furthered the case beyond conjecture into a legal inference. Lord MacMillan held that the test to establish whether there exists a presumption of negligence is the dividing line between conjecture and inference. He stated that a conjecture may be plausible but is of no legal value, as in essence it is a mere guess. A legal inference is deduced from the facts and, if it is a reasonable deduction, it may have the validity of legal proof. He said that to attribute a certain cause to the occurrence is always a matter of inference. The cogency of a legal inference of causation may vary in degree between practical certainty and reasonable probability. Where the coincidence of cause and effect is not a matter of actual observation, there is necessarily an interruption in the direct evidence, but this may be legitimately bridged by an inference from the facts actually

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knowledge of surgical operations and complications. The court was of the opinion that the maxim has no use in medical negligence cases. In *Ritchie v Chichester Health Authority* (1994) 5 Med LR 187 (QB), the defendants also argued that the maxim has no place in medical negligence cases. In *Delaney v Southmead Health Authority* (n 72) the court said that the maxim may apply in medical cases but not if there was sufficient medical evidence available from the medical experts.

[75]Jones (2008) (n 6) 308.See *Byrne v Boadle* (n 34) 722; *Scott v London & St Katherine Docks Co* (n 34) 596.

[76]*Byrne v Boadle* (n 34) 722.

[77]*Scott v London & St Katherine Docks Co* (n 34) 596.

[78]*Jones v Great Western Railway Co* (n 38) 39ff.

observed and proved. His Lordship referred to Lord Penzance in *Parfitt v Lawless*[79] who pronounced that from every fact that is proved, legitimate and reasonable inferences may be drawn, and all that is deducible from the evidence is as much proved for the purpose of a *prima facie* case as if it had been proved directly.

The presumption of negligence in a medical case was tested in *Cassidy v Minister of Health*.[80] Mr Cassidy suffered from Dupuytren's contracture[81] of his third and fourth finger and underwent an operation. Following the operation, his hand was put in a rigid splint. Subsequently, Mr Cassidy experienced severe pain, so he consulted Dr Rolandson and Dr Fahrni. They decided not to remove the splint. About 14 days later the splint was removed and Mr Cassidy presented with four fingers that were stiff and virtually useless. The Court of Appeal held that the hospital was responsible for all persons who treated the claimant, and, after treatment, the claimant was in a worse condition than before. The plaintiff raised an inference of negligence based on *res ipsa loquitur*. The court decided that it was impossible to reach a clear conclusion about the cause of the injury because the defendant did not call a medical expert. The defendant failed to defend the *prima facie* case of negligence and the court ruled in favour of the claimant.

Two aspects of the incident influenced the court's decision: that the surgeon was employed by the hospital and that the defendant presented no evidence in rebuttal. First, if the control of the medical intervention was in the hands of more than one professional person, all under the supervision of the employer, a general assumption of negligence may be possible, in accordance with the *prima facie* case. Had the surgeon been in private practice, factual causation would have presented a problem. To draw an inference of negligence might not have been possible, as specific evidence regarding the operation and follow-up treatment would have been essential, based on the fact that not everything was under the control of the surgeon. Second, the defendant's failure to refute the evidentiary burden, created by the *res*

[79]*Parfitt v Lawless* (n 36) 472, where the claimant challenged her late mother's will. Her mother left the bulk of her estate to a priest. The court found that the priest's role in her house was not enough to prove undue influence. The court compared the gifts of contracts *inter vivos* and a legacy under a will and discussed when 'the presumption of undue influence [will] arise'. The court found that there can be no presumption of undue influence.

[80]*Cassidy v Minister of Health* (n 21) 131, where Judge Denning said that the reason why the employer is liable is not because it can control the work of the surgeon, but because it has ultimate power over the surgeon and therefore control of the surgeon's conduct. This case is also discussed in para 3 above.

[81]Dupuytren's contracture is a fixed flexion contracture of the hand due to palmar fibromatosis. It is a proliferative connective tissue disorder that involves the palmar fascia of the hand. It causes the fingers to bend towards the palm of the hand so that they cannot be fully extended. Failure to exercise the hand after corrective surgery will cause contractures to form, causing the hand to become stiff. Alternatively, the cause of the stiff fingers might be an unsuccessful operation. See http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1798044 (accessed 14 June 2014).

ipsa loquitur maxim, led to the defendant being found liable. In order for the court to accept the inference of negligence the court relied on the assumption that the condition worsened as a result of the failure to treat. The only information before the court was evidence of a bad outcome. It appears that the plaintiff's success was based on a legal procedural mechanism. The plaintiff's *prima facie* evidence became conclusive evidence because of the defendant's silence. This supports the notion that any medical accident is *prima facie* evidence of negligence, and when the *res ipsa loquitur* maxim is accepted by the court, the defendant should rebut the inference of negligence with evidence showing that he took proper care in the circumstances or with an explanation of alternative cause of injury that negates negligence. If such an explanation is not presented, the claimant's case will remain unchallenged. Jones[82] warns against the oversimplification of medical matters. If a claimant came out of a hospital in a worse condition than when he was admitted, this does not *ipso facto* mean that there was negligence; the situation is merely *prima facie* evidence of negligence that can be refuted.

Some of the intricacies involved in the application of the *res ipsa loquitur* maxim under circumstances where negligence should be obvious from the facts are illustrated in *Mahon v Osborne*.[83] In this case, Mr Mahon underwent duodenal (small bowel) surgery for a duodenal ulcer. The surgeon used surgical packs to absorb bleeding and the bowel contents. This difficult emergency operation was performed by the surgeon alone. The surgeon conducted a swab count with the theatre sister. The wound was sutured but a swab was retained. The medical condition of Mr Mahon deteriorated and he had to undergo emergency surgery; the missing swab was discovered during surgery. The swab had already formed an abscess. The condition of Mr Mahon deteriorated further and he died. The mother of Mr Mahon instituted legal action. The majority *per* Lord Justice Scott pronounced that, without the assistance of medical experts to explain to the court 'the ordinary course of things' in the practice of medicine in a complicated surgical operation, the court was unable to say that the occurrence indicated negligence. His Lordship was unwilling to draw the negative inference required by the *res ipsa loquitur* maxim and explained that there might be surgical reasons for ending an operation as rapidly as possible. His Lordship held that the required medical care and treatment are unknown to the normal person in the street and the ordinary judge. His

[82]Jones (2008) (n 6) 309. This position was confirmed in *Roe v Minister of Health* (n 25) 80. The claimant went in for minor surgery and came out paralyzed. It was discovered that the medication in the vials was contaminated. The court held there is no magic in the *res ipsa loquitur* phrase; it is simply a submission that the facts establish a *prima facie* case against the defendant.
[83]*Mahon v Osborne* (n 43).

Lordship concluded that the surgeon is only bound to display the sufficient skill and knowledge of his profession. If an accident occurs, or there is some variation in the frame of a particular individual, and an injury happens, it is not the fault of the surgeon.

Dissenting from Lord Justice Scott, his Lordship Goddard held that the *res ipsa loquitur* maxim should undoubtedly apply, as there can be no question that, if a swab is retained, there can be no other inference than that it was left behind due to negligence. The surgeon should be called to explain his actions. The surgeon need not necessarily explain why he failed to detect the retained swab, but he should at least explain whether he exercised due care to prevent it being left behind. His Lordship expressed the opinion that if the claimant could not call on the surgeon for an explanation, then an unwarranted protection would be given to carelessness. His Lordship stated that information was needed from the surgeon, because with sufficient explanation all the facts of the cause of the accident would become known, and the court would be in a proper position to determine whether there was negligence or not.

From the conflicting opinions of the judges, it seems that swab cases are more complicated than they need be. The majority *per* Scott LJ stated that it is not every slip or mistake that imports negligence and it is necessary to consider the different circumstances that may present themselves for urgent attention.[84] A presumption of negligence is designed to infer lack of care from the objective facts. In the Australian case *Elliot v Bickerstaff*[85] it was held that the *res ipsa loquitur* maxim could not apply in a swab case in which the surgeon was cited and not the hospital, because the surgeon delegated the task of counting swabs to the theatre staff. The surgeon would at some stage seek confirmation from the theatre staff that all the swabs had been accounted for. This similar stance of the English court is seen in the later application of the maxim, explicitly expressed in *Ratcliffe v Plymouth & Torbay Health Authority*,[86] namely, that the maxim allows a plaintiff to come to court with *prima facie* evidence of negligence that should be answered, and that the plaintiff should obtain medical expert evidence to support his case once the maxim's function has run its course. Evidently, the retention of swabs or surgical instruments inside the patient, following a surgical operation, does not constitute negligence, only *prima facie* evidence of negligence. If, after an operation where a swab was retained, a surgeon is found not to be

[84]*Mahon v Osborne* (n 43) 14. Note that Scott LJ also dissented on whether the *res ipsa loquitur* maxim applied to cases where swabs had been retained.
[85][1999] NSWCA 453; (1999) 48 NSWLR 214.
[86]*Ratcliffe* (n 3) 174, where the plaintiff suffered from a severe neurological defect following an epidural being administered during an operation on his ankle.

negligent in leaving the swab behind, it is almost certain that the nurse responsible for the swab count will be found negligent.

4.3 The actual cause of the accident should be unknown

The value of the *res ipsa loquitur* maxim is that it enables a claimant who has no knowledge or inadequate knowledge about how the undesired medical incident occurred to rely on the accident per se and the circumstances of the accident as objective facts to infer negligence. It prevents the defendant, who most probably knows what occurred, from avoiding having to provide an explanation. This simply means that the law allows a presumption of negligence from the mere fact of the injury under the control of the defendant and that such a presumption will become conclusive evidence of negligence if not defended. It is important to make a fundamental distinction between not understanding the medical facts and not having any information available regarding the medical incident to determine the inferred cause of the injury.

It was established in *Barkway v South Wales Transport Co Ltd* that if all the facts are known but the uncertainty lies with the fact that more than one causes of the accident exists, then the question whether negligence has been established will be determined as the most probable cause and the maxim is not applicable.[87] The inference of negligence will suffice only if nothing more is put to the court and it is shown that 'in the ordinary course of things' it is more likely than not that the occurrence occurred without due care. The court held that the maxim is based on common sense, and the purpose of the maxim is to enable justice to be done when the facts bearing on causation and on the care exercised by the defendant are at the outset unknown to the plaintiff and ought to be within the knowledge of the defendant.[88] In *Hay v Grampian Health Board*[89] the court confirmed that the *res ipsa loquitur* maxim is not applicable when all the facts are known. In this case, the plaintiff suffered from a depressive illness, had previously attempted suicide at the same hospital, and then hanged himself with a scarf. He was resuscitated, but suffered permanent brain damage. The court

[87] *Barkway v South Wales Transport Co Ltd* (n 40) 118ff. In this case an omnibus left the road and injured pedestrians on the sidewalk. The judge demonstrated that the principles of the maxim cannot apply if there is more than one explanation before the court, and it is shown that in the ordinary course of things it would be more likely than not that the occurrence occurred without due care. The court reasoned that this approach is based on common sense.

[88] *Barkway* (n 40) 118ff.

[89] *Hay v Grampian Health Board* (n 57). The hospital neglected to monitor the claimant and he sustained severe brain damage after a failed suicide attempt.

was asked to consider whether the *res ipsa loquitur* principles were applicable. The court found that where all the facts are known, the case fails to be one where 'the facts speak for themselves' and the plaintiff must establish on the principles of tort that the defendant breached his duty to the plaintiff. The court followed the principles laid down by *Ballard v North British Railway Co*.[90]

The status of the maxim was reaffirmed in *Delaney v Southmead Health Authority*.[91] The plaintiff sustained an unexplained injury to her brachial plexus (the junction of nerves in the shoulder) following a cholecystectomy (an operation to remove the gall bladder). The claimant argued that the only real explanation was that the arm had been hyper-abducted and/or extensively over-rotated but there was no direct evidence available. Lord Justice Stuart-Smith held[92] that the maxim was not applicable. The judge said that, even if the maxim could have been applied to this matter, it was always open for a defendant to rebut a case by giving an explanation that was inconsistent with negligence, or for the defendant to show to the court that he had exercised all reasonable care. In rebuttal, the defendant-anaesthetist said that he took all reasonable care to insert the needle into the arm to administer the anaesthesia, which could not have caused the injury to the shoulder. His Lordship Stuart-Smith explained that the defendant should in his defence show that he took all reasonable care and that the unfortunate occurrence was due to a misadventure or that some other cause existed to explain the injury. A satisfactory explanation will allow the defendant to escape liability. The court found that the anaesthetist had exercised all due care in carrying out the procedure, even though the injury remained unexplained. Although the court entertained a presumption of negligence that the defendant was called to answer, the court held that in medical negligence cases, where full evidence, including evidence from experts on both sides, has been heard it is only in a rare case that the *res ipsa loquitur* maxim will assist the court. Lord Justice Stuart-Smith said that he was 'doubtful whether it is of much assistance in medical negligence at any rate when all the evidence in the case had been adduced.'[93]

The court's dismissal of the plaintiff's appeal cannot be faulted, but for different reasons. First, it seems that a more credible alternative cause of injury was not accepted by

[90]*Ballard v North British Railway* (n 8) 43, where the claimant claimed damages caused by a runaway railway wagon. This case is also referred to by Van den Heever & Carstens (n 5) 43, who quote C Foster '*Res ipsa loquitur*: The defendant's friend'1996 *SJ* 824: '[If] there is evidence, however slight, as to how the occurrence took place, the plaintiff has to rest his case wholly on the evidence and the maxim can never help him.'
[91]*Delaney v Southmead Health Authority* (n 72) 395. Stuart-Smith LJ said that a defendant can always rebut a case of *res ipsa loquitur.*
[92]Their Lordships Butler-Sloss and Dillon agreed.
[93]*Delaney v Southmead Health Authority* (n 72) 355ff and p 4 of judgment.

the court. Available and more credible medical information[94] presented to the court would have explained the traction injury to the brachial plexus. The injury was the result of pulling the patient by her arms when transferring her from the theatre bed to another bed. It seems the court was indecisive because of a lack of direct evidence. Second, the insertion of the needle into the arm of the plaintiff had no bearing on her shoulder injury. As such, the claimant possibly identified the wrong tortious actor in that the anaesthetist may not have assisted with moving the patient from one bed to another; it was uncertain who transferred the patient. The defendant was called to rebut the presumption of negligence based on *prima facie* evidence (the undesirable result) of lack of care. The anaesthetist had no duty to explain to the plaintiff the true facts (medical reality) of the case. He discharged his initial duty owed to the plaintiff, ie that the anaesthesia was performed with the proper skill and care. He therefore only had to refute factual causation allegations, ie that the anaesthetic agent or the administration thereof did not cause the injury. He simply explained to the court that he took reasonable care to insert the needle and that any injury during the anaesthesia was not related to the actual injury. Doubt as to the cause of the injury and failure to cite the correct defendant caused the plaintiff to lose the case. Adequate knowledge of the medical facts would have ensured that the correct parties were cited. The injury could have been caused by any one of the doctors, theatre personnel or general staff who transferred the claimant from one bed to another without taking proper care. Third, like *Cassidy v Minister of Health*,[95] mentioned previously,[96] the claimant in *Delaney v Southmead Health Authority*[97] emerged from an operation with an injury to a body part unrelated to the initial medical complaint. If the function of the maxim is

[94]There was evidence available from the literature, presented by the claimant's expert, similar to the article by A Narakas 'Surgical treatment of traction injuries of the brachial plexus' (1978) 133 *Clinical Orthopedics* 71–90. A detailed explanation is seen in KR Desai & AA Nemcek 'Iatrogenic brachial plexopathy due to improper positioning during radiofrequency ablation' (2011) 28(2) *Semin. Intervent. Radiol.*167–170, available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3193318/ (accessed 12 May 2014).Desai and Nemcek write that some brachial plexopathies (injuries to the shoulder nerves) are iatrogenic (caused by medical intervention) in nature. The mechanism of injury in the majority of cases is stretching or compression of the nerve tissue. The authors believe that prevention is crucial to minimise this form of patient morbidity. They state that it is the operator's responsibility to mitigate this risk by employing proper positioning techniques and communicating closely with the anaesthesia staff when transferring patients. This injury is well recognised among medical professionals. In all probability, the plaintiff was repositioned and the theatre personnel pulled her across from one bed to another by her arms. During the transfer procedure, the brachial plexus in the plaintiff's shoulder was injured. This averment was not presented to the court. The nursing personnel, who most likely transferred the patient, were not cited. Instead, the plaintiff averred that the anaesthetist, while administering the anaesthetic medication, caused the injury to the brachial plexus. The plaintiff made the incorrect allegation against the incorrect defendant and failed to cite the theatre personnel as alternative defendants. An inference of negligence should have been drawn because the plaintiff went into the operating theatre for a certain operation and came out with an unrelated serious injury to the shoulder.

[95]*Cassidy v Minister of Health* (n 21) 343ff, where the claimant went into hospital to be cured of two stiff fingers and came out of hospital with four stiff fingers and a useless hand.

[96]See paras 3 and 4.2 above.

[97]*Delaney v Southmead Health Authority* (n 72).

correctly understood one can argue that, based on the established principles of *Cassidy v Minister of Health*,[98] *Delaney v Southmead Health Authority*[99] it should have been a *res ipsa loquitur* case against the hospital and the doctor, because the plaintiff went into hospital to have her gall bladder removed and came out with a severe injury to her left shoulder. The hospital should have been called to explain how this could have happened under their control without negligence. However it is argued that the facts in *Delaney v Southmead Health Authority*[100] give rise to the court's failure to distinguish between not understanding the medical facts and not having any information available to determine what caused the injury. Furthermore, it appears that an insufficient understanding of the medical reality resulted in the claimant failing to present a case against both hospital and doctor based on ordinary tort principles with a high probability of success.

In *Bouchta v Swindon Health Authority*,[101] based on *Delaney v Southmead Health Authority*,[102] the court demonstrated the judicial reluctance to apply the *res ipsa loquitur* maxim to medical negligence cases. The plaintiff suffered damages when the ureter (tube between the bladder and kidney) was damaged during a hysterectomy. Four weeks after being discharged from hospital the claimant presented with a ureter leak and further correctional surgery was needed. The judge held that he was 'reluctant to apply such a test [*res ipsa loquitur*] to issues of medical judgment unless [he was] compelled to do so', and that the plaintiff had to satisfy the court that there was in this instance no good or satisfactory explanation for the injury. Accordingly, the defendants explained that it was a difficult operation because of the obesity of the plaintiff; they confirmed that they exercised the necessary care when removing the uterus in two phases, and ensured that they could palpate the ureter all along. They offered no explanation as to why and how the ureter had been damaged. The court found in favour of the plaintiff. The reluctance of the court to accept the application of the *res ipsa loquitur* maxim was noticeable. The court avoided any decision concerning the maxim. It can be argued that, perhaps in the light of all the information presented to the court, there was no need to justify the use of the *res ipsa loquitur* maxim.

[98] *Cassidy v Minister of Health* (n 21).
[99] *Delaney v Southmead Health Authority* (n 72) 355.
[100] Ibid.
[101] [1996] 7 Med LR 62 (CC) 22ff. See p 3 of his judgment. He decided that it would be correct to see whether the plaintiff has satisfied him that there was no good or satisfactory explanation for the injury in the light of the presented facts.
[102] *Delaney v Southmead Health Authority* (n 72) 395ff.

Puxon,[103] in her comments on *Bouchta v Swindon Health Authority*,[104] advises that the application of *res ipsa loquitur* principles should be put to rest as there is no room for such an evidential device in cases of medical negligence. She says the application of the *res ipsa loquitur* principles depends on the plaintiff showing that there is no explanation for the accident other than negligence. Once it is shown that the damage was not the result of negligence, the burden of proof will remain with the plaintiff.[105]As indicated before, the defendant-doctor will be more inclined to furnish a possible but not necessarily plausible explanation to defend his case than to assist the court to find the cause of the injury, thereby complicating a medical negligence case, and more so where the maxim is used. This seems to mean that the claimant will bear the burden of disproving the defendant's rebuttal arguments, together with having to prove that the injury was the result of negligence (the initial burden of proof).

5 Inconsistent application of the *res ipsa loquitur* maxim

In summary, after the cases of *Scott*[106] and *Byrne*,[107] it was found that the *res ipsa loquitur* maxim can be invoked where an incident occurred in circumstances under the control of the defendant where such occurrences do not usually happen[108] 'but for' the lack of proper care. The main function of the maxim is to permit an inference of negligence based on the fact of the accident. In the event that the defendant fails to rebut the inference of negligence, he will be found liable. From the objective facts, it should be evident that the finding of negligence is based on whether the defendant, who is in control and owed a duty of care to the claimant, breached that duty because he fell short of the standard of care expected. In order to meet the requirements of the *res ipsa loquitur* maxim, the facts of the case should be such that they allow an inference of negligence.[109] In a situation where the plaintiff relies only on the *res ipsa loquitur* maxim without medical expert evidence, the court will test the defendant's medical evidence in explanation to determine whether the conduct occurred with the

[103]Puxon (n 72) 62. She also referred to the summary of the court of the position of *res ipsa loquitur* in *Delaney v Southmead Health Authority* (n 72).
[104]*Bouchta v Swindon Health Authority* (n 101).
[105]*Delaney v Southmead Health Authority* (n 72) 359, where the court stated the position of *res ipsa loquitur* in medical negligence cases with a full list of relevant case law. Although the defendant did not give an explanation for what happened to the claimant, the judge accepted that the defendant's usual practice was a reasonable practice and that the claimant's injury remained a mystery.
[106]*Scott v London & St Katherine Docks Co* (n 34) 596.
[107]*Byrne v Boadle* (n 34) 722.
[108]*Saunders v Leeds Western Health Authority* (n 73) 255ff; *Ratcliffe* (n 3) 169ff.
[109]*Mahon v Osborne* (n 43);*Cassidy v Minister of Health* (n 21); *Roe v Minister of Health* (n 25).

necessary prescribed care. If the court rejects the defendant's explanation, the plaintiff's *prima facie* case will stand and the plaintiff will be successful. If the court accepts the explanation of the defendant, however, as an alternative non-negligent action that was performed with the prescribed care, the case of the plaintiff will fail in the absence of other medical expert evidence.

It was not consistently applied as was evident from *Saunders v Leeds Western Health Authority*,[110] where a four-year-old girl went for surgical repair to a congenital defect of the hip (Colonna's capsular arthroplasty).[111] She suffered cardiac arrest during anaesthesia and was not adequately resuscitated. She suffered permanent brain damage because she was without sufficient oxygen for a long period.[112] She was mentally incapacitated, suffered from spastic quadriplegia and had severely defective vision, thus requiring full-time medical assistance. The plaintiff relied on the *res ipsa loquitur* maxim, stating that–

> fit children do not suffer cardiac arrest when under anaesthetic if proper care is taken by those undertaking the administration of the anaesthetic, and control the condition of the child during the operation. [It is further said that] if the defendants cannot explain how the arrest occurred without negligence, then they are liable in that those who had the management of the anaesthetic process must inevitable have failed to exercise the ordinary skill of an anaesthetist.[113]

The defendant's explanation, in rebuttal, was rejected by the court. The defendant stated that the cardiac arrest occurred as a result of an unforeseen paradoxical air embolism[114] that blocked the coronary artery, and as a result thereof deprived the brain of oxygen. The medical

[110]*Saunders v Leeds Western Health Authority* (n 73) 255.
[111]It is not a common operation and the defendant had performed it only on three previous occasions. The medical expert described the operation in court: the femoral head is detached, a capsular sac produced about the head, and the head with its surrounding sac placed into a cup-shaped cavity formed by the surgeon with a curette or reamer.
[112]H Raskow, E Salanitre & LT Green 'Frequency of cardiac arrest associated with anaesthesia in infants and children' (1961) 28(5) *Paediatrics* 697–704, where it is indicated that the anaesthetic agents carry a high risk of cardiac arrest. Available at http://pediatrics.aappublications.org/content/28/5/697 (accessed 12 September 2014).
[113]*Saunders v Leeds Western Health Authority* (n 73) 255.
[114]See relevant article J Loscalzo 'Paradoxical embolism: Clinical presentation, diagnostic strategies, and therapeutic options' (1986) 112 *American Heart Journal* 141–145. A later article explains in more detail ie K Yeddula et al 'Paradoxical air embolism following contrast material injection through power injectors in patients with a patent foramen ovale' (2012) 28(8) *Int. J. Cardiovascular Imaging* 2085–90, where the authors explain that air embolism, even in patients with a high risk, is not common. Available at http://www.ncbi.nlm.nih.gov/pubmed/22302647 (accessed 12 September 2014).

information was discussed. The two anaesthetist-defendants prepared a memorandum in which the exact medical process was explained. In their version, the child's pulse was constantly monitored but her blood pressure was not monitored. The pulse was monitored by palpation. The one anaesthetist controlled the ventilator with his right hand and with the left they monitored the left radial and the temporal pulse. The other administered an analgesic, Pethidine (known for its hypotension-effect), and a neuromuscular blocking agent, Tubocurarine,[115] to produce paralysis and maintain anaesthesia. The court did not find the explanation convincing and decided in favour of the plaintiff.

The monitoring of the child's pulse without a cardiac monitor was challenged and the court questioned whether this constituted acceptable reasonable practice. The court stated that proper monitoring would have revealed different signs and might have included a forewarning of the cardiac arrest.[116] If such monitoring was not undertaken adequately it could have caused or contributed to the cardiac arrest. The court based its decision on its rejection of the defendant's explanation in rebuttal and an acceptance that the pulse was not monitored sufficiently. The judge (interpreted the maxim as a rebuttable presumption) held that 'the plaintiff's reliance upon *res ipsa loquitur* made it unnecessary for her to suggest a specific cause or causes for the cardiac arrest. She did not do so'.[117] It is not clear whether the court established factual causation, but once the alternative explanation as to how the heart stopped without negligence was rejected, the only conclusion remaining was that the cardiac arrest was the result of negligence.

In *Ritchie v Chichester Health Authority*,[118] the plaintiff received epidural anaesthesia during labour and as a result she contracted *cauda equina* syndrome. She suffered damage to the nerves in the lower part of her spine feeding the saddle area. She suffered from permanent

[115]The anaesthetists administered Tubocurarine, a neuromuscular blocking agent with a slow onset of more than five minutes and a long duration of 20 minutes. Despite administering agents like Pethidine and Tubocacarine, whose side effect is hypotension (lowering blood pressure), they failed to monitor the blood pressure of the child. See D Ostergaard, J Engbaek& J Viby-Mogensen 'Adverse reactions and interactions of the neuromuscular blocking drugs' (1989) 4(5) *Med Toxical Adverse Drug Exp* 351–368, available at http://www.ncbi.nlm.nih.gov/pubmed/2682131 (accessed 12 January 2015). The adverse reactions seen following the administration of neuromuscular blocking agents are mainly cardiovascular. Many drugs interact with neuromuscular blocking agents and there is often a potentiating of the neuromuscular effect. This is of clinical importance in the case of antibiotics, inhalational anaesthetics, lithium and cyclosporine. Difficulty in reversing the block may occur or may produce an unnoticed prolonged block effect.

[116]*Saunders v Leeds Western Health Authority* (n 73) 255. A fall in blood pressure would have been noticeable on a cardiac monitor, especially in the presence of an anaesthetic agent that is long acting and that produces hypotension, in addition to the effect of Pethidine, which is known for its hypotension effects.

[117]Ibid (page 358 col 1). See Puxon's comments (n 73), where she stated that the court's approach and management of medical evidence in 1984 had changed since the 1960s.

[118]*Ritchie v Chichester Health Authority* (n 74) 206ff.

lower back pain, lower limb weakness, bowel and bladder dysfunction, and sexual dysfunction.[119] The plaintiff relied on the *res ipsa loquitur* maxim, alleging that a neurotoxic substance was administered during the epidural that caused the symptoms. Thompson J referred to *Delaney v Southmead Health Authority*[120] and said that in his opinion the maxim was not precluded from being used in medical cases, and that medical negligence is not a special category that puts it outside the ordinary English law of negligence. However, the maxim may not help if sufficient medical evidence is available. A medical article was presented to the court showing the incidence of a wrong drug being administered causing similar symptoms. The judge held that 'it would be wholly unrealistic to assume that it could not and does not happen here'. The article assisted the finding that the accident should not simply be attributed to a 'medical mystery', which was the argument advanced by the defendants. The article supported the conclusion that the anaesthetist had injected a neurotoxic substance when administering the epidural anaesthesia. The court held that the plaintiff's account of the pain that she experienced at the time when the epidural was set up was accurate or substantially accurate. The defendants were held liable on the basis that the anaesthetist injected this neurotoxic substance. Thompson J explained that there is no obligation on the defendants to set up a positive case in an endeavour to show how the damage to the plaintiff occurred without any fault on their part. If they do, it adds to the burden on the plaintiff. The court continued that for the plaintiff to succeed she must first disprove the defendant's positive case and then show that the defendants were negligent, unless the principle of *res ipsa loquitur* worked for her in that the defendants' explanation was rejected. The judge dismissed the two positive defences advanced by the defendants (as an alternative explanation negating negligence) and accepted that the plaintiff discharged the onus of proof. It is evident from the facts that the court was able to establish a probable cause of the injury, which is different from *Saunders v Leeds Western Health Authority*,[121] where the reason for the cardiac arrest was not established but the claimant was successful, simply based on the fact that the defendant's explanation was rejected.

[119]See a relevant article by JR Gleave & R MacFarlane 'Prognosis for recovery of bladder function following lumbar central disc prolapse' (1990) 4(3) *British Journal of Neurosurgery* 205–209. A later article provides more detail ie ST Dawodu 'Cauda equina and conus medullaris syndromes', available at http://emedicine.medscape.com/ article/1148690-overview (accessed 12 September 2014).
[120]*Delaney v Southmead Health Authority* (n 72) 355.
[121]*Saunders v Leeds Western Health Authority* (n 73).

In *Howard v Wessex Regional Health Authority*[122] the plaintiff underwent a surgical operation of a sagittal split osteotomy to correct mandibular prognathism (protruding jaw). The plaintiff returned from theatre suffering from tetraplegia[123] (complete paralysis of the body from below the jaw) and averred that she was injured during surgery. The claimant relied on the *res ipsa loquitur* maxim. The claimant averred that an over-extension of her neck caused the injury, whereas the defendants argued that the claimant had suffered from a rare condition called fibro-cartilaginous embolism (blockage in a blood vessel in the spinal cord). The court held that the plaintiff has to show that the objective facts are indicative of and infer negligence and that negligence was the probable and likely cause of the injury. The plaintiff carries the onus of proof throughout the case, and the plaintiff did not discharge the onus resting on her to show that she suffered the tetraplegia as a result of the initial surgery. The *res ipsa loquitur* maxim was found to be inappropriate. The defendant's explanation that a fibro-cartilaginous embolism caused the tetraplegia was accepted, rather than the plaintiff's allegation that trauma caused her injuries. The judge concluded that there was no over-extension of the claimant's neck in theatre because no one in theatre noticed such an occurrence. It is important to note that, generically, the facts of this case should be similar to a *res ipsa loquitur* case: the plaintiff went into theatre able to walk and came out suffering from tetraplegia from the jaw down. Yet, as in *Mahon v Osborne*,[124] the inadequate medical expert evidence presented to the court by the claimant resulted in her defeat. If a claimant relies on the maxim without medical expert evidence to explain the expected standard of care, the maxim seems to be an unsatisfactory vehicle to discharge a burden of proof, especially if evidence of a careful and not careless action is offered. The claimant relied on the maxim in the *Howard* case without medical expert evidence and the court remained unconvinced because the surgeons testified that they took the appropriate care during the operation. This was the situation despite the fact that the most likely cause of the injury was before the court (in the form of the presumption created by the maxim), namely, that well-known trauma to the neck through over-extension of the neck for a prolonged period (the exact position of the claimant during surgery) caused the injury. The writer argues that the court was convinced to

[122][1994] 5 Med LR 57 (QB) 57.

[123]See a relevant article by GM Bedbrook 'Compression, flexion and extension injuries of the cervical spine with tetraplegia 'Proceedings of Nineteenth Veterans Administration Spinal Cord Injury Conference, Scottsdale, Arizona 1977 at 16–23. See a later article ie JH Whiteson et al 'Tetraparesis following dental extraction: Case report and discussion of preventative measures for cervical spinal hyperextension injury' (1997) 20(4) *J Spinal Cord Med.* 422–425, where the authors show that hyperextension is a likely cause of tetraplegia as opposed to fibro cartilaginous embolism (FCE); the latter is a rare condition in which a blockage in a blood vessel in the spinal cord occurs. When such blockage occurs, a section of the spinal cord dies.

[124]*Mahon v Osborne* (n 43) 14 and 23, where a swab was retained following a complicated operation.

accept an unchallenged explanation of a very rare event of fibro-cartilaginous embolism (only 29 documented cases in the world over the last 30 years), which was advanced as a defence 10 years after the above operation.[125] The explanation in rebuttal was presented by medical expert evidence, and the former, more probable cause of the injury was presented only in the form of a presumption. This is a paradigm example of the dangers posed by the *res ipsa loquitur* maxim.

In *Glass v Cambridge Health Authority*,[126] the plaintiff went for an exploratory laparotomy, because he sustained an injury to the abdomen. Under anaesthesia he suffered cardiac arrest and permanent brain damage. The anaesthetist failed to monitor the patient's medical condition during the transition from automatic to spontaneous ventilation. Rix J allowed the *res ipsa loquitur* maxim and thus placed an evidential burden on the defendant to refute the inference created by the maxim that the cardiac arrest was caused by hypoxia due to a lack of proper care. The defendant offered an explanation that during surgery a gas embolism entered the major blood vessels when the wounds of the plaintiff were disinfected with hydrogen peroxide. The court held that the defendant did not have to show that their explanation in rebuttal was more likely than not. It was sufficient for the defendant to show that the assistance to the patient during the transition from automatic ventilation to spontaneous ventilation was done with due care. This, in turn, displaced the *prima facie* inference created by the *res ipsa loquitur* maxim. However, the plaintiff had shown, on a balance of probability, that the defendant's lack of care in monitoring and supporting spontaneous ventilation caused the cardiac arrest, hypoxia and brain damage. The court found that the defendants failed to show an alternative cause of the injury, as the gas embolism theory was not accepted. They failed to refute the allegation that the inefficient transition from mechanic ventilation to spontaneous ventilation caused a period of hypoxia (lack of oxygen) that was allowed to deteriorate to such an extent that it caused cardiac arrest and ultimately brain damage. The court found for the plaintiff.

Ostensibly, when the *res ipsa loquitur* maxim is raised by the plaintiff, the court seems to look at two aspects. First, the question whether the facts or undesired incident support *prima facie* evidence of negligence that demands an answer; and second, whether there is an alternative explanation for the occurrence that negates negligence. The latter

[125]*Howard v Wessex Regional Health Authority* (n 122) referred to by Jones (n 6) 310. Argument borrowed from Jones (n 6). The explanation was implausible but the court simply would not believe that there was negligence and accepted the unlikely explanation of the surgeons.
[126]*Glass v Cambridge Health Authority* (n 13), where an exploratory laparotomy resulted in cardiac arrest and brain damage.

places a burden on the defendant to show an alternative cause of the harm in order to refute the *res ipsa loquitur* maxim. Unfortunately, this function of the maxim gave rise to implausible, ingenious and 'exotic'[127] explanations being offered by defendants.[128] Once the *res ipsa loquitur* maxim is accepted, the claimant has convinced the court that he has a *prima facie* case of negligence. This compels the defendant to rebut the claim; if he fails to do so, the court will find for the claimant. Based on the fact that the defendant only has to convince the court that there is another explanation (but not discharge an onus), the defendant may rely on any fanciful explanation.[129] If the claimant relied on the maxim in addition to presenting expert evidence, the fanciful explanation from the defendant will be refuted with convincing medical expert evidence regarding the true or more probable cause of the injury. Without medical expert evidence explaining the defendant's actions against the set standard of care and with only the presumption of negligence from the maxim, the claimant would be at a disadvantage to convince the court in his favour. The *res ipsa loquitur* maxim may assist a plaintiff in getting to court to compel an answer from the defendant, because a *prima facie* case was made out, based on an adverse medical error, but without medical expert evidence to support the plaintiff's case, the defendant can offer *any explanation* as an alternative cause of the harm and it may satisfy the court. Thus the risk for the plaintiff using the *res ipsa loquitur* maxim is twofold. First, if the plaintiff proceeds to court using the *res ipsa loquitur* maxim without medical expert evidence, the court may accept the defendant's explanation, and the plaintiff's case will fail. Second, in relying on the maxim the plaintiff attracts a further burden, ie disproving the defendant's explanation in reply to the *res ipsa loquitur* maxim. It is thus evident that it is safer for a plaintiff to proceed to court with the assistance of medical expert evidence when relying on the maxim for the reason that the defendant is now directed to refuting a particular allegation and will hardly present some exotic explanation. Furthermore, if the court decides that the plaintiff's reliance on the maxim is inappropriate, the plaintiff's case is supported with evidence to prove his case in any event, but this time with substantial medical evidence.

[127]See comments from Puxon in para 4.3.
[128]*Saunders v Leeds Western Health Authority* (n 73) 255 ie paradoxical embolism see (n 114) above; *Howard v Wessex Regional Health Authority* (n 122) 57 ie fibro-cartilaginous embolism.
[129]See argument above in *Howard v Wessex Regional Health Authority* (n 122) 57.

6 Explanations in rebuttal

As discussed above, some creative explanations have been offered by defendants as alternative causes of harm to escape a finding of negligence. Most cases relied on the maxim because of an inadvertent error, eg retained swabs and surgical instruments;[130] or neglectful care during the postoperative recovery period;[131] or administration of the wrong medical substance;[132] or damage to nerves as a result of unskilful or careless conduct and so forth. In an action for medical negligence the test for a breach of duty is to determine whether the defendant's conduct was reasonable in the specific set of circumstances. The court seeks to draw a balance between proper care and negligent care. A strict application of the maxim denies the process of justice to find such a balance. Medical evidence informs the court how the defendant ought to have behaved or the acceptable medical standard expected of the defendant: Did he fail to keep up with developments in his field of expertise? Did he take an unjustified risk at the time of the incident? Was the harm foreseeable at the time? Did he perform a task beyond his competence? When the *res ipsa loquitur* maxim is accepted without medical expert evidence from the plaintiff, the court acknowledges that the facts of the case support *prima facie* evidence of negligence. The court tacitly accepts that the hypothetical reasonable doctor would not have acted as the defendant did. The defendant has to offer an alternative explanation that shows that there was no negligence, but does not have to disprove negligence. It is argued that in these cases the court seems to find the standard of care (the hypothetical reasonable doctor standard) from the testimony of the defendant or the defendant's medical expert who may not be an independent witness and who may not testify whether the defendant's action was in accordance with internationally accepted standards dictated by the profession or that the defendant was not competent in his service delivery.[133]

6.1 An explanation offered by the defendant of an inherent risk or complication

In *O'Malley-Williams v Governors of the National Hospital for Nervous Diseases*,[134] the claimant underwent an aortogram[135] after stenosis of the right carotid artery was diagnosed.

[130] *Mahon v Osborne* (n 43), where a swab was retained following a complicated operation.
[131] *Glass v Cambridge Health Authority* (n 13) 91, 103, where an exploratory laparotomy resulted in cardiac arrest and brain damage.
[132] *Ritchie v Chichester Health Authority* (n 74) 187ff, where the plaintiff sustained *cauda equina* syndrome following an epidural.
[133] *R v Bateman* (n 18) 791 at 794 *per* Lord Hewart CJ where the court said that a qualified man may be held liable for recklessly undertaking a case which he knew was beyond his expertise.
[134] [1975] 1 BMJ 635.

The anaesthetist's first attempt to insert the stent through the femoral artery in the groin failed, and another attempt was performed to enter through the axilliary artery (under the arm). The plaintiff suffered a nerve injury, which resulted in paralysis of the right hand. His Lordship Justice Bridge rejected the inference of negligence and therefore the *res ipsa loquitur* maxim. The court found that nerve injury is a recognised complication of the medical procedure involved. The court held that a sufficient reasonable explanation for the injury had been furnished. The court also found that the failure to warn of such a remote risk[136] did not constitute a breach of the anaesthetist's duty of care. The court dismissed the plaintiff's claim.

Evidently the court allowed the 'remote risk' to be a reasonable and acceptable explanation for the nerve damage. It remains unclear how the test of 'reasonable care' was determined. The defendant's conduct with regard to sufficient and reasonable care was not clarified. The defendant should have been aware of the innate risks and complications of such a medical intervention and should have taken steps to avoid it. A reasonable physician would have stayed in touch with developments in the field and would have been aware that the axilliary artery carries a higher risk of injury than the femoral artery.[137] A reasonable physician would have performed the arteriogram via the femoral artery in the other leg, as it carries a lower risk of injury to the nerves. A reasonable physician would have consulted a more competent and experienced professional for assistance. In fact, the defendant-doctor had two previous failed attempts to insert the stent, which indicated a lack of skill and competence. Sufficient medical information offered, for example, by Erikson and Jorulf[138]

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[135]Radiography of the aorta after insertion of contrast material.

[136]See discussion of risks and complications in chapter 4 para 4.1. Also note that complications of a well-known inherent risk of an operation should be qualified. A defendant should not escape liability merely because the dreaded occurrence becomes a reality. This argument is inherently flawed. To walk across the street among the traffic carries the inherent risk of being hit by a car and suffering injury. Evidence is needed to indicate a cautious or careless action by the pedestrian or the driver. The careful or careless manner in which the pedestrian or the driver acted will render him blameless or liable. The fact that a complication is well known is no support for the argument that proper and adequate care was foreseen and guarded against while exercising the procedure. The same argument goes for the expression that it was simply 'bad luck'.

[137]See J Erikson & H Jorulf 'Surgical complications associated with arterial catherization' (1970) 4 *Scand. J. Thoracic & Cardiovascular Surg.* 69–75;AF AbuRahma et al 'Complications of arteriography in a recent series of 707 cases: Factors affecting outcome'(1993) 7(2) *Ann Vasc Surg.* 122–129, where the writers conclude that the trans femoral approach (groin area) when performing an arteriogram is substantially safer than the trans axillary route (arm), because of the high risk of nerve injury in the arm (the artery runs in close proximity to two nerves).

[138]*Ritchie v Chichester Health Authority* (n 74) 187ff, where the plaintiff sustained *cauda equina* syndrome following an epidural, as discussed in para 5 above. See Erikson & Jorulf (n 137).They argue that the complications associated with arterial catherization during an angiogram are well documented and that early

would have provided a different perspective to the defence of 'a known complication'. It appears that the court was distracted by the defendant's explanation that this medical intervention carried a high risk of injury. The reliance on the maxim, without medical expert evidence in support of the claimant's case, had the effect that the answer in rebuttal obscured the allegations of negligence. It is also worth mentioning that one aspect of the claimant's case was the failure to warn of the risk of injury. This aspect was rejected by the court in *O'Malley-Williams* on the basis that the risk was too remote. In *Bolam v Friern Hospital Management Committee*[139] McNair J applied the same test to the question of warning the patient as was applied to treatment and diagnosis namely: did the standard of the defendant fall below the standard of competent and diligent medical professionals in deciding whether or not to warn a patient?

6.2 An explanation offered by the defendant based on statistical medical evidence

Statistical evidence, reported in the medical literature, should be interpreted in the medical context for which it was created. In a research article the abstract sets out specific scientific questions from which a conclusion is drawn at the end of the research study.[140] In addition, these scientific medical conclusions are limited to strict protocols. The interpretation of data from such medical literature should be presented by a medical expert, well-versed in the particular discipline addressed by the statistical field, who can direct the court to a sound explanation and interpretation of the data. Conclusions should be relevant, substantiated and drawn from the material tested, and not drawn out of context.[141]

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surgical intervention and vascular repair can make all the difference between a permanent injury and a partial injury.

[139] *Bolam v Friern Hospital Management Committee* (n 23).

[140] Chapter 4 para 4.1 on risks and complications.

[141] To illustrate an incorrect approach to statistical evidence the following example is used: imagine evidence-based medical literature and statistical evidence indicate that there is a 0,04–4 per cent risk that a surgical injury may occur. It demonstrates that novice doctors still in the learning curve will have a higher risk of causing injury to the patient, ie a 4 per cent chance of causing injury as opposed to a more experienced doctor, who has a 0,04 per cent chance of causing injury to the patient. Legal argument irresistibly leans towards comparing it with the onus of proof and the balance of probability in determining causation, where a risk of 4 per cent seems minor. The 0,04–4 per cent risk referred to in the clinical trial is based on a review of several similar procedures and outcomes based on experience of the medical professionals. It indicates that, in the hands of an experienced surgeon, the risk is small and in the hands of an inexperienced surgeon, risk is substantially higher (9900 per cent increase). If this information, together with the experience of the surgeon and his place on the learning curve, is presented to court, inherent risks in operations will be interpreted in a different light.

In *Vadera v Shaw*,[142] the Court of Appeal accepted that the trial judge had been right to accept the findings of a statistical study. The case is about the alleged negligence of a general practitioner who prescribed contraception,[143] Logynon, to a 22-year-old Asian woman. She suffered a stroke and severe consequences. The court accepted scientific statistical evidence on the basis that it standardises legal and scientific evidence. This approach assisted the judge in coming to the conclusion that a reasonable medical professional would have considered the statistical evidence and would not have prescribed the drug. It is concerning to note that the possibility of using such evidence to determine factual causation in the future was raised.[144] The reluctance of the court to rely on statistical evidence is based on the wish to protect the independence of the judiciary and not to allow the scientist to usurp the role of the court. Statistical evidence should be seen and interpreted in the context of the purpose for which it was created, namely, to assist the medical profession in determining safety aspects, reliability, efficacy and so forth.

In *Demery v Cardiff and Vale NHS Trust*,[145] the plaintiff alleged that a delay of six days caused the on-going instability of her ankle and delayed healing. She based the allegations on medical expert evidence that showed a better outcome and success rate in a majority of cases where surgery was performed promptly. The trial judge indicated that the statistical rarity of such failures was of no assistance to him in showing the nexus between the delay and the prolonged disability. Evidently the statistical information was not presented in a clear and unbiased manner. Statistical evidence would have provided evidence, based on international medical scientific data, by way of clinical trials and meta-analysis. Such evidence would have led to the conclusion[146] that the longer surgical treatment is delayed, the higher the risk of complications, ie insufficient healing and resultant disability. A probable causational nexus was found in the medical literature between ankle instability and the later

[142]*Vadera v Shaw* [1998] 45 BMLR 162 at 174, also referred to by Jones (2008) (n 6) 456, where the statistical evidence indicated that in certain individuals this medication was contra-indicated as it can cause a stroke or other vascular incident.
[143]R Goldberg 'The contraceptive pill, negligence and causation: Views on *Vadera v Shaw*' (2000) 8(3) *Med LR.*
[144]*R v Clark* [2003] EWCA Crim. 1020, where a mother was convicted of murdering her child, based on statistical evidence presented by a certain Professor Meadow, who stated that there is a 1 in 73 million chance that sudden infant death syndrome (SIDS) will affect a second child as well. The mother was released from prison several years later, based on evidence of an alternative cause of harm. It is an example of a gross mistake made by an expert of calculating and relying on statistical evidence and confirms that courts should make careful use of statistical evidence.
[145][2006] EWCA Civ. 1131.
[146]See relevant literature by RL Brand, HM Black & JS Cox (1977) 5 'The natural history of inadequately treated ankle sprain' *American Journal Sports Medicine* 248–249. See a later article ie GL Slater, AE Pino & M O'Malley (2011) 'Delayed reconstruction of lateral complex structures of the ankle' (2011) 2(4) *World J Orthop.* 31–36, available at http://www.ncbi.nlm.nih.gov/pmc/a (accessed 14 August 2013).

development of osteoarthritis. This addresses the element of 'lack of care'. A medical professional's duty is to provide sufficient care to prevent further harm to his patient. Ignoring the higher risk of non-healing and complications relevant to a six-day delay in treatment is indicative of not complying with acceptable standards of care and constitutes a lack of care.

The court's view was that a statistical figure does not by itself give a claimant a cause of action.[147] However, it is argued that a material increase in the risk of a particular outcome is equivalent to a material decrease in the chance of escaping an undesired outcome or bad result.

6.3 An explanation offered by the defendant of a remote risk or rare medical condition

As discussed before,[148] the duty imposed by law is an undertaking by the doctor to provide advice, to diagnose, and to treat the patient with reasonable skill and care. Furthermore, since the doctor is in a position where others would reasonably rely upon his advice and judgment, he must inform the patient about significant risks and complications. Such a duty gives rise to a duty to warn the patient of material risks. In 2004, in *Chester v Afshar*,[149] the claimant claimed that the defendant failed to warn her about the risk of a *cauda equina* injury[150] following a spinal block injection that was administered to alleviate lower back pain. The claimant sustained injuries that involved dysfunction of the bladder, perineum, bowel, lower limbs and buttocks. The House of Lords pronounced that the claimant's injury was the product of the very risk that the claimant should have been warned about when she gave her consent. Accordingly, the injury was to be regarded as having been caused, in the legal sense, by the breach of the defendant's duty of care or failure to warn the patient.

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[147] *Hotson v East Berkshire Area Health Authority* [1987] AC 750 at 769. In *Bonnington Castings Ltd v Wardlaw* (n 31), the House of Lords held that the claimant does not have to establish that the defendant's breach was the main cause of the damage, provided that it materially contributed to the damage. In *McGhee v National Coal Board* (n 31), the House of Lords took the *Bonnington* argument one step further. The court interpreted 'material increase' in the risk as equivalent to a 'material contribution to the damage'.

[148] See para 2 above.

[149] *Chester v Afshar* (n 20). Arguments that convinced the court were that for the claimant it was a significant occurrence; for the defendant it was one of several; the claimant was clearly reluctant to undergo surgery and would have avoided it; the operation was not an emergency; it was unlikely that had she been informed about the risks that she would have agreed to the surgery; and the surgery was scheduled only three days after the consultation, which effectively prevented her from obtaining another opinion. The defendant did not appeal against the finding that he breached his duty to the claimant.

[150] *Cauda equina* syndrome (CES) is a serious neurological condition in which damage to the lumbar plexus (nerve roots) of the groin and inner thigh area causes problems with bowel and bladder function. See A Gardner, E Gardner & T Morley 'Cauda equina syndrome: A review of the current clinical and medico-legal position' (2010) 20(5) *European Spine Journal* 690–697.

When the doctor, Mr Afshar, accepted Miss Chester as a patient he became subject to a legal as well as professional duty to exercise reasonable care and skill in examining her, in assessing her case, and in advising her on the need for surgery to alleviate her condition. If she consented to surgery, he was bound to exercise reasonable care and skill in operating and in supervising her post-operative recovery. However, in addition, the surgeon was subject to a further duty: to warn the claimant of a small but unavoidable risk that the planned operation might lead to an injury known as *cauda equina* syndrome. If it was found that, had the claimant been warned, she would probably not have agreed to the surgery, she would be entitled to recover damages from the defendant. The claimant argued that, had she been warned, she would have minimised the risk of surgery by consulting a well-qualified surgeon in that specific field or she would have undergone alternative form of surgery.

With regard to a rare medical condition, Jones[151] argues that greater attention should be paid to the medical literature than to the personal experience of the individual expert witnesses, who may have little knowledge of the claimant's medical condition. He warns, however, against the scientific approach of the medical literature rather than a legal approach. If the consequences of the risk have far-reaching effects for the plaintiff, the medical professional has a duty to warn against this risk, whether it is a remote risk or not. The claimant enters into an agreement with the defendant because of the latter's skill and knowledge and his ability to weigh the risks of treatment against the risks of no treatment. The defendant should not influence the claimant in making a decision, as the ultimate decision, after being fully informed, lies with the claimant.

In the above case, unfortunately neither the background medical information nor the likely causes[152] of the injury were scrutinized. Although informed consent is fundamental

[151]Jones (2008) (n 6) 456, who refers to *Roughton v Weston* (2004), AHA EWCA Civ. 1509 at [17]–[18] and *Breeze v Ahmed* (2005) EWCA Civ. 223; [2005] All ER (D) 134 (Mar), where a doctor misdiagnosed a heart attack when the claimant presented with chest pains. The court emphasised that, where an expert relies on medical literature to support his opinion, the literature should be made available to the court. The defendant's expert witness referred to two articles in his oral evidence, from memory, and summarised the contents inaccurately.

[152]M Jain et al 'Cauda equina syndrome following an uneventful spinal anaesthesia' (2010) 54(1) *Indian Journal of Anaesthesia* 68–69. The authors present a case of a young female patient with persistent weakness of her lower limbs along with bladder and bowel incontinence following a caesarean section done 16 days before under spinal anaesthesia. The records revealed that spinal anaesthesia was given in L2-3 interspaces with a 23 G needle; 2.4 ml of 0.5% hyperbaric bupivacaine was administered. Three attempts were made before successful spinal puncture. There was no paraesthesia or back pain during needle placement or drug injection, but blood stained cord fluid was aspirated at the first attempt. There was adequate surgical anaesthesia after 12 minutes and the 45 minutes of surgical duration was uneventful. In the postoperative period, the anaesthetic effect showed no improvement after 12 hours. The patient developed faecal and urinary incontinence the next day. No improvement occurred within 15 days. The authors state that the most likely causes for the injury would be neurotoxicity, haematoma or trauma to the nerves or spinal cord.

before any kind of surgery or medical intervention, it bears no relevance to the cause of the injury. One would have expected a detailed investigation into the causes of such an injury and the exclusion of medical error. Inquiry about the reasonable steps taken to prevent such an injury would have been useful in assisting the court to arrive at a conclusion. Nevertheless, the importance of this case is twofold: the patient has a right to be appropriately warned and informed about the risks of a medical intervention, and, in some instances, the court is willing to depart from established principles of causation. In order for the claimant to establish causation, regarding the risks and complications, he has to show that he would have acted on the warning. In other words, he would not have consented to taking the relevant risk or, even if he had consented to taking the risk, he would have made decisions that would have altered the outcome of the risk. The court found that a modified approach to prove causation was justified, since causation was not established using conventional principles. This case is listed under the judicial relaxation of the burden of proof in medical negligence cases based on constitutional values.[153]

7The *res ipsa* loquitur maxim is extended

Before *Ratcliffe v Plymouth & Torbay Health Authority*[154] the accepted requirements for the *res ipsa loquitur* maxim were: (i) the cause of the injury or damage must be unknown;[155] (ii) the occurrence carries a high incidence of negligence;[156] and (iii) the instrument must have been under the defendant's control.[157] The *res ipsa loquitur* maxim was applied in an unpredictable manner. Sometimes the maxim was applied[158] and sometimes it was rejected.[159]

[153]Chapter 5 para 3.3 below.
[154]*Ratcliffe* (n 3) 172.
[155]*Bolton v Stone* (n 26) 850; *Hay v Grampian* (n 57) 128.
[156]*Cassidy v Minister of Health* (n 21) 574; *Roe v Minister of Health* (n 25) 66ff.
[157]See para 4.1 above. In *Morris v Winsbury-White* (n 65) 494–499 the claimant instituted action against the surgeon only. A tube remained in his bladder, which was revealed by means of a radiology examination. It was found that, subsequent to a prostate operation, a part of a tube was left in the bladder. The claimant instituted legal action. Because several people participated in performing the initial procedure, the defendant could not be found negligent as the patient's postoperative management was under the control of professional nurses, two resident medical officers and, only occasionally, the defendant. The instrument was not entirely under the control of the surgeon, and outside interference could have contributed to or caused the damage; thus, the maxim of *res ipsa loquitur* could not be applied.
[158]In *Cox v Saskatoon* [1942] 1 DLR 74, the plaintiff's arm was damaged during the course of donating blood. In *Bull v Devon Area Health Authority* (n 33), in the absence of an explanation for the delay, the judge had no choice but to find the defendant liable. In *Lindsay v Mid-Western Health Board* [1993] 2 IR 147, the patient went into a routine medical procedure, underwent anaesthesia, and failed to regain consciousness. To say that such an event does not call for an explanation from the defendants would defy reason and justice. The list is not exhaustive.
[159]*Considine v Camp Hill Hospital* (1982) 133 DLR (3d) 11, where the claimant became incontinent after a prostate operation; *Girard v Royal Columbian Hospital* (n 46), where the claimant suffered permanent partial

A few courts[160] expressed their reluctance to use the maxim in medical negligence cases, yet continued to apply the maxim as a procedural aid to get the matter to court and, following an explanation by the defendant, allowed the plaintiff to prove his *prima facie* case.

In 1998, there was a move to change the English legal system.[161] The new Civil Procedure Rules in England came into existence and the approach of the court leaned to change from an adversarial system to an inquisitorial system. Although the system now contains a more inquisitorial element with greater judicial involvement, it is fundamentally still adversarial in nature, especially regarding the burden of proof. Thus far, the system allowed the presiding officer to participate in investigating a case. The medical evidence presented by either the plaintiff or defendant could be examined by the court in order to determine causation. These changes had an effect on the application of the *res ipsa loquitur* maxim. According to Jones, the purpose of the maxim–

> is that it enables a claimant who has no knowledge, or insufficient knowledge, about how the accident occurred to rely on the accident itself and the surrounding circumstances as evidence of negligence, and prevents a defendant who does know what happened from avoiding responsibility simply by choosing not to give any evidence.[162]

He goes on to state[163] that in the absence of such evidence from the defendant, the defendant will be found liable. If the defendant does give evidence, showing no negligence, then the inference of the maxim is rebutted, but now the claimant has to present positive evidence to

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paralysis of the legs after anaesthesia; *O'Malley-Williams v Board of Governors of the National Hospital for Nervous Diseases*(n 134), where the claimant suffered neurological complications of partial paralysis of the hand after undergoing an aortagram; *Whitehouse v Jordan* [1980] 1 All ER 658ff, where the baby suffered cerebral palsy after a normal delivery. The list is not exhaustive.

[160]*Delaney v Southmead Health Authority* (n 72) 355, where the court questioned the use of the maxim in *Ritchie v Chichester Health Authority* (n 74) 187ff.

[161]Jones (2008) (n 6) 7, where the author states that the data relevant to medical accidents suggested that there was a general perspective, in England, of a medical malpractice 'crisis' and that litigation was more probably the symptom of an underlying problem of iatrogenic injury attributable to adverse events in the health system. Evidence showed that there were far fewer claims than the incidence of negligently inflicted injuries to patients. The problem resulted in an investigation into the legal system and eventually led to reform. Lord Woolf MR's 1996 review of the civil justice system played a role in the change. Jones describes the law reform in detail. Also see *Making Amends*, June 2003.

[162]Jones (2008) (n 6) 306 and 307.

[163]Ibid 321.

prove his initial case.[164] Jones explains that in practice this would be unlikely as the claimant would not have relied on the maxim in the first place if he had positive evidence of the defendant's carelessness. He refers to *Ratcliffe v Plymouth & Torbay Health Authority*[165] where the Court of Appeal indicated that the maxim would rarely be relevant in medical negligence cases because, in practice, parties would have obtained expert medical opinion. The author departs from previously accepted practices concerning the *res ipsa loquitur* maxim. He indicates that once the court needs more information to determine the presumption of negligence the maxim should strictly speaking be excluded,[166] yet if the evidence is such that the defendant should offer a credible explanation the maxim applies. Although there is no duty on the defendant to explain how the accident occurred, it seems to be accepted practice to request such an explanation. The justification for extracting such an explanation is given by Buxton LJ in *Lillywhite v University College London Hospitals NHS Trust.*[167] The judge said that a case of professional negligence can only be concluded by a finding of lack of care and in cases[168] where the facts are of an unusual nature like those in *Ratcliffe* and *Delaney,* there are only two explanations: either the doctor was physically careless in performing the operation or there was some underlying disease unknown to medicine. It is argued that this seems to be an over-simplification of the medical reality and its cause-and-effect intricate medical principles, particularly in view of the fact that sometimes there is a chain of events that ultimately led to or caused the harm. However, seen in this context, it seems that the only remaining use for the maxim is to facilitate an answer from the defendant in rebutting the *prima facie* inference ie effectively giving the maxim a status of a rebuttable presumption.

Using the maxim without the assistance of medical expert evidence is discouraged. Yet, the English court allowed a narrow and wider approach of the maxim as evident in *Ratcliffe v Plymouth & Torbay Health Authority*.[169] In this case, the court extended the

[164]*Ballard v North British Railway Co* (n 8) *per* Lord Dunedin referred to by Jones (2008) (n 6) 311.
[165]Jones (2008) (n 6) 311 refers to *Ratcliffe* (n 3)162ff, where the claimant underwent surgery to his right ankle. After the surgery, he presented with neurological complications. He experienced paralysis on one side from his waist down. The cause of the injury was unexplained. About six years after the injury an MRI scan revealed a lesion on the spinal cord. It did not solve the mystery, as the site of the injection differed from the location of the lesion. The judge held that the plaintiff's spinal injury could be attributed to the spinal injection, but was unable to determine how it occurred. The plaintiff's case was dismissed.
[166]Jones (2008) (n 6) 319.
[167][2005] EWCA Civ 1466; [2006] Lloyd's LR 268.
[168]See the discussion of *Ratcliffe* (n 3) below; the discussion of *Delaney v Southmead Health Authority* (n 72) in para 4.3 above; and the discussion of *Lillywhite v University College London Hospitals NHS Trust* (n 167) in para 9.1 below.
[169]*Ratcliffe* (n 3) 172–173.

application of the *res ipsa loquitur* maxim[170] to include a *res ipsa loquitur* case based on simple facts and a *res ipsa loquitur* case based on complicated medical facts. In *Ratcliffe* the claimant underwent surgery to his right ankle[171] after a previous injury to his ankle. He underwent general anaesthesia during surgery as well as a spinal anaesthetic to ease the pain. He emerged with a serious neurological defect, on the right side, from his waist downwards. He still had the general use of the leg, but had lost all superficial sensation in it. He complained of continuous, severe, deep-seated pain throughout the affected area. He suffered from anal sphincter and ejaculation disturbances. On an MRI, the medical experts identified an elongated lesion.[172] The medical experts had a lengthy discussion about possible disease-related explanations for the cause of the lesion. The court was unable to determine how the damage occurred[173] and rejected a most probable cause of injury by accepting the explanation of the defendant who claimed being precise and methodical in his conduct, and that he had taken special care during the administration of the spinal injection.[174] The anaesthetist-defendant maintained that he inserted the spinal needle at L3 to L4 with great care and precision and that the lesion was revealed as between T8 or T9. The scientific information presented to the court,[175] of an inadvertent subarachnoid injection of anaesthesia or analgesic causing the injury, was rejected. The incidence of 'neurologic complications of lumbar epidural anaesthesia and analgesia'[176] explained the consequences of such an inadvertent spinal injection into the subarachnoid space. The explanation of the medical experts, in reply to the *res ipsa loquitur* maxim, indicated a rare condition of non-systemic vasculitis,[177] which

[170]Not only is the maxim redefined, it introduces a situation where the maxim is supplemented with medical expert evidence. The role of the court has changed, as the judge has the power to require medical explanations from all the medical experts (claimant and defendant); with the procedural changes, conflicting expert opinion might extract the true explanation.

[171]The proposed surgery was a triple arthrodesis of his right ankle.

[172]An elongated lesion from T8 to S3 involving the right postero-lateral grey matter of the spinal cord or a patchy bilateral lesion extending from T9 downwards involving the spinal cord.

[173]A more likely cause of action was an 'inadvertent subarachnoid injection of anaesthetic or analgesic agent'.

[174]With regard to the medical information for an alternative cause of injury, direct traumatic spinal cord injuries caused by a spinal or epidural needle are rare but the occurrence of an injury after an injection at the L1-L2 site that migrates to T7-T12 was consistent with a spinal anaesthesia-related traumatic spinal cord injury. See PR Bromage & JL Benumof 'Paraplegia following intracord injection during attempted epidural anesthesia under general anesthesia' (1998) 23 *Regional Anesthesia Pain Medicine* 104–107, where the authors showed that an MRI of the spinal cord performed 36 hours after the epidural injection demonstrated hyper intensity in the spinal cord extending from T9 vertebra to conus with cord swelling on T2-weighted images. On post-contrast study, there was focal enhancement of the dura at T11–12 level consistent with intracord injection. See also M Netravathi et al 'Accidental spinal cord injury during anesthesia: A report' (2010) 13(4) *Ann. Indian Acad. Neurol.*297–298.

[175]EC Yuen et al 'Neurologic complications of lumbar epidural anaesthesia and analgesia' (1995) 45(10) *Neurology* 1795–1801.

[176]Ibid.

[177]MP Collins 'No systemic vasculitic neuropathy: Update on diagnosis, classification, pathogenesis, and treatment' (2009) 26*Front. Neurol. Neuroscience* 26–66. Some patients develop vasculitis clinically restricted to

they alleged may have been the possible underlying disease and cause for the neurological damage. It describes a possible weak area in the central nervous system brought about by surgical intervention and that maybe the cause of the non-systemic vasculitis.

The court found that the medical professional who administered the spinal anaesthesia performed it with the appropriate care, although he was unable to explain the cause of the injury (factual causation). The claimant's case was dismissed. On appeal, the claimant argued that the application of the *res ipsa loquitur* maxim raised an inference of negligence, which was not addressed by the court of first instance. The claimant argued that it is accepted practice that once the maxim is accepted, the burden to rebut the inference rests with the defendant. The defendant failed to discharge the burden of refuting the inference, as the defence they offered was a mere *possibility* of an alternative non-negligent cause of harm. This defence did not discharge the onus on the defendant. The court of appeal dismissed the appeal of the claimant and held that the finding was that the defendant performed the spinal anaesthesia with all proper care. The latter conclusion rendered the maxim of no effect, and the remaining inferences of negligence fell away. The claimant did not discharge the burden of proving that the defendant was negligent, as he failed to prove that his injury was as a result of the elongated lesion[178] caused by an inadvertent subarachnoid injection during spinal anaesthesia.

Lord Justice Brook stated[179] that in a very simple situation the *res* may speak at the end of the layman's evidence presented by the claimant, which is then buttressed by expert

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the peripheral nervous system (PNS), known as no systemic vasculitic neuropathy (NSVN), which is the most commonly encountered vasculitic neuropathy in pathologically based series. Diabetic and no diabetic radiculo plexus neuropathies are clinical variants of NSVN. NSVN is clinically similar to systemic vasculitis-associated neuropathies except for reduced severity. Patients most commonly present with progressive, stepwise pain, weakness and numbness over multiple months. Almost all exhibit a multifocal or asymmetric, distally accentuated pattern of involvement. The most commonly affected nerves are the common peroneal nerve in the leg and the ulnar nerve in the arm. See http://www.ncbi.nlm.nih.gov/pubmed/19349704 (accessed 12 January 2015).

[178]The medical experts could not agree about the pathology of the lesion and said that the lesion was caused by some pre-existing asymptomatic condition brought on by the stress of the operation. The claimant's expert witnesses did not furnish the court with a logically coherent explanation of what had probably happened.

[179]He referred to *Byrne v Boadle* (n 34). See also *Scott* (n 34); *Lloyde* (n 48); *Ballard* (n 8) 34; *Cassidy v Minister of Health* (n 21); *Roe* (n 25); *Bull* (n 33), where twins were born and the second twin sustained severe brain damage; *Delaney* (n 72), where the plaintiff went for a gall bladder operation and sustained injury to her shoulder; *Fallows v Randle* [1997] 8 Med LR 160, where the maxim was not helpful in a case where a sterilisation failed; *Ludlow v Swindon Health Authority* [1989] 1 Med LR 104, where the plaintiff alleged she was conscious during anaesthesia; *Bentley v Bristol & Western Health Authority* [1992] 3 Med LR 1, where the plaintiff sustained sciatic nerve palsy following a total hip replacement; *Moore v Worthing District* (n 49) 431, where the plaintiff developed ulnar nerve lesion; *Howard* (n 122), where the plaintiff became tetraplegic

evidence from the defendant. If the defendant were to call no evidence, the judge would be deciding the case on inferences he was entitled to draw from the whole of the evidence, including the expert evidence, and not on the application of the maxim in its purest form. Lord Justice Hobhouse summarised the mechanism of the *res ipsa loquitur* maxim[180] and explained that the claimant has to adduce some expert evidence to pass the *prima facie* test. The claimant may rely on 'some fairly broad based inference of negligence', but by the time he gets to trial, he should be able to make some more specific allegations, supported by expert evidence. His Lordship continued that the essential role of *res ipsa loquitur* is to enable a claimant who is not in possession of all the material facts to plead an allegation of negligence in an acceptable form, and to force the defendant to respond to it. However, once the defendant has responded then the question for the court is whether, in the light of that response and all evidence that has been placed before the court at the trial, both by the claimant and the defendant, the defendant has been negligent. His Lordship offered that in a case based on the maxim *res ipsa loquitur*, the acceptable response from the defendant would be to prove that the incident occurred without negligence. The claimant's *prima facie* case would now not be justified, unless a more specific case has been made out. If the defendant shows a legitimate basis for the injury but adduces that in the specific instance he exercised reasonable care, notwithstanding the outcome and his inability to explain the claimant's injury, he would succeed with his defence. His Lordship was of the opinion[181] that even the wisest among medical professionals would sometimes have to say: 'I simply do not know what happened'. He stated that the practice of medicine would be done a disservice if a careful doctor were ordered to make compensation as if he had been negligent.

His Lordship Justice Brooke provided a synopsis of the *res ipsa loquitur* maxim in *Ratcliffe v Plymouth & Torbay Health Authority*:[182]

> (1) In its purest form it is when the plaintiff relies on the *res* (the thing itself) to raise the inference of negligence, supported by ordinary human experience, with no need for expert evidence; [183]

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following an operation; *Ritchie* (n 74), where the plaintiff sustained injury to the saddle area; and *Saunders* (n 73), where a four-year-old girl suffered cardiac arrest.

[180]See the detailed discussion below in the same paragraph.

[181]*Ratcliffe* (n 3) 172–173.

[182]Ibid 172–173.

(2) In principle the maxim could be applied in that form in simple situations in the medical negligence field;[184]

(3) In contested medical negligence cases, the evidence of the plaintiff (which established the *res*) is likely to be buttressed by expert evidence to the effect that the matter that was complained about did not ordinarily occur in the absence of negligence;[185]

(4) By the close of the plaintiff's case, the judge must be able to infer negligence on the defendant's part, unless the defendant adduces evidence that discharges this inference;[186]

(5) The evidence might be that there is a plausible explanation of what might have happened which did not connote any negligence on the part of the defendant;[187]

(6) The defendant's rebuttal might satisfy the judge on a balance of probabilities, and reveal that the defendant exercised proper care. If the untoward outcome was extremely rare or was impossible to explain, the *prima facie* evidence would be rebutted;[188]

(7) In a very simple situation the *res* may speak for itself at the end of the lay evidence. In practice the inference is then buttressed by expert evidence adduced on the plaintiff's behalf and, if the defendant were to call no evidence, the judge would be deciding the case on the inferences he was entitled to draw from the whole of the evidence (including the expert evidence) and not on the application of the maxim in its purest form;[189]

(8) In the present case in which much expert evidence had been presented on both sides, the judge made the positive finding that the anaesthetist had performed the spinal injection in the appropriate place with all proper care. In those circumstances any possible inference of negligence falls away, and unless that finding is set aside, the plaintiff's case will fail;[190]

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[183]*Ratcliffe* (n 3) 172.
[184]Ibid 172.
[185]Ibid 172.
[186]Ibid 173.
[187]Ibid 173.
[188]Ibid 173.
[189]Ibid 173.
[190]Ibid 173.

(9) The finding that the injection was inserted in the correct space at the chosen level was inevitable and the judge's approach to the applicability of the doctrine *res ipsa loquitur* could not be faulted. [191]

Lord Justice Hobhouse concurred with Lord Justice Brook that the appeal should be dismissed. He reiterated the function of the maxim by stating that the plaintiff may or may not need to call evidence to establish a *prima facie* case. But, if the defendant chose not to call evidence, the court will have to decide whether the evidence adduced by the plaintiff suffices to satisfy the court that the defendant was negligent and that his negligence caused the plaintiff's injury. He commented 'there is no rule that a defendant must be liable for any accident for which he cannot give a complete explanation'.[192] The essential role of the *res ipsa loquitur* maxim is to enable the claimant who does not possess all the material facts to be able to allege negligence. A claimant, in pleading his case, will be expected to particularise his allegations of negligence only in a way that is appropriate to the state of his knowledge of what happened. By the time that case comes to trial the claimant should involve medical expert evidence due to the technicality of factual questions. He expressed the view that leading cases about the *res ipsa loquitur* maxim give sufficient guidance to litigators and judges about the proper approach to the drawing of inferences and said: '[I]f I were to say anything further it would be confined to suggesting that the expression *res ipsa loquitur* should be dropped from the litigator's vocabulary and replaced by the phrase "a *prima facie* case".'[193]

The court's dismissal of the claimant's appeal can possibly be faulted on factual causation principles. It is questionable why the court of first instance declined the more probable medical explanation of causation, ie the inadvertent spinal injection into the subarachnoid space. The court accepted that the spinal injection was done into the correct space and correct place, simply based on the defendant's evidence. This stands in contrast to international medical standards set by the medical profession that was peer reviewed and published as accepted medical principles, where such an injury was explained. Such medical literature should have formed part of the medical evidence before the court. The explanation in rebuttal, in response to the *res ipsa loquitur* maxim, made a few days into trial, explained a

[191] *Ratcliffe* (n 3) 73.
[192] Ibid 187.
[193] Ibid 187.

very rare and unexplained complication of surgery.[194] But the explanation in rebuttal was simply an alternative cause of injury, inconsistent with negligence. The court's acceptance that the defendant acted with proper care and its acceptance of an alternative cause of harm exculpated the defendant. The medical expert evidence on behalf of the claimant should have shown that the injury was consistent with an anaesthesia-related traumatic spinal cord injury with migration of the lesion to another level.[195] Nevertheless, the confirmation of the extended role of the *res ipsa loquitur* maxim implies that the maxim no longer has the exclusive meaning of the ancient Latin phrase (*the facts speak for themselves*) in simple cases; it also includes a generalised inference of negligence (lack of care) in more complicated cases, which is, in any event, consistent with *prima facie* evidence of negligence in English cases. It seems that in the uninformed mind, the unusual outcome of a medical incident under the control of the defendant-doctor indeed indicates *prima facie* evidence of *negligence* (lack of care) that can raise an inference in need of an answer. The court establishes factual causation and negligence from the medical evidence of the defendant in rebuttal if the claimant relied on the maxim without medical evidence. This is not useful to a South African plaintiff who even with such e wider application of the maxim still has to comply with delictual principles in law when inferring negligent conduct.

The above case reiterated the decision in *Delaney v Southmead Health Authority*,[196] where the court was satisfied with the explanation of the defendant exercising reasonable care. However, in *Delaney v Southmead Health Authority*,[197] the defendant was not the correct defendant and his explanation probably convinced the court of the uncertainty of the claimant's suggested cause of harm. It confirms that if the principles of *res ipsa loquitur* apply, the defendant's explanation may refute the inference of negligence with an explanation,[198] stating a cause of harm that excludes negligence, together with an assurance from the defendant that he exercised proper care. The judgment of the court in *Ratcliffe v Plymouth & Torbay Health Authority*[199] further confirms that the maxim has two applications: either it is applied in its purest form, ie where the negligence is so apparent that no further

[194]Collins (n 177) 'No systemic vasculitic neuropathy. The most commonly affected nerves are the common peroneal nerve in the leg and the ulnar nerve in the arm. See http://www.ncbi.nlm.nih.gov/pubmed/19349704 (accessed 12 January 2015).
[195]For alternative causation, see Bromage & Benumof 'Paraplegia' (n 174) where an MRI of the spinal cord demonstrated hyper intensity in the spinal cord with cord swelling. On post-contrast study, there was a focal enhancement of the dura consistent with intracord injection.
[196]*Delaney* (n 72) 355ff.
[197]*Delaney* (n 72) 355ff discussed in para 4.3 above.
[198]*Ratcliffe* (n 3) 359 Col. 2. See also C Foster '*Res ipsa loquitur*: The defendant's friend' 1996 *SJ* 824.
[199]*Ratcliffe* (n 3).

explanation is needed, and or in its wider form where detailed allegations are needed to support the inference of negligence. The claimant may initiate proceedings with the assistance of the maxim, but then needs to make specific allegations supported by medical expert evidence. The court effectively developed an extension of the maxim according to the nature of each case.

Foster[200] believes that *Ratcliffe v Plymouth & Torbay Health Authority*[201] is an example of a case where in certain circumstances the court will be sympathetic to a defendant who states that 'an untoward result' occurred, the explanation of which is unclear to him. If the 'untoward result' is extremely rare,[202] or cannot be explained by current medical knowledge, a judge may, on those grounds and after evaluation of all the evidence, dismiss a claimant's case. If the defendant can offer an explanation that excludes negligence, the claimant's case will fail. Alternatively, with an allegation of lack of care, the defendant only has to show that he exercised proper care to prevent injury and he will thus be able to avoid liability.[203] Accordingly, it is not essential for the defendant to explain how the accident happened, provided he gives evidence that he exercised reasonable care.[204] The defendant does not have to prove that his explanation is more probable than the plaintiff's version, but only that that he acted without negligence.[205] In this regard it is questionable whether the claimant will find the defendant's explanation of any assistance, as it may not even assist with establishing factual causation.

8 Limited use of the *res ipsa loquitur* maxim

According to Jones,[206] *Ratcliffe v Plymouth & Torbay Health Authority*[207] and *Delaney v Southmead Health Authority*,[208] demonstrate how limited the use of the *res ipsa loquitur* maxim is in medical negligence cases. The author argues that the use of the maxim provides no other certainty to the claimant; it only attracts a reasonable explanation from the defendant

[200]C Foster '*Res ipsa loquitur:* Clearing up the confusion' 1998 *SJ* 762; MA Jones '*Res ipsa loquitur* in medical negligence actions: Enough said' 1998 *Professional Negligence* 174, where the author states that it is rare for the maxim to play a conclusive role in a medical negligence case. One compares what actually happened with what should have happened if there was no negligence.
[201]*Ratcliffe* (n 3) 173.
[202] See the discussion of risks and complications in chapter 4 para 4.1.
[203]*Delaney* (n 72) discussed para 4.3 above; *Moore v R Fox* (n 42) 596–597; also see Van den Heever & Carstens (n 5) 45.
[204]*Bull* (n 33) 117.
[205]*Ratcliffe* (n 3) 172.
[206]Jones (2008) (n 6) 307–322.
[207]*Ratcliffe* (n 3). See para 9 above.
[208]*Delaney* (n 72).See para 4.3 above.

to show that reasonable care was exercised. Although the court appeared to have been strict in not accepting theories and hypothetical alternatives as explanation, the court was nevertheless persuaded to accept explanations that were not always based on 'the ordinary course of medical and scientific principles'.[209] As it stands, the acceptance or rejection of the defendant's explanation in rebuttal remains at the court's discretion, with the court being assisted by expert medical evidence. The court will look for a 'reasonable' explanation from the defendant that is an alternative cause not involving negligence, or the court will assess whether the defendant acted with the necessary care.[210] These alternatives seem to stand in an inverse correlation; thus, as the court suggested in *Ratcliffe*, the less plausible the defendant's explanation regarding the cause of the claimant's injury, the more the court will need to be satisfied that the defendant took due care. It is central for the claimant to prepare a *prima facie* case with the assistance of medical expert evidence based on tort law principles to determine a proper cause of action. It is widely accepted that a medical accident that caused harm to a plaintiff raises *prima facie* evidence of negligent conduct, which is sufficient to proceed to court with or without the maxim. Evidently, in the light of some of the inventive explanations offered by the defence, it is doubtful whether the maxim indeed assists a claimant. Although the maxim extracts an explanation from the defendant, clearly the explanation of the defendant sometimes may mislead the court,[211] as the latter fails to establish the accepted standard of care against which the defendant's actions can be assessed. It is the basis for factual causation. As there seems no logical reason for this other than a defendant set on providing an explanation devoid of negligence rather than providing a true cause of the injury, it may have to do with underestimation of the intricacies of the practice of medicine.

9 An analysis of the use of the *res ipsa loquitur* maxim in recent case law

In *Ratcliffe v Plymouth & Torbay Health Authority*,[212] the use and function of the *res ipsa loquitur* maxim was expanded and was applied in its broader form, because of complex medical negligence cases. The claimant relied on the maxim to get to court and to extract an explanation from the defendants, and then relied on medical expert evidence to proceed to a

[209]*O'Malley-Williams v Board of Governors of the National Hospital of Nervous Diseases*(n 134); *Roe v Minister of Health* (n 25) 80; *Ratcliffe* (n 3);*Saunders v Leeds Western Health Authority* (n 73) 355 and the South African case of *Pringle v Administrator Transvaal* 1990 (2) SA 379 (W). The list is not exhaustive.
[210]*Delaney* (n 72) 355.
[211]*Ratcliffe* (n 3) 162. See the discussion in para 7 above.
[212]*Ratcliffe* (n 3) 172. See para 7 above.

full trial. The issues were mostly what weight the court should give to the evidence or whether the presumption of negligence should be allowed. It seems that, sometimes the cause of the injury remained a mystery to the court where the court was unable to determine factual causation. The basic standard of care test is an assessment by the court of how the defendant-doctor ought to have behaved and the court was usually convinced that a medical professional acted with reasonable care. However the court became attentive to the answers of the defendants in rebuttal and seems to requests more detail. In *Lillywhite v University College London Hospital's NHS Trust*, [213]the court held that a defendant was obliged to exercise reasonable care in performing a scan, but also to exercise reasonable care in interpreting the results of the scan. The court said that the defendant did not 'pass the test of plausibility or possibility and she [Prof Rodeck] did not succeed in adducing explanatory material that put the initial assumption of negligence under question'.

9.1 Lack of care as part of the maxim: *Lillywhite v University College London Hospital's NHS Trust*

Lord Justice Buxton stated that this case was not a case of *res ipsa loquitur*, but a case in which the outcome that the defendant attributed to his medical interpretation or reading of a scan called for an explanation. The reading of images requires not only care, but also skill and judgment. The complaint in this case was that the requisite level of skill and judgment simply could not have been exercised given that the results produced were so disastrously wrong. In addition, an earlier reader in the person of Mrs Wright (radiographer) had not made the same errors.

The court was determined to qualify the defendant's explanation in rebuttal. In *Lillywhite v University College London Hospital's NHS Trust*[214] the claimant sought damages for loss, pain and suffering in consequence of the birth of her baby who suffered from holoprosencephaly, a severe malformation of the brain. During 1992, Mrs Lillywhite, the claimant, a 36-year-old woman went for an abnormality ultrasound scan when she was 18 weeks pregnant. The radiographer, a certain Mrs Wright, found that she could not see a part of the brain of the foetus called the *cavum septum*. When testifying in court she mentioned that she recalled this case as the 'case of the absent *cavum septum*'. She took multiple views

[213]*Lillywhite v University College London Hospital's NHS Trust* (n 167) 1466.
[214]*Lillywhite v University College London Hospital's NHS Trust* (n 167). Latham LJ summarised the history in detail at paras 7 to 32 of his judgment.

from different angles and remarked in her notes her inability *to visualise septum pelucidum and normal anatomy in the anterior brain*. She spoke to the obstetric consultant, as she was uncertain about the seriousness of the situation. They explained the serious situation to the plaintiff and referred her to Prof Rodeck at University College Hospital for a consultation five days later. As the claimant and her husband wanted to terminate the pregnancy in the event of an abnormality, she consulted a private radiologist the next day, a certain Dr Meire (first doctor). Dr Meire concluded that the foetal head was *high in the fundus and imaging was not easy with reverberations partially obscuring the proximal hemisphere*. He also stated that the ultrasound scan was rather less satisfactory than it might have been, yet he reassured the claimant and her husband against any abnormalities. Five days later, they consulted with Prof Rodeck (second doctor), who performed an ultrasound scan. She measured the different ventricles and spaces in the brain, revised her measurements, and found the distances between certain structures to be normal. She did not record pictures of the scan. Baby Alice was born 4 months later on 26 April, with semi-lobar holoprosencephaly towards the severe end of the spectrum (the forebrain of the embryo fails to develop into two hemispheres[215]). The child therefore had what is known as a mono ventricle. These abnormalities were present at the time when Prof Rodeck performed her ultrasound scan.

The portrayal and recognition of the abnormalities lie at the centre of the case. The claimant's case was simply that Prof Rodeck could not have exercised the standards of care that were expected in concluding that the brain showed no signs of abnormality. The claimant's experts were of the opinion that Mrs Wright (the radiographer who performed the test initially) had not been able to visualise the relevant brain structures because they were not there. The claimant called three experts in the field. The defendant's version was that two distinguished radiological experts had, within days of each other, concluded that there were no abnormalities and that they had identified structures that were consistent with normality. Prof Rodeck had carried out the examinations with due care.

On appeal His Lordship Latham stated that the task of the trial judge in evaluating the medical expert evidence was intrinsically difficult. Expert evidence indicated that holoprosencephaly was undetected in 40 to 60 per cent of scans.[216] He continued that there

[215]See explanation of hemispheres, available at http://www.medicinenet.com/script/main/art.asp?articlekey=15531 (accessed 3 March 2014).

[216]Some tests have a high rate of 'false negatives'. A false negative test indicates that a person does not have whatever is being tested for, while the person does in fact have it. Mammograms are known for having high rates of false negatives and false positives. While some of the false negative results stem from inaccuracy in reading the scans, other errors arise from the lack of sensitivity of the equipment. See

was no dispute about the standard of care exercised by Prof Rodeck. However, unlike the cases of *Ratcliffe* and *Delaney*, that was not the complete answer to the test. The *interpretation* of the scan should also have been done with reasonable care and, had Prof Rodeck exercised skill and care, she would have recognised the echoes from the scan as mimics (artefacts and not reliable). Prof Rodeck failed to identify or explain anomalies on the scan. The appeal was upheld[217] and the claimant's case succeeded. His Lordship Latham explained that, although the claimant referred to the maxim *res ipsa loquitur*, the claimant conceded that the maxim in itself provided no solution to the case. His Lordship said, that given the way the trial judge approached the evidence[218] and the conclusion that was reached, one should look with care at the extent to which the trial judge properly reflected on the strength of the claimant's argument. This argument was based on the simple proposition that Prof Rodeck purported to identify structures that were simply not there. Lord Justice Buxton, in agreeing with Latham LJ, stated that the trial judge found that Prof Rodeck performed the sonar with reasonable care. He explained that a professional man is required in the law of negligence and contract to display not only care, but care and skill.

He referred to His Lordship McNair's statement in *Bolam v Friern Hospital Management Committees*:

> How do you test whether his act or failure is negligent? In an ordinary case it is generally said you judge it by the action of the man in the street. He is the ordinary man ... But where you get a situation which involves some special skill or competence, then the test of whether there has been negligence or not is not the test of the man on top of the Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill.[219]

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http://patients.about.com/od/yourdiagnosis/a/How-Accurate-Are-Your-Medical-Test-Results.htm (accessed 19 April 2014).

[217]His Lordships Latham and Buxton concurred and Lady Justice Arden dissented from this judgment.

[218]The trial judge had accepted that the defendant had carried out the ultrasound with reasonable care.

[219]*Bolam v Friern Hospital Management Committees* (n 23) 586.

Latham LJ and Buxton LJ agreed that the explanations advanced by the defendant[220] 'were neither possible nor plausible,[221] and so did not discharge the inference referred to in the *Ratcliffe* formulation'. The majority decided that the defendants did not succeed in adducing explanatory material that questioned the initial assumption of negligence.

9.2 Comments on *Lillywhite v University College London Hospital's NHS Trust*

In non-medical terms, the *Lillywhite* case seems to be a clear-cut case of negligence. The claimant alleges that 'but for'[222] the incorrect interpretation of the scan and the failure to take care in confirming crucial medical structures in the brain, the foetus would have been aborted. In essence, the negligence lies in the defendant's lack of care in failing to exclude certain material doubts about the true medical condition of the foetus. The writer agrees with the court's approach that the presumption created by the maxim is unhelpful in this case, even with the extended use of the maxim, because the core aspects of the case revolved around *testimony*[223] regarding the required standard of care. The accepted standard of care was higher than the ordinary standard of care because of existing records of abnormalities in the brain that has to be ruled out. It was clear that the ultrasound scan performed by a radiographer raised much concern about the normality of the brain of the unborn foetus. This was the existing medical diagnosis at the time that had to be confirmed or excluded. More particularly, the defendant's duty (Prof Rodeck) was not only to interpret the images, but to weigh her findings against the suspicion of abnormalities and to rule that out. Furthermore, the consequences of a misdiagnosis or of failing to rule out abnormalities of the brain of the foetus were so severe that, the defendant ought to have requested assistance from other medical experts. This cannot be interpreted as showing an accepted standard of care; it is evidence of a lack of care ie substandard care. In other words, it was part of the defendant's duty of care to accept her lack of skill or simply to request confirmation of an uncertain

[220]The defendant's version was that two distinguished radiological experts had, within days of each other, concluded that there were no abnormalities and that they identified structures that were consistent with normality.

[221]*Lillywhite v University College London Hospital's NHS Trust* (n 167) 1466. Latham LJ explained that a plausible explanation had to be found for the defendant failing to note all three of the absent structures (in the brain). The defendant would have faced considerable difficulty in relation to missing even one structure; what seems to be insurmountable is the hurdle of establishing that there was a plausible explanation for missing all three.

[222]Ibid. See the *Bolam* test in *Bolam v Friern Hospital Management Committees* (n 23).

[223]In respect of the application of the maxim in South Africa, it is argued that if you need further evidence to determine the conduct of the defendant (the test for negligence in South African law of delict) then the maxim cannot apply.

diagnosis by referring the patient to more skilled and experienced colleagues. A court would be reluctant to find this particular defendant in breach of her duty had she referred the patient to another specialist even if he also missed the diagnosis.

In the leading case regarding *res ipsa loquitur, Ratcliffe v University College London Hospital's NHS Trust*,[224] the court made it clear that, in addition to using the maxim, the claimant should obtain medical expert evidence to support her case. One would have expected, therefore, in *Lillywhite v University College London Hospital's NHS Trust*[225] that, although the claimant succeeded with her action, the medical expert evidence would have been more detailed. From the concessions made by the court[226] in *Lillywhite* it is evident that the maxim *res ipsa loquitur* has perhaps not lost its appeal to claimants in spite of the ineffective use of the maxim for some time. It seems that with the move to a more inquisitorial system and the definitive principles of the maxim set out in *Ratcliffe v Plymouth & Torbay Health Authority*[227] in respect of a requirement that the claimant should obtain adequate medical expert evidence it may possibly have levelled the fields between claimants and defendants in medical negligence cases in England in its own context.

9.3 The effect of the maxim on *Thomas v Curley*

In a recent case, *Thomas v Curley,* [228]the application of the maxim came under attack. The maxim was pleaded in the trial court and the Court of Appeal had to decide whether the judge had incorrectly applied the *res ipsa loquitur* maxim. The court found that the trial judge correctly directed himself to assess the weight of the evidence and to decide whether the defendant was liable in circumstances where there was no explanation for the claimant's injuries. The claimant was diagnosed with a single gall stone in the gall bladder. The defendant advised her to undergo a laparoscopic cholecystectomy. During the operation the defendant found that the gall bladder was not inflamed and he found only a single stone. He also noted an abnormality in the anatomy of the claimant: instead of the cystic duct originating in the common bile duct it came from the right hepatic duct. The gall bladder was

[224]*Ratcliffe* (n 3) 162ff.
[225]*Lillywhite v University College London Hospital's NHS Trust* (n 167) 1466. See the summary of Latham LJ at para 13.
[226]*Lillywhite v University College London Hospital's NHS Trust* (n 167) 1466ff. Though the Court of Appeal considered that the maxim did not apply, Latham LJ emphasised that the defendant had a 'heavy burden' to show that he had exercised skill and care when he failed to correctly identify the structures of the brain.
[227]*Ratcliffe* (n 3) 162ff.
[228][2013] EWCA Civ 117.

removed. The claimant was discharged. A few days later she developed severe pain and was re-admitted. The diagnosis suggested an intra-peritoneal leak with appearances in keeping with a biliary leak from the region of the stump of the cystic duct. The defendant inserted a stent (tube inserted into a vessel to keep it open for drainage). The defendant arranged for follow-up in-hospital care with another surgeon as he left on vacation. The claimant's condition deteriorated and she developed acute renal failure. She was admitted to the high care facility where she consulted a hepato biliary surgeon. The latter performed an open laparotomy and repair operation during which 7 litres of bile were drained from the peritoneal cavity. She made a slow recovery and several months later were re-admitted for the removal of the stent. In the proceedings she alleged that the defendant was negligent in two respects. First, he caused an iatrogenic injury to the common bile duct of the claimant during laparoscopic surgery. Second, he failed to require fluid balance and renal monitoring of her condition when he went on vacation. The trial judge held that she discharged her onus of proof with regard to the first ground and awarded damages to the claimant.

On appeal the defendant claimed that the trial judge was incorrect in applying the maxim by drawing an inference of negligence (based on the *res ipsa loquitur* maxim only) where there was evidence as to why and how the result occurred,[229] and that there is doubt whether the maxim is of much assistance.[230] The defendant averred that since the claimant's case relied entirely on the *res ipsa loquitur* maxim the judge was wrong to conclude that the injury suffered was caused by the negligence of the defendant. It was the defendant's case that the maxim was incorrectly applied. The further background to the case was that the medical experts could not agree on certain medical aspects. The defendant's expert stated that the bile duct injury was an unavoidable bile duct injury whereas the claimant's expert stated that in a case of uncomplicated surgery (such as the case of the claimant) such an injury was avoidable. The defendant's appeal was based on the following: the claimant presented no evidence about whether the defendant exercised proper care during the operation; the injury was a well-recognised complication of the operation; the trial court should not have inferred and concluded from the fact of the injury (alone) that the defendant had been negligent; and the trial court's judgment was based on a mistaken reversal of the burden of proof.

[229]A requirement of the maxim stipulates that if all evidence is before the court the case should be presented on ordinary tort law principles.

[230]They referred to *Ratcliffe* (n 3) 162ff, where Hobhouse LJ said that '*res ipsa loquitur* is not a principle of law and it does not relate to or raise any presumption. It is merely a guide to help identify when a *prima facie* case is being made out. Where expert and factual evidence is being called on both sides at trial its usefulness will normally have been long since exhausted.'

The Court of Appeal found that the trial court based its findings on conclusive evidence of negligence: First, the abnormal anatomy of the claimant (ie the cystic duct was off the right hepatic duct and the injury was in the common bile duct) made negligence more likely because there was no reason why the surgery should have been in the region of the common bile duct where the injury occurred.[231] Second, the defendant could not explain such an injury and once the judge established that the injury was not in the area of the operation, evidence of the leak was compelling evidence that supported the claimant's case.[232] It became clear that the judge was not relying on the *res ipsa loquitur* maxim as he was not drawing an inference from the mere fact of the injury. It seemed that the maxim was initially used to get to court but with the exchange of medical expert opinion,[233] the claimant averred in addition that the most likely explanation for the injury was a diathermy injury, alternatively a tractions injury. None of this was refuted by the defendant. From this case, it seems that the change in procedural system motivates the claimant to furnish proper allegations for the injury other than a presumption of negligence based on the fact of the injury. It also seems that in the presence of medical expert evidence the court is reluctant to admit that a claim was based on the maxim only, since the court tested the actions of the defendant against the expected standard of care or medical reality. The writer argues that it seems that the maxim is no longer useful, because had the claimant argued that the defendant was *prima facie* careless, because he caused an injury in an area unrelated to the operation, the outcome would have been the same because the defendant could not (or perhaps he was unwilling) to explain the injury.

9.4 *Pearce v United Bristol Healthcare Trust*

An earlier case *Pearce v United Bristol Healthcare Trust*[234] was not based on the *res ipsa loquitur* maxim, however it is discussed because of the writer's argument that had the claimant followed the ruling in *Ratcliffe v Plymouth & Torbay Health Authority*[235] the outcome would have been different. As seen before,[236] the English court recognises the right of the patient to be informed about risks and complications in order to choose whether to allow the proposed treatment or to refuse the treatment and seek alternatives. Therefore, the

[231] *Thomas v Curley*(n 228) judgment para 29.
[232] *Thomas v Curley*(n 228) judgment para 32.
[233] *Thomas v Curley*(n 228) para 12.
[234] [1999] ECC 167; [1999] PIQR P53; (1999) 48 BMLR 118 CA (Civ Div).
[235] *Ratcliffe* (n 3) 162ff.
[236] See paras 2 and 3 above.

doctor has a duty of care to disclose material information to the claimant before treatment. However, the duty of the doctor is wider than mere disclosure because it also involves a discussion regarding treatment and diagnosis. The question inevitably addresses the prospects of the success or failure of the treatment; to what extent the doctor can override the decision of his patient and whether these cases will also have an impact on the use of the *res ipsa loquitur* maxim. In *Pearce v United Bristol Healthcare Trust,*[237] the Court of Appeal heard a case for negligence brought by the claimants in respect of a stillbirth. At the time when the claimant consulted the defendant the baby was 14 days overdue. The mother begged the doctor for an induction or caesarean section but the defendant-doctor was of the view that the proper way to proceed was to have a normal birth without any form of medical intervention. The claimant was discharged. The claimant testified that she was upset but accepted the advice of the doctor. The expert medical opinion was overwhelming that it would have been risky to induce the birth at that stage. Such an option was therefore, ruled out. From the pathologist's evidence, the baby died approximately five days later in the uterus.

The issues before the court were: should the defendant have advised the claimant about any increased risk of the baby being stillborn as a result of the passage of time? Had the doctor advised the claimant in this regard, would the outcome have been different? The court per Lord Woolf held that the 'but for'[238] test about the giving of advice or the failure to give advice should be applied. Lord Diplock stated that even in a case where (as here) no expert witness condemns the non-disclosure as being in conflict with accepted responsible medical practice, a judge can in certain instances conclude that disclosure was needed and that no prudent doctor would have failed to make it. Lord Templeman was of the opinion that the doctor should have an overriding duty to act in the best interests of the patient and to provide the patient with all necessary information to make a balanced judgment. Lord Woolf concluded that if there is a significant risk that would affect the judgement of a reasonable patient then in the normal course of events it is the responsibility of a doctor to inform the patient.[239] The court found that there was no significant risk and dismissed the claimant's case. The writer argues that had this case been argued on failure of inadequate treatment and/or diagnosis instead of lack of advice the outcome would have been different. Furthermore, in the light of the design of the maxim to presume negligence based on the fact

[237]*Pearce v United Bristol Healthcare Trust* (n 234) judgment p 1ff.
[238]*Pearce v United Bristol Healthcare Trust* (n 234) judgment p 5, where the court referred to *Bolam v Friern Hospital Management Committee* (n 23) 582.
[239]The judge relied on *Sidaway v Governor of the Bethlem Royal Hospital* (n 19) 871.

of the injury itself, without investigating the medical reality, it seems that the outcome would have been the same if this case had relied on the application of the maxim. But, if this case had been based on balancing the standard of care against the reality of the doctor's conduct, the court would have found in the claimant's favour. It was well-known at the time that the risk of injury to a baby increases with overdue babies.[240] It is unclear why the claimant did not follow the judgment of *Ratcliffe v Plymouth & Torbay Health Authority*[241] and base her case on the *res ipsa loquitur* maxim (for no other reason but a long standing tradition), and in addition, presented medical evidence in accordance with tort law principles based on a lack of care. Although the writer argues that the maxim does not assist a claimant, the thesis statement is that with expert medical evidence a claimant can substantiate allegations based on a lack of care. The medical reality of this case is complex but the standard of care required for the management and treatment of a post-mature pregnancy is obvious. From the above literature it is clear that the medical condition of the unborn baby must be closely monitored by looking for any signs of foetal distress, regular foetal movement, and heart rate in relation to the contractions of the uterus, and to perform repeat ultrasound scans to monitor the medical condition of the unborn baby. Any signs of foetal distress would indicate the need for a caesarean section (as induction was ruled out). The placenta supplies the baby with nutrients and oxygen but after 40 weeks it starts to wear out due to age, and will eventually stop functioning. If the baby remains *in utero* he will not be constantly supplied with sufficient oxygen and nutrients and will become distressed. Foetal distress is clear if the baby's heart rate shows signs of acceleration or deceleration and he passes faecal matter (meconium) in the womb. If the baby breathes this in, he will suffer from aspiration of meconium syndrome.[242] The baby will not survive on going distress. Had this information been presented to the court it may have concluded that the defendant failed his duty of care to the claimant and her unborn baby and was the direct cause of the death of the unborn foetus.

[240]PL Yudkin, L Wood , CW Redman 'Risk of unexplained stillbirth at different gestational ages'(1987) May 23; 1(8543): *Lancet* 1192–1194. Of 40,635 deliveries in 1978-1985, unexplained stillbirths were an important component (nearly a quarter) of all perinatal deaths. The rate of unexplained stillbirths (unexplained stillbirths divided by total births) was highest among pre-term deliveries, fell to a minimum at 39-40 weeks' gestation, then rose at 41-42 weeks. Rate is generally accepted as measuring risk, but since it is the population of undelivered, not delivered, infants that is at risk of intrauterine death, stillbirth risk would be better measured as the number of impending stillbirths divided by the total number of undelivered foetuses. With this measure the risk of unexplained stillbirth was least in pre-term pregnancies, rising fourfold after 39 weeks to a maximum at 41 weeks. At this time, it was also four times higher than at 33 weeks, in contrast to the rate, which was 19 times lower. http://www.ncbi.nlm.nih.gov/pubmed/2883499 (accessed 12 March 2016).

[241]*Ratcliffe* (n 3) 162ff.

[242]L Hilder, K Costeloe, B Thilaganathan 'Prolonged pregnancy: Evaluating gestation-specific risks of fetal and infant mortality' (1998) 105 (2) *British Journal of Obstetrics and Gynaecology* 169–173.

9.5 *Montgomery v Lanarkshire Health Board*

The English court traditionally applied the *Bolam*[243] test to cases where a duty to disclose was established and where such a duty was breached because of a negligent non-disclosure of risk. The court in *Chester v Afshar*[244] focused on the issue of causation and in fact favoured a reasonable patient approach. The application of the reasonable patient approach was confirmed in *Montgomery v Lanarkshire Health Board.*[245] It is submitted that although the claimant was successful with her case, the medical reality of this case was underestimated. The facts of this case are similar to the facts in the South African case, *Sibisi NO v Maitin,*[246] where the plaintiff was unsuccessful. In *Montgomery v Lanarkshire Health Board*, the claimant sued the defendant, alleging that the doctor who was responsible for her care during the ante-natal care should have informed her about the risk of shoulder dystocia and should have sufficiently managed the labour process. The claimant was a small woman and was expecting a larger than normal baby. The claimant suffered from diabetes. Women suffering from diabetes are more likely to have larger than normal babies and have a 9 to 10 per cent risk of shoulder dystocia occurring during vaginal delivery (because the shoulders of the baby are too wide to pass through the pelvis). The labour was induced by the administration of hormones. The process was slow and after several hours the labour became arrested. When the head of the baby descended during the labour process, the baby's shoulders became impacted and the defendant used forceps to deliver the baby. It took some time to deliver the baby and the baby was deprived of oxygen for more than 12 minutes during birth, which resulted in permanent brain damage.

The defendant testified that she did not routinely advise diabetic women of the risk of shoulder dystocia, because it was her opinion that they then almost always opt for a caesarean section. The claimant testified that had she been told about the risk of shoulder dystocia she would have opted for a caesarean delivery. The trial court interpreted the shoulder dystocia risk as significant, but not conclusive evidence of a breach of duty of care, because the same risk in vast majority of cases is dealt with by simple procedures and the chance of severe

[243]*Bolam v Friern Hospital Management Committee* (n 23). See para 2 above.
[244]*Chester v Afshar* (n 20). See para 2 and 6.3 above.
[245][2015] UKSC11; [2013] CSIH 3 para 83 where the court said that the responsibility for determining the nature and extent of a person's rights rests with the courts, and not with the medical professions.
[246][2014] ZASCA 156 at 11. See chapter 2 para 4.1.2.

injury to the baby was tiny.[247] The trial court held however that there had been no breach of duty by the defendant. The Court of Appeal allowed the appeal based on several aspects:[248] the shift in the doctor-patient relationship now allows for the fundamental value of self-determination; there is no reason to perpetuate the *Bolam* test in this context any longer as this test may allow the sanctioning of different medical practices without addressing patients' rights and values; the assessment of whether a risk is material is fact-sensitive and cannot be reduces to percentages and should be conveyed adequately to the patient; the doctor's advisory role involves proper dialogue to explain anticipated benefits and risks to the patent; and the lower court should have concentrated on the claimant's likely reaction if informed about the risk. The court is concerned not only with the risks to the baby but also with the risks to the mother. The court found that once the arguments departed from the medical considerations the *Bolam* test was inappropriate. The claimant was successful with her appeal.

The law requires the doctor to inform the patient of any material risks involved in medical treatment, as well as any alternative options available. However, it is obvious that the defendant also failed to take into account the possibility that shoulder dystocia might occur. As an obstetrician she ought to have been prepared for such an emergency. She could have allowed the claimant to start with a trial-run regarding the natural delivery and if the process was not progressing as planned, a caesarean section could have been performed. The defendant ought to have known that, the single most common risk factor for shoulder dystocia is the use of a vacuum extractor or forceps (used in this case) during delivery.[249] In other words, she ignored the signs of obstruction and tried to force the head of the baby through the birth canal with a forceps delivery of the head. The defendant was the creator of the emergency. This was the medical reality of the case and was contrary to the expected standard of care. It is commended that the English court appreciates the role of the patient when consenting to any medical intervention as is evident from the decisions[250] in *Pearce v United Bristol Healthcare Trust* and *Chester v Afshar.* The courts held that the need for proper informed consent was part of English law. The patients' interest in their own physical

[247] *Montgomery* (n 245) judgment para 28.
[248] *Montgomery* (n 245) judgment para 87-91.
[249] EG Baxley and RW Gobbo 'Shoulder dystocia' (2004) 69(7) *American Family Physician* 1707–1714 at http://www.aafp.org/afp/2004/0401/p1707.html(accessed 22 March 2016).
[250] *Pearce v United Bristol Healthcare Trust* (n 234) para 9.4 above; *Chester v Afshar* (n 20). See para 2 and 6.3 above.

and mental health is protected as well as their right to autonomy and their freedom to decide over their bodily integrity.

10 Conclusion

The English cases that are analysed above establish a pattern for the use of the *res ipsa loquitur* maxim. A presumption of negligence is made based on the fact that a medical intervention under the control of the defendant went wrong and the claimant sustained unnecessary injuries. If the claimant relies on the *res ipsa loquitur* maxim, the defendant is compelled to furnish an answer to defeat the rebuttable inference of negligence. Furthermore, some cases[251] illustrate that because the plaintiff relied simply on the *res ipsa loquitur* maxim and failed to present evidence, the court focused on the defendant's explanation, unaided by evidence to the contrary. The result was that the court had to determine factual causation from a biased defendant refuting the action of the claimant. The defendant's response effectively dictates the next step in the process. If the court accepts the defendant's explanation and his assurance that the medical intervention was performed with proper care and skill, the plaintiff's case will be defeated. The obligation on the defendant to reply with an answer that shows there was no negligence resulted in the defendant sometimes presenting explanations that were exotic[252] and imaginative to escape liability, with a focus on avoiding liability rather than on explaining the medical reality. As far back as 1939, with *Mahon v Osborne,*[253] the court prompted the plaintiff to present medical expert evidence, even with the use of the maxim, in order for the court to establish causation from the medical evidence. Some applications and interpretations of the maxim gave the claimant a false sense of security, and inaccurate and insufficient medical evidence[254] resulted in an unwarranted defeat for the claimant. Sometimes the maxim did not encompass causation when the wrong defendant[255] was sued. Various conceptualisations of the maxim were observed,[256] but it

[251]*Glass v Cambridge Health Authority* (n 13) 107; *Ritchie v Chichester Health Authority* (n 74) 187.
[252] See Puxon on 'exotic' explanations at para 4.3 above.
[253]*Mahon v Osborne* (n 43) 14ff, where a swab was left in the abdomen during complicated surgery.
[254]*O'Malley-Williams v Board of Governors of the National Hospital for Nervous Diseases* (n 134) 635. A reasonable physician would have stayed in touch with developments in the field and would have been aware that the axilliary artery carries a higher risk of injury than the femoral artery. The defendant failed in previous attempts to insert the stent in the femoral artery, which should have been indicative of lack of skill.
[255]*Morris v Winsbury-White* (n 65) 494. The claimant instituted action against the surgeon only. A tube remained in the bladder, which was revealed by means of a radiology examination. In this case it was found that, subsequent to a prostate operation, part of a tube was left in the bladder. The claimant instituted legal action. Because several people participated in the initial procedure, the defendant could not be found negligent, as the patient's postoperative management was under the control of professional nurses, two resident medical

became clear that the court was reluctant to oversimplify the medical aspects of a medical accident.[257]

In 1998, with the move towards a more inquisitorial system, the court established strict rules for the future use of the maxim.[258] *Ratcliffe v Plymouth & Torbay Health Authority*[259] formally widened the scope of the *res ipsa loquitur* maxim. The maxim was not only relevant in its purest form, but was also used in cases where the negligence was not patent from the objective facts. But the court held that this should be done in addition to presenting expert medical information. It also appears that the court remained lenient towards medical professionals under circumstances where they stated 'I simply do not know what went wrong'.[260] In *Lillywhite v University College London Hospital's NHS Trust*,[261] the English court explicitly rejected the *res ipsa loquitur* maxim, although this might have been in respect of this particular case, however, the court agreed that the inference of negligence called for an explanation from the defendant clarifying how she missed the diagnosis. The court accepted a *prima facie* inference of negligence and sought answers regarding the subjective reasoning of the defendant at the time, in explaining the steps taken to prevent the injury. The case turned on the court qualifying 'lack of care' to include 'lack of skill and competence' and whether the defendant provided a 'plausible explanation' for her failure to recognise the absence of images on a brain scan. In *Thomas v Curley*[262] the defendants challenged the use of the maxim and argued on appeal, that the *res ipsa loquitur* maxim was incorrectly accepted and applied by the trial judge. Regarding the application of the *res ipsa loquitur* maxim, the Court of Appeal noted that–

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officers and, only occasionally, the defendant. The management of the instrument was not entirely under the control of the surgeon, and outside interference could have contributed to or caused the damage; therefore, the *res ipsa loquitur* maxim could not be applied.

[256]*Mahon v Osborne* (n 43) 14, 23, where a swab was retained following a complicated operation and the court found that an ordinary reasonable man could not determine what precautionary measures the surgeon should have taken, and thus medical expert evidence was needed; *O'Malley-Williams v Board of Governors of the National Hospital for Nervous Diseases* (n 134), where the court held that the *res ipsa loquitur* maxim did not apply due to the inherent risk of the operation.

[257]*Bouchta v Swindon Health Authority* (n 101) 62; *Delaney v Southmead Health Authority* (n 72) 355.

[258]*Ratcliffe* (n 3) 187.

[259]*Ratcliffe* (n 3). See para 7 above.

[260]*Ratcliffe* (n 3) 176.

[261]*Lillywhite v University College London Hospital's NHS Trust* (n 167) judgment para 7-32.

[262]*Thomas v Curley* (n 228) judgment para 10.

> the judge was not drawing an inference of negligence from the mere fact of injury to the common bile duct during an operation. He was addressing the particular circumstances of this particular case in the round, having regard to all the evidence and having assessed its weight. This is apparent from his reference to the fact that this was an uncomplicated procedure some distance removed from the site of the common bile duct injury.[263]

It appears that the English court was relying on medical literature and medical information presented by the medical experts, and questioned whether the care of the defendant was in accordance with the accepted standard of care. The court was also reluctant to accept a blanket statement from the defendant that the surgery was complicated and there was a known risk of complications. The court looked particularly at the cause of the leak in the abdomen in relation to the location of the bile leak.

It is possible that the English court at present regards *res ipsa loquitur* as a phrase that represents an evidentiary principle that belongs to the past. It seems that any medical accident which is unexpected in nature, will lead to an inference of lack of sufficient care in a situation completely under the control of the defendant-doctor as this would be interpreted as *prima facie* evidence that calls for an explanation from the defendant-doctor.[264]. This thesis argues that the maxim gives the court a further burden in determining the medical reality; first, determining whether the maxim is applicable; second, giving effect to the presumption and; third, testing causation from the defendant's answer in rebuttal as well as from the facts and evidence of the case. Not only does the court have to find the cause of the injury, it also has to examine all the complex notions relevant to the maxim to determine if the injury supports an inference of negligence. Nevertheless, the writer argues that the plaintiff should pre-empt the creative responses of the defendant by presenting medical evidence that constitutes the medical reality and causation in accordance with the decision in *Ratcliffe*, thus preventing the defendant from sending the court on a course that does not serve the plaintiff's case. The English court's approach towards a more inquisitorial system is admired as it means that, in spite of any presumptions or public expectations that an injury occurred because of an alleged lack of care, negligent conduct will be tested on a preponderance of probability in accordance

[263]*Thomas v Curley* (n 228) judgment para 26.
[264]In *Lillywhite v University College London Hospital's NHS Trust* (n 167), the maxim was rejected by the court but the court addressed the issue of lack of care and skill.

with tort law elements and with the involvement of the court to request medical expert testimony to clarify certain medical principles. In other words, whether the plaintiff relies on a presumption or not, the court will test whether the defendant breached his duty of care against acceptable medical principles and whether the defendant exercised his duty in a careful and skilful manner in accordance with the expected standards.

From its first appearance in the law of negligence, the *res ipsa loquitur* maxim inspired the court to prescribe various limitations. The plaintiff has to show that the *res* (that caused the injury) was under the exclusive control of the defendant, and then establish the defendant's liability by presenting direct evidence. Where direct evidence is not available, the plaintiff asks the court to draw an inference of negligence that constitutes *prima facie* evidence from the fact of the injury that calls for an explanation in rebuttal. The plaintiff has the benefit of the maxim as a defendant is called to answer in rebuttal when the maxim is accepted. But, when a defence is presented showing a cause without negligence, the plaintiff continues with his case by presenting evidence to negate the response from the defendant and to prove his initial case. A wise plaintiff in England would rely on the maxim in addition to presenting medical expert evidence as that would direct the defendant's defence in rebuttal and minimise the chance of exotic explanations.

The next chapter demonstrates the mechanism of medical aetiology,[265] based on principles of evidence-based medicine recognised in the international arena. The medical scientific principles or management of injuries and disease are acknowledged throughout the world. The medical profession publishes its research findings for the benefit of all members of the profession and as such sets a medical and scientific standard. The purpose is to correlate its findings for the better good of society and the medical profession. It is the accepted standard of care set by the medical profession. It is proposed that medical facts and reasoning are based on the process used by a medical professional to make a diagnosis or identify a disease. This is done to prescribe the correct treatment plan for the patient. Medical experts should interpret and explain an adverse event or injury to the court based on their medical knowledge and reasoning using the medical facts available. This is the basis for factual causation from which legal conclusions can be drawn but it has the potential for misinterpretation if not perceived from a medical point of view. It is argued that if a general inference of negligence is based on the fact of the injury alone, then the sometimes complex

[265]A medical cause of a disease or illness.

process of determining the aetiology of the injury, otherwise known as a medical reality, is underestimated and very often missed completely.

CHAPTER 4: THE RELATIONSHIP BETWEEN THE MEDICAL CLINICAL PROCESS AND FACTUAL CAUSATION

1 Introduction

The previous chapters addressed the medical law principles in South Africa and England, as well as the different applications of the *res ipsa loquitur* maxim in South Africa and England. In South Africa, the courts have been precluded from applying the *res ipsa loquitur* maxim in medical negligence cases since 1924.[1]Academic authors[2] have argued that the decision in *Van Wyk v Lewis*[3]case was misdirected and that the maxim should be applied in South Africa. Recently, the orthodox stance of the court was contested,[4] but the court explicitly discouraged any further use of the *res ipsa loquitur* maxim in medical negligence cases, thus leaving the 1924 decision in *Van Wyk v Lewis*[5]untouched.

Further investigation into the application of the *res ipsa loquitur* maxim in England demonstrated that the English law of tort functions differently from the law of delict in South Africa. Both the South African and the English courts faced a dilemma in resolving factual causation, which stems from the standard set by the medical profession and the interpretation of the facts. The court decisions demonstrate that the misinterpretation of the medical facts led to inappropriate legal conclusions regarding factual causation and liability. However, English law allows for a generalised presumption of lack of care of a defendant-doctor based on the fact of the injury in circumstances unexpected in nature, which were particularly under his control. This will call from such a defendant-doctor to explain the injury, whereas the South African delictual law principles dictate that the maxim is simply a factual presumption and key facts should be available to infer negligence (*culpa* and fault) from the facts alone. This thesis argues that in South Africa, key facts should include information regarding the defendant's conduct and standard of service delivery, before the court can presume negligence (*culpa*) from the facts. Furthermore, determining whether the defendant's conduct fell below the standard of care expected (the element of negligence) depends on the testimony of medical expert evidence so that the court can evaluate the care provided to the plaintiff. This is why the maxim would seldom apply to medical negligence cases in South Africa.

[1]*Van Wyk v Lewis* 1923 E 37; (1924) AD 438.
[2]P van den Heever & P Carstens *Res Ipsa Loquitur and Medical Negligence* (2011).
[3]*Van Wyk* (n 1).
[4]*Goliath v MEC for Health in the Province of Eastern Cape* 2014 ZASCA 182.
[5]*Van Wyk* (n 1).

The thesis argues that the science of medicine is complex as the expected medical standard and processes have to be explained and tested against internationally accepted medical standards described in the published literature in order to appreciate the medical facts in the context of each case. The mechanism and functioning of the human body expressed in medical context, as cause and effect, will establish the medical reality from which factual causation is determined. With the movement in medical practice towards evidence-based[6] medicine principles, medical information has become freely available, as medical research studies are published or reviewed to benefit the medical profession in its decision-making and to contextualise medical facts. Medical scientific research studies are performed to assist medical professionals in determining the risks and complications of particular medical procedures. These studies maintain that scientific medical evidence should be objective, free from bias, real, logical and rational. The medical scientific research conclusions are population-based,[7] and it is the obligation of the medical professional to interpret the scientific studies in the light of the specific patient. The medical research studies and conclusions are specific to a particular population with a specific set of characteristics to test a particular result, but are not specific to a particular individual. The medical research is probabilistic not deterministic, ie it is not a finding of fact or a search for proof but it is rather a refutation of a hypothesis. In other words, its aim is to find the best available treatment for the particular patient or the best available medicine to halt or prevent a disease. Because the body reacts differently to certain things, for example, an allergic reaction or inflammatory reaction, the practice of medicine is aimed at excluding several diagnoses and treating the most probable diagnosis. A diagnosis is never exhaustive and is always on going and changing, in accordance with new medical evidence that becomes available. Medical expert evidence in court should be based on evidence-based medicine principles that are published globally for comments from peer medical professionals. The medical expert should base his medical conclusions about the facts of a medical negligence case on published medical literature and not only on his personal opinion. If the medical condition or occurrence falls outside the scope of the research study and no similar study is available, the medical expert is allowed to use his professional knowledge to hypothesise the relevance of the study to the case in point. Undoubtedly, the premise and function of the law is significantly different from

[6]See para 3.2 below.

[7]M Luckham 'Informed consent to medical treatment and the issue of causation: The decision of the House of Lords in *Chester v Afshar* [2004] UKHL 41'. The doctor–patient relationship is focused on the individual encounter. http://www.revolvy.com/main/index.php?s=Causation%20in%20English%20law (accessed 15 December 2015).

that of medical science, as medical negligence is based on attributing fault to a particular entity or individual for the injuries sustained or the adverse outcome of a particular individual. Adjudication is based on the *stare decisis* rule to ensure legal certainty and the decision can be altered only by the authority of a higher court. The previous two chapters illustrated that insufficient medical evidence can lead to incorrect legal inferences and conclusions.

The objective of this chapter is to demonstrate that in medical negligence cases the legal conclusion of negligence cannot be made without an adequate understanding of the medical facts (the medical reality) from which factual causation emanates. This chapter provides an overview of the process of medical diagnosis, treatment and prevention. It explains from a medical perspective the variety of considerations to take into account in ascertaining the standard of care expected from a reasonable medical professional. The expected standard of care for a medical professional[8] is determined by the legal convictions of the community, the accepted standard dictated by legislation and the medical profession. The medical professional has a legal duty to use his skill, competence and experience to diagnose, treat and care for the patient without causing further injury to the patient. The study demonstrates with selected case studies the importance of having a proper understanding of the medical reality in South African law, before making presumptions based on medical facts or arriving at legal conclusions. The selection of medical cases is based on previous discussed case law except for reference to the laparoscopic procedure. This procedure was selected because of the frequency of injuries related to this procedure. It carries a high risk of complications associated with it and the more experienced the surgeon is with these high technological procedures, the lower the occurrence of injury ie the level of the surgeon on the learning curve. The latter is more discussed in this chapter.

2 The composition of a medical diagnosis

A medical diagnosis[9] is the temporary result of the medical diagnostic process and can change depending on the treatment or status of the disease. The patient consults with the medical professional, who listens to the medical history provided by the patient about specific complaints. After the initial diagnostic impression the clinician forms a working diagnosis.

[8]Chapter 2 para 4.1.
[9]JP Langlois 'Making a diagnosis' in MB Mengel, WL Holleman & SA Fields (eds) *Fundamentals of Clinical Practice* (2002) 204; W Treasure 'Chapter 1: Diagnosis' in *Diagnosis and Risk Management in Primary Care: Words that Count, Numbers that Speak* (2011).

The clinician examines the patient and may initiate further diagnostic tests to support or reject his working diagnosis. Any abnormalities detected in the patient are considered within the clinician's knowledge of anatomy (the structure of the human body), physiology (the function of the human body) and pathology (the causes and effects of disease). The signs and symptoms direct the clinician to the area of concern. The physiology of the relevant anatomical structure may or may not indicate an underlying pathology (something that is wrong with the anatomy or physiology). Further diagnostic studies, such as imaging, ie radiological studies, magnetic resonance imaging and ultrasound scans, and biochemical blood tests, may be performed to find support for the working diagnosis. The clinician will consider psychological issues (human behavioural aspects) in the process of reaching a final diagnosis of a disease or disorder. The term, 'medical diagnosis', refers to a process of elimination that starts with a critical diagnosis and proceeds through the alternative diagnoses. The clinician classifies the medical condition into different categories that have been described by medical opinion regarding the treatment or prognosis.

If the working diagnosis is ruled out, the clinician considers alternative differential diagnoses with the same signs and symptoms. The diagnostic process works towards eliminating the differential diagnoses. The diagnostic process should not be seen as a linear process but rather an iterative one, whereby a process is repeated in order to find a desired goal. Once the disease or disorder has been identified, the clinician investigates the aetiology[10] of the disease, which might be useful for the treatment plan. The diagnostic process leads to a diagnostic opinion and a proposed management plan. The clinician explains the patient's medical condition to the patient before embarking on the proposed management plan. The explanation should entail information regarding the aetiology of the disease or condition, the progression of the illness, the prognosis of the medical condition, the possible outcome, and alternative treatment options. The treatment plan should include suggested therapy, alternatives if the patient has a reaction to therapy and treatment, follow-up consultations, and proposed possibilities regarding the general evolution of the disease. Any resistance to the treatment observed by the medical professional or an insufficient response from the patient to the treatment should warrant a second look at the working diagnosis. If incidental findings are made that did not form part of the original diagnostic process, the more serious condition should take priority over a less serious condition. The

[10] 'Aetiology' (British) or 'ethiology' (American) is the study of the cause of diseases, the cause or origin of a disease, the study of causation or causality, as in philosophy, biology or physics. See http://dictionary.reference.com/browse/etiology (accessed 14 November 2014).

clinician should involve other specialists as necessary. Unexpected results will affect the initial hypothesis of the diagnosis or will be discarded, based again on the gravity of the new finding. The clinician uses his medical knowledge and clinical experience to determine whether a pattern exists in the signs and symptoms; this is called 'pattern recognition'. Clinical signs and symptoms are associated with disorders or disease patterns. The clinician should consult medical literature regarding the latest information on diagnosis, medication or management of a medical condition, ie evidence-based medicine. One of the basic reasons for evidence-based medicine principles is to ensure recognised and safe measures of treatment for patients.

3 Safety aspects in medicine and their nexus with a standard of care

In South Africa the practice of medicine is regulated by legislation[11] and regulations, which are developed or changed from time to time and published in the *Government Gazette*. The Health Ministry, in accordance with the National Health Act[12] and other relevant statutes, dictates the standard of the practice of medicine. Hospital policies and protocols are based on legislation and guidelines published by the Minister of Health and parastatals[13] to set the standards. Medical schools and universities, while complying with the legislation and regulations, also provide an educational standard for medicine based on safe medical practice in accordance with international standards, research principles and evidence-based medicine principles. The Health Professions Council of South Africa (HPCSA)[14] publishes guidelines

[11]Medical law in South Africa is governed by, inter alia: the Constitution of South Africa, 1996, which contains the Bill of Rights; the National Health Act 61 of 2003 and Regulations, which form a framework for a structured uniform health system; the National Core Standards, published in 2011 by the Department of Health; the Health Professions Act 56 of 1974 and Regulations, which control the health professions; the Health Professions Council of South Africa, which provides ethical rules and guidelines (such as Undesirable Business Practice); the Pharmacy Act 53 of 1974, which controls the pharmaceutical business; the Medicines and Related Substances Control Act 101 of 1965; the South African Nursing Act 33 of 2005 and Regulations, which control the nursing profession; the Consumer Protection Act 68 of 2008; and the common law. South Africa is also part of the World Health Organization (WHO). WHO has published certain guidelines regarding ethics in clinical research: seehttp://apps.who.int/iris/bitstream/10665/85371/1/9789241505475_eng.pdf (accessed 4 October 2014). The mission of the WHO South Africa Country Office is to promote the attainment of the highest sustainable level of health by all people living in South Africa through collaboration with the government and other partners in health development, and the provision of technical and logistic support to country programs.
[12]National Health Act 61 of 2003 and Regulations, a framework for a structured uniform health system.
[13]A parastatal has some political authority and serves the state indirectly, eg the Health Professions Council, which derives its authority from the Health Professions Act 56 of 1974.
[14]The HPCSA website: http://www.hpcsa.co.za/conduct_rules.php (accessed 12 February 2014). See LC Coetzee & PA Carstens 'Medical malpractice and compensation in South Africa' (2011) 86 *Chi.-Kent. L. Rev.* 1263, available at http://scholarship.kentlaw.iit.edu/cklawreview/vol86/iss3/10 (accessed 16 February 2014). They quote the following: the South African court recognised that the HPCSA is 'truly a statutory *custos morum* of the medical profession, the guardian of the prestige, status and dignity of the profession and the public

for medical professionals that describe a safe practice of medicine. These guidelines provide an overview of the ethical standard of care[15] that can be expected by a patient.[16] The above standards are pertinent to the understanding of medical malpractice in medical negligence litigation. A medical professional should comply with the prescribed standard of care[17] to avoid liability. A medical professional has a legal duty[18] to use his skill, competence and experience to manage the medical condition of the patient and not to harm him. This means acting in accordance with prescribed standards, foreseeing risks and complications, and taking steps to prevent such risks[19] and complications by exercising reasonable care under the circumstances. A medical professional is not measured by the standards of the most skilled member of the profession,[20] or by the standards of the least skilled member of the profession. He is governed by the standard of the reasonably[21] competent medical professional in that particular field of practice.[22] The expertise of a novice surgeon is developed under the supervision of an experienced surgeon, because students have to learn their craft and are in the early phase of their career (learning curve).[23] A medical professional in his capacity as manager or supervisor (academic and clinical), moreover, has a legal duty to the patient to ensure that qualified, skilled medical professionals are appointed to perform any surgical

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interest in so far as members of the public are affected by the conduct of members of the profession to whom they had stood in a professional relationship'. They refer to *Veriava v President of the South African Medical and Dental Council* 1985 (2) SA 293 (T) 307); *De la Rouviere v South African Med and Dental Council* 1977(1) SA 85(N) 97; *Phathela v Chairman Disciplinary Committee South African Medical and Dental Council* 1995 (3) SA 179 (T) 182; *Groenewald v South African Medical Council* 1934 TPD 410.

[15]The defendant-doctor may use it as a defence (exculpatory evidence) and the plaintiff may use it to show that the standard was not optimum in the necessary circumstances. If the standard of care was not met, the defendant would be in breach of his legal duty owed to the patient, and his action would be wrongful.

[16]See chapter 2 para 4: if the defendant was in breach of his legal duty, his actions would be interpreted as wrongful conduct and therefore unlawful.

[17]If a medical professional departs from known principles and standards he should furnish satisfactory reasons for doing so. If he fails to provide such evidence, his actions would be interpreted as a breach of his legal duty and wrongful.

[18]Chapter 2 para 4.

[19]Chapter 2 para 4 and para 4.1 below.

[20]SA Strauss 'Medical law - South Africa' in *International Encyclopaedia of Laws* (eds R Blapain and H Nys) (2006) 45–58; PA Carstens & DL Pearmain *Foundational Principles of South African Medical Law* (2007) 264; *S v Burger* 1975(4) SA 877 (A). Also see chapter 2.

[21]Strauss (n 20) 41, 61–62 refers to *Carreira v Berwind* 1986 (4) SA 60 (Z) 66; *Michael v Linksfield Park Clinic (Pty) Ltd* 2001 (3) SA 1188 (SCA); *Van Wyk* (n 1)443–444, 455–456; *Collins v Administrator, Cape* 1995 (4) SA 73 (C) 81.

[22]Strauss (n 20) 41, 61–62; NJB Claassen & T Verschoor *Medical Negligence in South Africa* (1992) 115–118; AD Mahomed & DJ McQuoid-Mason *Introduction to Medico-Legal Practice* (2001) 5; SA Strauss & MJ Strydom *Die Suid Afrikaanse Geneeskundige Reg* (1967) 104.

[23]See para 4.2 below.

operation.[24] Public safety aspects include safety[25] in the preparation and use of medicine, the prescription of medicine, and the practice of medicine.

3.1 Clinical trials for the registration of medication

The regulatory control of medication in South Africa is performed by the Medicine Control Council[26] in accordance with regulations describing health research, in terms of the National Health Act and the Medicines and Related Substances Act 101 of 1965.[27] In 2006 the Department of Health published 'Guidelines for Good Practice in the Conduct of Clinical Trials'[28] for investigators, ethics review committees and pharmaceutical manufacturers. The Guidelines give directions regarding the study rationale and motivation, the study designs, and the data management of the study used to arrive at a conclusion.[29]

3.2 Evidence-based medicine for efficacy of medical procedures

The thesis argues that the jurist should familiarise himself with the concept and content of evidence-based medicine, as the published literature explains the latest available medical information in a particular field, as well as risks and complications of treatment plans. It describes the standard of care set by the profession. Medical procedures and medical treatment plans should be designed to ensure patient safety and ensure that medical

[24]Any shortage of experienced medical professionals should be dealt with at an administrative level and should not be the problem of the individual doctor. Failure to deal with this by a higher authority should be interpreted as a breach of a legal duty which is wrongful. For it to be negligent the other elements relevant to delictual liability should be satisfied as well. See chapter 2 para 4.

[25]In an unreported case the plaintiff, a 60-year-old man, was incorrectly diagnosed as suffering from a pheochromatocytoma (growth in his adrenal gland). He underwent surgery to remove it (left adrenalectomy). During surgery the inexperienced surgeon tore the inferior mesenteric vein and, in an attempt to repair it, ligated the superior mesenteric artery. As a result almost all of the blood flow to the small and large intestines was cut off. The patient died a slow, painful death, since one is unable to live without bowels. A proper repair operation by an experienced vascular surgeon would have most probably resulted in only the partial loss of the patient's small or large bowel. Essentially, the surgeon caused the death of this patient. For an illustration of the anatomy of the inferior mesentery vein, see https://www.google.co.za/images?hl=en-ZA&q=illustration+of+inferior+mesetery+vein&gbv=2&sa=X&oi=image_result_group&ei=B6jxU9vjNrTA7AaAuIDABA&ved=0CBUQsAQ (accessed 26 March 2014).

[26]The Medicines Control Council is a statutory body that regulates the performance of clinical trials and ensures compliance with the guidelines of the Department of Health.

[27]As amended.

[28]Department of Health 'Guidelines for good practice in the conduct of clinical trials with human participants in South Africa' (2006), available at http://www.kznhealth.gov.za/research/guideline2.pdf (accessed 29 June 2014).

[29]Incorrect interpretation of the study data and analysis and false claims made based on data by companies in advertising material may lead to inaccurate conclusions by the general consumer. This may lead to harm and is not in the best interests of the public.

recommendations are valid and reliable.[30] Evidence-based medicine is defined[31] as the 'conscientious, explicit and judicious use of current best evidence in making decisions about the case of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research'. The clinician uses evidence-based medicine information to update his knowledge in a certain field and to keep up with new research and developments. Furthermore, he accumulates information that enhances his own knowledge and clinical experience, which should improve his communication with his patients. Peter Yellowlees[32] proposes that evidence-based medicine can be the third person in the consultation rooms and can assist doctors to communicate effectively with their patients. According to Mayer,[33] evidence-based medicine may be seen as an attempt to standardise the practice of medicine. The author cautions that even if the approach suggested by evidence-based medicine is the best approach to a clinical problem, the clinician should test if the individual patient will benefit from that treatment. In this regard, Swinglehurst et al[34] express their concern that when a clinician follows, for example, a template-driven diabetes check-up, 'serious non-diabetes related symptoms that the patient mentions in passing' may not be documented or taken into account. Greenhalg et al[35] suggest standardisation and compliance with real evidence-based medicine principles, because the 'ethical care'[36] of the patient should be the first concern; 'individualized evidence should be in a format that clinicians can understand';[37] decisions would be 'shared with patients through meaningful conversations';[38] and evidence-based principles would be applied at 'community level for evidence based public health'.[39]The

[30]I Simera et al 'Transparent and accurate reporting increases reliability, utility and impact of your research: Reporting guidelines and the EQUATOR Network' (2010) 8 *BMC Med* 24; L McCormack et al *Communication and Dissemination Strategies to Facilitate the Use of Health-related Evidence*, Evidence Reports/Technology Assessments 213 (US Agency for Healthcare Research and Quality (2013)).
[31]DL Sackett et al 'Evidence-based medicine: What it is and what it isn't' (1996) 312 *BMJ* (7023) 71–72, available at http://www.hsl.unc.edu/services/tutorials/ebm/what is.htm (accessed 2 March 2014)
[32]P Yellowlees 'The Internet: A third "person" in our consultation rooms' (2009), available at http://www.medscape.com/viewarticle/589642 (accessed 24 March 2014).
[33]D Mayer *Essential Evidence-Based Medicine* (2004) 15.
[34]D Swinglehurst, T Greenhalg & C Roberts 'Computer templates in chronic disease management: Ethnographic case study in general practice' (2012) 2(6) *BMJ Open* e001754.
[35]T Greenhalg, J Howick & N Maskrey 'Evidence based medicine: A movement in crisis?' (2014) 348 *BMJ* g3725. http://www.ncbi.nlm.nih.gov/pubmed/24927763.
[36]Ibid, where they explained that policymakers must resist the use of 'evidence' when vested interests are at stake; evidence should transcend conflicts of interest.
[37]Ibid, where the care of the individual patient is the top priority.
[38]Ibid. 'Real shared decisions' means finding out what matters to the individual patient, what is at stake for them and making judicious use of professional knowledge.
[39]Ibid. Only a fraction of the available evidence is presented in usable form for the non-expert.

thesis previously illustrated, with reference to the South African case of *Sibisi NO v Maitin*,[40] how the medical reality was overlooked, regardless of evidence-based medicine principles, and where research studies were undertaken with the explicit goal of reducing medical costs and with no emphasis on patient care. In the English case of *Montgomery v Lanarkshire*,[41] the trial court was initially also misdirected because the defendant testified that she did not inform the claimant of the risk of shoulder dystocia because, had the claimant been told of the risk, she would have inevitably chosen to have a caesarean section. The defendant also mentioned that if she felt that it was 'fair to allow somebody to deliver vaginally' and then complications occurred a caesarean section would be performed. The writer argues that the defendant failed to act according to her own good intentions and failed to avoid the complications in accordance with good medical practice principles.

In conflict with the nature of evidence-based medicine principles, managed health care organisations prescribe medical treatment plans to curtail medical costs.[42] Such an approach is seemingly in accordance with clinical trial studies to assess the risks.[43] In this regard, Kruger states that evidence-based medicine has its limitations. There may be a potential for bias when research is conducted where there is 'commercial value involved' for what is tested, as it might 'generate good return on investment'. She states that another potential for bias is 'publication bias', as only positive results are published, which leaves a gap in the data on outcomes that cause harm to patients. She continues that evidence-based medicine is a–

[40][2014] ZASCA 156 at 11. This case is discussed in chapter 2 para 4.1.2.
[41][2015] UKSC 11; [2013] CSIH; [2010] CSIH 104. The issue before the Supreme Court was whether an obstetrician and gynaecologist was negligent in managing the medical condition of the claimant during pregnancy and whether it caused brain damage to the child. The court accepted that where treatment involved a 'substantial risk of grave adverse consequences' a judge could conclude that a patient has the right to self determination. Lords Kerr and Reed reasoned that an adult of sound mind was entitled to decide which of the available treatments to undergo. The duty of the doctor was to ensure that the patient is aware of any material risks or reasonable alternatives. Further points emerged: first, assessing the significance of a risk was fact-sensitive and cannot be reduced to percentages. Second, in order to advise, the doctor must engage in dialogue with her patient. Third, the therapeutic exception is limited, and should not be abused. This case is discussed in chapter 3 para 9.5.
[42]CE Pienaar *An analysis of evidence-based medicine in context of medical negligence litigation* (unpublished LLM dissertation, University of Pretoria 2011) 170, available at http://upetd.up.ac.za/thesis/available/etd-09212011-130356/unrestricted/dissertation.pdf (accessed 3 February 2012). Pienaar describes research done for cost-effective purposes and refers to DJ Rouse et al 'The effectiveness and costs of elective caesarean delivery of fetal macrosomia diagnosed by ultrasound' (1996) 276 *JAMA* 1480–1486.
[43]L Rychetwik et al 'A glossary for evidence based public health' (2004) 58(7) *Journal of Epidemiology and Community Health* 538–545.

> shared value in the sense that we all want to be treated with the best proven intervention and therefore we do expect health care professionals to practice their profession by combining their individual skill with evidence-based medicine.[44]

The gold standard for evidence-based clinical information is the double-blind randomised controlled trial, according to Slowther *et al*.[45] The authors confirm that the value of such trials is that they limit the use of inefficient treatment and promote effective treatment. Pienaar[46] summarises the essentials of evidence-based medicine and the value that it might have for lawyers. She describes the different grading of clinical trials with different reliability levels, viz randomised controlled studies, controlled studies, cohort studies, case control studies, cross-sectional studies, review studies, systematic review studies and meta-analysis studies. She proposes that evidence-based medicine consists of research, such as clinical trials that are reported and published, but it also includes groups of specialists that do systematic reviews on clinical trials and provide a collective opinion. A third strand of evidence-based medicine consists of the meta-analyses of clinical data that have been published. This is an expansion of the database and a very effective way of re-analysing available material. It is therefore a scientific overview of the clinical data of the clinical trials. The process of systematically appraising and classifying the research material is done in an attempt to assist the clinician with a summarised version of available evidence. The Cochrane Centres,[47] founded by the epidemiologist Archie Cochrane, are a group with offices worldwide who study and grade scientific research studies. They acknowledge the difference between a systematic review study and a meta-analysis, as these studies do not have the same grading. The systematic review study is a collective opinion based on a subjective interpretation of scientific material by a panel of experts, whereas the meta-analysis consists of conclusions made from combining and re-analysing existing scientific data, ie extending the database. Guidelines[48] published by an organisation[49] are usually a special case of a systematic review, but may be

[44]M Kruger 'The ethical approach to evidence-based medicine' (2010) 23(2) *Current Allergy and Immunology* 93; also see Greenhalg, Howick & Maskrey (n 36).
[45]A Slowther, S Ford & T Schofield 'Ethics of evidence-based medicine in the primary care setting' (2004) 30 *J. Med. Ethics* 151–155.
[46] Pienaar (n 42) 78–81.
[47]AL Cochrane *Effectiveness and Efficiency: Random Reflections on Health Services* (1972). Also see http://www.cochrane.org/about-us/evidence-based-health-care (accessed 2 April 2014); A Levin 'The Cochrane Collaboration' (2001) 135 *Ann Intern Med* 309–312.
[48]JS Burgers *et al*, for the AGREE Collaboration 'Towards evidence-based clinical practice: An international survey of 18 clinical guideline programs' (2003) 15 *Internal Journal Quality Health Care* 31–45.
[49]See the HPCSA website, http://www.hpcsa.co.za/conduct_rules.php (accessed 12 February 2014), where they provide guidelines to the profession.

biased towards a particular treatment modality, and their recommendations should therefore be approached with circumspection. Modern medical guidelines should be within the paradigm of evidence-based medicine and based on an examination of current evidence.

Conclusions in the medical research literature report on the risks and complications for that particular group of patients chosen for the study, in accordance with the study design and rationale. The study material reveals a level of complication or the complication rate as well as statistical evidence regarding the learning curve.[50] The learning curve is calculated as the risk of injury relevant to that study design. For example, suppose evidence-based medicine literature reports that the risk of surgical injury in a particular surgical intervention is between 0,04 and 4 per cent. This difference in complication rate may indicate, among other possibilities, that a novice medical professional still in the beginning stages of his learning curve will have a higher risk of causing injury to the patient (ie a 4 per cent chance of causing injury), whereas a more experienced medical professional has a 0,04 per cent chance of causing injury to the patient. The clinician should discuss the risks, complications and proposed treatment plan with the patient. Evidence-based medicine dictates the collective medical standard of care and gives a good overview regarding a medical disease, disorder or injury. Even if some of the medical professionals have their doubts about the true value of evidence-based medicine in general, the law certainly needs a collective medical standard. The court will use such a standard as the standard expected from the hypothetical reasonable medical professional and will measure whether the conduct of the defendant-doctor was adequate and according to this standard at the time of the incident. It follows that a medical professional, when offering an explanation in rebuttal of the *res ipsa loquitur* maxim should be tested and asked for reasons for not following such a 'collective standard'.

4 Understanding certain concepts of the medical process

Certain complex concepts in medicine have an impact on the legal process, which is effectively unrecognised when using the *res ipsa loquitur* maxim. Frequently, the medical

[50]Chapter 3 para 6.2; also para 4.2 below. Legal argument irresistibly leans towards comparing it with the onus of proof and the balance of probability in determining causation, where a risk of 4 per cent seems minor. The risk of between 0,04 and 4 per cent, referred to in the clinical trial is based on a review of several similar procedures and outcomes based on the experience of the medical professionals. These figures indicate that in the hands of an experienced surgeon the risk is small and in the hands of an inexperienced surgeon the risk is substantially higher (9900 per cent increase). If this information, together with the experience of the surgeon and his place on the learning curve, is presented to court, inherent risks in operations will be interpreted in a different light.

process is a chain of events leading to the injury and such a sequel of events cannot be described as a thing ('*res*') unless the *res* is the presumption of lack of care based on the fact of the injury . This concept was not accepted in South Africa[51] but accepted in England[52] if an unexpected injury occurs in a situation under the control of the defendant. In South Africa appeals were made for the re-introduction of the maxim and for its application in medical negligence cases. Support for the request was based on the English court's use of the maxim. It is argued that the maxim will rarely find application in South Africa in intricate medical negligence matters, as it satisfies only part of the element of wrongfulness,[53] namely that of unjustified harm to the patient and not those of negligence (*culpa*) ie factual causation and legal causation.[54] In South Africa, when from the facts the conduct of the defendant cannot be determined without further evidence then the maxim cannot be applied. This was evident in *Van Wyk v Lewis*[55] when the court was reluctant to find the defendant negligent based on the fact of that a swab had been left behind.

The following concepts, inherent in the science of medicine, are extracted from previous chapters to explain some of the medical facts relevant to factual causation. First, a patient has the right to be fully informed regarding the risks and complications of a medical procedure before consenting to it.[56] Informed consent is a prerequisite and makes an otherwise wrongful act lawful. It is justification for the harm done by the medical professional in performing a surgical operation. Any material risk and complication should be communicated to the patient and should form part of the consent obtained from the patient.

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[51]*Van Wyk* (n 1), where the court said that the fact of the injury is not enough evidence and 'it does not mean that the plaintiff can stop when he has brought some evidence from which negligence should be inferred'. Also see *Goliath* (n 4), where the court avoided discussing the maxim and decided the case on the merits. See chapter 2 para 8.

[52]*Ratcliffe v Plymouth & Torbay Health Authority* (1998) PIQR 170 Lloyds Med LR 162, where the purest form of the maxim was discussed as an incident in the ordinary human experience and where in a simple situation the thing may speak for itself, but in a case with complicated medical facts the maxim may apply but by the time the plaintiff gets to trial he should be able to make specific allegations based on medical expert opinion. See chapter 3 para 7.

[53]Chapter 2 para 4.1.

[54]Chapter 2 para 8.

[55]*Van Wyk* (n 1).

[56]Patient autonomy has been endorsed as a fundamental right and medical paternalism rejected. See FFW van Oosten *The doctrine of informed consent in medical law* (unpublished LLD dissertation, Unisa 1989) 12–13, 414. It was confirmed by the decision of Ackermann J in *Castell v De Greeff* 1994 (4) SA 408 (C) p 426:
It is in accord with the fundamental right of individual autonomy and self-determination to which South African law is moving. This formulation also sets its face against paternalism, from many other species whereof South Africa is now turning away. It is in accord with developments in common law countries like Canada, the United States of America and Australia, as well as judicial views on the continent of Europe.
The court referred to the High Court of Australia decision of *Rogers v Whitaker* (1992) 109 ALJR 625; [1993] 4 Med LR 79, where it was accepted that, although accepted medical practice may set the standard, it is for the court to determine whether the defendant's conduct conforms to the standard of reasonable care.

Therefore, informed consent is part of the legal duty owed to a patient and has a bearing on the element of wrongfulness.[57] Second, a missed opportunity or loss of chance relates to the effect of a breach of duty on an individual with compromised health who has been deprived of a better chance to live longer or a better chance to enjoy better health. It has a bearing on the determination of factual causation, legal causation and damages. Lastly, as seen from previous examples, the interpretation of statistical information in the medical literature is directly related to the medical research study for which it was designed and should not be misconstrued as having any bearing on causation in law. These concepts will be discussed below to place them in the context of medical negligence litigation.

4.1 Risks and complications in medicine

The medical professional is aware of the risks and complications of a planned procedure. It should be discussed with the patient as the patient has the right to bodily integrity and self-determination. A risk is defined by Kausek[58] as a combination of the likelihood of an occurrence of a 'hazardous event or exposure' and the 'severity of the injury or ill health' that can be caused by the event. The risk of any medical intervention is the likelihood that a known complication can occur. Each medical procedure has its own known risks. Each medication has risks, as displayed in the package insert. Each prescribed medical treatment plan has its own known risks, usually documented in medical educational books and medical literature based on scientific studies. The general definition of a complication[59] is that it is an unfavourable evolution of a disease, a health condition or therapy. The following errors may result in injury to the patient:

- wrong diagnosis;
- failure to attend to the more serious differential diagnosis first;
- insufficient information conveyed to the patient;
- failure to warn the patient about risks;

[57]Chapter 2 para 4.
[58]J Kausek *OHSAS 18001: Designing and Implementing an Effective Health and Safety Management System* Government Institutes (2007) at http://synugecoru.exteen.com/20140806/ohsas-18001-designing-and-implementing-an-effective-health (accessed 12 May 2014).
[59]According to the Merriam-Webster dictionary, it is a secondary disease or condition that develops in the course of a primary disease or condition and arises either as a result of it or from independent causes. See 'Complication (medicine)' at http://www.medicinenet.com/script/main/art.asp?articlekey=25405 (accessed 6 April 2014).

- failure to communicate with other health professionals about the patient when such communication was required;
- errors during surgical intervention, eg perforation of an organ; and
- failure to monitor the condition of the patient under anaesthesia or in the recovery room.

An error either exacerbates the medical condition of the patient or creates new health problems due to the medical complications that occurred. A complication may be iatrogenic, meaning 'brought forth by the physician', or independent of the initial treatment, for instance, a pre-existing condition. A risk that was foreseen that became a reality is the occurrence of a known complication in the medical process.[60] For a practical illustration of risks and complications, laparoscopic surgery is used as an example. Laparoscopic surgery is also known as 'button-hole surgery', whereby surgeons operate through a small incision in the body using specially designed instruments. Injury to certain body parts when entering the abdominal cavity with the instrument during the performance of a laparoscopic surgical process is a risk of the operation; an injury that occurs is described as a complication of laparoscopic surgery. In a laparoscopic gall bladder removal operation (laparoscopic cholecystectomy) a complication of the operation could include any injury to the biliary tract (common bile duct or common hepatic duct or cystic duct injuries)[61] or injury to the small or large intestines or any other organs.

Understandably, an explanation by a defendant 'that it is a known complication' of that particular surgical procedure[62] offered in his defence may not be sufficient to avoid liability.[63] The patient should be informed not only about the risk of the operation but also about any serious consequence of such an injury. Furthermore, the risks of an operation should be narrowed down to that particular patient. For example, if a patient has a history of previous surgery to the same area as the planned surgery, such a patient has an increased risk

[60]Accidents can occur without negligence. Also see the English cases *Considine v Camp Hill Hospital* (1982) 133 DLR (3d) 11, Nova Scotia SC where the medical information stated that the risk of incontinence is identified and reported to occur in between 1 and 4 per cent of cases. Also see M Jones *Medical Negligence* (2008) 317 fn 390. The test for lack of care in England and negligence in South Africa is for the surgeon to show the steps that he took to prevent the plaintiff from becoming one of the 1 to 4 per cent of cases, as statistical evidence is silent on whether the complications ensue without reasonably required care.
[61]J C Russell *et al* 'Bile duct injuries' (1996) 131 *Archives of Surgery* 382–388.
[62]An explanation in rebuttal of the *res ipsa loquitur* maxim used in England; see chapter 3 para 6.1.
[63]See chapter 2 para 4.2, where it is explained that a defendant should have foreseen such a known risk and should have taken precautions for it not to occur in order to escape liability.

of complications like bowel obstruction due to adhesion formation.[64] The surgeon has to obtain a full medical history from the patient to be in a position to anticipate complications. The patient relies on the professional knowledge of the medical professional to act in the patient's best interest. The details discussed with the patient about the known risks and complications of a particular operation will support the defendant in rebutting allegations of negligence.[65] The court will investigate whether the defendant foresaw the risk and whether he guarded against that risk for that particular operation.[66] For example, if the incidence of a laparoscopic injury is 2 per cent (ie the risk of such an injury occurring is 2 out of 100 operations), the defendant should disclose the steps he took to prevent the plaintiff being one of the 2 per cent. The assessment of the defendant's actions will determine whether the defendant exercised sufficient care.[67] If no steps were taken, or the steps taken to avoid any risks or complications do not appear in the medical professional's operation notes, an inference of insufficient care could be drawn and the defendant could be found liable. A thorough analysis of a laparoscopic cholecystectomy operation is addressed at a later stage.[68]As discussed previously, in contrast with South African law, the English system allows for a claimant to advance to court on allegations based on a breach of the duty of disclosure,[69] where the court evaluates whether the adequate information would have made a difference to the patient's subjective decision and the outcome. In South African, lack of informed consent can be argued by a plaintiff to show a defendant breached his legal duty in terms of the element of wrongfulness, but does not assist with the determination of the rest of the elements like causation and negligence (*culpa*). A plaintiff should include allegations

[64]PS Mueller 'Complications of adhesion formation after abdominal and pelvic surgery' (2013).Adhesions were implicated in 56 per cent of postoperative small bowel obstructions. Adhesion formation after abdominal and pelvic surgery can cause small bowel obstruction, female infertility, difficulties at reoperation, and chronic abdominal pain. To estimate the disease burden of these complications, investigators in the Netherlands conducted a systematic review and meta-analysis of 196 studies that involved 151 000 patients. Overall incidence of postoperative small bowel obstruction from *any* cause at any time after surgery was 9 per cent. In studies in which causes of postoperative small bowel obstruction were confirmed, adhesions were the most common cause (56 per cent). Incidence of adhesive small bowel obstruction varied with previous surgery: paediatric surgery, 4,2 per cent; lower gastrointestinal (GI) tract surgery, 3,2 per cent; urological surgery, 1,5 per cent; upper GI tract surgery, 1,2 per cent; and abdominal wall surgery, 0,5 per cent. Incidence of adhesions was lower after laparoscopic surgery (1,4 per cent) than after open surgery (3,8 per cent). In-hospital mortality was 2,5 per cent. Incidence of inadvertent bowel injury during repeat abdominal surgery was 3,3 per cent (5,8 per cent in studies in which lysis of adhesions could be confirmed). Fertility was lower in women who had undergone colorectal surgery for inflammatory bowel disease than in women who had not had such surgery (odds ratio, 0.15). In patients with chronic postoperative pain, adhesions were identified as the most likely cause (57 per cent). See http://www.jwatch.org/ na32500/2013/11/27/complications-adhesion-formation-after-abdominal-and (accessed 12 January 2014).
[65]Chapter 2 para 4.
[66]The element of negligence as part of delictual liability is discussed in chapter 2 para 4.2.
[67]Chapter 2 paras 4.2 and 7.
[68]See para 6 below.
[69]Chapter 3 para 9.5.

based on the management of the risks and complications and whether the defendant-doctor guarded against it in terms of the delictual principles.[70]

4.2 Learning curve

The term 'learning curve' usually describes the increase of proficiency following a number of trials and is also called the 'experience curve', the effect of which for different industries ranges from 10 per cent to 25 per cent, according to Hax.[71] Magrina[72] writes that risks and complications of a specific procedure in medicine and the incidence of injury during a specific procedure are directly related to the position on the learning curve attained by the surgeon. It can be said that in the medical profession, a clinician inexperienced in a specific procedure is placed in the initial phase of the learning curve.[73] It follows that difficult operations carry a high risk, or a high complication rate, depending on the position that a surgeon occupies on his own learning curve. To illustrate, during 2014, in the United States, 750 000 laparoscopic surgery operations were performed.[74] According to Afdhal et al,[75] the study yielded an 'overall serious complication rate that remains higher than that seen in open cholecystectomy, despite increasing experience with the procedure'.[76] The authors suggest, as a possible reason, that the complication rate of open cholecystectomy has increased because of declining experience in open surgery, as 'this approach is now reserved for the most complicated and challenging cases'.[77]

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[70]Chapter 2 para 7 and particularly *Sibisi NO v Maitin* (n 40), where the Court of Appeal avoided discussing informed consent and as such wrongfulness, because the court stated that once it has held that there was no negligence (*culpa*), there is no need to address further concepts. The court dismissed the plaintiff's case.

[71]AC Hax & NS Majluf 'Competitive cost dynamics: The experience curve' (1982) 12 (5) *Interfaces* 50–61. If a task is performed a number of times, then less time is required in the follow-up iterations. See also TP Wright 'Factors affecting the cost of airplanes' (1936) 3(4) *Journal of Aeronautical Sciences* 122–128, where it was determined that with the production of aircraft the labour time decreased by 10 to 15 per cent as workers became more skilled.

[72]JF Magrina 'Complications of laparoscopic surgery' (2002) 45 *Clinical Obstetrics and Gynaecology* 469–480. The learning curve is described using terms like mortality (the incidence of death) or morbidity (any damage short of death) or the incidence of illness in a population.

[73]AN Hopper, MH Jamison & WG Lewis 'Learning curves in surgical practice' (2007) 83(986) *Postgrad Med J* 777–779.

[74]Ibid.

[75]NH Afdhal & CM Vollmer 'Complications of laparoscopic cholecystectomy' Literature review (2014), available at http://www.uptodate.com/conyents/complications-of-laparoscopic-cholecystectomy (accessed 29 May 2015).

[76]Cf CM Vollmer & MP Callery 'Biliary injury following laparoscopic cholecystectomy: Why still a problem?' (2007) 133 *Gastroenterology* 1039 and MH Khanet al 'Frequency of biliary complications after laparoscopic cholecystectomy detected by ERCP: Experience of a large referral centre' (2007) 65 *Gastrointestinal Endoscopy* 247.

[77]The statistics regarding the learning curve should distinguish between uncomplicated open cases and uncomplicated laparoscopy cases, as the results may support a false perception.

The learning curve becomes relevant in determining the skill and competence of a doctor (surgeon)[78] and forms part of the required standard of care expected from the medical profession.[79] It would be wise for the patient to request particulars from the surgeon regarding his skill and experience[80] before consenting to surgery. This should form part of the required informed consent obtained from the patient, especially in private health care institutions where the doctor does not work under supervision. Furthermore, with a complicated operation, it is appropriate for a patient to consult with more than one specialist before the operation. Such a complex situation is discussed below with regard to laparoscopic operations.[81]

4.3 Loss of chance

The phrase 'loss of chance'[82] is not recognised in South African law, although it is well known in principle. If an attorney fails to bring a medical negligence claim against a

[78]It is relevant to the element of wrongfulness, as the medical professional gave himself out to have certain skills and experiences.

[79]*The Lancet* (1998) 351 (9117) 1669 4 June 1998, T Treasure 'Lessons from the Bristol case' (1998) 316 *BMJ* 1685. In this article Prof Treasure, Head of Cardio Thoracic Surgery at St George's Hospital London, suggests that the individual surgeon should keep records of his performance for auditing. In the Bristol case in England the General Medical Council investigated a case of professional misconduct against three clinicians. The Council found that two cardiac surgeons had continuously poor surgical outcomes in the Paediatric Department of the hospital. The investigation also revealed the unwillingness of the clinical head of the department to use the power of his managerial position to intervene in clinical activities. The Royal College of Surgeons and the Department of Health were aware of the poor success rate in paediatric cardiac surgery at Bristol, yet failed to act to force a change in practice. S Gallivan *Report to the Bristol Royal Infirmary Inquiry: Learning Curves in Relation to Surgery* A Discussion Paper – No. 572 (2000). Prof Gallivan is from the Clinical Operational Research Unit of the Department of Mathematics. Gallivan, a mathematician, was asked to do a report to the Bristol Royal Infirmary Inquiry about the learning curves in relation to surgery. He states that surgery 'requires a high degree of medical knowledge and also a high degree of manual dexterity'. He also states that the 'learning curve' for an individual surgeon would indicate a move towards more skill or 'proficiency' as he gains experience. Clinical data from many surgeons might illustrate a learning curve or measure efficiency but an individual surgeon would deviate considerably from this data. It is clear that junior surgeons would be slower and possibly less effective than their more experienced and senior colleagues. In addition there are many ethical problems associated with 'surgical learning', but ultimately 'less experienced surgeons have to operate in order to learn their craft'. With regard to risk compensation he offers that the junior will be supervised until such time that he has gained sufficient experience, but he warns against risk migration. This means that, because the senior surgeon is now dealing with the more complicated cases, he will experience an increase in mortality in his records and because cases are transferred to the junior surgeon that tend to be more difficult for him, the mortality for the junior surgeon can also be expected to increase unsupervised.

[80]The 'reasonably experienced doctor' will have qualifications and experience similar to his peers in the same discipline. See para 3 above.

[81]See paras 6 and 7 below.

[82]In England a lost chance is actionable and in such a claim the client in the action against the solicitor does not have to prove that he would have won the other case, merely that he has lost some 'right of value' in an action of reality and substance. See *Kitchen v Royal Air Force Association* [1985] 1 WLR 563, where damages were awarded on the basis that the claimant had a one-third chance of success. Damages are then discounted to reflect his chances of success in the original action. In South Africa a plaintiff has to prove his original claim against the doctor in order to be successful against the attorney.

defendant-doctor within the time prescribed by statute,[83] the attorney will attract liability. The plaintiff can now claim compensation from the attorney. The case will be based on negligence of the attorney, as he failed to honour his professional legal duty owed to his client, whereby the client lost the chance to be compensated for his injury. The amount of compensation, however, will be similar to that which the plaintiff would have claimed from the defendant-doctor. The causation of the latter action needs to be established in court before the case against the attorney can continue. The design of the loss of chance legal argument is based on circumstances in medical negligence cases where the plaintiff is unable to use the 'but for' argument to show causation, because he was likely to die from the medical condition even before the negligence and the negligence increased the risk of death or accelerated the risk.

The English case *Gregg v Scott*[84] is a good example of where a missed diagnosis can give rise to a claim based on the 'loss of chance' of a better outcome. In South Africa such a claim would be based on negligence, ie a doctor neglecting his legal duty to the patient, and thus increasing the risk of harm to the patient. In *Gregg v Scott*, the claimant developed non-Hodgkin's lymphoma, which presented as a lump under his left arm. The lump was incorrectly diagnosed as a benign collection of fatty tissue and the medical professional failed to refer the claimant to another specialist. Therefore, treatment was delayed for nine months. The delay in treatment significantly reduced the claimant's chances of survival from 42 per cent to 25 per cent. The trial judge dismissed the claim on the basis that for a person with this condition the chances of a cure were in any event less than 50 per cent, so it was more probable than not that the claimant would have been in his present position even if treatment had started promptly. The case went to the Court of Appeal and then to the House of Lords. The majority in the House of Lords confirmed the decision and dismissed the claimant's claim.[85] In the House of Lords the claimant advanced two arguments: first, the 'quantification' argument (the delay in diagnosis had caused physical damage, as the treatment was now more severe and the claimant was therefore entitled to be compensated based on his reduced life expectancy as a matter of assessing the quantum of damages); and second, the 'loss of chance' argument (the reduction in the claimant's chances of survival

[83]Prescription Act 68 of 1969.

[84]*Gregg v Scott* [2005] UKHL 2. For a detailed discussion see Jones (n 60) 503. The Court of Appeal dismissed the claim and the majority decision in the House of Lords agreed with that decision.

[85]The approach basically implies that all medical conditions with a survival rate of less than 50 per cent are hopeless, which is scientifically not correct. In the minority decision, Lord Nicholls commented that, if a patient's prospects of recovery were to be treated as non-existent whenever they fell short of 50 per cent, the law would 'deserve to be likened to the proverbial asses'.

from 42 per cent to 25 per cent was something of value and the claimant was entitled to be compensated for that loss. Despite significant disparity in the respective opinions of the House of Lords, the majority dismissed the claimant's action.

Turning to the medical information[86] available, one sees that survival rates[87] are based on a treatment study of people who had the disease for a given period. But such a study cannot predict what will happen in the case of an individual.[88] Many other factors have an influence on the outcome (prognosis), namely, the type of lymphoma, the stage of the disease at the time of the diagnosis, and the treatment received. The five-year survival rate for people with non-Hodgkin's lymphoma is 69 per cent and the 10-year survival rate is 58 per cent. An international prognostic index shows that the outlook or prognosis depends on the patient's age, the stage of the lymphoma, the spread of the lymphoma outside the lymph system, how well the patient can complete normal daily activities, and the blood serum level of lactate dehydrogenase (LDH), which increases with the amount of lymphoma in the blood. A distinction is made between different types of the disease as a particular type of lymphoma has different stages. For purposes of explanation, the disease follicular lymphoma is used. The Follicular Lymphoma International Prognostic Index (FLIPI)[89] revealed that early detection in this group has a survival rate of 91 per cent (first 5 years) and 71 per cent (10 years) and late detection in this group has a survival rate of 53 per cent (first 5 years) and 36 per cent (10 years). Treatment options also depend on the type of lymphoma and the stage of

[86]See http://www.cancer.org/cancer/non-hodgkinlymphoma/detailedguide/non-hodgkin-lymphoma-factors-prognosis (accessed 15 June 2014).

[87]A Carroll *Survival rates are not the same as mortality rates* (2010), available at http://theincidentaleconomist.com/wordpress/survival-rates-are-not-the-same-as-mortality-rates/ (accessed 15 June 2014). Carroll explains survival rates with the following hypothesis: if there was a new cancer of the thumb killing people, from the time the first cancer cell appears, one has nine years to live with chemotherapy. From the time one can detect a lump, one has four years to live with chemotherapy. In the event that there is no way to detect the disease until one feels a lump, the five-year survival rate for this cancer is 0, because within five years of detection, everyone would die, even on therapy. If a new scanner is now invented that can detect thumb cancer when only one cell is there, ie early detection, everyone will still be dying four years after they feel the lump. But since the new scanner is making the diagnosis five years earlier, the five-year survival rate is now approaching 100 per cent. Everyone is now living for nine years with the disease. Meanwhile, in England, they believe the scanner does not extend life and decided not to pay for it. Their five-year survival rate is still 0 per cent. The initial mortality rate is unchanged as the same number of people is dying every year.

[88]The statistical numbers for a survival rate are part of a survival analysis. They are the number of people in a treatment group or study group alive for a given period (five years). These figures are important to determine prognosis and treatment value. It is not specific for individuals, as treatment options might be different since the study or the general health of the individual might be different to the study group. The medical expert will take into account the net survival rate which is disease specific and which filters out mortality from other causes. The disease-free survival rate, metastasis-free survival and progression-free survival will also form part of the analysis of the medical expert in respect of the individual patient.

[89]See http://www.cancer.org/cancer/non-hodgkinlymphoma/detailedguide/non-hodgkin-lymphoma-factors-prognosis (accessed 15 June 2014).

the disease. Follicular lymphoma is usually treated with chemotherapy, radiation, immunotherapy and stem cell transplants.

Although there is an inherent problem in deciding a case[90] on statistical information, it is acceptable to use it in context. The statistical information reveals an early and late detection group: to summarise, in the early detection group there is a 91 per cent survival rate and in the late detection group there is a 53 per cent survival rate.[91] It means that in a certain segment of the population tested for follicular lymphoma, 91 per cent survived the first five years when the disease was detected in the early stages, and only 53 per cent of the group survived the first five years in the advanced stages of the disease.

In applying the statistical information to *Gregg v Scott*[92] several arguments are relevant. First, one has to determine if the study is relevant to the specific individual with regard to the type of cancer, the age of the individual and the stage of cancer. This determination will be made by a medical expert who will ascertain if the individual fits the study design. Without taking any detailed medical analysis into consideration, the court found that the claimant's chances of survival were reduced from 42 per cent to 25 per cent, ie a reduction in the prospects of a successful outcome. Second, the failure to arrange for follow-up tests of the lump under the claimant's arm is a *complete*[93] failure (the defendant entirely missed the opportunity). The defendant should have foreseen the increased risk if the test was not done and should have prevented this risk. He was 100 per cent negligent and thus failed in his duty to the plaintiff. The defendant failed to prevent further harm to his patient as he failed to ensure that the claimant remained in the survival rate category of 42 per cent. By failing to do so he directly contributed to the claimant's reduced life expectancy (factual causation) and accelerated pain and suffering (or accelerated death). Because of the onset of more radical treatment, the pain and suffering was worsened by the anguish of knowing that the disease could have been detected earlier. Third, the statistical evidence serves only to

[90]*Fairhurst v St Helens and Knowsley Health Authority* [1994] 5 Med LR 422, where the judge, when faced with statistical figures, states that the medical expert seeks scientific certainty as opposed to the notion of standard of 'proof' (balance of probability), which depends on the event being 'more likely than not'. It contrasts with the rigorous standards of proof required in scientific inquiry.

[91]If one person survived year 5 and died in year 6 the percentages could have been 100 per cent survival rate in the first five years and 44 per cent in the last five years, depending on the number of people used in the treatment study. The design of the study is not applicable to the individual patient; however, a medical expert can use the research material to postulate the survival chances of an individual.

[92]*Gregg v Scott* [2005] UKHL 2. For a detailed discussion see Jones (n 60) 503.

[93]Emphasis in the argument of the study ie also total or 100 per cent failure.

'quantify the damages'[94] of the plaintiff. It has a substantial bearing on general damages like pain and suffering and loss of amenities of life. Further, it has a bearing on the future medical costs: the medical expert for the claimant should outline the most probable treatment in the given circumstances needed for the individual to remain part of the survival statistics. The latter will entail the optimum medical treatment required for this specific individual to give him optimum chance to remain a survivor. The statistical period relevant to the individual's health will affect the period for which future medical treatment is claimed and may be adjusted by the medical expert based on the individual person's health status (life expectancy). Furthermore, the loss of income and income capacity will also depend on the statistical period used and may possibly be adjusted by medical experts. Lastly, when medical negligence reduces a less than probable chance of survival but there still remains a residual chance of survival after the negligence, the quantifying claim should not be the product of the reduction in the chance of survival and the full value of the loss, but only the residual value of the loss.[95] For example, if the full value of the loss is R100 000 and the chance of survival before the negligence was 42 per cent and after the negligence it was 25 per cent, the damages comprise 17 per cent (42per cent less 25 per cent) divided by the residual value of the loss, 75 per cent (100 per cent less 25 per cent), which equals R22 666.66. The defendant was not the cause of the claimant's medical condition and therefore can only be liable for the reduction caused by his negligence.

5 Medical accidents

The standard of care is usually contested in medical negligence cases, as the plaintiff alleges that the defendant breached his legal duty[96] by not adhering to the expected standard of care. The test for negligence[97] is whether a reasonable medical professional in similar circumstances would have foreseen the risk and guarded against it. In addition, questions of factual causation are compounded further in surgical procedures, where the patient consents to a physical injury to alleviate a medical disease or condition. Medical expert evidence has

[94]RJ Rhee 'Loss of chance, probabilistic cause, and damage calculations: The error in *Matsuyama v Birnbaum* and the majority rule of damages in many jurisdictions more generally' (2013), where a detailed suggestion is made of the calculations of residual chance of survival. Available at http://scholarship.law.ufl.edu/cgi/viewcontent.cgi? article=1488&context=facultypub (accessed 2 February 2014).
[95]Ibid. He suggests the following calculation rule J= award of damages; D= full damages; P= pre-negligence chance of survival; R= post-negligence chance of survival. J=D x (P-R)/(1-R).
[96]Chapter 2 para 4.1.
[97]Chapter 2 para 4.2.

to provide an explanation of the anatomy of the patient, the purpose and expectations of the surgery, the risks and complications of the surgery, and any medical alternative options for the patient to establish the medical realities from which factual causation is derived. In surgical alternatives, a distinction is made between open surgical techniques and laparoscopic surgical techniques, as the risks and complications of these procedures are different. Medical accidents, such as surgical errors, are often described as iatrogenic injuries[98] (caused by medical professionals). Surgical procedures are the cause of many medical injuries and therefore the *res ipsa loquitur* maxim seems an easy option to get past negligence and causation. As discussed before, according to the non-medical person, an undesired and unfortunate outcome to a surgical intervention may *ipso facto* speak of negligence. It was evident from previous chapters that South African law acknowledges a surgical accident as a breach of a legal duty and part of the element of wrongfulness in delict, but the incident *per se* is not sufficient to establish negligent conduct. All the elements[99] of delictual liability should be satisfied. On the other hand, the English court[100] acknowledges that an adverse event unexpected in nature even such as a surgical accident under the control of the defendant-doctor allows for an inference of lack of care (*prima facie* evidence) and the inference of negligence will become conclusive evidence of negligence if the claim is not rebutted by the defendant.[101]

Surgery is a medical field that has many subdivisions. Abdominal surgery, as part of 'general surgery',[102] is the focus here because of the controversial legal arguments in *Van Wyk v Lewis*.[103] As seen before, Van den Heever and Carstens[104] believe that the medical facts in *Van Wyk v Lewis*[105] were incorrectly interpreted.[106] They indicate that the act of leaving a swab in the abdominal cavity of the plaintiff should be interpreted as an 'absolute' and not a 'relative', as required by the *res ipsa loquitur* maxim. It is not disputed that swabs or instruments are not ordinarily left in the patient's body and may indicate a lack of care. It appears that the authors suggest that the English system be followed in respect of the maxim and that the mere fact of the retained swab under the control of the defendant-surgeon should

[98]Definition available at http://medical-dictionary.thefreedictionary.com/Iatrogenic (accessed 11 March 2014).
[99]Chapter 2 para 4.
[100]Chapter 3 para 2.
[101]Chapter 3 para 2.
[102]A surgeon now specializes in one of several different specialties, for instance, cardiothoracic surgery or neurosurgery.
[103]*Van Wyk* (n 1).
[104]Van den Heever & Carstens (n 2) 33.
[105]*Van Wyk* (n 1).
[106]Chapter 2 para 8.

be enough to infer of lack of care and negligence on the part of the surgeon. It contrasts with the law of delict in South Africa.[107] If no information is available regarding the conduct of the surgeon during surgery (element of negligence) or circumstances that link the surgeon's actions with the unfortunate outcome (causation) or the patient's medical condition during surgery, the maxim is not applicable. In this regard, a retained swab case is inconclusive evidence of negligent conduct, which does not allow allegations of negligence without additional information. It is argued that, in South Africa medical negligence is only established when a court is in a position to weigh the defendant's action against the expected standard of care described by the medical expert. Therefore, it almost always has the effect that the fact of the injury is inconclusive evidence of negligence (*culpa* or liability), because the circumstances relevant to the harmful occurrence necessitate an analysis to establish factual causation, culpable conduct and, finally, liability.

5.1 Reconstruction of *Van Wyk v Lewis*

In order to demonstrate the complexity of establishing factual causation in a seemingly simple medical negligence case, the study turns to the *locus classicus Van Wyk v Lewis*.[108] The plaintiff presented with the signs and symptoms of an inflamed appendix[109] and underwent surgery for the removal of the appendix. When the abdomen was surgically opened the surgeon discovered that the gall bladder was also affected by the overt abdominal infection. Furthermore, the surgeon perceived signs of superficial necrosis. The surgeon decided to drain the gall bladder. When the surgeon made an incision into the gall bladder[110] septic matter gushed out. The surgeon struggled to suture the gall bladder because of the friability[111] of the organ. In order to increase visibility he packed the wound with several swabs. Subsequently, the swabs were removed and the wound closed. A swab was retained in the abdomen. A few months later the plaintiff evacuated a piece of muslin (swab) from her rectum, and the plaintiff instituted action against the surgeon. The matter was heard in the Appeal Court in Bloemfontein and His Lordship Justice Wessels explicitly rejected the maxim. He stated that 'the mere fact that a swab is left in a patient is not conclusive of negligence'. His Lordship envisaged cases where it would be better to suture the patient in an

[107]The elements are required by the law of delict; see chapter 2 para 4.
[108]*Van Wyk* (n 1).
[109]Carstens & Pearmain (n 20) 776; Van den Heever & Carstens (n 2) 29.
[110]In 1924 it was not common medical practice to remove the gall bladder, but only to drain it. Today a cholecystectomy (removal of gall bladder) would have been performed.
[111]Sepsis causes the organ to become progressively necrotic; see the further discussion of the topic below.

emergency and deal with the swab-finding at a later stage. To further complicate that matter, the surgeon delegated the swab counting to the theatre sister, who was not a party to the legal action.

5.2 Medical features related to abdominal surgery in *Van Wyk v Lewis*

The medical facts of *Van Wyk v Lewis*[112] seem to be simple to the uninformed person: negligence (and thus liability) should be obvious from the fact that a swab was left behind. However, the case illustrates a different medical reality ie a complicated set of medical facts. Not only did the plaintiff suffer from a perforated appendix, but the overt infection in the abdomen affected the gall bladder as well.[113] Several factors contribute to the intricacy of this matter: an intra-abdominal infection; the treatment and the complications thereof; a gall bladder infection (cholecystitis); the operation in respect of the gall bladder itself; and the mechanism that caused the swab migration from the intra-abdominal cavity into the intestines in order to have it excreted. The medical literature, provided by Pieracci et al[114] and Menichetti et al,[115] states that the procedure to treat intra-abdominal infection depends on the anatomical site of infection, the degree of peritoneal inflammation, the patient's underlying condition, and the available resources of the treatment centre. It appears that the medical condition of the plaintiff would have been classified as complicated because 'the infectious process proceeds beyond a single organ, causing either localised or diffuse peritonitis'. The suggested treatment should include both surgical and antibiotic[116] therapy. Pieracci et al[117] state that abdominal sepsis is a complex condition that consists of many factors that can progress to conditions of 'varying severity'. It may impair the functioning of vital organs, which could lead to multiple organ failure and death. If the septic conditions remain untreated, they can lead to global tissue hypoxia, tissue damage and death. If a surgeon discovered such a condition after opening the abdomen, he would appreciate the gravity of

[112] *Van Wyk* (n 1).
[113] To ensure correctness, the medical information available in 1924 should be used in this case and antibiotics were not yet established in 1924. However, the purpose of this discussion is to obtain the medical facts pertaining to the open operation technique, disregarding the date.
[114] FM Pieracci & PS Barie 'Management of severe sepsis of abdominal origin' (2007) 96(3) *Scandinavian Journal of Surgery* 184–196.
[115] F Menichetti & G Sganga 'Definition and classification of intra-abdominal infections' (2009) 21 *Journal Chemother.* 3–4.
[116] Considering that in 1924 antibiotic medication was not yet available, the option to treat the plaintiff with antibiotics did not exist. Penicillin was discovered in 1928. See http://www.nature.com/nrd/journal/v12/n5/fig_tab/ nrd3975_T1.html (accessed 15 June 2014).
[117] Pieracci et al (n 114) 184–196.

the medical condition of the patient. In the above instance, he found a perforated appendix and sepsis in the abdomen in addition to the diagnosed cholecystitis. Such a medical condition is still currently interpreted as 'complicated'.[118] The medical condition of the plaintiff in *Van Wyk v Lewis*[119] would most probably have been classified as an emergency due to the perforated organ and overt sepsis. Once a medical situation is classified as an emergency another set of rules is established.[120] The surgeon probably took general precautions to prevent the further spread of the septic material by packing the swabs into the abdominal cavity. It is argued that, if the surgeon had pleaded that it was an emergency situation to justify his neglect in leaving the swab behind, he would have been faulted for not following up on the medical condition of the patient.[121]

In addition to the infection in the abdomen, another complication that the surgeon discovered was the presence of cholecystitis. Cholecystitis (infection of the gall bladder), according to Vollmer et al,[122] occurs when bile is trapped in the gall bladder because of the cystic duct being blocked by a gallstone. This can occur repeatedly. It leads to swelling and irritation that cause the gall bladder to become thick and hard so that it does not function as before. Without treatment to eliminate the gallstones, it is likely that gall bladder perforation may occur, which can be life-threatening. The surgeon in *Van Wyk v Lewis*[123] found overt sepsis as a result of a perforated appendix, which affected the gall bladder and signs of superficial necrosis of the gall bladder, which in turn created a higher risk of perforation. When considering the technique used for the gall bladder removal operation, the thesis looked at the literature provided by Rothlin et al[124] and Rice et al.[125] These authors state that with an acute inflamed gall bladder the spillage of bile into the abdomen has an incidence of between 10 per cent and 40 per cent, and spillage of gallstones into the abdominal cavity has an incidence of between 6 per cent and 30 per cent. Spillage of bile or gallstones into the

[118]Pieracci et al (n 114) 184–196.
[119]*Van Wyk* (n 1). See chapter 2 para 3 and 8.
[120]One of the requirements of negligence is that a risk should have been foreseeable. In an emergency the complications will be unexpected. Although the surgeon would know about complications in general, he would not have been able to foresee aspects in an emergency operation. Unexpected intra-operative findings may not have been prevented even by the prudent medical professional. However, the surgeon is expected to take general precautions to prevent further injury.
[121]The surgeon did not perform the operation in his own town but was brought from outside. His legal duty is then to refer the patient to a local doctor for follow-up treatment.
[122]CM Vollmer, SF Zakko & NH Afdhal 'Treatment of acute calculous cholecystitis' (2014), available at http://www.uptodate.com/contents/treatment-of-acute-calculous-cholecystitis (accessed 30 May 2014).
[123]*Van Wyk* (n 1). See chapter 2 para 3 and 8.
[124]MA Rothlin, O Schob & R Schlumpf 'Stones spilled during cholecystectomy: A long term liability for the patient' (1997) 7 *Surgical Laparoscopy Endoscopy Journal* 432–434.
[125]DC Rice, MA Memon & RL Jamison 'Long term consequences of intra-abdominal spillage of bile and gall stones during laparoscopic cholecystectomy' (1997) 1 *Journal Gastroenterological Surgery* 85–91.

abdomen can cause abdominal wall abscesses or other intra-abdominal abscesses. Such a spillage into the abdomen is a further complication of the operation. The surgeon appears to have contained the spillage of bile by using the swabs to prevent further bile spillage into the abdominal cavity to manage the associated sepsis.

A further medical complexity relevant to this case is directly related to factual causation. How did a swab, left either on the outside of the gall bladder cavity or that of the abdominal cavity, cross into the gastrointestinal tract to be evacuated? When considering this migration of the swab that was left behind, the formation of a fistula (duct into the gut) was investigated. Pal[126] defines an intestinal fistula as an abnormal connection between two body cavities, for instance, from the abdominal cavity to the small intestine. A fistula that closes will form an abscess with infection inside. Pal emphasises that a large number of fistulas heal without surgical intervention; the location and symptoms created by the fistula determine the next medical step. It is probable that an asymptomatic fistula was formed between the abdominal cavity and the intestines of the plaintiff. The retained swab was likely excreted from the abdomen to the intestines and out via the gastro-intestinal route. No evidence was presented regarding symptoms like pain, fever, tenderness and a general feeling of ill health. These symptoms would have been an indication of the severity of the complication. None of these symptoms and further *sequelae* was recorded and seemingly the retained swab was excreted by means of fistula formation and the plaintiff recovered completely.

For completeness of the discussion and simply to understand the medical reality, a brief overview of the prognosis of a similar plaintiff reveals that, according to Ali et al,[127] leakage of fluids such as bile into the peritoneum may lead to minimal generalised peritonitis, which in turn may lead to fibrotic adhesions. In young people the mortality rate will be less than 10 per cent, but in older people the mortality rate will be as high as 40 per cent. The adhesions might cause the obstruction of the small bowel which will lead to surgical correction, which in turn will increase adhesion formation. Although the record of *Van Wyk v Lewis* makes no mention of these serious complications, it is mentioned here in an attempt to show the standard of care at the time of the occurrence and clarify the complexity of the long term effects that such a complication may have on a similar plaintiff.

[126]N Pal 'Intestinal fistula treatment and management' (2013), available at http://emedicine.medscape.com/article/197486-treatment (accessed 14 April 2014).
[127]N Ali & BM Gali 'Causes and treatment outcome of perforation peritonitis in north eastern Nigeria' (2010) 14 *Surgical Practice* 92–96.

5.3 Legal opinion regarding *Van Wyk v Lewis*

The majority judgment in *Van Wyk v Lewis*[128] rejected the *res ipsa loquitur* maxim. Some South African authors disagreed with these findings.[129]Their approach was similar to that of the English court:[130] the fact that an object is retained in the abdomen of a patient during surgery (unexpected nature of the event) and under the control of the surgeon should create a factual inference of negligence based on the fact of the injury that calls for an explanation from the defendant. They were of the opinion that the retained swab is 'absolute'[131] evidence of negligence (*prima facie* evidence of breach of a legal duty), and that regardless of the circumstances of the operation the surgeon should have foreseen the harm of a retained swab and should have guarded against it (culpable conduct). In other words, *res ipsa loquitur*[132] 'the facts speak for themselves'. To assess this argument, the requirements of the maxim[133] should be tested against the facts in *Van Wyk v Lewis*[134] in the light of the complex medical reality discussed above. It is evident that at least two requirements of the maxim were not met. First, negligence must be inferable from the occurrence without requesting more information and, second, the occurrence must be under the surgeon's control. In accordance with the law of delict[135] in South Africa, delictual liability is proved when the elements of wrongfulness, negligence and causation are established. From the medical information available[136] it is clear that the element of wrongfulness would be established,[137] but it is not

[128]*Van Wyk* (n 1).
[129]Strauss & Strydom (n 22) 279; Van den Heever & Carstens (n 2) 28.
[130]Chapter 3 para 2. The English court allows an inference of negligence based on an adverse event under the control of the defendant in medical negligence cases and, if the *res ipsa loquitur* maxim is applied, the defendant has to defend his case by showing that proper care was exercised and by showing an alternative cause of harm negating negligence.
[131]Van den Heever & Carstens (n 2) 28. The authors listed the requirements for the maxim as: a similar occurrence does not happen without negligence; there is a high risk of negligence; the fact of negligence is concluded from the occurrence; the presence or absence of negligence must be an absolute and, if the court has to look at circumstantial evidence, the maxim can no longer apply; an inference of negligence can only be made if the cause is unknown.
[132]In *Groenewald v Conradie* 1956 (1) SA 184 (A) 187 F, Rumpff J states that '*wanneer dit nodig is enkel en alleen om na die betrokke gebeurtenis te kyk sonder die hulp van enige ander verduidelikende getuienis*'. The requirements for the maxim are (a) the thing (*res*) must be under the management or control of the defendant and, if some intervening incident becomes evident, then the maxim cannot apply; (b) the accident does not ordinarily happen without negligence – if a vehicle, for instance, veered to the wrong side of the road, then experience tells us the driver did not exercise reasonable care; and (c) there must be no evidence to explain the occurrence, ie an absence of explanation must exist.
[133]See fn 131 and 132 above and chapter 2 para 8.
[134]*Van Wyk* (n 1). See chapter 2 para 3 and 8.
[135]Chapter 2 para 4.
[136]See para 5.2 above.
[137]Chapter 2 para 4.1. When a swab is left behind in the abdomen, it is a breach of the legal duty owed by the surgeon to the patient not to harm. Therefore, it is an infringement of a patient's rights. The surgeon failed to act according to prescribed and accepted standards with skill, care and diligence, in the best interests of his patient.

possible to determine whether the surgeon was negligent[138] without hearing further evidence.[139] Furthermore, the management of the swab-count in theatre was not under the surgeon's control,[140] but was delegated to the theatre sister. This information was not available to the plaintiff when relying on the maxim. It is argued that the lack of information for determining negligence (*culpa*) is the most likely reason for the court's reluctance to accept the maxim. The argument supports the idea that the maxim was rejected on two counts: (i) *de lege lata* as all the elements of the law of delict were not satisfied in applying the maxim; and, even if the maxim could apply, (ii) *de facto*, taking into consideration the all-encompassing medical intricacies of a medical negligence case. There is not enough information available for a court to ascertain whether there was reason for leaving the swab behind at the time. Medical expert evidence should explain to the court the standard of care essential to similar circumstances and this will put a court in a position to determine whether the conduct of the defendant-surgeon was substandard.[141]

In a case of negligence, based on the same facts, the plaintiff would have had difficulty in proving liability. First, the plaintiff has to adduce that the defendant acted wrongfully by breaching his legal duty to the plaintiff, ie the surgeon left a swab in the abdomen and therefore failed to adequately treat and care for the plaintiff in accordance with expected standards. Second, the plaintiff has to prove that the defendant was negligent by not acting in accordance with the standard of a hypothetical, reasonable medical professional in the same circumstances (culpable conduct), ie foreseeing certain complications and taking reasonable steps to prevent foreseeable risks and complications. The court would also consider whether it was an emergency as in a medical emergency the legal duty of the defendant becomes less onerous because that particular medical emergency could not have been foreseen and prevented. The manner in which the defendant manages the emergency will be scrutinised, considering his ability to plan in advance. Lastly, the plaintiff has to prove

[138]Chapter 2 para 4.2. To determine whether the defendant failed to act reasonably and therefore negligently, the plaintiff has to show that the defendant failed to foresee risks and complications and failed to take steps to prevent those risks and complications.
[139]*Van Wyk* (n 1) *per* Wessels JA, where the court foresaw circumstances where the patient's medical condition is so severe that the surgeon may decide to close the abdomen until the patient's condition has improved.
[140]Although the actions of the nursing sister were also under the surgeon's control, the court found that the surgeon delegated this task to the nursing sister.
[141]Incidentally, considering that it was a complicated medical emergency and the surgeon saved the plaintiff's life, the plaintiff would have had substantial difficulty in convincing the court that the defendant's care was substandard. The inconvenience of the excretion of the swab cannot outweigh the fact that the plaintiff survived a complicated emergency operation while remaining in a fairly 'good' condition.

that the wrongful and negligent action of the defendant was the factual cause of the damage,[142] which was not too remote so as to ascribe liability to the defendant.

As an afterword, from the facts it is clear that sepsis was found when opening the abdomen. The perforated appendix was the source of the sepsis and was removed. The gall bladder was affected by the inflammation and, when it was opened, according to the standard at the time; septic contents contaminated the abdominal cavity. The septic contents were contained with swabs, one of which was misplaced. The further emergency management would have been to prevent the severe medical condition, ie peritonitis (inflammation of the abdominal cavity). It is also clear that the defendant was successful in preventing peritonitis, a very serious condition, as the patient was discharged after a period of time. Furthermore, in claiming damages, the plaintiff refused to pay for the defendant's medical services but she did not claim for future medical treatment or expenses.[143] Currently, the medical literature shows that the *sequelae* of such a medical condition, inflammation of the intestines, may result in adhesions that may lead to long-term effects like obstruction of the small bowel or colon, which can be an emergency situation in itself. There is no evidence of such an occurrence. It is argued that the plaintiff should have been unsuccessful against the defendant, and would again be unsuccessful if a similar case were to arise today in South Africa, based on insufficient evidence regarding the elements of negligence and factual causation with or without the assistance of the *res ipsa loquitur* maxim.

6 Laparoscopic procedures in general

A further problem in determining factual causation arises from different surgical techniques. The risk and complications of a laparoscopic procedure is different from those of open surgery. The thesis discusses laparoscopic procedures because of the misconception that it is a potential case for the uninformed to use the application of the *res ipsa loquitur* maxim, based on the fact of the injury (perforation) that occurred as a result of the surgical technique.

[142]With regard to factual causation and non-remoteness of damage, the plaintiff has the burden of proving that it was the swab that caused the constant pain in her abdomen, for example, and not the sepsis that resulted from the spilt contents of the gall bladder and perforated appendix (which occurred through no fault of the defendant). It would have been difficult to provide evidence to show the link between the event and the *sequelae*, ie factual and legal causation.

[143]It is uncertain whether medical information regarding the prognosis of the plaintiff would have been available in 1924.

Laparoscopic procedures[144] (also called minimal invasive surgery) can be performed on different areas of the body. In general this type of surgery is known as endoscopic surgery, but is usually named for the area, eg if performed in the chest or thoracic cavity it is called a thoracoscopy. The benefit of a laparoscopic process is that the patient experiences less pain and less bleeding, as the incision is smaller, and the patient has a shorter hospital stay. The risks[145] of entrance injuries are injury to blood vessels, intestines and other organs. Perforation of the major blood vessels can result in severe haemorrhaging and death, and the perforation of intestines can result in infection of the abdominal cavity (peritonitis) and ultimately death. An added risk for laparoscopic operations is previous surgery[146] in the same area, as this may result in dense adhesions (scar tissue) that may complicate the surgical field. The adhesions often distort the anatomy of the patient and limit visibility through the laparoscope.

6.1 Therapeutic laparoscopic procedure for endometriosis – a case study

Medical information about the relevant anatomy and underlying disease provides the background and circumstances of a particular patient in a particular scenario. Although it seems obvious that injury to organs other than the proposed aim of the laparoscopic surgery should lead to an inference of negligence, it is more complicated than that. In order to demonstrate the medical complexity from which factual causation emanates, the therapeutic laparoscopic procedure is analysed. In an unreported case, [147] a 27-year-old woman, Ms A, consulted with Dr B, a specialist gynaecologist, as she was suffering from severe pelvic pain. About three months before this consultation, Dr B confirmed, with a diagnostic laparoscopy, that Ms A was suffering from endometriosis. No histology report was available. Ms A was treated conservatively for 18 months. Ultrasound investigations did not reveal any abnormality in the kidneys or other organs. Ms A underwent a therapeutic laparoscopic

[144]NJ Soper, LL Swanstrom & WS Eubanks *Master of Endoscopic and Laparoscopic Surgery* (2004) describe a process whereby fibre-optic light devices and cameras are inserted through a 4 cm surgical hole, together with surgical instruments, gas-inflation tubes and suction tubes.
[145]See para 4.1 above on risks and complications.
[146]The Royal College of Obstetricians and Gynaecologists 'Guideline No 49 on Preventing Entry-related Gynaecological Laparoscopic Injuries'(2008), available at http://www.rcog.uk/womens-health/clinical-guidance/ standards-gynaecology (accessed 12 December 2013). In an attempt to reduce these kinds of injuries the Royal College of Obstetricians and Gynaecologists in England has published guidelines wherein they concluded that the incidence of injury is between 1/1000 and 12.5/1000, depending on the experience of the surgeon. They state that the risk of injury to vascular structures (blood vessels), urological injuries (ureter injuries) or intestinal injuries (bowel injuries) when performing any gynaecological laparoscopic procedure will increase if the patient presents with previous abdominal operations. The adhesions will distort the anatomy and limit the visibility of the operation field of the surgeon.
[147]Case was settled out of court during the first day of trial.

procedure in order to treat the endometriosis. Dr B damaged Ms A's ureter while inserting a stent to assist with urine drainage from the kidney to the bladder. Three days later Ms A was discharged with an indwelling catheter. A month later Ms A was readmitted and a ureteric re-implantation operation were performed. The stent was removed two months later. Ms A then presented with constant bladder infections and pelvic pain. She claimed compensation based on the negligence of Dr B. In rebuttal Dr B claimed that the adverse event is a known complication of laparoscopic surgery in the presence of endometriosis, and denied liability.

6.2 Medical information about endometriosis

Research[148] indicated that endometriosis[149] is a gynaecological condition where the endometrium (inner lining of the uterus) grows outside the uterine cavity. It occurs during the reproductive years in about 6 to 10 per cent of women. Symptoms depend on the site of activity and are common in women who are infertile. Endometriosis cannot be cured but is treated using pain medication, hormonal treatment and/or surgery.

The lesions[150] are hormone-sensitive and pain sometimes correlates with the menstrual cycle. Recurrent, intense pelvic pain is one of the major symptoms of endometriosis. Other symptoms[151] are chronic fatigue and constipation. Pain can occur at any time during the month and can be caused by adhesions or inflammation in the pelvic cavity. Complications like pelvic cysts, cysts of the ovaries, ruptured cysts and abdominal obstruction may occur because of the abdominal adhesions. Cysts can occur on the fallopian tubes, ovaries, front or back of the uterus, uterine ligaments, back of the intestines (ie back of the sigmoid colon), bladder and ureter (the tube between the kidney and bladder). Cysts may spread to the cervix (mouth of the uterus) and vagina.

The cause or pathophysiology of endometriosis[152] is likely to be 'multifactorial' and an 'interplay' between several factors, viz predisposing factors like ageing and genetics, metabolic changes, inflammation and formation of ectopic endometrium. Uncertainty exists

[148]The study used the Internet and common search applications to obtain general information about the disease and specific literature was then consulted.
[149]C Bulletti et al 'Endometriosis and infertility' (2010) 27(8) *Journal of Reproductive Genetics* 441–447. See http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2941592/.
[150]K Ballard et al 'Can specific pain symptoms help in the diagnosis of endometriosis? A cohort study of women with chronic pelvic pain' (2010) 94(1) *Fertility & Sterility* 20–27.
[151]Ibid.
[152]BC Fauser et al 'Contemporary genetic technologies and female reproduction' (2011) 17(6) *Human Reproduction Update* 829–847.

about the cause and the effects of the condition and this is so regarding any of the pathophysiology of endometriosis. Inflammation[153] plays a primary role in the aetiology and causes pain.

The medical history of the patient and physical examination will lead the gynaecologist to suspect[154] endometriosis. Ultrasound may or may not show the lesions, depending on their size, and is mostly used to determine the effect of the adhesions on other organs. Lesions show histology features similar to endometrial tissue. Frequently, lesions are overlooked during a diagnostic laparoscopy due to their location. The only way to confirm a diagnosis of endometriosis is with a laparoscopy or other form of surgery, whereby a biopsy of the lesion is taken and sent for a histological examination (a pathologist will confirm the pathology of the specimen through a microscope). This will be done with circumspection because of the risk of haemorrhage and the hidden nature of the lesion formation.

Endometriosis[155] has been graded in order to facilitate decisions about surgery and the type of surgical intervention. Stage I endometriosis may have little disease and severe pain, and Stage IV may have little pain and severe disease or vice versa. In young women surgical treatment aims to restore the normal pelvic anatomy as far as possible. Laparoscopic surgery is considered due to minimal scar tissue formation. According to Liakakos,[156] '55–100% of women develop adhesions following pelvic surgery which can result in infertility, chronic abdominal and pelvic pain, and difficult re-operative surgery'.

Efficacy studies[157] depend on the initial complaint of the patient. Both medicinal and surgical interventions produce roughly equivalent pain-relief benefits. Pain recurs in 44 per cent of women with medicinal treatment and in 53 per cent with surgical interventions. Each approach has its advantages and disadvantages. Surgical intervention is more effective than medicinal intervention in attempting to address infertility.

From the above medical information it is evident that in the case under discussion:

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[153]RO Burney & LC Giudice 'Pathogenesis and pathophysiology of endometriosis' (2012) 98(3) *Fertility & Sterility* 511–519.
[154]M Nisolle et al 'Histological study of peritoneal endometriosis in infertile women' (1990) 53(6) *Fertility & Sterility* 984–988.
[155]American Society for Reproductive Medication 'Revised American Society for Reproductive Medicine classification of endometriosis: 1996' (1997) 67(5) *Fertility & Sterility* 817–821.
[156]T Liakakos et al 'Peritoneal adhesions: Etiology, pathophysiology, and clinical significance' (2001) 18(4) *Dig Surg* 260–273.
[157]D Kapoor & W Davila *Endometriosis* (2005); eMedicine and American Academy of Family Physicians *Diagnosis and Treatment of Endometriosis* (1999).

(1) Ms A was a young person, thus Dr B had to determine the extent of the endometriosis because it can affect fertility and may cause haemorrhaging;
(2) Dr B should have been aware that ultrasound is not reliable for detecting lesions, but may reveal the obstruction or occlusion of tubes and any abnormal accumulation of fluid in the pelvic cavity;
(3) Dr B opted for a period of conservative treatment by prescribing certain medication, but this was unsuccessful;
(4) Dr B considered surgery as a last option, presumably based on the severity of the disease; and
(5) Dr B considered laparoscopic surgery in order to restore normal pelvic anatomy, because it involves minimum scar tissue formation, minimum adhesion formation and minimum haemorrhaging.

6.3 Legal considerations regarding a laparoscopic procedure for endometriosis

Van den Heever and Carstens[158] would regard the above case study as a potential case for the application of the *res ipsa loquitur* maxim, based on the iatrogenic[159] injury to the ureter. The same arguments regarding the *res ipsa loquitur* maxim in *Van Wyk v Lewis*[160] are relevant to this matter.[161] The element of wrongfulness is not disputed, because the defendant owed his legal duty to the plaintiff not to cause harm. The elements[162] of negligence (*culpa*) and factual and legal causation are left unsatisfied. Further evidence regarding the conduct of a reasonable professional providing reasonable care as well as medical information explaining the circumstances of the injury or steps taken to prevent injury to the plaintiff would have excluded the maxim.

The maxim in South Africa requires that the key facts have to be so obvious that all the elements in delict can be inferred. The medical reality is intricate and potentially far removed from the observations of the uninformed person. Several issues need to be clarified by the medical expert: (i) perhaps the laparoscopic operation should not have been the operation of choice because of the high probability of a distorted anatomy as a result of

[158]Van den Heever & Carstens (n 2) 28.
[159]Caused by the doctor.
[160]*Van Wyk* (n 1). See chapter 2 para 3 and 8.
[161]See para 5 above.
[162]Chapter 2 para 4.

adhesion formation in the pelvic area[163] caused by the disease and because of the limited visibility with the laparoscopic instrument; (ii) surgical intervention, without the indication of an emergency, is the last choice of treatment option because of the propensity of the disease to form adhesions and adhesions distort the anatomy; (iii) there is a real possibility that the previous diagnostic laparoscopy to confirm the diagnosis was contraindicated because a clinical diagnosis is usually made without surgical intervention; (iv) the level of skill of the surgeon, ie his place on the learning curve, should be ascertained because of the high level of complication of this particular operation; and (v) the reason for not requesting the assistance of a urologist during surgery to discern the ureter should be established. In summary, the medical condition of endometriosis forms adhesions when the lesions are healed. This has a high risk of injury during a laparoscopic operation because the scar tissue distorts the anatomy of the patient. With limited visibility through the laparoscope the inexperienced surgeon may not be aware of the changed anatomy and thus such an operation carries a higher risk of causing injury to organs. The need for laparoscopic surgery should only be undertaken in extreme or emergency circumstances to justify such a high risk to the patient. It is negligent (culpable conduct) to foresee a material risk and fail to take steps to prevent it. Therefore the steps taken by the defendant to avoid the risk should be weighed against the complications that occurred. Seen in context of the medical facts, it is clear that an inference of negligence on the fact of the injury (the design of the maxim under circumstances under the control of the defendant even if it was unexpected in nature) does not explain the expected standard of care under similar circumstances and does not address the medical reality. Without the evidence of a medical expert, it is not possible to appreciate all the risks involved. From a medical point of view, when applying the maxim in South Africa, there are at least three grounds for possible negligence: first, the reason for the operations if it was not an emergency; second, the fact that conservative treatment was not considered and that the operation was most likely not the correct choice of operation and perhaps even contra-indicated; third, the level of expertise of the surgeon or the fact of the injury (what occurred during surgery) that caused the perforation. From a legal point of view, the non-medical person unfamiliar with the medical reality will simply state *res ipsa loquitur* without any appreciation for the complexity of the case. If the court for some reason allows the maxim, the surgeon may simply rebut the maxim by stating that he took all reasonable care but the

[163]Evident from the literature in para 6.2 above: Endometriosis causes inflammation that result in adhesions. Adhesions may lead to bowel obstruction and may distort the anatomy. Lesions are not easily detected due to their location. The risk of perforation of lesions (cysts) and severe peritonitis outweighs the risk of the injury during the operation.

adhesions distorted the anatomy and visibility and that was the (non-negligent) cause of the injury. Furthermore, if one involves the services of a medical expert informing the court above the medical reality, the need for the maxim falls away. The mere fact that non-medical persons often do not understand the intricate medical facts does not mean that the court can revert to the maxim. As opined previously, an inability to interpret medical facts is not the same as insufficient medical facts (medical facts not available).

Turning to the facts of the case, Ms A consulted with Dr B as she was suffering from severe pain. Further investigation was clearly needed, as the lesions (cysts) may have involved the ovaries or may have ruptured. Perforation of the cysts may advance to peritonitis and, if peritonitis is untreated or the treatment is unsuccessful, peritonitis may lead to subsequent multi-organ involvement.[164] The high risk of injury due to the nature of the disease from intra-pelvic adhesions should be weighed against the temporary relief offered by surgery and the surgical outcome.

The above example of laparoscopic procedures in a patient suffering from endometriosis illustrates the importance of the involvement of the medical expert to give a medical explanation of the facts that are also the basis for factual causation. Each individual case is different. A surgeon who decides to perform a laparoscopy on a woman suffering from endometriosis has to furnish reasons in the presence of the high risk of injury.[165]

7 Laparoscopic cholecystectomy

A second case of laparoscopic injury is discussed to establish the elements of factual causation in delict, from the medical facts of the case. The previous case of a laparoscopic procedure in relation to endometriosis demonstrated the medical intricacies and aetiology of a disease that can affect the decision of performing the procedure. It shows that a medical professional should discuss the risks and complications of the procedure with the patient. However, the decision to perform laparoscopic surgery on a patient suffering from gall bladder disease is sufficiently different because it is based on the surgical history of the patient.

[164]See the discussion of peritonitis in para 5 above.

[165]The anatomy might be distorted as a result of adhesions, which will complicate the surgery. In contrast, a ruptured lesion is an emergency with far-reaching consequences if not treated, and it calls for urgent surgical intervention. In the right hands, a laparoscopic operation involves minimal invasive surgery, with less scar tissue formation, minimum adhesions and less haemorrhaging.

7.1 Laparoscopic cholecystectomy procedure – a case study

In an unreported case[166], a 40-year-old woman was admitted with upper abdominal pain associated with nausea and vomiting. The hospital record reflected that she had a surgical history of previous abdominal operations. Haematological investigations showed a raised white cell count (13.4) and neutrophil count (10.4).[167] An ultrasound of the abdomen revealed–

> [that] no obvious masses or lesions [were found], no obvious duct dilatation [was found], [that the] gallbladder appears distended with multiple calculi present, [that the] gallbladder wall [was] thickened and measures 9 mm – [it was] suggestive of acute or chronic cholecystitis with gall stones.

The patient was diagnosed with cholecystitis and was advised that a cholecystectomy was indicated. It was agreed between the doctor and the patient that a laparoscopic cholecystectomy should be the choice of operation, and it was performed. The surgical notes of the doctor indicated that–

> the entrance of three ports were done supra umbilical, sub costal was under vision, that the gallbladder was mobilized, but after clipping cystic bile duct it was decided to convert the repair operation to open surgery. A small traction injury was found next to junction of cystic duct and common bile duct. It was repaired. Wound closed with corrugated drain and skin clips.

On the first post-operative day the patient complained of severe pain, nausea and vomiting, and was initially kept under observation.[168] She constantly complained of pain and feeling ill. She was discharged on the fourth day. Twenty-two days later the patient presented with cramping, abdominal pain, abdominal distension, weakness, dizziness and fainting. Her vital signs revealed a raised blood pressure and raised pulse rate. She developed spiking temperatures. She was diagnosed with ascites and mild jaundice and a CT scan revealed–

[166]The case became settled prior to completion of the trial and all the medical information was obtained from the hospital record.
[167]An indication of an infectious condition.
[168]These symptoms raise a high suspicion of a leak, especially after a laparoscopic procedure.

> fluid collection in sub hepatic space, extending to the lesser sac and Morrison's pouch. Intra-hepatic bile ducts are normal and proximal common bile duct is in continuity with the collection in the GB fossa, distal common bile duct and pancreatic ducts are normal. Extensive free fluid noted in the rest of the abdomen. Highly suggestive of proximal common bile duct transection with biliary ascites.

She was transferred for an emergency ERCP[169] operation and the ERCP revealed a complete transection of the common bile duct. She recovered well in High Care and later in the ward. Further repair surgery was scheduled. She remained weak with compromised health.

7.2 Medical information relevant to the laparoscopic cholecystectomy

The rate of bile duct injury remains as high as 1.4 per cent during laparoscopic cholecystectomy operations. In order to understand the extent of the above injury a closer look at the anatomy[170] of the gall bladder is necessary. The gall bladder is found under the lower surface of the liver. Bile is conveyed from the liver to the small intestine by means of ducts. The gall bladder, where bile is stored, lies between the liver and the small intestine. From the common hepatic duct the bile is carried by the cystic duct to the gall bladder. The common hepatic duct forks into the cystic duct and the common bile duct. When the gall bladder and cystic duct are removed, the only remaining duct is the common hepatic duct, which then is named the common bile duct and which conveys the bile to the small intestines. The latter duct is vitally important as it is the only channel that conveys the bile from the liver to the small intestines. Injury to the bile-passages can lead to occlusion or narrowing, blocking the flow of bile from the liver and causing subsequent liver damage. Injury to the bile-passages leads to leakage of bile into the abdominal cavity which leads to covert infection and life-threatening peritonitis (infection in the abdominal cavity). Sepsis can affect any of the organs and lead to 'fatal sepsis'.[171]

[169]Endoscopic retrograde cholangio pancreatography (ERCP) is a procedure that uses an endoscope and X-rays to look at the liver and bile ducts to determine any pathology.
[170]B Broome 'Bile duct injury complications of laparoscopic cholecystectomy' *Medical Legal Art* (2009) 1–19, available at http:www.medicallegalblog.com/2009/05/bile-duct-injury-complications-of.html (accessed 19 May 2014).
[171]Ibid.

Correctional surgery is complicated. Sicklick et al[172] explain that widespread laparoscopic operations like laparoscopic cholecystectomy lead to a higher incidence of major bile duct injuries. They opine that proper early diagnosis and appropriate treatment are 'paramount in preventing life-threatening complications like cholangitis, biliary cirrhosis, portal hypertension, end-stage liver disease and death'. Their data suggests that primary surgeons attempt to repair the injury themselves against the odds, as data revealed 'that only 17% of primary repair attempts are successful and no secondary repair attempts performed by the laparoscopic surgeon are successful'. The expertise of an experienced hepato-biliary surgeon is needed to repair these complex injuries to ensure optimum short-term and long-term outcomes. They state that the control of sepsis is via radiological intervention and any ongoing bile leaks are managed with the use of biliary stents. Reconstruction surgery should be delayed until all infection has been resolved.[173] The rate of bile duct injuries increased after the introduction of laparoscopic cholecystectomy according to Archer et al.[174] Once a bile duct injury has occurred another set of statistics becomes relevant. The management of bile duct injuries has a complication rate of 42,9 per cent according to Sicklick et al,[175] with a postoperative mortality rate of 1,7 per cent. The authors explain that of the 175 patients who were researched and who underwent biliary reconstruction surgery, three died postoperatively, of whom one had overwhelming sepsis and consequential multiple organ failure. He succumbed on day 57. They opine that early referral to centres with 'experienced hepato-biliary surgeons and skilled interventional radiologists' are crucial for optimum results. The seriousness of the consequences of bile duct injuries was confirmed by

[172]JK Sicklick et al 'Surgical management of bile duct injuries sustained during laparoscopic cholecystectomy' (2005) 24(5) *Annals of Surgery* 786–795.

[173]See management of injury in S Bhoyrul et al 'Trocar injuries in laparoscopic surgery' (2001) 192(6) *J Am Coll. Surgery* 677–683. The study investigated technical information of different trocar types. They investigated 629 trocar injuries from 1993 to 1996 and found that there were three types of injuries: injury to major blood vessels, bowel injuries and abdominal wall haematomas (localised collection of blood). There had been 32 deaths. Of the deaths, 26 (81 per cent) were related to major blood vessel injuries and 6 (19 per cent) were related to bowel injuries. The diagnosis of an enterotomy (or bowel injury) was delayed in 10 per cent of the cases and the mortality rate in this group was 21 per cent because of overwhelming sepsis and multiple organ failure.

[174]SB Archer et al 'Bile duct injury during laparoscopic cholecystectomy' (2001) 234(4) *Ann Surgery* 549–559. The study investigated whether surgeon residency training influenced the occurrence of common bile duct injury. The study found that the incidence of the injury increased by 0,5% per cent and injuries were more commonly reported early in the surgeon's learning curve. Most surgeons learnt how to perform a laparoscopic cholecystectomy through one- to three-day postgraduate courses and often incorporated the procedure into their practices without supervision. Consequently, during the first procedures the surgeons become 'anatomically confused and unwittingly transect the bile duct early in the resection'. Although it was clear that inexperience caused the early biliary injuries, the increase in number of injuries continued, which was an indication that the situation did not improve. The authors opine that it appears that one-third of the injuries are not related to inexperience but are rather due to fundamental errors in the technique.

[175]Sicklick et al (n 172) 786–795.

Gentileschi et al,[176] who revealed that 33 bile duct injuries were reported from the total of 13 718 operations, which gives an incidence of 0,24 per cent. Of the 33, nine (27,3 per cent) had no 'clinico-pathologic justification'.[177] The authors reported that of the 33 injuries, 4 deaths (12,1 per cent) were reported. Furthermore 24 (72,7 per cent) of the bile duct injuries resulted from a direct injury, 7 (21,2 per cent) from electro-cautery thermal injury, and the remaining 2 (6,1 per cent) from the misplacement of clips.

7.3 Legal discussion of the laparoscopic cholecystectomy

Once again Van den Heever and Carstens[178] would argue that the *res ipsa loquitur* maxim should apply. They could argue that the transection of the common bile duct injury in itself a sufficient basis for inferring negligence, as it was performed without the necessary care, based on the approach of the English court.[179]At most, according to South African delictual principles, the injury to the common bile duct could be seen as evidence of a breach of the legal duty not to harm and as such wrongful in nature, yet the elements of negligence (culpable conduct) and factual causation cannot be justifiably established on that basis alone. Because the element of negligence (*culpa*) addresses information about the conduct of the defendant (foreseeability and prevention of harm), the defendant should not have performed surgery or dissected in an area where his visibility was impaired. It is inferred that the inability to see his instruments caused him to transect the common bile duct. In the above matter the defendant redeemed himself and corrected his surgical error by converting to open surgery. He performed a repair operation and, had everything gone well after the corrective surgery that would have been the end of it. But the further conduct of the defendant renders him liable. With full knowledge of the injury, the defendant should have monitored the medical condition of the plaintiff and should have been sensitive to any signs and symptoms indicating a leak from the repair operation. Since signs of a leak became evident, he should have performed an investigative (re-look) operation earlier, which would have detected the leak. He should have then obtained the services of a more experienced surgeon to repair the damage ie a hepato-biliary surgeon.

[176]P Gentileschi et al 'Bile duct injuries during laparoscopic cholecystectomy' (2004) 18(2) *Surgical Endoscopy* 232–236. The authors are an association of surgeons in Rome that investigated the field of laparoscopic surgery with the use of two groups. Group A was analysed from 1994 to 1998 and Group B from 1998 to 2001.
[177]The reason for the operation was not justified.
[178]Van den Heever & Carstens (n 2) 36.
[179]Chapter 3 para 2.

The defendant would have been negligent in performing the initial laparoscopic operation only if such a procedure was contraindicated. From the above medical information it is clear that previous surgery to the same area causes the formation of adhesions, which in turn may cause bowel obstruction and other complications. Laparoscopic surgical intervention in such circumstances may lead to reduced visibility as a result of these adhesions and may contribute to the injury of other organs. At all material times the defendant should have been aware of the possibility of such an injury and should have monitored the medical condition of the plaintiff for signs thereof; any failure to do so would be classified as a breach of his legal duty. The plaintiff bears the onus of proving his case with sufficient medical information for the court to arrive at a conclusion of negligence (liability). It is argued that the maxim in complex medical cases would significantly increase the risk of the court being unclear as to what occurred during the medical incident. For this reason it is argued that no legal conclusion or inference can or should be drawn without an appreciation of the medical reality and by comparing the expected standard of care against the delivered standard of care. This effectively excludes the maxim.

8 Reappearance of the *res ipsa loquitur* maxim in South Africa

It was previously argued that medical causes and effects are too complex to allow for the *res ipsa loquitur* maxim because the medical reality should be appreciated before arriving at a legal conclusion. This argument is demonstrated in a recent case, *Ntsele v MEC for Health Gauteng Provincial Government*,[180] where the South African court re-visited the maxim, based, inter alia, on the recommendation of Van den Heever and Carstens.[181] As previously indicated,[182] the authors argue that the court's decision in *Van Wyk v Lewis*[183] is based on a material misdirection.[184] This misdirection was analysed by the court in *Ntsele v MEC for Health Gauteng Provincial Government*.[185] In *Buthelezi v Ndaba*,[186] the elements of factual

[180]2013 (2) All SA 356 (GSJ); *Goliath v MEC for Health in the Province of Eastern Cape* (n 4) 60.
[181]Van den Heever & Carstens (n 2) 36.
[182]Chapter 2 para 8.
[183]*Van Wyk* (n 1). Van den Heever & Carstens (n 2) 36. They believe that the fact that a swab was left in the abdomen should be seen as 'absolute' or conclusive evidence and not regarded as 'relative' or rebuttable evidence, as it does not depend on the surrounding circumstances.
[184]They opine that the ruling of the 1924 *Van Wyk v Lewis* case was 'based on fundamental misdirection' and the judgment should not be regarded as 'incontrovertible authority for the proposition that the doctrine of *res ipsa loquitur* cannot be utilized.' It was recommended that the court should open the door for the maxim.
[185]*Ntsele* (n 180). The court successfully applied the maxim but the judgment is *ipso facto* flawed as the *stare decisis* rule was not followed. See chapter 2 para 8, fn 311 and discussion in para 8.1 below.
[186]2013 ZASCA 72; 2013 (5) SA 437 (SCA). See discussion of the case in para 8.2 below.

and legal causation were overlooked and the maxim rejected based on the conclusion that the medical reality is too complex. The application of the maxim is discouraged in *Goliath v MEC for Health in the Province of Eastern Cape*,[187] based on the decision of the English court in *Ratcliffe v Plymouth and Torbay Health Authority*,[188] as it clashes with the law of delict in South Africa. *Ntsele v MEC for Health Gauteng Provincial Government*[189] and *Buthelezi v Ndaba*[190] are discussed to demonstrate how far the medical reality is from the general perceptions of negligence in uninformed persons. A real understanding of the medical facts will allow for the determining of factual and legal causation and the element of negligence.

8.1 A discussion of *Ntsele v MEC for Health Gauteng Provincial Government*

In *Ntsele v MEC for Health Gauteng Provincial Government*[191] the baby of the plaintiff suffered severe brain damage after a substantial delay in the delivery of the baby. The plaintiff had had a previous caesarean section. The new pregnancy was uneventful. The plaintiff attended a prenatal clinic where all prescribed prenatal pregnancy tests were conducted, which appeared to be normal. On 7 September 1996 the plaintiff experienced labour pains. She arrived at the clinic at 05h00. She was attended by two nurses who failed to monitor the foetal heart rate and labour contractions. The membranes of the uterus of the plaintiff were ruptured to accelerate birth. No progress was made and the plaintiff was transferred to hospital. It is unclear by whom and why the decision was made to transfer her to hospital. She arrived at the hospital at 08h00. No doctor was available to examine the plaintiff, and the nurses provided no follow-up treatment. The plaintiff was given her clinic file and instructed to register her admission. The registration took two hours. She was thereafter transferred to a ward. She informed the nurses at the hospital that her membranes were ruptured at the clinic. A cardiotocograph (CTG) was applied to her abdomen for 20 to 30 minutes to monitor the impact of the contractions on the foetal heart. Later, at an uncertain time, a doctor arrived, spoke with the nurses and examined the mother. The doctor instructed her to push down. She 'pushed' for a long time but the birth process did not progress. The doctor decided to perform an episiotomy. After an uncertain time, which according to the

[187] *Goliath* (n 4).
[188] (1998) PIQR 170 Lloyds Med LR 162.
[189] *Ntsele* (n 180). See chapter 2 para 8, fn 311 and discussion in para 8.1 below.
[190] *Buthelezi* (n 186).See discussion in para 8.2 below.
[191] *Ntsele* (n 180). See judgment para 5 for facts of the case.

plaintiff seemed like an eternity, she gave birth. The plaintiff immediately noticed that the baby was not crying or breathing properly. The nurses took the baby to the theatre where he was resuscitated. It was confirmed that the baby suffered from cerebral palsy. The baby was discharged 20 days later.

The plaintiff's case was based on allegations that the nursing personnel at the clinic and at the hospital did not monitor the unborn baby's condition adequately. Insufficient hospital records were available to explain the circumstances during birth. This absence of evidence led the judge to conclude that the event should be interpreted as having an 'unknown cause'.[192] Mokgoatlheng J referred to Van den Heever and Carstens[193] and stated that the nature of the case was indeed such that the plaintiff had established a *prima facie* case of negligence which, according to the court, cast an evidential burden on the defendant to rebut the probability of negligence. Quoting *Van Wyk v Lewis*[194] and Van den Heever and Carstens,[195] the judge suggested that, in the alternative, the plaintiff has to show that the event happened in a manner that inferred a high probability of negligence on the part of the defendant's employees. The judge was of the opinion that the cause of injury was unknown to the plaintiff and that it was exclusively within the defendant's knowledge. The judge held that, as a result of the 'unknown cause',[196] the court was allowed to draw an inference of negligence by applying the doctrine of *res ipsa loquitur*. According to the court, the inference of negligence was based on the *res ipsa loquitur* maxim because the court was presented with 'exceptional circumstances'.[197]

The defendants argued in rebuttal that the plaintiff had not proved her case and the court should grant absolution from the instance. They cautioned that the court should not be swayed to favour the plaintiff because it was understandably sympathetic.[198] The defence

[192]An unknown cause is one of the prerequisites of the *res ipsa loquitur* maxim.
[193]*Ntsele*(n 180). See judgment para 5(c).
[194]*Van Wyk* (n 1). See *Ntsele* (n 180) judgment para 105.
[195]Van den Heever & Carstens (n 2) 34. See *Ntsele* (n 180) judgment para 111.
[196]It is argued that insufficient recordkeeping by the hospital is per se indicative of not complying with the standards of care prescribed by legislation such as the National Health Act, the Nursing Act and the Nursing Regulations for Midwives. Non-compliance with legislation is unlawful or wrongful but the other elements of delict should be satisfied before arriving at a conclusion of negligence (negligence, factual causation and non-remoteness of damage).
[197]*Ntsele* (n 180) judgment para 106. His Lordship was led by the English case *Hucks v Cole* [1993] 4 Med LR 393,where Denning LJ stated: 'A doctor is not negligent simply because something goes wrong. It is not right to invoke against him the maxim of *res ipsa loquitur* save in extreme cases.'
[198]*Ntsele* (n 180) judgment para 34. The judge referred to *Broude v McIntosh* 1998 (3) SA 60 SCA regarding 'absolution from the instance'. The study agrees with the defendants in this matter, as the plaintiff was unsuccessful in showing that the defendants' employees had failed to take reasonable measures to prevent the delay in treatment, that the delay was the cause of the asphyxia (lack of oxygen), and that the asphyxia was the

referred to *Macleod v Rens*[199] and stated that the maxim, if applied correctly, merely creates an inference of negligence and is not 'a magic formula [that] permits the court to side-step or gloss over a deficiency in the plaintiff's evidence'. The defendants in rebuttal disputed evidence based on causation. The defendants averred that a possibility existed that the brain damage (cerebral palsy) occurred in the womb before the birth process. This alternative explanation, if accepted by the court, would lead to the conclusion that the birth process, even if it occurred without the necessary care, could not have caused the injury to the child, as the damage occurred during pregnancy.

The judgment is flawed from the outset, based on the *stare decisis* rule of law. The majority in *Van Wyk v Lewis*[200] rejected the application of the *res ipsa loquitur* maxim, which precluded a lesser court from ruling differently. Furthermore, even if this court was not precluded from applying the maxim based on the *stare decisis* rule, the facts do not support the application of the maxim. In South African law an adverse event does not allow for an inference of negligence (culpable conduct). All the elements of delictual liability should be satisfied by the key facts of the case. There was no evidence to support the allegation that the care provided by the nursing personnel was below standard.

Allegations determining factual causation and negligence (*culpa*) are complicated and should at least have addressed the following:

(i) The fact that the doctor and nursing personnel failed to provide the required standard of care relevant to obstetric procedures. From a non-medical viewpoint this aspect seems obvious but from a medical perspective information was lacking information regarding previous pregnancies, the management of and problems during prenatal care, whether the plaintiff was full term when the membranes were ruptured and labour initiated, whether the head was still high during the initial delay in labour progress; whether the readings of the CTG were normal or indicative of a baby in distress, whether the cervix of the mother was dilated when she was asked to push, and so forth;

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cause of the brain damage. If the plaintiff had had a Nursing Services Manager who set the standard of what was expected in accordance with legislation, the allegations would have been substantiated.

[199] *Ntsele* (n 180) judgment para 59 ff. The judge referred to *Macleod v Rens* 1997 (3) SA 1039 (E) 1048 where the court warned that inferential reasoning sometimes only serves to disguise conjecture.

[200] *Van Wyk* (n 1). See chapter 2 para 8.

(ii) The fact that they should have been aware that foetal distress during previous pregnancies may repeat itself;

(iii) The fact that they should have been aware that natural delivery following a previous caesarean carries a high risk of complications due to the formation of scar tissue in the uterus;[201]

(iv) The fact that the premature rupture of membranes carries a high risk of injury to the foetus;[202]

(v) The fact that it is vital to monitor the foetal heart rate[203] to determine the status of the foetus, especially with a history of a previous caesarean;

(vi) The fact that a failure to monitor the foetal heart rate constitutes substandard care, as it allows the unborn baby to remain in distress without any medical assistance;

(vii) The fact that poor progress[204] in the labour process when there is a history of a previous caesarean section is indicative of complications;

(viii) The fact that, without competent, experienced and skilled personnel to perform the cardiotocogram (CTG),[205] the diagnostic aid becomes ineffective. The decelerations and accelerations seen on the CTG illustrate the reaction of the foetal heart of the unborn baby during contractions and the birth process, and should not be ignored but followed up with the medical professional;

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[201] S Boyles 'Are repeat C-sections safer than natural birth?' *WebMD* (13 March 2012), available at http://www.webmd.com/baby/news/20120313/are-repeat-c-sections-safer-than-natural-birth (accessed 12 June 2014). In this article it is indicated that labour augmentation and induction has an increased risk of uterine rupture, and that foetal distress as the reason for the previous caesarean section may repeat as risk.

[202] *Premature rupture of membranes (PROM)* – An intact amniotic membrane is important to contain the amniotic fluid which cushions and allows the foetus to move, protects the foetus from infection, and prevents umbilical cord compression that may cut off the supply of oxygen and nutrients to the foetus. The primary concerns with PROM are increased risk of maternal and/or foetal infection, premature delivery of the foetus, and the increased likelihood of umbilical cord compression. See http://www.mdguidelines.com/premature-rupture-of-membranes (accessed 3 January 2015).

[203] *Intrapartum foetal heart rate monitoring* – umbilical cord compression will show prolonged decelerations etc. See http://www.perinatology.com/Fetal%20Monitoring/Intrapartum%20Monitoring.htm (accessed 12 May 2014).

[204] *Poor progress in labour* – Prolonged labour results in maternal exhaustion and dehydration, the need for epidural analgesia for pain relief, maternal pyrexia, possible maternal or foetal infection, the need for operative deliveries, babies with less than optimum outcome, postpartum haemorrhage, the need for blood transfusion and possible postpartum poor well-being. In developing countries it may lead to obstructed labour, foetal or neonatal death, uterine rupture, the need for symphysiotomy or destructive operations on the foetus, the late sequel of vesicovaginal fistula and, in rare instances, maternal death due to sepsis or haemorrhage. See http://www.sciencedirect.com/science/article/pii/S0957584704001167 (accessed 12 May 2014).

[205] *Intrapartum foetal heart rate monitoring* – umbilical cord compression will show prolonged decelerations etc. See http://www.perinatology.com/Fetal%20Monitoring/Intrapartum%20Monitoring.htm (accessed 12 May 2014). See note 191.

(ix) The fact that inducing and thereby augmenting[206] natural birth, in the presence of a previous caesarean section, increases the risk of foetal distress and the risk of uterine rupture; and

(x) The fact that inducing and augmenting the birth process, in the presence of foetal distress, may cause inadequate or over-stimulated uterine contractions or an irritated uterus, with a serious possibility of lack of oxygen for the baby (birth asphyxia), which may result in cerebral palsy of the baby.

The aforementioned medical expert evidence was available at the time the case went to court to establish factual causation and negligence. On a preponderance of probability, the weight of the evidence presented by the plaintiff was incomplete. The plaintiff relied on a generalised allegation that a delay in treatment and the failure to monitor the status of the foetus caused the injury to the baby. This is not a reliable form of reasoning, as such an allegation assumes a causal chain and a general inference of negligence without medical expert evidence, from which it remains impossible to draw a reliable legal conclusion. The court's determination should depend on an analysis of the cogent reasoning of medical expert evidence, which for all purposes excludes the application of the maxim. The element of wrongfulness is not problematic, but in order for the court to determine the element of negligence (*culpa*) the court has to hear evidence regarding the conduct of the nursing personnel and the doctors weighed against the expected standard of care. Assuming that the CTG readings did not show a baby in distress, the initial actions of the nursing personnel would have been inadequate and not according to accepted medical standards, but they would not have been liable as these actions did not cause of the harm. Every medical aspect of this case forms part of the medical chain of events that should be analysed to determine negligence, causation and then liability.

8.2 A discussion of *Buthelezi v Ndaba*

Soon after *Ntsele*,[207] another attempt to reintroduce the maxim followed. In *Buthelezi v Ndaba*,[208] the defendant performed a total abdominal hysterectomy[209] on the plaintiff. About

[206]World Health Organization 'Recommendations for the induction of labour' (2011), available at http://whqlibdoc.who.int/publications/2011/9789241501156_eng.pdf (accessed 12 June 2014): Induction of labour should be performed with caution since the procedure carries the risk of uterine hyper stimulation and rupture and foetal distress.
[207]*Ntsele* (n 180). See para 8.1 above.

six weeks after the operation the plaintiff began to suffer from urinary incontinence, as urine was leaking from her vagina. The medical professionals determined that a vesicovaginal fistula[210] had developed, which caused the problem. The fistula did not develop right after the operation but only about six weeks later. The plaintiff underwent a number of urological repair operations. Relying on the aforementioned medical facts, the plaintiff instituted legal action against the gynaecological surgeon who performed the hysterectomy. Although the medical experts agreed that the fistula did not start spontaneously and was triggered by something that occurred during the hysterectomy, they did not agree on the cause of the fistula. Medical experts for the plaintiff maintained that damage occurred to the blood supply of the wall of the bladder during dissection of the bladder from the uterus or when stopping the blood oozing from the vaginal vault while removing the cervix. Medical experts for the defendant argued that no one knew how the fistula developed, as it occurred six weeks after the operation and whatever reason was provided to the court was speculative. The plaintiff's case was dismissed on appeal.

From the medical literature[211] it is evident that an abdominal hysterectomy is the surgical removal of the uterus and the cervix through an abdominal incision. The cervix is removed from the upper part of the vaginal vault and then the vaginal vault is sutured closed. The bladder lies in front (anterior) of the uterus and, although the uterus and the bladder are in close proximity, they do not share a wall. At the beginning of the operation the bladder is separated from the uterus. Previous surgery in the area, for example, caesarean section operations, might cause adhesions to form between the uterus and the bladder. Furthermore, medical literature provided by Hilton and Cromwell[212] investigates the rates of vesicovaginal and urethrovaginal fistula formation among women undergoing hysterectomy. They found

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[208]*Buthelezi* (n 186). See chapter 2 para 8.
[209]This is the surgical removal of the uterus and cervix.
[210]A vesicovaginal fistula is an abnormal fistulous tract extending between the bladder (vesico) and the vagina that allows the continuous involuntary discharge of urine into the vaginal vault.
[211]Cf a discussion of abdominal hysterectomy at http://www.mayoclinic.org/tests-procedures/abdominal-hysterectomy/basics/definition/prc-20020767 (accessed 15 April 2014).
[212]P Hilton & DA Cromwell 'The risk of vesicovaginal and urethrovaginal fistula after hysterectomy performed in the English National Health Service – a retrospective cohort study examining patterns of care between 2000 and 2008' (2012) 119(12) *British Journal of Obstetrics & Gynaecology* 1447–1454. They found that among 343 771 women undergoing hysterectomy, the overall rate of fistula was 1 in 788. The rate varied by indication and procedure, being highest following radical hysterectomy for cervical cancer (1 in 87; 95% CI 61-128) and lowest following vaginal hysterectomy for prolapse (1 in 3861; 95% CI 2550-6161). After total abdominal hysterectomy for endometriosis, menstrual problems or fibroids, the risk of fistula was lower in women aged 50 years or over than in women under 40 years (adjusted odds ratio 0.61; 95% CI 0.38-0.98). The overall rate of fistula increased by 46 per cent during the study period.

that the risk of a urogenital fistula was associated with the type of hysterectomy and the indication for the hysterectomy. They observed that the risk was lower immediately after hysterectomy for benign conditions in women aged 50 years or over and increased during the further period of the study. Tancer,[213] in a retrospective study, found that total abdominal hysterectomy was the most common procedure to precede a vault fistula.

It is essential that medical expert evidence is based on available medical literature to provide an overview of the points under discussion. In the above case the plaintiff presented with a predisposing risk factor for a vesicovaginal fistula:[214] the plaintiff was diabetic, HIV-positive, had had a previous caesarean section and had been struggling with chronic pelvic infection at the time, all of which have an effect on the bladder wall. Allegations relevant to factual and legal causation and negligence relate to information such as:

(i) the defendant ought to have been aware that the plaintiff had a high risk of vesicovaginal fistula because of her medical history and should have taken steps to prevent such an injury;

(ii) the bladder wall may have been friable as a result of predisposing factors, and so special care should have been taken when dissecting the bladder from the uterus;

(iii) a simpler operation to remove the uterus without the cervix might have carried a smaller risk of vesicovaginal injury and fistula formation;

[213]ML Tancer 'Observations on prevention and management of vesicovaginal fistula after total hysterectomy' (1992) 175(6) *Surgical Gynaecology & Obstetrics* 501–506. A retrospective study of genital fistulas of the lower urinary tract revealed 91 per cent to be postsurgical. Of these, 91 per cent occurred after gynaecological procedures. Total hysterectomy was the most common antecedent procedure (n = 110), and the resulting lesion was the vault fistula. Abdominal total hysterectomy was the most frequent operation to precede a vault fistula (n = 92) and almost 70 per cent occurred in the absence of factors identified as placing the patient at risk for injury to the bladder. Such risk factors included prior uterine operation, especially caesarean section, endometriosis, recent cold-knife cervical conisation and prior radiation therapy. Twenty-four fistulas occurred despite recognition at the time of hysterectomy of injury to the bladder and its prompt repair. Thirty patients had undergone earlier failed attempts at repair elsewhere. Three fistulas closed spontaneously. One hundred and seven were repaired by the Latzko technique. There were nine failures, each of which was successfully repaired by a repeat Latzko operation when vaginal re-epithelisation was complete. Suggestions to avoid injury to the bladder during abdominal total hysterectomy include use of a two-way indwelling catheter when risk factors are present, use of sharp dissection to isolate the bladder, use of extraperitoneal cystotomy when dissection is difficult, filling the bladder when injury is suspected and repair of an overt bladder injury only after mobilisation of the injured area. A Latzko repair of a vault fistula is advised because complications are minimal, the postoperative patient is comfortable and the period of hospitalisation is five days or less.

[214]R Meeks & MD Ghafar 'Vesicovaginal and urethrovaginal fistulas' (2012) *Glob. Libr. Women's Med.*, available at http://www.glowm.com/section_view/heading/Vesicovaginal%20and%20Urethrovaginal%20Fistulas/item/64 (accessed 7 July 2014). The authors state that some predisposing risk factors for vesicovaginal fistula include a history of pelvic irradiation, caesarean section, endometriosis, prior pelvic surgery or pelvic inflammatory disease, diabetes mellitus, concurrent infection, vasculopathies and tobacco abuse.

(iv) several alternative hypotheses existed that could have been the cause of the fistula, of which the most obvious were leakage from the vaginal vault and injury to a friable bladder wall during dissection;

(v) the defendant should have been aware that the plaintiff was predisposed to develop a vesicovaginal fistula and should have followed up and re-examined her with tests such as a cystoscopy or sonography; and

(vi) although the occurrence of a fistula *per se* might not be an indication of negligence (*culpa*), the lack of follow-up care to detect the injury may indicate substandard medical care.

Undoubtedly, the complicated medical concerns provide for legal questions, of which the most difficult would be factual and legal causation. The injury occurred six weeks after the medical intervention. On the one hand, assisting the plaintiff's case, the medical condition of the plaintiff carried a high risk of such injury, which called for an examination of the manner in which this was managed. On the other hand, several alternative causes of injury were identified, which counted against the plaintiff's case: damage to the wall of the bladder during surgery, a leak that weakened the wall and developed later, and even the presence of HIV compromised the immunity of the plaintiff, resulting in infection at the surgical site. The medical causes and effects should be based on logical medical principles.[215] If an alternative cause of injury is suggested by the same facts and it obscures a most probable explanation for the injury it constitutes conjecture and the plaintiff's case must fail. The plaintiff's case was dismissed on the strength of *Van Wyk v Lewis*[216] with the court stating 'that the maxim could rarely, if ever, find application in cases based on alleged medical negligence'. The court explained that the human body and its reaction to surgical intervention are very complex. It cannot simply be said that, because there was a complication, the surgeon must have been negligent in some respect. The court held that–

[215]Meeks et al (n 214). The aetiology (cause) of a vesicovaginal fistula at the time of hysterectomy is uncertain. Some fistulae are the result of an unrecognised bladder laceration at the time of dissecting the bladder free of the cervix. Even cystotomies that are repaired have a risk of fistula formation. A fistula may also arise from avascular necrosis secondary to crush injury or erosion of a vaginal cuff suture into the bladder. A fistula may also follow an uncomplicated operation, as the result of a pelvic haematoma that ruptures into the bladder postoperatively. Devascularising the bladder or vaginal cuff could lead to fistula formation and can be minimised with mobilisation of tissue planes. Other causes exist like radiation-induced fistulas, vaginal foreign bodies, direct trauma and infections.

[216]*Van Wyk* (n 1) 462.

> logic dictates that there is even less room for the application of the maxim in a case like this, where it has not even been established what went wrong; where the views of experts are all based on speculation – giving rise to various, but equally feasible possibilities – as to what might have occurred.[217]

9 Conclusion

Only when one properly understands the medical realities of a particular harmful incident is one in a position to judge whether the doctor-defendant acted unreasonably or failed to take reasonable steps to guard against foreseeable harm, and whether the injury was caused by the medical professional's culpable actions. With reference to several case studies, this chapter illustrated the depth and intricacy in medical reasoning and showed that the diagnostic process is a process of elimination that attempts to determine the most probable cause of illness, running in parallel with initial provisional treatment, if necessary, and eventually overflowing into definitive treatment. For example, a recording of a high temperature is a sign of a possible underlying disease or infection. Further blood tests may confirm or exclude evidence of an infection, eg the white cell count may be raised. Further radiological investigation may point, for example, to an abscess in the abdominal cavity. Diagnosis is a constant process that is analysed and re-analysed with several changes if need be to the diagnosis, until the medical condition of the patient improves. A vast amount of medical literature is available globally for the medical professional to keep abreast of the best available medical evidence in the field. The medical professional's search for the underlying cause and effect of a disease or illness forms the basis for factual causation in law. The particular conduct of the professional during that particular time and in those circumstances is measured against that of a reasonable medical professional in the same field.

The delictual elements of factual and legal causation[218] link the defendant's action directly with the injury. First, it is a medical question that asks the medical expert to furnish the court with a medical explanation regarding what occurred ie setting the expected standard of care for the court. Second, if the medical reality is appreciated, the elements of factual and legal causation will be investigated to link the defendant's action ie the delivered standard of care, with the injury and then to determine whether liability can be attributed to the defendant. Third, from the evidence led by the defendant in defending the allegation of

[217] *Buthelezi* (n 186) para 16.
[218] Chapter 2 para 4.3.

negligence the court determines whether his conduct was consistent with the expected standard of care or whether it was negligent. For example, in *Ntsele v MEC for Health Gauteng Provincial Government*,[219] the defendant in his defence presented an alternative non-negligent cause of injury, viz that the foetus suffered injury (asphyxia) in the womb[220] during the antenatal period and before the mother went into labour. If that scenario was accepted by the court, the harm was caused by something other than the defendant's management of the labour process as the foetus was injured whilst in the womb and before any medical involvement of the defendant. On the same facts, the plaintiff would not have proved factual causation as the injury was then unrelated to the defendant-doctor's management of the labour process. The plaintiff would have lost her case. In order for the plaintiff to be successful, she has to show evidence of lack of care during the birth process. This will show the legal nexus between the inadequate actions and the health status of the foetus during birth. On the other hand, if the plaintiff has *prima facie* proved her case and the defendants have failed to provide medical expert evidence showing that the injury to the baby occurred before the birth process, the defendant would not be successful in his defence. It is argued that negligence and causation cannot be determined without a proper evaluation of the expected care against the delivered care and so understanding the medical reality. This *ipso facto* excludes the application of the maxim for the vast majority of, if not all, medical negligence cases.

[219] *Ntsele* (n 180). See para 8.1 above.

[220] The defendants had to indicate that any of the following aspects formed part of the antenatal period. R Liston, D Sawchuck & D Young 'Fetal health surveillance: Antepartum and intrapartum consensus guideline (2007) 29(9) *Journal of Obstetrics & Gynaecology Canada* p 545ff. During the antenatal period, episodes of lack of foetal growth, foetal movement, cardiac function and heart rate and clinical picture will point to abnormalities. Previous history of stillbirths or premature abortions is indicative of antenatal problems. See http://sogc.org/wp-content/uploads/ 2013/01/gui197CPG0709r.pdf, chap 3 (accessed 14 March 2014).

CHAPTER 5: SYSTEMATIC ANALYSIS AND FUNDAMENTAL OBSERVATIONS

1 The current legal status

Paul Feyerabend stated that paradigms are based on different assumptions regarding the structure of their domain which makes it impossible to compare them in a meaningful way. This thesis argues that the application of the *res ipsa loquitur* maxim in medical law leads to false impressions because medical paradigms are significantly different from legal paradigms. The research was based on a subsection of the law of evidence, namely, the factual presumption of negligence and causation evoked by the *res ipsa loquitur* maxim within the ambit of medical negligence litigation. The research material from South Africa comprised case law and conflicting legal arguments. These inconclusive findings resulted in the introduction of material from the United Kingdom and Wales in search of clarification. English cases were selected based on less complicated medical principles although the study gravitated towards cases where legal principles eg causation and negligence with reference to the application of the *res ipsa loquitur* maxim were demonstrated. The thesis (i) discussed the legal position of the maxim in South Africa and in England; (ii) addressed the application of the maxim in medical negligence cases in both jurisdictions; and (iii) focussed largely on the medical reality of each case to determine how the English court deals with the elements of negligence and causation when accepting the maxim. The latter investigation was required because the South African court, unlike the English court, does not allow for a presumption of negligence based on lack of care - in the wider sense - when an unexpected injury occurred under the control of the defendant. Since 1924, the South African court has excluded the application of the *res ipsa loquitur* maxim for medical cases. Recent cases attempted to re-introduce the maxim, with uncertain results. The study explored academic arguments that favoured the application of the maxim, stating that the South African court should follow the English example[1] and should allow for the *res ipsa loquitur* maxim to be invoked in all medical cases in South Africa. The thesis discovered that, according to South African law, a retained swab is only subjective evidence of negligence in the uninformed mind and that the South African court should be presented with enough evidence to balance the actions of the defendant against the globally accepted medical standard dictated by the profession. The study argued that the South African court's rejection of the maxim in medical law is

[1] *Van Wyk v Lewis* 1923 E 37; 1924 AD; also see chapter 2 paras 4 and 8. A presumption of negligence on the fact of the injury in circumstances under the defendant's control is in line with the English court's approach of the maxim. See chapter 3 para 3.

defensible. In a medical negligence case the elements of factual causation, legal causation and negligence can only be determined once the medical principles are explained. The delictual elements are disregarded when the *res ipsa loquitur* maxim is pleaded causing a plaintiff to be insufficiently prepared in a medical case.

Since English law has influenced South African law, it is unsurprising to see some similarities between the English system of tort law and the South African law of delict. Both the South African court and the English court experienced problems with determining causation ie the *conditio sine qua non* of a medical case. As the element of factual causation stems from the medical chain of events explained in the medical reality, this notion in the determination of liability is the source of much confusion, particularly if a plaintiff is not assisted by a medical expert. Furthermore, it seems from the contemporary use of the *res ipsa loquitur* maxim in England that the court encourages the use of the maxim, but with supporting expert medical evidence in complex cases.[2] Both the English[3] and the South African[4] courts seem to hold that sufficient medical expert evidence should be presented in support of medical cases. The thesis argues that it indicates that the courts need to understand medical reality to allow the *prima facie* test. Both legal systems dictate that the defendant has to comply with the expected standard of care determined by common law, the community and the profession. The conduct of the defendant is weighed against the conduct of a reasonable doctor from the same branch of the profession who exercises skill and care in following the accepted standard of care. The satisfactory standard of care is more than mere skill and care. It describes the method or safe practice or standard to follow in order to avoid risks and complications in a medical intervention. It is explained to the court by the medical experts in context of medical principles.

It was noteworthy to find that the legal jurisprudence governing the law of tort in England and the law of delict in South Africa has developed along different lines, evident from the incrementally changing common law of both countries. The intention of the English court to move to a more inquisitorial system in 1998 and the change in the practice directives[5] certainly allows the court to participate in the medical fact-finding duty, even if it still

[2]*Ratcliffe v Plymouth & Torbay Health Authority* [1998] Lloyd's LR 162 (CA), where Brook J said that in a simple case the *res* may speak at the end of the layman's evidence, and the judge would decide the case on inferences drawn from all the evidence. Hobhouse J said that the claimant may rely on some broad-based inference of negligence but has to adduce some expert evidence to pass the *prima facie* test.
[3]*Ratcliffe* (n 2); also see chapter 3 para 7.
[4]*Van Wyk* (n 1); also see chapter 2 para 4.
[5]The Civil Procedure Rules 1998 came into force on 26 April 1999.

remains predominantly adversarial in nature. On the other hand, the South African court remains adversarial in nature, revealing a substantial and procedural difference in the presentation of medical negligence cases between the countries. The South African court is a trier of fact and a trier of law, and does not enter the litigation arena. The court ultimately decides whether the plaintiff has discharged his onus of proof on a balance of probabilities based on all the elements in delict, namely, factual and legal causation, wrongfulness and negligence. The court weighs all the evidence and determines the most probable cause of the harm. In South Africa the Rules of Court[6] allow for exceptions to pleadings and applications to have the matter dismissed where the plaintiff's allegations lack the averments necessary to sustain an action. If a South African plaintiff is relying on a presumption of negligence based on the fact of the injury, then there is a considerable risk that the case will be dismissed because the plaintiff failed to allege a proper 'cause of action'. An English claimant, with the use of the *res ipsa loquitur* maxim (where he presented expert medical evidence), gets a preview of the alternative cause of injury explained by the defendant before advancing to trial. This rebuttal is in reaction to a presumption of lack of care – the function of the maxim - because of the unusual nature of the injury in circumstances under the control of the defendant. The English parties may appoint a joint medical expert but may also instruct their own experts to present their cases. Although the English court actively participates in pre-trial case management procedures the medical cause of the injury is still presented independently to the court. When the maxim is applied, the court has to be convinced that the defendant's explanation in rebuttal of the *res ipsa loquitur* maxim is plausible but, without medical expert evidence to evaluate the evidence of the defendant, this would be very difficult. This was evident in *Saunders v Leeds Western Health Authority*[7] where a four-year-old child went for a hip-repair operation and suffered cardiac arrest. The extremely rare complication of paradoxical embolus was offered as an explanation in rebutting the claimant's claim of insufficient skill, care and management of her medical condition. If this case was presented to the South African court, the plaintiff would have to provide adequate medical evidence to show that, the defendant ought to have foreseen certain risks and complications and guarded against it - such as cardiac arrest; That his failure to act with the required skill and care - below standard - when weighed against the actions of a hypothetical reasonable doctor (the accepted standard), caused the injury.

[6]The Supreme Court Act 59 of 1959, Rule 23.
[7][1993] 4 Med LR 355. See discussion in chapter 3 para 3.

The two legal systems show further differences when one ventures into the legal technicalities. In accordance with the law of delict in South Africa,[8] if a defendant owed a legal duty to the plaintiff not to cause harm to the plaintiff and he failed in his duty to the plaintiff, the actions of the defendant would be wrongful. The South African court accepts that a medical accident or adverse event may be grounds for satisfying the element of wrongfulness in cases of injury to property or person, but without establishing the further elements of delictual liability the South African plaintiff will not be successful with his action. A South African court requires a proper understanding of the medical reality as the basis for determining the cause of injury - factual causation - as an element in delict. The notion of legal causation is then determined from the sequence of events deciding which is the more operative cause in law of the claimant's damage. In addition, the element of negligence (*culpa*) is tested when the conduct of the defendant is investigated to determine his role in the cause of the injury and whether it was in accordance with accepted medical practice. It would be unproductive to test for negligence, which the defendant should have foreseen and guarded against, without understanding the risks and complications of a medical intervention (what to foresee and prevent). Potential risks and complications of a medical event, obtained from the set standard of the profession, alert a doctor to the dangers of the planned medical intervention and the appropriate steps to avoid them. For example, if there was a risk of bleeding during surgery, the court would test whether the defendant (aware of the risk) took certain measures to avoid such a risk. If he did not, his conduct would be below standard and he would be liable. If any one of the elements in delict is not addressed and satisfied the plaintiff's case will fail. The South African court does not accept the application of *res ipsa loquitur* in medical negligence cases. It was held that in order to be placed as near as possible in the same position of the defendant-doctor, the court need to be provided with the accepted standard of the profession. A court cannot decide a case in the abstract without considering the medical evidence explained by a medical expert in context with the surrounding circumstances. The court in *Van Wyk v Lewis* stated that in medical negligence cases more evidence is needed to determine negligence (*culpa*) than what an inference based on the fact of the injury (the *res ipsa loquitur* maxim) allows. The court held that such an inference is not even *prima facie* evidence of negligence,[9] as there are cases where negligence cannot be inferred from the accident itself. The South African court is reluctant to arrive at a

[8]Chapter 2 para 4 for a discussion of all the elements of the law of delict in South Africa.
[9]*Van Wyk* (n 1), where Innes CJ held that the *res ipsa loquitur* maxim is relevant in cases where the occurrence is such that the court can infer negligence from it. In this case negligence was not obvious from the events.

legal conclusion following an inference of a general kind of negligence,[10] as found in the design of the *res ipsa loquitur* maxim. It is argued that the *res ipsa loquitur* maxim does not discharge all the requirements of a claim based on delictual liability in South African medical law. As it stands, a plaintiff has to bring an action for negligence (fault) based on all the elements of delictual liability. The plaintiff has to make particular allegations that the defendant breached his legal duty owed to the plaintiff by not acting with the necessary skill and care in accordance with the expected standard of care. These allegations will meet all the elements of the delict based on expert medical evidence where the medical expert explained the medical reality and the cause of injury. The plaintiff's cause of action is thus based on the elements of wrongfulness, negligence, factual causation, legal causation and damage.

In England, according to the law of tort,[11] negligence is proved if a duty of care owed to the claimant by the defendant was breached and it caused the damage suffered by the claimant. The element of duty of care includes foreseeability and prevention of possible harm. The English court allows for a general form of an inference of negligence based on the unexpected nature of the injury that occurred in a situation under the control of the defendant. An adverse event is interpreted (in its broader sense) as *prima facie* evidence of a lack of care and a breached duty of care that calls for an answer from the defendant. The English court accepts the use of the *res ipsa loquitur* maxim as an evidentiary principle functioning as a rebuttable inference of negligence. Although in a medical case the English court discourages the use of the maxim without supporting expert evidence, a claimant might succeed, based on the alleged lack of care of the defendant, without addressing the element of factual causation in particular.[12] In other words, the cause of injury may be perceived as rather basic ie the unusual nature of the undesired outcome of the incident under the control of the defendant invokes a presumption that the defendant's lack of skill and care caused the claimant's injury. This is enough to seek an explanation from the defendant. Several English cases[13] illustrate such a general inference of negligence without a particular medical explanation about the

[10] *Macleod v Rens*1997 (3) SA 1039 (E) 1047I–J.
[11] Chapter 3 para 2 for a discussion of principles of the law of tort in England.
[12] *Cassidy v Minister of Health* (1951) 2 KB 343; 1 All ER 574; *Glass v Cambridge Health Authority* [1995] 6 Med LR 91 (QB).
[13] *O'Malley-Williams v Board of Governors of the National Hospital of Nervous Diseases* [1975] 1 BMJ, where the claimant underwent an aortogram after stenosis of the right carotid artery was diagnosed and he suffered a permanent injury to the nerves of his right hand; *Mahon v Osborne* [1939] 2 KB 14 at 23, where the claimant underwent surgery for a duodenal ulcer and a swab was retained; *Delaney v Southmead Health Authority* [1995] 6 Med LR 355, where the claimant went for a cholecystectomy and postoperatively discovered an injury to the brachial plexus which was unrelated to the planned operation.

exact cause of the injury.[14]Because England has adopted a more inquisitorial model and in complicated medical cases claimants in England almost invariably present expert evidence and no longer rely on the maxim *without* expert evidence the need for the maxim might, in principle, disappear. It is concluded that in complicated cases the English court if relying on the maxim without presenting expert evidence will experience all the same risks which is argued as the basis for justifiably rejecting the maxim in South Africa.

2 Historical insights

The thesis found that the history of the South African law of delict has developed but has in principle remained strongly rooted in its historical past. The influence of Roman law is seen in the legal systems of England and Wales as well as in the South African legal system, and has provided the basis for tort law principles and the principles of the law of delict respectively. In Roman law there existed a number of civil wrongs of which the more important ones were *damnum injuria datum* and *injuria.*[15] Mason[16] explains that the Romans decided upon a 'practical remedy' by which they 'extended the doctrine of civil obligations' to cover the realm of personal property; one recognises the basis of recent civil law principles in this approach. Mason states that the 'punitive vengeance' of the Twelve Tables evolved into legal sanctions to compel compensation when private property was damaged. Frier[17] argues that, while the ancient Romans 'were under no general obligation' to ensure that others did not experience material loss, they were required 'to act with care' in circumstances where their actions risked causing such loss to another. Citizens of Rome were obliged to understand the 'prerequisites of social life' and were expected to tailor their actions to avoid causing loss to others.[18] It is for this reason that Ulpianus 'construes *iniuria* as loss inflicted by *culpa*' even when 'the wish to harm' was absent, for one has a duty to be careful and aware of the consequences of one's actions. The civic obligations implicit in the notions of

[14]See chapter 3 para 3, 4.3 and 5. It is different from delictual law in South Africa. Cf chapter 2. In South Africa, the elements required proving liability in general and in medical negligence cases are: (1) an act or a failure to act; (2) wrongfulness; (3) negligence; (4) causation; and (5) damage. These elements relate to the same delict. Each element has its separate test and prerequisites. The above elements give rise to a delictual action based, for example, on medical negligence.

[15]Chapter 2 para 2. Except in the case of *injuria* causing physical injury to the person (from the Twelve Tables), the remedy will usually be based on *actio injuriarum* (a purely penal action).

[16]Chapter 2 and A Mason 'The standards of care and the Lex Aquilia' (2002), available at http://www.roman-empire.net/articles/article-021.html (accessed 14 June 2014).

[17]Chapter 2 para 2; BWA Frier *Casebook on the Roman Law of Delict* (1989).

[18]In Case 19 Paul maintains that a tree-trimmer on private land is liable for killing a passing slave by 'throwing down a branch'. In failing to call out a warning, ie to 'foresee what a careful person should have foreseen', he had violated these social prerequisites.

culpa and *dolus* imply the existence of an unwritten standard of care; Frier even describes the adherence to the aforementioned obligations as a 'duty of care'. This led to an extension to Aquilian liability, which often included liability for individual omissions of duty. The principle of *boni mores* was established, which forms part of the determination of wrongfulness in delictual liability.[19] Although South African law is based on the Roman-Dutch law introduced by Dutch settlers who dictated the procedural law in South Africa,[20] the annexation of South Africa by the British during 1860 influenced South African law. Currently, the South African court is still strongly influenced by the English court in medical negligence matters[21] but the common law developed in different ways. The South African court remains reluctant to apply the maxim and the English court regards the maxim as an important measure to assist the claimant in getting to court. The variances between the legal systems were investigated with regard to the constitutional right to bodily integrity and fair administrative principles, namely, whether the maxim should not be considered as a tool to assist a plaintiff to court. Because s 39(1)*(b)* of the South African Constitution dictates that a court, tribunal or forum must promote the spirit, purport and objects of the Bill of Rights, a future South African court may allow a substantial departure from its historical principles, by bending the principles of the rule of law when considering a medical negligence case. Some of these constitutional considerations are discussed below.

3 Principal findings

The thesis adopted the approach that when perceptions are based on assumptions made from elements within a domain (the law) it becomes difficult to compare it in a material way with a different domain (medicine).[22] When the *res ipsa loquitur* maxim is applied in medical law in South Africa, it causes confusion because of the different paradigms, law and medicine. An adverse outcome for a patient has different meanings for the legal profession than it does for the medical profession, and therefore the fact of the injury in a medical case in South Africa cannot lead to an inference of negligence - not even a rebuttable presumption of negligence. It is merely a possibility of negligence, as the basis (medical reality) from which the conclusion (*culpa* and/or liability) is to be drawn is abstract and uncertain. If the medical

[19]Chapter 2 para 4.
[20]Chapter 2 para 2.
[21]Chapter 2 para 3; *Goliath v MEC for Health in the Province of Eastern Cape* 2014 ZASCA 182, where the English case *Ratcliffe* (n 2) was discussed.
[22]Chapter 1 para 1.

standard cannot be determined then the elements of negligence and factual causation remain indeterminable for the South African plaintiff. The purpose of the maxim is to request the court to draw a negative factual inference from the available facts, which cannot be done reliably in the South African law, if the facts are not meaningful. The cause of the injury is usually not easily determinable to an uninformed person and for that matter, the court. Put differently, the application of the maxim, as the law stands in South Africa, should have all the key facts to allow the court to infer a high probability of negligence (*culpa* and liability) from the occurrence of an unexplained fact of the injury. It is argued that, in South Africa, this is similar to asking the court to discount a deficiency in the plaintiff's evidence or even to allow the unsatisfactory finding that the defendant was negligent in some general or unqualified manner and then put a reverse onus of proof on the defendant. The maxim remains inappropriate for medical negligence cases in South Africa or any other field of specialisation, for that matter, because the elements in delict cannot reliably be determined from the fact of the harm (injury) alone. The English court clearly places more weight on the maxim and this becomes evident when a defendant does not rebut the presumption. It is then perceived as a *prima facie* case. It has a reverse-onus effect because, if an English plaintiff advances to court based on the maxim alone and the defendant does not rebut the maxim, the plaintiff will be successful without knowing exactly what caused the injury or why the defendant's conduct was perceived to be negligent (careless); the only fact that would be known, is that the injury was probably caused by the defendant. Once it was recognised that the common law of the two systems developed differently – the reason why the maxim can be applied in England and not in South Africa - the writer considered whether a relaxation in legal principles eg causation, could level the balance in the doctor-patient relationship.

3.1 Overview of the conclusion of the study

In conclusion, the thesis emphasises that the South African court has to appreciate and understand the medical scientific principles of a medical case in order to weigh the set standard of the profession against the standard delivered by the defendant. This makes the design of the maxim inappropriate for South African medical law. The writer's approach was substantiated with discussion throughout the study of clinical medicine explaining the causes of injury against the expected standard of care ie the management of a patient to diagnose, to treat and to prevent further injury or disease. The clinician examines the patient and by means of the diagnostic process eliminates other possible diagnoses from the more serious to the

lessor serious diagnoses. The medical professional, being aware of research in his specific field of expertise, uses it to find the best available information and treatment for his patient, ie the standard of care against which he will be measured. The patient makes an informed decision based on the clinician's assessment of the risks of the planned treatment against its benefits. Evidence-based literature is perceived and interpreted as the collective opinion of a body of medical experts. Departure from an acceptable standard of care and medical practice may be evidence of negligence, unless it is justified. A medical expert reports on information obtained from nursing notes, hospital records, diagnostic results and clinical notes of the defendant-doctor to establish whether the care was in accordance with accepted standards or whether it was substandard. The medical course is a chain of events and the South African plaintiff has to establish whether the defendant-doctor exercised the same reasonable care as a hypothetical doctor in accordance with the prescribed standard. For example, if a clinician failed to make a correct diagnosis the court will look at the information that was available to the defendant-doctor at the time, and how he eliminated other causes to arrive at the diagnosis. The thesis illustrates within medical context that, an unaware South African plaintiff would undoubtedly fail to show causation and negligence, in most cases, without the assistance of a medical expert.

The reconstruction of medical scenarios from previous case law was used to demonstrate that, once the medical cause of the injury/disease/illness becomes comprehensible, the basis for factual causation is established. If a cause of action is presented that is corroborated by medical expert evidence, the plaintiff has a *prima facie* case of negligence which means it is sufficient evidence to call for an answer in rebuttal. The defendant now has to refute the evidence or his case will fail because of the evidence against him. The previous chapter showed that the process of testing the elements in delict against the medical reality is multifaceted and based on legal reasoning. For example, the conduct of the defendant is established by hearing his subjective evidence namely, that he was aware of a complication and how he took steps to prevent it. This cannot be inferred by the use of the *res ipsa loquitur* maxim in South Africa. The weight that the South African court gives to the maxim is not enough to compel an answer from the defendant. This is not the result of a misdirection by the South African court, but rather a result of ascribing functions to the maxim that are not consistent with the South African law of delict. To reiterate the stance of the South African court: the court is unable to impose liability on a defendant if insufficient information is available to place the court in the same position in which the defendant had

been and to allow for an evaluation against the prescribed standard of care. A South African plaintiff would be unwise to use the maxim based on an unsupported and superficial acceptance that an adverse outcome typically arises from negligence (*culpa* or liability) in medical negligence cases; besides being inconsistent with delictual principles, the unfortunate outcome may be because of an underlying disease and completely unrelated to negligence.

In the cases involving retained swabs, one sees that the English court, as far back as 1939 in *Mahon v Osborn*,[23] was reluctant to attribute negligence to the defendant based on an obvious case of a retained swab, because of the court's incapability to understand the 'ordinary process' of medicine. More recently, the English court discourages the use of the maxim without the support of medical expert evidence, but has not excluded the use of the maxim.[24] Without medical expert evidence, the English claimant may rely on the maxim to compel an explanation from the defendant, but then carries the risk that the defendant's explanation may be accepted by the court. The mere fact that the defendant has to rebut the presumption of negligence against no other evidence from the claimant puts the claimant at a disadvantage. The court now has to find the medical reality without the benefit of weighing the expert evidence against the accepted standard of care, based on the fact that the defendant might concentrate on defending his case rather than providing the required standard of care. The evidentiary presumption of negligence of the maxim carries more weight in the English court than in the South African court. The function of the maxim, in England, creates a *prima facie* inference of negligence based on the fact of the unusual injury (lack of care) in circumstances under the control of the defendant. The defendant has to explain why he should not be found in breach of his legal duty of care. In his defence, he has to provide evidence that he acted with the required skill and care. The maxim is given the weight of a rebuttable presumption, which effectively creates a reverse onus of proof at least to discharge the presumption and the defendant has to provide a non-negligent explanation of the injury. It is argued that this is one of the main reasons why the maxim is successful in England and not in South Africa. Furthermore, the English court has the benefit that the move towards a more inquisitorial system may place the presiding officer in a better position to determine the lack of care and the origin of the cause of harm from the medical facts, either from the defendant's medical expert in rebuttal or the claimant's medical expert evidence. The risk for the claimant remains: the defendant's creative explanations may be accepted by the court if the claimant

[23]Mahon (n 13) 23, 31, where Scot LJ stated that not every mistake imports liability and it is sometimes necessary to consider the different circumstances before deciding whether the defendant was negligent.
[24]*Ratcliffe* (n 2). See chapter 3 para 7.

presents no further scientific medical evidence. Perhaps the English court acknowledges the extended status of the *res ipsa loquitur* maxim for no other reason than to compel an answer in rebuttal from the defendant early in the case. The problem is that any explanation from the defendant in rebuttal cannot be discharged by the claimant if accepted by the court. The use of this evidentiary tool available to the claimant may have a procedural advantage – giving a claimant a preview of the defendant's explanation of the cause of the injury. However, such an argument is not convincing in the light of the exotic explanations that was given in rebuttal by the defendants, for example in the *Saunders* case discussed above.

In South Africa it was found, at best, in *Van Wyk v Lewis*[25] and *Goliath v MEC for Health in the Province of Eastern Cape*,[26] that there was evidence indicating a possibility of insufficient care, because of a perceived lack of preventing foreseeable harm – the element of wrongfulness. Indeed, in *Van Wyk v Lewis*[27] the defendant was faced with a very difficult operation in order to save the patient's life,[28] and testified regarding the care he took to establish whether a swab was retained. Of importance is that the court was correct not to apply the *res ipsa loquitur* maxim in the presence of inconclusive circumstantial evidence, regardless of the retained swab. In *Goliath v MEC for Health in the Province of Eastern Cape*[29] the defendant performed a 'routine hysterectomy operation' in 'a modern surgical theatre in circumstances where there were no suggestions that the plaintiff's life was in danger', with no information to refute the allegation of negligent conduct. No information was led regarding the careful or careless conduct of the defendants' actions eg 'counting of swabs prior to sewing-up the patient' and so forth. In this case, the defendant failed to refute the allegations of negligence and, 'although the procedure performed on [the plaintiff] was under the control of the [defendant's employees], and what they did or did not do was exclusively within their direct knowledge, none of these employees were called to testify'. In the latter case, the court[30] referred to the English case *Ratcliffe v Plymouth and Torbay Health Authority*,[31] stating that 'it is likely to be a very rare medical negligence case in which the

[25]*Van Wyk* (n 1), where a swab was retained in the abdomen of the plaintiff and later evacuated.
[26]*Goliath* (n 21), where a swab was retained that caused recurrent infection, which was surgically removed at a later stage.
[27]*Van Wyk* (n 1).
[28]Chapter 4 para 5.2 for a detailed discussion of the case. If the surgeon presents evidence that the function of the theatre sister was to keep track of all the swabs used because he had to attend to other more urgent aspects of the operation, then the defendant might escape liability. If the theatre sister was a party to the legal proceedings and failed to show that she took steps to confirm proper swab-counting actions to avoid the retention of swabs, she would have neglected her legal duty to the doctor and the patient.
[29]*Goliath* (n 21) para 16ff.
[30]*Goliath* (n 21) para 17.
[31]*Ratcliffe* (n 2) para 48.

defendants take the risk of calling no factual evidence, when such evidence is available to them, of the circumstances surrounding a procedure which led to an unexpected outcome.' Ponan J continued, arguing from the English case, that–

> in a civil case it is not necessary for a plaintiff to prove that the inference that she asks the court to draw is the only reasonable inference, it suffices for her to convince the court that the inference that she advocates is the most readily apparent and acceptable inference from a number of inferences.[32]

The defendant failed 'to adduce any evidence, whatsoever, [and] accordingly took the risk of a judgment being given against him.' The success of the plaintiff's case was not based on any general presumption of fact but on insufficient evidence provided by the defendant to rebut the plaintiff's *prima facie* case of negligence. The plaintiff, on a preponderance of probability, discharged the onus of proof, which rested on her. Of significance, and to be welcomed, is the reluctance of the court to apply the *res ipsa loquitur* maxim and to discourage the use of the maxim in any future medical cases.

As it stands, assessed, argued and reconfirmed, the South African court's approach in *Van Wyk v Lewis*[33] is firmly in place as before, and the *res ipsa loquitur* principles are *de lege ferenda* not accepted in medical negligence cases. Although the court in *Goliath v MEC for Health in the Province of Eastern Cape*[34] did not explicitly reject the maxim, it discouraged any further use of the *res ipsa loquitur* maxim in medical negligence cases. It is argued that the South African court's continued rejection of the maxim has contributed to the development of using proper medical expert evidence to provide *prima facie* evidence against defendants. To reiterate, the study agrees with Van den Heever and Carstens,[35] but from another perspective:

> Thus, if the aforegoing assessment cannot be made by having regard to the occurrence alone, so that the surrounding circumstances must also be considered in order to arrive at a conclusion, *res ipsa loquitur* does not find application.

[32]*Goliath* (n 21) para 19ff, quoting *AA Onderlinge Assuransie-Assosiasie Bpk v De Beer* 1982 (2) SA 603 (A); *Cooper and Another NNO v Merchant Trade Finance Ltd* 2000 (3) SA 1009 (SCA).
[33]*Van Wyk* (n 1). See chapter 2 para 3 and 8.
[34]*Goliath* (n 21). See chapter 2 para 8.
[35]P van den Heever & P Carstens *Res Ipsa Loquitur and Medical Negligence* (2011) 136.

This is indeed the reason why the maxim should not apply to medical negligence cases in South Africa as the uninformed person and court, for that matter, cannot make legal conclusions without the benefit of appreciating medical reality based on medical expert evidence.

3.2 The difference in the use of the maxim between South Africa and England

The core dissimilarity between the application of the *res ipsa loquitur* maxim in England and in South Africa lies in the difference between the two legal systems, the management of the design of the maxim and the interpretation of the inference of negligence created by the maxim. The English court allows the maxim, to 'prevent a defendant who does know what happened from avoiding responsibility simply by choosing not to give any evidence'.[36] In *Mahon v Osborne* Goddard LJ stated that the surgeon is in control of the operation and '[i]f, therefore, a swab is left in the patient's body, it seems to me clear that the surgeon is called on for an explanation'.[37] The South African court said that, according to the principles of delict, a presumption of negligence (fault) cannot be attributed to the defendant simply based on a retained swab. All the delictual elements should be established before inferring negligence or determining negligent conduct. The court in *Macleod v Rens*[38] stated that the application of the maxim leads 'to the somewhat unsatisfactory finding that the defendant was negligent in some general or unspecified manner'. In *Van Wyk v Lewis*[39] the court held that the maxim only allowed for an allegation of lack of care and skill, and the correctness of such an allegation can be determined only after considering all the facts. It is not an absolute test and depends on the circumstances of the case. The court has to be placed as closely as possible in the position of the defendant to test for negligent conduct. Sufficient medical information is needed for the court to weigh all the evidence on a balance of probability. Blum AJ confirmed this stance in *Pringle v Administrator Natal*.[40] Van den Heever and Carstens[41] argue that the occurrence of a retained swab is presumed negligent conduct until proven otherwise. The defendant should explain his actions similar to the English system.

[36] *Mahon* (n 13). See chapter 3 para 3.
[37] *Mahon* (n 13) 50.
[38] *Macleod* (n 10) 1048.
[39] *Van Wyk* (n 1) 444ff.
[40] 1990 (2) SA 379 (W) 380, where the judge referred to *Van Wyk* (n 1). The court indicated that 'this maxim cannot be invoked where negligence or no negligence depends on something not absolute but relative'.
[41] Van den Heever & Carstens (n 35) 136.

The thesis argues that this cannot be a plea to introduce a legal presumption in the place of a factual presumption created by the maxim, as it would elevate the maxim to a rebuttable presumption in law. It is not the accepted function of the *res ipsa loquitur* maxim or factual presumptions in South Africa. It is unsatisfactory to suggest that the element of negligence (*culpa*) should be overlooked when raising a presumption of negligence based on the injury. It is not possible to determine from the circumstances - a retained swab - whether the defendant could have foreseen and prevented the occurrence. There may be countless alternative explanations for why a swab was retained, for example the patient went into cardiac arrest (heart failure) during abdominal surgery and they had to abort the operation or the surgeon becoming ill and so forth. Such circumstances will justify the wrongful act of leaving a swab behind, and such reasons were mentioned by the court when it rejected the *res ipsa loquitur* maxim. The thesis also demonstrated that a medical emergency[42] may justify apparently negligent conduct (*culpa*), as the medical professional may not have been in a position to foresee the injury. However, the accepted standard suggests that he should manage such an emergency with skill and competence to alleviate the injury (the element of negligence).

The South African delictual law does not allow a general allegation of negligence based on lack of care, *even in a situation where the injury occurred under the control of the defendant-doctor*. The South African court interprets it as a mere possibility of lack of care if all the circumstances are not known. In the latter situation, the elements of negligent conduct (*culpa*) and factual causation are not evident from the available facts of the particular occurrence. Therefore, it does not give rise to a *prima facie* case of liability or an obligation on the defendant to answer in rebuttal. The South African court was very clear that the standard of care against which the defendant should be weighed cannot be determined without the assistance of medical experts. Thus, the argument is not whether the maxim should be interpreted as meaning conclusive evidence of negligence (irrebuttable presumption of negligence) or even *prima facie* evidence of negligence (rebuttable presumption of negligence), the true issue is that the fact of the injury in South Africa, is a mere possibility of negligence that needs to be tested. If the court does not have enough evidence from the fact of the injury to place itself in the position to ascertain whether the defendant delivered the required standard of care, the court cannot request the defendant to

[42]Chapter 4 para 5.2 for a discussion of emergency circumstances.

defend the action. The court would not even recognise the fact of the injury as a cause of action without sufficient medical evidence to support such an allegation.

3.3 General constitutional considerations

The thesis considered the statement that the application of the maxim may level any imbalance in the doctor-patient relationship that results from the fact that the patient sometimes does not even know what occurred under anaesthesia and is therefore at a disadvantage. The thesis celebrated the South African court's relaxation of legal principles of causation in circumstances where the element of negligence was proved and linked with the injury suffered by a South African plaintiff. It showed the court appreciates and recognises the constitutional rights of a patient to be treated with bodily integrity in a dignified and fair manner. The Constitution of South Africa[43] is the overriding law of the country, and is the legal foundation for the rights and duties of the citizens of the country. It also defines the government's duties to its citizens. Chapter 2 of the Constitution - the Bill of Rights - provides for civil, political and socio-economic rights, and applies to all law, including the common law. The Bill of Rights binds Parliament, the government and the judiciary. Sections 10, 11, 27 and 33[44] of the Constitution are relevant to medical law.

The Constitutional court continues to develop the common law as held in *Carmichele v Minister of Safety and Security*[45] where the court dictated that there is a general obligation on the court to develop the common law to promote the values enshrined in the Constitution. Section 27 deals with health rights in the context of the limited resources of the state:

> (1) Everyone has the right to have access to–
>
> (a) health care services, including reproductive health care;
>
> (b) sufficient food and water; and
>
> (c) social security, including if they are unable to support themselves and their dependents, appropriate social assistance.
>
> (2) The state must take responsible legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights.

[43]The Constitution of the Republic of South Africa, 1996 (the Constitution)..
[44]Section 10 describes the right to dignity; s 11 describes the right to life; s 27 describes the right to health care, food, water and social security; and s 33 describes the right to just administrative action.
[45]2001 (4) SA 938 (CC).

(3) No one may be refused emergency medical treatment.

In 1997, the South African Constitutional Court adapted the convictions of the community.[46] The constitutional rights concerning health care delivery were restricted because of limited public resources.[47] The right to health care is now a qualified right because of the economic limitations of the state. In certain instances, eg with renal dialysis, the state cannot assist all chronic patients, even though they may be the neediest and terminal patients. It was demonstrated that the court did not take into consideration general principles about 'who shall live when not everyone can' or was not dictated to by ethical determinations, but allowed the state to restrict such a right because of economic decisions.[48] This restricted right to health resources (an adapted constitutional right) has affected the law of delict as the court tests the element of wrongfulness against the expectations and convictions of the community. In addition, the court considered the 'reasonableness'[49] of the change in public policy considerations with its impact on the community. The Constitutional Court approved the

[46]*Soobramoney v Minister of Health (Kwazulu-Natal)* 1997 ZACC 17; 1998 (1) SA 765 (CC); 1997 (12) BCLR 1696; see chapter 2 para 4.1. Also see *Government of Republic of South Africa v Grootboom* [2000] ZACC 19; 2001 (1) SA 46 (CC); 2000 (11) BCLR 1169 (CC), where the Constitutional Court was faced with another challenge of constitutional rights. The court acknowledged that in certain instances the rights of the poor and socially disadvantaged might be frustrated. In this case, the court held the state to a much more rigorous standard for 'reasonableness', requiring that it should give consideration to the needs of the most disadvantaged in the fulfilment of its constitutional obligations. The Constitutional Court reiterated that executive policies should be challenged if they are found to be unreasonable.

[47]*Soobramoney* (n 46). The 'universal' constitutional right to medical treatment was challenged and changed because of the under-resourced health care system of the state. It was common cause that the life of the plaintiff could be prolonged with the assistance of renal dialysis machines, but his medical condition could not be cured. The court explains that if Mr Soobramoney were to be given the full benefit that he claimed, he would be receiving more than what everyone else received. The standards were set in accordance with availability of renal dialysis services and resources. The court encourages the public to challenge these executive policies if they are found to be unreasonable.

[48]*Soobramoney* (n 46). Also see C Petrini 'Triage in public health emergencies: Ethical issues' (2010) 5(2) *Internal Emergency Medicine*137–144. General concepts about medical disasters, public health and triage are outlined. Triage is the term used to decide the order of treatment when there are a large number of patients. Petrini describes triage in the context of public health emergencies and disaster settings, and discusses the main ethical values at stake in triage. Possible conflicts between competing values are outlined. Special attention is given to possible conflicts between the protection of individual interests (typically of clinical ethics and humanitarian ethics), and the pursuit of collective interests (typical of public health and triage). Hippocratic ethics are compared to utilitarian ethics and to perspectives that emphasise the principle of justice. Three ethical attitudes are suggested that may contribute to a resolution of competing values: protection of human dignity, precaution and, especially, solidarity. Personalism promotes the collective good by safeguarding and giving value to the well-being of each individual. A personalistic perspective is suggested as a way to deepen the concept of solidarity as a pillar both of clinical and public health ethics.

[49]The 'reasonableness' in the context of wrongfulness should not be confused with the 'reasonableness' in the context of the element of negligence, where the action of a defendant is tested against a reasonable doctor acting under similar circumstances. See chapter 2 para 4.1, where the court refers to *Le Roux v Dey* 2011 (3) SA 274 (CC) 315.

limited rights of citizens and changed the common law regarding public policy because of the limited resources of health care delivery.

One may criticise the court in *Soobramoney v Minister of Health (Kwazulu-Natal)*[50] for failing to distinguish between resources made available and resources that ought to have been made available. For no apparent reason, the court avoided scrutinising the allocation of resources. One would have expected an investigation into the allocation of funds and the possible misappropriation of funds, in the light of the ongoing mismanagement and findings of fraudulent misappropriation in government funding. One also would have expected an adequate analysis regarding the ethical rationale behind the set of rules that was adopted,[51] as medical principles conflict with utilitarian principles. Is it good policy for medical professionals to have to decide on social principles? If the decision is based on utilitarian principles, one should look into doing the greatest good for the greatest number, or adopt the do-no-harm principle, or make a decision on the 'who shall live when not everyone can' principle. If the decision is based on clinical medical principles, the worst-off patients would be treated first, as they are the neediest and the most urgent cases, and have the lowest prospects of recovery. Maybe the poor and disenfranchised are the worst off. Does that mean wealth determines certain rights? The aforementioned questions are some of the controversial issues that one would have expected to see in the court's reasoning, before it limited the constitutional rights of the poor. Remarkably, the South African Constitutional Court opens the door to another form of discrimination as it differentiates between the poor and the wealthy in respect of the right of access to medical treatment. One is alarmed at the prospect that in the future the court might confuse limited resources with a lack of resources due to mismanagement. Soon, limited resources will equal lack of intensive-care beds, lack of vaccination, lack of anti-retroviral and tuberculosis medication, lack of medical facilities and so forth. Despite understanding and applying the aforesaid medical standards and principles and notwithstanding the properly presented legal arguments, certain rights may never be protected or the breach thereof enforced for the poor, until the court reconsiders its position or the state addresses the issue of inadequate resources.

It was argued throughout the study that the *res ipsa loquitur* maxim was rejected because in medical negligence cases the maxim does not satisfy all the elements of delictual liability. In the light of the developing common law regarding the restricted constitutional

[50] *Soobramoney* (n 46).
[51] See Petrini (n 48).

rights of poor patients, it is clear that *res ipsa loquitur* is too plain a term to even include the extent of the element of wrongfulness. Public policy considerations have been redefined and no longer support the 'feeling' of the general *boni mores*, as the expected right to health care has been confined to a qualified right against available resources. Information in this context has to be provided to the court, which *ipso facto* excludes the application of the maxim.

As discussed previously[52] the South African Constitution not only protects individuals against the state, it also applies to the legal relationships between citizens. The South African courts must develop the common law and customary law by promoting the spirit, purport and objects of the Bill of Rights. All constitutional rights of human beings should be acknowledged and respected. The constitutional court moved towards a substantive approach that incorporates aspects eg socio-economic and even environmental circumstances, when deciding whether a right had been infringed. This transforming purpose of the Constitution is placing the emphasis on human right values and embracing the spirit of the Constitution. In the context of medical law and the *res ipsa loquitur* maxim, if, for constitutional and policy considerations, the South African court should decide to depart from established principles and imposes a genuine reverse onus on a doctor-defendant to show cause why he should not be negligent (rebuttable presumption), it would, in turn, encroaches on a defendant's right to fair and administrative justice. Such a change could also encourage litigation for the wrong reasons based on unrealistic expectations that lack merit. It is, however, commendable to see the new constitutional approach of the South African court in *Premier of the Western Cape v Loots NO,*[53] *Lee v Minister for Correctional Services*[54] and the recent case, *Oppelt v Head: Health, Department of Health Provincial Administration: Western Cape.*[55] In the latter case, the court applied a more flexible approach of factual causation principles and ruled in favour of the plaintiff, despite the fact that the plaintiff was unable to show that, had he been treated in time, he would not have been paralysed. Similar to the English court in *Chester v Afshar*[56] where patients' rights and a lighter burden of proof on the claimant were seen to bend traditional causation principles, the South African judiciary is now more willing to challenge medical opinion in medical negligence cases.

[52]Chapter 1 para 1; chapter 2 paras 1, 7, 9.
[53][2001] ZASCA 32, where causational principles were relaxed. See chapter 2 para 7.
[54]2013 (2) SA 144 (CC), where factual causation principles were applied in a flexible manner. See chapter 2 para 4.3 and 7.
[55][2015] ZACC 33. See chapter 2 para7.
[56](2004) All ER (HL). See chapter 3 para 6.3

The arguments of Van den Heever and Carstens[57] were considered. They argue that:

(i) the maxim should apply to medical cases because a plaintiff is treated unequally if he is deprived of the right to use the maxim;

(ii) the maxim will assist a plaintiff who is at a disadvantage because he has no medical knowledge of what happened;

(iii) the maxim is not prejudicial to the defendant as it only calls for an explanation;

(iv) if a plaintiff is barred from invoking the maxim, this should be seen as unfair discrimination;

(v) the maxim may be broadly translated into the right to the highest attainable standard of health with reference to processes and outcomes.

The thesis argues that the suggested use of the maxim, ie similar to the English system's use of the maxim, would elevate the maxim to a level not consistent with legal principles in South Africa. The maxim is a mere factual presumption that might in certain circumstances call for an answer in rebuttal, which would rarely happen in a medical case. The South African court is clear[58] that in order for the court to apply the maxim in the first place the court must be convinced that the fact of the injury indicates a high probability of negligence. This is not possible in a medical case as the information before the court (the fact of the injury) has no meaning for the court without the medical context and the circumstances of the case being explained. The South African court held explicitly[59] that sufficient evidence should be available for the court to place itself in the exact same position as the defendant-doctor. If this is not possible, the maxim is not appropriate. The thesis argues that a medical case must be based on *prima facie* evidence of negligence supported by medical expert evidence. In addition, the thesis argues for the South African court to continue to be flexible in its application of legal concepts, such as factual causation, in order to properly consider the autonomy of persons and the dignity of patients. This approach may assist the plaintiff by levelling the playing fields and by making the doctor more aware of patients' rights.

[57]Van den Heever & Carstens (n 35) 151ff.
[58]Chapter 2 para 8.
[59]*Van Wyk* (n 1). See chapter 2 paras 3 and 8.

3.4 Specific constitutional considerations

The introduction of these specific constitutional considerations at this late stage is *obiter* but, it is included because of its impact on the doctor-patient relationship, particularly that of the patient. As indicated above, the new constitutional considerations towards human dignity and human worth and the court's aim to protect and promote constitutional values in a fair and just manner may eradicate certain perceived injustices in future. The following case highlights the manner in which patients' rights can be affected when a court is insensitive to the plight of the patient. The Prescription Act[60] states that the period in respect of any delictual claim - including a claim for damages for personal injury - is limited to three years. Reducing the time period for an action to be brought to court would be wrongful if it limits an existing right or deprives an individual of a remedy to bring a legal action to court, unless it is reasonable and justifiable.

In *Truter v Deysel*[61] the plaintiff challenged the Prescription Act as the six surgical interventions on which the claim was based occurred over a period of seven years. The plaintiff lost the sight in one eye as a child and then developed a cataract (clouding of the lens) in the remaining eye. The fact that he lost his eyesight in his remaining eye and eventually the eye itself gave rise to the plaintiff's claim. In July 1993, the first defendant, who was in her seventies, performed a cataract operation with a lens implantation on the plaintiff. The medical expert information (only explained in 2000) revealed that the removal of a cataract involves the removal of the natural lens of the eye by means of a high frequency ultrasound device that breaks the cloudy lens into small pieces which are then gently removed. All the remnants of the cloudy lens have to be removed and then replaced with an artificial lens. The artificial lens is positioned behind the iris and pupil of the eye in the same location as the natural lens. The operation is performed through a small opening in the peripheral cornea (side of the front part of the eye) to gain access to the lens. Much of the thin clear membrane that surrounds the natural lens is left intact to receive the artificial intraocular lens. In the plaintiff's case the posterior clear membrane (capsule) of the lens remained hazy. This occurs as a result of clouding of the part of the lens covering that remains after surgery,

[60]The Prescription Act 68 of 1969 sets the time limits for the instituting of civil actions.
[61]2006 (4) SA 168 (SCA); 2005 (5) SA 598 (C), reported by PA Carstens & DL Pearmain *Foundational Principles of South African Medical Law* (2007) 858ff.

and is called posterior capsule opacification.[62] The cloudiness affects the vision of the patient and it is corrected by means of a YAG laser capsulotomy, whereby a laser is used to cut a hole in the clouded back lining of the lens capsule. This allows light to pass through the membrane to the retina at the back of the eye and improves the vision of the patient.

The YAG laser capsulotomy performed by the first defendant was not successful. Residual natural lens material was left behind and the natural lens covering (capsule) was damaged to such an extent that there was no natural 'bed' to receive the artificial lens. Furthermore, the plaintiff developed corneal oedema (swelling of the front covering of the eye) and a prolapse of the iris of the eye that needed correction. The plaintiff still could not see and further removal of residual lens material was needed. The plaintiff, having lost all trust in the first defendant, consulted the second defendant, who found that the first lens had slipped into the vitreous material of the eye because of the damaged 'bed'. He also had to remove the vitreous material from the front part of the eye as it had seeped through the gap caused by the capsule damage. He furthermore had to remove the residual lens material. He inserted a new intraocular lens and had to secure it by placing a stitch through the sclera of the eye as the natural cover (capsule) had been damaged. The plaintiff's eyesight remained compromised and, in addition, he suffered from decompensation (deterioration) of the cornea. He consulted another eye surgeon who performed a corneal graft. A stitch became septic and, after a long battle with the sepsis, they had to eviscerate the plaintiff's eye. The plaintiff wrote to the Health Professions Council (HPCSA) to complain that a simple cataract operation had resulted in such a severe consequence. The plaintiff failed to obtain a medical expert report that indicated that the medical intervention was not done according to the required standard of care and only obtained such a report seven years later in 2000.

The court of first instance ruled that, in terms of s 12(1) of the Prescription Act, prescription is initiated when a debt becomes due and a debt becomes due, in terms of s 12(3), when the creditor acquired knowledge of the identity of the debtor and of the facts from which the debt arose, provided that he would be deemed to have such knowledge[63] if he

[62]'Nd:YAG laser posterior capsulotomy after cataract surgery', available athttp://www.webmd.com/eye-health/cataracts/ndyag-laser-posterior-capsulotomy-for-cataracts (accessed 2 January 2015).

[63]Van Zijl v Hoogenhout *[2004] ZASCA 84; [2004] 4 All SA 427 (SCA), where a victim of child abuse went through emotional and psychological trauma and claimed for compensation against her wrongdoer. The court held that when prescription is raised as a defence it is the defendant who bears the onus of establishing as a matter of probability that prescription commenced to run and had expired before the action was instituted, and he or she is not relieved of that burden only because the material facts might be within the exclusive knowledge of the plaintiff. The court found for the plaintiff, based on the fact that there is ample corroboration to be found*

could have acquired it through reasonable care.[64] The court *a quo* held that prescription can begin to run only when the plaintiff acquired 'meaningful knowledge' of the wrong against him. The court ruled in favour of the plaintiff. On appeal the decision was reversed. The Supreme Court of Appeal stated that a conclusion of negligence can be drawn from a particular set of facts, which is not itself a fact but rather evidence, and, as such, the presence or absence of negligence is not a fact; rather, the presence or absence of negligence is a conclusion of law to be made by the court in the presence of all the circumstances of the specific case. The court held that s 12(3) of the Act does not require knowledge of the relevant legal conclusions or of the existence of an expert opinion that supports such conclusions. Therefore, the cause of action of the plaintiff is complete as soon as damage is suffered, not only in respect of loss sustained by him but also in respect of all loss sustained.

Van den Heever and Carstens[65] suggest that the Supreme Court of Appeal in *Truter v Deysel*[66] effectively opened the door for the *res ipsa loquitur* maxim to be reintroduced to medical negligence cases. Together with Carstens and Pearmain[67] they argue that the fact that the court stated that the plaintiff should institute an action against the defendant as soon as there is any indication of harm sustained, *even if the plaintiff has no supporting expert medical opinion that the harm or damages sustained are a result of alleged medical negligence,* may imply that the *res ipsa loquitur* maxim has 'slipped in through the back door'.

It is argued in support of Van den Heever and Carstens[68] and Carstens and Pearmain[69] that the court in *Truter v Deysel*[70] erred in holding that the plaintiff should advance to court without understanding the medical reality from which the cause of action is derived. The court failed to appreciate that a legal conclusion is based on an understanding the merits of the matter; therefore, the study disagrees that the *res ipsa loquitur* should have applied. The special plea of prescription should have been heard in the context of the medical reality obtained from the medical expert. The legal arguments should have illustrated to the court

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in a comparison between the experiences of the plaintiff and the professionally described sequelae of an abuse victim with a history like that of the plaintiff.
[64]*Truter* (n 61) 603G–I.
[65]Van den Heever & Carstens (n 35) 172ff.
[66]*Truter* (n 61), reported by Carstens & Pearmain (2007) (n 61) 858ff.
[67]Carstens & Pearmain (2007) (n 61) 857ff.
[68]Van den Heever & Carstens (n 35) 174ff.
[69]Carstens & Pearmain (2007) (n 61) 858ff.
[70]*Truter*(n 61), reported by Carstens & Pearmain (n 64) 858ff.

how ineffective such a judgment was in a medical negligence case. During the course of six surgical operations over a period of seven years, not only did the plaintiff lose his eyesight but also his eye. Without the support of medical expert evidence, the elements of factual causation, legal causation and negligence have been lost to the plaintiff and, for that matter, the court. In retrospect, if the plaintiff complied with the direction of the court and brought an action for negligence based on generalised allegations of negligence, should he base the allegations on the fact that his eyesight initially deteriorated, that he later lost his eyesight, or that he lost his eye eventually, or on all three of the incidents? Such information is not in the plaintiff's knowledge. Furthermore, what is the cause of action on which these allegations should be based? If based on a vague, unidentifiable wrongful act that may or may not have caused the plaintiff's loss of his eyesight and later his eye, the Rules of Court make it possible for the defendant to take exception that the claim is 'vague and embarrassing and lacks averments necessary to sustain an action', and the plaintiff would have his action dismissed in any event.

To follow the arguments of Van den Heever and Carstens[71] although not supported by the law of delict in South Africa,[72] yet allowed by the English court,[73] if the allegations of negligence could hypothetically be based on the adverse outcome alone (the design of the *res ipsa loquitur* maxim), the plaintiff could have chosen any one of the undesired outcomes as the basis for generalised negligence or a lack of skill and care. Assuming the court allowed a general allegation of negligence in support of the plaintiff's case (an inference of fact created by the *res ipsa loquitur* maxim); the defendants (having full knowledge of factual causation and negligence) would have been in a superior position to rebut the plaintiff's allegation. The case of the plaintiff would have been unsuccessful or dismissed based on the lack of a cause of injury. Assuming that the court allowed the case on the fact of the injury, any alternative explanation from the defendants (consistent with the facts or not) would have turned the argument in favour of the defendants. It is argued that, even if a general allegation of negligence was allowed in South African law, like the extended *res ipsa loquitur* maxim in England, it would not have been of any assistance to the plaintiff, but would rather have added to the plaintiff's burden to defend the response from the defendant in rebuttal and then to prove the case.

71Van den Heever & Carstens (n 35) 174ff.
72Chapter 2 para 8.
73Chapter 3 para 2.

The Prescription Act,[74] the foundation of the Supreme Court's approach in *Truter v Deysel*,[75] is relevant to the element of wrongfulness, as it changes the common law of the country and the convictions of the community (the *boni mores*). After a period of three years a plaintiff loses the right to enforce any delictual claim against a defendant. This limit is regarded as reasonable for a potential defendant as records are not kept indefinitely.

One might be able to argue that the solution for the plaintiff in the latter case may lie in challenging the constitutionality of such a statute of limitations in medical negligence cases where the medical condition or disability is ongoing (as was the case of Mr Deysel). One might also be able to dispute the interpretation of the Act, based on the plaintiff's inability to navigate the intricacies of medical science, but it is proposed that the answer lies with the medical professionals. In *Truter v Deysel* the medical professionals neglected their duty to inform the plaintiff about the medical facts and merits of the matter. As demonstrated throughout the thesis, the true medical clinical course explained by a medical expert forms the basis from which factual causation (and the other delictual elements) can be determined. Mr Deysel consulted several medical experts who simply failed to provide the medical reality. Mr Deysel requested assistance from the HPCSA, who failed in their duty to determine the medical reality of the case.

To request the court to reintroduce the archaic *res ipsa loquitur* maxim because of arguments of constitutional fairness or justice is avoiding the true issue. It is not the answer to introduce concepts that are not compatible with the South African law of delict, and there is doubt about their effectiveness in other jurisdictions. The answer should rest with the substantive approach of the Constitution of South Africa. In recent times, the South African court would take into consideration the right to bodily integrity and patient autonomy and the fact that the patient was not fully informed about the risks and complications. The court would, in accordance with the right to equality principles, balance the prejudice for the defendant against the prejudice for the plaintiff. The court may well consider the appointment of an independent medical assessor for the plaintiff, in the absence of proper medical expert evidence.

[74]The Prescription Act 68 of 1969, s 12(3) states that a debt becomes due when the creditor acquired knowledge of the identity of the debtor and of the facts from which the debt arose, provided that he would be deemed to have such knowledge if he could have acquired it by exercising reasonable care. See also *Truter* (n 61) 603G–I.
[75]*Truter* (n 61) reported by Carstens & Pearmain (n 61) 858ff.

4 Conclusion

The different approaches and opinions of legal analysts have been tested and the final conclusion of the thesis is in direct conflict with the recommendations of Van den Heever and Carstens in respect of the *res ipsa loquitur* maxim.[76] The thesis answered the questions raised in chapter 1.[77] The thesis found that the maxim is applied differently in South Africa and England, which effectively does not advance the argument to reintroduce the maxim to South African medical law. The South African function of the maxim, as a factual presumption, is allowed where facts can be inferred from other key facts. This was confused with a rebuttable presumption that creates a legal duty that should be answered by the defendant. The South African plaintiff, relying on the maxim in a medical case without supporting evidence, will have his case dismissed because he has not shown a cause of action. The South African court requests a plaintiff in a medical case to present sufficient evidence in order for the court to weigh such evidence against the conduct of the defendant in testing whether the standard of care fell below the requisite standard. In a medical case the evidence of an adverse event can never be interpreted as 'absolute' evidence that attracts a rebuttable presumption of negligence. It will always be relative evidence that attracts a possibility of negligence that still needs to be proved. This is as a result of the difference between the medical context and an ordinary occurrence of everyday life. When applying the *res ipsa loquitur* maxim in a medical negligence case, the facts of an occurrence (a medical adverse outcome) do not have meaning for an uninformed person without medical expert evidence. Therefore a presumption of fact cannot be made without understanding the medical reality, which would be the situation in all medical cases. The approach of the South African court is defensible: the court cannot test the alleged breach of a legal duty based on abstract evidence or on an unspecific or ill-defined allegation of negligence. The finding of liability should be based on a balance of probability taking into consideration all the facts and circumstances of the case, thus disqualifying the maxim *res ipsa loquitur* for all medical negligence cases in South Africa. In the rare situation where sufficient facts are available to establish a *prima facie* case then, in accordance with the rules of the maxim *per se*, the maxim is inappropriate as all the evidence is available to run the case on *prima facie* evidence. Most importantly, it was found that all the delictual elements should be deduced from the key facts for a court to accept the maxim. Throughout the analysis it was found that in medical negligence cases, when the application

[76]Van den Heever & Carstens (n 35) 34.
[77]Chapter 1 para 3.5.

of the *res ipsa loquitur* maxim was invoked, it was done in a 'general and unspecified manner',[78] neither substantiated by medical facts and medical interpretation nor in terms of delictual law requirements. The *res ipsa loquitur* maxim in a medical case creates an ambiguity similar to that found in the original use of the maxim in Cicero's speech[79] in defence of his friend Milo. Today one can appreciate that Cicero did not refer to particular facts but to general unspecified facts that led to the event. As it stands, the application of the maxim in medical negligence cases in South Africa has not been permitted since *Van Wyk v Lewis*[80] and this decision remains unaffected. The court in *Goliath v MEC for Health in the Province of Eastern Cape*[81] categorically discouraged the use of the maxim in any future medical negligence case. Although it is sometimes difficult for plaintiffs to obtain justice given this difficulty of establishing medical negligence that caused the injury, the *res ipsa loquitur* maxim is no solution to this problem, for all the reasons given before. In South Africa the maxim is a false friend, to both plaintiff and defendant. The *res ipsa loquitur* maxim has become *de facto* and *de lege ferenda* redundant in medical law in South Africa.

Lastly, the right to equality is guaranteed in the South African Constitution and everyone has the right to the protection and benefit of the law. Equality includes the full and equal enjoyment of all rights and freedoms for its people. The South African court now takes into consideration the broader context of patients' rights, and where harm is caused by a powerful group (eg a hospital) in respect of a disempowered and vulnerable group (eg patients), the constitutional rights of both parties must be considered, as well as the fact that in practice a poor and uneducated patient rarely has a voice in determining the course of his medical care. By importing other measures like reforming the South African civil procedure by introducing inquisitorial elements in our court procedure, enabling a greater degree of judicial questioning of witnesses or using mandatory medical court assessors may assist with correcting any possible imbalance.[82]The more flexible approach by the South African legal system regarding the rules of causation or negligence in respect of such material inequality as seen in *Oppelt v Head: Health, Department of Health Provincial Administration: Western Cape,*[83] potentially following the example of the English court in *Chester v Afshar*[84] is

[78]*Macleod* (n 10) 1048, where the court warned against a court glossing over a deficiency of a plaintiff's case and finding a defendant negligent in a general and unspecified manner. See chapter 1 para 1.2.
[79]Chapter 1 para 1.1 n 24.
[80]*Van Wyk* (n 1).See chapter 2 paras 3 and 8.
[81]*Goliath* (n 21). See chapter 2 para 8.
[82]Chapter 1 para 3.4.
[83]*Oppelt* (n 55); see chapter 2 para7.
[84]*Chester v Afshar* (2004) All ER (HL); see chapter 3 para 6.3.

celebrated and may well result in patients being correctly compensated in future, if they have suffered harm.

ABBREVIATIONS

AC	Appeal Cases
All ER	All England Reports
BMJ	British Medical Journal
BMLR	British Medical law Reports
Ch	Law Reports, Chancery Division
CLR	Commonwealth Law Reports
ER	England Reports
EWCA	England and Wales Court of Appeal
KB	Law Reports, King's Bench Division
Lloyd's LR	Lloyd's Law Reports
L R Exch	Law Report Exchequer Chambers
Med LR	Medical Law Reports
NSWLR	New South Wales Law Reports
QB	Law Reports, Queen's Bench Division
QC	Queen's Counsel
RTR	Road Traffic Reports
SJ	Solicitor's Journal
TLR	Times Law Reports
UKHL	United Kingdom House of Lords
WLR	Weekly Law Reports
AD	Appeal Division
LAWSA	Law of South Africa
SALC	South African Law Commission
SALJ	South African Law Journal

SAPL	South African Public Law
THRHR	Tydskrif vir Hedendaagse Romeins Hollandse Reg
TSAR	Tydskrif vir Suid-Afrikaanse Reg
TPD	Transvaal Provincial Division
NZLR	New Zealand Law Reports
civ	Civil
col	column
crim	Criminal
ff	following pages
J	Journal
L	Law
p	page
vol	volume

CASE LAW

SOUTH AFRICA

A

AA Onderlinge Assuransie-Assosiasie Bpk v De Beer 1982 (2) SA 603 (A)
Administrator Natal v Edouard 1990 (3) SA 581 (A)
Administrateur, Natal v Trust Bank Bpk 1979 (3) SA 824 (A)
*Administrateur v Van der Merwe*1994 ZASCA 83; 1994 (4) SA 347 (A)
Administrator, Natal v Stanley Motors Ltd 1960 (1) SA 690 (A)
Allot v Paterson and Jackson 1936 SR 221
Alston v Marine and Trade Insurance Co 1964 (4) SA 112 (W)
Applicant v Administrator Transvaal 1993 (4) SA 733 (W)
Arthur v Bezuidenhout and Mieny 1962 (2) SA 566 (A)

B

Bayer South Africa v Frost 1991 (4) SA 559 (A)
Blyth v van den Heever 1980 (1) SA 191 (A)
BOE Bank Ltd v Ries 2002 (2) SA 39 (SCA)
Bredell v Pienaar 1924 CPD
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Buls and Another v Tsasarolakis 1976 (2) SA 891 (T)
Buthelezi v Ndaba ZASCA 72; 2013 (5) SA 437 (SCA)
Butters v Cape Town Municipality 1993 (3) SA 521 (C)

C

Cape Town Municipality v Paine 1923 AD 207
Cape Town Municipality v Bakkerud 2000 (3) SA 1049 (SCA)
Carreira v Berwind 1986 (4) SA 60 (Z) 63
Carmichele v Minister of Safety and Security and Another 2001 (1) SA 489 (SCA) and 2001 (4) SA 938 (CC)
Castell v De Greeff 1994 (4) SA 408
Clinton-Parker v Administrator Transvaal 1996 (2) SA 37 (W)
City Council of Pretoria v Walker 1998 (3) BCLR 257 (CC)
Cooper & another NNO v Merchant Trade Finance Ltd 2000 (3) SA 1009 (SCA)
Collins v Administrator Cape 1995 (4) 73
Coppen v Impey 1916 CPD
Country Cloud Trading CC v MEC, Department of Infrastructure Development 2014 (2) SA 214
Crown Chickens (Pty) Ltd t/a Rocklands Poultry v Rieck 2007 (2) SA 118 (SCA)

D

Dalion Materials (Pty) Ltd v Cintrust (Pty) Ltd 1978 (3) SA 599 (W)

Delphisure Group Insurance Brokers Cape (Pty) Ltd v Dippenaar and Others 2010 (5) SA 499 (SCA)
De la Rouviere v. South African Med and Dental Council 1977 (1) SA 85 (N)
Dube v Administrator Transvaal 1966 (4) SA 260 (T)
Dudley Lee v the Minister of Correctional Services 2011 (6) SA 564 (WCC), 2012 (3) SA 617 (SCA), ZACC 30

E
*Eskom v Hendriks*2005 (5) SA 503 (SCA)
Esterhuizen v Administrator Transvaal 1957 (3) SA 710 (T)

F
F v Minister of Safety and Security 2005 (6) SA 419 (CC)
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