

The Locality Rule in the South African Public Health Care System Observations and Applications

by

Andries Nicolaas Jan Daniël Alberts

Submitted in fulfilment of the requirements for the degree

MPhil (Medical Law and Ethics)

In the Faculty of Law,
University of Pretoria

October 2016

Supervisor: Prof PA Carstens

Table of contents

Declaration of originality	4
Abbreviations and subject-specific terminology	5
Chapter 1; Executive summary and Research Question	
1. Executive summary	7
2. Defining the research question	7
Chapter 2; Ethical-legal background	
1. Ethical background	11
2. Legal background	14
Chapter 3; Aim, Objectives, and Hypotheses	
1. Aim	17
2. Objectives	17
3. Hypotheses	17
Chapter 4; Literature overview	
1. USA	
1.1. <i>Small case</i>	18
2. SA	
2.1. <i>Van Wyk case</i>	19
2.2. <i>Tembani case</i>	19
2.3. <i>Oppelt case</i>	21
2.4. <i>Nyathi case</i>	21
Chapter 5; Discussion	
Background	23
1. Clinical Environment	
1.1. Difference between SA ^{Pub} HC- and SA ^{Pub} HC ^{Acad} Hospitals	25
1.2. <i>Van Wyk case</i>	27



1.3.	<i>Tembani case</i>	28
1.4.	<i>Oppelt case</i>	28
2.	Physical Environment	
2.1.	<i>Small case</i>	29
2.2.	<i>Van Wyk case</i>	29
2.3.	<i>Tembani case</i>	30
2.4.	Power outages	30
2.5.	Vital medications	30
2.6.	Vacant posts	31
2.7.	Available resources	32
2.8.	Case reports	32
2.9.	Medical malpractice litigation storm	35
3.	Psychological Environment	
3.1.	Hours of duty	37
3.2.	Workplace conditions	39
3.3.	Environmental responsibility	41
3.4.	Practitioner-patient ratio	42
3.5.	Administrator-clinician ratio	44
3.6.	Staff shortages	44
3.7.	Transformation and Equity	45
3.8.	Public perception	48
3.9.	Financial mismanagement	50
3.10.	Political will	52
3.11.	Medical records	53
3.12.	Salaries	53
Chapter 6; Conclusions and recommendations		
1.	Deficiencies at three levels	54
2.	NHI	54
3.	On-going application of the LR	55
4.	Recommendation	55
5.	SA ^{Pub} HC Practitioners' liability	56
6.	Weaknesses of the study	56

Chapter 7; Bibliography

1.	Books	57
2.	Case law – domestic	57
3.	Case law – international	58
4.	Discussion documents and policy papers	58
5.	Internet sources	58
6.	Journal articles – domestic	58
7.	Journal articles – international	59
8.	Legislation	59
9.	Newspaper reports	60
10.	Other	60
11.	Acknowledgments / Consultations	61



Abbreviations and subject-specific terminology

Abbreviations

SA ^{Pub} HC System;	South African Public Health Care System
SA ^{Pub} HC Hospital;	South African Public Health Care Hospital
SA ^{Pub} HC ^{Acad} Hospital;	South African Public Health Care Hospital linked to an Academic Institution (University Medical School)
SA ^{Pub} HC Practitioner;	South African Public Health Care Practitioner
SA ^{Priv} HC System;	South African Private Health Care System
LR;	Locality Rule

Subject-specific terminology

Practitioner;	Used interchangeably with “Health Care Practitioner”. Serves as an umbrella term incorporating Interns, General Practitioners, Medical Officers, Registrars, Specialists, and Consultants. When referring to a Practitioner as “he”, “him”, or “his”, it also implies the opposite gender i.e. “she”, “her”, and “hers”
Intern;	Medical Doctor during the first 2 (of 3) compulsory years employed in the SA ^{Pub} HC System immediately following graduation
General Practitioner;	Medical Doctor without a field of specialization, working in Private Practice, i.e. “GP”
Medical Officer;	Medical Doctor without a field of specialization, working in the SA ^{Pub} HC System (SA ^{Pub} HC- or SA ^{Pub} HC ^{Acad} Hospital)
Registrar;	Medical Doctor without a field of specialization, working in a SA ^{Pub} HC ^{Acad} Hospital while training to become a Specialist or Consultant
Specialist;	Medical Doctor with a specific field of specialization
Consultant;	Medical Doctor with a specific field of specialization, employed specifically in a University teaching position in a SA ^{Pub} HC ^{Acad} Hospital
Locality;	Used interchangeably with “environment” and “facility”. The term includes any working environment where health care services are rendered to the public i.e. hospitals, clinics, practitioners’ rooms

Chapter 1

1. Executive summary

Provision of health care to the almost 60 million people residing in South Africa (SA) relies on two separate Health Care Systems operating in intermingled geographical proximity, yet in truth representing vastly different working environments or Localities.

This study is necessary against the stark reality that - generally speaking - the quality of health care in one Locality (SA^{Pub}HC System) is inferior to that in the other Locality (SA^{Priv}HC System) and this to a seemingly increasing magnitude.

The study will set out firstly, to identify clinically-relevant factors both from International and SA court rulings where the LR was applied – mostly in the traditional geographical context. Clinically-relevant factors from every-day clinical practice in the SA^{Pub}HC System will then, secondly, be identified and examined.

Based on these locality-specific clinically-relevant factors, the projected output of the study will extend towards identifying specific areas where SA^{Pub}HC Practitioners may be at risk of litigation by virtue of subjective and/or objective factors present in their specific Locality. Additionally, and of equal importance, is the identification of areas where timeous intervention could prevent adverse clinical outcomes, enhance service delivery, and improve patient care.

The projected impact of this study - so it is yearned for - will be firstly towards the possibility of the recognition of the SA^{Pub}HC System as a compromised environment. The second impact - flowing from the first - would be toward the possibility of the on-going application of the LR by the Judiciary in cases of medical negligence litigation involving SA^{Pub}HC Practitioners.

2. Defining the research question

The LR originated in the USA *circa* 1880 when Practitioner access to medical facilities, resources, and knowledge in that (geographically vast) country was neither universal, nor even. The LR was born out of the need to help protect Practitioners from medical negligence claims by recognizing that

*“physicians in rural and remote areas had limited access to facilities, resources and knowledge.”*¹ No provision however, is made for the LR in SA Medical Law, and SA^{Pub}HC- and SA^{Priv}HC Practitioners are hence painted with the same brush.

With the rapid sharing of knowledge and skill, courtesy of the explosion in global communication, the limitations in access *“to facilities, resources and knowledge”* were to disappear, and together with that, also the LR. Almost 50 years ago the future of the LR - at least as far as the USA was concerned - was prognosticated in no uncertain terms; *“(the LR would) gradually disappear almost completely”*.² In *Van Wyk v Lewis*,³ the SA locus classicus on medical negligence where the LR surfaced as subtext, Innes CJ observed that *“The ordinary medical practitioner should exercise the same degree of skill and care, whether he carries on his work in the town or the country, in one place or another. The fact that several incompetent or careless practitioners happen to settle at the same place cannot affect the standard of diligence and skill which local patients have a right to expect.”* More recently Van der Merwe and Olivier⁴, and Strauss⁵ held that, in view of modern developments, no justification exists for retention of the LR. The anti-LR drive received additional momentum with Ginsberg writing⁶ *“The locality rule, a topic of much discussion over many years in legal and medical scholarship, is archaic, anachronistic, and in fact, insulting to modern medicine. It is time to put this rule to rest.”*

Calls for doing away with the LR rest on three pillars;

2.1. Global village concept

With Online-learning (fax, Skype, YouTube, Vimeo, teleconferences, etc) and hands-on workshops being part of every-day medical life, the world has effectively become a global village, and medical skills should rapidly and equally permeate all Localities across any geographically vast or diverse landscape. Carstens & Pearmain⁷ make mention of *“telemedicine”* also known as *“cybermedicine”*. Two additional factors contribute to repeated and effective soaking of even the most remote of working environments with regularly updated medical knowledge. These are;

¹ Ginsberg MD. *The Locality Rule lives! Why? Using Modern Medicine to eradicate an unhealthy law.* 61 Drake L. Rev. 321 (2013).

² Waltz JR. *The Rise and Gradual Fall of the Locality Rule in Medical Malpractice Litigation.* DePaul Law Review Volume XVIII 1968-1969 pg 415 (1969).

³ *Van Wyk v Lewis* 1924 AD 438. Henceforth referred to as “the Van Wyk case”.

⁴ Van der Merwe NJ, Olivier PJJ. *Die Onregmatige daad in die Suid Afrikaanse Reg.* 5th ed. Pretoria: JP van der Walt, 1985.

⁵ Strauss SA. *Doctor, Patient and the Law.* 2nd ed. Pretoria: JL van Schaik, 1963.

⁶ Ginsberg *supra* 324. Marc Ginsberg is Assistant Professor of Law at The John Marshall Law School in Chicago.

⁷ Carstens & Pearmain. *Foundational Principles of South African Medical Law* (2007, LexisNexis) 638.

2.1.1. Good Practise Guidelines, and

2.1.2. Continuous Professional Development (CPD) Programmes

2.2. Standard of medical care

It is a well-established principle in our law that “*A medical practitioner is not expected to bring to bear upon the case entrusted to him the highest possible degree of professional skill, but he is bound to employ reasonable skill and care; and he is liable for the consequences if he does not.*”⁸

In deciding what is reasonable, the court will have regard to the general level of skill possessed and exercised by members of the branch of the profession to which the Practitioner belongs. Although the evidence of qualified Practitioners is of the greatest assistance regarding what the general level is, it may well be influenced by local experience. Hence it is possible, although unlikely, that all of the Practitioners in a LR jurisdiction could end up engaging in practicing substandard medicine. (The LR requires a Practitioner to provide reasonable skill and care matching that of a Practitioner in a similar [or same] community).

2.3. Expert witness

This aspect of the calling for the doing-away with the LR focuses on the need for expert witnesses in medical negligence litigation since “*the plaintiff bears a burden to establish the standard of care through expert witness testimony.*”⁹ It is not only the plaintiff who requires the input from an expert witness. The defendant-Practitioner requires an expert witness to testify on his compliance with the expected standard of care. It may however, prove difficult to engage and expert-witness Practitioner, since an expert from the same community may not be willing to testify against a colleague, and a witness from another community may not be qualified to testify due to unfamiliarity with local practice. This dilemma limits the availability of witnesses and expert opinion, and in addition also degrades the quality of the evidence produced by the plaintiff. The unfortunate result is the possibility of a small group of Practitioners not only establishing a local standard of care well below that which the law requires,⁸ but also potentially effectively insulating themselves from liability in cases of negligence.

Why then has this not happened, why has the LR not disappeared despite sensible arguments against its continued existence? Moreover, why has the LR recently re-surfaced as subtext in two

⁸ *Mitchell v Dixon* 1914 AD 519 at 525.

⁹ *Ginsberg supra* 331.

prominent cases in SA?^{10 11} At least two uncomfortable yet relevant questions, *specifically relating to the SA^{Pub}HC System*, mandate attention:

- Are there clinically-relevant factors¹² present impacting negatively on patient care which may leave the SA^{Pub}HC Practitioner vulnerable in cases of medical malpractice litigation?
- And if so, does sufficient evidence exist for the recognition of the SA^{Pub}HC System as a compromised environment? Is there indeed a shadowy side to the SA^{Pub}HC System deserving of the retention and continuous application of an “*archaic, anachronistic, and in fact, insulting to modern medicine*”⁶ Judiciary Rule?

To answer these questions the “*objective reality of the locality*”¹³ known as the SA^{Pub}HC System, deserves to be scrutinized. The latter quote hence unlocks the research question: Is the SA^{Pub}HC System, as working environment, deserving of the application of the LR in a new, non-geographic, format?

¹⁰ *S v Tembani* 2007 1 SACR 355 (SCA). Henceforth referred to as “the Tembani case”.

¹¹ *Oppelt v Head: Health, Department of Health Provincial Administration: Western Cape* [2015] ZACC 33. Henceforth referred to as “the Oppelt case”.

¹² This term refers to subjective- (to some extent within the influence of the Practitioner) and objective (beyond the influence of the Practitioner) factors inherent to a specific Locality likely to directly impact on clinical outcomes in the Locality; be it favourable or unfavourable.

¹³ Carstens PA. *The locality rule in cases of medical malpractice*. De Rebus June 1990 (421-3).

Chapter 2

Ethical-legal background

1. Ethical background

The statement; *“In civilized society, law floats in a sea of ethics”* serves as vessel upon which the following section soars or sinks.¹⁴

1.1. The Constitution of the Republic of SA¹⁵ represents the highest ethical-legal authority in the country. In this regard;

1.1.1.the State is bound to respect, protect, promote and fulfil the rights enshrined in Chapter 2 which is a cornerstone of democracy in SA¹⁶

1.1.2.the State must take reasonable legislative and other measures within its available resources to achieve the progressive realisation of the right of the people of SA to have access to health care services¹⁷

1.1.3.no one may be refused emergency medical treatment¹⁸

1.1.4.every child has the right to basic health care services¹⁹

1.1.5.everyone has the right to an environment that is not harmful to their health or wellbeing.²⁰

1.2. With regard to health care, the State has specific duties. The State primarily is a judicial institution with a judicial duty concerning its citizens. Government bears a judicial duty to make laws, and through effective governance enforce these (its own) laws, inter alia in the Health Care Sector. Having initiated a National Health Care Service, the State then holds the responsibility of continuously administering this Service, and cannot – as a matter of ease or escape – pass on this duty and responsibility to the Practitioners employed in the SA^{pub}HC

¹⁴ Earl Warren (1891-1974); 14th Chief Justice of the United States of America, 1953 – 1969.

¹⁵ The Constitution of the Republic of South Africa, 1996. (Hereafter referred to as “the Constitution”).

¹⁶ The Constitution, Bill of Rights, Section 7(2).

¹⁷ S 27 (2).

¹⁸ S 27 (3).

¹⁹ S 28 (1) (c).

²⁰ S 24 (a).

System.²¹ The State is hence obligated to fulfil its duties in terms of the Constitution, and must pass progressive legislation to give adherence to its constitutional obligations. Contained within this judicial duty rests an ethical duty as subtext. The State has the ethical duty of overseeing justice. Justice as a principle refers to fairness. In health care specifically, justice refers to the fair treatment of patients. The obligations of justice may be divided as follows;²²

- 1.2.1. Respect for morally acceptable laws – legal justice.
- 1.2.2. Respect for people’s rights – rights-based justice.
- 1.2.3. Fair distribution of limited resources – distributive justice.

Of note is the constitutional requirement from the State that constitutional obligations “*be performed diligently and without delay*”.²³

1.3. The Health Professions Act (HPA)²⁴ governs the Medical Profession, and states that the Health Professions Council of South Africa (HPCSA) is the ultimate governing body in this relation. The HPCSA promulgated “*Guidelines for Good Practice in the Health Care Professions (2006)*”²⁵. One of the most important of these ethical and professional rules is Rule 27A representing ethical values expected from Practitioners by the community at large. In the context of this mini-dissertation Rule 27A(e) maintains that a Practitioner shall at all times keep his professional knowledge and skills up to date.

1.4. Ethical duties of the Practitioner

1.4.1. The Practitioner has an ethical duty to himself in maintaining a professional practice – alternatively; to maintain professionalism in his Locality. Health Care Practitioners should:²⁶

- 1.4.1.1. Keep their equipment in good working order.
- 1.4.1.2. Maintain proper hygiene in their working environment.
- 1.4.1.3. Keep accurate and up-to-date patient records.
- 1.4.1.4. Refrain from engaging in activities that may affect their health and lead to impairment.

²¹ Heiberg PJ. Professor of Education, Department of Education and Culture (House of Assembly) 1986-1994, philosopher. Personal discussions.

²² Moodley *et al.* *Medical Ethics, Law and Human Rights – A South African Perspective* 73.

²³ *Mlatsheni v The Road Accident Fund* 2009(2)SA 401(E) para 14.

²⁴ 56 of 1974.

²⁵ Government Gazette R717/2006.

²⁶ HPCSA. *Guidelines for Good Practice in the Health Care Professions*. General Ethical Guidelines for the Health Care Professions. Booklet 1(8.2).

1.4.1.5. Ensure that staff members employed by them are trained to respect patients' rights, in particular the right to confidentiality.

1.4.2. The Practitioner has an ethical duty to others and society. Being registered as a Health Care Professional with the HPCSA confers on Practitioners the right and privilege to practise their profession. Correspondingly, Practitioners have moral and ethical duties to others and society, their colleagues and the public.²⁷ The core ethical values and standards required of Health Care Practitioners²⁸ include (i) Respect for persons, and (ii) Best interest or well-being (in addition to a number of others²⁹).

1.4.2.1. *Respect for persons.* Health Care Practitioners should respect patients as persons, and acknowledge their intrinsic worth, dignity, and sense of value. It may be of particular importance in the section of the population relying on the SAPHC System for health care services. This section of the population includes those marginalized by virtue of lack of financial resources, often contributing to a lack of a sense of intrinsic worth, dignity, and self-value.

1.4.2.2. *Best interests or well-being* includes

1.4.2.2.1. *non-maleficence;* the implication being that Practitioners should not harm or act against the best interests of patients, even when the interests of the latter conflict with their own self-interest, and

1.4.2.2.2. *beneficence;* the implication being that Practitioners should act in the best interests of patients even when the interests of the latter conflict with their own personal self-interest.

1.5. The responsibilities of patients are outlined in the Health Care Professions' Guidelines for Good Practice.³⁰

²⁷ HPCSA *supra* Booklet 1 (1.1).

²⁸ HPCSA *supra* Booklet 1 (2.3).

²⁹ *Human rights:* Practitioners should recognise the human rights of all individuals. *Autonomy:* Practitioners should honour the right of patients to self-determination or to make their own informed choices, and to live their lives by their own beliefs, values and preferences. *Integrity:* Practitioners should incorporate these core ethical values and standards as the foundation for their character and practice as responsible health care professionals. *Truthfulness:* Practitioners should regard the truth and truthfulness as the basis of trust in their professional relationships with patients. *Confidentiality:* Practitioners should treat personal or private information as confidential in professional relationships with patients - unless overriding reasons confer a moral or legal right to disclosure. *Compassion:* Practitioners should be sensitive to, and empathise with, the individual and social needs of their patients and seek to create mechanisms for providing comfort and support where appropriate and possible. *Tolerance:* Practitioners should respect the rights of people to have different ethical beliefs as these may arise from deeply held personal, religious or cultural convictions. *Justice:* Practitioners should treat all individuals and groups in an impartial, fair and just manner. *Professional competence and self-improvement:* Practitioners should continually endeavour to attain the highest level of knowledge and skills required within their area of practice. *Community:* Practitioners should strive to contribute to the betterment of society in accordance with their professional abilities and standing in the community.

³⁰ HPCSA *supra* Booklet 3 (3.1-10). Responsibilities of the Patient. Every Patient or Client has the following responsibilities: 1 To take care of his or her own health, 2 to care for and protect the environment, 3 to respect the rights of other patients and health care providers, 4 to utilise the health care system properly and not to abuse it, 5 to know his or her local health

Of note is the Constitutional provision that the State must fulfil its duties as resources permit. Surely the ethical duties as outlined above, likewise, can only be fulfilled by the Practitioner as resources in his Locality, i.e. in the SA^{Pub}HC Facilities, permit. The obvious difference (between State and Practitioner) lies in the fact that the Practitioner as individual has no resources. In the day-to-day running of the SA^{Pub}HC System purchasing of consumables and equipment are controlled by non-clinical employees in procurement sections of the individual SA^{Pub}HC System Localities. These sections in turn are subject to the Departments of Health of the specific Provinces. Ultimately, however, decisions regarding resources in the Locality where the SA^{Pub}HC Practitioner works, are made at a national level, very far removed from the dysfunctional Anaesthesia Workstation³¹ in the operating Theatre at the SA^{Pub}HC Hospital. Referring back to the ethical duty of the Practitioner in maintaining a professional practice as listed above; equipment past their guaranteed lifetime can hardly be kept in good working order, and proper hygiene is directly dependent on Cleaning Staff employed by the facility. Staff members employed in clinical positions by the human resources section of the Facility (with no input from the Practitioner³² heading the particular department) presents an ethical dilemma with regards to ensuring compliance to maintaining a professional practice.

2. Legal background

2.1. International law

The Constitution states that international law must be considered by our Judiciary when interpreting provisions in the Bill of Rights, yet foreign law may be considered.³³

2.1.1. American Medical Law is universally acknowledged as the origin of the LR, at least in part due to the geographical vastness of the USA. At the time the LR surfaced for the first time there was no consistency or uniformity in medical training or facilities in the

services and what they offer, 6 to provide health care providers with relevant and accurate information for diagnostic, treatment, rehabilitation or counselling purposes, 7 to advise health care providers of his or her wishes with regard to his or her death, 8 to comply with the prescribed treatment or rehabilitation procedures, 9 to enquire about the related costs of treatment and/or rehabilitation and to arrange for payment, 10 to take care of the health records in his or her possession.

³¹ An Anaesthesia Workstation is a cabinet-like structure housing much of the apparatuses used by the Anaesthetist during the conduct of an anaesthetic. The monitor (also housed by the Anaesthesia Workstation) is a computer screen continuously displaying essential data to the attending Anaesthetist on the patient's well-being during anaesthesia – i.e. how deep the patient is asleep, electrical and mechanical activity of the heart, oxygen content in the blood, blood flow to (e.g.) the brain and lungs, blood pressure, body temperature, etc. These would represent the minimum standards for monitoring during Anaesthesia as stipulated by the South African Society of Anaesthesiologists.

³² HPCSA *supra* Booklet 1 (8.2.5).

³³ S 39(1)(b).

USA. In its original format the LR holds that a Practitioner is judged by the standard of care in his particular Locality, i.e. it places a geographical dimension on the professional standard of care in medical negligence litigation.

2.1.2. Dr Levi Howard was a Country Practitioner residing and practising in Lowell, Massachusetts, in the USA, for many years. On occasion he was consulted by a patient, Mr Small, for an injury to his arm. The wound was quite extensive in that nerves, tendons, arteries, and even sections of bone were exposed. Dr Howard did what he could in caring for the wound, but was nevertheless sued for malpractice in dressing and caring for the wound. Confronted with the issues of (i) the suitability of Dr Howard's care, and (ii) the appropriate standard of care applicable to him as "country" Physician and Surgeon, the Supreme Judicial Court of Massachusetts found Dr Howard's conduct not negligent, and voiced the following: *"It is a matter of common knowledge that a Physician in a small country village does not usually make a specialty of Surgery, and, however well informed he may be in the theory of all parts of his profession, he would, generally speaking, be but seldom called upon as a Surgeon to perform difficult operations. He would have but few opportunities of observation and practice in that line such as public hospitals or large cities would afford. The defendant ... being the Practitioner in a small village ... was bound to possess that skill only which Physicians and Surgeons of ordinary ability and skill, practicing in similar localities, with opportunities for no larger experience, ordinarily possess; and he was not bound to possess that high degree of art and skill possessed by eminent Surgeons practicing in large cities, and making a specialty of the practice of Surgery."* This case³⁴ became celebrated as the origin of the LR, the rule placing a geographical dimension on the professional standard of care in medicine. Stated in another way: The LR is directed at the *"skill and learning commonly possessed and exercised by members of the profession who are of the same school and who practice in same or similar localities"*³⁵.

2.1.3. More recently only 21 states maintain a version of the LR whereby a Practitioner is judged by the standard of care in his particular geographical locality.³⁶ Most states hold to a national standard of care and skill for all Practitioners to adhere to.

³⁴ *Small v Howard* 128 Mass. 131 (1880). Henceforth referred to as "the *Small* case".

³⁵ Sherman Irvin. *The standard of care in malpractice cases*. Osgoode Hall Law Journal 222 vol 4 (226), 1966.

³⁶ Lewis MH et al. *The Locality Rule and the Physician's Dilemma, Local Medical Practices vs the National Standard of Care*. Journal of the American Medical Association, June 20, 2007.

2.2. SA law

2.2.1. The Constitution provides for the right to access to health care as basic human right in SA. Enactment of legislation however is needed to ensure the rights afforded in the Constitution are realized. The National Health Act (NHA)³⁷ as regulator of national health provides for uniformity in respect of health services across the nation by setting a National Health System which;

2.2.1.1. “encompasses public and private providers of health services”³⁸ and

2.2.1.2. “provide(s) in an equitable manner the population of the Republic with the best possible health services that available resources can afford”.³⁹ Workplace conditions in any given environment, or Locality, to a large degree depends on available resources. In the context of National Health, “available resources”, and specifically *how it is allocated*, is the topic of much debate – *vide infra*.

2.2.2. In the early 20th century reference to the LR was made by a court in SA, a country likewise of significant span, when the term “locality” was used in 1924 in the *Van Wyk* case.³ In different judgements the Appellate Division rejected⁴⁰ and accepted the LR. Regarding the latter view, Wessels JA elaborated on the use of the LR and agreed with American case law that the locality of practice is a factor that must be taken into account when assessing the conduct of the Practitioner when he stated; “*It seems to me, therefore, that the locality where an operation is performed is an element in judging whether or not reasonable skill, care and judgment have been exercised.*”⁴¹ Dr Lewis’ conduct was found to not have been negligent. This case still is the *locus classicus* on medical negligence in SA, with the LR strongly surfacing as subtext.

2.2.3. Although several cases of medical negligence were decided by the courts since then, the LR has never again been scrutinised, it has not yet been judicially revisited.⁴² More recently new life as it were, was blown into the LR when it surfaced as subtext in two prominent cases.^{10, 11}

³⁷ 61 of 2003.

³⁸ NHA Chapter 1 (2)(a)(i).

³⁹ NHA Chapter 1 (2)(a)(ii).

⁴⁰ *Van Wyk supra* 444.

⁴¹ *Van Wyk supra* 457.

⁴² Carstens & Pearmain in *Foundational Principles of South African Medical Law* 637.

Chapter 3

Aim, Objectives, and Hypotheses

1. Aim

1.1. To consider whether evidence exists supporting the recognition of the current-day SA^{Pub}HC System as a compromised Locality, deserving of the continued application of the LR in cases of medical negligence litigation involving SA^{Pub}HC Practitioners

2. Objectives

2.1. To identify clinically-relevant factors¹² highlighted by the Judiciary in the application of the LR both in the USA and SA

2.2. To identify clinically-relevant factors present in-and-around the current-day SA^{Pub}HC System¹²

3. It is hypothesised that:

3.1. The current day SA^{Pub}HC System represents a compromised environment, deserving of the application of the LR in cases of medical negligence litigation

3.2. A number or clinically-relevant factors¹² have been identified (or alluded to) by the Judiciary in cases of medical malpractice litigation where the LR was applied; both in the USA and SA

3.3. Subjective- and objective clinically-relevant factors¹² abound in the current-day SA^{Pub}HC System

Chapter 4

Literature overview

1. USA

1.1. A fairly wide range of terminology, *aimed at describing conditions in various Facilities*, has been employed in the original formulation and application of the LR. A number of these have been selected:²

1.1.1. Eminent Surgeons practicing in larger cities were said to possess a “*high degree of art and skill*”⁴³ not expected of a GP in a small village.

1.1.2. Courts a century ago were probably justified in adopting a presumption that the large city Practitioner enjoyed “*broader experience*” than his country cousin, and greater access to the “*latest medical knowledge*” and to the most advanced and elaborate “*facilities*” and “*equipment*”.⁴⁴

1.1.3. Reference has also been made to “*standards of medical practice*”⁴⁵ as well as “*similarity of conditions*”⁴⁶ in the realm of properly-qualified-to-testify experts.

1.1.4. “*education and training*” as well as “*technique in training*”⁴⁶ have also been considered as background factors inherently linked to Practitioners from different Localities.

1.1.5. The “*number and quality of hospitals, laboratories and medical schools*”⁴⁷ are typical considerations concerning the standard of care governing the defendant, in the context of Locality in medical negligence litigation.

1.1.6. “*available special resources*”⁴⁸, and “*medical and professional means available*”⁴⁹ have also been used.

1.2. In the *Small case*³⁴ reference was made to the care expected of “*the Practitioner in a small village*”.

⁴³ Waltz *supra* 410.

⁴⁴ Waltz *supra* 411.

⁴⁵ Waltz *supra* 412.

⁴⁶ Waltz *supra* 413.

⁴⁷ Waltz *supra* 415.

⁴⁸ Waltz *supra* 419.

⁴⁹ Waltz *supra* 418.

This fairly substantial collection of terms neatly stacks up into three piles of Locality-specific clinically-relevant factors¹² swaying the day-to-day character of any medical facility, including the current-day SA^{Pub}HC System (*vide infra*).

2. SA

The LR has not been judicially revisited since *Van Wyk*³ case, and hence a much less impressive range of clinically relevant factors¹² have been highlighted by the Judiciary.

2.1. In the *Van Wyk*³ case a swab remained in the abdominal cavity following a life-saving laparotomy. Dr Lewis, a Surgeon at the Frontier Hospital in Queenstown in the Eastern Cape, performed an emergency laparotomy on a patient sent to him by a GP. Commencing at about 20H00, “*artificial light*” had to be used, and despite Dr Lewis’ best knowledge, and an assurance from the Scrub Nurse that all swabs were accounted for, a swab remained in the patient’s abdomen after completion of the operation. No special emphasis was placed on the possible contribution of the (lack of) light as such in the ruling. The swabs used intra-operatively for clearing away blood, was different from the ones usually available. The Surgeon was subsequently sued but found not guilty by Wessels JA on the charge of negligence.

2.2. In the *Tembani* case¹⁰ the big divide between SA^{Pub}HC System and the SA^{Priv}HC System was emphasized with reference to “*medical infrastructure*”, “*resources*”, “*competent medical staff*” and other “*SA medical realities*”.

2.2.1. The stance taken by Cameron JA⁵⁰ in the *Tembani* case¹⁰ is to be welcomed at two levels;

2.2.1.1. The Judge’s ruling merits the unavoidable inference that the “*locality*” where medical treatment is administered (specifically if it is a SA^{Pub}HC Hospital where health care services are compromised) will have a definite influence on the subsequent liability of the attending medical staff.

2.2.1.2. The Judge’s stance is in addition welcomed in view of the timely breaking of an increasingly uneasy silence regarding conditions in SA^{Pub}HC System, conditions

⁵⁰ In his judgement Cameron JA took the stance that substandard/negligent medical treatment in South African public hospitals is neither abnormal nor extraordinary.

which have lately been deteriorating. We're no longer living in the early 20th, but in the early 21st century, and delivery of substandard health care can no longer be laid at the door of the geographical isolation of selected facilities. That door has forever been opened – in the current open-door global-village context access to medical knowledge (by virtue of online-learning, hands-on workshops, good-practice guidelines etc) is universal.

We need to look elsewhere, beyond the LR in its traditional format, when investigating poor health care delivery by the SA^{Pub}HC System. It is hoped that this mini-dissertation succeeds in identifying a number of SA^{Pub}HC System-specific factors contributing to this sorry state of affairs.

2.2.2. The plaintiff in the *Tembani* case (a young lady) was shot on the night of 14/12/96 and taken to Tembisa Hospital; a laparotomy was performed 4 days later on 18/12/96, she was transferred to the Critical Care Unit 5 days later on 23/12/96, and a second laparotomy performed 1 day later on 24/12/96. The patient died 4 days later on 28/12/96. The accused's defence was built on conditions in Tembisa Hospital (a prototype large urban SA^{Pub}HC Hospital) which he claimed to have been the cause of death – as opposed to the gunshot wounds he inflicted. Hence, in this case, the issue of legal causation was discussed at length. It seemed to the Witwatersrand Local Division, following the approach of English law, to be "*of overriding importance that the original wound inflicted by the accused was an operating and substantial cause of the death of the deceased.*" If, at the time of death, the original wound is still an operating and substantial cause of death, then the death is a result of the wound, even if another cause was also operating. The court thus appeared to endorse the "*proximate-cause*" criterion, also known as direct-consequences or individualisation theory, of legal causation. The court added that death is not the result of the original wound if it is just the setting in which another cause operates. Only if the second cause is so overwhelming as to make the original wound merely part of the history may it be said that death does not flow from the wound. The contribution of the second cause (the ineptitude of the staff at Tembisa Hospital) was significant. The original wound were however of sufficient significance to have caused the death of the plaintiff. The accused was found guilty on the charge of murder and sentenced to 18 years' imprisonment. The LR strongly surfaced as sub-text in the case.

- 2.3. In the *Oppelt* case⁵¹ a rugby player sent between 3 hospitals following a neck-injury sustained during a rugby match. Conditions at Groote Schuur Hospital Emergency Department on the day, were described as “*near hellish*”. A closed reduction of a cervical spine injury was performed only after more than thirteen hours and thirty minutes. (Injury occurred at 14H15 on March 23, 2002, and closed reduction performed at 03H50 on March 24, 2002). In this regard the National Patients’ Rights Charter provides for the right of a patient to receiving “*timely emergency care at any health care facility that is open, regardless of one’s ability to pay*”.⁵¹ Mr Charles Oppelt, who was 17 years old at the time of the injury, was left a quadriplegic, permanently paralyzed from his neck down. The LR surfaced as subtext in the ruling. To this author this case exposes a critical weakness in the SA^{Pub}HC System, be it at the level of the Ambulance Service (taking critically injured patients to the wrong SA^{Pub}HC Facility) or at the level of the SA^{Pub}HC Hospitals *per se* (lack of competence to deal with critically traumatized patients).
- 2.4. In *Nyathi v MEC, Department of Health, Gauteng and Others*⁵², the plaintiff suffered a stroke following incorrect insertion of a central venous line which had to be placed as part of his clinical management following severe burns. This case resembles the *Oppelt* case in that a critically injured patient was transferred between different SA^{Pub}HC Facilities; in this case from Pretoria Academic- to Kalafong Hospital. *Continuity of treatment is always to some degree interrupted, if not completely lost, with such transfers*. In the *Oppelt* case the result was quadriplegia, in the *Nyathi* case it was equally horrific if not worse - a severely disabling stroke. This case likewise exposes a perilous weakness in the SA^{Pub}HC System at Clinical-Management level, where triage is at stake. Was Pretoria Academic Hospital in truth completely full, to the extent that a critically injured patient had to be transferred to another Facility?

Can there really be doubt in the mind of any reasonable person that the SA^{Pub}HC System represents a compromised environment?

⁵¹ HPCSA *supra* Booklet 3 (2.3a).

⁵² (2008) ZACC 8. Henceforth referred to as the *Nyathi* case.

3. This short overview, in summary, exposes a number of clinically-relevant factors
 - 3.1. identified by the Courts in the USA – a geographically vast country – from a time period prior to the worldwide explosion of electronic communication
 - 3.2. from the SA *locus classicus* on negligence from Frontier Hospital in Queenstown in 1924, i.e. small town rural SA prior to the era of electronic communication
 - 3.3. from the current-day SA^{Pub}H System;
 - 3.3.1. death in urban major hospital following abdominal sepsis
 - 3.3.2. quadriplegia urban major hospital following cervical trauma
 - 3.3.3. stroke following iatrogenic injury

What is the story - the scenes - unfolding day-to-day before the eyes of the SA^{Pub}HC Practitioner employed in the SA^{Pub}HC System in 2016? Which areas of sub-optimal lighting need to be exposed and taken into consideration in cases of medical negligence litigation? This will form the core of the discussion that follows.

Chapter 5

Discussion

Background

The term “Locality” as used in “LR” is loaded concept. What does it refer to, and what should it refer to; properly functioning equipment, functionality of the hospital, functionality of the operating theatres, knowledgeable personnel, sufficient staffing, well-oiled referral systems? Certainly all of these would and should be included; however, there is more to it.

From the list assimilated from the American and SA cases where the LR surfaced, it is clear that factors taken into account by the Courts in the application of the LR gave birth to a number of reasonably-well demarcated groups. To fit the style of this mini-dissertation, and to allow for a more detailed analysis, Locality-specific clinically-relevant factors¹² have been grouped into three categories, being; subjective factors setting the Clinical Environment, objective factors setting the Physical Environment, and a combination of subjective- and objective factors setting the Psychological Environment.

Regarding the three groups as outlined above, two points need to be raised here:

- Although some of these factors individually may seem to not impact directly on the day-to-day running of the SA^{Pub}HC System, most actually do. Corporately however, they paint a real archetype of the working environment, or Locality, as context within which the professional performance of the SA^{Pub}HC Practitioner needs to be viewed. The theatre where the Medical Man performs his art, his performing stage as it were, is defined by the sum-total of clinical, physical, and psychological factors. However small it may be, individually each factor represents an asset, or a liability. Each factor in its own right contributes towards the smooth running of a well-oiled machine, or to the groans of a dysfunctional system grinding to a painful halt.
- Overlapping between groups admittedly does occur, but should not cloud the overall picture.

Regarding the running of the SA^{Pub}HC System it will be beneficial to the reader to grasp that a small minority of SA^{Pub}HC Hospitals are linked to university medical schools, i.e. academic institutions. Academic health complexes are partnerships between health establishments and educational institutions, working together to educate and train Health Care Personnel and conduct research. In the interest of clarity this sub-category of hospitals will be referred to as SA^{Pub}HC^{Acad}Hospitals.

In SA^{Pub}HC^{Acad}Hospitals the bulk of clinical work is performed by Medical Officers (labouring towards becoming Registrars), Registrars, and Consultants; the Clinical Environment is by nature perceived as challenging and stimulating, the Physical Environment generally is reasonably-well equipped, and hence the Psychological Environment is conducive to good patient care.

In SA^{Pub}HC Hospitals the bulk of clinical work is performed by career Medical Officers and Specialists. Generally speaking academic challenges (Clinical Environment) are not a prominent aspect of every-day activities, facilities (Physical Environment) are not well equipped (especially in the more remote areas), and the Psychological Environment often not conducive to good patient care. This however by no means represent a generalization.⁵³

1. Clinical Environment

Subjective factors, to a large degree within the sphere of influence of the Practitioner, set the **Clinical Environment** of the Locality. The competence⁵⁴ of a Practitioner is to a large degree subjective, i.e. within the sphere of his own influence - hence the **Clinical Environment** is to a large degree dependent on the Practitioner. The competent Anaesthetist - by way of an example - is the one who is technically skilled (dexterity) to gently manipulate the fibre-optic scope during an awake fibre-optic intubation, as well as academically versed (knowledge) to be intimately familiar with a variety of pharmacologic agents to be administered to the patient in order to facilitate the procedure in cases of a life-threatening airway. The competent Urologist - by way of another

⁵³ A relative of this author, with no access to private healthcare, recently underwent major cancer-surgery in a SA^{Pub}HC Hospital near Cape Town. The Clinical, Physical, and Psychological environments were all perceived as excellent.

⁵⁴ "Competence" (Afrikaans = "bekwaamheid") as used in this context relates to how well a Practitioner is equipped to manage a patient as "individual person with a specific disease", and not "the fractured leg in bed 6" or, "the stomach cancer in bed 5". The term embraces at least three facets; technical skills (relating to dexterity), academic proficiency (relating to knowledge), and empathy (relating to the Practitioner's personal character) hence; competence = dexterity + knowledge + empathy. The Afrikaans terms "vaardigheid", "kennis", and "empatie" admirably communicates the message; "bekwaamheid" = "vaardigheid" + "kennis" + "empatie". To be maintained at a level patients are deserving of, both dexterity and knowledge require continuous training and updating (subjective effort by the Practitioner). Dexterity and knowledge, as duo, set the standard of patient care in the locality, ultimately spilling over as improved clinical care.

example - is the one who is technically skilled (dexterity) to operate the robot in a three-dimensional view during a robotic radical prostatectomy, as well as academically versed (knowledge) to be familiar with the pelvic anatomy in order to preserve tiny, yet critically important, nerves ensuring the best possible post-operative outcome. To truly claim competence the two Practitioners need to add, in addition to their mental and physical skills, a healthy dose of empathy. Increased competence is obtained and maintained by continuous professional education in the form of self-study, attending workshops and lectures, etc. Viewed even in isolation (apart from the Physical Environment) superior competence must impact positively on patient care in any specific Locality – it is arguably the single most important factor. If the product is bricks, straw is needed, if however the product is health care, a suitable Physical Environment is required. The dictum that “*a practitioner, wherever he may be, cannot be expected to perform miracles or to make bricks without straw*”⁵⁵ stands out in the medical malpractice litigation environment like Pithom and Raamses did in the Egyptian desert.⁵⁶

1.1. Regarding the **Clinical Environment** a significant differences between SA^{Pub}HC Hospitals and SA^{Pub}HC^{Acad}Hospitals exist:

1.1.1. Practitioners employed in SA^{Pub}HC Hospitals are Medical Officers and Specialists. The emphasis for these - often very experienced and competent - Practitioners would be on service delivery, with no or little incentive to prioritize academic achievement. Teaching and academic excellence typically would not be viewed as components of every-day life in a SA^{Pub}HC Hospital, academic excellence *per se* simply isn't primarily expected of Specialists. Keeping up with the latest developments would imply a conscious subjective commitment to subject-reading, and attending congresses and courses. In this regard international visits are hindered – if not rendered impossible – by cost. In the final analysis it could result in a **Clinical Environment** where a mediocre approach - relating to the very latest international developments - unfortunately may creep in over time. Although it does not automatically imply a lesser level of patient care⁵³, one cannot but notice the striking resemblance to the spirit breathed by the arguments for doing-away with the LR. The second and third arguments deal with the (unlikely) possibility of poor standard of care in isolated localities where the objective standard would be the reasonable Practitioner in a similar (i.e. another SA^{Pub}HC) Locality. The Practitioners would then effectively be immunized from the role played

⁵⁵ Gordon *et al.* *Medical Jurisprudence* (Edinburgh: Livingston 1953) 113.

⁵⁶ The Holy Bible. English Standard Version. Exodus 1;11

by the expert witness. An expert witness from another locality might not be familiar with local conditions and hence not qualify as witness. An expert witness from the same Locality may well not be willing to testify against his colleagues. There nevertheless remains an ethical duty regarding professional competence and self-improvement:⁵⁷ *“Practitioners should continually endeavour to attain the highest level of knowledge and skills required within their area of practice”*. Because of the particular challenges the field of Obstetrics and Obstetric Anaesthesia (by way of an example) pose, particular matching expertise is required. This author is not convinced that the average rural SA^{Pub}HC Facility is equipped for these unique encounters. The Eastern Cape Department of Health is facing a potential R14-billion in claims for 1820 babies born with brain injuries linked to errors and high-risk pregnancies.⁵⁸ In releasing the massive claims figures, Health Department Superintendent-General Thobile Mbengashe said the National Treasury and Eastern Cape Premier Phumulo Masualle and his executive were monitoring the situation. He added the Department had paid out R259-million in damages in the 2015-16 financial year alone for 62 claims, and that R59-million was paid to the State Attorney for legal costs. Such massive claims obviously serve to further deplete available resources.

Discussion: Practitioners forced – by virtue of the realities of the SA^{Pub}HC System – to care for high-risk pregnancies and premature babies find themselves facing the exact-same challenges Country Practitioners in the USA faced in the 1880s, the very challenges that originally gave birth to the LR. There are striking resemblances between small-town USA 1880, and the SA^{Pub}HC System 2016. SA^{Pub}HC Practitioners need the application of the LR.

Positive cross-pollination from other SA^{Pub}HC Facilities, which may or may not hold to the same standard of care, is unlikely to occur regularly, contrary to what is seen in SA^{Pub}HC^{Acad}Hospitals where Registrars rotate between Facilities.

1.1.2. Practitioners employed in SA^{Pub}HC^{Acad}Hospitals are Medical Officers, Registrars, and Consultants. Teaching and training occur on a daily basis, and the subjective pursuit of competence (dexterity and knowledge) is relentless. In our multi-cultural society the first component of true medical competence to fall by the way-side, is empathy. If not

⁵⁷ HPCSA Booklet 1 *supra* 2.3.12.

⁵⁸ *Bhisho's R14bn baby 'bill'*. LexisNexis News October 20, 2016.

for a number of other reasons, then at least due to the language barrier hindering professional, focussed and informative one-to-one pre-operative counselling.

- 1.1.2.1. Medical Officers (would-be Registrars) compete for a limited number of government-funded Registrar posts available at a limited number of SA^{Pub}HC^{Acad}Hospitals at (again) a limited number of training facilities (i.e. Universities). Appropriate work ethic is ensured by the obligation of achieving the competence required to apply for a Registrar post when such becomes available.
- 1.1.2.2. Registrars (would-be Specialists or Consultants) compete for attaining the competence required of a Specialist within the allowed set period, usually four or five years, after which the specific exit specialist exams are attempted and the Registrar position vacated.

Registrars rotate to a number of facilities during their years of specialization, and positive cross-pollination between SA^{Pub}HC^{Acad}Hospitals readily occurs, unlike the reality at SA^{Pub}HC Hospitals.

- 1.2. In the *Van Wyk*³ case the competence⁵⁴ of no member of the medical team was questioned. Evidence showed that in accordance with the usual practice generally, and at Frontier Hospital specifically, the defendant had (firstly) relied upon the Scrub Nurse to count and check the swabs used, (secondly) made as careful a search as the critical condition of the patient permitted at the conclusion of the operation, and (thirdly) believed - together with the Scrub Nurse - that all the swabs were accounted for before the abdomen was closed. The fact that the Anaesthetist urged Dr Lewis to conclude the surgical procedure, although likely contributing to the swab remaining in the abdomen, did not reflect on the competence of either the Anaesthetist or the Surgeon. In Dr Lewis' own words: "*It was a very critical operation indeed. It was doubtful whether she would come through it: it was doubtful the whole way through and I was very anxious the whole time and I asked the Anaesthetist how she was, and he said: 'Get her off as soon as possible'*". Given identical conditions any other Anaesthetist would in an identical manner have advised any other Surgeon operating at any other Locality. The requirement to urgently complete the procedure at that time was not inherent to the specific Locality, but to the specific clinical scenario i.e. urgency is inherent to emergency abdominal surgery in septic patients.

In the judgement the LR was not made part of the negligence test but surfaced as subtext.

- 1.3. In *Tembani* case¹⁰ reference was made specifically to the medical care provided by the Hospital. The day after admission the plaintiff complained of abdominal pain and also started vomiting. The first proper clinical examination took place 4 days after admission. The cause of death officially recorded and proved at the trial - septicaemia as a consequence of a gunshot wound through the chest and abdomen - came as no surprise. The reasonable Practitioner would not have missed (clinical examination, X-rays etc) the fact that the bullet had passed through the right hemi-thorax, passed through the diaphragm, and entered the abdominal cavity. The reasonable Practitioner would have (i) foreseen the possibility of harm (hollow viscus perforation and septicaemia following a gunshot injury with the bullet entering the abdomen) and (ii) taken steps (by immediately, or very soon afterwards (but not only 4 days later), performing a laparotomy) to guard against it. This author's personal interpretation of Cameron JA's words would be that the public attending a SA^{Pub}HC Hospital can expect a **Clinical Environment** where the competence⁵⁴ lacks to properly care for a patient suffering a bullet-wound penetrating the chest and abdomen.⁵⁰ Incompetence, therefore, is implied in the "*objective reality of the locality*"¹³ that is Tembisa Hospital, a prototype major SA^{Pub}HC Facility.
- 1.4. The *Oppelt*¹¹ case involved 3 SAPH Hospitals (including well-known Grootte Schuur and Conradie SA^{Pub}HC^{Acad}Hospitals) and no inference was made towards *lack of* competence from any of the Practitioners involved. If anything there may have been an *overload of* tested- and untested clinical approaches toward management of a cervical-spinal injury put forward. It is this author's personal opinion that the harm that came in the form of quadriplegia had its roots in all of the Clinical-, Physical-, and Psychological environments, with the first making the least significant contribution toward the eventual outcome.

2. Physical Environment

Objective factors, i.e. factors beyond the sphere of influence of the Practitioner, set the **Physical Environment**. Objective factors for the most part relate to the availability of competent personnel, and access to a properly equipped facility. In this regard the words of Gordon, Turner, and Price,

again come to mind;⁵⁵ “a practitioner, wherever he may be, cannot be expected to perform miracles or to make bricks without straw”.

- 2.1. In the *Small*³⁴ case it is unlikely, yet unclear whether the **Physical Environment** impeded in any respect on Dr Howard’s clinical management of the injury to Mr Small’s arm. What Dr Howard had access to in terms of resources (medical equipment etc), was in step with that available to the ordinary Country Practitioner in that Locality at the time.

- 2.2. What were the objective factors setting the **Physical Environment** to Dr Lewis, defendant in the SA *locus classicus* on medical negligence, on that fateful night in 1922 in the Eastern Cape? Firstly, the surgical procedure was performed utilizing artificial light (operation commenced at 20H00⁵⁹) which may well have reduced Dr Lewis’ ability to properly visualize the surgical field, contributing to the moderate degree of sepsis⁶⁰ postoperatively as well as the oversight leading to the retained swab. The fact that “artificial light” had to be used was inherent to the geographical locality in the sense that it generally has less of a chance of occurring in a major city where electricians are more readily available to shed light on matters after-hours. Secondly, the swabs handed to him by the Scrub Nurse were not the usual swabs used in that Hospital during surgery – they were smaller and no identifying string was attached.⁶¹ This may likewise have contributed to the degree of sepsis – smaller swabs have less ability to soak up blood and puss, and more ability to go missing in bloodied anatomical crevices behind loops of bowel. Urban facilities are more likely to have larger reserves of these swabs, and Surgeons are less likely to have to put up with consumables they’re not familiar with. The point is that Locality-specific objective factors beyond the control of the medical team set a **Physical Environment** conducive to the (now known) less-than-optimal outcome. Hence Wessels JA’s remark that “the locality where an operation is performed is an element in judging whether or not reasonable skill, care and judgment have been exercised”.⁶²

The LR was not applied by the Court in the determination of negligence, but was present as sub-text.

⁵⁹ Van Wyk *supra* 442.

⁶⁰ Van Wyk *supra* 455.

⁶¹ Van Wyk *supra* 466.

⁶² Van Wyk *supra* 457.

- 2.3. No specific reference to a lack of equipment or consumables was made by Cameron JA in the *Tembani* case¹⁰. The inference is that in this important case, the unfortunate outcome (death) can mostly be attributed to a combination of factors from the Clinical- and Psychological Environments.

Conditions elsewhere in the current-day SA^{Pub}HC System regrettably paint a murky picture.

- 2.4. Power outages. A power outage during a Caesarean Section forced Practitioners to use torches during the critical operation performed at East Griqualand and Usher Memorial Hospital.⁶³ Desmond Motha, spokesperson for KZN's Health MEC, Sibongiseni Dhlomo, said the Department had Maintenance Staff at hospitals to ensure that all machinery was in working order. Motha said on the night in question, there was load shedding and the standby generator kicked in and was operational for an hour. *"However, it began to malfunction during the second hour of load shedding. At this point, Maintenance Personnel were brought in to inspect the generator. The power returned 15 minutes later. It was later discovered the malfunction was due to a loose wire."* It went well with no harm to the mother and child. In contrast to this fortunate outcome, the death of a premature baby at Kimberley Hospital was blamed on load shedding.⁶⁴ The Northern Cape Department of Health however insists that the generator had not stopped working. In another case a Practitioner at Letaba Hospital near Tzaneen said the Hospital's generator had failed during a power outage; *"We had patients on ventilators and we could only save so few because you need two hands to ventilate manually and we found ourselves choosing who to save. There are days when I regret becoming a doctor even though it was my dream."*⁶⁵
- 2.5. Clinics and Hospitals often - if not regularly - run out of vital medications. Vital medicines such as insulin for diabetics, children's vaccines, and HIV and Tuberculosis treatment are running short in Mpumalanga,⁶⁶ which has been plagued by medicine shortages for most of this year. According to *Health-e News'* Citizen journalists, who monitor the supply of medicines in local clinics every month, monthly stock-outs have occurred at health facilities since February. Mpumalanga Department of Health spokesperson Dumisani Malamule denied that there have been drug stock-outs in the Province, but documentation shows that some medicines ordered by facilities in July were not available at the Provincial Depot.

⁶³ *Power outage during critical operation.* Medical Brief Africa's Medical Media Digest, April 21, 2015.

⁶⁴ *Load shedding blamed for prem death.* Medical Brief Africa's Medical Media Digest, November 26, 2014.

⁶⁵ *Death and despair in Limpopo's hospitals.* Medical Brief Africa's Medical Media Digest, June 1, 2016.

⁶⁶ *Mpumalanga clinics run out of vital medicines.* Medical Brief Africa's Medical Media Digest, August 31st, 2016.

A Department of Health Community Worker confirmed that she has seen patients turned away from clinics without treatment. Major SA^{Pub}HC^{Acad}Hospitals have not been spared this scourge. Patients at Chris Hani Baragwanath Academic Hospital have been sent home without their medication because of a shortage of essential medicines.⁶⁷ Several sources at the Hospital said that, on occasion, there were no anti-depressants, no fixed-dose combination antiretrovirals, only one anti-psychotic and many more shortages of essential medicines. Providing more detail on the shortage, Dr Greg Jonsson, Head of the HIV Psychiatric Programme said; *"I have mentally ill people with HIV and I cannot offer them any psychiatric drugs, and now I cannot even offer antiretrovirals. We are constantly in crisis mode."* Vital medications also include drugs required for keeping patients asleep during operations (anaesthetic agents).⁶⁸ It was reported that non-urgent surgeries at Chris Hani Baragwanath Hospital had to be cancelled because of a lack of anaesthetic drugs. The report noted that Health Department spokesperson Prince Hamnca was not available for comment in this important matter at the time. On occasion this has outright been attributed to the National Department of Health's poor management of a key tender, an allegation flatly denied by top government officials.⁶⁹

2.6. Filling of vacant posts in the SA^{Pub}HC System remains contentious. Following the retirement of the HOD of Anaesthesiology at a major SA^{Pub}HC^{Acad}Hospital near Cape Town on December the 31st 2015, the new HOD commenced duties on January the 1st 2016. At an equivalent SA^{Pub}HC^{Acad}Hospital in Gauteng the HOD retired on November 30th 2015, and interviews for the position of HOD held in October 2015. At the time of completion of this mini-dissertation (October 31st 2016) the post remains vacant, with the residual members of staff simply having to pick up the additional load. In this regard Health Minister Dr Aaron Motsoaledi issued a media statement: *"We want to put it on record that there are no medical posts frozen in this country . . . if there is freezing of posts by government departments, they have nothing to do with medical doctors as posts in the health sector are exempted . . . anybody who knows a doctor who is unemployed due to 'frozen posts' must forward the name of such a doctor to me urgently and I will make sure that they are placed by the end of next week"*, but doesn't provide his mobile number or email address.⁷⁰ Dr Motsoaledi's statement follows media reports that as many as six Provincial Departments of Health have instituted formal or informal *"moratoria"* to prevent or strictly control the

⁶⁷ *Medicine shortages hit Bara patients.* Medical Brief Africa's Medical Media Digest, December 10, 2014.

⁶⁸ *Lack of anaesthetics a "looming crisis".* Medical Brief Africa's Medical Media Digest, November 25, 2014.

⁶⁹ Tamar Kahn. *Wrangle over medicines shortage.* Business Day Live, November 13, 2014.

⁷⁰ <http://m.news24.com/health24/News/Public-Health/department-of-health>

filling of posts, according to Rural Health Advocacy Project (RHAP) research. Among the responses to Dr Motsoaledi's statement was a letter from the South African Society of Anaesthesiologists (SASA) pointing out that what was said by the Minister does not reflect what is experienced in Departments of Anaesthesia throughout the country. *"The reality experienced by our members in the workplace is that there are definite freezes and delays, with financial constraints overriding some strategic objectives"* serves as but one quote from the SASA letter, signed by Prof Johan Diedericks, SASA President at the time. This type of, at the face of it, ill-informed comment by the Health Minister serves only to further undermine the **Psychological Environment**. *"If the Locality where we are employed is not deserving of the Minister being kept up to date about, what's the sense in even raising any other issues?"* – or so the reasoning of the SA^{Pub}HC Practitioner might be.

2.7. The term *"available resources"*³⁹ of course is the source of much emotion and heated debate in overcrowded Surgical Wards of SA^{Pub}HC Hospitals where disillusioned patients lie, waiting to be operated. The thought of 3 additional Senior Surgical Consultants, who could have been appointed permanently with the salary paid to one of the recently appointed officials at the SABC, leaves a bitter taste. Much worse is the thought of about 52 additional Senior Medical Consultants appointed for 5 years in the SA^{Pub}HC System for the same amount of money spent on increasing the security at Nkandla. One also is left contemplating the significant impact a small number of ambulances could have on life in rural Eastern Cape Province. According to the Eastern Cape Health Action Crisis Coalition - composed of organisations campaigning to fix the Province's Public Health System - the Human Rights Commission published a report on Emergency Medical Services in the Eastern Cape Province early in 2016 stating that the Provincial Health Department must urgently improve access to ambulances and patient transport in the Province.⁷¹ By October 2016, nothing had changed.

2.8. On the 14th of April 2016 a 5.2 kilogram 9-month old infant presented with an acute upper gastro-intestinal bleed at a SA^{Pub}HC^{Acad} Hospital in Gauteng, geographically located within easy reach of a number of SA^{Priv}HC Hospitals. The medical team (Surgeon and Anaesthetist) had to urgently conclude whether to provide care on site, or to transfer to an alternative facility.⁷² The former was decided on. A gastroscopy under general anaesthesia was

⁷¹ Ernest Mabuza. *Still no ambulances for the Eastern Cape, says health campaigners*. LexisNexis October 4, 2016.

⁷² This would have implied the immediate availability of an appropriate level of transport (ambulance) service as well as staffing for the care of a bleeding infant during transport. Additionally it would have implied locating an alternative facility

performed utilizing an adult gastroscop⁷³ since no paediatric scope was available. During the course of the procedure the gastroscop malfunctioned. A second (adult) gastroscop was located elsewhere in the hospital and collected. A gastric lesion requiring a biopsy was identified. A biopsy forceps could not be found in theatre and had to be looked for elsewhere in the hospital. Due to the on-going bleeding the infant required a blood transfusion. None of the porters employed by the hospital was available to collect blood from the blood bank at that specific time. An attending Medical Student was dispatched for this purpose. The patient was wheeled into theatre at 15H10, and arrived in the post-anaesthesia recovery room at 16H32, i.e. 82 minutes. No member of the medical team (Anaesthetist, Paediatric Surgeon, Theatre Nurse) frowned on the duration of the procedure, or on the details of what transpired – it was considered the norm for that hospital.

2.9. On the 29th of July 2016 a 3-month old infant had an elective surgical repair of a congenital orthopaedic abnormality at a SA^{Pub}HC^{Acad}Hospital in Gauteng. Minutes after the operation commenced the monitor on the Anaesthesia Workstation³¹ turned blank. No data on the amount or concentration of oxygen or anaesthetic gases delivered by the Workstation, or received by the infant, was available to the Anaesthetist. An oxygen cylinder was hastily sourced and the anaesthetic method changed to an intravenous technique. Surgery was concluded as rapidly as was feasible. Apart from letters written to the Hospital Clinical Engineer (the prescribed response), no other actions were initiated by any of the members of the medical team (Anaesthetist, Orthopaedic Surgeon, Theatre Nurse).

2.10. On the 16th of September 2016 at about 12H00 all oxygen flow to the Main Theatre Complex, as well as the Adult and Neonatal Critical Care Units of a SA^{Pub}HC^{Acad}Hospital in Gauteng was unexpectedly cut.

catering for paediatric surgical patients, including the availability of a Paediatric Surgeon and Anaesthetist, as well as a Paediatric Intensive Care with a vacant bed – and, most importantly, the willingness of the facility to accept the patient. Based on experience gained over a number of years, the less daunting of the two prospects was easily identified by the medical team.

⁷³ A gastroscop is a tube passed through the mouth, down the oesophagus and into the stomach of a patient. The Practitioner can then (directly on a video-screen) see structures along the path in order to locate pathology, in this case the origin of the bleeding. The size (diameter) of the gastroscop selected *must* be based on the age (i.e. physical size) of the patient. The use of a too large sized gastroscop may result in tearing of the oesophagus with disastrous consequences, including the demise of the patient.

Discussion: Against the background of these last 3 clinical scenarios stand 2 realities. The first is that Practitioners have an obligation to report defective equipment to their employers and failure to do so may be an offence in terms of the Occupational Health and Safety Act.⁷⁴ They should be aware that according to the common law they may be held liable for harm caused to others through defective equipment in circumstances where they knew or ought to have known about the defect and negligently failed to report it or to stop using the equipment. The second reality against the background of the last 3 scenarios is that a Practitioner is bound to bring to bear upon the case entrusted to him *reasonable skill and care*. Ultimately reasonable skill and care is that exercised by the ordinary Practitioner in the same (or similar) Locality. The care provided in these examples certainly was not in line with the professional skill and care exercised at other hospitals which (in a geographical sense) would have defined the “Locality” of the specific SA^{Pub}HC^{Acad}Hospital(s). If the care provided was not in line with the standard of practise in that geographical area, were the conduct of the medical teams negligent, or should their conduct be judged within the context of the compromised Locality wherein they operated? The spirit breathed by the original version of the LR certainly addresses some of the issues demarcating the reality of the current-day SA^{Pub}HC System as acted out in the *Tembani*- (at Tembisa Hospital) and *Oppelt* cases (at Conradie Hospital). To this cast, unfortunately, the medical teams and their paediatric patients, as portrayed in the 3 clinical vignettes presented, have to be added.

It is the author’s conviction that the lack of a significant outcry following each of these last 3 incidents reflects the degree to which the reigning **Physical Environment** has over a period of time drained the Practitioners’ energy to rise for what they know is right and acceptable, as opposed to wrong and unacceptable. *The conviction of even the most dedicated of Practitioners to act morally-correct in line with their ethical stand, crumbles with relentless exposure to clinical scenarios where the lesser of two evils has to be decided on in the interest of the patient – day, after day, after day.* This however, is a precarious position to be caught in, since the legal test for medical negligence (in the context of criminal liability), is one of reasonable foreseeability and preventability.⁷⁵ Would a reasonable competent Practitioner *in the same circumstances* have (i) foreseen the possibility of harm through his actions or omissions, and would a reasonable competent Practitioner *in the same circumstances* have (ii) taken steps to prevent harm from ensuing. It is clear that the specific circumstances or “Locality” where the medical intervention or treatment is administered plays a decisive role in the assessment of whether the conduct of the accused Practitioner was negligent or not. The point here is that – in the context of specifically the **Physical Environment** – measures

⁷⁴ 85 of 1993.

⁷⁵ *Kruger v Coetzee*. 1966(2) SA 428(A).

available to Practitioners in order to prevent harm (legal test for medical negligence) or death is limited to the reporting of shortages and breakages in consumables and equipment. Reporting typically entails a frustrating journey winding through ill-defined administrative processes and chasing signatures from unavailable procurement officers. Consultants in e.g. Anaesthesiology, although intimately familiar with the required specifications, and highly skilled in the functioning of Anaesthesia Workstations,³¹ are not allowed to source quotations for these from supplying companies in cases where Stations have matured beyond their careers, necessitating replacement. In a recent incident a request to one of the CEO's of a SA^{Pub}HC^{Acad} Hospital to have an ultrasound machine (used daily in the Anaesthesia Department of the Hospital) repaired, was met by a claim that ultrasound is not used in the clinical practice of Anaesthesia.⁷⁶ Replacing of equipment must be done by the procurement section at each SA^{Pub}HC Hospital.

A small number of real-life incidents from a limited number of facilities have been presented. In a Locality the magnitude of the SA^{Pub}HC System, however, inability by Practitioners to take steps to prevent harm may potentially result in waves of medical malpractice litigation. Why has this not happened at a significant scale, how far are we indeed from the medical malpractice litigation storm referred to by Pepper?⁷⁷ After all, it is clear that the SA^{Pub}HC System as Locality has its unique realities.¹³ These realities include the fact that in many SA^{Pub}HC Hospitals, with regards to the **Physical Environment**, the only preventative measure of immediate potential value to the patient, is referral to other facilities in yet the same system – other facilities where likewise the soil is fertile for medical negligence cases to sprout due to deficiencies in the **Physical Environment**. This author would submit that the SA^{Pub}HC System has to a large degree been shielded from this perfect storm, or Swiss-cheese scenario, by virtue of a number of factors:

- Much of the shameful realities occurring in SA^{Pub}HC Hospitals are not known to the public, or to the legal fraternity – after all, it often is the weak, the elderly, the poor, the social outcasts, that end up in Orthopaedic Wards and wait for days or weeks to have a fractured hip operated – simply because postoperative care in the ward following major surgery leaves much to be desired, and no alternative for postoperative care (e.g. bed in High Care Unit) is available due to lack of funds, facilities, or trained Critical Care Nurses.
- Another factor is that Registrars - who traditionally are high-performing individuals - are driven to achieve a specified level of competence⁵⁴ (dexterity and knowledge) within a set time-period. There is no time to get involved in issues beyond what is demanded of them – they want to get the job done, pass the exams, and start a career (often in New Zealand or the UK).

⁷⁶ Personal experience.

⁷⁷ Pepper MS, Slabbert MN. *Is South Africa on the verge of a medical malpractice litigation storm?* SAJBL June 2011 (4)(1).

- Interns likewise labour to get the job done, be registered with the HPCSA as Health Practitioner, and move on. The “*on site*” recipe for survival is something to the effect of “*head down and endure*”.
- Yet another factor may well be the lack of awareness of their legal (Constitutional) rights from a significant portion of the population. The case of *Loni v Member of the Executive Council of the Department of Health of the Eastern Cape Government*⁷⁸ has been described as what must be one of the grossest cases of State Health Department neglect yet heard in post-democratic SA.⁷⁹ The Plaintiff, aged just 17, arrived at Cecilia Makiwane Hospital – a Tertiary Teaching Hospital outside East London in the Eastern Cape – on the evening of 6 August 1999. A gunshot wound in his left buttock had shattered his left femur. Staff at the Radiology Department that evening were so drunk they could not take X-rays. According to the Orthopaedic Surgeon currently treating the Plaintiff, he “*effectively received no treatment at all*” during the first four days of admission to the Hospital before he was taken to the Orthopaedic Department. No tetanus injection was given to him, though it is routine in gunshot wound treatment. His wound was not dressed to prevent further contamination of the site. He was given no antibiotics or wound debridement to remove dead tissue, both of which would be normal practice. No Practitioner so much as examined him. He was ultimately discharged from Hospital, the wound still suppurating, with just some over-the-counter medicine. He is now classified disabled. His Attorneys launched a negligence action on his behalf in March 2012, but the State claimed that it was too late; the claim had become prescribed.
- Regarding fellow Consultants that this author converse with daily – their likely response to a question regarding their **Physical Environment**, would be; “*I’ve reported on numerous occasions, and it’s never made any difference. It’s a waste of time*”.
- SA-trained Practitioners have traditionally been held in high esteem internationally, resulting in them being scattered throughout Health Care Systems in the entire Western World. (This author has encountered ex-SA Practitioners in all of the 7 hospitals where he was employed (UK and Canada)). The perception that “*our Doctors*” in “*our hospitals*” are the best in the world, is still imbedded in the minds of a significant portion of the SA population. However-much that may or may not represent reality, another reality is that recent changes involving the structure and functioning of the SA^{Pub}HC System may have slipped the attention of the public in general. If and when this new reality dawns the numerous holes in the slice of Swiss-cheese might just line

⁷⁸ *Loni v Member of the Executive Council of the Department of Health of the Eastern Cape Government* (CA338/2015) [2016] ZAECHC 101.

⁷⁹ ‘*Scandalous’ treatment by Eastern Cape hospital, but damages claim fails*. Medical Brief Africa’s Medical Media Digest, October 26, 2016.

up perfectly, unleashing the perfect medical malpractice litigation storm, and leaving a mouldy taste on the palate.

3. Psychological Environment.

The combined influence of Subjective and Objective circumstances in the SA^{Pub}HC System ultimately determines the reigning **Psychological Environment**, reflecting the mood or tone, alternatively the atmosphere, of the specific working Environment or Locality. In the final analysis the issue at stake here is a befalling ambience *conducive to patient care*.⁸⁰ Realities foundational to the **Psychological Environment** are not as perceptibly evident as are those foundational to the Clinical- and Physical Environments, yet to the discerning scholar the **Psychological Environment** represents an iceberg submerged below each suspecting and non-suspecting SA^{Pub}HC Hospital, from time-to-time raising its ugly head in a number of different formats. These include:

3.1. Hours of duty

3.1.1. The SA^{Pub}HC System is under pressure urgently to reduce the working hours of Interns nationally following Western Cape Health's decision to slash maximum shifts from 30 to 24 hours. There had been growing calls - falling on deaf ears - from junior Practitioners nationwide for new regulations on working hours, which reached a crescendo when 25-year old Paarl Hospital Intern Ilne Markwat was killed in a car crash after allegedly falling asleep at the wheel after a long shift. Another life was also lost in the crash. Commenting recently HPCSA spokesperson Priscilla Sekhonyana said: *"The Medical and Dental Board, at its meeting held on July 16, 2016, resolved that the maximum working hours for Interns be reduced from 30 to 26 hours. The HPCSA welcomes this as long as services to the public will not be hampered."*⁸¹ This of course is nothing beyond polished politically-correct public rhetoric. One could however argue that it does move beyond the usual rhetoric – it expands the implications of the well-known expression; *"talk is cheap"*. Reducing the maximum number of working hours of Practitioners employed in an evidently overburdened SA^{Pub}HC System, without increasing the number of Practitioners available, automatically imply less soldiers in the battle field at any given moment. It is a mathematic no-brainer. This

⁸⁰ "Care" or "professional clinical patient care" hence thrives in a psychological environment conducive to patient care, which in turn is founded on a combination of clinical (subjective) and physical (objective) factors.

⁸¹ *Junior doctors given shift relief*. Siyavuya Mzantzi Cape Times, August 15, 2016.

kind of cheap talk may well be at a tremendous cost; that of more deaths due to more Interns falling asleep at the wheel. The HPCSA knows that the number of available Interns cannot be increased overnight. The Council also knows that the number of patients reporting to SA^{Pub}HC Hospitals is continuously increasing. Why then welcome a resolve “*that the maximum working hours for Interns be reduced from 30 to 26 hours*” while at the same time reassuring the Public that “*services (to the public) will not be hampered.*”?⁸¹ The argument is polished on the Practitioners’ side (less working hours), and even more so on the public’s side (services will not be hampered) - and talk remains cheap indeed. One cannot but contemplate – if the solution is that simple, why hasn’t anybody implemented it years ago? The math simply doesn’t add up, neither does wearing different coloured arm-bands to indicate (? warn) the public regarding the number of hours the particular Intern has been at the helm.⁸² An Intern wearing a red armband is a potential risk and should be allowed time to rest. One ponders who would authorize this “*rest*” when the Emergency Department of a major SA^{Pub}HC Hospital resembles a war zone or “*near hellish*”⁹⁵ scene (as in the *Oppelt* case). One may also muse whether this “*rest*” will come at the risk of leaving patients unattended, or being absent from duty and not getting signed off as having completed the compulsory 2 years as Intern, or increasing the workload of fellow-Interns. The solution simply does not lie in using Interns as cannon-fodder, and it does not lie in ill-considered one-liners like “*the maximum working hours for Interns be reduced from 30 to 26 hours*”, but at a different level, a level where appropriately skilled professionals do calculations regarding budgetary allocations taking into account a number of realities, including the influx of foreign nationals choking the SA^{Pub}HC System.

In the interim the SA^{Pub}HC Locality remains compromised, deserving of the application of the LR.

- 3.1.2. Registrars paint a different picture; competition to complete training within the set period of time leaves complaining regarding hours of duty (and unfortunately also complaints regarding the ***Psychological Environment***) a non-possibility.

Discussion: These circumstances; (i) Interns obliged to work for two years in a SA^{Pub}HC Hospital (and yet another Community Service Year to follow), and (ii) Registrars competing for a limited number of posts and having to complete their training within 4 to 5 years, create an ideal scenario for abuse of *two groups of exceptionally important Medical Professionals in the chain of clinical service*

⁸² *Beware the dopey docs.* Monica Laganparsad Times Live 26 September, 2016.

delivery in the SA^{Pub}HC System. Interns *will* do what is required of them; if not, 6 years of university-level studies go to waste – they legally cannot practice Medicine in SA or anywhere else without having completed the compulsory 3 years as outlined above. Likewise, Registrars *will* do what is required to obtain the technical (relating to dexterity) and academic (relating to knowledge) competence⁵⁴ required to pass the exams relating to their Speciality. Together they make for - what any employer would consider - a dream team; at the possible cost unfortunately, of more falling-asleep-behind-the-wheel deaths. The disturbing reality is that it's not only Practitioners (in this example Interns and Registrars) who suffer, those they care for (patients) are evidently also in line for a rude awakening. Sobering results emerged from research by the Department of Anaesthesia at McGill University Health Centre in Montreal, Canada.⁸³ Patients operated in the late day (15H30 – 23H29) were 1.43 times more likely to die, and patients operated in the night (23H30 – 07H27) were 2.17 times more likely to die than those operated on during regular daytime (07H30 – 15H29) working hours. *“Provider fatigue during anaesthesia and surgery”* has been identified as one of a number of possible causes. An environment (like the SA^{Pub}HC System) where long hours of duty – including having to perform anaesthesia and surgery after midnight – is the order of the day, reflects a compromised environment where an increase in medical malpractice litigation may turn out to be the only lucid component of every-day Practitioner-patient contact. The Medical Profession has traditionally been a well-respected and much sought-after career, but a calling to die for? – not likely! Junior, inexperienced Practitioners trapped in such a setting deserve at least the reassuring company of the LR.

3.2. Workplace conditions

3.2.1. It's been said that a picture speaks a thousand words, and one can but hope that this proves true regarding the ***Psychological Environment*** SA^{Pub}HC Practitioners daily face. In September 2016 a film on the life of a number of SA^{Pub}HC Practitioners was shown at the Jozi Film Festival (both at the Eyethu Lifestyle Centre in Soweto on Saturday the 17th and at the Rosebank Cinema Nouveau on Sunday the 18th). The 82 minute film has also been entered into several International Film Festivals, including the Public Health Film Festival in the UK and the Denver Film Festival in the USA. SA-born Francois Wahl, a chartered accountant with a passion for filmmaking, directed and produced the much anticipated documentary; *“Doc-U-Mentally – last doctors standing”* (pun intended), which he believes is an apt title since *“junior doctors*

⁸³ *Night surgery carries double the mortality risk.* Medical Brief Africa's Medical Media Digest, August 31, 2016.

must be insane to work under the conditions they do".⁸⁴ The film follows 5 different Practitioners from vastly diverse backgrounds working at Ngwelezane Hospital in Empangeni in KwaZulu-Natal. It aims to show the race against time for these Practitioners, and how working 30 hour shifts impacts their mood, performance, stress and anxiety levels, as well as personal safety. In this regard, keep in mind what was earlier highlighted regarding Interns; they *will* do what is required of them. If not, 6 years of university-level studies go to waste – they cannot practice Medicine as registered Medical Practitioners in this country or anywhere else without having completed the compulsory 3 years as required by law. A recent UCT study indicated that up to 16% of Interns are not showing up for compulsory Community Service and may be lost to the Health Sector, which is up from an average of 11% from 2001 to 2007.⁸⁵ Interns, together with Registrars, paint only one side of the coin.

3.2.2. There however remains but another side - that of Nurses employed in SA^{Pub}HC Hospitals. There is a **Psychological Environment** where empathy and competence (dexterity and knowledge) - *in the normal day-to-day run of things* - are neither rewarded nor acknowledged. An Environment at times typified by a *tomorrow-is-another-day* approach. In the *Tembani* case the "*standard of nursing care was . . . poor.*"⁸⁶ Arguably the worst "*support*" to offer SA^{Pub}HC System Nurses during these difficult times comes from none other than Health Minister Dr Aaron Motsoaledi, who caused a stir by allegedly referring to them as the "*devils in white*"⁸⁷ at an International Nurses-Day event in Seshego, Limpopo. Dr Motsoaledi in addition, is said to have labelled SA^{Pub}HC Practitioners as "*uncaring*" at the same event.

3.2.3. Embarrassingly as it is to admit – the truth remains that Ngwelezane (rural) and Tembisa (urban) Hospitals represent a reasonable mix of the standard of care that the public, accessing SA^{Pub}HC Localities, must come to expect. Following the recent judicial recognition about the stark reality of the SA^{Pub}HC System landscape,¹⁰ one would hope for a renewed scrutiny of the SA^{Pub}HC System with regards to the application of the LR in cases of medical negligence claims. The author would, in addition, hope that this mini-dissertation would aid sensibly in this process.

⁸⁴ The skills portal – skills for success. *Film documents junior doctors plight*. <http://www.skillsportal.co.za/content/film-documents-junior-doctors-plight>. Accessed September 16, 2016.

⁸⁵ *Community service rankles with some but SA's young doctors are here to stay* — UCT study. Medical Brief Africa's Medical Media Digest, May 25, 2016.

⁸⁶ *Tembani supra* 360.

⁸⁷ *SA's nurses: Devils or Angels?* Medical Brief Africa's Medical Media Digest, May 18, 2016.

3.3. Environmental responsibility

3.3.1. According to findings published recently in the World Health Organisation's Global Tuberculosis Report 2016,⁸⁸ last year almost 10 000 Health Care workers were reported to have contracted TB around the world: 30% of these were from China with SA accounting for the second-highest proportion at 21%. This must impact negatively on the **Psychological Environment** as well as the Physical Environment with increased absenteeism due to ill-health, and must represent a compromised, if not outright dangerous, Locality.

3.3.2. Hazardous biological agents are infectious and toxic, and the OHS Act⁷⁴ states that employers shall provide and maintain as far as is reasonably practicable a working environment that is safe and without risks. The Act provides for the protection of persons, other than employees (i.e. patients), who may be affected by hazards associated with the workplace, and for the designation of Health and Safety Representatives and the setting up of Health and Safety Committees. Patients furthermore have a right to a *“healthy and safe environment that will ensure their physical and mental health or well-being, including . . . waste disposal, as well as protection from all forms of environmental danger, such as pollution, ecological degradation or infection.”*⁸⁹

3.3.3. Health Care Practitioners have a number of duties toward the environment, including:

3.3.3.1. Conservation of natural resources.⁹⁰ Health Care Practitioners should recognise that they have a responsibility to ensure that in the conduct of their affairs they do not in any way contribute to environmental degradation.

3.3.3.2. Disposal of health care waste.⁹¹ Health Care Practitioners should protect the environment and the public by ensuring that healthcare waste is disposed of legally and in an environmentally friendly manner.

Discussion: Of 407 SA^{pub}HC System facilities (spread out over all 9 provinces) inspected in 2014/2015, 91 Facilities complied while 316 did not comply regarding management of hazardous biological agents (22% compliance level). The worst performing Provinces included the Eastern Cape 18%, Gauteng 9%, and Limpopo at a spine-chilling 0% compliance. In 2016 another inspection was conducted. The Eastern Cape improved to 67%, but Gauteng- and Limpopo Provinces continued on

⁸⁸ SA's health workers hard hit by TB. Medical Brief Africa's Medical Media Digest, October 26, 2016.

⁸⁹ HPCSA *supra* Booklet 3 (2.1).

⁹⁰ HPCSA *supra* 11.1.

⁹¹ HPCSA *supra* 11.2.

their downward trend and noncompliance at 0% respectively. Northern Cape and KwaZulu-Natal Provinces likewise succeeded in maintaining their downward trend regarding compliance.⁹² Apart from the obvious risk of injury to patient and Practitioner alike, the data presented reflects disregard by SA^{Pub}HC System management for the very law that is supposed to protect them. Can the law in its strictest sense be applied in cases of medical negligence litigation arising from an environment where an atmosphere of blatant disregard for the law prevails? It is respectfully submitted that, should legal action arise against a Practitioner from a facility where compliance with the OHS Act is 0%, the dire **Psychological Environment** of the Locality - and the impact it has on employees - at least be deliberated by the legal team, prior to judgement. After all, apart from the reporting of non-compliance, there really remains no other avenue open to SA^{Pub}HC Practitioners towards cleaning up their environment / facility.

3.4. Practitioner-patient ratio

3.4.1. In the *Tembani* case⁹³ Cameron JA noted that *“the hospital was understaffed, especially over weekends, and that the doctor/patient and nurse/patient ratios were woefully inadequate.”*

3.4.2. In the *Oppelt*⁹⁴ case the critical Practitioner on duty was a Registrar specialising in Neurosurgery. She testified that at the time, in a single 24 hour shift, she had to serve both Groote Schuur and the Red Cross Children’s Hospital which she accomplished by driving between the two. She recalled that the Nursing Staff in the Trauma Unit at Groote Schuur were usually *“incredibly busy”*, treating between 6 and 10 acutely ill patients at any one time, while trying to assist Practitioners. Cameron J referred to it as a *“near-hellish”* situation.⁹⁵

Discussion: These two scenarios (*Tembani* and *Oppelt*) taken from SA^{Pub}HC Hospitals symbolize a compromised environment conducive to medical negligence cases sprouting from circumstances beyond the immediate control of the SA^{Pub}HC Practitioner. In both cases the LR surfaced as subtext. The cases paint a Locality deserving of recognition as such (i.e. compromised) in cases of medical negligence litigation. In fact, this author submits that this is what was accomplished in the *Oppelt* case when Cameron J in his minority judgement stated; *“In light of the desperate situation of resource scarcity and pressure on the medical personnel, we cannot say he [the patient] was*

⁹² *Gross biohazard safety violations in SA public health sector*. Medical Brief Africa’s Medical Media Digest, September 21, 2016.

⁹³ *Tembani supra* 359-360.

⁹⁴ *Oppelt supra* 101.

⁹⁵ *Oppelt supra* 102.

*inappropriately treated.*⁹⁶ The minority judgment, written by Cameron J (Jappie AJ concurring), agreed in part with the majority judgment's conclusion, but differed in two respects. First, Cameron J reasoned that the plaintiff (Mr Charles Oppelt) was not refused emergency medical treatment and remarked that the majority of Judges placed insufficient weight on the extremely difficult circumstances in which the Medical Personnel worked on the day of the plaintiff's injury. Second, the minority judgment found that the Department and its personnel were not negligent because Newton's four-hour theory⁹⁷ was new, unpublished, and unknown to them. It would only be fair to hold the Department's Medical Personnel to the standard of the "*general level of knowledge*" in 2002 – a standard that they met. Cameron J would have dismissed the appeal.

The ethical duty of Practitioners to care despite a detrimental Practitioner-patient ratio, seems to be unmatched by Government's sense of constitutional duty to supply the means by which Practitioners are to meet the demand. Few informed would argue that Public Health Services in the Western Cape are equal to, or better than, that in most other provinces, yet it strains under the burden of having to provide care to 3 out of every 4 persons living in that Province.⁹⁸ In Limpopo- and Mpumalanga Provinces there are only 9, and 6, full-time Gynaecologists respectively. The implication is that there is only one full-time Gynaecologist for almost 300 000 women in Limpopo. The equivalent ratio in Mpumalanga is 1:297 000.⁹⁹ One would hope that the current exodus of Gynaecologists from Private Practice¹⁰⁰ would positively impact on this skewed ratio in that they might seek employment in the SA^{Pub}HC System. With management in the latter having been "*politicized*",¹⁰¹ it however is unlikely to happen.

In May 2016 the number of patients (2448) awaiting surgical procedures at the Charlotte Maxeke Hospital in Johannesburg has increased by about 1000 in comparison to the highest number at any given time during 2015.¹⁰² The good Practitioner should be concerned about 10 patients kept waiting for surgery, or even 5. A significant percentage of elderly patients presenting at Orthopaedic Departments in SA^{Pub}HC Hospitals do so due to hip fractures. The elderly become confused merely by being hospitalized and removed from their known environment. They need to be operated on ASAP to avoid complications which would prolong hospitalization and increase morbidity and mortality. However, what unfortunately often happens, is the following; the operation is postponed due to a lack of operating time (each surgical discipline is allocated a limited number of hours per

⁹⁶ Oppelt *supra* 103.

⁹⁷ A theory that reduction of a cervical fracture or dislocation within specifically 4 hours improves outcome.

⁹⁸ 75% in the WC have no medical cover. Medical Brief Africa's Medical Media Digest, August 24, 2016.

⁹⁹ Public sector lack of gynaecologists. Medical Brief Africa's Medical Media Digest, May 12, 2015.

¹⁰⁰ Obstetrics is in a state of crisis. Medical Brief Africa's Medical Media Digest, September 4, 2016.

¹⁰¹ Katharine Child. *Gynaes in wrong places*. Times Live 07 May, 2015.

¹⁰² Reneilwe Dhludhlu. *1000 meer wag op operasies in Maxeke*. Beeld Nuus Wednesday 11 May 2016 pg 9.

week to perform surgery), or a lack of surgical drapes, or orthopaedic equipment, or a bed in ICU for post-operative care. Within 48 hours elderly patients start becoming confused. This is followed by an increase in complications; pressure-sores, pneumonia, and renal failure are high on the list. Eventually the patient ends up in the Critical Care Unit prior to having been operated, courtesy of a pneumonia and/or renal failure. This patient then occupies a bed to the next patient waiting to have a fractured hip repaired. The chances of a walking discharge for either of the two rapidly disappear with each passing day. What should happen is; surgery on the day of admission (day 0) with Critical Care admission postoperatively for days 1 and 2, transfer to the Orthopaedic Ward on day 3 or 4, and discharge home after a week or so. At WF Knobel Hospital, a Practitioner who works with cancer patients said: *“I’ve seen patients wait month after month to be seen by a specialist. I’ve seen people decay. I’ve seen cancer consume them alive. This is a serious injustice to our people.”*¹⁰³ Patients lying in hospital wards suffering in this fashion have a desperately negative impact on the **Psychological Environment** within which SA^{Pub}HC Practitioners have to practice their profession - in a caring and compassionate custom. It unfortunately is true that Practitioners will, and do, eventually build up protective walls around themselves to survive in this type of environment.

3.5. Administrator vs Clinician ratio

Provision of clinical care in the SA^{Pub}HC System is burdened by an unhealthy 3:1 Administrator-vs-Practitioner ratio.¹⁰⁴ The number of salaried Practitioners increased from 2296 (2005) to 3897 (2015) in 10 years. Over the same period the number of “Senior Executives” more than doubled (from 21 to 44) and the number of “Public-servant Administrators” increased from 11830 to 13477. Nationally the growth among all Practitioners, Pharmacists and Pathologists over the past 3 years was 3%. Over the same period, the ranks of Senior Public Healthcare Administrators in SA swelled by 12%. It may well be questioned whether Health Care Authorities are informed, let alone staying abreast, of the particular demands of clinical service delivery within the boundaries of SA^{Pub}HC Hospitals.

3.6. Staff shortages

3.6.1. A current shortage of 574 Practitioners and 1209 Nurses in Gauteng Public Hospitals has been revealed in a written reply by Gauteng Health MEC Qedani Mahlangu.¹⁰⁵ Mahlangu added that the majority of posts were vacant due to a process of natural

¹⁰³ *Death and despair in Limpopo’s hospitals.* Medical Brief Africa’s Medical Media Digest, June 1, 2016.

¹⁰⁴ Hospital bureaucrats outnumber doctors three to one in SA. Miles Kemp, The Advertiser December 28, 2015.

¹⁰⁵ *Gauteng Health releases staff shortage stats.* Medical Brief Africa’s Medical Media Digest, September 7, 2016.

attrition. She however did not expand on what was driving this process of “*natural attrition*”, and neither why it was not affecting Private Health Facilities in the same Locality, i.e. Gauteng, to the same degree. Nationally the current shortfall on Practitioners (1151 Gr 1 Medical Officers, 110 Medical Registrars, 78 Community Service Medical Officers, 160 Grade 1 Medical Specialists, 58 Intern Medical Officers, and 17 Clinical Unit and Department Heads) amounts to 1574. In this regard the MEC has been urged to “*not be complacent as the shortages do affect the quality of patient care and training needs to be stepped up*”.¹⁰⁶

3.6.2. According to the Democratic Nursing Organisation of South Africa (Denosa), KwaZulu-Natal’s Public Hospitals are suffering a “*nursing crisis*” with a shortage of General and Specialist Nurses at Public Hospitals and Clinics.¹⁰⁷ Concerns about overworked and underpaid Nurses in the Public Sector taking early retirement, have been raised. Significant staff shortages in an environment where the product is human health cannot but define the environment as compromised. This further fuels the negative perception of the ***Psychological Environment***.

In light of the staff shortages attempts are made to take medical care out of the SA^{Pub}HC Hospitals to the communities, and by doing so relieve the pressure on SA^{Pub}HC Facilities. Employment in specific Departments in SA^{Pub}HC^{Acad}Hospitals hence involve participation in Departmental outreach programs. Community Health Services supplied by UCT to the residents of Khayelitsha was suspended in August 2016 following attacks on Medical Students, including an incident where a group of 6 was robbed at gunpoint.¹⁰⁸

3.7. Transformation and equity

3.7.1. Professor Richard Hift recently stepped down from his position as Dean of the UKZN Medical School. It followed two weeks after the University’s Student Representative Council (SRC) embarked on strike action, calling for a black Dean to be appointed to allow for transformation at the University.¹⁰⁹

Discussion: Strike action, as measure to enforce transformation along racial lines in critically important management positions, represents a dubious approach to the pursuit of excellence. Merit, on the other hand, as measure to enforce transformation in critically important managerial positions, represents an open, competition-driven process in the pursuit of excellence. Only the

¹⁰⁶ Democratic Alliance Gauteng shadow Health MEC Jack Bloom

¹⁰⁷ *Union says KZN is in a ‘nursing crisis’*. Medical Brief Africa’s Medical Media Digest, June 1, 2016.

¹⁰⁸ *Violence halts UCT health services in Khayelitsha*. Medical Brief Africa’s Medical Media Digest, August 24, 2016.

¹⁰⁹ *Dean of beleaguered UKZN med school steps down*. Medical Brief Africa’s Medical Media Digest, August 17, 2016.

pursuit of excellence in dexterity and knowledge (competence⁵⁴) can positively transform the **Psychological Environment**, and hence health care delivery in the SA^{Pub}HC System.

3.7.2. At selected SA^{Pub}HC^{Acad}Hospitals appointment of Registrars is based purely on ethnicity, without any regard for academic achievement or clinical experience.¹¹⁰ The Constitution provides that everyone is equal before the law and has the right to equal protection and benefit of the law.¹¹¹ This implies equal treatment in respect of employment, and equal opportunity to develop. The Constitution further provides that nobody may be unfairly discriminated against on grounds of a number of factors including race, ethnic origin, or colour.¹¹² Regarding affirmative action the Employment Equity Act¹¹³ lists designated groups of persons who were previously disadvantaged. Applying the principle of affirmative action, where Practitioners *who are equally qualified* apply for the same job - particularly in the Public Sector - preference should be given to those Practitioners who come from the most previously disadvantaged designated groups.

Discussion: Registrars and Medical Officers, in their common goal of healing the sick, work intimately together in Clinical Departments in SA^{Pub}HC^{Acad}Hospitals. These Practitioners - working long and stressful shifts while sharing the burden of preparing for challenging exams - are intimately familiar with each other's academic proficiency and technical skills. They know exactly who are the better qualified. With race, rather than merit, as chief selection criterion for appointment of Registrars, discontent is fuelled. When merit, rather than race, is employed as chief selection criterion for promotion, healthy competition and respect for one another's achievement develops. This is the first step towards again having our Practitioners wear the crown of being "*the best in the World*". According to Chris Archer, a Gynaecologist and Head of the SA Private Practitioners' Forum, many of his colleagues would love to work in the SA^{Pub}HC System if it were well-managed: "*(The Public Sector) has politicised management, runs out of drugs, or has broken or poorly maintained equipment*".¹⁰¹

Regarding equity, it is this author's view that SA^{Pub}HC Practitioners (if not the public at large) are seeking guidance, if not a model, regarding the handling of the complex challenges associated with transformation and equity. Advocates are trained to resolve complex issues. The anxious eyes of many SA^{Pub}HC Practitioners facing the obstacle of representing a less-favoured ethnic group are on

¹¹⁰ Personal experience.

¹¹¹ Constitution *supra* S 9(1).

¹¹² Constitution *supra* S 9(3)(4).

¹¹³ 55 of 1998.

blindfolded Lady Law holding the balancing scale. Claims that the Cape Bar has been in turmoil for years over “*transformation*”¹¹⁴ hence makes for disconcerting reading. Tensions apparently have been simmering since the Bar implemented its access to work policy on October the 1st this year, which it says is intended to reform briefing practices – practices which currently are said to favour white Advocates. *Advocates for Transformation* has dismissed the Society’s move and has called for it to be removed from the General Council of the Bar and for black Advocates to refuse elevation to Senior Counsel. Tanya Golden, the Bar’s chairman, hailed the policy as a “*progressive transformation initiative*”. But Greg Papier, Chairman of *Advocates for Transformation*, said similar policies had failed. He accused the Society’s white members of cherry-picking black Advocates to sit on the Council and its subcommittees. To assist the blindfolded Lady maintaining her balance, a Greg Papier-equivalent would do well to “*accuse*” the SA^{Pub}HC System of “*head-hunting*”¹¹⁵ (the term preferred to “*cherry-picking*” in the SA^{Pub}HC System) black Medical Officers, Registrars, and Consultants for appointment in SA^{Pub}HC^{Acad}Hospitals.

Where should the Practitioner, overlooked for appointment to a vacant post despite possessing superior competence⁵⁴ (dexterity and knowledge) to the successful candidate, go to for help? Certainly not the judiciary who’s been unable to sort the same challenge in their midst! Blindfolded Lady Law, or at least then her agents in the SA^{Pub}HC System, have been peeping, looking at colour when it comes to appointing Practitioners to critically important positions, that’s as clear as black on white. From the foregoing it can be concluded that clear guidance from the Judiciary is not imminent, and the bloody equity-battle fought in the corridors and theatres of SA^{Pub}HC Hospitals will rage on, continuously undermining the ***Psychological Environment*** in the SA^{Pub}HC System – a System populated by Practitioners in desperate need of protection in the form of a LR.

Looking back at a Medical Career of about 35 years (working in the SA^{Pub}HC System (both SA^{Pub}HC- and SA^{Pub}HC^{Acad}Hospitals), the SA^{Priv}HCS, the National Health System in the UK (6 different NHS Hospitals including academic exposure in Cambridge), group Private Practice in the UK, and Private Practice in British Colombia in Canada), it is this author’s sincere conviction that patients, universally and above all other criteria, deeply value and appreciate a competent⁵⁴ Practitioner. Neither transformation nor equity has value in this regard. Only Practitioners known (if not famous) for their competence - based on merit rooted in technical skills (dexterity) and academic proficiency (knowledge) - can and will restore the mood in the ***Psychological Environment*** in the SA^{Pub}HC

¹¹⁴ Philani Nombembe. *Learned friends fall out*. LexisNexis October 10, 2016.

¹¹⁵ Used in a flimsy context aimed to applaud and acclaim the Practitioner “hunted” and eventually appointed. Actually, the exact opposite is true. Reality is that this rather suggests (?admits) that the “hunted” was unable to compete and overcome in the open market. By rather openly competing for vacant positions, the most competent candidate will be selected, and yet another tiny brick lain in eventually rising the SA^{Pub}HC System out of its current misery.

System. Isn't that what we want for ourselves (as SA^{Pub}HC Practitioners) and for our patients (the largely innocent party in this *cherry-picking head-hunting* competition)? Crampy politically-driven focus on equity and transformation will continue to destroy the **Psychological Environment**. There probably are few things worse than being a competent Practitioner deserving of academic rewards, yet subconsciously wearing a "quota" wreath. That is one of the unfortunate, yet inevitable, spin-offs from the forced allocations of posts based on ethnicity.

3.8. Public perception

3.8.1. One does indeed question whether commitment to patient care is priority if 36 patients from a selected group in the care of the SA^{Pub}HC System, die within a relative short space of time. In this regard the Minister of Health, Dr Aaron Motsoaledi, has asked the Health Ombudsman to investigate allegations that the 36 patients in Gauteng died after being transferred from Life Esidimeni into the care of Non-Governmental Organizations earlier this year.^{116, 117} The news resulted in an outcry from the families of the deceased and undermined public perception of the SA^{Pub}HC System. Those who lost their lives were part of some 2000 Psychiatric patients transferred to other facilities after the Provincial Health Department cancelled its long-running contract with Esidimeni Hospital.¹¹⁸ This Private Facility has provided long-term Chronic Mental Healthcare for over a period of 40 years to thousands of patients in Gauteng under contract from the Provincial Government. Public perception was further dented since it was only after an official question in the Gauteng legislature was asked, that Gauteng Health MEC Qedani Mahlangu revealed the news of the deaths of the patients in the NGOs in a period of about four months. To top this embarrassment it was claimed that Mahlangu dodged questions regarding the psychiatric patients' release.¹¹⁹ The fact remains that these patients were, both prior to and after having been transferred, under the care of the SA^{Pub}HC System. A new twist in this saga developed when the front page of the Pretoria News revealed that *"An NGO from Cullinan, east of Pretoria, allegedly entered into a fraudulent contract with a government official to take care of 73 mental patients, some of whom have since died."*¹²⁰ Fraud, denial, death – what next? Isn't the SA^{Pub}HC System supposed to be populated by Health Care Officials proudly wearing an honesty-and-

¹¹⁶ 36 psychiatric patients die after transfers to NGOs. Medical Brief Africa's Medical Media Digest, September 14, 2016.

¹¹⁷ Psychiatric patient crisis — death toll rises to 37. Medical Brief Africa's Medical Media Digest, October 5, 2016.

¹¹⁸ Investigation into psychiatric patient deaths. Medical Brief Africa's Medical Media Digest, September 1, 2016.

¹¹⁹ Health MEC dodges questions on psychiatric patients' release. Medical Brief Africa's Medical Media Digest, September 7, 2016.

¹²⁰ NGO deaths: fraud claim. Pretoria News & Business Report, pg 1. Tuesday September 27, 2016.

integrity badge? To any straight-thinking citizen this paints an *absolutely-no-confidence* picture of the SA^{Pub}HC System, a compromised environment deserving of having its employees protected during medical malpractice litigation.

Little surprise that a Nurse had her head bashed against a wall at Odi Hospital in Mabopane by frustrated members of the public.¹²¹

3.8.2. Claims by a female patient of having been raped by a Practitioner inside a SA^{Pub}HC Hospital¹²² further dents the public perception of the SA^{Pub}HC System. It goes without saying that any accused person is innocent until proven guilty by a court of law, yet this category of publicity is fertile soil for negative **Psychologic Environment**.

3.8.3. Concern regarding the poor expertise and language skills of some of the foreign Practitioners employed in Gauteng has been expressed after it emerged that their numbers had swelled by almost 500 since 2015.¹²³ Claims about “*four Cuban doctors at the Bheki Mlangeni Hospital in Soweto who can barely speak English, write poor scripts and are accused by other staff of endangering patients*” have been made. Appointing Spanish (only) speaking Practitioners in a country with 11 official languages where Practitioner-patient communication as it is, is challenging, elevates the hurdle to an inter-Practitioner level. How does that contribute to patient care, or to healthy inter-Practitioner communication, or towards building a **Psychological Environment** conducive to patient care? Is this perhaps an example of perceived scoring of political points by publically parading diplomatic issues ahead of patient care?

3.8.4. Public perception is best summarized by a recent report boldly proclaiming that the SA Public “*fear*” the medical care provided by the SA^{Pub}HC System.¹²⁴ The magnitude of this fear is evidenced by the fact that, although angered by the increase in Private Health Care premiums,¹²⁵ the public still opt to stomach the extra cost rather than being exposed to the (perceived) nauseating environment that is the SA^{Pub}HC System. Arguing the case,

¹²¹ Ntando Makhubu. *Patient death triggers attack on hospital nurse*. <http://www.iol.co.za/news/crime-courts/patient-death-triggers-attack-on-hospital-nurse-2014472>. Accessed August 30, 2016.

¹²² *Limpopo doctor faces rape allegations*. Medical Brief Africa’s Medical Media Digest, June 1, 2016.

¹²³ *Gauteng got 500 new foreign doctors in 2016*. Times Live, TMG Digital September 29, 2016.

¹²⁴ *MEDIESE SKEMAS. Verbruikers vrees staatsorg. Lede kwaad, maar betaal dus maar hul duurder premies*. Nellie Brand-Jonker, Beeld Sake. September 22, 2016 pg 19.

¹²⁵ *MEDIESE SKEMAS supra*. Momentum Health announced an increase of between 9.9% and 15%. Discovery Health Medical Scheme announced an increase of up to 14.9% (Coastal Core Plan). This stands against an inflation rate of 5-6% and salary increases of 5-7%.

journalist Brand-Jonker quotes Gregory Setzkorn¹²⁶: *“For most members [of private medical schemes] public health care is not an option because of the horror stories they regularly read in the media”*. What an embarrassing indictment to all diligent Practitioners and Nurses employed in the SA^{Pub}HC System!

3.9. Financial mismanagement

3.9.1. Mpumalanga’s Health MEC Gillion Mashego is facing pressure to resign.¹²⁷ It is claimed that he

- 3.9.1.1. failed to implement a turn-around strategy suggested by the SA Human Rights Commission in 2014
- 3.9.1.2. underspent the budget by R85.3-million because of staff shortages and delayed appointments
- 3.9.1.3. destroyed expired medication that included antiretroviral drugs, tuberculosis medicines and vaccines valued at R5-million over the past two years due to improper storage and staff shortages
- 3.9.1.4. increased the maternal mortality rate
- 3.9.1.5. abolished 12 326 posts, 3 120 of which were funded
- 3.9.1.6. faces R60-million in lawsuits for medical negligence because doctors were overworked, and
- 3.9.1.7. lost R500-million in conditional grants that were meant to build hospitals and clinics, which were eventually never built.
- 3.9.1.8. It is also claimed that no single SA^{Pub}HC Hospital in Mpumalanga was complying with vital and extreme measure of the National Core Standards.

3.9.2. Mashego (in his position as MEC being the highest ranking official in Mpumalanga Health) has been criticised for allegedly issuing a directive for the appointment of a woman as a cleaner at a hospital after her mother was killed by a state ambulance.¹²⁸ Provincial Health Department spokesman Dumisani Malamule said Mashego only mitigated in a process he initiated after the Department and the Masemola family reached an agreement that the latter should build a house and employ one of the family members. He said the Department saved a lot of money by building a house and employing

¹²⁶ Setzkorn is the Chairman of the Healthcare Benefits Committee at the Financial Intermediaries Association of Southern Africa (FIA).

¹²⁷ *Mabuza won't be pushed to fire Health MEC accused of endangering lives*. Sizwe Sama Yende, City Press, September 27, 2016.

¹²⁸ *MEC gives victim's family a job to avoid R20m lawsuit*. IOL, September 28, 2016.

Masemola as her family could have sued it for R20-million as a result of the accident. Based on the data presented, one may well reason on the MEC's ability to distinguish right from wrong (or *vice versa*, if need be).

If that indeed reflects the morality of the highest-ranking official in the Provincial Health Department one can but await the medical malpractice litigation storm⁷⁷ referred to by Pepper. At the eye of the storm will be the SA^{Pub}HC Practitioner, caught up in a compromised environment. Even if only half of the claims were true, Mashego should immediately resign. The term "*Public perception*" obviously also includes Practitioner perception, which - if coloured by data as presented above - has a desperately negative impact on the ***Psychological Environment*** reigning in hospitals affected by such acts and omissions.

3.9.3. A short distance across the Provincial border the KwaZulu-Natal Health Department is sitting on a R4.1-billion irregular spending "*black hole*", and things are in such a sorry state that the Auditor-General cannot fathom the full extent of what is a growing problem.¹²⁹ MPLs heard a litany of problems and recurring excuses and explanations, prompting Maggie Govender, Chairwoman of the Standing Committee on Public Accounts (Scopa), to conclude that Officials perhaps thought the Department was a place to "*go and eat*". "*You have to stop the scourge of nonsense that is happening,*" she also added. With that kind of stinging slap-on-the-wrist consequence for R4.1-billion gone missing, this author can visualize the impressive queue of impatient applicants - merit aside for now - eagerly eyeing a permanent appointment, by hook or by crook, in *that* Department. The KZN Health Department is now forming a "*crack*" team of medical and legal experts to stem the rising tide of medical negligence claims, which this year alone totals R10.6-billion, against it.¹³⁰

What has become of political will towards clean governance? Tough to stomach as it is, it supports the notion that the SA^{Pub}HC System represents a desperately compromised environment deserving of the ongoing application of the LR as protective measure towards the diligent SA^{Pub}HC Practitioners and Nurses. In light of the reigning conditions referred to in the

¹²⁹ KZN Health's R4.1 billion spending black hole. Mayibongwe Maqhina. IOL, October 19, 2016.

¹³⁰ KZN Health team to stem medical negligence claims. Medical Brief Africa's Medical Media Digest, October 26, 2016.

Health Departments of Mpumalanga and KZN, one may well question whether “*criminal*” wouldn’t be a more apt description than “*compromised*”?

3.10. Political will

3.10.1. The political will to provide universal access to health care lacks. It is clear when looking at the desperation evident in the level Health Care Workers are forced to go to in an attempt to draw attention to their plight from those in politically relevant positions. Health Care Workers marching up-and-down dusty streets are a regular occurrence in SA. In the Northern Cape a corruption task team was formed by former Health MEC Mac Jack who listed flawed lease agreements, undeclared employee interests and fraudulent procurement of equipment and supplies as some of the corrupt activities uncovered by the Northern Cape Health Department.¹³¹ The team investigated R200-million worth of corruption-related activities but the new Health MEC, Lebogang Motlhaping, has yet to release the report. A lack of political will – if not basic managerial competence - is also clear when beholding the amounts spent on bailing out the SAA, and the amounts mentioned in connection with the purchasing of a private jet for the exclusive use of top-level government officials.

3.10.2. In comparison to these billions of rand, Practitioners and Nurses in some SA^{Pub}HC Hospitals in the Free State Province who have worked up to 16 hours on shifts have only been paid for 10 hours.¹³² A “*hospital nightmare*” – as it is referred to by the Treatment Action Campaign and Section 27 – is unfolding in the Free State. Political will is driven by the ticking of crosses in the shadows of electoral booths. With maturing of democracies voters’ crosses are more-and-more aligned with issues where personal wellbeing is at stake; and excellent example would be Health Care. Lack of access to health care has toppled governments in developed democracies. Only the future, as it were, will reveal the effect of Obamacare on American politics. For this our democracy arguably is too young, with votes cast based on traditional loyalty rather than the reality that Public Health Care provision – at least at SA^{Pub}HC facilities not linked to training institutions – is in shambles.

3.10.3. Not only does it seem as though there is a lack of political will to provide universal access to health care, there now quite astoundingly, seems to be attempts at denying a

¹³¹ *Northern Cape workers march against health crisis*. Medical Brief Africa’s Medical Media Digest, October 5, 2016.

¹³² *A Free State ‘hospital nightmare’ is unfolding – NGOs*. Medical Brief Africa’s Medical Media Digest, September 21, 2016.

duty of care to patients.¹³³ In response to a damages claim for a botched operation, Gauteng Health denies in papers filed before the High Court that it owes any “*duty of care*” to patients. Not only is there no law obliging the State to provide “*proper, sufficient and reasonable health services to members of the public*” but “*paying compensation to individual claimants depletes the funds for health in favour of individual victims and undermines the principle of solidarity and equitability*”, the State-Attorney argues.

3.11. Keeping of medical records

The remark by Cameron J in the *Tembani* case that “*The medical records were deficient and no proper discipline was enforced in keeping them. The standard of nursing care was evidently poor*”¹³⁴ likely represents fruit from the already undermined **Psychological Environment** in the SA^{Pub}HC System, rather than contributing to poor health care delivery.

3.12. And last, but not least, regarding the **Psychological Environment** SA^{Pub}HC Practitioners face; unexpected, un-announced non-payment of the overtime component of salaries, is not exceptional.⁷⁶

The question remains, how may Practitioners be protected from the realities they face due to the great divide in health care in SA?

¹³³ *Gauteng Health denies it owes any ‘duty of care’ to patients – Landmark plea.* Medical Brief Africa’s Medical Media Digest, October 19, 2016.

¹³⁴ *Tembani supra* 359-60.

Chapter 6

Conclusions and Recommendations

1. Deficiencies at three different levels in the SA^{Pub}HC System have been identified and scrutinized as much as is allowed for in a mini-dissertation.
 - 1.1. Subjective clinically-relevant factors impacting on the running of the SA^{Pub}HC System set the scene for the **Clinical Environment**. SA^{Pub}HC Hospitals are populated by salaried career Medical Officers and Specialists who often labour on without any incentives. SA^{Pub}HC^{Acad}Hospitals are populated by Registrars and Consultants; clinical competence generally approach that of Specialists in the SA^{Priv}HC System.
 - 1.2. Objective clinically-relevant factors impacting on the running of the SA^{Pub}HC System set the scene for the **Physical Environment**. SA^{Pub}HC Facilities (Hospitals and Clinics alike) are desperately short on maintenance, equipment, and consumables - especially in more remote areas.
 - 1.3. A combination of Subjective- and Objective clinically-relevant factors impacting on the running of the SA^{Pub}HC System set the scene for the **Psychological Environment**. Public perception of the SA^{Pub}HC System is at an all-time low. Race as only criterion for appointment of Registrars to the limited number of posts have a devastating effect on the **Psychological Environment**.
2. NHI

The deficiencies in the SA^{Pub}HC System at three different levels have been recognized by Government, and the solution ostentatiously put forward is the National Health Insurance (NHI).¹³⁵ Clarity on who would foot the bill for such an elaborate system lacks. Nearly 6 years after its announcement a draft set of NHI “*financing scenarios*” is expected to be ready for Provincial Health MECs in October 2016, according to Health Minister Dr Aaron Motsoaledi.¹³⁶ In this regard the Hospitals’ Standards Regulations have been severely criticized.¹³⁷ McQuoid-Mason¹³⁸ points out that shortages in (amongst others) radiology equipment resulting in harm to

¹³⁵ Green Paper titled “*Policy on National Health Insurance*” August 12, 2011.

¹³⁶ DoH finalising a draft set of NHI ‘*financing scenarios*’. Medical Brief Africa’s Medical Media Digest, August 31, 2016.

¹³⁷ Hospital standards regulations ‘*unworkable*’. Medical Brief Africa’s Medical Media Digest, May 12, 2015.

¹³⁸ McQuoid-Mason DJ. *Public health officials and MEC’s should be held liable for harm caused to patients through incompetence, indifference, maladministration or negligence regarding the availability of hospital equipment*. S Afr Med J 2016;106(7):681-3.

patients, undermines the public's confidence in the SA^{Pub}HC System facilities, *and its ability to host a National Health Insurance scheme*. It however is not only at the financial level where difficulties are being encountered. A bleak picture regarding the availability of Practitioners available to the NHI is also painted, with up to 80% of Practitioners preferring not to work for the State because of poor working conditions, and up to 17% of newly qualified Practitioners considering emigration.¹³⁹ It is clear that the NHI as solution to current challenges in the SA^{Pub}HC System is all but enthusiastically embraced. For the Practitioner currently employed in the SA^{Pub}HC System, pinning his hopes on the LR rather than the NHI, is more likely to pay dividends.

3. Ongoing application of the LR

Although predicted elsewhere, the disappearance of the LR in South Africa is not on the cards just yet. In fact, albeit dressed in a different, non-geographical gown, the LR is here to stay. This author would argue in favour of the LR in view of the clear divide between the SA^{Pub}HC- and the SA^{Priv}HC Systems as laid bare in this mini-dissertation. The application of the LR will assist the courts in more accurately assessing the conduct of the Practitioner within the context of one of the two differing Localities, in case of a medical negligence claim. Furthermore, the rise in medical negligence suits recently observed in SA¹⁴⁰ would decrease if the LR was implemented because the SA^{Pub}HC Practitioner would then not automatically be equated with the SA^{Priv}HC Practitioner.¹⁴¹

4. Recommendation

Are the behaviours and bustles, the conducts and commotions, within the walls of the SA^{Pub}HC System Facilities meriting of a continued application of the LR by the Judiciary in cases of medical negligence litigation involving SA^{Pub}HC Practitioners? In view of the data presented a positive response is presented, and it is respectfully recommended that the Judiciary consider a new, SA-specific interpretation of the term "Locality". An interpretation where "Locality" no longer is defined by geography, but rather by innumerable individual pieces of oddly shaped administrative red tape and petty politicking tumbling down in a seemingly *ad lib* fashion to create the currently existing working environment of the SA^{Pub}HC Practitioner. An environment

¹³⁹ SA's shortage of medical doctors – a bleak picture. Medical Brief Africa's Medical Media Digest, October 20, 2016.

¹⁴⁰ According to the MPS medical negligence lawsuits have more than doubled in the past two years and in the last five years claims that add up to R5-million or more has increased with 900%. The Gauteng Department of Health and Social Development reported that in the year 2009/10 their medical malpractice lawsuits added up to R573-million. See Malherbe J "Counting the Cost: The Consequence of Increased Medical Malpractice Litigation in SA" (2013) *South African Medical Journal* 83.

¹⁴¹ De Bruyn Danielle. *Lack of access to equal public health care and the locality rule in South Africa: a comparative study*. Submitted in fulfilment of the requirements for the degree LLM in the Faculty of Law, University of Pretoria, August 2016. Unpublished 63.

borne out of necessity, hosting in excess of 40 000 employees, a working environment deserving of its own identity, a working environment known as the SA^{Pub}HC System, representing - as I've attempted to argue - a thoroughly circumscribed and distinctively unique "Locality". A Locality, in the final analysis, deserving of Practitioner and patient support and praise alike, as if one's life depends on it.

5. Liability

For those SA^{Pub}HC Practitioners eyeing the LR as means to escape liability there remain but one sting in the tail. Applied even in its strictest sense, the LR offers no protection against incompetence, indifference, maladministration, or negligence.¹⁴² Those found guilty on any of these accounts and who cause harm to others, have no immunity. In fact, not even the employer (through vicarious liability) presents a safe harbour against harmful negligent or intentional wrongful acts or omissions.¹⁴³ Where the SA^{Pub}HC System (or the relevant Provincial MEC for Health, or Minister of Health) is vicariously liable for the conduct of a SA^{Pub}HC Practitioner, the Practitioner may (in addition) still be held personally liable.¹⁴⁴

Weaknesses of the study

Collectively the SA^{Pub}HC Hospitals do not represent a homogenous Locality.⁵³ Likewise, the SA^{Pub}HC Practitioners by no means represent a homogenous collection of professionals.⁵³

In contrast, the SA^{Priv}HC System does represent a fairly homogenous collection of Facilities.

Positive achievements by the SA^{Pub}HC System were not emphasized – the media however, has of late not been flooded by acclamations on the excellence of the SA^{Pub}HC System.

A disproportionately large amount of the information collected was from the immediate environment of the author, a seasoned SA^{Pub}HC Practitioner.

¹⁴² McQuoid-Mason *supra* 48.

¹⁴³ McQuoid-Mason *supra* 49-50.

¹⁴⁴ *Feldman (Pty) Ltd. v Mall* 1945 AD 733.

Chapter 7

Bibliography

Books

Carstens PA & Pearmain D. *Foundational Principles of South African Medical Law*. Durban; LexisNexis 2007.

Dhai A & McQuoid-Mason DJ. *Bioethics, Human Rights and Health Law: Principles and Practice*. Cape Town; Juta and Company 2010.

Dutton I. *The Practitioner's guide to Medical Malpractice in South Africa*. Cape Town; Siber Ink 2015.

Gilmore SA. *Finding Legal Information in South Africa (3rd edition)*. Pretoria; Pretoria University Law Press 2014.

Gordon *et al.* *Medical Jurisprudence*. Edinburgh; Livingston 1953.

McQuoid-Mason DJ & Dada M. *A-Z of Medical Law*. Cape Town; Juta and Company 2011.

Moodley K. *Medical Ethics, Law and Human Rights. A South African Perspective*. Pretoria; Van Schaik Publishers 2011.

Pieterse M. *Can Rights Cure? The impact of human rights litigation on South Africa's health system*. Pretoria; Pretoria University Law Press 2014.

Strauss SA. *Doctor, Patient and the Law. 2nd ed.* Pretoria; Van Schaik Publishers 1963.

Van der Merwe NJ & Olivier PJJ. *Die Onregmatige daad in die Suid Afrikaanse Reg. 5th ed.* Pretoria; JP van der Walt, 1985.

Case law – domestic

Kruger v Coetzee 1966(2) SA 428(A).

Mitchell v Dixon 1914 AD 519.

Mlatsheni v The Road Accident Fund 2009(2) SA 401(E).

Nyathi v MEC, Department of Health, Gauteng and Others 2008 ZACC 8.

Oppelt v Head: Health, Department of Health Provincial Administration: Western Cape (2015) ZACC 33.

S v Tembani 2007 1 SACR 355 (SCA).

Van Wyk v Lewis 1924 AD 438.

Case law – international

Small v Howard 128 Mass. 131, 35 Am. Rep. 363 (1880).

Discussion documents and policy papers

Department of Health, Republic of South Africa. National Health Insurance in South Africa: Policy paper (2011).

Internet sources

Business Day Live

City Press

Independent Online News

Times Live

The Law Dictionary

The Law, Science & Public Health Law Site

Journal articles - domestic

Carstens PA. “Judicial Recognition of Substandard Medical Treatment in South African Public Hospitals: The Slippery Slope of Policy Considerations and Implications for Liability in the Context of Criminal Medical Negligence”. (2008) *South African Public Law Journal*.

Carstens PA. “The locality rule in cases of medical malpractice”. (1990) *De Rebus*.

Carstens PA. “Medical Negligence as Causative Factor in South African Criminal Law: Novus Actus Interveniens or Mere Misadventure?” (2006) *South African Criminal Journal*.

Howarth GR. “Challenging the cost of clinical negligence.” (2016) *South African Medical Journal*.

Howarth GR & Carstens PA. "Can private obstetric care be saved in South Africa?" (2014) *SA Journal of Bio-ethics and Law*.

Malherbe J. "Counting the Cost: The Consequence of Increased Medical Malpractice Litigation in SA". (2013) *South African Medical Journal*.

McQuoid-Mason DJ. "Public health officials and MEC's should be held liable for harm caused to patients through incompetence, indifference, maladministration or negligence regarding the availability of hospital equipment". (2016) *South African Medical Journal*.

Otto SF. "Medical Negligence". (2004) *South African Journal of Radiology*.

Pepper MS & Nöthling Slabbert M. "Is South Africa on the Verge of a Medical Malpractice Litigation Storm?" (2011) *South African Journal of Bioethics and Law*.

Van den Bout AH. "Know the boundaries within your scope of your practice". (2008) *SA Orthopaedic Journal*.

Journal articles - international

Adams JP *et al.* Quality and outcomes in anaesthesia: lessons from litigation. (2012) *British Journal of Anaesthesia*.

Ginsberg MD. "The Locality Rule Lives! Why? Using Modern Medicine to Eradicate an 'Unhealthy' Law". (2013) *Drake Law Review*.

Ginsberg MD. The Persistent Locality Rule. Outdated Law imposes geographic dimension on the standard of care. (2013) *AAOS Now*.

Lewis MH *et al.* The Locality Rule and the Physician's Dilemma. Local Medical Practices vs the National Standard of Care. (2007) *Journal of the American Medical Association*.

Michota FA & Donnely MJ. Medicolegal issues in perioperative medicine: Lessons from real cases. (2009) *Cleveland Clinic Journal of Medicine*.

Oosthuizen WT & Carstens PA. Medical malpractice: The extent, consequences and causes of the problem. (2015) *Journal of Contemporary Roman-Dutch Law*.

Oosthuizen WT & Carstens PA. Re-evaluating medical malpractice: A patient safety approach. (2015) *Journal of Contemporary Roman-Dutch Law*.

Sherman I. The Standard of Care in Malpractice Cases. (1966) *Osgoode Hall Law Journal*.

Tessler MJ *et al.* Association between Anesthesiologist Age and Litigation. (2012) *Anesthesiology*.

Van Oosten FFW. Professional Medical Negligence in Southern African Legal Practice. (1986) *Medicine and Law*.

Waltz JR. "The Rise and Gradual Fall of the Locality Rule in Medical Malpractice Litigation". (1969) *De Paul Law Review*.

Legislation

Constitution of the Republic of South Africa

Department of Health (1997) White Paper for the Transformation of the Health System in South Africa. Government Notice 667 published in *Government Gazette* 17910 of April 16, 1997.

Department of Health (2011) Policy on National Health Insurance. Government Notice 657 published in *Government Gazette* 34523 of August 12, 2011.

White Paper: National Department of Health (2015) National Health Insurance for South Africa: Towards Universal Health Coverage. GN 1230 in GG 39506 of 11 December 2015.

Employment Equity Act 55 of 1998.

Health Professions Act 56 of 1974.

National Health Act 61 of 2003.

Occupational Health and Safety Act 85 of 1993.

Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000.

Newspaper reports

Beeld Nuus

Cape Times

Government Gazette

Pretoria News and Business Report

Other

De Bruyn D (2016). *Lack of Access to Equal Public Health Care and the Locality Rule in South Africa: a comparative study*. LLM (unpublished) Dissertation University of Pretoria.

Oosthuizen WT (2014). *An Analysis of Healthcare and Malpractice Liability Reform: Aligning Proposals to Improve Quality of Care and Patient Safety*. LLM (unpublished) Dissertation University of Pretoria.

Rules of Conduct of the Health Professions Council of South Africa.

Scharf GM (2014). *The Medico-legal pitfalls of the Medical Expert Witness*. Submitted in accordance with the requirements for the degree of Master of Law at the University of South Africa (unpublished).

Acknowledgments / Consultations

- Consultant Anaesthetists (colleagues)
 - Dr Frans Botha
 - Dr Sheila Naidoo
 - Dr Hannelie Schutte
 - Dr Dawid Van der Merwe
 - Dr Mariana Voigt
- Fourie PJHL, Prof
- Heiberg PJ, Prof
- Howarth G, Dr
- Landman W, Prof
- Oosthuizen W, Mr
- Scharf G, Dr