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LACK OF ACCESS TO EQUAL PUBLIC HEALTH CARE AND THE LOCALITY RULE IN SOUTH AFRICA: A COMPARATIVE STUDY

By

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Summary

In South Africa a large divide exists within the health care sector. Health care provided in the private sector cannot be equated to that of the public sector, as the resources, quality and access in the public sector is a pipeline dream, not a reality.

This dissertation aims to address this inequality of health care by acknowledging the stark realities the government seek to avoid when it comes to public health care. The only way to address the quality of health care is to admit to the lack of resources, and to deal with the situation according to these realities, instead of living in utopia. The link between the Locality Rule, access to equal public health care and medical negligence must be clear from the outset. It must be noted that the dissertation does not suggest that the Locality Rule will ensure the quality of health care to be equalised in the two sectors, but rather that it will be used as a tool to ensure that cognisance is taken of the differences that exists, and that medical negligence will be assessed based on these differences in the respective sectors. It needs to be mentioned that the sources used in this dissertation is updated until May 2016.

The Locality Rule is therefore suggested as an interim solution to the standard of health care South Africans are faced with, until such a time that a proper solution (the complete implementation of the proposed National Health Insurance) can be implemented.

The dissertation acknowledges the need for physicians practising in the public sector to be held to a compromised standard of care and skill than physicians practising in the private sector. The link between the Locality Rule and medical negligence can be found in that medical negligence cannot merely be assessed as a rule of circumstance - which is in itself extremely vague. The use of the Locality Rule will ensure that these surrounding circumstances are taken into account by the judiciary, every single time they are faced with a medical negligence claim.

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List of Abbreviations

ANC – African National Congress

BMA - British Medical Association

CC – Constitutional Court

GDP - Gross Domestic Product

ICCPR - Covenant on Civil and Political Rights

ICESCR - International Covenant on Economic, Social and Cultural Rights

HPCSA – Health Professions Council of South Africa

MPS – Medical Protection Society

NHA – National Health Act

NHI - National Health Insurance

NHS – National Health Services

PAS – Physician Assisted Suicide

SAMDC - South African Medical and Dental Council

SAMRC – South African Medical Research Council

SCA – Supreme Court of Appeal

UDHR - Universal Declaration of Human Rights

WHO – World Health Organisation

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Chapter 1

Introduction

1 Introduction and Background

The Constitution[1] provides for access to health care,[2] but this bare concept, without taking into account "equal access", is open to multiple interpretations.[3] The problem is not so much access to health care in South Africa but rather the disparate quality of health care noted between the private and public sectors (in other words, private and public hospitals). The underlying cause of this divide is rooted in poverty, with an unemployment rate of 25%, South Africa is ranked 8th on the worst-unemployment-rate list.[4] The wealthy have the ability and willingness to pay for better health care, while the poor are satisfied if they receive any form of health care, no matter the quality. Unfortunately for South Africa, the poor constitutes the majority of the population and therefore the demand for health care in the public sector far outweighs that of the private sector. The public sector has to provide health care to about 80% of the population, while the private health care sector is small, but fast growing, because the majority of resources and finances allocated to health care is still devoted to this sector.[5]

The attempt to properly regulate health care and the consequences of the lack of such implementation is still experienced in South Africa today. Even though much effort has been made in the past twenty years to ensure access to health care in the

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[1] The Constitution of the Republic of South Africa, 1996, hereafter referred to as "the Constitution".

[2] S 27 of the Constitution.

[3] The definition of "health care services" as provided for in our supreme law will be discussed in detail in Chapter 2 titled 'Health care in South Africa: The reality versus the legislative framework'.

[4] City Press, "SA ranks 8th on worst unemployment rate list", accessed: 17 August 2015 http://www.news24.com/Archives/City-Press/SA-ranks-8th-on-worst-unemployment-rate-list-20150429.

[5] Pieterse M *Can Rights Cure?: The Impact of Human Rights Litigation on South Africa's Health System* (Pretoria: Pretoria University Law Press 2014) 6.

public sector, the issue of quality still remains. Health care reform remains a primary objective of the South African government. The public sector used to face two main problems, access to health care and the quality thereof. Since the enactment of the Constitution and section 27 which entrenched the right to access to health care, the problem is not so much access to health care anymore, but rather the quality of care in the public sector.

The lack of resources not only manifests in technological, financial and infrastructural resources, but the availability of uniform trained physicians in the public sector. The main reason for lack of physicians in the public sector lies in the fact that 73% of medical physicians in South Africa, practise in the private sector, leading to a doctor-patient ratio of one doctor for every 4219 people in the public sector.[6] The lack of medical physicians in the public sector is directly proportional to the lack of quality health care afforded to patients.[7]

Due to the fact that equal access to health care is not a reality in South Africa, medical negligence lawsuits against medical professionals are increasing tremendously.[8] The lack of uniform health care forms a backdrop to this dissertation which in turn creates a context for the argument developed. In any given case of medical carelessness, in light of the inequality in access to South African health care it must be asked whether the medical negligence resulted due to the actions or inactions of the medical professional - namely due to his or her skills, training or

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[6] SouthAfrica.info, "Health care in South Africa", accessed: 17 August 2015 http://www.southafrica.info/about/health/health.htm#.VdGhF5ExGFI.

[7] Coetzee LC & Carstens PA "Medical Malpractice and Compensation in South Africa" (2011) *Chicago-Kent Law Review* – "The chairman of the South African Medical Association, Norman Mabasa, said that the current incidence of medical malpractice is the result of 'the skills shortage in the public health system'".

[8] According to the Medical Protection Society (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 period of 2009/2010 their medical malpractice lawsuits added up to R573 million. The Health Professions Council of South Africa (HPCSA) further reported that during the period of April 2011 to March 2012 they received 2 403 complaints by patients, regarding medical negligence - See: Malherbe J "Counting the Cost: The Consequence of Increased Medical Malpractice Litigation in SA" (2013) *South African Medical Journal* 83.

judgement - or whether the medical negligence can be attributed to the quality of health care and the resources available to the medical professional in his or her location?

This dissertation aims to make use of the Locality Rule (as it is known in medical law)[9] as a tool of addressing the quality and non-equal access to health care in South Africa. This Rule entails that the standard of care exercised by a medical professional must accord with the standard expected or known in that community – therefore a physician practising in rural areas (public health care facilities) should be held to a compromised standard than a physician practising in urban areas (private health care facilities).[10] It must be made clear that in saying the dissertation aims to use the Locality Rule as a tool in addressing health care in South Africa, does not entail that the Rule will provide all South Africans access to equal health care. The Locality Rule addresses the inequality of health care by providing medical practitioners with legal protection against medical negligence claims that were out of their control and therefore not their fault. In such a way the Rule takes cognisance of the realities of the public health care sector.

The problem is twofold: Firstly, the Locality Rule as such does not find any application in the South African medical law and secondly we also do not have access to equal health care in South Africa. This twin problem results in medical practitioners facing an onslaught on medical negligence claims for unfortunate outcomes that are out of their control (and therefore not their fault) because the outcomes are caused by location-based factors. This is exactly why this dissertation advocates the implementation of the Locality Rule. Until our economy and society can develop to such a state where section 27 of the Constitution can be effectively amended to ensure South Africans *equal* and *quality* access to health care - no matter the location (therefore no matter the hospital/clinic) - the Locality Rule needs

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[9] This Rule entails that a physician from a small town or a physician practicing in a rural area cannot be held to the same standard (of medical care) as a physician practicing in the big city (an urban area). This Rule is based on the fact that the location of the practices of these two physicians differ which results in unequal resources being available to each physician – See: Morrison AB 'Torts' in Brennan WJ (ed), *Fundamentals of American Law* (Oxford: Oxford University Press 1996) 255.

[10] Cawthon EA 'Cases' in *Medicine on Trial: A Handbook with Cases, Laws and Documents* (ABC-CLIO 2004) 94.

to be implemented in our country.[11] A cautionary note in this regard is necessary: This dissertation however takes the stand that the Locality Rule in medical negligence cases should not result in complete or absolute protection of medical practitioners. The Rule should rather be taken into account as a contributing factor in regard to surrounding circumstances whenever the judiciary is faced with assessing the conduct of a physician in a medical negligence lawsuit.[12]

Carstens & Pearmain ask the following question:

> Can the excellence, infrastructure, diagnostic and other medical equipment of, for example Johannesburg General Hospital, truly be compared with the facilities of a mission hospital/clinic in a remote rural area?[13]

Until we can say that we have access to equal health care in both the private and public health sectors,[14] it is only fair to protect the reputation and dignity of the health care professionals whose skills and training is compromised due to their locality of practice - hence why South African medical law demands the implementation of the Locality Rule.

2 Research Problem

As alluded to above, the problem unpacked in this dissertation is the fact that we do not have access to equal (quality) health care in South Africa, coupled with the absence of the Locality Rule in our law. With patients realising the shift in the nature of the doctor-patient relationship (and therefore becoming more aware of their rights)

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[11] If this section is amended to provide for equal access to health care (in the private and public sector) only then can the Locality Rule be removed from our legal system and only then can it be said that the standard of health care is presumed to be the same everywhere in South Africa (See: *Van Wyk v Lewis* 1924 AD 438*).*

[12] Carstens PA & Pearmain D 'Professional Medical Negligence' in *Foundational Principles of South African Medical Law* (Durban: LexisNexis 2007) 636-638.

[13] Carstens & Pearmain (2007) 638.

[14] The Court in *S v Tembani* 2007 1 SACR 355 (SCA) made it clear that a tremendous divide exists between the public and private sphere. See 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) *SA Public Law* 169.

medical negligence suits are no longer considered a "slam-dunk" in favour of the medical professional.[15] In fact the roles have now been reversed as patients are seemingly afforded more protection and sympathy from courts, with little (or no) regard given to the circumstances (more specifically the circumstances the physician found himself or herself in at the time that the medical negligence ensued) of the case.

In this dissertation it is argued that the Locality Rule must be implemented (based on a comparative study with the American and English legal systems)[16] in order to level the playing field in instances where the locality of practice can be directly linked to the medical negligence occurred. Therefore, until South Africa can move towards health care that is equal in the public and private sector, it is only fair to implement the Locality Rule in order to acknowledge the current substandard health care South Africa is experiencing.

3 Research Questions

The following research questions will be addressed in this dissertation:

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[15] A good example hereof is the case of *Khoza v Member of the Executive Council for Health and Social Development of the Gauteng Provincial Government* 2015 (3) SA 266 (GJ) where it was held that the negligence caused by the hospital staff is directly linked to the brain damage suffered by the child.

[16] S 39 of the Constitution states the following:

"Interpretation of Bill of Rights

39(1) When interpreting the Bill of Rights, a court, tribunal or forum—

(a) must promote the values that underlie an open and democratic society based on human dignity, equality and freedom;

(b) must consider international law; and

(c) may consider foreign law".

This entails that the Supreme law of the country places an obligation on courts and other judicial arms to consider international law. Where foreign law may be considered, there is a prerequisite (an obligation) to consider international law. The fact that this dissertation takes the form of a comparative study is therefore directly in line with s 39 of the Constitution.

a) Why can it be said that it is problematic that unequal access to health care is coupled with the absence of the Locality Rule in South African law?
b) What is the current legislative framework for medical negligence claims in South Africa?
c) What is the Locality Rule, where did it originate from and where is it applied today?
d) What does the jurisprudence of South African medical negligence teach us and to what extent does it comply with modern conceptions of the doctor-patient relationship?
e) What are the arguments in favour of implementing the Locality Rule as an interim solution in light of relevant South African case law and the National Health Insurance?

4 Assumptions

The assumptions, based on the research questions, are as follows:

a) It is assumed that the Locality Rule is not implemented in South Africa and that a stark divergence exists between the public health care sector and the private health care sector in South Africa.
b) It is assumed that the current health care realities (specifically evident in the public health care sector) overrides the legislative provisions enacted to deal with these medical realities.
c) It is assumed that the Locality Rule originated in either American or English law and that it is still applied in American medical law today and that there has been a major shift in the doctor-patient relationship.
d) It is assumed that the claim for negligence in South Africa matches such a claim in English law, but that the American law differs completely.
e) It is assumed that the implementation of the long-awaited NHI will take too long, and therefore the Locality Rule is required as an interim solution to NHI.

5 Methodology

5.1 Description of Methodology

This dissertation mainly takes the form of a *capita selecta* comparative study. Throughout the dissertation South Africa's medical law, as it relates to the Locality Rule, is compared to that of the American legal system as well as the English legal system.

At first glance it may appear surprising to choose American law as a central feature of this comparative study as South Africa has abolished the jury system while America has not;[17] since *S v Makwanyane* the death penalty is no longer operative in South Africa[18] while it still features in some American states;[19] and South African law is generally applied throughout the whole country while some American laws have state-specific application. However, the key reason why American law has been selected is because the Locality Rule originated in this jurisdiction. In endeavouring the comparative exercise, I will be attentive to the areas of friction between South African and American law, but the ultimate goal is to show how the Rule may be adapted to apply in South African medical law, sensitive to our unique context.

English law is relevant for the comparative study due to the fact that both South African and American medical negligence claims are based on the English common law. The difference in the jurisdictions is found in its respective case law, which accompanies the English common law in assessing medical negligence.[20]

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[17] In 1969 the jury system was abolished in South Africa in terms of the Abolition of Juries Act 34 of 1969.

[18] See *S v Makwanyane* 1995 (6) BCLR 665 (CC).

[19] According to the Death Penalty Information Centre, thirty-two states in America still apply the death penalty.

[20] Budetti P & Waters TM *Medical Malpractice Law in the United States* (2005) Prepared for the Kaiser Family Foundation 2.

5.2 Reasons for Method Chosen

This specific method of using a comparative study as the golden thread throughout the dissertation - as opposed to discussing the three legal systems separately - is arguably the most conceptually clear way of understanding the relevance of the Locality Rule in South African medical law and the need for its application. The comparative study will demonstrate both the advantages and the pitfalls of implementing this Rule as pertaining to medical negligence suits in South Africa. Another reason for selecting these two jurisdictions for the comparative study is the fact that South Africa is compared to a country where the Rule has been applied (America), but also to a country where the Rule has never been applied (England).

6 Structure and Content Overview

The dissertation comprises of four substantive chapters (with the first chapter being the introduction, and the last chapter the conclusion). The aim of the second chapter is to discuss the presence or absence of an effective legislative framework relevant to the application of the Locality Rule in South Africa. This chapter will provide a historical overview of the development of the regulation of health care and the reform thereof in South Africa. The chapter will also focus on providing statistics regarding the dissimilarity that exists in the public health sector and the private health sector. The right to health and health care is provided for in multiple legislative forms. The Constitution (more specifically section 27 contained in the Bill of Rights) is merely the starting point. The Constitution refers to medical and health care issues (directly and/or indirectly) in other provisions as well.[21] Other sources that are discussed in this chapter include international law that led to the development and enactment of

[21] The following provisions in the Constitution: S 9 (equality clause), s 11 (right to life), s 12 (freedom and security of a person), s 14 (right to privacy) – just to name a few; See: Domenech B Policy Documents "What the Constitution Says About Health Care" 2009. https://www.heartland.org/policy-documents/what-constitution-says-about-health-care Accessed 3 November 2015; Hassim A, Heywood M & Berger J *Health and Democracy* (Siber Ink: 2007) 32-34; Jones M 'Medical Negligence in Context' in *Medical Negligence, 3rd ed, (*London: Sweet and Maxwell 2003) 52-55; Slabbert MN 'Medical Law' in *Medical Law in South Africa* (Kluwer Law International 2011) 38-45;

the right to health care in South Africa. Legislation such as the National Health Act[22] is also investigated, as well as medical ethics and ethical codes on health care in South Africa for example the HPCSA Rules of Conduct[23] as well as those of the SAMRC.[24]

The third chapter introduces the main concept of the dissertation, namely the Locality Rule. The history, origin and application (or lack thereof) of the Rule in South Africa is discussed in detail, in light of the three countries chosen for this comparative study.[25] This chapter delves into the history of the Rule in English law[26] and its application throughout America. It traces the origin of the Rule in American case law, with specific reference to the most important cases in terms of the origin and expansion of the Rule.[27] The interpretation of the Rule itself is discussed, and additionally the development of the Rule throughout the years is also expounded on. The chapter also refers to medical expert opinions, as it is an important aspect that forms the foundation of the Locality Rule.[28]

Chapter four's purpose is to provide an overview of a medical negligence claim in the three chosen countries for the comparative study, and to compare these claims with one another. The chapter will also focus on medical negligence case law in South Africa[29] in light of the basic principles of medical negligence as applied in South Africa,[30] together with a discussion of the history and application of the concept of

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[22] National Health Act 61 of 2003.

[23] Health Professions Council of South Africa; See 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.

[24] Medical Research Council.

[25] South African Law, American Law and English Law.

[26] Nathan HL *Medical Negligence: Being the Law of Negligence in Relation to the Medical Profession and Hospitals* (London: Butterworth 1957) 21.

[27] See: *Brune v. Belinkoff* 235 N.E.2d 793 (Mass. 1968); *Carbone v. Warburton* 11 N.J. 418, 94 A.2d 680 (1953); *Pederson v. Dumouchel* 431 P.2d 973 (Wash. 1967); *Small v. Howard* 128 Mass. 131, 35 Am. Rep. 363 (1880); *Robbins v. Footer*. 553 F.2d 123. 179 U.S.App.D.C 389.

[28] ID Giesen *International Medical Malpractice Law* (1988) 273-275.

[29] *Blyth v Van den Heever* 1980 (1) SA 191 (A); *Collins v Administrator, Cape* 1995 (4) SA 73 (C); *Michael v Linksfield Park Clinic (Pty) Ltd* 2001 (3) SA 1188 (SCA); *S v Kramer* 1987 (1) SA 887 (W).

[30] See: Carstens & Pearmain (2007) 619-623.

medical negligence.[31] This discussion also briefly touches on the difference in application of medical negligence in South African law,[32] English law[33] and American law.[34] The chapter discusses the standard of care required from a physician in regards to medical law and more specifically the doctor-patient relationship. This discussion focuses on the fact that if we want to change and improve the quality of health care in South Africa, obtaining the patient's perspective on health care and recognising the rights of patients constitutes a good start to transform, or at least equalise, the health care sectors in South Africa.[35]

Chapter five focuses on arguments for the implementation of the Locality Rule. The main focus is a case discussion of three South African cases pertaining specifically to medical negligence and the Locality Rule – namely, *Van Wyk v Lewis,*[36] *S v Tembani*[37] and *Oppelt v Head: Health, Department of Health Provincial Administration: Western Cape.*[38] These three cases were chosen for the discussion as they paint a good picture of the judiciary's views towards medical negligence and

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[31] See: Zietsman JC "Medical Negligence in Ancient Legal Codes" (2007) *Akroterion* 87-98; Carstens & Pearmain (2007) 606-618.

[32] See: McQuoid-Mason D "What Constitutes Medical Negligence? – A Current Perspective on Negligence versus Malpractice" (2010) *SA Heart Journal* 248-251.

[33] See: De Cruz P 'Medical Negligence and Professional Accountability' in *Comparative Healthcare Law*, 4th ed (London: Routledge-Cavendish 2001) 233-237; Furrow B, Greany T, Johnson S & Jost T 'Physician Liability for Patient Injury' in *Health Law: Cases, Materials and Problems*, 2nd ed (St. Paul: West 1987) 269-271; Jones M 'Medical Negligence in Context' in *Medical Negligence, 3rd ed,* (London: Sweet and Maxwell 2003) 52-55.

[34] See: Strauss S 'International Trends in Medical Malpractice Liability in the Sixties: A Cause for Alarm' in *Doctor, Patient and the Law: A Selection of Practical Issues* (South Africa: Van Schaik 1980) 291-294; De Ville K & Freeman RB (eds), 'The More Things Change…' in *Medical Malpractice in the Nineteenth-Century America: Origins and Legacies (The American Experience)* (America: NYU Press 1992) 206-210; Strauss SA 'Malpractice Liability: Doctor, Insure Thyself!' in *Doctor, Patient and the Law: A Selection of Practical Issues* (South Africa: Van Schaik 1980) 301-305.

[35] Phaswana-Mafuya N, Peltzer K, Stevenson Davids A "Patients' Perceptions of Primary Health Care Services in the Eastern Cape, South Africa" (2011) *African Journal for Physical*, *Health Education, Recreation and Dance* 502-503.

[36] 1924 AD 438.

[37] 2007 1 SACR 355 (SCA).

[38] [2015] ZACC 33.

the circumstances surrounding it. *Van Wyk v Lewis*[39] is considered to be the *locus classicus* with regards to South African medical negligence at the time of 1924.[40] This case however lies at the one end of the spectrum saying that the standard of health care in South Africa is expected to be equal everywhere, whereas *S v Tembani*[41] lies on the other end of the spectrum in saying that medical negligence can now be expected in public hospitals.[42] *Oppelt v Head: Health, Department of Health Provincial Administration: Western Cape*[43] confirms the fear that this dissertation seeks to express, namely that the judiciary is not considering the surrounding circumstances when assessing medical negligence, and that the judiciary should be forced to do so through the implementation of the Locality Rule. The chapter ends off explaining why the National Health Insurance cannot be solution to South Africa's current health care regime, illustrating why the Locality Rule can be seen as the most viable interim solution.

[39] 1924 AD 438.

[40] Carstens & Pearmain (2007) 636.

[41] 2007 1 SACR 355 (SCA).

[42] See para [27] and [29] of the judgment; Carstens (2008) *SA Public Law* 173.

[43] [2015] ZACC 33.

Chapter 2

Health Care in South Africa: The Reality versus the Legislative Framework

Overview

The reality of the South African public health care system is something that cannot be disputed. The lack of well-equipped state hospitals and clinics, the shortage of sufficiently trained physicians, the scarcity of technological and medical resources, the lack of proper and suitable infrastructure, a deficiency in financial resources and the discrepancy in the apportionment of resources in the public and private sectors – are only a few of the major problems the South African health sector experiences. This chapter illustrates that the reality of public health care in South Africa does not coincide with the legislative framework envisioned. The history of the (multiple attempts at) public health care reform in South Africa over the past hundred years will be explored as well as the right to health care as it features in international law. The purpose of this chapter is to give a background to the unequal reality of the health care system in South Africa and also to illustrate that even though numerous attempts have been made at sustainable health care reform those have proven to be futile.

1 Introduction

The right to access to public health care in South Africa is clearly enshrined in section 27 of the Constitution, that provides the right of access to health care. However, a more controversial issue is the extent and the quality of health care that is to be provided in terms of this section. This chapter focuses on comparing the quality of health care in the public and private health care sectors to the legislation enacted to regulate these sectors. The chapter therefore compares the reality of health care to the tools intended to regulate and transform this reality and asks the

question of whether or not the legislature has in fact succeeded till now in effecting change within the public health care sector.

Health care in South Africa is mainly regulated by legislative enactments based on making Constitutional provisions a reality. These legislative provisions are applied and interpreted by the courts, whose function it is to hold the executive accountable for its obligations in relation to health care-related rights. The purpose of this chapter is to construct a legislative framework and overview of the right to health care in South Africa, in order to illustrate that an improvement has been made in relation to regulating health care, but that a divide unfortunately still exists between the private and public health spheres. The division fails to give effect to the constitutional right to equality guaranteed in section 9 of the Constitution. The aim here is to provide a better understanding of why a doctrine such as the Locality Rule is required in South Africa, given the current inequalities in health care that persists, until uniform, quality, access to health care can be guaranteed to all people living in all areas.

This chapter commences with an historical overview of health-care legislation and regulation in South Africa. The chapter traces the development of such laws over the past decade. A comparison, founded in statistics, between health care in the public sector and health care in the private sector follows. The purpose of this comparison is to sketch a realistic picture of the health care poor South Africans face and therefore to illustrate the discrepancies between the two-tier health care system South Africa has. Thereafter an overview of current law pertaining to health care, with a comprehensive discussion of the Constitution, focusing mainly on section 27 in the Bill of Rights (but also highlighting the importance of other relevant health care-related provisions in our Supreme law) is discussed. Other sources relating to medical law and health care discussed in this chapter are: medical ethics and ethical codes on health care, for example the HPCSA Rules of Conduct[1] as well as the SAMRC's guidelines on ethical medical research. A thorough discussion on the importance of medical ethics is presented in this chapter together with what it entails and how far we are prepared to go with ethical debates when it comes to the interlink

[1] See 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.

between medicine and the law.[2] This chapter is not limited to domestic laws on health care but it also provides an overview of international health care laws applicable and relevant to South Africa, especially reflecting on the World Health Organisation (WHO) and the origin of section 27 of the Constitution, to be found in international law.

As a point of departure, I recall the words of Madam Justice Navi Pillay, the former United Nations High Commissioner for Human Rights and South African jurist, who explained the importance of health care in light of human rights by saying:

> I share the commitment of the international human-rights machinery to realising the right to health. Promoting and securing the right to enjoyment of the highest attainable standard of health is ethical; it is a legal obligation and a step towards our fight to end poverty, discrimination, and exclusion.[3]

2 History and Development of Health Care in South Africa

2.1 Pre-1994

The need for health care regulation in South Africa was first realised after the 1918 influenza epidemic.[4] Prior to this epidemic the view in South Africa was that health

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[2] Herring J 'Ethics and Medical Law' in *Medical Law and Ethics* (Oxford University Press 2008) 10-17.

[3] Chikte U "Health and Human Rights in South Africa" (2009) *Journal of the South African Dental Association* 2 refers to the December 2008 issue of the "The Lancet" in which Madam Justice Navi Pillay made this comment.

[4] Richards G "The Threat of a New Influenza Pandemic – Are We Doing Enough?" (2006) *South African Medical Journal* 195; "The Influenza Epidemic" South African History Online Date unknown. http://www.sahistory.org.za/article/influenza-epidemic (Accessed 15 July 2015) states that "In March 1918 an international influenza pandemic broke out, that led to the deaths of 50 million people worldwide. The pandemic spread simultaneously in Europe, Asia and North America over a twelve-month period between the last months of 1918 and the beginning of 1919… According to historian, Howard Philips, the 'Spanish flu' spread to South Africa in two waves, the first being via the port of Durban…The second wave of infection spread from Cape Town harbour…".

care and other related issues rested on the shoulders of each individual and his/her family – most definitely not the government, as is the expectation nowadays.[5] After the 1918 epidemic the Public Health Act[6] came about which intended to establish a central authority to regulate health and health care in South Africa. Prior to this enactment the closest thing South Africa had to regulation of health care was the Department of Internal Affairs regulating three areas, namely mental illness, leprosy and the district-surgeon system.[7] Ngwena refers to the Public Health Act as the "genesis of the modern health care system,"[8] and for nearly six decades this Act regulated the regulation of health care in South Africa.[9] The aim of this legislation was based on three objectives – in which the Act itself was not successful.[10] Firstly the Act provided for a National Department of Public Health[11], secondly the establishment of provincial administrators,[12] and finally forming local authorities[13] – therefore catering for health care on all levels of government.[14] As mentioned before, the Act was unsuccessful, even though quite a few amendments were brought to the original Act.[15] The National Department of Public Health failed to coordinate with the

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[5] Ngwena C "Equity and the Development of the South African Health Care System: From the Public Health Act of 1919 to the Present Day" (2003) *Fundamina* 127.

[6] 36 of 1919.

[7] *Id.* 128; Van Rensburg HCJ, *Health and Health Care in South Africa,* 2nd ed (Pretoria: Van Schaik Publishers 2012) 83.

[8] *Id.* 127.

[9] Van Rensburg (2012) 97.

[10] One of the main reasons for the unsuccessfulness of the Act was due to the three tiers of authority, namely national, provincial and local, wanting to attend to their own interests and promoting their own interests above that of the others – therefore a lack of teamwork from the three tiers led to the demise of the 1919 Act – See Van Rensburg (2012) 83.

[11] The National Department of Public Health was responsible for the following areas, namely: services regarding district surgeons; advancement of environmental health coupled with the control of contagious diseases; the controlling of mentally ill institutions, leprosy and tuberculosis.

[12] The main concern of provincial administrations was based on hospitals, therefore the establishing, managing and maintaining of health care facilities.

[13] The establishment of local authorities by the Public Health Act 36 of 1919 was to act as agents on behalf of the National Department of Public Health.

[14] Ngwena (2003) *Fundamina* 128.

[15] Ngwena C & Cook R 'Chapter 4: Rights Concerning Health' in Brand D & Heyns C H (eds) *Socio-economic Rights in South Africa* (South Africa: PULP 2005) 129.

local authorities to act as its agents and the provincial authorities neglected primary health care (community health). This Act was however doomed to fail from the outset, as it was impossible for this 1919 Act to meet the demands of South Africa during that time, not even taking into account the societal changes (mostly due to governmental reform and health issues) that were to come.[16]

Due to the failure of the first proper attempt at health regulation in South Africa, the government decided to address this issue by establishing a commission of enquiry. In 1942 the National Health Service Commission (better known as the Gluckman Commission) was established by the government in light of addressing the regulation of health care in South Africa.[17] The Commission was instructed to investigate, report and provide recommendations.[18] The Gluckman Report of 1944 was published and the Commission's recommendation was to establish one uniform health authority, with government providing health care instead of the earlier model based on familial obligations. The uniform health care system suggested by the Gluckman Commission was to be free to all citizens, financed through taxation.[19]

The Gluckman Commission indicated four broad categories of problems associated with health care at the time, namely: a lack of coordination (the existing health services of the time was largely fragmented), shortages of services (this constituted shortages with regards to both facilities and health care personnel, especially in the rural areas), private practice (the problem was that health care admission was based

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[16] *Id.* 128-129 – Ngwena elaborates on the societal and health issues that South Africa had to face during this time: "The Great Depression, the poverty among blacks as well as whites, large scale industrialisation, rapid urbanisation, expansion of the black labour class, desperate housing conditions, unhygienic living conditions and widespread malnutrition began to express themselves partly in rising conditions of poor health. Tuberculosis epidemics, nutritional deficiency diseases, venereal disease and high levels of morbidity, high infant and maternal mortality among all sectors of the population indicted the 1919 Act and underscored its deficiencies".

[17] *Id.* 129.

[18] The Commission had to investigate, report and make recommendations on two aspects in particular: firstly the ultimate goal of an organised national health service and, secondly, what financial, administrative and legislative resources will be required to reach this goal – See: Van Rensburg (2012) 85.

[19] Dhai A "Healthcare reform in South Africa: A step in the direction of social justice? (2011) *South African Journal of Bioethics and Law* 48-49.

on the ability of the patient to pay, instead of the need for health care services) and finally, inappropriate emphasis and priorities (the focus was curative and not preventative).[20]

One of the most radical suggestions made by the Commission was for the abandonment of private health care.[21] Unfortunately the recommendations made by the Commission were never implemented, even though they were considered. Later on, in 1948 the recommendations made by the Gluckman Commission were completely disregarded by the National Party,[22] leaving the country in the same position it found itself in at the time the 1919 Public Health Act was disputed. Once again health care was not the main priority of the government.

Soon after the failure of the Gluckman Commission (or rather the failure of the government to correctly reflect on the submissions of the Commission)[23] it was realised that reform in the health care sector was desperately required in South Africa. As a result hereof the Health Act[24] was enacted.[25] The main objective of this enactment was to repeal the 1919 Act. When reflecting on the (attempted) health care reform during this period, it must be borne in mind that Apartheid philosophy inevitably influenced the laws of the time.[26] Section 14(a) of the Act expressed the purpose of the Act being to provide "comprehensive health services for the population of the Republic of South Africa". However, the "population" that the Act referred to was mainly considered to be the rich, white South Africans in accordance with the Apartheid politics operative at the time, as there were formal separation of

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[20] *Ibid*; Brand & Heyns (eds) *(*2005) 127; Moyakhe NP "Quality healthcare: An attainable goal for all South Africans?" (2014) *South African Journal of Bioethics and Law* 80.

[21] Brand & Heyns (eds) *(*2005) 129-130.

[22] *Id.* 130; Kautzky & Tollman (2008) *South African Health Review* 19 – "The accession to power of the National Party, and rise of segregationist apartheid rhetoric and policies saw the remaining political proponents of health system reform removed from office…".

[23] Dhai (2011) *South African Journal of Bioethics and Law* 49.

[24] 63 of 1977.

[25] Brand & Heyns (eds) (2005) 130 – it repealed and replaced the 1919 Act.

[26] *Ibid;* Ngwena (2003) *Fundamina* 128 mentions that during this time a number of factors had an influence on the quality and quantity of products and services that people were entitled to, which included the service of health care. Some of the factors Ngwena mentions are geographical location (therefore where people resided), income and, most importantly, race.

health care services provided for in the "homelands for the African population".[27] From an equality-inspired reading of the Act, it failed in its purpose and aim and therefore, once again the reform intended for the health care sector in South Africa was a disappointment. There were two main factors that led to the failure of the 1977 Act,[28] namely, race and the reduction of governmental power in the health sector - private health care being the preferred option.[29] It goes without saying that race-based inequality was, with hindsight, most probably the biggest downfall of this enactment, being that white people were favoured in the distribution and quality of health care available during this time.[30]

The privatisation of health care originated during this time and, as is evident today, it still has a lasting effect on the South African health-care sector.[31] At this time it was clear that equality was not the objective or concern of the government's policies at large, and therefore clearly not an objective in health care either. This resulted in limited access to health care for the population, coupled with a lack of access to quality of health care.[32]

In 1980 the State President decided to continue with the notion of health-care reform that South Africa had been *attempting* to implement during that stage. In promoting

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[27] See: Kautzky & Tollman (2008) *South African Health Review* 21; Van Rensburg (2012) 91-95 for a detailed discussion of homeland health and health care segregation.

[28] Kautzky & Tollman (2008) *South African Health Review* 20.

[29] Brand & Heyns (eds) (2005) 129 explain that "… [t]he enactment of the Health Act of 1977 did little to change to any substantial degree the reality of a system that was biased towards urban, curative, hospital-based care".

[30] For a discussion on a "legacy of inequality" see: *id*. 127; and Dhai (2012) *South African Journal of Bioethics and Law* 2, who notes the following: "During the apartheid era, disproportionate resource allocation policies by the state at a systemic level resulted in poor-quality and inferior services being available to black people".

[31] Brand & Heyns (eds) (2005) 131.

[32] The 1977 Act cannot only be viewed in light of its failures as some positive aspects came about as a result of this enactment. Firstly, the establishment of the National Health Policy Council as well as the Health Matters Advisory Committee. Secondly, the shift occurred from a curative mindset regarding health and health care, to one based on preventative measures. Thirdly, a clearer indication of the duties and responsibilities of the different role-players in health care in South Africa was given. See: Van Rensburg (2012) 98-99.

the reforms, he appointed the Browne Commission of 1980, which was divided into four committees, to investigate divergent aspects regarding the South African health care.[33] The Commission succeeded in pointing out (the now already well-known) shortcomings of the health-care system of the time.[34]

The Commission made three main recommendations with reference to health reform. Firstly, it recommended the formulation and implementation of a National Health Plan. Secondly, it suggested placing an increased priority on preventative care, instead of curative care - therefore suggesting that a larger portion of the health budged should have been allocated to primary health care. Thirdly, the Commission advocated for the privatisation of health care and therefore an increase in the establishment of private health care facilities.[35] Following the recommendations made by the Browne Commission, the National Health Plan of 1986 was implemented with the main aim of bringing about unity within the existing health care structures.[36] Unfortunately the failure of the National Health Plan of 1986 did not lie in its content but rather in the lack of proper execution, combined with the influence of the political dispensation of the time.[37] During the close of the 1980s and the beginning of the 1990s the main health-care reform initiative by government was centred on privatisation.[38] By reflecting on the health care system prevalent in South Africa today, we can see that this reform initiative is the one that remained.

2.2 Post-1994

The reform of health care became a serious issue at the turn of government in 1994. The main theme of equity implemented throughout the country also seeped into the

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[33] *Id*. 100-101.

[34] See: *Id*. 101 for a detailed discussion of these shortcomings reaffirmed by the Commission.

[35] *Idem*.

[36] See: *Id*. 102-104 for a detailed discussion of the content and scope of application of the National Health Plan.

[37] *Ibid*.

[38] *Id.* 105; Brand & Heyns (eds) (2005) 130 - note that "Privatisation was regarded as indispensable to achieving inefficiency, devolving responsibility to the individual and reducing the state's financial burden".

health-care sector, making it one of the main objectives of health care in South Africa. In the transformation of South Africa into a democracy by the African National Congress (ANC), the party presented a National Health Plan for South Africa. This Plan provided for a national reform in health care, something that was attempted, but not yet achieved.[39]

Every aspect of health care in South Africa came under review, in line with this Plan, namely all organisations, institutions and legislative enactments. Its purpose was to address not only the fragmentation of health care, but also the duplication thereof.[40] Within the first term of the new government (1994-1999) significant health-related changes came into effect, for example: firstly, the amalgamation of the fourteen health departments, that were previously divided based on race, into one national health system;[41] secondly, free public health care; and finally, free public health care for pregnant women as well as mothers with children below the age of six.[42] One of the most important policy documents came with the enactment of the White Paper for the Transformation of the Health System in South Africa of 1997[43] as a result of officials appointed from each of the nine provinces under the supervision of the National Department of Health. These officials were tasked with drafting an "implementation strategy for the development of the decentralised, district-based health system".[44] This document allowed government to meticulously set out its intended health-care reform strategy, of which two specific strategic institutions came into being, namely the provision of Primary Health Care as well as the District Health System.[45]

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[39] This Plan was inspired by the findings of the Gluckman Commission and underpinned by the Alma Ata Declaration. See: Kautzky & Tollman (2008) *South African Health Review* 23.

[40] *Ibid*.

[41] SouthAfrica.info, "Health care in South Africa" Date unknown. http://www.southafrica.info/about/health/health.htm#.VdGhF5ExGFI Accessed 17 August 2015.

[42] Naledi T, Barron P & Schneider H "Primary Health Care in SA since 1994 and the Implications of the New Vision for PHC Re-engineering" (2011) *South African Health Review* 18.

[43] *Ibid*; Kautzky & Tollman (2008) *South African Health Review* 23; Hassim A, Heywood M & Berger J *Health and Democracy* (Siber Ink: 2007) 97-98.

[44] Kautzky & Tollman (2008) *South African Health Review* 23; Van Dokkum N "The Evolution of Medical Practice Law in South Africa" (1997) *Journal of African Law* 189.

[45] Brand & Heyns (eds) (2005) 144; Van Dokkum (1997) *Journal of African Law 189.*

One of the most important contributions to health-care law in South Africa came with the enactment of the 1993 Constitution and the 1996 Constitution, the latter making provision for access to health care in section 27 of the Bill of Rights. The constitutional enactment of health-care rights suddenly changed the way that health care would be viewed in South Africa. Health care was neither seen as a familial responsibility, nor merely an obligation that had to be fulfilled by government, but suddenly health care was viewed as a human right, awarded to "everyone" (this time in the democratic sense of the word) and entrenched in the supreme law of the country. It is not captured in a mere legislative provision as it used to be. Health care in South Africa suddenly became an almost tangible reality and not a mere pipeline dream.

It can therefore be said that from 1994 health-care reform has definitely been set into motion. Health care is now regarded as a governmental priority and a human right. Not only has reform been initiated by an entrenched human right in the Supreme law, but regulating health care – the ultimate aim of the 1919 Act – has been achieved in South Africa in light of the following legislative enactments since the new constitutional dispensation, for example: the Choice on Termination of Pregnancy Act,[46] Tobacco Products Control Amendment Act,[47] Pharmacy Amendment Act,[48] Medical Schemes Amendment Act,[49] Medicines and Related Substances Control Amendment Act,[50] Mental Health Care Act,[51] and finally the National Health Act.[52]

It must be mentioned that even though a great effort has been made since 1994 to alter and improve health care and health-care regulation in South Africa, many of these efforts have gone unnoticed due to the increasing awareness and effects of

[46] 92 of 1996.

[47] 12 of 1999.

[48] 1 of 2000.

[49] 62 of 2002.

[50] 59 of 2002.

[51] 17 of 2002.

[52] 61 of 2003.

HIV/AIDS in South Africa.[53] Even though it can be said that health care has now become a priority for government in comparison to the position pre-1994, factors such as the prevalence of HIV/AIDS and tuberculosis places more unnecessary strain on the public sector, while the private sector is left almost untouched.[54]

3 The Right to Health Care in International Law

Before the impact of international law on the development of health care law, regulations and policies in South Africa can be discussed, the relevance of referring to and applying international law must be examined. Section 39(1)(b) of the Constitution clearly states that international law *must* be considered by our judiciary when interpreting any provisions in the Bill of Rights, whereas foreign law *may* be considered.[55] This section is further supported by the following sections in the

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[53] Harrison D "An Overview of Health and Health Care in South Africa 1994 – 2010: Priorities, Progress and Prospects for New Gains" Discussion Document by the Henry J. Kaiser Family Foundation (2010) 2.

[54] In *Treatment Action Campaign v Minister of Health* 2002 (4) BCLR 356 (T) the Court made the following observation: "We know that throughout the country health services are overextended. HIV/AIDS is but one of many illnesses that require attention. It is, however, the greatest threat to public health in our country"; See also: Naledi T, Barron P & Schneider H "Primary Health Care in SA since 1994 and the Implications of the New Vision for PHC Re-engineering" (2011) *South African Health Review* 18; Kautzky & Tollman (2008) *South African Health Review* 25.

[55] Section 39(2):

> "When interpreting the Bill of Rights, a court, tribunal or forum:
> (a) Must promote the values that underlie an open and democratic society based on human dignity, equality and freedom;
> (b) Must consider international law;
> (c) May consider foreign law."

See also Currie I & De Waal J *The Bill of Rights Handbook* (South Africa: Juta and Company 2013) 146-147. There is a new version of Currie & De Waal. Check that out. And I would also add reference to the relevant part of Woolman & Bishop (eds) *Constitutional Law of South Africa* (2006, 2nd Ed, OS). You can access it on Juta via the library website. These are the two big Bill of Rights sources and it would be incomplete to refer to one and not the other. The *Bill of Rights Compendium* on Butterworths could also be relevant – also available online.

Constitution, namely sections 231, 232 and 233.[56] Section 231 explains when a treaty will be binding on South Africa. Section 232 explains that customary international law is law in South Africa unless it contradicts the provisions of the Constitution or any other legislation. Finally, section 233 relates to the application of international law and states the following: "When interpreting any legislation, every court must prefer any reasonable interpretation of the legislation that is consistent with international law over any alternative interpretation that is inconsistent with international law".

In many instances the judiciary has commented on the importance of international law in regards to our law, a few examples are *CC Maynard et al v The Field Cornet of Pretoria*,[57] *S v Makwanyane,*[58] *Government of RSA v Grootboom*[59] and *Carmichele v Minister of Safety and Security.*[60] In the latter two cases it was made clear by the Constitutional Court that the Constitution obliges the South African judiciary to have regard to international law when interpreting rights contained in the Bill of Rights. Now that the importance of the application of international law is known in relation to constitutional obligations, the content thereof and the contribution towards the development of health care laws in South Africa can be discussed.

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[56] Pieterse M *Can Rights Cure? The Impact of Human Rights Litigation on South Africa's Health System* (Pretoria: Pretoria University Law Press 2014) 16; Hassim, Heywood & Berger (2007) 128.

[57] (1894) 1 SAR 214 at para [223] – "municipal law must be interpreted in such a way as not to conflict with the principles of international law…" See also: Dugard J *International Law: A South African Perspectiv*e, 4th ed (Cape Town: Juta 2013) 23. Take note that this case was decided long before the enactment of the Constitution. It goes to show that even then importance was placed on the implementation and application of international law in regards to South African law in some instances.

[58] 1995 (3) SA 391 (CC) para [35]: "[P]ublic international law would include non-binding as well as biding law. They may both be used under the section as tools of interpretation. International agreements and customary international law accordingly provide a framework within which [the Bill of Rights] can be evaluated and understood…". See also: Hassim, Heywood & Berger (2007) 128-129.

[59] 2001 (1) SA 46 (CC) para [26]: "The relevant international law can be a guide to interpretation but the weight to be attached to any particular principle or rule of international law will vary. However, where the relevant principle of international law binds South Africa, it may be directly applicable." See also: Hassim, Heywood & Berger (2007) 129.

[60] 2001 (10) BCLR 995 As Dugard (2013) 68 explains, "[t]he Constitutional Court has shown clearly that the spirit, purport and objects of the bill of rights – which reflects the underlying precepts of the Constitution and the fabric of South African society – are inextricably linked to international law…"

It is important to mention that in terms of international law a broader right to "health" exists in addition to "health care" and "primary health care".[61] In 1948 the right to health was for the first time expressed as a right in article 25 of the Universal Declaration of Human Rights (UDHR). As mentioned above, the right to health is considered to have a very broad meaning and provides for food, clothing, housing, medical care, and so forth.[62] After this enactment, the constitution of the World Health Organisation (WHO) came into effect within the same year,[63] providing that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being…".[64] Two covenants[65] were drafted for the purpose of supplementing the UDHR, namely the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR).Together these three instruments constitute the "International Bill of Rights".[66] Article 12[67] of the ICESCR is of particular importance as it focuses on equal access to health care,[68] an objective envisioned for the entire world, not only South Africa.

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[61] Yamin AE "The Right to Health under International Law and its Relevance to the United States" (2005) *American Journal of Public Health* 1156.

[62] See Hassim, Heywood & Berger (2007) 133. Article 25 of the UDHR reads as follows:

"1. Everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

2. Motherhood and childhood are entitled to special care and assistance. All children, whether born on or out of wedlock, shall enjoy the same social protection".

[63] Arai-Takahashi Y 'The Role of International Health Law and the WHO in the Regulation of Public Health' in Martin R (ed) *Law and the Public Dimension of Health* (Routledge-Cavendish 2001) 113; Hassim, Heywood & Berger (2007) 133; Yamin (2005) *American Journal of Public Health* 1156.

[64] See: Brand & Heyns (eds) (2005) 108 - The Constitution of the WHO provides the following definition for health as not only being "the absence of disease or infirmity ", but also attaining a state of "complete, physical mental and social well-being".

[65] These covenants came into force in 1977.

[66] Hassim, Heywood & Berger (2007) 134-135.

[67] Article 12 of ICESCR reads as follows: "The state parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health".

[68] Hassim, Heywood & Berger (2007) 137; Martin (ed) (2001) 119, 149; Yamin (2005) *American Journal of Public Health* 1156.

One of the most important contributors to health-care regulation and implementation throughout the entire world is the WHO. The WHO is instrumental because it has legislative powers to enact guidelines, regulations and declarations in the international sphere relating to health and health care. An example of a document produced by the WHO is the Declaration of Alma Ata.[69] The importance of this Declaration lies in the fact that it assisted in the recognition of health care as a human right,[70] a human right guaranteed in South Africa, with reference to section 27 of our Constitution,[71] but more importantly, the idea of primary health care was realised in South Africa due to this Declaration.[72] From the above it is therefore evident that international law had a great impact on the development of the right to health care in South Africa as we know it today.

4 Public Health Care versus Private Health Care – The Reality in South Africa

> The hard and unpalatable fact is that if the appellant were a wealthy man he would be able to procure such treatment from private sources; he is not and has to look to the state to provide him with the treatment. But the state's resources are limited and the appellant does not meet the criteria…[73]

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[69] The main goal of this Declaration is "the highest possible level of health".

[70] Gillam S "Is the Declaration of Alma Ata Still Relevant to Primary Health Care?" (2008) *British Medical Journal* 536.

[71] The right to health and health care as a human right is protected and provided for in the following: Article 25 of the *Universal Declaration of Human Rights*, Article 12 of the *International Covenant on Economic, Social and Cultural Rights*, Article 24 of the *Convention on the Rights of a Child*, Article 5 of the *Convention on the Elimination on All Forms of Racial Discrimination*, Articles 12 and 14 of the *Convention on the Elimination of All Forms of Discrimination Against Women*, Article 11 of the *Declaration on Rights and Duties of Man* and Article 25 of the *Convention on the Rights of Persons with Disabilities* – See: "What is the Human Right to Health and Health Care?" NESRI (National Economic and Social Rights Initiative) Date unknown. http://www.nesri.org/programs/what-is-the-human-right-to-health-and-health-care Accessed 24 August 2015; Yamin (2005) *American Journal of Public Health* 1156, 1160.

[72] Brand & Heyns (eds) (2005) 144.

[73] *Soobramoney v Minister of Health (KwaZulu-Natal)* 1998 (1) SA 765 (CC) para [31].

Substandard health care in South Africa in the public sector is an undisputed fact. It is high time that not only South Africans, but more importantly, the South African government, face the reality of the poor quality and sometimes absence of health care experienced in the public sector. What is puzzling is the fact that this is said of a country that spends more than 8.5 percent of its Gross Domestic Product (GDP) on health care,[74] which surpasses the minimum recommended level of the WHO which is a minimum of 5%.[75] Still, the public sector, which has to provide health-care services to more than 80% of the country,[76] including government, government employees and government-related groups,[77] lacks both quality and adequate access. One might question how this is possible.[78] The answer lies in the fact that most of the resources allocated to health in the GDP is still pumped into the private sector[79], increasing the quality of health care and the medical technology available to provide better and faster health care.[80] In 2010 it was reported that roughly R875 is spent on a patient in a year in the public health care sector, whereas roughly R6500

[74] This amounts to around about R200 billion (in the year 2009/2010) – See: Naledi, Barron & Schneider (2011) *South African Health Review* 18.

[75] The WHO recommend that countries spend a minimum of 5 percent of their GDP on health and health care – See: Department of Health, Republic of South Africa National health insurance in South Africa: Policy paper (2011) 9; Pieterse (2014) 8; Oosthuizen (2014) LLM (unpublished) Dissertation University of Pretoria 123; Moyakhe (2014) *South African Journal of Bioethics and Law* 80.

[76] Pieterse (2014) 6.

[77] Human A "The Tale of Two Tiers: Inequality in South Africa's Health Care System" (2010) *UBCMJ* 33.

[78] It is suggested that even though South Africa spends more than the minimum required amount on health and health care, the poor health outcomes can be attributed to the difference and inequities that exist between the public health care sector and the private health care sector. See: Department of Health, Republic of South Africa National health insurance in South Africa: Policy paper (2011) 9.

[79] Expenditure allocated to health and health care in South Africa is derived from three main sources, namely general revenue - especially allocated to public sector expenditure, medical scheme financing for private sector expenditure and out-of-pocket payments. See: Department of Health, Republic of South Africa National health insurance in South Africa: Policy paper (2011) 9.

[80] Pieterse (2014) 6; Human (2010) *UBCMJ* 33; See also: Kautzky & Tollman (2008) *South African Health Review* – In 2007 it was said: "… the private sector now absorbs an estimated 62% of national health expenditure providing medical care to approximately seven million people".

is spent on a patient in a year in the private health care sector.[81] This is more than seven times that which the public sector can afford due to resource allocation and the demand of patients. Unfortunately the reality is that the level of health care provided is directly linked to the patient's economic class.[82]

Furthermore, statistics prove that the majority of health care professionals choose to practice in the private sector due to the availability of financial, technological and infrastructural resources. This in turn leads to better health care circumstances, decreasing the probability of medical negligence claims against medical physicians. In 2007 statistics already proved that 63% of general practitioners practise in the private sector,[83] leaving the public health care sector with approximately 1 medical physician for every 4219 people – clearly having a direct effect on the quality of health care experienced.[84] The lack of human resources in the public sector cannot only be attributed to the appeal and resource availability of the private sector but also due to emigration of medical physicians.[85] Just as the private health care sector provides more opportunities and better resource allocation and access, the international opportunities far outweigh that of the private sector – leading to the emigration of medical graduates, diminishing the availability of human resources in the South African medical sector.

A key characteristic of the private health sector is the over-priced, usually unnecessary, treatment options. This leads to some of the wealthier South African citizens not being able to afford private health care services. As a result these patients have to find health care somewhere else and so they also end up in the

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[81] Hugo JFM, Couper ID, Thigiti J & Loeliger S "Equity in Health Care: Does Family Medicine Have a Role?" (2010) *The African Journal of Primary Health Care and Family Medicine* 2.

[82] Moyakhe (2014) *South African Journal of Bioethics and Law* 81.

[83] Kautzky & Tollman (2008) *South African Health Review* 24.

[84] SouthAfrica.info, "Health care in South Africa" Date unknown. http://www.southafrica.info/about/health/health.htm#.VdGhF5ExGFI Accessed 17 August 2015 ; Gaede B & Versteeg M "The State of the Right to Health in Rural South Africa" (2011) *South African Health Review* 103 – "A recent study found that the provinces with the greatest health burdens, least economic resources and largest populations received the smallest share of national public healthcare funds".

[85] Kautzky & Tollman (2008) *South African Health Review* 24.

public-health domain. It can therefore be said that the inability of patients to afford the rates that go with the privatisation of health care force them into the public health sector. This in turn leads to a heavier burden placed on the public sector which is experiencing increasing resource shortages.[86] While most resources are pumped into the private sector, those that actually reach the public sector are often misappropriated or wasted due to lack of proper administration and regulation.

Even though this dissertation highlights the inequality that exists between the two sectors, and the corollary that South Africa does not have a uniform health care system, does not mean that reform has to occur only in one of these sectors. Both sectors have an obligation to effect health care reform through transformation. For the private sector this will entail a decrease in resource allocation while for the public sector it will mean an improvement in the quality of services administered to patients, which might prove to be the more difficult reform of the two. It is therefore said that health care in the private sector cannot be curbed by lessening financial assistance until the quality of public health care has been addressed, as both sectors need to bridge the gap in health care.[87]

5 The Constitution's Role in Health-Care Law

5.1 Introductory Remarks

The first real breakthrough in health-care regulation came with the enactment of the Constitution. The reason why this constituted such a major breakthrough was because for the first time access to health care was entrenched in the form of a human right in section 27 of the Constitution. It must however be mentioned that this is not the only section in the Supreme law for the protection and the enforcement of rights relating to health care. This part of the dissertation aims to provide an outline of the constitutional sections relating to health care, starting with the most important, namely section 27.

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[86] Pieterse (2014) 120.

[87] *Id*. 150.

5.2 Section 27: The Right to Access to Healthcare

As it has been indicated several times in this dissertation, the enactment of section 27 of the Constitution was a major development in terms of access to health care in South Africa, but what does section 27 entail? The section reads as follows:

> "27 Health care, food, water and social security
>
> (1) Everyone has the right to have access to –
> (a) Health care services, including reproductive health care;
> (b) Sufficient food and water; and
> (c) Social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.
> (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.
> (3) No one may be refused emergency medical treatment."

The first observation that must be made regarding this section is that it refers to these aspects as rights, therefore a citizen of South Africa has the *right* to have access to health care services, food, water and social security.[88] Section 27 is therefore seen to be a basic human right,[89] which does not confer absolute rights, but rather relative rights and is subject to section 36 of the Constitution, like all other rights contained in the Bill of Rights.[90] It is important to take note that this section does not impose an obligation on government to immediately provide health-care services to the entire population free of charge.[91] However, as Brand and Heyns indicate:

> Section 27 does not merely enjoin the state to refrain from unfairly interfering with the right of an individual to pursue health care services in a liberal state. Its broader

[88] The discussion surrounding section 27 of the Constitution will be limited to the right to access of health care services.

[89] Hassim, Heywood & Berger (2007) 34; Currie & De Waal (2013) 564-568.

[90] Brand & Heyns (eds) (2005) 131.

[91] Hassim, Heywood & Berger J (2007) 232; Carstens PA & Pearmain D, *Foundational Principles of South African Medical Law* (Durban: LexisNexis 2007) 37.

> significance lies in the fact that it imposes upon the state a positive duty to provide care according to need rather than [the] ability to pay.[92]

With regard to this important right, Carstens mentions that the term "health care services" is not defined by or in the Constitution.[93] It must therefore be assumed that the term is intended to be applied in its widest possible sense. This is confirmed by the express mention of "including reproductive health care" within the provision. This means that "health care services" in section 27 does not only provide for a curative notion of health care, but it also involves a preventative notion, illustrating the intended wide meaning of the term.[94]

The second observation that must be made regarding section 27 is the fact that it only provides for "access" to health care. This single word changes the entire meaning of the right. Affording someone "access" to health-care services cannot be equated to affording someone "direct" health-care services. The nature of the right is altered by this one word.[95] Stating that it is a right to access to health care services entails that it is not merely an obligation placed on the state but that a reciprocal obligation exists on the receiver. Therefore the state bears the duty to provide access to health care - given it is able to and the necessary resources are available - but there is also a duty on the person executing his or her right to make some kind of effort (therefore to take responsibility) in terms of his or her health care.[96] The argument is made that the word "access" ensures a broader meaning to the

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[92] Brand & Heyns (eds) (2005) 132.

[93] Carstens & Pearmain (2007) 39.

[94] *Ibid* – An important observation here is the fact that section 27 provides for both a curative and preventative notion of health care – this is exactly the type of health care South Africa was looking for when health care reform came into motion. It can therefore be said that this aim was achieved with the enactment of the Constitution - moving away from a health care system focused solely on finding a cure for health care issues, to one focusing on prevention, coupled with a cure.

[95] See: Pieterse (2014) 123 – He explains that having a rights-based approach health and health care ensures that government is held accountable and for transparency when it comes to the resources that accompany health care.

[96] Carstens & Pearmain (2007) 41.

provision, which in turn allows for a broader focus on things that might have been excluded from "health care services" if the term had not been used.[97]

The third observation that can be made regarding section 27 of the Constitution is the fact that it contains a limitation within itself. The right to access to health care is limited internally by the fact that the section states that the right is subject to the availability of resources in South Africa.[98] Therefore the government is constitutionally protected by limiting its obligation to the availability of resources to provide such access.

In order to better understand the applicability and operational aspects of section 27 and the way in which the judiciary respond to cases involving socio-economic rights, case law must be discussed and assessed.[99] This discussion of legal precedent is limited to three Constitutional Court judgments,[100] namely *Soobramoney v Minister of Health (KwaZulu-Natal) (hereafter "Soobramoney* case*")*,[101] *Government of the RSA v Grootboom (hereafter "Grootboom* case*")*[102] and *Minister of Health v Treatment Action Campaign (No 2) (hereafter "TAC* case*").*[103] An important cautionary note

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[97] *Ibid* – "It includes state activities in the maintenance and the upgrading of public hospitals and ambulances, referral systems between municipal, provincial and national health facilities, the licensing of public and private health establishments, programmes for the education and retention of sufficient numbers of health professionals necessary to provide health care services and the creation of a non-discriminatory environment in the health sector".

[98] *Id.* 37.

[99] Currie & De Waal (2013) 564-568.

[100] These are however not the only important cases relating to socio-economic issues. *Mazibuko v City of Johannesburg* 2010 (4) SA 1 (CC) – where the right to water was discussed as a socio-economic right; *Jaftha v Schoeman; Van Rooyen v Stoltz* 2005 (2) SA 140 (CC) – in relation to the right to adequate housing as a socio-economic right; *Khoza v Minister of Social Development, Mahlaule v Minister of Social Development* 2004 (6) SA 505 (CC) – the first access to social security cases to be heard by the Constitutional Court.

[101] 1998 (1) SA 765 (CC).

[102] 2001 (1) SA 46 (CC).

[103] 2002 (5) SA 721 (CC). Please take note that this dissertation focuses on *Minister of Health v Treatment Action Campaign (*No 2) 2002 (5) SA 721 (CC) and not *Minister of Health v Treatment Action Campaign (*No 1) 2002 (5) SA 703 (CC). (No 1) deals with interlocutory proceedings that needed to be dealt with urgently prior to the appeal from the High Court, whilst (No 2) is the appeal itself.

should be made that only *Soobramoney* and *TAC* link directly to the right to access to health care, while *Grootboom* more broadly relates to the positive duties of the state in terms of socio-economic rights.[104]

The *Soobramoney* case[105] is of specific importance because it was the first case regarding socio-economic rights to reach the highest court in the country,[106] and therefore set the ground rules regarding cases of this nature. This case concerned the constitutionality of resource rationing of a public (state) hospital pertaining to a patient who was denied life-sustaining renal dialysis treatment due to a resource rationing policy effective in Kwa-Zulu Natal.[107] The patient argued that failure of the state to provide him this treatment transgresses his constitutional rights,[108] namely the right to life,[109] the right not to be refused emergency medical treatment[110] and ultimately the right to have access to health care and health care services.[111] The Court dismissed the case based on an interpretation of section 27(1) of the Constitution, namely the right to have access to health care, instead of section 27(3), the right not to be refused emergency medical treatment.[112] The Court explained that while renal dialysis can be seen as urgent treatment, it is not viewed as "emergency treatment" and therefore not considered to be an infringement of section 27(3) of the Constitution.[113] The importance of this case lies in the fact that the Court made it

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[104] Hassim, Heywood & Berger (2007) 33, 35 – What makes section 27 so unique is the fact that it provides positive and negative duties for the state. A positive duty relates to the state acting in certain circumstances and possibly in a certain manner, for example section 27(1): "Everyone has the right to have…" A negative duty prevents the state from doing something, for example section 27(3): " No one may be refused…"; See also section 7 of the Constitution; The Court in *Carmichele v Minister of Safety and Security* 2001 (10) BCLR 995 (CC) para [43] interpreted section 7 of the Constitution to illustrate how rights positively bind the state.

[105] 1998 (1) SA 765 (CC).

[106] *Id*. 35.

[107] *Ibid*; *Soobramoney v Minister of Health (KwaZulu-Natal*) 1998 (1) SA 765 (CC) para [3]; Pieterse (2014) 27.

[108] *Soobramoney v Minister of Health (KwaZulu-Natal*) 1998 (1) SA 765 (CC) para [7].

[109] Section 11 of the Constitution.

[110] Section 27(3) of the Constitution.

[111] Section 27(1) of the Constitution.

[112] *Soobramoney v Minister of Health (KwaZulu-Natal*) 1998 (1) SA 765 (CC) para [22].

[113] Hassim, Heywood & Berger (2007) 36.

clear that section 27, especially section 27(1), does not entail that there rests an obligation on government to provide any health care to any patient at any time, but that the inherent limitation within this right - namely section 27(2) stating "within the available resources" - prevents such a situation.[114]

In the *Grootboom* case[115] the issue was not the right to access to health care, but rather the right to adequate housing, found in section 26 of the Constitution, and the relationship that exists between this section and section 28(1)(c), namely the right of every child to adequate shelter.[116] Mrs Grootboom, together with a group of homeless people, challenged the Provincial Housing Plan based on their constitutional right to adequate housing.[117] Miss Grootboom and the other Respondents in this case were evicted from their informal settlements situate on private land that was intended to be used for formal-low cost housing.[118] The Court however held that section 27 of the Constitution does not entail that there rests an obligation on the shoulders of the state to provide housing to any person free of charge, but that it is up to the state to devise and establish reasonable plans to ensure that socio-economic rights, such as section 26, are realised.[119] The Constitutional Court held that the state had failed to do this and therefore found in favour of Mrs Grootboom and the rest.[120] Important in this case was the fact that the Court held that socio-economic rights cannot be viewed in isolation, but that these rights must rather "be read together in the setting of the Constitution as a whole".[121] The Court had the following to say about socio-economic rights and the obligation that rests on the state:

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[114] *Ibid*.

[115] 2001 (1) SA 46 (CC).

[116] *Id*. 39.

[117] Pieterse (2014) 27.

[118] *Government of the RSA v Grootboom* 2001 (1) SA 46 (CC) para [4].

[119] See: *Government of the RSA v Grootboom* 2001 (1) SA 46 (CC) para [34] – [35], [93]; Hassim, Heywood & Berger (2007) 38.

[120] *Government of the RSA v Grootboom* 2001 (1) SA 46 (CC) para [95] – [96].

[121] *Id.* para [24] – "The state is obliged to take positive action to meet the needs of those living in extreme conditions of poverty, homelessness or intolerable housing. Their interconnectedness needs to be taken into account in interpreting the socio-economic rights, and, in particular, in determining whether the state has met its obligations in terms of them".

> The state is required to take reasonable legislative and other measures. Legislative measures by themselves are not likely to constitute constitutional compliance. Mere legislation is not enough. The state is obliged to act to achieve the intended result, and the legislative measures will invariably have to be supported by appropriate, well-directed policies and programmes implemented by the executive. These policies and programmes must be reasonable both in their conception and their implementation. The formulation of a programme is only the first stage in meeting the state's obligations. The programme must also be reasonably implemented. An otherwise reasonable programme that is not implemented reasonably will not constitute compliance with the state's obligations.[122]

In the *TAC* case[123] the Constitutional Court was faced with the issue of the restriction of the Nevirapine drug used for the prevention of HIV transmission from a mother to a child, specifically in the public health sector. The Treatment Action Campaign (TAC) instituted an action based on a constitutional infringement[124] on the right to access to health-care services, specifically section 27(1) and 27(2), and requested that the drug to be made available throughout the entire country.[125] The High Court held in favour of TAC,[126] but the government appealed to the Constitutional Court. In rejecting the appeal, the Constitutional Court held that the government policy restricting the availability of this drug is both unconstitutional and unreasonable.[127] The Court made this decision based on the rigidity and inflexibility of the policy[128] and therefore ordered for the drug to be made available by government to both hospitals and clinics nationwide.[129]

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[122] *Id.* para [42].

[123] *Minister of Health v Treatment Action Campaign* (No 2) (2002) 5 SA 721 (CC).

[124] *Minister of Health v Treatment Action Campaign* (No 2) (2002) 5 SA 721 (CC) para [99] – "The primary duty of courts is the Constitution and the law …Where state policy is challenged as inconsistent with the Constitution, courts have to consider whether in formulating and implementing such policy the state has given effect to its constitutional obligations".

[125] "*Minister of Health v Treatment Action Campaign (TAC)* (2002) 5 SA 721 (CC)" ESCR-Net Date unknown. https://www.escr-net.org/docs/i/403050 Accessed 25 August 2015.

[126] *Treatment Action Campaign and Others v Minister of Health and Others* 2002 (4) BCLR 356 (T).

[127] Pieterse (2014) 28.

[128] *Ibid*; *Minister of Health v Treatment Action Campaign* (No 2) (2002) 5 SA 721 (CC) para [80].

[129] *Minister of Health v Treatment Action Campaign* (No 2) (2002) 5 SA 721 (CC) para [95]; "*Minister of Health v Treatment Action Campaign (TAC)* (2002) 5 SA 721 (CC)" ESCR-Net Date unknown. https://www.escr-net.org/docs/i/403050 Accessed 25 August 2015.

5.3 Other Constitutional Provisions Relevant to Health-Care Law

The Constitution refers to health and health care issues (directly and/or indirectly) in provisions other than section 27.[130] These provisions will be discussed in this section in light of access to equal health care and the right to access to health care.

(i) Section 9 – Equality: Section 9 of the Constitution is the equality clause. This section links with the right to health-care services in the sense that section 27 contains its own entrenched equality clause. When reading section 27(1)(a) the first word is "everyone". This term indicates that the section entirely forbids discrimination and/or exclusion whether individual or group-based. The section therefore implicitly guarantees the right to access to health care to personal people and the right is thus unconditional when it comes to the beneficiaries of the right, and implemented equally.[131] Section 9, being the general equality clause, read with section 27 entails that access to health care services must be provided without any (direct and/or indirect) discrimination.[132] The question however still remains why equality has not been achieved in the public and private health sectors? In South Arica we have achieved equality in many aspects in society through the implementation of section 9 of the Constitution, for example, with regards to gay and lesbian marriages,[133] equality in the workplace,[134] in terms of gender,[135] *etcetera*. But what about the use of section 9 to equalise the quality of health care in the public and private health care sectors? The main right in the Supreme law granting access to health care starts with the word "everyone" echoing the wording of the equality clause in the Constitution. Why then after twenty-one years of a democracy are South Africans still

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[130] The following provisions in the Constitution: S 9 (equality clause), S 11 (right to life), S 12 (freedom and security of a person), S 14 (right to privacy) – just to name a few; See: Slabbert MN 'Medical Law' in *Medical Law in South Africa* (Kluwer Law International 2011) 38-45; Hassim, Heywood & Berger (2007) 34; Brand & Heyns (eds) (2005) 126-127.

[131] Pieterse (2014) 20 – Pieterse refers to section 27(1)(a) containing an "equality-threshold".

[132] Brand & Heyns (eds) (2005) 131 – "Thus, personal attributes or characteristics such as race, gender, religion or HIV status cannot *per se* be relied upon by health care providers as a basis for denying treatment, as that would constitute unfair discrimination under section 9(3)".

[133] *Minister of Home Affairs and Another v Fourie and Another* 2006 (3) BCLR 355 (CC).

[134] See eg *South African Police Services v Solidarity obo Barnard* 2014 (10) BCLR 1195 (CC).

[135] See eg *Bhe v Khayelitsha Magistrate* 2005 (1) BCLR 1 (CC).

faced with such a big divide in the public and private health care sectors when the main right to health care, found in our Supreme law, envisages equality within itself and is supported by the equality clause in section 9?

(ii) Section 10 – Human Dignity: Carstens & Pearmain are of the opinion that "there is a close connection between health and human dignity".[136] The connection between health and human dignity is of significant importance when it comes to the biological functioning of a human body, for example when the patient is of vegetative state or when dealing with Physician Assisted Suicide (PAS).[137] Dignity therefore relates to the quality of such a patient's life when it comes to health care, and human dignity is a right contained in the Bill of Rights, just as the right to access to health care.[138]

(iii) Section 11 – Life: The right to life goes hand in hand with access to health care in Section 27 of the Constitution. If access to health care is denied, whilst resources are available, the right to life might be infringed. Such a theory must however be approached with caution due to the fact that the right to life have limitations when it comes to protecting life or extending it with the help of health care services.[139] A balancing act should be conducted between the right to life and the right to human dignity. Is it truly worth it keeping someone alive in order to abide by his or her right to life whilst at the same time infringing on his or her right to human dignity by keeping him or her in a vegetative state? The question will also be if this form of "life" can really be considered to accomplish the right of life.

(iv) Section 12 – Freedom and security of the person: Section 27 of the Constitution complements section 12(2)(a) which affords everyone the right to bodily and psychological integrity, therefore entailing that the patient is actively involved, and therefore has a say regarding physical and mental care decisions that are made.[140] Section 27(1)(a) specifically provides for access to reproductive health services and

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[136] Carstens & Pearmain (2007) 29.

[137] *Ibid*.

[138] In *S v Makwanyane and Another* 1995 (6) BCLR 665 the Court held: "…[h]uman beings are entitled to be treated as worthy of respect and concern".

[139] Carstens & Pearmain (2007) 27.

[140] Moyakhe (2014) *South African Journal of Bioethics and Law* 81.

therefore when these two sections are read with one another it provides for the protection and the right to each female individual to freely decide regarding abortion[141] and to do so free from any discrimination (with reference to the entrenched equality clause in section 27, combined with section 9 of the Constitution).

(v) Section 14 – Privacy: The right to privacy in health care is of extreme importance. By exposing health records or a patient's diagnosis constitutes the infringement of the right to privacy as entrenched in section 14 of the Constitution.[142] It is important to keep in mind that a physical examination of a patient is only considered lawful if the patient waived his or her right to privacy.[143]

6 Health Care under the National Health Act[144]

The Constitution ensures for the entrenchment of the right to access to health care services as a human right in South Africa, but the enactment of legislation is needed to ensure the rights afforded in the Constitution are made a reality. Legislation therefore allows constitutional rights to be executed and enforced. Earlier in the chapter mention was made of legislation that has truly made an impact on health care in South Africa and it can therefore be said that these enactments have ensured that the broadly-defined right afforded in section 27 of the Constitution is now being applied throughout the geographical borders of the country. This section of the dissertation will focus on the National Health Act (NHA) and its desired application, because it is seen as "the most important, overarching health legislation to implement the constitutional rights on health and to structure and govern the entire health system".[145]

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[141] Brand & Heyns (eds) (2005) 132; Choice of Termination of Pregnancy Act 92 of 1996; *Christian Lawyers Association v Minister of Health and Others* 2005 (1) SA 509 (T).

[142] See in this regard the case of *NM and Others v Smith and Others* 2007 (5) SA 250 (CC).

[143] Carstens & Pearmain (2007) 32.

[144] 61 of 2003. It is important to take note of the fact that some of the sections of this enactment only came into effect in 2005.

[145] Van Rensburg (2012) 135; Naledi, Barron & Schneider (2011) *South African Health Review* 19.

The NHA repealed the Health Act of 1977 and, except for slight changes, the enactment – for the most part – gives effect to the White Paper for the Transformation of the Health System in South Africa of 1997.[146] The Act mainly has two objectives,[147] firstly to regulate national health and health care and, secondly, to ensure that uniformity is achieved in health-care services across the country.[148] The NHA creates a public-health system divided into three levels, namely national, provincial and district.[149] The NHA ensured and gave effect to legislative enactment of a policy that President Nelson Mandela announced in 1995, namely the provision of public health care free of charge for pregnant females as well as children below the age of six.[150] This policy was taken further in the NHA by ensuring free public health care to anyone lacking coverage from his or her medical scheme.[151] Some other important contributions afforded by the NHA include: the recognition of a range of health rights available to health care beneficiaries and users,[152] together with the duties of the health care providers and key role-players in South Africa and the establishment of regulatory, monitoring, administrative, consultative and advisory bodies.[153]

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[146] *Ibid*.

[147] For a detailed discussion on the aim of this enactment, see the Preamble to the National Health Act 66 of 2003, which highlights, amongst other things: "…to actively promote and improve the national health system"; "provide for a system of cooperative governance and management of health services…"; "establish a system based on decentralised management, principles of equity, efficiency,…"; "promote a spirit of cooperation… ".

[148] Van Rensburg (2012) 135; Naledi, Barron & Schneider (2011) *South African Health Review* 19; Dhai (2011) *South African Journal of Bioethics and Law* 48.

[149] See Hassim, Heywood & Berger (2007) 101 - for a detailed discussion of the three tiers of public health care.

[150] *Id.* 102.

[151] *Ibid*.

[152] *Ibid*.

[153] Examples of these include: The National Health Council, National Health Consultative Forum, Provincial Health Councils, Provincial Health Consultative Forums, District Health Councils, Hospital Boards, Clinic Committees, Forum of Statutory Health Professional Councils, National Health Research Committee, National Health Research Ethics Council. See: Hassim, Heywood & Berger (2007) 104; and Carstens & Pearmain (2007) 246 for a detailed discussion on the duties and functions of each of these bodies.

7 Ethical Codes

7.1 Introductory Remarks

In this chapter the Constitution and legislation (the NHA in particular) has been discussed in relation to medical law, specifically health care services and the right to access thereto. This part of the dissertation now turns to consider the role of ethics in medical law and acknowledges and discusses the relevance of ethics in the medical environment. Kong-lung observes that:

> With the advances in medical sciences and growing sophistication of the legal framework in modern society as well as increasing awareness of human rights and changing moral principles of the community at large, doctors and other healthcare workers alike are now frequently caught in difficult dilemmas in many aspects arising from daily practice.[154]

In addition to standard legal rules, there are certain subconscious expectations and morals of the society at large to which medical physicians are bound to. These are usually known as "ethical obligations", or "medical ethics", and usually entail controversial aspects of medicine such as abortions, euthanasia, breach of confidentiality, *etcetera*.[155]

Before the different Codes on medical ethics and the regulatory and enforcing bodies in South Africa can be discussed, it is prudent to firstly define, in brief terms, what the term "medical ethics" entails. The British Medical Association (BMA) defines "medical ethics" as "the application of ethical reasoning to medical decision making".[156] The term is also defined as "the values and guidelines governing decisions in medical practice".[157]

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[154] Kong-lung HAU "Law and Ethics in Medical Practice: An Overview" (2003) *Medical Section* 3.

[155] *Id*. 4 – Kong-lung explains in his article that there are four fundamental principles of medical ethics, namely; respect for patient autonomy, non-maleficence as a principle (a general duty to avoid harm or damage to a patient at all costs), duty of beneficence (a general duty to only do good onto the patient and look out for his/her best interests) and justice and fairness.

[156] See: *BMA* 2009; Herring *Medical Law and Ethics* (Oxford University Press 2008) 11.

[157] "Medical Ethics" Medical Dictionary Date unknown. http://medical-dictionary.thefreedictionary.com/medical+ethics Accessed 27 August 2015.

These definitions provide a good meaning of medical ethics, but understanding the concept requires the comprehension of the term "ethics" itself. "Ethics" can be defined as: "a branch of philosophy dealing with values pertaining to human conduct, considering the rightness and wrongness of actions and the goodness or badness of the motives and ends of such actions".[158]

7.2 The Role of the South African Medical Research Council in Upholding Medical Ethics

The South African Medical Research Council (SAMRC) was established in 1969 and it is aimed at improving the health and the quality of life of the population. Its research focuses mainly on the ten highest causes of death and women's health.[159] The main importance of the SAMRC lies in the fact that even though it is focused on health research, it has published the South African Medical Council Guidelines on Ethics for Medical Research (1993) in order to assist and guide them in their daily health research.

7.3 *Health Professions Council of South Africa and its Role in Upholding Medical Ethics*

The more important health-related body is however Health Professions Council of South Africa (HPCSA). The HPCSA was established by the Health Professions Act.[160] This Act governs the medical profession and also states that the HPCSA is

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[158] *Ibid*; See also: Frenkel DA "Focus: Current Issues in Medical Ethics" (1979) *Journal of Medical Ethics* 53 – "Ethical standards of professionals often exceed those required by law. A physician charged with alleged ill-conduct may be acquitted or exonerated in criminal or civil court proceedings, yet disciplinary proceedings may be initiated against him with reference to the same conduct on the ground that his conduct was unethical".

[159] South African Medical Research Council Date unknown. http://www.mrc.ac.za Accessed 28 August 2015.

[160] 56 of 1974. This Act has been amended by the Health Professions Amendment Act 29 of 2007. The long title of the Act is as follows: "To establish the Health Professions Council of South Africa and professional boards; to provide for control over the education, training and registration for and practising of health professions registered under this Act; and to provide for matters incidental

the ultimate governing body in this relation.[161] The HPCSA replaced the South African Medical and Dental Council[162] together with the Interim South African Medical and Dental Council.[163]

The objects of the HPCSA are amongst other things to: Assist in the promotion of the health of the population of the Republic; co-ordinate the activities of the professional boards established in terms of the Act; communicate to the Minister information of public importance; serve and protect the public in matters involving the rendering of health services, *etcetera*.[164] Section 4 of the Health Professions Act[165] outlines the powers and therefore responsibilities of the HPCSA, whilst section 5 contains the Constitution of the HPCSA.

The HPCSA promulgated "Guidelines for Good Practice in the Health Care Professions (2006)".[166] These are ethical and professional rules of the HPCSA which include things such as fees and commission,[167] professional confidentiality,[168]

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thereto". See in this regard for example Coetzee LC & Carstens P "Medical Malpractice and Compensation in South Africa" (2011) *Chicago-Kent Law Review* 1263.

[161] Even though the HPCSA is seen to be the ultimate and supreme governing body in relation to the medical profession, it is assisted by twelve professional boards that operate under the jurisdiction of the HPCSA – See: Carstens & Pearmian (2007) 250.

[162] The SAMDC. In *Veriava v President, South African Medical and Dental Council* 1985 (2) SA 293 (T) it was held that the SAMDC is seen as the "*custos morum*" (the guardian of manners and/or morals) in relation to the medical profession – this also relates to the role and purpose of the HPCSA, which replaced the SAMDC – See: Carstens & Pearmain (2007) 250.

[163] *Ibid*; Oosthuizen (2014) LLM (unpublished) Dissertation University of Pretoria 8 – For a detailed discussion surrounding the HPCSA, the history of its origin and the powers and obligations it has see: Carstens & Pearmain (2007) 250-256; Oosthuizen (2014) LLM (unpublished) Dissertation University of Pretoria Chapter 1; Dhai A & McQuid-Mason DJ *Bioethics, Human Rights and Health Law: Principles and Practice* (Cape Town: Juta and Company 2010) 30-34; Van Rensburg (2004) 385-399.

[164] Section 3 of the Health Professions Act 56 of 1974 sets out both the objectives and functions of the HPCSA – for a detailed discussion on all the objectives of the HPCSA see: Section 3 of the Health Professions Act 56 of 1974; Carstens & Pearmain (2007) 251; Oosthuizen (2014) LLM (unpublished) Dissertation University of Pretoria 9-11.

[165] 56 of 1974.

[166] In the Government Gazette R717/2006 - it must be noted that these are the new ethical rules as opposed to the Old Code of Ethical Rules (1976).

[167] Rule 7.

retention of human organs,[169] *etcetera*. One of the most important Rules is Rule 27A pertaining to the main responsibilities of health practitioners.[170] This Rule is particularly important as it places certain obligations and expectations on medical physicians. These are not seen as legal rules, enforceable by law and captured in legislation, but rather ethical values expected from physicians by the community at large.[171]

8. Conclusion

From the above breakdown and overview of health-care regulation and enactment from the pre-constitutional era till where we are today, it is clear that since the new

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[168] Rule 13.

[169] Rule 14.

[170] Main responsibilities of health practitioners

27A. A practitioner shall at all times

(a) act in the best interests of his or her patients;

(b) respect patient confidentiality, privacy, choices and dignity;

(c) maintain the highest standards of personal conduct and integrity;

(d) provide adequate information about the patient's diagnosis, treatment options and alternatives, costs associated with each such alternative and any other pertinent information to enable the patient to exercise a choice in terms of treatment and informed decision-making pertaining to his or her health and that of others;

(e) keep his or her professional knowledge and skills up to date;

(f) maintain proper and effective communication with his or her patients and other professionals;

(g) except in an emergency, obtain informed consent from a patient or, in the event that the patient is unable to provide consent for treatment himself or herself, from his or her next of kin; and

(h) keep accurate patient records.

[171] The legal status of these rules are discussed in Carstens & Pearmain (2007) 264 – "As to the legal status of the Ethical Rules … courts of law are evidently not bound … in determining legal liability for medical malpractice, the Ethical Rules … will undoubtedly be an important consideration in ascertaining what constitutes medical malpractice". Another important factor is that penalties can be administered if these ethical rules are not adhered to. For a detailed discussion on the penalties awarded by the HPCSA, see Carstens & Pearmain (2007) 270.

constitutional dispensation health care and its regulation has definitely become a priority for South Africa. What remains evident throughout the phases of health reform and development is the fact that even after the Apartheid-era, the divide between the public health sector and the private health sector has remained. Ngwena highlights this by saying that "[t]he divide between a first rate but expensive private health care sector and a second class public health sector remains".[172]

Not only has this divide remained within health care but the concept of separation between the private sector and public sector has intensified.[173] According to the Constitution the obligation rests on the state to ensure that health-related rights are brought into action and therefore made a reality for South Africans.[174] It is evident from the discussion of the NHA that legislation needs to be utilised as a tool to implement and execute rights afforded in the Constitution, but that transformation and restructuring of South Africa's health care system and the discrepancy between the public sector and private sector will not be addressed through the enactment of legislation alone. Furthermore, the discussion of Constitutional Court judgments relating to socio-economic rights confirms the aforementioned in the context of the judiciary. Just as the transformation of the health care system will not be achieved through the legislative or executive branches alone, the judicial branch will not succeed by itself to bring about this reform.

It is however up to the judiciary to hold the other two branches accountable in terms of health-related rights.[175] Yet, even if the judiciary is the capable and willing arm of government to succeed in executing and implementing health-related rights, it still faces another issue – access to courts in its broadest sense.[176] As was mentioned in

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[172] Ngwena (2003) *Fundamina* 133.

[173] See for example the Supreme Court of Appeal ruling in *S v Tembani* 1 SACR 355 (SCA), where the Court held that substandard care is now to be expected in public hospitals – without referring to the impact of such a decision on the private health care sector.

[174] Pieterse (2014) 24 – "While the primary task of translating the health-related rights in the Constitution into a lived reality for the people of South Africa rests with the legislature and the executive, the rights are also justiciable, meaning the courts have a say in the manner…".

[175] Pieterse (2014) 50-51.

[176] See: Langa P "Transformative Constitutionalism" (2006) *Stellenbosch Law Review* 354-359 – Langa mentions specifically five challenges to transformative constitutionalism being: Access to equal

the opening statements to this dissertation, the public-health sector mainly comprises of the poor because the wealthy are able to pay for quality health care services. This means that the poor are faced with taking a matter to court in order to attempt attaining the quality of health care that the wealthy part of the population is able to pay for, but access to justice, just as access to quality health care, is not a reality for the poor. Access to courts, lack of awareness regarding their rights and the necessary processes that need to be followed, accompanied by language barriers, lack of transformation and lack of access to legal advice, due to legal costs or availability, are only some of the factors that pose obstacles to ensuring the judiciary succeeds in enforcing health-related rights.

It can therefore be concluded that even though much effort has been put into transforming and addressing the inequalities of the past (pre-1994) in relation to health care in South Africa, the reality still outweighs the legislation enacted. Unfortunately we have really good legislation but this dissertation makes the argument that we fail to apply it to the realities of health care. Why? Not due to a lack of enactment of legislation giving effect to the constitutional rights, but rather due to a lack of enforcement and tools such as policy documents and regulations assisting in the application and implementation of these well-drafted pieces of legislation.

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justice, Legal education, Legal culture, Responsibility for transformation and reconciliation and finally Creating a climate for reconciliation. The first of these challenges being “access to equal justice” is specifically relevant to this dissertation. Langa states that: “Equal justice means that the fruits of justice are there for all to enjoy”.

Chapter 3

The Locality Rule: Origin, History and Application

Overview

In the previous chapter the reality of health care standards (in the public and private sectors of health care) in South Africa was discussed. The chapter illustrated that even though much effort has been put into health reform in the public sector (specifically), the divide between the two sectors remain. Unfortunately the reality in South Africa is that we do not have access to equal health care in the public and private sectors. This chapter serves to introduce the Locality Rule as a method of recognising the divide between these two sectors, and addressing it accordingly. The chapter suggests that the locality of practice of the physician must play a role when it comes to assessing medical negligence. This however, in South Africa, is not the case; the physician practising in the public health care sector is held to the same standard of care as a physician practising with all the necessary resources at his or her disposal. In order to make the suggestion for the Locality Rule to be implemented as an interim solution to the current health care regime in South Africa, the origin, history and (current) application thereof needs to be addressed in order to determine if the Rule, in fact, will be a viable option for South Africa (a developing country) to implement.

1 Introduction

> Medicine is the art of the possible, and each physician owes the duty to care optimally and treat by making the best resources available even if he referred the patient elsewhere.[1]

[1] Michaud GL & Hutton MB "Medical Tort Law: The Emergence of a Special Standard of Care" (1981) *TULSA Law Journal* 731.

When one thinks about the duty of the physician to (attempt to) heal the patient, the surrounding circumstances, resources, medical technology and equipment (or lack thereof) are rarely taken into account. The abilities of the physician are rather seen as supernatural and therefore the public often believes the physician could truly make bricks from straw.[2] Healy, by referring specifically to ancient healers and not so much to the modern doctor, explains that:

> [T]he healer's ability was based less on his competence to treat and heal than on his ability to communicate with the gods through visions and dreams.[3]

Based on Healy's quote, it is important to mention that people still view medical practitioners in the same light. The focus of this chapter is the main concept of the dissertation, namely the Locality Rule. The meaning, history, origin and application of the Rule are discussed in detail in light of the three countries chosen for this comparative study.[4] This chapter delves into the history of the Rule in English law (or lack thereof)[5] and its application throughout America. It traces the origin of the Rule in American case law, with specific reference to the most important cases in terms of the expansion of the Rule over time.[6] The interpretation and the development of the Rule throughout the years are discussed with reference to various states in America.

The main purpose of the chapter is to illustrate why and how the Rule is/was applied in specific states in America in order to demonstrate the potential relevance it has for South African medical negligence jurisprudence. The chapter also focuses on the arguments for and against the application of the Rule – even though these arguments are based on the comparative jurisdictions (mainly America, as this is where the Rule has been applied) and limited therefore in

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[2] Gordon I, Turner R & Price TW *Medical Jurisprudence (*Edinburgh: Livingston 1953) 113.

[3] Healy J *Medical Negligence: Common Law Perspectives* (London: Sweet & Maxwell 1998) 8.

[4] South African Law, American Law and English Law.

[5] Nathan HL *Medical Negligence: Being the Law of Negligence in Relation to the Medical Profession and Hospitals* (London: Butterworth 1957) 21.

[6] See: *Brune v. Belinkoff* 235 N.E.2d 793 (Mass. 1968); *Pederson v. Dumouchel* 431 P.2d 973 (Wash. 1967); *Leighton v. Sargent* 27 N.H. 460 (1853) and *Small v. Howard* 128 Mass. 131, 35 Am. Rep. 363 (1880).

application to South Africa. The chapter concludes by assessing the application of the Locality Rule in the chosen jurisdictions as it currently stands.

2 The Locality Rule and its Purpose

2.1 Introductory Remarks

Before the origin and history of the Locality Rule can be examined, it is important to first understand what this Rule entails. The Locality Rule requires that the standard of care exercised by a medical professional must accord with the standard expected or known in the community he or she practises. Therefore physicians practising in the public sector would be held to a different standard of care than physicians practicing in the private sector.[7] As Stewart indicates:

> This rule states that a defendant physician will escape tort liability in a malpractice action if he can show that he has conformed to the standards of medical practice prevailing in his community or a similar one.[8]

The question asked in this dissertation - with specific reference to South African medical law - is whether it is fair for a physician practising in a public hospital in

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[7] Cawthon EA 'Cases' in *Medicine on Trial: A Handbook with Cases, Laws and Documents* (ABC-CLIO 2004) 94; Cowles DR "*Russo v. Griffen*: The Death of Vermont's Locality Rule in Legal Malpractice" (1987) *Vermont Law Review* 298; Danzon PM *Medical Malpractice: Theory, Evidence and Public Policy* (Harvard University Press 1985) 144; Fagurland DE "Legal Malpractice: The Locality Rule and Other Limitations of the Standard of Care: Should Rural and Metropolitan Lawyers be Held to the Same Standard of Care?" (1988) *North Dakota Law Review* 662; Fox JE & Russell JF "The Locality Rule and Medical Malpractice: A Judicial Awakening" (1971) *Memphis State Law Review* 379; Haavi EM *Holding Health Care Accountable: Law and the New Medical Marketplace* (USA: Oxford University Press 2001) 22; Holder AR *Medical Malpractice Law* (2nd ed) (New York: John Wiley & Sons 1978) 58; McKenzie Jr. FC "Torts – Willingness to Abrogate the Locality Rule in Medical Malpractice Suits Indicated" (1972) *Mississippi Law Journal* 587; Miller RD *Problems in Health Care Law* (Jones and Bartlett 2006) 599; Stewart WJ "The Locality Rule in Medical Malpractice Suits" (1969) *California Western Law Review* 125; Stoia SJ "*Vergara v. Doan*: Modern Medical Technology Consumes the Locality Rule" (1993) *Journal of Pharmacy and Law* 108.

[8] Stewart (1969) *California Western Law Review* 125.

Mamelodi to be held to the same standard of care and skill as a physician practising in a private hospital in Sandton? Carstens & Pearmain ask the question whether the facilities and equipment available in an urban hospital (private health care facility) can really be compared to that of a rural hospital (public health care facility) in South Africa. They reflect on this question by saying that the question does not say that if you practise in the private sector you are automatically considered to be a "better" medical practitioner. They continue by saying that both physicians in the public and private sectors have received the same (or similar) medical training. The difference between the two is that the physician in the private sector has access to better medical facilities and more resources than the physician in the public sector.[9] Do these physicians really have the same resources at their disposal? Do they truly practise medicine in the same circumstances?

Section 27 of the Constitution[10] - which provides access to health care - was discussed in the previous chapter. The question remains, how can we protect medical practitioners from the realities that they face that are out of their control due to the circumstances they find themselves in, in light of the unequal access to health care in South Africa?[11] It is important when assessing medical negligence that all factors and contributing circumstances of a particular case are taken into account. The question however becomes whether the standard of care and skill

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[9] Carstens PA & Pearmain D *Foundational Principles of South African Medical Law* (Durban: LexisNexis 2007) 638 – "In South Africa, specifically in remote tribal areas, one finds an absence of proper medical facilities and equipment and hospitals/clinics are mainly concerned to save human lives, provide access to primary health care, and to treat and prevent serious medical complications. Doctors and nursing staff in these hospitals/clinics do their best under difficult medically compromised circumstances. There are often shortages of medical staff and in many instances the doctors do not have access to the same medical facilities of their counterparts in the larger city centres".

[10] The Constitution of the Republic of South Africa, 1996, hereafter referred to as "the Constitution".

[11] It is easy to argue that the Locality Rule does not have a place in a country where the health care (medical treatment and education) is uniform and equal throughout that country – such as England. The Locality Rule however should become an option when this is not the case – hence why it is suggested for South Africa.

exercised or expected from a medical physician can be influenced by his or her locality of practice?[12]

The Locality Rule originated in America, where it was developed due to the reality of small-town doctors practising without even the most basic of requisite resources, while specialist practitioners practised in large, urban hospitals with an abundance of medical reserves.[13] The Rule has many forms and variations, as will be discussed below, but the following five elements are common in all the variations of the Locality Rule:

(1) a reasonable or ordinary degree of skill and learning
(2) commonly possessed and exercised by members of the profession
(3) who are of the same school or system as the defendant
(4) and who practise in the same or similar localities
(5) and an exercise of the defendant's good judgment.[14]

The Locality Rule was mainly developed to assess the competency of the physician but in actual fact it has two functions.[15] On the one hand the Rule provides the standard of care against which the conduct of the physician must be tested and, on the other, it illustrates the competency of the expert witness who testifies either on behalf of or against the physician – therefore his or her competency (personal knowledge) to testify in regard to a certain community or locality.[16] Waltz mentions this double-purpose of the Locality Rule by saying:

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[12] Carstens PA "The Locality Rule in Cases of Medical Malpractice" (1990) *De Rebus* 421.

[13] Morrison AB *Fundamentals of American Law* (Oxford: Oxford University Press 1996); Richards EP & Ratbun KC *Medical Care Law* (Jones and Barlett Learning 1999) 20; Haavi (2001) 22.

[14] MicCoid AH "The Care Required of Medical Practitioners" (1959) *Vanderbilt Law Review* 559; Smerge R "Negligence – Medical Malpractice – the Locality Rule" (1968) *De Paul Law Review* 330.

[15] Cohen AB *et al Technology in American Health Care: Policy Directions for Effective Evaluation and Management* (America: University of Michigan Press 2004) 361.

[16] Scott SA "Torts – Evidence – Medical Malpractice: Locality Rule Abandoned in Alabama and Family Practitioner Held to National Medical Neighbourhood Standard of Care" (1984) *Cumberland Law Review* 252; Morrison (1996) 255.

On a practical level, the locality rule has influenced not only the professional standards demanded of medical men but also the availability of witnesses to establish the physicians' culpable deviation from those standards.[17]

2.2 First Function of the Locality Rule – Standard of Care

The first function of the Rule is to establish the standard of care and skill against which the conduct of the medical physician is tested to determine whether or not his or her actions or inactions do in fact constitute negligence.[18] The standard imposed on medical physicians is that of the "reasonable man" test (as will be discussed in the following chapter). The first leg (function) of the Locality Rule however came into effect when it was realised that the rigid and formalistic "reasonable man" test could not be applied to medical physicians finding themselves in divergent circumstances and unforeseeable conditions.[19] The standard of care (the skill and knowledge of the physician) against which the physician was held was founded upon that of other medical physicians practising medicine in the same/similar geographical area – hence the birth of the Locality Rule.[20]

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[17] Waltz JR "The Rise and Gradual Fall of the Locality Rule in Medical Malpractice Litigation" (1969) *De Paul Law Review* 409.

[18] In *Blair v. Eblen*, 461 S.W.2d 370 (KY. 1970) the Court held: "The defendant in a medical malpractice case is under a duty to use that degree of care and skill which is expected of a reasonably competent practitioner in the same class to which he belongs, acting in the same or similar circumstances" – See Bowden KR "Standard of Care for Medical Practitioners – Abandonment of the Locality Rule" (1972) *Kentucky Law Journal* 209.

[19] Fox & Russell (1971) *Memphis State Law Review* 379 – "Accordingly, in determining whether a physician has performed with the requisite skill and care in the treatment of his patients, the law has taken into consideration several factors, one of which is the locality or neighborhood in which a physician practices".

[20] Holder (1978) 58.

2.2 Second Function of the Locality Rule – Competency of the Medical Expert

Originally the Rule was developed in terms of substantive law, the second function of the Locality Rule however illustrates why the true use of the Rule was evident in procedural law.[21] Medical negligence is measured or assessed by consulting expert witnesses, hence why expert evidence[22] is provided for in the Locality Rule.[23] In these cases the burden rests on the plaintiff to prove that the physician failed to comply with the standard of care and skill required from him or her in treating the plaintiff.[24] Expert testimony is therefore required to establish both the standard of care and skill expected from a physician in a particular community, as well as to determine whether there was a breach in this duty.[25] The main reason for the courts allowing the testimonies of expert witnesses in medical negligence lawsuits is due to the fact that the experts are qualified in a field in which the presiding officer might have no (or limited) expertise and/or experience.[26] The courts therefore allow expert witnesses in their respective fields to testify to assist the courts in making the correct findings.[27]

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[21] Fox & Russell (1971) *Memphis State Law Review* 383; Stewart (1969) *California Western Law Review* 125.

[22] For a clear guide and insight into expert medico-legal testimony see: Van den Heever P & Lawrenson N *Expert Evidence in Clinical Negligence: A Practitioner's Guide* (1st ed) (Cape Town: Juta 2015).

[23] Richardson Jr. JY "Virginia Abolishes Locality Rule in Medical Malpractice" (1979) *University of Richmond Law Review* 928.

[24] Michaud & Hutton (1981) *TULSA Law Journal* 722.

[25] Fagurland (1988) *North Dakota Law Review* 673.

[26] Fox & Russell (1971) *Memphis State Law Review* 383; Healy has the following to say about calling an expert witness in a medical malpractice lawsuit – "The facility to call an expert witness is a significant exception to the general evidentiary rule excluding opinion evidence, which rule is soundly predicated on the premise that it is for the court to form all the relevant inferences of fact and then to apply the law…" - Healy (1998) 74.

[27] *Ibid*.

> In those cases where the alleged injury is beyond the medical comprehension of the layman, expert testimony is essential to a plaintiff's case.[28]

The need for expert testimony in American cases concerning medical negligence was realised as early as 1860 in Arkansas,[29] due to the fact that it became evident that the jury was incapable of deciding matters pertaining to medical negligence, as they had no expertise in this matter.[30]

In terms of the Locality Rule, American courts often rejected expert testimony if the presiding officer was of the opinion that the expert called to testify was not familiar enough with the standard of care expected from a physician practising in the relevant community.[31] The locality therefore determined the competency of the physician testifying against the accused physician in the sense that the expert physician testifying had to be familiar with the standard of care and skill practised in that specific community in order to testify in favour of, or against the accused physician.

3 Origin and History of the Locality Rule

3.1 Short Case Discussion

While it is disputed when exactly the Locality Rule surfaced for the first time, the country of origin is not.[32] The Locality Rule originated in American medical law,[33]

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[28] *Ibid.*

[29] See the case of *Tatum v. Mohr*, 21 Ark. 349 (1860) in Gibson B "National Standard of Care – A New Dimension of the Locality Rule" (1983) *Arkansas Law Review* 162.

[30] *Id*. 162 – After 1860 the Arkansas Supreme Court in *Lanier v. Trammell* 207 Ark. 372, 180 S.W.2d 818 (1944) stated that standard of care is not common knowledge and that expert testimony is therefore a prerequisite when it comes to medical negligence cases.

[31] *Ibid*.

[32] "Courts rejecting the locality rule have also noted that the locality rule did not appear in English common law in medical malpractice cases but was unique to American jurisprudence…" – See Schlender EL "Malpractice and the Idaho Locality Rule: Stuck in the Nineteenth Century" (2008) *Idaho Law Review* 367. This statement is contradicted solely by the following two authors which state that the Locality Rule was developed by English law and thereafter adopted by the American

and surprisingly not English medical law, as might have been suspected.[34] At the time the Rule surfaced for the first time there was no consistency or uniformity in

courts – See Teitelbaum JB & Wilensky SE *Essentials of Health Policy and Law (Essential Public Health)* (Jones and Bartlett Learning 2012) 217.

[33] See Waltz (1969) *De Paul Law Review* 410; Schlender (2008) *Idaho Law Review* 367; Scott (1984) *Cumberland Law Review* 252.

[34] It is very surprising that the Locality Rule did not originate in England, but something that must be mentioned is the "Good Samaritan" Rule. It can be argued that this principle in medical law might have led to the development and implementation of the Locality Rule as we know it today. What proves specifically interesting is that even though the Locality Rule did not originate, nor was implemented, in England, Ficarra explains that the "Good Samaritan" Rule did find application in England, and is seen as a responsibility implemented in English law centuries ago – See Ficarra BJ *Surgical and Allied Malpractice* (USA: Thomas Books 1968) 938; *Regina v. Istan*, 17 Cox C. C. 602 Engl. This principle can be traced back to Biblical times found specifically in Luke 10:25-37 which reads as follows: "But a certain Samaritan as he journeyed came upon him, and seeing him, was moved with compassion. And he went up to him and bound up his wounds" – See: Ficarra (1968) 938; Crowe E, Study.com, "What is the Good Samaritan Law? – Definition, History and Cases" Date Unknown. http://study.com/academy/lesson/what-is-the-good-samaritan-law-definition-history-cases.html Accessed 27 November 2015. The definition for the "Good Samaritan" Rule in medical law can be explained as follows: "… [It] offers legal protection to individuals who render aid to any injured person. As long as the good Samaritan uses 'reasonable care' when providing assistance, he or she cannot be sued or prosecuted if the person they are trying to help is unintentionally injured further" - See Crowe E, Study.com, "What is the Good Samaritan Law? – Definition, History and Cases" Date Unknown. http://study.com/academy/lesson/what-is-the-good-samaritan-law-definition-history-cases.html Accessed 27 November 2015. As expressed earlier in this footnote, it can be argued that the Locality Rule is based on this principle. In terms of the "Good Samaritan" Rule the physician could not be held liable for his actions because he/she found themselves in an emergency situation and therefore had to attend to the patient as best possible given the surrounding circumstances. The Locality Rule is based on the same premises in the sense that the surrounding circumstances and lack of resources must be taken into account in assessing the conduct of the medical physician to determine whether or not it does in actual fact qualify as medical negligence. Pegalis & Wachsman refer to a statement made by the Medical Ethics of the American Medical Association in saying: "A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability" – See Pegalis SE & Wachsman HF *American Law of Medical Malpractice* (New York: The Lawyers Co-operative Publishing Co. 1980) 20; Principles of Medical Ethics American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610, Section 5. In relation to the fact that the physician has a choice to whom he attends, Jones explains that: "…[A]lthough there is no legal obligation upon a doctor to play the "Good Samaritan" and render assistance to a stranger who has been involved in

facilities, equipment or medical education (training) throughout America. The Rule therefore developed prior to the standardisation of medical training.[35] These cases clearly illustrate the need for a doctrine such as the Locality Rule, as it allowed rural physicians (as referred to in America) to be held to a different standard of care and skill than urban physicians, who might have been exposed to better training and certainly better circumstances (facilities and equipment) than the average rural physician.[36] During this time in America the Locality Rule succeeded in attaining substantive equality between physicians who found themselves in diverging circumstances.[37]

The Rule first surfaced in the 1870s, making its first official appearance (and therefore its birthplace)[38] in the case of *Small v. Howard.*[39] This case resulted in the first official statement by a court of the Locality Rule.[40] Mention of the Locality Rule was however made ten years prior to *Small v. Howard,*[41] in the Kansas Supreme Court matter of *Tefft v. Wilcox*[42] where it had already been mentioned

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an accident, a doctor who chooses to do so will owe a duty of care to the patient. The duty arises from the performance of the act" – See Jones MA *Medical Negligence (3rd ed) (*London: Sweet and Maxwell 1991) 23.

[35] Richards & Ratbun (1999) 20 – "…[t]here was a tremendous gulf between the skills and abilities of university trained physicians and the graduates of the unregulated diploma mills"; Stoia (1993) *Journal of Pharmacy and Law* 108; Richardson (1979) *University of Richmond Law Review* 929; Cowles (1987) *Vermont Law Review* 298.

[36] "While the rule was not expressly connected to any economic or political mandate, it was originally designed to protect doctors in rural areas who could not be expected to exhibit the skill and care of urban doctors" - See Schlender (2008) *Idaho Law Review* 367.

[37] Best A & Barnes DW "Professionals" in *Basic Tort Law: Cases, Statutes and Problems* (Aspen Publishers Online 2007) 431.

[38] Armstrong DD "Medical Malpractice – The Locality Rule and the Conspiracy of Silence" (1970) *South Carolina Law Review* 812; Bach BJ "The Erosion of the Locality Rule and the Qualification of Experts Testifying in Medical Malpractice Suits in Virginia" (1981) *GMU Law Review* 100; Ginsberg MD "The Locality Rule Lives! Why? Using Modern Medicine to Eradicate an 'Unhealthy' Law" (2013) *Drake Law Review* 322*;* Stewart (1969) *California Western Law Review* 125.

[39] 128 Mass. 131 (1880).

[40] Cohen BR "The Locality Rule in Colorado: Updating the Standard of Care" (1980) *University of Colorado Law Review* 588; Stewart (1969) *California Western Law Review* 124.

[41] 128 Mass. 131 (1880).

[42] 6 Kan. 33 (1870).

that a physician practising in a rural area in America could not be held to the same standard of care as a physician practising in the City. Therefore it can be inferred that the Kansas Supreme Court indirectly relied on the Locality Rule, even though the term as such was not coined yet.[43]

The instrumental case of *Small v. Howard*[44] (hereafter referred to as the *Small* case) was heard in Massachusetts, where the defendant (Dr Howard) was a country surgeon and physician who was qualified as a general practitioner only performing minor surgeries.[45] The defendant practised in a town with a population of 2500 people.[46] The plaintiff was severely injured (his wrist was brutally wounded)[47] in an accident involving glass and required an operation by a physician who was highly skilled in this field – therefore a specialist in the field, not a general practitioner.[48] The plaintiff died after the defendant attempted to perform this very difficult procedure himself (without possessing the required skill) which he has never done before, being a rural physician and general practitioner.[49] An important factor in this case is the fact that the defendant could have and should have referred the plaintiff to an imminent surgeon who was merely four miles away during the ten days that the defendant treated the plaintiff.[50] In a medical

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[43] Cohen (1980) *University of Colorado Law Review* 588 – The Kansas Supreme Court in *Tefft v. Wilcox* 6 Kan. 33 (1870) held that in a case concerning medical negligence (in this specific case it was the negligent diagnosis of a dislocated shoulder) it is the mandate of the jury to consider the community in which the physician was practicing in relation to the quality of care and skill that was exercised (own emphasis); McKenzie (1972) *Mississippi Law Journal* 588; Ginsberg (2013) *Drake Law Review* 326.

[44] 128 Mass. 131 (1880).

[45] Baldauf KE "Non-Resident Expert Testimony on Local Hospital Standards" (1969) *Cleveland State Law Review* 493-494.

[46] Smerge (1968) *De Paul Law Review* 329; Stewart (1969) *California Western Law Review* 124; Fox & Russell (1971) *Memphis State Law Review* 381.

[47] Cohen (1980) *University of Colorado Law Review* 588; Stewart (1969) *California Western Law Review* 124; Fox & Russell (1971) *Memphis State Law Review* 381.

[48] Ginsberg (2013) *Drake Law Review* 328.

[49] Stewart (1969) *California Western Law Review* 124.

[50] King JF & Coe WB "The Wisdom of the Strict Locality Rule" (1974) *Baltimore Law Review* 223; Cohen (1980) *University of Colorado Law Review* 588; Stewart (1969) *California Western Law Review* 124.

malpractice lawsuit brought against the defendant, it was requested for the Court to hold the defendant to a different (higher) standard of care and skill than what was applied in the community he practised. The Supreme Judicial Court held the following:

> …he 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.[51]

The Court held that a rural physician (countryside physician) would not ordinarily attempt a specialty surgery like this.[52] This type of physician would rarely perform surgical operations at all, which results in the conclusion that such a physician's exposure to this type of skill would be minimal. The Court therefore held a rural physician cannot, and will not, be held to the standard of care and skill expected of a urban physician who on a daily basis is faced with similar situations and who is expected to possess this skill.[53]

The Court ultimately held the defendant liable to the standard of care and skill expected from a rural practitioner in the same or similar community. To some extent the Court therefore found in favour of the defendant (rejecting the higher standard of care) leading to the development of a general rule that the standard of care exercised by a country (rural) physician cannot be compared to that of physicians practising in large cities.[54] Therefore, the standard of care exercised by a rural physician cannot be equated to that of a physician practising in a large city with different resources available to him or her.

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[51] See *Small v. Howard* 128 Mass. 131, 35 Am. Rep. 363 (1880) 365.

[52] Fox & Russell (1971) *Memphis State Law Review* 381*;* 128 Mass. 131 (1880) at 132 – "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".

[53] Smerge (1968) *De Paul Law Review* 329.

[54] Baldauf (1969) *Cleveland State Law* Review 494; Fox & Russell (1971) *Memphis State Law Review* 381; Ginsberg (2013) *Drake Law Review* 323.

3.2 Variations of the Locality Rule

There are two forms of the Locality Rule, namely the original form, known as the "strict" Locality Rule or the "*same location*" rule and the "modified" Locality Rule, also known as the "*similar location*" rule.[55] The "*same location*" rule is based on the standard of care in the defendant's specific community/locality[56] whereas the "*similar location*" rule pertains to similar communities to the one the defendant operates in.[57] In the *Small* case the "*similar location*" rule was adopted.[58] Later on, as the Rule developed it became the "*same location*" rule, requiring expert witnesses who have practised in the *same* location as the defendant doctor to testify in the alleged negligence action.[59] In the case of *Leighton v. Sargent*[60] a very strict form (namely the "*same location*" rule) surfaced for the first time – it is said that in this case the Locality Rule was articulated for the first time,[61] even though most sources see the birthplace of the Rule to be the *Small* case. This entails that this case coined the "*same location*" rule, whereas the *Small* case applied the "*similar location*" rule. As time went on however, the "*same location*" rule was rejected in favour of the "*similar location*" rule, due to the harshness and strictness of the "*same location*" rule,[62] as well as the inability to obtain expert witnesses from the *same* community[63] - ultimately returning to the judgment of *Small v. Howard.*[64]

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[55] Fox & Russell (1971) *Memphis State Law Review* 380.

[56] Gibson (1983) *Arkansas Law Review* 166.

[57] Casenotes *Torts: Case Note Legal Briefs* (Aspen Publishers Online 2009) 85; Gibson (1983) *Arkansas Law Review* 167.

[58] Ginsberg (2013) *Drake Law Review* 330.

[59] Fox & Russell (1971) *Memphis State Law Review* 384.

[60] 27 N.H. 460 (1853).

[61] King & Coe (1974) *Baltimore Law Review* 222.

[62] Anderson AL "Standard of Care for Medical Practitioners – The Locality Rule" (1969) *South Dakota Law Review* 349; Danzon (1985) 144.

[63] Gibson (1983) *Arkansas Law Review* 167.

[64] 128 Mass. 131 (1880); See: Baldauf (1969) *Cleveland State Law Review* 493-494; Scott (1984) *Cumberland Law Review* 252-257; Waltz (1969) *De Paul Law Review* 409-410; Armstrong (1970) *South Carolina Law Review* 812.

The original standard was therefore modified by extending the geographical boundaries of the standard to not only be limited to that specific community but to extend to similar communities, affording an expanded and less strict version of the original Locality Rule.[65] The "*similar location*" rule was therefore based on the similarity of two communities. The similarity was not to be based on population, but it had to be established by comparing the standard of medical advances and facilities.[66]

Even though the "*similar location*" rule variation of the Locality Rule is the more accepted variation, it in itself causes confusion.[67] The question the courts are faced with - in terms of this relaxed form of the Rule - is what exactly qualifies as a "similar" community?[68] This confusion has led to most states that previously supported the "*similar location*" rule abandoning the Rule in its totality. This is why most states in America now advocate for a national standard of care and skill for all medical physicians to adhere to all over the country.

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[65] See Smerge (1968) *De Paul Law Review* 333-334 which quoted *Flock v. J. C. Palumbo Fruit Co.*, 63 Idaho 220, 118 P.2d 707 (1941) in saying: "So far as medical treatment is concerned, the borders of the locality and community have, in effect, been extended so as to include those centers readily accessible where the appropriate treatment may be had which the local physician, because of limited facilities or training is unable to give"; Fox & Russell (1971) *Memphis State Law Review* 386.

[66] Michaud & Hutton (1981) *TULSA Law Journal* 726; Fox & Russell (1971) *Memphis State Law Review 386-387*.

[67] Fox & Russell (1971) *Memphis State Law Review 388*.

[68] Anderson (1969) *South Dakota Law Review* 350; Fox & Russell (1971) *Memphis State Law Review 386-387* – "Some courts have asserted that "similar community" should be defined on the basis of socioeconomic factors such as population, type of economy, and income level. However, most courts maintain that "similar community" should be examined in terms of medical factors such as availability and proximity of medical facilities and the physician's opportunity to further his medical expertise through the observation and discussion of acceptable alternative practices which might exist".

4 Development and the Demise of the Locality Rule (In Some States)

By the 1970s there was a distinction drawn between general practitioners and specialists. Specialist physicians purport to have undergone specialised training[69] and therefore were held against the national standard, whereas general practitioners did not assert to possess any special skill.[70] The difference between the two are explained as follows:

> [T]he difference between a duty owed by a specialist and that owed by a general practitioner lies not in the degree of care required, but in the amount of skill required.[71]

The Locality Rule was primarily developed to protect general practitioners, not specialists, hence illustrating the initial phases of the demise of the Rule.[72] The glory of the "*similar location*" rule in the *Small* case was short-lived. The following two cases had a great impact on the development and/or demise of the Locality Rule in America, namely *Pederson v. Dumouchel*[73] (hereafter *Pederson* case) and *Brune v. Belinkoff*[74] (hereafter *Brune* case). Both of these cases resulted in the demise of the Rule developed in the *Small* case.

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[69] It is important to note that the specialist is held to the standard of the ordinary, competent specialist, and not against the standard of the most experienced or best trained specialist there is – See Jones (1991) 83; *O'Donovan v. Cork County Council* [1967] I.R. 173, 190.

[70] Pegalis & Wachsman (1980) 57; Stauch M, Wheat K & Tingle J *Sourcebook on Medical Law* (2nd ed) (Australia: Cavendish Publishing 2002) – "…[T]he standard of care against which the doctor will be judged is not going to be that of the ordinary reasonable man who enjoys no medical expertise. Instead, in holding himself out as possessing the special skills of his profession, the doctor is under a duty to conform to the ordinary standards of that profession"; Holder (1978) 59-60; Van Dokkum N "The Evolution of Medical Practice Law in South Africa" (1997) *Journal of African Law* 180.

[71] Pegalis & Wachsman (1980) 57; See *Valentine v. Kasier Foundation Hospitals* (1961, 1st Dist) 194 Cal App 2d 282, 15 Cal Rptr 26.

[72] Walston-Dunham B '*The Development of Medical Malpractice Law' in Medical Malpractice Law and Litigation* (Cengage Learning 2005) 52-53.

[73] 431 P.2d 973 (Wash. 1967).

[74] 235 N.E.2d 793 (Mass. 1968).

The *Pederson* case was brought before the Supreme Court of Washington in 1967. The case concerned a motor vehicle accident in which the plaintiff sustained minor injuries and was thereafter admitted to the hospital under the care of the defendant (Dr Dumouchel). The plaintiff had to undergo a minor surgery to repair a jaw fracture, sustained in the motor vehicle accident – a dentist (Dr Heikel) attended hereto. The defendant however left the hospital before Dr Heikel commenced with the surgery, and was nowhere to be found when complications occurred in the jaw repair.[75] A lawsuit was thereafter brought against the defendant, dentist and hospital, for medical negligence as a result of the damage sustained, allegedly caused by the operation.[76] The court *a quo* found in favour of the defendants, based on the Locality Rule.[77] The importance of this case however lies in the development of the Locality Rule when the plaintiff took the case on appeal.[78] In the appeal the Court held that that the standard of care is the care and skill expected from the average physician in his own class, operating in the same or similar circumstances.[79] The Court further held that the locality of practice (therefore the geographical boundary) is merely a factor that should be taken into account when assessing the alleged negligence of the physician.[80] The Court in the *Pederson* case observed that:

> The degree of care which must be observed is… that of an average, competent practitioner acting in the same or similar circumstances. In other words, local practice within geographic proximity is one, but not the only factor to be considered. No longer is it proper to limit the definition of the standard of care which a medical doctor or dentist must meet solely to the practice or custom of a particular locality, or similar locality, or a geographic area.[81]

Another important observation made by the Court was the fact that the standard of care and skill, as discussed by the Court, is not limited to medical physicians only, but equally applies to hospitals. The Court therefore held the conduct of the

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[75] Fox & Russell (1971) *Memphis State Law Review* 390.

[76] *Ibid*.

[77] *Ibid*.

[78] *Ibid*.

[79] 431 P.2d 973, 978 (Wash. 1967).

[80] See the discussion of this case by Scott (1984) *Cumberland Law Review* 259.

[81] 431 P.2d 973, 978 (Wash. 1967).

hospital, in allowing the dentist to continue with the procedure without a medical physician being present, to amount to negligence.[82]

One year after the *Pederson* case, the *Brune*[83] case was heard. What proves interesting about this specific case is the fact that the same court that established the Locality Rule in 1880,[84] was the court that abandoned it in 1968.[85] In the *Brune* case, the Supreme Judicial Court of Massachusetts overruled the earlier case of *Small v. Howard*.[86] The facts of *Brune* are as follows. The plaintiff was in labour when the defendant, a specialist anaesthesiologist, administered a spinal anaesthetic to the plaintiff.[87] The surgery was conducted and completed without any complications. Eleven hours after the surgery the plaintiff climbed out of bed, slipped and fell. Hereafter the plaintiff complained of numbness accompanied by weakness in her left leg.[88] Her condition persisted till the date of the trial in which the defendant was sued for medical negligence due to the fact that the condition of the patient was caused by an overdose of an element contained in the anaesthetic administered to her.[89] The Court held a nation-wide (national) standard to be more applicable than the Locality Rule, in the case of both the general practitioner and specialist.[90] The Court held that instead of using the Locality Rule as a test for medical negligence, the following should be applied:

> The proper standard is … if a general practitioner, has exercised the degree of care and skill of the average qualified practitioner, taking into account the advances in the profession. In applying this standard it is permissible to consider the medical resources available to the physician as one circumstance in determining the skill and care required.[91]

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[82] Baldauf (1969) *Cleveland State Law Review* 497.

[83] 235 N.E.2d 793 (Mass. 1968).

[84] In *Small v. Howard* 128 Mass. 131 (1880).

[85] Armstrong (1970) *South Carolina Law Review* 814.

[86] 128 Mass. 131 (1880).

[87] Stewart (1969) *California Western Law Review* 130.

[88] Ginsberg (2013) *Drake Law Review* 330.

[89] 235 N.E.2d 793 (Mass. 1968); Stewart (1969) *California Western Law Review* 130; Fox & Russell (1971) *Memphis State Law Review* 391.

[90] Bowden (1972) *Kentucky Law Journal* 212.

[91] 235 N.E.2d 793 (Mass. 1968).

In reaching its decision, the Court took into account the fact that the hospital where the defendant practised and attended to the plaintiff was only fifty miles away from one of America's leading medical centers.[92] The Court therefore completely reversed its earlier decision in the *Small* case, and henceforth abandoned the Locality Rule in favour of the national standard. Professor Waltz explains the significance of the two decisions as follows:

> *Brune* suggests a nationwide standard for both specialists and general practitioners…*Pederson* is more cautious [as it only holds] the medical man to that degree of care and skill established in areas accessible to him…[93]

5 Arguments in favour of the Locality Rule

From the outset it must be stated that there are not many arguments in favour of the implementation of this Rule. However, the arguments against the implementation of the Rule are formulated for countries where the application of such a Rule would be futile. In a country such as England, or America (nowadays), the Rule would simply serve as a "get-away" mechanism for medical physicians, because the standard of health care in these countries is seen to be uniform. In other words, the Rule is abandoned because it would assist physicians to escape medical negligence claims. In South Africa, which is a developing country, this is not the case. As it has been argued in chapter 2, a clear divide exists between public health care and private health care. Therefore the application of the Locality Rule will assist the courts to more accurately assess the conduct of a medical physician in light of the public/private healthcare divide.

The main argument in favour of the application of the Rule is the fact that each case would be painted with a different brush (in light of the surrounding circumstances) if the Rule is properly applied. This Rule allows for the stark reality of the medical health care system in South Africa to be realised. The advantage of the Rule flows from the fact that all medical negligence suits cannot be treated in

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[92] Fox & Russell (1971) *Memphis State Law Review* 391.

[93] Waltz (1969) *De Paul Law Review* 418; Armstrong (1970) *South Carolina Law Review* 814.

light of the same circumstances or a uniform standard, as South Africa does not offer uniform medical health care throughout the geographical boundaries of the country. The often hidden reality is that the resources available in South Africa do not equate to those available in developed countries such as England or America. The Locality Rule therefore allows the court - while testing whether or not the physician exercised the standard of care and skill expected from him or her - to assess medical negligence in light of the physician's locality of practice. The Rule therefore "protects" the public sector medical physician in the sense that his or her equipment, resources and circumstances cannot be compared to that of a private sector medical physician in South Africa. The Rule allows the disadvantaged rural physician (public sector medical physician) to be held to a different standard (based on his or her locality of practice) than the strict standard an urban physician (private sector medical physician) is held to, because the implementation of the Rule appreciates the lack of uniformity of health care in South Africa.[94]

As a result of the arguments presented in favour of the Locality Rule above, it follows that the rise of medical negligence suits, which have been observed in South Africa,[95] would therefore decrease if the Rule was implemented in South Africa because the public health care physician's conduct is not automatically equated to that of the private health care physician. The implementation of the Rule in South Africa will therefore assist in controlling the recent uprising in medical negligence lawsuits in South Africa.

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[94] As was discussed in the first chapter to this dissertation.

[95] 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 2009/2010 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.

6 Arguments against the Locality Rule

6.1 Introductory Remarks

In this section it will become evident that the arguments against the implementation of the Locality Rule far outweigh the arguments in favour thereof (as mentioned above). It must however be noted that these arguments against the implementation of the Rule all originated in countries where the Rule is either applied in a limited sense, or not at all – therefore the Rule is not required. Another important factor that must be mentioned prior to this discussion is the fact that South Africa finds itself in a completely different socio-economic framework and therefore most of these arguments against the Locality Rule will not be applicable to South Africa.

6.2 "Conspiracy of Silence" Theory

The most common argument against the implementation and use of the Rule is linked to its second function, namely the fact that the Rule provides protection for medical physicians against medical negligence claims, in the sense that medical physicians refuse to testify against their fellow physicians.[96] This means the Rule makes it very difficult for the plaintiff to succeed in building his or her case against the defendant resulting in protection from the bench in favour of the medical profession.[97] This protection materialised in the form of the phenomenon known as "conspiracy of silence".[98] This issue relates to the fact that the Locality Rule requires expert medical testimony of another physician practising in the same or similar community who is aware of the standard of care applied in the given

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[96] See Ginsberg (2013) *Drake Law Review* 373 – "Trial courts should not engage in a screening process and disqualify medical expert witnesses due to unfamiliarity with a supposed local standard of care".

[97] See Schlender (2008) *Idaho Law Review* 367.

[98] Cohen *et al* (2004) 361; Pegalis & Wachsman explains this phenomenon as follows: "The inability to obtain expert medical testimony to support a patient's action against a doctor or a hospital, the lack of access to medical records, as well as the alteration of medical records, might well be lumped together under a category called 'conspiracy of silence'." See Pegalis & Wachsman (1980) 28-33; Van Dokkum (1997) *Journal of African Law* 182.

community.[99] This however makes it very difficult for the plaintiff to succeed in his or her case against the defendant physician as the "conspiracy of silence" theory holds the view that a physician will rarely (if ever) testify against his or her fellow physician.[100] It is therefore not only difficult for the plaintiff to succeed because the expert testimony given on behalf of the physician is almost guaranteed to be in his or her favour, but the possibility for the plaintiff to obtain a physician willing to testify on the plaintiff's behalf is almost impossible.[101] William Nolen expresses the dilemma by saying:

> We are too afraid of hurting the feelings of our confreres, of losing referrals from them, of being over-critical. We lean over backward in order not to judge our fellow-doctors too harshly, and often we do this to such an extreme that it poses a threat to the well-being of patients. A surgeon practically has to become a mass murderer before his fellow surgeons will take away his surgical privileges.[102]

6.3 "Same or Similar Community" Dilemma

The Rule further creates obstacles for the plaintiff regarding the use of expert opinion, as it requires an expert from the same or similar community to testify.[103]

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[99] Ficarra (1968) 58 – "The term 'conspiracy of silence' has been applied to those cases wherein a meritorious plaintiff may not be able to find a single physician of good standing in his county who will testify for him".

[100] Armstrong (1970) *South Carolina Law Review*; Pegalis & Wachsman (1980) 28-29; Van Dokkum (1997) *Journal of African Law* 182.

[101] Cawthon (2004) 94; Miller (2006) 599; Pegalis & Wachsman – through the case of *Ardoin v. Hartford Acci. $ Indem. Co*. (1978, La) 360 So 2d 1331 – expresses the view that the demise of the Locality Rule can be linked to the "conspiracy of silence" phenomenon as it prohibits the plaintiff from obtaining the testimony of an expert medical witness – See Pegalis & Wachsman (1980) 29.

[102] Nolen WA *A Surgeon's World* (Random House Incorporated: 1972) 177-179; Pegalis & Wachsman (1980) 29.

[103] In *Sheeley v. Memorial Hospital* 710 A.2d 161 (1998)165-166, the Rhode Island Supreme Court quoted *Wilkinson v. Vesey*, 295 A.2d 676 (1972) 682 in saying the following about the Locality Rule: "…the rule legitimizes a low standard of care in small communities, it fails to address a potential "conspiracy of silence" in the plaintiffs locality, which precludes the possibility of obtaining expert testimony, and such a rule is outdated due to modern transportation and communication systems".

This dilemma not only limits the availability of witnesses and expert opinion but also the quality of the evidence produced by the plaintiff.

6.4 Uniform Health Care and Medical Training

Another argument against the application of the Rule is based on uniform healthcare. Uniform health care entails that there is consistency and uniformity throughout the country in all medical training, resources and technology. The Rule is not needed if uniform healthcare exists.[104] This argument is especially evident in England because suggesting the implementation of the Locality Rule would entail that the standard of care and skill differs from one part of the country to another – which according to them is not the case.[105] The argument on uniform health care and therefore uniform standard of care is surfacing more and more throughout America.[106] Some states in America still opt for the Locality Rule (some variation thereof), but most states are in favour of a national standard of care (uniform health care).[107] The implementation of the Locality Rule will therefore hinder such a national standard.

6.5 Advancement of Technology

Another argument worth mentioning is the famous argument regarding the advancement of technology.[108] In most countries it is argued that technology,

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[104] Fox & Russell (1971) *Memphis State Law Review* 399.

[105] Nathan (1957) 21; Stewart (1969) *California Western Law Review* 130 – In his article Stewart explains that in *Pederson v. Dumouchel* 431 P.2d 973 (Wash. 1967) the Supreme Court of Washington observed that England employs the same standard of care throughout its geographical boundaries.

[106] This is surfacing in the form of a national (or nation-wide) standard of care.

[107] Fox & Russell (1971) *Memphis State Law Review* 399-400.

[108] Smerge (1968) *De Paul Law Review* 335 – "From the time that this standard first appeared there have been significant changes in our population pattern, particularly, the shift from rural to urban areas. There has been a marked increase in the quality of our transportation. With the significant advances in the communications media, radio, television, and the printing industry, news of improvement in the medical profession is available to any doctor in the country. In addition to these advances, the quality of medical education has vastly improved. In 1906 there were 162 medical

especially medical innovations, is advancing at such a rate that rural physicians can no longer say they do not have access to the same technology as urban physicians.[109] Carstens & Pearmain make mention of "telemedicine" also known as "cybermedicine".[110] The two authors are of the opinion that this aspect will definitely have an influence on the application of the Locality Rule but to what extent will only become known in time. In saying this they however also note that the use of the Rule will only become futile if both rural and urban physicians (therefore physicians all over the country in both the public and private health care sectors) have uniform access to these telecommunication forms and facilities.[111]

6.6 Fear of Substandard Care and Skill

A fear created by the Locality Rule is that physicians would rather choose to practise in rural areas (public medical care facilities) than urban areas (private medical care facilities), as the standard of care and skill to which they are held is lower than in urban areas. The fear therefore exists that the physicians would

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schools in the United States. Nearly all of them were scantily equipped, had no hospitals, and few, if any, had expert teachers. The course of education then, was two annual sessions of six months each, with the general requirement for admission to school being a high school education. Realising that improvements in the training of doctors were desperately needed, committees were formed which investigated the schools. In 1910 a comprehensive study was published which classed the schools according to degree of excellence as either A, B, or C. With this publication many of the schools, out of embarrassment or disgrace, were forced to either terminate activities or merge with a class A school. In 1923 there were only 80 medical schools, and these were far advanced from any of those of 1906. The size of medical endowments had increased, new buildings and better laboratories were constructed, and better trained teachers, with more efficient methods of instruction, were attracted".

[109] Carstens & Pearmain (2007) 637; Gibson (1983) *Arkansas Law Review* 165.

[110] This is known as the increase in use of things such as the internet, emails and other well-known telecommunication forms.

[111] Carstens & Pearmain (2007) 638; Bach (1981) *GMU Law Review* 107 – Bach explains that even though the development and implementation of technology in the medical profession might be on the rise - a "time lag" exists. He explains this "time lag" by stating that this newly developed technology is not readily available in all communities. He further explains that the same goes for a new medical technique – practitioners are not immediately schooled in the technique, it takes time and resources to be implemented.

establish a standard of care and skill in a particular community far below what is actually required or expected of them.[112]

6.7 Variations of the Locality Rule

Anderson mentions that the fact that different forms of the Rule are applied, is in itself problematic.[113] The fact that some states do not apply the Rule at all, while others apply a strict version in contrast to states that apply a more lenient one, creates confusion and inconsistencies which is a disadvantage for the implementation of the Rule.[114] The Rule therefore has no uniformity in its application in America due to some states abandoning the Rule and others adopting either the strict version thereof or a lenient one - which is viewed as another argument against the implementation of the Rule.[115]

Ginsberg explains that (in America specifically) when a court rejects the implementation of the Locality Rule the following notions are used to back its decision: the Rule minimises the number of qualified experts,[116] and/or modern medicine does not allow for the Rule or the national standard makes the application of the Rule ineffective.[117] These observations clearly summarise the discussion above.

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[112] Baldauf (1969) *Cleveland State Law Review* 493-494; 497; Michaud & Hutton (1981) *TULSA Law Journal* 722.

[113] Anderson (1969) *South Dakota Law Review* 356.

[114] *Ibid* – "… maintaining the rule will also yield an increased number of inconsistent interpretations and applications of the locality rule…"; Stewart (1969) *California Western Law Review* 130; Schlender (2008) *Idaho Law Review* 368 – "It is also extremely difficult to determine which communities are actually similar".

[115] The application of the Rule in the various states in America is discussed later on in this chapter.

[116] See Waltz (1969) *De Paul Law Review* 420 as well.

[117] Ginsberg (2013) *Drake Law Review* 370.

7 Application of the Locality Rule

7.1 Application in Modern American Law

It must be noted that times have changed and the medical conditions available in America have improved since the initial development and origin of the Locality Rule. In some states in America, the Rule has however remained, or at least variations of it, indicating its stubbornness and the clear need that still exists for this principle.[118]

Today the Locality Rule lives on in various forms but it is however only applied in six American states.[119] These states include New York, Arizona, Idaho, Virginia, Tennessee and Washington.[120] What proves interesting is the fact that these six states all apply the strict form of the Locality Rule, namely the "*same location*" rule.[121] The rest of the states in America apply the national standard of care when it comes to medical negligence suits and have therefore completely abandoned the Locality Rule.[122]

In New York, the Rule originated in *Pike v. Honsinger*.[123] Although the existence and application of the Rule was disputed in *Riley v. Wieman*,[124] the Court of Appeals of New York[125] in 2002 reiterated the importance of the "*Pike* Locality Rule" hence the continued existence of the Locality Rule in New York. In Arizona the Rule is statutory based and found in section 12.563 of the Arizona Revised Code.[126] The Rule is encapsulated in two statutes in Idaho, namely Idaho Code 6-

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[118] Smerge (1968) *De Paul Law Review* 331.

[119] MedScape "The Verdict is in – The Locality Rule" Tony Francis 2013. http://boards.medscape.com/forums/?128@@.2a57045b!comment=1 Accessed 25 November 2015; Ginsberg (2013) *Drake Law Review* 333.

[120] *Ibid*.

[121] Ginsberg (2013) *Drake Law Review* 333.

[122] See the discussion of Willis CJ "Establishing Standards of Care: Locality Rules or National Standards" (2009) *American Academy of Orthopaedic Surgeons Journal*.

[123] 49 N. E. 760 (1898) – See Ginsberg (2013) *Drake Law Review* 348.

[124] 528 N.Y.S.2d 925, 928 (App. Div. 1988).

[125] In *Nestorowich v. Riccotta*, 767 N. E.2d 125, 128 (N.Y. 2002).

[126] See Ginsberg (2013) *Drake Law Review* 353-354.

1012[127] and Idaho Code 6-1013.[128] In Virginia the Locality Rule can be found in the Virginia Code in section 8.01-581.20.[129] In Tennessee the Rule is found in statutory form in the Tennessee Code, section 29-26-115 (a)-(b) (2012).[130] Finally, the Locality Rule in Washington is captured in section 7.70.040 of the Washington Revised Code.[131]

7.2 Application in English Law

In the American case of *Pederson*[132] (discussed above) the Court observed that the Rule had never been suggested or applied in English law, and that a uniform standard of care is applied in England.[133] Lord Nathan indicates that if the Rule were to be suggested in English law, the suggestion would be rejected by the courts.[134] The reason being that it would mean that the standard of care would not be uniformly applied throughout the country.[135] No trace of the application of the Rule in English law could be discovered in my research and it is therefore concluded that the Rule has never surfaced in English law – and most probably never will.

7.3 Application in South African Law

No provision for the Locality Rule is made in South African medical law, which is why it is suggested in this dissertation that it be recognised. The only mention of the Rule featured in a 1924 case (which will be thoroughly discussed in the final

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[127] *Id*. 335 - Proof of Community Standard of Health Care Practice.

[128] *Ibid* - Testimony of Expert Witness on Community Standard.

[129] *Id*. 349-350.

[130] *Id*. 343.

[131] *Id*. 353-354.

[132] 431 P.2d 973 (Wash. 1967).

[133] Anderson (1969) *South Dakota Law Review* 352.

[134] Nathan (1957) 21.

[135] See Bowden (1972) *Kentucky Law Journal* 210; Flemming JG "Developments in the English Law of Medical Liability" (1959) *Vanderbilt Law Review* 640-641; Nathan (1957) 21; Karlson HC & Erwin RD "Medical Malpractice: Informed Consent to the Locality Rule" (1979) *Indiana Law Review* 688.

chapter to this dissertation) in which the Rule was both praised and completely rejected in the same judgment.[136] Currently, because of the failure to implement the Rule, both public health care and private health care physicians are painted with the same brush. Even though it is clear that quality of health care in the public sphere cannot be equated to that of the private sphere, public health care physicians are unfairly treated and assessed on the same level as private health care physicians because South Africa is living under a false belief of equal access to health care throughout the geographical boundaries of the country.

Cognisance must be taken of the fact that this dissertation does not suggest that the Locality Rule must be employed in South Africa because it will transform section 27 of the Constitution to provide access to *equal* health care, and not mere access to health care as it currently does. The application of this doctrine is suggested for South Africa, based on the fact that we do not have equal access to health care, therefore we cannot test all doctors against the same standard of care and skill. The facilities and working environment for public health care physicians differ drastically for that of private health care physicians. The Locality Rule would therefore ensure that the conduct of physicians are tested against the surrounding circumstances of the case, instead of a national standard as is used in England and as advocated for in most states in America.

7.4 Analysis of the Chosen Jurisdictions

In terms of application of the Rule in the three chosen jurisdictions for this comparative study the following summative observations can be made: In America the Rule is applied inconsistently (with no uniformity) throughout the country, which resulted in the Rule being adopted and implemented in various forms in some states and abrogated completely in many other. With regards to England, no authority could be found for the implementation or suggestion of the Rule. The only mention of the Rule in English law that was discovered illustrated the fact that the Locality Rule has never been suggested in English courts and will never be adopted as the standard of health care in England is viewed to be uniform.[137] In

[136] *Van Wyk v Lewis* 1924 AD 438.

[137] Nathan (1957) 21.

terms of our own jurisdiction it was found that in 1924[138] mention was made of the Rule but that it does not find application in the South African medical law, which results in the unfair treatment and assessment of public health care physicians in comparison to private health care ones.

8 Locality Rule versus National Standard of Care

The Locality Rule is a doctrine unique to American law.[139] From the discussion above it is clear that the Rule originated in America and has thereafter either been modified or rejected completely in most American states.[140] The result of the abandonment of the Rule by some of these states is what we find in the *Brune* case,[141] namely a national standard when it comes to specialists[142] and for general practitioners a state-based standard.[143] Most courts refer to the "national standard of care" as the "specialty standard of care" which rejects geographical boundaries as influencing the standard of care and skill exercised by or expected from the physician in favour of "professional proficiency".[144]

One of the points of criticism (as mentioned earlier) raised against the Locality Rule is that it is applied in various forms and therefore creates confusion because its content is not uniform across the country. This is however true for the national

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[138] *Van Wyk v Lewis* 1924 AD 438.

[139] Bowden (1972) *Kentucky Law Journal* 210.

[140] It is interesting to note that a doctrine that had so much influence since the 1900s not only originated in America, but also never found application elsewhere – especially in English law.

[141] 235 N.E.2d 793 (Mass. 1968).

[142] Shandell RE, Smith P & Schulman FA, 'Securing the Expert' in *The Preparation and Trial of Medical Malpractice Cases* (Law Journal Press 1990) 7-18; MedScape "The Verdict is in – The Locality Rule" Tony Francis 2013. http://boards.medscape.com/forums/?128@@.2a57045b!comment=1 Accessed 25 November 2015.

[143] Danzon (1985) 144.

[144] Michaud & Hutton (1981) *TULSA Law Journal* 730.

standard as well – even though this standard is suggested as a solution to the Locality Rule.[145] Michaud and Hutton state:

> The national standard of care has been applied throughout the country in a non-uniform manner. Several courts have followed the lead of the medical profession and have established a national standard of care for all physicians, completely abandoning any locality limitations. Other courts limit the application of the national standard to specialists. The Court of Appeals for the District of Columbia has further restricted national specialty standards to board certified specialists.[146]

From the above quotation it is clear that the national standard of care also fails to be applied uniformly throughout the country and therefore disappoints in correcting the Locality Rule, as initially envisaged. Karlson & Erwin argue that the goal in America is for the overall improvement in health care and therefore the level of practice itself.[147] If this is the goal then it is unclear why the goal would be achieved by increasing the standard to which these physicians are held to in areas where they are performing to the best of their abilities, taking into account the surrounding circumstances and lack of facilities and resources available to them.[148] The means therefore does not justify the end.

9 Conclusion

As stated in this chapter, the most common argument against the use or implementation of the Locality Rule is the fact that technology, communication and medicine are improving. The gap between public and private health care is allegedly diminishing as a result of these advances.[149] The main purpose of the Locality Rule is to have different standards of care against which a physician's conduct is measured, based on his or her locality of practice. The argument

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[145] Michaud & Hutton (1981) *TULSA Law Journal* 731-732.

[146] *Ibid*.

[147] Karlson & Erwin (1979) *Indiana Law Review* 666.

[148] *Ibid* - "In summary, there is probably much to be lost and little to be gained by adopting a national or state standard. Those who favor abandonment of the similar locality rule have lost sight of the reason for the rule and how it developed".

[149] Best & Barnes (2007) 431.

against the use of the Locality Rule - based on the advancement of medicine - however proposes that the working circumstances for each physician is the same or at least similar and therefore no need exists for the implementation of this Rule. This argument definitely carries weight when it comes to some countries and therefore this argument might be well-founded for a country such as America or England, but in a developing country such as South Africa this is the sought after dream in medicine – *not* the reality. Newly developed medical technology is available in South Africa but the difference between South Africa and England, or America, for example, is the fact that these new innovations are not equally accessible throughout the geographical boundaries of South Africa, whereas this is true for England and most states in America.

This chapter might have proven to be a bit confusing, as it provides more arguments against the implementation of the Rule, than arguments for it, but what has to be remembered is that the Locality Rule originated in America and the fact that there is an advancement in technology and uniformity in resources and medical training in America does *not* make it a reality for all countries. The health-care status of South Africa cannot be equated to that of America or England which is why the Locality Rule needs to be implemented in South Africa, until such a time that we can say we no longer only have access to health care,[150] but access to *equal* health care in the public and private sphere.

South Africa is aiming for uniformity of health care whereas America and England claims to already have achieved this status. The question becomes, how then can a Rule that assisted America in ensuring the fairness of standard of care when resources, training and technology was still lacking not be considered for a country that still finds itself in this situation? I reiterate the observation made by Gordon in this regard: “The point is that a practitioner, wherever he may be, cannot be expected to perform miracles, or to make bricks without straw.”[151]

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[150] Section 27 of the Constitution of the Republic of South Africa, 1996.

[151] Gordon *et al* (1953) 113.

Chapter 4

Medical Negligence: Comparing the Three Jurisdictions

Overview

The premise of this dissertation is that the implementation of the Locality Rule in South Africa will ensure that cognisance is taken of the surrounding circumstances and lack of various resources in the different geographical areas of South Africa and ultimately that medical negligence must be analysed based on these factors and not on the actions of the accused physician alone (except if his actions single-handedly led to the medical negligence that occurred). Medical negligence in South Africa entails a reasonable person test, more specifically a reasonable expert test which takes into account the expertise of the medical physician. The importance of this chapter lies in the fact that it does not discredit the use of the reasonable expert test in the assessment of medical negligence but rather suggests that the Locality Rule must accompany the reasonable expert test in the assessment of medical negligence due to the inconsistency in medical resources, training and infrastructure in the public and private health care sectors.

1 Introduction

This chapter focuses on medical negligence by comparing it in the three jurisdictions chosen for this dissertation. The chapter embarks on providing an overview of the history of medical negligence and the liability of the physician. The discussion on medical negligence focuses on explaining how these types of claims are approached by the courts, the damages awarded in such a claim, as well as the consequences for the physician who is found liable in a medical negligence lawsuit. The aforementioned is done in light of the three chosen jurisdictions,

namely South African, English and American law. The focus of this chapter is also on the case law, relating to medical negligence in the respective jurisdictions.

The aim of this chapter is to determine whether or not a claim for medical negligence differs substantially within the three jurisdictions or whether the principles of medical negligence in these jurisdictions are in fact similar. In the premise that a claim for medical negligence is comparable in South Africa, America and England, the application of the Locality Rule in South African medical law will be more comprehensive and the reason for selecting these jurisdictions for the comparative study will be evident.

2 The Origin of the Liability of the Physician for Medical Negligence

In order to better understand the concept of medical negligence and a medical negligence claim, the concepts' origin must first be traced. This part of the dissertation traces the development of the physician's liability from Egypt to Greece to the Roman Empire.

The earliest written form of medicine can be traced to the papyri in Egypt as long ago as 3000 BC.[1] The Smith Papyrus[2] and the Ebers Papyrus[3] were the most important medical texts in Egypt.[4] The right to become a physician was reserved for a certain class of people and anyone from this class interested in practising medicine had to study ancient books containing teachings laid down and captured in writing by their predecessors.[5] An important factor regarding ancient Egyptian medicine and the practise thereof is the fact that the Egyptians believed that health was not only affected by earthly surroundings but, more importantly, by

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[1] Porter R *The Greatest Benefit to Mankind: A Medical History of Humanity from Antiquity to the Present* (London: Fontana Press 1999) 47.

[2] It consisted mainly of surgical principles and methodology.

[3] It dealt mainly with specific diseases and herbal cures.

[4] *Id*. 47-48; Smith S "The History and Development of Legal Medicine" in *Legal Medicine* by Gradwohl RBH (Scotland 1954) 2.

[5] *Ibid*.

supernatural forces.[6] The link between religion and medicine was therefore evident.[7] The principle existed that if you practised medicine based on religious concepts and standard practises you were free from liability for negligence, however, if you followed alternative practices not based on religion and standard methods and negligence occurred, you were held liable for your actions.[8] The Code of Hammurabi in 2030 BC referred to the concept of medical negligence and more specifically the liability of a physician whose actions resulted in the death or harm of the patient.[9] The consequences hereof resulted in the cutting off of the physician's hand.[10]

Healing and medicine in Greece was also based more on religion than knowledge and the competence of the physician to treat the patient. The Greeks however followed a more realistic and scientific approach to medicine than the Egyptians.[11] The extent to which the Greeks relied on the medical findings and practices of the

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[6] *Id*. 49 – "… in particular evil spirits stealing into the body through the orifices…Health was associated with correct living, being at peace with the gods, spirits and dead; illness was a matter of imbalance which could be restored to equilibrium by supplication, spells and rituals".

[7] "The healer's ability was based less on his competence to treat and heal than on his ability to communicate with the gods through visions and dreams" – see: Healy J *Medical Negligence: Common Law Perspectives* (London: Sweet & Maxwell 1998) 8.

[8] Amundsen DW "The Liability of the Physician in Roman Law" in *International Symposium on Society, Medicine and Law* by Karplus H (ed) (Amsterdam: Elsevier 1973) 17 – "A physician-priest who, following the established methods of treatment, failed to save his patient was free from any guilt; however, one using heterodox methods was subject to capital punishment if his patient should die". It can further be mentioned that this view was also followed in China in 1647: "…[T]he physician who practiced contrary to established procedure, and lost his patient, was permanently barred from the profession unless intentional homicide was proved, in which case the physician was beheaded".

[9] *Id*. 18 – A physician practicing in Spain was also protected against negligence, however if the actions of the physician resulted in the death of his/her patient the physician would lose his compensation.

[10] *Id*. 17 - "If the doctor has treated a gentlemen with a lancet of bronze and has caused the gentleman to die, or has opened an abscess of the eye for a gentleman with a bronze lancet, and has caused the loss of the gentleman's eye, one shall cut off his hands".

[11] Healy (1998) 8; Gradwohl *Legal Medicine* (1954) 1,4; Porter (1999) 33 – "Since sickness raise profound anxieties, medicine develops alongside religion, magic and social ritual".

Egyptians is unknown[12] but what is clear from the Greeks is the fact that medicine was based more on natural philosophy, and through this, the Greeks criticised the supernatural view the Egyptians had towards medicine and healing.[13] Plato and Aristotle, for example, had quite a lot to say about the competence of the medical physician during that time.[14] Plato wrote that a physician not only requires the knowledge of how to administer drugs but also the knowledge of when and in which circumstances the drugs must be administered.[15] Aristotle reaffirms the writings of Plato in saying that:

> Even in medicine, though it is easy to know what honey, wine and hellebore, cautery and surgery are, to know how and to whom and when to apply them so as to effect a cure is no less an undertaking than to be a physician.[16]

The Greek model of medicine and the liability of the physician quickly spread throughout the Mediterranean, but Rome, being as stubborn as it was, wanted nothing of this model.[17] Rome, during this time, did not believe in physicians and held the view that healing should occur within the family itself, therefore through the *paterfamilias*.[18] From this view it was evident that anyone could hold himself out as being a physician.[19] It was during the early Empire that healing through a physician was first recognised in Rome.[20] Medicine was based on the Greek model but more extensive and progressive.[21] The main difference between Greece and Rome was the fact that the physician was seen by the Romans as an aid to the patient, attending to his or her every need in healing him or her, as opposed to

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[12] *Id*. 50; A common factor between the Egyptians and Greeks was the fact that both of them instituted categories of medical practitioners, therefore the development of specialists medical practitioners – see: Healy (1998) 8.

[13] *Id*. 53 "[T]he Hippocratic doctors scolded the traditional healers".

[14] Amundsen (1977) *Journal of the History of Medicine and Allied Sciences* 183.

[15] See: *Ibid*; Plato *Phaedrus* 268 A-C.

[16] See: *Ibid*; Aristotle *Nicomachean Ethics* 1137a.

[17] Porter (1999) 69.

[18] *Ibid* – Roman writers such as Cato (234 – 149 BC) held the following: "Beware of doctors, they would bring death by medicine".

[19] Amundsen *International Symposium on Society, Medicine and Law* (1973) 20.

[20] Porter (1999) 70.

[21] Gradwohl *Legal Medicine* (1954) 5.

someone who made contact with the gods in order to ensure healing.[22] Zietsman traces the concept of the liability of the physician in Roman law.[23] He first makes a reference to Ulpian concerning the administering of drugs:

> If she administered it with her own hands, she is held to have slain killed (*occidisse*), but if she gave it for the woman to take herself, an action in factum should be given.[24]

He also refers to Justinian regarding the standard of care and skill that is required from a physician:

> Whether a doctor is being held to a higher duty of care because he is a doctor, or because he is offering medical treatment does not make any difference – his carelessness amounts to *imperitia* (lack of skill) which Justinian regards as negligence in terms of the *Lex Aquilia*.[25]

From the above it is evident that the idea of medicine as well as the need and the value of the physician was already realised in ancient Egypt but that the concept itself has undergone extensive development from being directly linked to religion and the supernatural to a more realistic and patient-orientated approach.[26]

The current doctor-patient relationship needs to be discussed in order to better understand this development of medicine from a pure religious approach to a more patient-oriented one.

3 The Doctor-Patient Relationship

3.1 Introductory Remarks

It is important to realise that if we seek to change and improve the quality of health care in South Africa, obtaining the patient's perspective on health care and, more

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[22] Porter (1999) 82.

[23] Zietsman J C. "Medical Negligence in Ancient Legal Codes" (2007) *Akroterion* 90.

[24] See Digest 9.2.7.8. in Zietsman (2007) *Akroterion* 91.

[25] See Inst. 4.3.7. in Zietsman (2007) *Akroterion* 92.

[26] The relationship between the doctor and patient will be discussed in detail in Chapter 4 of this dissertation, tracing the development and transformation thereof.

importantly recognising the rights of patients, is a good start.[27] This is why the doctor-patient relationship is of cardinal importance. As soon as a physician accepts the responsibility to care for a patient this relationship takes effect.[28] This relationship is established based on the law of obligations founded in contract or delict.[29]

Realising the rights of a patient entails that the doctor-patient relationship does not constitute a one-way street. Due to the recent shift in the relationship, as discussed hereafter, corresponding duties exists in this relationship; therefore duties are imposed on both the physician and his or her patient.[30] The main duty imposed on the physician is to care and attend to the patient while the main duty imposed on the patient by this relationship is to provide the physician with as much information as possible to enable the physician to adequately diagnose the patient.[31] An additional duty on the patient that arises from this relationship is that the patient

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[27] Phaswana-Mafuya N, Peltzer K, Stevenson Davids A "Patients' Perceptions of Primary Health Care Services in the Eastern Cape, South Africa" (2011) *African Journal for Physical, Health Education, Recreation and Dance* 502-503; Annas GJ & Healy, Jr JM "The Patient Rights Advocate: Redefining the Doctor-Patient Relationship in the Hospital Context" (1974) *Vanderbilt Law Review* 248, 268 – "Patients have rights as citizens that they do not forfeit when they become sick and enter a health care institution".

[28] Kratz M "The Doctor-Patient Relationship" (1984) *Resource News* 5.

[29] Carstens PA & Pearmain D *Foundational Principles of South African Medical Law* (Durban: LexisNexis 2007) 283; Strauss SA & Strydom MJ *Die Suid-Afrikaanse Geneeskundige Reg* (Suid Afrika: Van Schaik 1967) 104; Slabbert MN *Medical Law in South Africa* (Kluwer Law International 2011) 69; Oosthuizen WT (2014) *An Analysis of Healthcare and Malpractice Liability Reform: Aligning Proposals to Improve Quality of Care and Patient Safety* LLM Dissertation University of Pretoria 43.

[30] Kratz (1984) *Resource News* 6; Oosthuizen (2014) 50 – 67 - Oosthuizen discusses the duties of the physician to be: "The duty to treat the patient, the duty to attend to the patient once treatment has begun, the duty to obtain the patient's consent, the duty to inform the patient and the doctor's duty to exercise due care and skill".

[31] *Ibid*.

must adhere to the instructions given by the physician.[32] Kratz sums this relationship up by saying:

> The essence of the doctor-patient relationship is summed up by the word "relationship". It is an arrangement whereby the patient and the doctor assume certain obligations toward each other to work together in maintaining the patient's health.[33]

3.2 Shift in the Relationship

There has however been a tremendous shift in this relationship in comparison to its original form.[34] The doctor-patient relationship in its original form was based on paternalism.[35] This entails that a layperson has limited or no knowledge of medicine, hence he or she literally places their life in the hands of the doctor,[36] which entails that the physician is the only one who can make an informed decision

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[32] *Ibid* – It must be mentioned that due to the development of the relationship this duty is seen slightly different today. The patient is no longer obliged to follow the instructions of the physician, but makes his/her own informed (by the physician) decision regarding his/her own care.

[33] *Ibid*.

[34] Teff H, 'Involving the Law' in *Reasonable Care: Legal Perspectives on the Doctor-Patient Relationship* (Oxford: Clarendon 1994) 29; Medical Protection "The End of Paternalism". Date unknown http://www.medicalprotection.org/uk/advice-booklets/mps-guide-to-ethics---a-map-for-the-moral-maze/chapter-1---ethics-values-and-the-law/the-end-of-paternalism Accessed 9 December 2015; Michael Kirby had the following to say about paternalism in 1983 already: "The days of paternalistic medicine are numbered .The days of unquestioning trust of the patient also appear to be numbered. The days of complete and general consent to anything a doctor cared to do is also numbered" – see Kirby M "Informed Consent: What does it Mean?" (1983) JME in Giesen D "Vindicating the Patient's Rights: A Comparative Perspective" (1993) *Journal of Contemporary Health Law and Policy*; Annas & Healy (1974) *Vanderbilt Law Review* 251.

[35] Paternalism is defined as: "[T]he usurpation of decision-making power, by preventing people from doing what they have decided, interfering in how they arrive at their decisions, or at- tempting to substitute one's judgment for theirs, expressly for the purpose of promoting their welfare" - See Buchanan DR "Autonomy, Paternalism and Justice: Ethical Priorities in Public Health" (2008) *American Journal of Public Health* 16.

[36] Medical Protection "The End of Paternalism". Date unknown http://www.medicalprotection.org/uk/advice-booklets/mps-guide-to-ethics---a-map-for-the-moral-maze/chapter-1---ethics-values-and-the-law/the-end-of-paternalism Accessed 9 December 2015.

regarding what treatment is harmful or beneficial to the patient.[37] We are however moving away from "only-the-doctor-knows" because the concept of "patient autonomy" is becoming more prominent.[38] This entails that the power dynamics in the relationship have evolved. No longer is the patient trapped in an unequal power relationship where the physician makes the decisions and the patient is unable to exercise his or her rights.[39] Suddenly the patient must consent to the procedure and the consent has to be informed consent - meaning the physician must explained the entire procedure, with the advantages and disadvantages, to the patient and the decision whether or not to continue with the procedure lies in the hands of the patient. The main reason behind this shift lies in the recent focus on ethics and human rights.[40]

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[37] Burcher P "The Patient-Doctor Relationship: Where are we Now?" (2015) *University of Toledo Law Review* 584; Annas & Healy (1974) *Vanderbilt Law Review* 251 – the physician takes the responsibility of making any and all major decisions linked to the health care of the patient.

[38] Siegler M, Dudley Goldblatt A, 'Clinical Intuition: A Procedure for Balancing the Rights of Patients and the Responsibilities of Physicians in Spicker SF, Healey JM & Engelhardt HT (eds) *The Law – Medicine Relation: A Philosophical Exploration* (London: D Reidel Publishing Company 1981) 5-9; Herring J, 'Ethics and Medical Law' in *Medical Law and Ethics* (Oxford University Press 2008) 1; Annas & Healy (1974) *Vanderbilt Law Review* 251 – Annas & Healy explain that the original (traditional) doctor-patient relationship as we know it takes the fact that "doctor knows best" completely for granted; See in this regard specifically s 12 of the Constitution, Labuschagne & Carstens explains that s 12(2)(b) "supports and promotes the principle of patient autonomy". This is achieved because of the fact that this section provides "security", coupled with "control over one's body" – See Labuschagne D & Carstens PA "The Constitutional Influence on Organ Transplants with Specific Reference to Organ Procurement" (2014) *Potchefstroom Electronic Law Journal* 230.

[39] Goodwin & Richardson explains that Gatter illustrates this relationship to be a vertical one, where the physician is holding the top position and is awarded "disproportionate power" – see Goodwin M & Song Richardson L "Patient Negligence" (2009) *Law and Contemporary Problems* 241.

[40] Hall explains that society is moving away from this "parent-child relationship" that doctors used to have with their patients – see Hall H, Science- Based Medicine "Paternalism Revisited" (2008) https://www.sciencebasedmedicine.org/paternalism-revisited/ Accessed 9 December 2015; Burcher (2015) *University of Toledo Law Review* 584 – he explains that the reason for the term "paternalism" comes from this parent-child-like relationship Hall also talks about.

In order to better understand the shift in the doctor-patient relationship, the term "patient autonomy"[41] needs to be analysed. This term means that patients should be allowed to question the decisions of the physicians and be allowed make informed decisions regarding their own health, based on their rights and also the treatment available to them.[42] As indicated above, the focus is more on the "relationship" now as Kratz argues and therefore there exists an element of shared decision-making among the doctor and patient. The patient is now seen as an "autonomous being" entitled to be fully informed by the physician prior to making the final decision regarding a procedure.[43]

This shift to patient autonomy, away from paternalism, is however not without its shortcomings. Healy explains:

> Under the Hippocratic Oath, physicians swore by Apollo and by Aesculapius to do good and to avoid harm – otherwise known as the ethical principles of *beneficence* and *non-maleficence* – but also to keep secret and never revel all that may come to be known in the exercise of the profession.[44]

The shift away from paternalism was a big accomplishment for the patient, as it empowers the patient to be in control of decision making with regards to his or her health and therefore reaffirms the patient's right to self-determination.[45] The questions that arise when it comes to patient autonomy are: How far does it go? When can the doctor intervene in the decision-making process while at the same time respecting the rights and wishes of the patient? When does the expertise of the physician trump patient autonomy?

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[41] "Autonomy" is defined by Dworkin as "self-rule" – see Dworkin RB "Getting what we should from Doctors: Rethinking Patient Autonomy and the Doctor-Patient Relationship" (2003) *Health Matrix* 238.

[42] Medical Protection "The End of Paternalism". Date unknown http://www.medicalprotection.org/uk/advice-booklets/mps-guide-to-ethics---a-map-for-the-moral-maze/chapter-1---ethics-values-and-the-law/the-end-of-paternalism Accessed 9 December 2015.

[43] Van Dokkum N "The Evolution of Medical Practice Law in South Africa" (1997) *Journal of African Law* 175.

[44] Healy (1998) 9.

[45] Annas & Healy (1974) *Vanderbilt Law Review* 269*; See also section 12(2)(b) of the Constitution.*

4 Medical Negligence versus Medical Malpractice

Fault occurs in two forms, namely intention and negligence. The main difference between intent and negligence is that intent amounts to a state of mind whereas negligence is a form of behaviour.[46] The form of fault that the judiciary is most often confronted with in medical lawsuits is that of negligence.[47] It is therefore very important to distinguish the term "medical malpractice" from "medical negligence" as these terms are often conflated or confused with one another.[48]

The term "medical malpractice" is much broader than "medical negligence" as it provides for both forms of fault, namely intentional and negligent commissions or omissions[49] by the medical physician.[50] As the term itself indicates, "medical negligence" is limited to the negligent omissions and commissions of the physician measured in an objective sense.[51] In South Africa we mainly speak of medical negligence but in American and English law the term medical malpractice is used more often. The terms should however not be used synonymously, as the one has a much wider application than the other.

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[46] McQuoid-Mason D "What Constitutes Medical Negligence? – A Current Perspective on Negligence versus Malpractice" (2010) *South African Heart Journal* 248.

[47] It is important to remember that fault is an element of a delict which can present itself in one of two forms, namely *culpa* (negligence) or *dolus* (intention). According to Carstens & Pearmain the most common form in health care services is that of *culpa* - see Carstens & Pearmain (2007) 522; *Mitchell v Dixon* 1914 AD 519; *Webb v Isaac* 1915 EDL 273; *Lymberie v Jefferies* 1925 AD 236; *Prowse v Kaplan* 1933 EDL 257; *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T); *Blyth v Van den Heever* 1980 (1) SA 191 (A); *S v Kramer* 1987 (1) SA 877 (W); *Pringle v Administrator, Transvaal* 1990 (2) SA 379 (W); *Castell v De Greef* 1993 (3) SA 501 (C); *Collins v Administrator, Cape* 1995 (4) SA 73 (C); *Michael v Linksfield Park Clinic (Pty) Ltd* 2001 (3) SA 1188 (SCA) – just to name a few.

[48] Healy (1998) 39.

[49] Omissions and commissions.

[50] McQuoid-Mason (2010) *South African Heart Journal* 248.

[51] Healy (1998) 39 – "Medical malpractice is now largely synonymous with the medical negligence action, though it may be taken to cover the much fewer cases of intentional trespass to the person or assault and battery on patients…"; See Van Dokkum discussion on forms of medical negligence, for example misdiagnosis or negligence in an operation - Van Dokkum (1997) *Journal of African Law* 181.

5 An Increase in Medical Negligence Claims?

Unfortunately for the medical industry, but fortunately for society, medical negligence claims are on the rise and are thus becoming a frequent phenomenon.[52] Chris Bateman sums the situation up by saying:

> A combination of patient-claims litigators becoming smarter, fast evolving (and expensive) medical technology and growing patient awareness has sent the cost of reported negligence claims soaring by 132% in South Africa over the past two years.[53]

The Medical Protection Society (MPS)[54] reported that in the period 2010/2011 the reported medical negligence claims have more than doubled,[55] while claims adding up to R1 million or more have increased by a staggering percentage of 550%. Claims exceeding R5 million have soared by 900% and in the year 2011 the MPS settled its highest claim in South Africa to date, namely R24 million.[56] The HPCSA reported that in the period between April 2008 and March 2009 roughly 90 doctors

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[52] Ficarra BJ *Surgical and Allied Malpractice* (USA: Thomas Books 1968) 55; Howarth G *et al* "Public Somnambulism: A General Lack of Awareness of the Consequences of Increasing Medical Negligence Litigation" (2014) *South African Medical Journal* 752; Medical Chronicle "Medical Litigation: A National Health Crisis Requiring Urgent Solutions" 2011. http://www.medicalchronicle.co.za/medical-litigation-a-national-health-crisis-requiring-urgent-solutions/ Accessed 7 October 2015; 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* 29 – "…[t]he country may be on the verge of a medical malpractice litigation 'storm', as the number and size of claims appear to be increasing rapidly'.

[53] Bateman C "Medical Negligence Pay-Outs Soar by 132% - Subs Follow" (2011) *South African Medical Journal* 216 – Take note that the time period he refers to is 2010 and 2011.

[54] The MPS is the biggest protection organisation of health and health care in the world, specialising in protecting not only medical and health care professionals, but also the dental industry.

[55] Malherbe J "Counting the Cost: The Consequence of Increased Medical Malpractice Litigation in SA" (2013) *South African Medical Journal* 83; Medical Chronicle http://www.medicalchronicle.co.za/medical-litigation-a-national-health-crisis-requiring-urgent-solutions/.

[56] Malherbe J (2013) *South African Medical Journal* 83; "Medical Negligence Claims & Compensation in South Africa" Claim Help. Date unknown. http://www.claimhelp.co.za/medical-negligence/ Accessed 29 September 2015.

were investigated and found guilty by the Council of unprofessional conduct[57] and that since the year 2005 until 2010, 44 doctors have been struck from the roll due to either unprofessional or unethical conduct.[58] After considering the aforementioned statistics, can the question of whether South Africa is in fact facing a medical negligence crisis still be left unanswered?[59] South African Health Minister Aaron Motsoaledi believes otherwise. In March 2015 he said the following:

> South Africa is experiencing an explosion in medical malpractice litigation in the public and private sector.[60]

When looking at the English and American legal systems the increase in medical malpractice litigation is also evident. Unfortunately it is said that America is already facing its third medical malpractice litigation crisis[61] and therefore this is not a new phenomenon for America,[62] as can be said for South Africa.[63] America is known as

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[57] Including: misdiagnosis, overcharging, charging services that were not delivered, refusing to treat patients, etc.

[58] Naidoo S, Sunday Times, "Thousands of Doctors 'Negligent'". 2010. http://www.timeslive.co.za/sundaytimes/2010/06/06/thousands-of-doctors-negligent Accessed 7 October 2015; Pepper & Nöthling Slabbert (2011) *South African Journal of Bioethics and Law* 29.

[59] An interesting factor that must be mentioned is how can we say we do not have a medical malpractice crisis/storm in South Africa, when the increase in these cases have led to an increase in the cost of insurance for physicians? The example given by Child in her article is the staggering amount a gynaecologist must pay for insurance, which can be up to R300 000.00 per year – this in turn results in the increase of patient costs and causes this profession to be unsustainable – see Child K, The Times Live "Hospital Horrors Costing SA Plenty" 2014. www.timeslive.co.za/news/2014/01/17/hospital-horrors-costing-sa-plenty Accessed 8 October 2015.

[60] News24, Health24, "SA's Shocking Medical Malpractice Crisis". March 2015. http://www.health24.com/News/Public-Health/SAs-shocking-medical-malpractice-crisis-20150309 Accessed 12 October 2015 - ""The nature of the crisis is that our country is experiencing a very sharp increase - actually an explosion in medical malpractice litigation - which is not in keeping with generally known trends of negligence or malpractice"; Van Dokkum (1997) *Journal of African Law* 177.

[61] Bal BS "An Introduction to Medical Malpractice in the United States" (2009) *Clinical Orthopaedics and Related Research* 339 – Medical malpractice lawsuits first arose with regularity in America in the 1800s, however since the 1960s these claims have increased to such an extent that they are now considered to be a common occurrence in the medical law world in America.

[62] By 1964 one out of every seven medical practitioners have already been part of some or other medical negligence law suit – hence why it can be said that America is the leader of the medical

the leading Western country in terms of medical-malpractice litigation and the highest occurrence of claims.[64] Ficarra explains that the reason for the "malpractice epidemic" - as he calls it - is that "the general public is lawsuit-conscious".[65]

England, on the other hand, is taking a different stance. While the South African Health Minister openly admits that we are clearly facing a medical malpractice (negligence) litigation crisis and America is declaring their third crisis, England takes the stance that even though medical malpractice claims are increasing, the problem is inflated by declaring it a "crisis", as such.[66] New discoveries in medical technology and the testing of new cures and equipment will automatically lead to an increase in medical malpractice claims, as will the fact that the population increases and more diseases are discovered. This increase can however not lead to exaggerating the problem by declaring it a "crisis".[67] Before 1980 medical negligence actions were almost unheard of in England, say authors Kennedy & Grubb.[68] Since then there has been a clear indication of an increase in both the

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malpractice crisis – see: Strauss SA *Doctor, Patient and the Law: A Selection of Practical Issues* (South Africa: Van Schaik 1980) 301; Ficarra (1968) 55.

[63] Thorpe KE "The Medical Malpractice 'Crisis': Recent Trends and the Impact of State Tort Reforms" (2004) *Health Affairs* 20; ADMD Mavioglu & Alkan Law Office "Medical Malpractice: A Critique of the Turkish and American Approaches to Awarding Non-Economic Damages" Date Unknown. http://www.admdlaw.com/medical-malpractice-a-critique-of-the-turkish-and-american-approaches-to-awarding-non-economic-damages/#.VjccnZExGFI Accessed 2 November 2015; It will be ludicrous to compare the medical negligence crisis to that of the front runner, namely America, but that does not mean that South Africa is not facing a crisis as such. In South Africa this type of litigation is however on the rise – see: Strauss (1980) 301

[64] Van Dokkum (1997) *Journal of African Law* 177.

[65] Ficarra (1968) 55, 57; C Alvarez in *Modern Medicine* (1963) states: "Clever California lawyers sue not for the old-fashioned 5, 000 to 10, 000 dollars, but for 250, 000 to 750, 000 dollars" – see Ficarra (1968) 57.

[66] Herring (2010) 130; It must however be mentioned that quite a few English jurists agree to the rise in medical malpractice claims and have gone as far as to state on record that recently there has been an increase in this type of litigation – see: Strauss SA *Doctor, Patient and the Law: A Selection of Practical Issues* (South Africa: Van Schaik 1980) 295.

[67] Wheat K "Is there a Medical Malpractice Crisis in the UK?" (2005) *Journal of Law, Medicine and Ethics* 444.

[68] Kennedy I & Grubb A *Principles of Medical Law* (Oxford: Oxford University Press 1998) 284.

occurrence of cases as well as the cost associated with these cases.[69] The authors however caution against calling it a "crisis" as such since no concrete evidence exists to prove this increase.[70] The statistics in England however prove otherwise.[71] The National Health Services (NHS) Litigation Authority who is responsible for handling all claims reported that in the period between 2008 and 2009 roundabout £769 million went to clinical negligence claims, resulting in a staggering increase from £633 million in 2007/2008 and £432 million in 2003/2004.[72] The question remains whether or not England simply refuses to admit to the crisis by saying it would result in over-exaggeration of the state of affairs.

In order to better understand this crisis, it is important to assess the rules of a medical negligence claim.

6 Assessing Medical Negligence

6.1 Introductory Remarks

The main aim of this chapter is to compare a claim of medical negligence in South Africa, to such a claim in England and America. The following section therefore provides an overview of the concept of medical negligence and how it is assessed within the three chosen jurisdictions. The discussion firstly addresses the assessment (and therefore basic principles) of medical negligence in South Africa, thereafter England and finally conclude with America. The discussion regarding South Africa is substantiated with relevant medical negligence cases illustrating the

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[69] *Ibid*.

[70] *Ibid* – "Since… [1980] a significant upsurge and litigation has occurred and led some to argue that claims for medical negligence are now out of control, just as in the United States of America, and that litigation has reached 'crisis proportions'".

[71] Jones MA *Medical Negligence (3rd ed) (*London: Sweet and Maxwell 1991) – Jones explains that even though it is difficult to determine the exact amounts and numbers relating to medical malpractice actions, it can be said with certainty that in the last ten years these claims have increased. He goes on to say that from 1983 to 1987 alone, the actions have doubled.

[72] Herring (2010) 130.

application of such claims. The most important case regarding medical malpractice in England will also be addressed as this case laid the foundation for testing the standard of care of the physician.[73]

From the outset the basic principles must be laid down. For example the evidential burden rests on the plaintiff throughout the trial.[74] This evidential burden in a civil trial is on a preponderance of probabilities. This evidence can either be direct evidence, circumstantial evidence or a combination of the two.[75] Another important factor that must be kept in mind is the fact that it is up to the court itself, and not the medical profession, to determine the relevant standard of care and skill required from the medical profession.[76]

6.2 South Africa

In South African law the general test for negligence is that of the *bonus paterfamilias*, namely the reasonable person test.[77] This test is used to assess the

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[73] *Bolam v Friern Hospital Committee* [1957] 2 All E.R. 118.

[74] As was found in *Van Wyk v Lewis* 1924 AD 438; Hyman DA & Silver C "Medical Malpractice and Compensation in Global Perspective: How does the U.S. Do It?" (2011) *Chicago-Kent Law Review* 169; De Cruz P *Nutshells: Medical Law (1st ed)* (London: Sweet & Maxwell 2002) 137; Jones (1991) 95; Goldberg R "Medical Malpractice and Compensation in the UK" (2011) *Chicago-Kent Law Review* 146; Otto SF "Medical Negligence" (2004) *South African Journal of Radiology* 20; Kennedy & Grubb (1998) 392.

[75] Van den Heever P & Carstens PA *Res Ipsa Locquitur and Medical Negligence: A Comparative Survey* (Cape Town: Juta 2011) 1.

[76] McQuoid-Mason (2010) *South African Heart Journal* 250; McK Norrie K "Medical Negligence: Who Sets the Standard?" (1985) *Journal of Medical Ethics 135*.

[77] It must be stated that the reasonable person is merely a fictitious person. According to Neethling & Potgieter: "The reasonable person is not an exceptionally gifted, careful or developed person, neither is he underdeveloped nor someone who recklessly takes chances or who has no prudence. The qualities of the reasonable person are found between these two extremes" – see: Neethling J & Potgieter JM *Law of Delict* (Durban: LexisNexis 2010) 135; Coetzee LC & Carstens P "Medical Malpractice and Compensation in South Africa" (2011) *Chicago-Kent Law Review* 1282, Neethling J & Potgieter JM *Law of Delict* (Durban: LexisNexis 2015) 41-154.

carelessness of a person and is an objective test.[78] The test for negligence comprises of two legs, namely reasonable foreseeability and reasonable preventability.[79] However, when dealing with an expert, such as a medical professional, the test for negligence is adjusted to take into account the skills and knowledge of such an expert.[80] This test is known as the reasonable expert test and the ordinary reasonable person test will not apply.[81] This is a clear indication that the standard of care expected from the reasonable expert is therefore higher than that of the reasonable person.[82] In the same manner that a distinction is drawn between a normal person and an expert, a distinction is drawn between an

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[78] Otto (2004) *South African Journal of Radiology* 19; Van Dokkum (1997) *Journal of African Law* 180; Coetzee & Carstens (2011) *Chicago-Kent Law Review* 1282 – Although the test is an objective test, a subjective element does present itself upon the assessment of the negligence of an expert.

[79] Coetzee & Carstens (2011) *Chicago-Kent Law Review* 1282; For years the test for negligence has been accepted as it was enunciated in *Kruger v Coetzee* 1996 (2) SA 428 (A); See also Otto (2004) *South African Journal of Radiology* 19. In this case the test is outlined as follows:

Culpa (negligence) arises if:

(a) a *diligens paterfamilias* in the position of the defendant –
    (i) would foresee the reasonable possibility of his conduct injuring another … and causing him patrimonial loss; and
    (ii) would take reasonable steps to prevent such an occurrence; and
(b) the defendant failed to take such steps.

[80] According to Carstens & Pearmain the starting point when discussing the reasonable expert/professional test when it comes to medical negligence lies with two cases, the first case *Lee v Schönnberg* (1877) 7 Buch 136 and the second being *Kovalsky v Krige* (1910) 20 CTR 822. These two cases were the earliest cases affording the judiciary a chance to rule on medical negligence. What proves to be important regarding both these judgments, is the fact that both courts referred to the English case of *Lanphier v Phipos* (1838) 8 C. & P. 475. The English judgment established the following principle: "There can be no doubt that a medical practitioner, like any professional man, is called upon to bring to bear a reasonable amount of skill and care in any case to which he has to attend; ant that where it is shown that he has not exercised such skill and care, he will be liable in damages" – see Carstens & Pearmain (2007) 619.

[81] Neethling & Potgieter explains that the reasonable expert is identical to the reasonable person, except for the fact that when conducting the reasonable expert test the relevant expertise as pertaining to that expert is taken into consideration - see Neethling & Potgieter (2010) 140; Carstens & Pearmain (2007) 621.

[82] Oosthuizen (2014) 92; Carstens & Pearmain (2007) 621 – "Where the expert is a medical practitioner, the standard is that of the reasonable medical practitioner in the same circumstances".

expert and a specialist. This can be illustrated through the use of an example. A distinction is drawn between the reasonable doctor and the reasonable anaesthetist. Thus a general practitioner is distinguished from a specialist medical physician.[83] When a specialist medical physician is involved, the test once again changes from the reasonable expert test to that of the reasonable specialist test - taking into consideration his or her field of specialisation.[84]

There are quite a few instrumental cases when it comes to the law of medical negligence[85] but this discussion will be limited to the most relevant cases in South African law. The purpose of this discussion will be to better equip the reader in understanding how medical negligence is assessed in South African law through practical examples in the form of case law. The cases that will be discussed in brief in this section is *Blyth v Van den Heever*[86] where the Court reaffirmed the test for negligence to be that of reasonable foreseeability and reasonable preventability; *S v Kramer*[87] where the Court expressly held that in dealing with instances pertaining to an expert, the normal reasonable person test must be replaced with the reasonable expert test*; Collins v Administrator, Cape*[88] where the Court referred to the care and skill expected from the reasonable South African physician; *Michael v Linksfield Park Clinic (Pty) Ltd*[89] where the Court held that the proof of medical

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[83] Carstens & Pearmain (2007) 623 – Reasonable general practitioner test vs the reasonable specialist test; Pegalis SE & Wachsman HF *American Law of Medical Malpractice* (New York: The Lawyers Co-operative Publishing Co. 1980) 57 – The authors relate the following quote from *Valentine v Kasier Foundation Hospitals* (1961, 1st Dist) 194 Cal App in highlighting the difference between a general practitioner and a specialist: "The difference between a duty owed by a specialist and that owed by a general practitioner lies not in the degree of care required, but in the amount of skill required" – See in this regard also *S v Kramer* 1987 (1) SA 887 (W).

[84] Carstens & Pearmain (2007) 623; Oosthuizen (2014) 92; Jones explains that if a general practitioner commences with a procedure requiring some form of specialty he/she would be held to the reasonable specialist test, therefore if he/she fails to meet this standard he/she will be held negligent according to the specialist standard – see: Jones (1991) 83.

[85] For example: *Van Wyk v Lewis* 1924 AD 438; *Pringle v Administrator, Transvaal* 1990 (2) SA 379 (W); *Castell v De Greef* 1994 (4) SA 408 (C), etc.

[86] 1980 (1) SA 191 (A).

[87] 1987 (1) SA 887 (W).

[88] 1995 (4) SA 73 (C).

[89] 2001 (3) SA 1188 (SCA).

negligence lies in the opinions of expert witnesses. Finally *Nyathi v MEC, Department of Health, Gauteng and Others*[90] where the Constitutional Court declared section 3 of the State Liability Act[91] to be unconstitutional in regard to preventing the attachment of state property in order to settle debts owed by the state will be discussed.

6.2.1 *Blyth v Van den Heever*[92]

This case concerned an error in the diagnosis of a patient and the question of whether or not such an action can amount to medical negligence. The plaintiff was involved in a horse-riding accident in which he sustained multiple fractures in his right arm. The plaintiff was treated by the local general practitioner and underwent open reduction surgery of both the radius and the ulna. After the surgery the patient's right arm was encased but the physician did not realise the consequences of a cast being applied too tightly, which resulted in severe sepsis of the arm. The sepsis resulted in all the tissue being destroyed in the plaintiff's arm. The plaintiff decided to institute action proceedings against the defendant for a claim of damages. In the court *a quo* absolution from the instance was granted because the Court held that the plaintiff and defendant's versions of the events that occurred were equally probable and therefore a ruling in favour of one of the parties could not be made. The case was taken on appeal where Corbett JA relied on the basic principles of the law of delictual negligence in awarding the plaintiff damages of about R70 000.[93] In this case the Court enunciated the test for negligence is reasonable foreseeability and preventability, even in a case concerning the reasonable expert, as opposed to the reasonable person. The Court did this by stating that the reasonably skilled medical physician in the circumstances and position of the respondent (the defendant) would have foreseen the possibility of

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[90] *Nyathi v MEC, Department of Health, Gauteng and Others* (2008) ZACC 8.

[91] 20 of 1957.

[92] 1980 (1) SA 191 (A).

[93] It must be noted that this is a considerable amount for damages awarded by a court in light of the time this case was heard.

the sepsis and could therefore have reasonably prevented the sepsis from ensuing.

6.2.2 *S v Kramer*[94]

This case pertains to the test of medical negligence. The defendant was a surgeon who was assisted by an anaesthetist to perform a tonsil operation on a ten-year old girl. The anaesthetist however failed to insert the endotracheal tube into the trachea of the patient. As the defendant was removing the left tonsil, he noticed an excess of bleeding, dark in colour, also that the patient showed signs of consciousness. The defendant also noticed signs of cyanosis (lack of oxygen). The defendant attempted to save the patient but it was already too late and the patient died due to a lack of oxygen. The defendant was charged with culpable homicide.[95] The Court considered the test for medical negligence and noted that the ordinary test for negligence, namely that of the *diligens paterfamilias,* could not be applied to medical negligence cases because the ordinary person does not possess the needed expertise required here.[96] Therefore the Court held the reasonable expert test must be applied in cases concerning the possible negligence of an expert.

6.2.3 *Collins v Administrator, Cape*[97]

In this case it had to be determined whether or not the actions of any of the staff members at Tygerberg Hospital could be found to amount to negligence. A sixteen-month-old baby suffered severe cerebral hypoxia after the tracheostomy tube, on which she was dependent for ventilation, was displaced. The baby entered into a permanent vegetative state with irreversible brain damage resulting

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[94] 1987 (1) SA 887 (W).

[95] It is relevant to note in this case the defendant was faced with a criminal charge, namely that of culpable homicide instead of a delictual action.

[96] The Court referred to, amongst others: Boberg (The Law of Delict); *Mitchell v Dixon* 1914 AD 519; *Van Wyk v Lewis* 1924 AD 438; *Webb v Isaac* 1915 EDL 273, etc.

[97] 1995 (4) SA 73 (C).

in no intellectual function. In addition, she has no self-awareness and no awareness of environmental stimuli. It was ruled that she had no prospects of recovery and it was most likely (and to be expected) that she would die within the next few years. This case specifically focused on the fact that every patient is entitled to due and proper care and skill. The Court confirmed that the care and skill expected is what a reasonable South African practitioner would exercise in similar (not the same) circumstances.[98] An important comment by the Court (especially in relation to locality of practice and the lack of medical resources in South Africa) was the following: "It is common knowledge that the hospital authorities are desperately short of money."[99]

After a thorough consideration of all the relevant medical personnel in the specific case, together with the surrounding circumstances, the Court held the hospital to be negligent in failing to adhere to this reasonable care and skill expected.

6.2.4 *Michael v Linksfield Park Clinic*[100]

This case is extremely important for medical negligence as it assisted in determining the boundaries for expert medical evidence (which is essential in medical negligence cases) either in support of or to defend an allegation of medical negligence. The plaintiff injured his nose in a sports accident and developed problems with his sinuses. He consulted with a physician at a private clinic in Johannesburg. The physician insisted that it is a small problem that could be rectified easily with a small operation. During the procedure the physician was assisted by an anaesthetist who injected cocaine into the nostril area of the

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[98] It is important that this indirectly refers to locality of practice. By stating that the reasonable care and skill in similar circumstances is expected of a practitioner in South Africa, means that the care and skill exercised in South Africa is not uniform, but rather dependable upon the surrounding circumstances. Another important factor that must be considered is the fact that the Court refers to "similar" and not the "same" circumstances, favouring the more relaxed (and preferred) "similar locality rule".

[99] *Collins v Administrator, Cape* 1995 (4) SA 73 (C) see page 95.

[100] 2001 (3) SA 1188 (SCA).

plaintiff.[101] The plaintiff however suffered cardiac arrest upon which defibrillators were applied in order to shock the patient's heart back into action. Unfortunately the defibrillators in the operating room were not working and by the time that the nurses located alternative ones it was already too late and the plaintiff had suffered brain damage. The plaintiff's family instituted a medical negligence claim against the anaesthetist. The family had experts flown in from New York to testify against the anaesthetist.

The Court held that the proof of medical negligence lies in the opinions of expert witnesses, but that the court is not bound to accept such opinions.[102] The Court rejected the evidence of the experts put forth by the family of the plaintiff based on the fact that they did not carry credibility with the court, and therefore the appeal court dismissed the claim.[103]

6.2.5 *Nyathi v MEC, Department of Health, Gauteng*[104]

In this case the applicant suffered second and third-degree burn wounds covering thirty percent of his body. He sustained this injury when a paraffin stove was thrown at him. He was initially admitted to Pretoria Academic Hospital where a central venous line was incorrectly inserted. Hereafter he was transferred to Kalafong Hospital where the personnel failed to detect this incorrect insertion. Due to the negligence of these two facilities, the applicant suffered a stroke where after he was declared severely disabled. The applicant instituted a claim for medical negligence against the MEC for Health, Gauteng. What is important about this case is that the state admitted to the negligence but still refused to compensate the victim. The applicant applied to the High Court for an order declaring section 3 of

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[101] This is an accepted practice in ear, nose and throat surgeries. As was mentioned in the case, cocaine is used as a local anaesthetic as well as a vasoconstrictor – meaning that it is common cause that the nasal lining bleed easily and this needs to be constricted with the use of cocaine.

[102] It held that medical assessments are a matter of clinical judgement which the court will not be able to assess without the use of expert evidence. For more guidance in relation to the topic of expert medical evidence, see: Van den Heever P & Lawrenson N *Expert Evidence in Clinical Negligence: A Practitioner's Guide* (1st ed) (Cape Town: Juta 2015).

[103] *Michael v Linksfield Park Clinic* 2001 (3) SA 1188 (SCA) para [106].

the State Liability Act 20 of 1957 to be declared unconstitutional. This section prevented the attachment of any state property for the satisfaction of a judgment debt. The Court held the nature of this section, being a blanket ban on any execution, attachment or any other similar process, to be unconstitutional. The judgment was referred to the Constitutional Court for confirmation. The majority held that this section unjustifiably limits the right to equal protection of the law and violates judicial authority and public administration.[105] The Constitutional Court confirmed the decision of constitutional invalidity of the High Court but suspended its order for a period of 12 months affording Parliament a chance to enact legislation to better deal with the enforcement and execution of money debts against the state.[106]

6.3 England

In English law, negligence is assessed in the same manner as South African law, in other words with the reasonable person test.[107] However, as soon as the person

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[105] Section 3 of the State Liability Act 20 of 1957 therefore infringes on section 9(1) of the Constitution. The Court further held the section to infringe on the right to dignity (section 10 of the Constitution) as well as access to courts.

[106] A comment must be made in light of the order made in *Nyathi v MEC, Department of Health, Gauteng and Others* (2008) ZACC 8. It can be argued that when the Court settled for a judgment in which it suspended its order for 12 months in order for Parliament to deal with the issue properly, that once again the highest court in the country opted for a decision based on policy considerations. Whenever the court is faced with a difficult decision where toes will be stepped on, it opts for the safe option, one that finds a balance between the interests of the parties involved. This can be referred to as a decision based on policy considerations, which is a value judgment. Such a judgment is based on fairness, reasonableness and what is considered to be ultimately just. This should not be seen as "bad" judgment, but rather one where the Court takes the safe route, trying to satisfy both parties. This is exactly what happened in this case. Instead of the Court enforcing its judgment in declaring section 3 to be unconstitutional and therefore invalid, it referred the matter to Parliament, in order for it to deal with the situation more effectively. See *S v Daniels* 1983 (3) SA 275 A.

[107] " …[A]ny conduct that falls short of the standard expected of a person where a duty of care is owed and which causes foreseeable damage to another person" – see: De Cruz (2002) 117; De Cruz P *Comparative Healthcare Law* (*4th ed*) (London: Routledge-Cavendish 2001) 233.

holds himself out as being an expert, the reasonable expert test applies.[108] Kennedy & Grubb refer to *Blyth v Birmingham Waterworks Co*[109] to explain the reasonable man test:

> Negligence is the omission to do something which a reasonable man, guided upon those considerations which ordinarily regulate the conduct of human affairs, would do, or doing something which a prudent and reasonable man would not do.

Lord Nathan refers to the case of *Hunter v. Hanley*[110] in which it was stated that:

> The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with reasonable care.

He explains that in order to assess whether the conduct of the physician amounts to negligence, the *omissio* or *commissio* must not be assessed according to perfect standards but rather in terms of the surrounding circumstances. He makes it very clear that this however does not mean that English law condones the use of the Locality Rule as such. This does not entail that the *standard* of care and skill differs due to the circumstances of each case but rather that the *degree* of care (not the standard) can be different in each case.[111] Thus, the standard is always

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[108] Kennedy & Grubb (1998) 285; In the English case of *Mahon v Osborne* [1939] 1 ALL ER 535 it was held:
"It is such a degree of care as a normally skillful member of the profession may reasonably be expected to exercise in the actual circumstances … It is not every … mistake which imports negligence, and … it is peculiarly necessary to have regard to the different kinds of circumstances that may present themselves for urgent attention"; Lord Nathan expresses it as follows: "There is imposed therefore upon the medical man not merely a duty to use proper care but also a duty to possess and exercise proper skill" – see: Nathan HL *Medical Negligence: Being the Law of Negligence in Relation to the Medical Profession and Hospitals* (London: Butterworth 1957) 20; Strauss SA *Doctor, Patient and the Law: A Selection of Practical Issues* (South Africa: Van Schaik 1980) 36 – "The standard of care required of a medical practitioner who undertakes the treatment of a patient is not the highest possible degree of professional skill, but reasonable skill and care.

[109] (1856) 11 Exch 781, 784.

[110] [1955] S. L. T. 213; De Cruz (2002) 125.

[111] Lord Nathan provides the following scenario to explain his argument: "It would be unreasonable, for example, to judge by the same criteria the conduct of a practitioner who by necessity performs an operation in a remote country district or in the patient's own house and the conduct of one who

considered to be that of the reasonable practitioner but the care in the given circumstances can vary.[112]

In order to succeed with a medical malpractice claim, the patient must prove three elements, namely:

a) The physician owed the patient a duty of care;
b) The physician breached that duty;
c) The breached of duty resulted in harm caused to the patient.[113]

In order for the patient to prove that the physician breached this duty of care, he or she must prove that the physician's actions did not adhere to the standard required of him or her in the given circumstances. The following case set the groundwork in this regard.

6.3.1 *Bolam v Friern Hospital Committee*[114]

This is one of the most instrumental cases concerning medical negligence in English law.[115] Mr Bolam had to undergo electroconvulsive therapy due to a diagnosis of clinical depression.[116] This treatment is known for all the possible injuries it may cause and medical opinion on how exactly to deal with these injuries was divergent at the time. Mr Bolam sustained a pelvic fracture during one of his sessions and blamed the hospital for being negligent in that the physician was in breach of the required standard of care and skill.[117] This case is the *locus classicus* in English law for the standard of care required from a physician. The Court held the test to be the following: "professionals are not guilty of negligence if they acted

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operates in a modern hospital with expert assistance and every up-to-date appliance to hand." See Nathan (1957) 23.

[112] *Ibid*.

[113] Kennedy & Grubb (1998) 293; Goldberg (2011) *Chicago-Kent Law Review* 143; De Cruz (2001) 236.

[114] [1957] 2 All E.R. 118.

[115] Jones (1991) 4.

[116] De Cruz (2002) 125.

[117] Samantha A & Samantha J "Legal Standard of Care: A Shift from the Traditional Bolam Test" (2003) *Clinical Medicine* 443; De Cruz (2002) 125.

in accordance with the practice accepted by a responsible medical body as proper". This formulation by the court became known as the "Bolam Test". McNair J held:

> But where you get a situation which involves the use of some special skill or competence, then the test whether there has been negligence or not it not the test of the man in the Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent… it is sufficient if he exercises the ordinary skill of an ordinary compete tent man exercising that particular art.[118]

Mr Bolam was unable to prove that the physician did in fact breach the standard required of him and therefore he failed in his claim.[119]

The test formulated in the *Bolam* case has however undergone much scrutinisation in English law in the last two decades.[120] The main criticism against this case is the fact that the test allows the standard of care and skill to be subjectively established by the physicians themselves.[121] The courts therefore have to rely on these expert physicians to determine whether or not the accused physician abided by the standard of care and skill expected of him or her. The following case has taken the "Bolam Test" to the next level.

6.3.2 *Bolitho v City & Hackney Health Authority*[122]

The facts of this case were briefly as follows: Two-year-old Patrick Bolitho was left unattended to after he suffered cardiac arrest as a result of respiratory failure –

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[118] [1957] 2 All E.R. 118, 121 – see Kennedy & Grubb (1998) 336.

[119] Samantha & Samantha (2003) *Clinical Medicine* 444.

[120] Goldberg (2011) *Chicago-Kent Law Review* 144.

[121] Samantha & Samantha (2003) *Clinical Medicine* 445; See Kennedy & Grubb (1998) 341 regarding *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 All ER 643, 649 (emphasis added) where the Court held: "The *Bolam* principle may be formulated as a rule that a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice. In short, the law imposes the duty of care; but the standard of care is a matter of medical judgment".

[122] [1997] 4 All ER 771.

due to the aforementioned he suffered severe brain damage.[123] The reason provided by the accused physician for not attending to the child was that her omission was based on a "school of thought" that medical intervention in the given circumstances would not have altered the outcome thereof.[124] The interesting fact regarding this case is that the vast medical opinion supported the physician's decision therefore indirectly adhering to the "Bolam Test". However the court went beyond Bolam in saying that:

> The court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis. In particular, in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable and respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter.[125]

This case therefore indicates a shift from the courts merely relying on the body of knowledge of expert physicians when it comes to assessing the standard of care and skill, to rather opting for an "enquiring approach".[126]

6.4 America

From the outset it must be stated that American case law will not be discussed in this section of the dissertation except for the case of *Helling v. Carey*,[127] as the vast majority of these cases, linking to medical negligence, have already been covered in the previous chapter.[128] The reason why only the one case will be discussed is because this case illustrates the link between medical malpractice in relation to malpractice lawsuits and how it can affect the standard of care.[129] The

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[123] Kennedy & Grubb (1998) 344.

[124] Samantha & Samantha (2003) *Clinical Medicine* 444.

[125] [1997] 4 All ER 771, 778 - see Kennedy & Grubb (1998) 339.

[126] Samantha & Samantha (2003) *Clinical Medicine* 446.

[127] (1974) 83 Wash 2d 514, 519 P2d 981, 67 ALR3d 175.

[128] See Chapter 3 of this dissertation for an extensive discussion of American medical negligence case law, in order to circumvent unnecessary repetition.

[129] Pegalis & Wachsman (1980) 10.

basic principles regarding medical malpractice law in America is touched upon in this section.

Medical malpractice[130] law in America originated from English common law.[131] It is however not limited to English common law as it is influenced and extended by each state's respective case law.[132] This means that the basis of medical malpractice law is founded in English common law – more specifically a subdivision of tort law dealing with professional negligence – but the law is developed through legal precedent developed and applied in each state in America. What proves to be extremely important when it comes to assessing medical negligence in American law is the fact that American medical law cases are addressed individually according to the different state laws and not governed by federal law.[133]

Ficarra defines the term "negligence" as "… careless conduct that causes unintentional harm".[134] In America it is important for the medical malpractice claim to be instituted within a certain period in order to comply with the statute of limitation.[135] When instituting the claim it is of paramount importance that the plaintiff (the patient) establishes that a doctor-patient relationship existed, because the physician can only be held liable in terms of his or her own patient.[136] Thereafter the plaintiff has to prove that the physician failed to provide care in accordance with the applicable standards which in turn resulted in the medical negligence. As it has been mentioned in the previous chapter of this dissertation, these standards have transformed and developed tremendously in America. A physician used to be held to the standards expected of him or her in the given

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[130] Bal (2009) *Clinical Orthopaedics and Related Research* 340 - Medical malpractice can be defined as: "any act or omission by a physician during treatment of a patient that deviates from accepted norms of practice in the medical community and causes an injury to the patient".

[131] Budetti P & Waters TM *Medical Malpractice Law in the United States* (2005) Prepared for the Kaiser Family Foundation 2.

[132] *Id*. 339; Budetti & Waters (2005) 2.

[133] Bal (2009) *Clinical Orthopaedics and Related Research* 339.

[134] Ficarra (1968) 59 - He goes on to say that malpractice is negligence.

[135] *Id.* 153; Budetti & Waters (2005) 2.

[136] Budetti & Waters (2005) 3.

community he or she practised in, however, as recent case law has indicated, courts in some states are moving towards a national standard of care and therefore away from the Locality Rule.[137] Lord Nathan explains that what makes American medical law different from that of English and South African medical law is the fact that the locality of practice is taken into consideration in some American states while there is no express application of this Rule in South Africa or England.[138]

Just as in South African and English law, negligence is assessed based on the reasonable person test.[139] In an American medical malpractice lawsuit, just as with English law, in order for the patient to succeed with an action against the physician, the following elements must be established:

a) A duty existed on the physician to treat and care for the patient;
b) A breach of the above-mentioned duty in the sense that he either failed to attend to the patient or the physician did not live up to the required standard of care and skill;
c) A *nexus* between the duty owed and the breach of the duty; and
d) Damage ensuing as a result of the breach of the duty in order for the patient to claim reparation.[140]

In the case of *Helling v. Carey*[141] the plaintiff was a young woman who was placed under the care of the defendant ophthalmologists. At the age of 32 the plaintiff was diagnosed with severe and irreversible visual loss as well as primary open-angle glaucoma which was undiagnosed and untreated until this age. It must be further

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[137] *Ibid.*

[138] Nathan (1957) 23-24.

[139] *Id*. 340 – "The reasonable person standard is a legal fiction, created so the law can have a reference standard of reasoned conduct that a person in similar circumstances would do, or not do, in order to protect another person from a foreseeable risk of harm".

[140] *Id*. 342; Ficarra (1968) 59; In English law the plaintiff only has to prove three elements in this regard, namely all of the elements found in American law, excluding the element requiring a nexus between the breached duty and the damage caused – see: Herring (2010) 104; De Cruz (2001) 233-234.

[141] (1974) 83 Wash 2d 514, 519 P2d 981, 67 ALR3d 175.

noted that the defendants failed to execute an intraocular pressure test during the plaintiff's earlier years.[142]

During the course of the trial, medical experts were called by the Court to testify as to the standard of care expected from the physician specialist practising in the same or similar circumstances as the defendant ophthalmologists. The medical experts testified that the said standard of care did not entail that routine glaucoma pressure tests be conducted on patients under the age of 40, as this disease is extremely rare at and below the given age. The defence of the defendants was based on the evidence given by the medical experts and therefore they contended that they should be excused from liability because they adhered to the standard of care. Contrary to what was expected, the Court nevertheless found the defendants guilty in this regard and awarded damages to the plaintiff. The main reason behind the Court's decision was the fact that even though the probability of diagnosing a patient under the age of 40 with glaucoma was one in 25 000, that one patient still deserves the same standard of care given to patients over the age of 40. To substantiate its argument, the Court held that the intraocular pressure test was a fairly easy and inexpensive test for a physician to conduct. The Washington Supreme Court concluded that that the ophthalmology profession, as a whole, is guilty of a negligent standard and as such the Court could impute this negligent liability to the defendants at hand.

The main criticism against this case lies in the fact that even though the defendants adhered to the standard of care expected from them (as testified to by medical experts) they were still found guilty and held liable.[143] The case serves as a warning to the medical profession as a whole, in that an individual physician cannot expect to escape personal liability simply because he or she adhered to the standard expected from him or her in the same of similar circumstances, therefore the universal standard, which in itself might (as in this case) prove to be careless.[144]

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[142] See Pegalis & Wachsman (1980) 10.

[143] *Id*. 11.

[144] Ibid – "… the plaintiff in order to prevail shall be required to prove by a preponderance of the evidence that the defendant or defendants failed to exercise that degree of skill, care and learning

7 Consequences (Liability) of Medical Negligence

Above, the position of the plaintiff in medical negligence disputes was discussed. The consequences for the defendant (usually the medical practitioner) now beckons discussion. Depending on the consequences of the negligence, certain procedures follow. In South Africa the following possibilities might arise: If the court finds the physician's conduct to amount to medical negligence and the physician's actions or inactions amount to unprofessional conduct, a disciplinary hearing will ensue by the Health Professions Council of South Africa.[145] If the medical negligence resulted in the death of the patient, the possibility of a conviction of culpable homicide also arises.[146] It must be mentioned, in relation to a criminal case, that the doctor-patient relationship is not provided for in criminal law but crimes such as culpable homicide can occur in the medical world.[147] Finally, and the most common claim brought against a medical practitioner, is that of a civil claim for damages.

In America compensatory liability (in other words a civil action for compensatory damages), just as in South Africa, is the most common claim initiated against the defendant. The possibility of criminal liability is exceptional but possible. A decision regarding criminal prosecution lies with the prosecutors of the respective states.[148] The possibility of a civil fraud claim is not unheard of. Such a claim is based on the

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possessed by other persons in the same profession and that as a proximate result of such failure, the plaintiff suffered damages…" See further Wash Rev Code 4.24.290 (1975).

[145] Howarth (2015) *South African Medical Journal* 425.

[146] See: McQuoid-Mason (2010) *South African Heart Journal* 251; Howarth (2015) *South African Medical Journal* 425; *S v Mkwetshana* 1965 (2) SA 493 (N) – where the physician was convicted on culpable homicide as a result of negligently causing the death of the patient due to the administration of an overdose of medication by the said physician. In *S v Nel* 1987 TPD Unreported, the physician was also convicted on culpable homicide in the court *a quo* after it was ruled that the negligence of the physician led to the demise of the patient. On appeal the court *a quo's* judgment was set aside as the court held the accusation could not be proven beyond reasonable doubt - see Carstens & Pearmain (2007) 695; 644.

[147] Coetzee & Carstens (2011) *Chicago-Kent Law Review* 1272 – if the physician intentionally kills the patient his conduct amounts to murder, therefore something like active euthanasia constitutes murder.

[148] Hyman & Silver (2011) *Chicago-Kent Law Review* 170.

proposition that the conduct of the physician amounts to medical malpractice and is often initiated by a whistle-blower.[149]

In terms of English law it is important to note that when it comes to medical malpractice liability the majority of medical physicians are afforded insurance by the National Health Service (NHS).[150] Those physicians fortunate enough to call themselves "NHS employee doctors" are not held personally liable when it comes to a medical malpractice claim and is also exempted from buying insurance coverage.[151] The action is therefore brought against the NHS and not against the physician in his or her personal capacity.[152] In regard to medical practitioners who are not fortunate enough to call themselves NHS employees, the abovementioned liability finds application. Therefore the legal consequences for a medical practitioner who finds himself or herself in a case of medical negligence can either incur a criminal prosecution,[153] a civil claim,[154] professional disciplinary proceedings or a NHS complaints procedure can be instituted.[155]

8 Awarding Damages

Since it has been established earlier in this chapter that a medical malpractice litigation crisis features in all three chosen jurisdictions and that all three jurisdictions allow claims for civil damages, it is important to determine how the court goes about awarding damages in such an claim.

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[149] *Ibid*.

[150] Bal (2009) *Clinical Orthopaedics and Related Research* 345.

[151] *Ibid*.

[152] Library of Congress "Medical Malpractice Liability: United Kingdom (England and Wales)" 2015. http://www.loc.gov/law/help/medical-malpractice-liability/uk.php Accessed 2 November 2015.

[153] Herring (2010) 102 –The most common charge is gross negligence manslaughter, but if the scenario presents itself that the medical practitioner attended to the patient without his/her consent, a charge of battery can also be lodged.

[154] *Id.* 103 – A claim for damages based on either tort law or breach of contract.

[155] *Ibid;* De Cruz (2001) 234-235.

> When a doctor makes an error in your treatment, what legal compensation will be available? This is the central question in current medical malpractice litigation, one that is not easily answerable and that depends largely on the country in which you live.[156]

When it comes to claiming damages relating to medical negligence, it can either be contractual damages or delictual damages.[157] In South Africa, the main aim of the court in awarding contractual damages on account of medical negligence is to attempt to place the plaintiff in the same position prior to the medical negligence ensuing.[158] According to Visser & Potgieter the plaintiff can alternatively recover damages *ex delicto* for damage as a result of negligent conduct.[159] There are three principal actions if a patient seeks to claim *ex delicto*[160], namely: the *actio legis Aquiliae*[161] to recover damages, the *actio injuriarum*[162] and the action for pain and suffering to claim satisfaction.[163] It is easy for the court to calculate the damage that occurred if the damage resulted in financial loss but the calculation becomes increasingly difficult when the extent of physical injuries must be assessed and compensated monetarily.[164] It is possible for the same action to be a contractual breach as well as a delictual breach.[165]

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[156] ADMD Mavioglu & Alkan Law Office Date Unknown. http://www.admdlaw.com/medical-malpractice-a-critique-of-the-turkish-and-american-approaches-to-awarding-non-economic-damages/#.VjccnZExGFI.

[157] Carstens & Pearmain (2007) 623 – See Chapter 5 to Chapter 8 of the book in this regard; Coetzee & Carstens (2011) *Chicago-Kent Law Review* 1269 - 1271.

[158] McQuoid-Mason (2010) *South African Heart Journal* 251; Herring (2008) 121; This is the position in both English law and American law – see: Stauch M, Wheat K & Tingle J Sourcebook on Medical Law (*2nd ed*) (Australia: Cavendish Publishing 2002) 351; Herring (2010) 121; Van Dokkum (1997) *Journal of African Law* 179.

[159] Potgieter *et al Law of Damages* (South Africa: Juta Publishers 2012) 48.

[160] Van Dokkum (1997) *Journal of African Law* 179.

[161] Specifically intended to recover damages.

[162] For the redress for an intentional injury sustained to one's personality.

[163] This is granted for a negligent physical injury.

[164] Herring (2008) 121.

[165] Coetzee & Carstens (2011) *Chicago-Kent Law Review* 1285 – If this is the case, the patient can claim in the alternative and the court will award damages to the patient based on the most beneficial claim.

The damages awarded by the court is however not limited to patrimonial loss[166] – therefore damages measurable in monetary loss[167] – but it can also include non-patrimonial loss,[168] for example loss of amenities of life as well as damages for pain and suffering.[169] If damages are claimed based on breach of contract, only patrimonial damages can be claimed, however if an action is instituted based on a delictual breach both patrimonial and non-patrimonial damages can be recovered.[170]

In English law it must be noted that no special rules exists in cases of medical malpractice claims but that the general rules pertaining to tort law and law of damages still finds application.[171] According to these general rules both pecuniary

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[166] Visser & Potgieter defines patrimonial loss as follows: "Patrimonial loss (as a subdivision of damage) is the diminution in the utility of a patrimonial interest in satisfying the legally recognized needs of the person entitled to such interest", or "the loss or reduction in value of a positive asset in someone's patrimony or the creation or increase of a negative element of his or her patrimony (a patrimonial debt)" – see Potgieter *et al* (2012) 51; Patrimonial loss includes, for example, future and past medical costs, loss of income, maintenance, etc – see Coetzee & Carstens (2011) *Chicago-Kent Law Review* 1285.

[167] This for example amounts to loss of present earnings as well as loss of future earnings, loss of support of dependants and present and future medical expenses – See McQuoid-Mason (2010) *South African Heart Journal* 251; Coetzee & Carstens (2011) *Chicago-Kent Law Review* 1285.

[168] Visser & Potgieter defines non-patrimonial loss as follows: "Non-patrimonial loss is the diminution of a damage-causing event, in the quality of the highly personal (or personality) interests of an individual in satisfying his/her legally recognised needs, but which does not affect his/her patrimony" - See Potgieter *et al* (2012) 103.

[169] *Supra;* Bal (2009) *Clinical Orthopaedics and Related Research* 340; *Singh v Ebrahim* (413/09) 2010 ZASCA 145 - In this case the new born (Nico) was born severely disabled due to a hypoxic brain injury that occurred during birth. The specialist gynaecologist admitted that due to his medical negligence the injury occurred. The parents of the new-born took the matter on trial. The Supreme Court of Appeal awarded the following damages: R126 694,77 to the plaintiffs in their personal capacities, R13 579,20 in their representative capacities on behalf of their other son and R11 069 070,50 in their representative capacities on behalf of the disabled new born (Nico).

[170] *Ibid*.

[171] Deutsch E & Schreiber HL (eds) *Medical Responsibility in Western Europe* (Springer Science & Business Media: 2012) 148-150.

and non-pecuniary damages are awarded[172] and the courts opt for a "standard" award, which means they try and award damages based on same or similar cases that they have heard, allowing for increases due to factors such as inflation or differentiating circumstances.[173]

In American law the increase in medical malpractice suits have led to an increase in non-economic damage awards,[174] which in turn resulted in the majority of states in America passing statutory limitations in order to protect the guilty party (the physician) from outrageous claims by the patient.[175] The difference between the American legal system to that of South Africa and England does not lie in the application of medical law but rather in the core principles of the legal system itself. For example the compensation awarded by American courts is determined by the members of the jury, something which South Africa has long abandoned. The jury follows the instructions of the presiding officer but is left with assessing the evidence in determining the amount to be awarded to the plaintiff.[176] It is therefore clear that no "standard" award is followed as in the English legal system and this in turn has resulted in colossal claims in America. Like in the South African system, a medical malpractice claim in America is also founded in either tort or contract.[177]

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[172] Pecuniary loss is also known as special damages, whereas non-pecuniary loss is known as general damages – see: Stauch *et al* (2002) 351.

[173] *Id*. 151.

[174] ADMD Mavioglu & Alkan Law Office Date Unknown. http://www.admdlaw.com/medical-malpractice-a-critique-of-the-turkish-and-american-approaches-to-awarding-non-economic-damages/#.VjccnZExGFI.

[175] Harris L "Tort Reform as Carrot-and-Stick" (2009) *Harvard Journal on Legislation* 163; ADMD Mavioglu & Alkan Law Office Date Unknown. http://www.admdlaw.com/medical-malpractice-a-critique-of-the-turkish-and-american-approaches-to-awarding-non-economic-damages/#.VjccnZExGFI – Roughly thirty-nine states in America have passed tort reform liability restrictions on medical malpractice claims since 1975.

[176] ADMD Mavioglu & Alkan Law Office Date Unknown. http://www.admdlaw.com/medical-malpractice-a-critique-of-the-turkish-and-american-approaches-to-awarding-non-economic-damages/#.VjccnZExGFI.

[177] Hyman & Silver (2011) *Chicago-Kent Law Review* 167.

Once again compensatory damages that are awarded can either be economic loss or non-economic loss.[178]

Therefore this discussion has once again illustrated that even though the chosen jurisdictions all have their respective legal systems, when it comes to medical malpractice lawsuits there is commonality in the principles that find application.

9 *Res Ipsa Loquitur*

When it comes to assessing medical negligence a discussion regarding the medical law maxim of *res ipsa loquitur* deserves mention. This doctrine entails that the facts of the case speak for itself. In *Goliath v Member of the Executive Council for Health, Eastern Cape*[179] the Court defines the maxim as follows:

> Broadly stated, *res ipsa loquitur* (the thing speaks for itself) is a convenient Latin phrase used to describe the proof of facts which are sufficient to support an inference that a defendant was negligent and thereby to establish a *prima facie* case against him.[180]

The South African courts have been reluctant in applying this principle in cases concerning medical negligence and therefore the doctrine does not find application in South African medical law.[181] Carstens & Pearmain explain that the principle is generally regarded by the courts as a form of inferential reasoning which results in an inference of negligent conduct based on much scrutiny, as oppose to a presumption of negligence, as the principle itself suggests.[182]

The relevant question in this regard is how does the maxim relate to, or influence the Locality Rule? Van den Heever & Carstens are of the following opinion:

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[178] *Id*. 169.

[179] 2015 2 SA 97 (SCA).

[180] *Goliath v Member of the Executive Council for Health, Eastern Cape* 2015 2 SA 97 (SCA) para [10].

[181] Carstens & Pearmain (2007) 857; McQuoid-Mason (2010) SA Heart Journal 250; See *Van Wyk v Lewis* 1924 AD 438 which is the leading authority for this doctrine; *Goliath v Member of the Executive Council for Health, Eastern Cape* 2015 2 SA 97 (SCA) para [5].

[182] *Ibid*.

> If regard must be had to the surrounding circumstances to establish the presence or absence of negligence, the doctrine does not find application.[183]

The purpose of the implementation of the Locality Rule is to force the judiciary to consider the surrounding circumstances in every medical negligence case in order to determine whether these circumstances had an influence on the negligence that ensued. According to Van den Heever & Carstens this therefore entails that the Locality Rule extinguishes the application of *res ipsa loquitur,* as the maxim cannot be considered if the surrounding circumstances are taken into consideration. It can therefore be said that the maxim could be used as a defence against the Locality Rule, as the maxim does not support the view that the surrounding circumstances must be considered. Instead the facts as they stand speak for themselves and therefore, through inferential reasoning, negligence is *prima facie* established.

This dissertation however advocates for the implementation of the Locality Rule given the current state of South Africa's public health care sector. By incorporating the *res ipsa loquitur* maxim into our medical law will not only directly oppose the implementation of the Locality Rule but more importantly further suppress the progress and transformation the National Health Insurance seek to accomplish. The maxim will allow courts to make inferences of negligence based on only what is before them, whereas the Locality Rule forces a Court to place itself in the shoes of the defendant at the time of the alleged negligence, to determine whether the physician himself or herself is in fact responsible for the medical negligence, or whether the surrounding circumstances could have had an influence.

10 Conclusion

It is therefore concluded that even though the law in these three jurisdictions differ substantially from one another, a claim for medical negligence is somewhat based on the same or at least very similar principles. The purpose of illustrating this is to convey the point that because such a claim is similar in South Africa, England and America, adopting the Locality Rule in relation to medical negligence from

[183] Van den Heever P & Carstens PA *Res Ipsa Locquitur and Medical Negligence: A Comparative Survey* (Cape Town: Juta 2011) 27.

American law into the South African legal system - as one of the factors a court should consider when assessing the conduct of a practitioner – is feasible and achievable, because these jurisdictions coincide in regard to assessing medical negligence.

Not only will it be feasible to adopt the Rule into our legal system, this chapter also served to demonstrate that it will be extremely beneficial taking into consideration the divide between public hospitals and private hospitals evident from the practical case discussions used as examples of the health-care system in South Africa.

In this chapter the importance of the test for negligence, (the reasonable person, the reasonable expert or the reasonable specialist test, depending on the circumstances of the case) has been established. However what remains of tremendous importance is the fact that the test for negligence (including medical negligence) is determined by the defendant's actions within the given circumstances.[184] Therefore the surrounding circumstances in establishing the medical negligence is a factor the courts cannot exclude from the test, it is instrumental in assessing medical negligence.

The question then becomes the following: How can the Locality Rule not find application in the South African medical law if it is clearly an integral part of the surrounding circumstances of assessing medical negligence? The answer here is that the courts in some instances consider the locality of practice as part of the circumstances considered but unfortunately considering the locality of practice is not a prerequisite for assessment of medical negligence and therefore by incorporating this Rule into our legal system will force the courts, as a ground rule, to consider the locality of practice and therefore the resources available to the medical professional at hand.

[184] Jones (1991) 60.

Chapter 5

The Locality Rule in South Africa: A Viable Interim Solution?

Overview

With the introduction of the National Health Insurance (NHI) and the recent commentary requested from the public on the National Health Insurance White Paper, hope for the long-awaited health-care reforms that South Africa so desperately needs might just become a reality in the future. Unfortunately the implementation of this intended reform is still more than a decade away and therefore an interim solution for the current health-care situation is required. This chapter discusses the implementation of the Locality Rule, as an interim solution in South Africa, while reflecting on the judiciary's attitude towards the current health-care situation. Three very important cases are discussed in this chapter, one directly linked to the Locality Rule and the other two indirectly. All three these cases indicate the need for a Rule like the Locality Rule. The importance of this chapter lies in the discussion of the possible methods of implementing the Locality Rule in South Africa. The previous chapters have touched on the reality of health care and health-care legislation in South Africa, the origin and history of the Locality Rule, the nature of a medical negligence claim in South Africa, America and England but this chapter focuses on combining all this information in such a way as to reach a practical conclusion in giving effect to the Locality Rule.

1 Introduction

In the preceding chapters the quality and development of South Africa's health-care system was discussed together with the stark reality of the divide that currently exists between the public- and private health-care sectors. The origin and history of the Locality Rule was detailed as well as claims for medical negligence in

the three respective jurisdictions. In light of the previous chapters, the purpose of the present discussion is to answer the following question: Is the Locality Rule a viable interim suggestion for the current South African health care system?

This chapter continues to paint the picture (as was done in the first chapter and throughout the rest of the dissertation) of the stark reality of health care in South Africa, but, this time, South African case law will specifically be used in illustrating the court's opinion on South Africa's current and past health-care system.[1] This chapter illustrates the clear need for the Locality Rule in South Africa based on the content of the previous chapters. The chapter therefore considers *de lege lata,* and will discuss and advocate, *de lege ferenda,* that the Locality Rule should be implemented in the South African medical law system.

The most important part of this chapter is a critical discussion of three key medical negligence cases in South African law linked to the need for the application of the Locality Rule. This discussion focuses on the differences and similarities between the judgments and critically assesses the impact that these cases have on medical negligence.

A very important part of this chapter is the discussion of the newly developed, but not yet fully implemented, National Health Insurance (NHI) Plan. In this chapter the stance is taken that the NHI is intended as a solution for the state of health care that we face in South Africa, but due to the prolonged implementation of the Plan (occurring in three phases over the next decade or so), the solution is not current and therefore the Locality Rule needs to be implemented in the interim. The argument that may be formulated against the implementation of the Locality Rule due to the NHI's implementation is therefore accordingly also dealt with and addressed in this chapter.

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[1] What are the "realities" of the health care system this dissertation keeps on referring to? Child refers to the following (real) examples in her article, namely a new-born who went blind due to the fact that doctors failed to correctly diagnose the child, or a child's penis that was mistakenly amputated whist in the care of a physician - See Child K, The Times Live "Hospital Horrors Costing SA Plenty" 2014. www.timeslive.co.za/news/2014/01/17/hospital-horrors-costing-sa-plenty Accessed 8 October 2015.

At the end of this chapter it will be evident why the Locality Rule is desperately needed in South Africa and that mention of the Rule, both directly and indirectly, has already been made by our courts, but that the Rule has never been taken seriously and therefore never been given effect to.

2 Reason for the Chosen Case Discussions

Three specific cases were singled out for this case discussion. The first two cases, namely *Van Wyk v Lewis*[2] and *S v Tembani*[3] were chosen because, when interpreted, it becomes clear that they represent the two opposite sides of the health-care spectrum in South Africa. The third case of *Oppelt v Head: Health, Department of Health, Provincial Administration: Western Cape*[4] paints the picture of health-care realities and futile fights of the physicians. All three cases make reference to the health-care system and deal with medical negligence but the one expresses the view that the standard of health care in this country is uniform (equal) throughout the geographical boundaries,[5] the other one is of the opinion that the standard is not the same but that we can "expect" medical negligence in the public sector of medical health care,[6] while the third case illustrates that even though we acknowledge that health care is not uniform in South Africa, a minority judgment, even though it might be correct, will not prevail. The aim of discussing these three South African medical-law cases in detail is to demonstrate that while some judgments and judges are finally acknowledging the health-care realities in South Africa, it still does not result in fair decisions when it comes to the medical physicians risking their reputations and careers, because the judiciary continues to favour the patient and not health care reality.

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[2] 1924 AD 438.

[3] SACR 355 (SCA).

[4] [2015] ZACC 33.

[5] *Van Wyk v Lewis* 1924 AD 438.

[6] *S v Tembani* 1 SACR 355 (SCA).

3 *Van Wyk v Lewis*[7] Case Discussion

3.1 Introductory Remarks

Van Wyk v Lewis[8] (hereafter "*Van Wyk* case") *is* considered to be the *locus classicus* with regards to medical negligence in South African medical law,[9] even though the judgment was handed down as long ago as 1924.[10] In different judgments the Appellate Division rejected[11] and accepted[12] the Locality Rule. This case however lies at the one end of the spectrum in saying that the standard of health care in South Africa is expected to be equal everywhere.[13] Before discussing this case in detail, it must be mentioned that the discussion will be limited to its application of, and reference to the Locality Rule, and therefore the case will not be discussed in its totality.

3.2 Facts

This case is an appeal from the (then) Queenstown Local Circuit Division to the (then) Appellate Division. The plaintiff was admitted to the hospital where the defendant practised as a surgeon. The defendant was required to conduct a very dangerous but urgent abdominal operation on the plaintiff that same evening.[14] The procedure was a difficult one where the defendant, an anaesthetist (Dr Thomas) and a nurse (Sister Ware) attended to the plaintiff during the night. During the operation the patient's appendix was removed. The gall bladder was in such a

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[7] 1924 AD 438.

[8] *Van Wyk v Lewis* 1924 AD 438.

[9] Carstens PA "Medical Negligence as Causative Factor in South African Criminal Law: *Novus Actus Interveniens* or Mere Misadventure?" (2006) *South African Criminal Journal* 168.

[10] Carstens & Pearmain (2007) 636; Strauss SA *Doctor, Patient and the Law: A Selection of Practical Issues* (South Africa: Van Schaik 1980) 302.

[11] See *Van Wyk v Lewis* 1924 AD 438 at page 444.

[12] *Van Wyk v Lewis* 1924 AD 438 at page 457.

[13] 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) *SA Public Law* 176.

[14] *Van Wyk v Lewis* 1924 AD 438 at page 439, 442.

condition that the defendant decided to drain the gall bladder.[15] The anaesthetist instructed the defendant to get the patient out of surgery as soon as possible.

During the closing of the patient at the end of the procedure, a medical swab was left inside the body of the plaintiff.[16] According to general hospital procedures, it was up to the nurse to count the usage of swabs during the given procedure and, by the end of the surgery, the defendant and the nurse agreed that all the swabs were accounted for and removed. This was however not the case. During the operation one swab was overlooked and about a year later, the swab passed from the plaintiff's body, with limited damage.[17] It must be mentioned that the patient made a quick recovery and was discharged soon after the procedure. During the year after the operation, the plaintiff consulted with the defendant a few times where she complained that she was suffering from discomfort but never pain.[18] The plaintiff nonetheless instituted an action against the defendant for damages as a result of the alleged medical negligence.[19]

3.3 Judgment

In its judgment the Court broadly considered four legal questions: Firstly the submission of evidence by the plaintiff, secondly the question of onus of proof, thirdly the standard of care and skill expected, and finally the surrounding circumstances – in other words, the Court applied the Locality Rule.[20]

The first legal question the Court had to answer was whether or not the evidence of the plaintiff could be accepted into a court of law. However in terms of relevance (with regards to the Locality Rule) this question will not be considered in this discussion. Another factor the Court had to consider was on whom the burden of

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[15] During such a procedure swabs are used to prevent the spreading of sepsis into the body – See *Van Wyk v Lewis* 1924 AD 438 at page 442.

[16] *Id*. at page 443.

[17] *Ibid*.

[18] *Ibid*.

[19] *Van Wyk v Lewis* 1924 AD 438 at page 439.

[20] *Id.* at page 443-446.

proof (onus) rested.[21] The plaintiff relied on the maxim *res ipsa loquitur*[22] in arguing that the onus rests on the defendant to disprove the negligence and not on the plaintiff to prove the existence of the negligence.[23] The Court however rejected this argument[24] and held throughout the entire trial that the onus rests on the plaintiff – and therefore the onus will not shift.[25]

The Court stated that before the liability of the defendant can be determined in regard to whether his conduct amounts to negligence or unskillfulness, the Court first had to consider the standard of care and skill (diligence) required by the defendant in terms of the third question. Only thereafter could the Court consider the surrounding circumstances (in terms of the Locality Rule) of the procedure to assess the conduct of the defendant.[26] The importance of this case lies in the fact that the Court unanimously enunciated the test of reasonable foreseeability and preventability as the test for medical negligence. The Court reaffirmed the judgment of *Mitchell v Dixon*[27] in which it was held that it is not expected of the medical practitioner to exercise the highest possible degree of skill but rather a reasonable degree of care and skill when attending to patients.[28] The Court elaborated on the meaning of this reasonable care and skill and held:

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[21] The general rule regarding on whom the onus rests is he who asserts must prove. However in this case the plaintiff alleged that the fact that the swab was left inside the plaintiff's body constitutes *prima facie* proof of negligence on the side of the defendant. The plaintiff further alleged that this prima facie proof entails that the onus has now shifted to the defendant to disprove his negligence.

[22] The thing (incident) speaks for itself.

[23] This maxim was discussed in detail in this case, but Innes CJ however held that there is no absolute test when it comes to this element, but rather that such a test depends on the circumstances of the case.

[24] The main reason for rejecting the argument of the plaintiff for the shift of the onus was based on the fact that the Court held the incident itself (the swab being left inside the patient during surgery) is an important factor, but it must be considered in light of all other medical evidence submitted.

[25] The Court referred to the case of *Frankel v Ohlsson's Breweries* 1909 TS 957 in relation to the transfer of onus from one party to the other.

[26] *Van Wyk v Lewis* 1924 AD 438 at page 443-444.

[27] *Id.* at page 519.

[28] See *Van Wyk v Lewis* 1924 AD 438 at page 444; Otto SF "Medical Negligence" (2004) *SA Journal of Radiology* 19.

> In deciding what is reasonable the Court will have regard to the general level of skill and diligence possessed and exercised at the time by members of the branch of the profession to which the practitioner belongs.[29]

The Court finally attended to the fourth question, namely the surrounding circumstances. Innes CJ in the majority judgment, completely rejected the thought of applying a principle such as the Locality Rule in South Africa:

> [B]ut I desire to guard myself from assenting to the principle approved in some American decisions that the standard of skill which should be exacted is that which prevails in the particular ***locality*** where the practitioner happens to reside. The ordinary medical practitioner should, as it seems to me, exercise the same degree of skill and care whether he carries on his work in the town or the country …[30]

Wessels JA in a minority concurring judgment differed substantially from Innes CJ in regard to the Locality Rule.[31] He held:

> It seems to me, however, that you cannot expect the same skill and care of a practitioner in a country town in the Union as you can of one in a large hospital in Cape Town or Johannesburg …[32]

During his judgment, Wessels JA elaborated on the use of the Locality Rule[33] 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 physician.[34]

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[29] *Van Wyk v Lewis* 1924 AD 438 at page 444.

[30] *Ibid* [my emphasis].

[31] Carstens explains in Carstens & Pearmain (2007) 637 that in the case of *Webb v Isaac* 1915 EDL 273 support can be found for the minority judgment of Wessels JA in discussing the Locality Rule – "There are excellent reasons for this rule of law, because it seems to me that of the law required in every case that a practitioner should have the highest degree of skill, it would lead to this result – that in remote country districts and even in country districts at no very great distance from the large centers, it would be impossible to find a country practitioner[s] who would take the risk of attending a patient, if he was always expected to exercise the highest degree [o]f skill obtainable in the medical professional".

[32] *Van Wyk v Lewis* 1924 AD 438 at page 457.

[33] The Court stated that if several incompetent and careless physicians practice in the same area cannot have an influence on the standard of care and skill that patients have a right to. See Carstens (2006) *South African Criminal Journal* 168.

The majority found in favour of the defendant based on the consideration of the above-mentioned four questions together with a few other factors. Firstly the Court held that given the circumstances and the difficult and urgent nature of the operation, the plaintiff came off easy and the damage was not as severe as it could have been.[35] Secondly the Court held that it cannot be said that just because the defendant left a swab inside the plaintiff's body does it mean the defendant did not exercise the reasonable skill, care and judgment as the average surgeon in his position would have displayed.[36] Following the previous point, the Court held that leaving a swab within a patient cannot be said to be negligent *per se*. The urgency of the procedure might have outweighed the time it would have taken to search for and count all the swabs.[37] Based on the above the Court therefore dismissed the appeal in favour of Dr Lewis.

4 *S v Tembani*[38] Case Discussion

4.1 Introductory Remarks

The judgment of *S v Tembani*[39] (hereafter *"Tembani* case") has created an uproar not only in the medical-law community but also in the medical community itself. Where the Court in the Van *Wyk* case[40] is of the view that the standard of health care is considered to be uniform, *Tembani* can be argued to reflect the other end of the spectrum in saying that medical negligence can now be expected in public hospitals.[41]

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[34] See 1924 AD 438 at page 457; *Small v. Howard 128 Mass. 131, 35 Am. Rep. 363 (1880).*

[35] *Van Wyk v Lewis* 1924 AD 438 at page 454.

[36] *Id.* at page 471.

[37] *Ibid*.

[38] 2007 1 SACR 355 (SCA).

[39] *Ibid*.

[40] 1924 AD 438.

[41] See para [27] and [29] of the judgment; Carstens (2008) *SA Public Law* 173; 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 202.

4.2 Facts

The appellant in this case was convicted of murder in the court *a quo*.[42] The appellant shot his girlfriend at least twice, point blank, once in the chest (penetrating her lung, diaphragm and abdomen) and once in the calve muscle. He had the direct intention of killing her.[43] The victim was admitted to Tembisa Hospital on the night she was shot by the appellant where she died fourteen days later due to septicaemia.[44] On the night she was admitted to the hospital the medical staff cleaned her wounds, administered antibiotic medication to her and also inserted an intercostal drain. Her abdomen injury was sufficiently and effectively treated but the hospital staff failed to provide her with the necessary care required in terms of the first twelve hours after her admission.[45] The day after her admission she complained of abdominal pain and also started vomiting. She was only properly examined for the first time four days after she was admitted to the hospital.[46] Another contributing factor to her death was the lack of timeous and appropriate surgery as well as the fact that she was left insufficiently attended to.[47]

In the court *a quo* the appellant pleaded not guilty whilst reserving his defence.[48] The defendant also decided to exercise his right to remain silent and therefore refused to testify.[49] His argument was that he was not guilty of her death as the hospital staff was grossly negligent in treating her and that due to their gross negligence she died.[50] He therefore contended that the medical negligence of the

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[42] *S v Tembani* 1999 (1) SACR 192 (W) – para [1].

[43] *Id.* para [3].

[44] *Id.* para [4]-[5] - The words of Dr Peters, the district surgeon who performed the post mortem investigation on the victim were as follows: *"…*by then everything had gone septic*".*

[45] *Id.* – para [5].

[46] *Ibid*.

[47] *Id.* - See para [1] – [6].

[48] *Id.* para [2].

[49] *Ibid*.

[50] *Id.* – para [4].

hospital was a *novus actus interveniens*[51] and therefore that he could not be charged with murder as he was not the cause of her death.[52]

4.3 Judgment

The legal question that the Supreme Court of Appeal (SCA) had to answer was whether an accused who inflicted a wound on a victim could escape liability for the crime if the wound inflicted is fatal, but rapid medical treatment could have saved the victim if the conduct of the hospital staff did not amount to medical negligence.[53]

In answering this question, the Court referred to the court *a quo*[54] that *prima facie* held the actions of the hospital to amount to medical negligence.[55] The presiding officer further stated that Tembisa Hospital was understaffed; the patients outnumbered the nurses and doctors on a large scale, which resulted in the nurse-patient and doctor-patient ratios not being adequate; and also that the medical records of patients were not sufficiently attended to and reflected multiple discrepancies.[56]

The SCA also took into account that the court *a quo* attributed these factors to budgetary constraints and more importantly the lack of adequate resources within the hospital.[57] The court *a quo* however held that the negligence, given the circumstances, is not "so overwhelming" and therefore the appellant was

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[51] This is known as new intervening act – therefore his argument was based on the fact that the medical negligence of the hospital broke the causal chain of events. He therefore admitted that he is the factual cause of her death, but the medical staff is the legal cause of her death, and therefore at most he can be guilty of attempted murder.

[52] *S v Tembani* 2007 1 SACR 355 (SCA) – See para [4].

[53] Please take note that the discussion of *S v Tembani* 2007 1 SACR 355 (SCA) will only touch upon criminal law when it contributes to the discussion at hand, and will therefore be limited in its application to medical negligence and the subtext of the Locality Rule.

[54] *S v Tembani* 1999 (1) SACR 192 (W).

[55] *Id.* para [6].

[56] *Id.* para [7].

[57] *Ibid.*

accordingly still found guilty.[58] In the SCA's judgment the Court held that if the accused had the intention to inflict a fatal wound, it means that he was aware of the fact that death might be the outcome of his actions – therefore he could not base his argument on the fact that the medical intervention failed to prevent the consequence of his intentional actions. In this regard the Court notes:

> The deliberate infliction of an intrinsically dangerous wound, from which the victim is likely to die without medical intervention, must in my view generally lead to liability for an ensuing death, whether or not the wound is readily treatable, and even if the medical treatment later given is sub-standard or negligent, unless the victim so recovers that at the time of the negligent treatment the original injury no longer poses a danger to life.[59]

The Court went on to make a very important statement, one which is often disregarded or construed in such a way as to deceive reality. The Court correctly reflected on the scarcity and "maldistribution" of medical resources available in South Africa.[60] The Court also held that it would be unfair to simply ascribe liability to an accused based on the false belief that a patient will in all circumstances be exposed to acceptable medical treatment or merely have accessibility to such treatment. In regards to this the Court held:

> [I]t presumes levels of service and access to facilities that do not reflect the living conditions of a considerable part, perhaps the majority of the country's population. To assume the ***uniform*** availability of sound medical intervention would impute legal liability in its absence on the basis of a fiction …[61]

The presiding officer however held that not even in a scenario arising from "gross negligence" should the accused succeed in escaping criminal liability if he/she has caused the death of another human being.[62] The appeal was therefore dismissed.

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[58] *S v Tembani* 2007 1 SACR 355 (SCA) – para [9].

[59] *Id.* para [25].

[60] *Id.* para [27].

[61] *Id.* para [7] (my emphasis).

[62] *Id.* para [29].

5 *Oppelt v Head: Health, Department of Health Provincial Administration: Western Cape*[63] Case Discussion

5.1 Introductory Remarks

Oppelt v Head: Health, Department of Health, Provincial Administration: Western Cape[64] (hereafter *"Oppelt* case") is a recent medical-law case in which the majority of the Constitutional Court (CC) held in favour of the plaintiff. The minority judgment however, creates the more logical argument and is therefore favoured by this dissertation. The discussion of the *Oppelt* case will therefore focus on the minority judgment and merely touch on the majority judgment.

5.2 Facts

Oppelt was a seventeen-year old boy who on the 23rd of March 2002, while playing the position of hooker in a rugby game, was seriously injured in a scrum.[65] The damage he sustained to his spinal cord resulted in paralysis which in turn resulted in him becoming quadriplegic. The scrum collapsed and Oppelt incurred a bilateral cervical facet dislocation of the vertebrae in his neck.[66] Oppelt was attended to at three separate hospitals. He was initially taken to Wesfleur Hospital, thereafter to Groote Schuur Hospital, and finally transferred to the specialised spinal cord injury unit at Conradie Hospital.[67]

In this case the timeline is of crucial importance as the persuasive evidence presented in the High Court was that of Dr Newton who testified that if Oppelt received emergency medical treatment within four hours after the scrum collapsed,

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[63] [2015] ZACC 33.

[64] *Ibid*.

[65] *Oppelt v Head: Health, Department of Health, Provincial Administration: Western Cape* [2015] ZACC 33 – para [88].

[66] *Ibid*.

[67] *Id*. para [4].

his chances of recovery would have substantially increased.[68] The timeline can therefore be summarised as follows: an ambulance was called forty minutes after the scrum collapsed and arrived ten minutes later.[69] After the accident the ambulance took Oppelt to the nearest hospital, which was Wesfleur Hospital in this instance.[70] Dr Venter (a casualty physician) attended to Oppelt upon arrival, whereafter Venter phoned Dr Rothemeyer at Groote Schuur Hospital in an attempt to obtain advice.[71] Rothemeyer instructed Oppelt to be transferred to Groote Schuur Hospital urgently via helicopter because Groote Schuur had specialists in spinal cord injuries.[72] Unfortunately no helicopter was available at the time and so Oppelt was transferred via ambulance.[73] It is important to note that during this time Oppelt's treatment still fell within Newton's four-hour theory. Approximately two hours after Oppelt arrived at Groote Schuur he was examined by Rothemeyer.[74] After examining Oppelt and consulting with a fellow spinal cord specialist, Rothemeyer suggested that Oppelt be transferred to Conradie Hospital.[75] Oppelt was admitted to Conradie approximately twelve hours after his scrum injury where the closed reduction procedure (suggested by Newton) was performed on Oppelt about two and a half hours thereafter – however by then it was too late.[76]

Oppelt instituted a delictual claim against the defendant on the premises that the hospital's actions were negligent and that they failed to provide him emergency medical treatment.[77] In the High Court emphasis was placed on the evidence led by Dr Newton, in regard to the four-hour theory, as mentioned above.[78] The High Court held that the unreasonable delays by the various hospitals enforced the fact that Oppelt was denied access to emergency treatment and therefore found in

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[68] *Id*. para [20] – [31].

[69] *Id*. para [112].

[70] *Ibid*.

[71] *Ibid.*

[72] *Ibid*.

[73] *Ibid*.

[74] *Ibid*.

[75] *Ibid*.

[76] *Ibid*.

[77] *Id*. para [89].

[78] The Court found his evidence to be both "logical" and "well-reasoned" – See para [7].

favour of Oppelt.[79] The Respondent lodged an appeal with the Supreme Court of Appeal (SCA). The SCA found in favour of the Respondent and held that Oppelt failed to illustrate on a balance of probabilities that the evidence provided by Dr Newton was valid.[80] Oppelt applied for leave to appeal to the CC and was granted leave to appeal.[81]

5.3 Judgment

The majority judgment of the CC[82] found in favour of Oppelt by holding that the criticism levelled against Dr Newton by the SCA was unfounded.[83] The Court further held that had Oppelt received the correct treatment within the prescribed time his condition could have been avoided.[84] The Court therefore concluded that Oppelt was denied emergency medical treatment, which in turn led to his current condition.

The minority judgment, written by Cameron J,[85] took the opposite view. Cameron held that the fact that Oppelt was attended to at three different institutions and urgent decisions were made as to his condition is evident of the fact that he was not denied emergency medical treatment.

> Mr Oppelt was assessed, stabilised, and catheterised. He was given oxygen and a high dose of steroids. The system received him and treated him with due care. It afforded him the standard of treatment the circumstances demanded of reasonable hospital personnel… He was not refused treatment.[86]

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[79] In terms of s 27(3) of the Constitution – See para [7].

[80] The Court held: "…Dr Newton's theory was based on too small a sample and that his statistical approach was not reliable" – See para [8].

[81] *Id*. para [9].

[82] Written by Molemela AJ (Mogoeng CJ, Moseneke DCJ, Froneman J, Khampepe J, Madlanga J, Nkabinde J and Theron AJ concurring).

[83] *Id*. para [42].

[84] *Id*. para [48] – [52].

[85] Jappie AJ concurring – see para [99].

[86] *Oppelt v Head: Health, Department of Health, Provincial Administration: Western Cape* [2015] ZACC 33 - See para [100].

In discussing the extent of section 27 of the Constitution Cameron J referred to *Soobramoney v Minister of Health, KwaZulu-Natal*[87] in which the Court held that access to health care is directly linked to the availability of resources.[88] The Court held that in light of the lack of resources and the pressure on the available medical personnel at the time, it cannot be found that Oppelt was not given emergency medical treatment, nor can it be found that he was treated inappropriately.[89]

In determining whether the Department's personnel acted negligently in treating Oppelt, Cameron J considered *Kruger v Coetzee (*hereafter *"Kruger* case")[90] in terms of the test for negligence of reasonable foreseeability and reasonable preventability, as well as *Mitchell v Dixon*[91] in terms of the standard expected from medical professionals. In terms of the *Kruger* case the question is therefore whether the hospital personnel could have foreseen that Oppelt would become permanently paralysed. In this instance Cameron J held the answer to be affirmative.[92] In answering the question of reasonable preventability, Cameron J used the timeline as set out above to illustrate that in attending to the Oppelt in the various ways that they did, the institutions, in making emergency decisions regarding Oppelt's treatment, did in fact try to prevent his condition.[93] In assessing the standard expected from a medical physician Cameron J referred to the fact that Dr Newton, in the High Court decision already, admitted to the fact that at the time there was no consensus as to his four-hour theory, and that it was in fact "brand new".[94] Dr Rothemeyer testified that at the time of Oppelt's incident she had never

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[87] (1) SA 765 (CC) para [20].

[88] "Dr Rothemeyer… 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… the nursing staff… were… treating between six and ten acutely ill patients at any one time…" - *Oppelt v Head: Health, Department of Health, Provincial Administration: Western Cape* [2015] ZACC 33 para [100].

[89] *Id*. para [103].

[90] 1966 (2) SA 428 (A).

[91] 1914 AD 519 at 525.

[92] *Oppelt v Head: Health, Department of Health, Provincial Administration: Western Cape* [2015] ZACC 33 para [109] – [110].

[93] *Id*. para [112] – [114].

[94] "… [t]here were no academic articles directly supporting his approach" - See para [119] – [120].

even heard of Dr Newton's theory and, if she had, she would have applied it.[95] Cameron J therefore concurred that given the facts above, and the fact that Dr Rothemeyer was not exposed to Dr Newton's theory, reasonable steps were taken by the hospital personnel to prevent Oppelt's paralyses and therefore it cannot be held that Oppelt was refused emergency medical treatment, neither can their actions be held to constitute negligence.

6 Critical Discussion of V*an Wyk, Tembani and Oppelt* in Context of the Locality Rule

This part of the chapter is aimed at critically discussing the three main cases in this chapter in order to determine the link between them and, more importantly, analysing the effect that these judgments, directly or indirectly, have on the Locality Rule.

It can be argued that in the *Van Wyk* case the judiciary goes too far in its view that the standard of health care is considered to be the same everywhere in South Africa and that the Locality Rule should thus be rejected. On the other hand, in the *Tembani* case the judiciary also goes too far in saying that substandard medical treatment is to be expected as part of the South African public hospitals.[96] In the *Oppelt* case the majority of the Court once again did not acknowledge the rarity of available resources and again found in favour of the plaintiff due to ignorance of the reality faced by medical practitioners in South African public hospitals. In South Africa we neither have a perfect health care system, nor can it be said that medical negligence is simply to be expected in our public health care facilities. A statement like this would open the floodgates in medical negligence litigation – leading to an immense increase in medical negligence lawsuits and judgments automatically in favour of the plaintiff in each matter. It can therefore be said that these judgments

[95] "In March 2002, Dr Newton's view did not even constitute a 'school'… Dr Newton's theory was published for the first time only in December 2011" - See para [125], [129] – [130].

[96] Carstens (2008) *SA Public Law* 176.

represent extreme alternatives as well as fallacies in the health-care system – all of them being a distortion of the reality in South Africa.

In *Van Wyk* the Court failed to face the stark reality of health care in South Africa. It must be noted however, that the judgment might have been appropriate for that time (more than a decade ago), but that the judgment can be said to be anachronistic and must be reconsidered in light of the health care realities South Africa faces today. The fact that the Court failed to decide unanimously regarding the need for the application of the Locality Rule can be seen as portraying doubt in terms of the way our health care system is assessed. Wessels JA in a minority concurring judgment argued in favour of the Rule whereas Innes CJ in the majority refused to allow the application of the Locality Rule. Could it be that the courts, already in 1924, realised the need to protect the medical profession against the foreseen increase in medical negligence suits? Could it be that the courts then already realised that a divide exists in the public and private health spheres indicating a need for the circumstances surrounding the conduct of a physician to be taken into account? Is this why the judiciary therefore failed to completely reject the idea of the Locality Rule – then already realising the possible need for such a maxim to be considered? By simultaneously accepting and rejecting the Rule, it is evident from the *Van Wyk* case (the *locus classicus* on medical negligence in South Africa) that the Court in 1924 already noticed the need for the surrounding circumstances and locality of practice to play a definite role in assessing medical negligence in a developing country such as South Africa.

One of the main points of criticism against the majority judgment in *Van Wyk* is the fact that the Court wrongly rejected the Locality Rule. The majority judgment rejected this Rule based on the fact that Innes CJ believed that the Locality Rule allows for the standard of health care to be lowered. He therefore rejected the Rule because he was under the impression that the Rule causes the standard of skill and care expected from a medical professional to be lowered and that he or she therefore does not have to abide by the care expected from him or her by the patient. It is argued that the majority reached its conclusion, rejecting this doctrine, based on an incorrect impression of the purpose of the Rule and therefore made a ruling based on what it believed the Locality Rule to be, and not what it actually is. It must be stated that the Locality Rule does not allow the standard of care and skill

to be lowered but rather the surrounding circumstances - therefore the locality of practice - to be taken into consideration when medical negligence is assessed. The standard of care expected from a public health care physician still coincides with the standard of care expected from a private health care physician – the difference is simply that the public health care physician might find himself or herself in a locality where resources are scarce. The scarcity of resources does not entail that the physician can now disregard the standard of care and skill expected of him or her.

In *Tembani* the question becomes whether the Court, by stating that medical negligence can be expected in public hospitals, is in fact recognising the Locality Rule indirectly?[97] By stating that substandard medical treatment is to be expected in public hospitals, the Court is saying that when the locality of the procedure is analysed, and it is determined that negligence in fact occurred in a public hospital, negligence should not be a surprise but should have been anticipated. The fact that substandard care is to be expected in public hospitals means the surrounding circumstances, and therefore the locality of practice, is taken into account when assessing negligence, hence the unintentional (but unmistakable) recognition of the Locality Rule in the *Tembani* SCA decision.

Something that must be discussed is the fact that the locality of practice in this decision is restricted to public hospitals because no reference was made in the judgment to private hospitals. The Court is therefore measuring the negligence against the locality of where the conduct of the physician occurred – therefore in public hospitals (and where public hospitals are located) medical negligence is to be expected, whereas in private hospitals this is not the case. Substandard care (medical negligence) is therefore to be expected in the public health care sector.

The Court therefore did not extend its judgment to private institutions which proves the fact that the health-care system in South Africa is not viewed to be uniform. A clear divide exists between the public- and private health-care spheres. By distinguishing these two from one another, and by expressly commenting on the

[97] Carstens is of the opinion that even though *S v Tembani* was a criminal case decided based on causation, the Locality Rule "*surfaced as the subtext of the decision*". See Carstens (2008) *SA Public Law* 169.

lack of resources allocated to medical heath care in South Africa, the Court undoubtedly accepts the reality of health care in our country and the stark divide that exists between the public- and private sectors.[98]

Tembani therefore accepts the fact that the locality of practice will have an influence in assessing a physician's conduct, even though the Locality Rule was not expressly mentioned in this case. It however becomes relevant to ask whether the judgment of *Tembani* implies that even though South Africans have the right to access to health care as granted by our Supreme law,[99] we do not have access to quality health care (in the public sphere).[100]

In the *Oppelt* case the severity of the injury outweighed the reality of the available medical resources. In *Tembani* the Court finally admitted to the divide that exists between the public- and private health-care sectors but in *Oppelt* the Court once again returned to the position enunciated in *Van Wyk*. The majority judgment in *Oppelt* once again failed to acknowledge the realities of the public health care sector and decided the outcome of the case without taking these factors into account. The *Oppelt* judgment therefore illustrates that even though the Court in *Tembani* states that medical negligence can be expected in public institutions, the courts still do not take into consideration the realities of public health care institutions. The *Tembani* case confirmed a feasible need for the Locality Rule to be implemented, but the *Oppelt* decision illustrates a desperate and urgent implementation of the Locality Rule.

The courts need to be forced to consider the realities of the public health care sector. *Oppelt* makes it clear that even though these realities are present and have a major influence on the outcome, the courts are not compelled to consider them.

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[98] Carstens captures this perfectly in his article on *S v Tembani*, by stating: "However, after the judgment in *S v Tembani* 2007 1 SACR 355 (SCA), it is apparent that the big divide between public and private health care in South Africa (private hospitals and public hospitals) with reference to medical infrastructure, resources, competent medical staff and other 'South African medical realities', will have a decided influence on the question of whether the locality of a medical practice is to be considered as a factor when assessing criminal medical negligence, specifically in the context of medical care in public hospitals". See Carstens (2008) *SA Public Law* 169.

[99] S 27 of the Constitution.

[100] Carstens (2008) *SA Public Law* 177.

The implementation of the Locality Rule will oblige the judiciary to consider the state of the public health care sector and therefore acknowledge the lack of health, human, financial and infrastructural resources. As soon as this can be accomplished, an incorrect decision, such as the majority judgment in *Oppelt*, will not be attained.

Even though the judgment of *Van Wyk* illustrated confusion in terms of the application of the Locality Rule and even though the court in *Tembani* and *Oppelt* did not expressly refer to the Rule, it is evident from these cases that a need exists for this Rule. Health care in South Africa is definitely not of the same standard everywhere, as initially claimed by Innes CJ in *Van Wyk.* Are we really prepared to go as far and agree with the SCA in *Tembani* in saying that we can now expect medical negligence in any public hospital? By doing this we are excusing the occurrence of medical negligence in the public sector and in turn failing to improve and develop the health care in South Africa by hiding behind this facade.

If we truly are at this point in South Africa where we not only admit to the divide between public hospitals and private hospitals openly (as done in the *Tembani* judgment), but we acknowledge negligence as an everyday occurrence in public hospitals, then it becomes clear why the locality of practice needs to be one of the main factors taken into consideration in the assessment of negligence.[101]

Up and till the decision of *Tembani* the Locality Rule has not yet been reassessed since the case of *Van Wyk* in South Africa, and even though Innes CJ's viewpoint in rejecting the application of the Locality Rule seems to be the preferred stance,[102] Wessels AJ's acceptance of the Rule has never been outright rejected by a court.[103] It might be that even though the court in *Tembani* and *Oppelt* did not

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[101] In the case of *Viita v. Dolan*[101] the Supreme Court of Minnesota confirmed an instruction form a lower court the locality of practice – therefore the locality where the physician operates – is merely one of the circumstances a court has to take into consideration when assessing the alleged negligence of the physician - Bowden KR "Standard of Care for Medical Practitioners – Abandonment of the Locality Rule" (1972) *Kentucky Law Journal* 212.

[102] Carstens & Pearmain (2007) 637.

[103] The only criticism against the acceptance of the Locality Rule by Wessels AJ is by the writers Gordon, Turner and Price: *"*What difference can it possibly make to the skill and care required of a practitioner in himself, whether he has a patient in Cape Town or some remote farm on the edge of

expressly refer to the Rule, that the judgments handed down (especially the majority judgment in *Oppelt* which is not preferred by this dissertation) is the awakening our health care system (and government) need to see that the reality of a lack of medical resources available in South Africa requires the application of the Locality Rule to be seriously revisited as soon as possible.

7 What about the National Health Insurance?

7.1 What is National Health Insurance?

The counter-argument for the implementation of the Locality Rule is most definitely that the new health-care transformation manifesting by way of the proposed National Health Insurance (NHI) and the fact that provision for health reform and attending to the lack of quality health care in the public sector has already been addressed by way of the NHI.

In August 2011 a Green Paper was released by the Minister of Health with the title "Policy on National Health Insurance"[104] with the purpose of another attempt at health-care reform in South Africa with far-reaching consequences. Oosthuizen explains that the objective of the current government's NHI plan is to provide universal coverage in terms of health care.[105] He further states that the only way to reach this objective is to improve the quality of health care in the public sector and

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the Kalahari desert? The other view seems to arise from a confusion of thought between skill and care and the circumstances they must be exercised. A country practitioner may often be obliged to attend to a patient in most difficult and trying circumstances, but sometimes a town practitioner is placed in an emergency in an equally unpleasant position". See: Gordon I, Turner R & Price TW *Medical Jurisprudence (*Edinburgh: Livingston 1953) 112.

[104] Oosthuizen WT (2014) *An Analysis of Healthcare and Malpractice Liability Reform: Aligning Proposals to Improve Quality of Care and Patient Safety* LLM Dissertation University of Pretoria 115.

[105] *Ibid*.

therefore to align the public health care sector with the private health care sector and therefore to equalise the various resources within these sectors.[106]

On 17 February 2016 commentary was opened to the public to comment on the National Health Insurance White Paper in the Pretoria News Newspaper. In this publication the NHI was described as follows:

> NHI is a health financing system that is designed to pool funds to provide access to quality, affordable personal health services for all South Africans based on their health needs, irrespective of their socio-economic status... NHI seeks to realise universal health coverage for all South Africans.[107]

The publication goes further by stating that the implementation of the NHI will ensure that each and every South African will be entitled to the right to access of comprehensive health care as envisioned and provided for in section 27 of the Constitution, and with the NHI this would be free of charge.[108]

7.2 How will the NHI work?

In 2009 the Minister of Health decided to appoint a National Health Insurance Advisory Committee in order to advise the Minister regarding the progress and development of the policy and the legislation to follow.[109] The NHI will be based on the following principles: Firstly, and most importantly, section 27 of the

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[106] *Ibid* – "The ANC based the argument for reform on the observed inequities of the current health system, stating that it intends to address the structural and systemic issues through redistributive and social justice measures".

[107] National Health Insurance – Commentary on the National Health Insurance White Paper, Pretoria News Newspaper, Separate publication, 17 February 2016 1.

[108] *Ibid* – "NHI will therefore ensure that all South Africans, poor or rich, young or old, have access to and use affordable, quality health care services, regardless of their socio-economic status"; Health24 "How South Africa's NHI will work" 2015. www.health24.com/news/public-health/how-south-africas-nhi-will-work-2015121 Accessed 25 February 2016 - The NHI fund will be applicable to South African citizens as well as permanent residents. In regards to refugees, a special, alternative will apply to them.

[109] Oosthuizen WT (2014) LLM Dissertation University of Pretoria 117-118.

Constitution; effectiveness; efficiency; social solidarity; appropriateness; equity; and importantly, affordability.[110]

The question asked by most South Africans regarding the implementation of the NHI plan is how exactly it will work. The NHI will comprise of a fund known as the NHI Fund that will purchase health-care services for the country.[111] The follow-up question is then where the NHI Fund will acquire the funds to provide the entire population with health care services. The government answers this question by stating that the funding will be procured through various pre-payment sources, mainly based on general taxes.[112]

What is significant to note regarding the implementation of the NHI is that it will be implemented in three different phases over the next fourteen years, which already started in 2012.[113] The timeline looks as follows: Within the first five years public-health service delivery will be implemented, focus will be placed on the government and management of the health-care sectors in South Africa in order to equalise the two sectors to improve the quality of health care for South Africans.[114] In this first phase *The Ideal Clinic* programme will become effective and existing hospitals and clinics will undergo inspection and certification by the Office of Health Standards Compliance.[115]

The second phase will provide for the implementation of the NHI Fund together with the structures put in place to ensure the governance and execution of the NHI

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[110] *Id*. 134; Department of Health (2011) Policy on National Health Insurance 16.

[111] National Health Insurance – Commentary on the National Health Insurance White Paper, Pretoria News Newspaper, Separate publication, 17 February 2016 1; Health24 "How South Africa's NHI will work" 2015. www.health24.com/news/public-health/how-south-africas-nhi-will-work-2015121 Accessed 25 February 2016.

[112] *Ibid*.

[113] National Health Insurance – Commentary on the National Health Insurance White Paper, Pretoria News Newspaper, Separate publication, 17 February 2016 1; Health24 "How South Africa's NHI will work" 2015. www.health24.com/news/public-health/how-south-africas-nhi-will-work-2015121 Accessed 25 February 2016; Naidoo S "The South African National Health Insurance: A Revolution in Health-Care Delivery" (2012) *Journal of Public Health* 149.

[114] Naidoo S (2012) *Journal of Public Health* 150.

[115] *Id*. 2.

Fund.[116] This phase will also be used to establish additional funding and revenue as well as awarding and apportioning this additional revenue. Amendments to the Medical Schemes Act 131 of 1998 will also be initiated during this phase, as well as continuing of the certification process that will be initiated in phase 1.[117] The final phase of the implementation will see the finalisation of the certification system to prepare the institutions for contracting with the NHI Fund.[118]

7.3 Benefits of the NHI

The NHI plan comprises of the following benefits:

- Ensuring every South African is entitled to quality health care, no matter your race, socio-economic stance, age or gender.
- The NHI will protect patients against out-of-pocket payments and therefore minimise their financial risk – this will also result in health care that is completely free.
- NHI will ensure that payment towards the fund is much lower than the current medical schemes in South Africa.
- The implementation of the NHI is based on improving the quality of health care – this is one of its main objectives.
- Envisioning improvement of public health care sector – specifically financial and human resources.
- The NHI also seeks to hold the structures responsible for the funding thereof accountable in terms of the general health care funding.[119]

7.4 National Health Insurance versus the Locality Rule

The implementation of the NHI can be seen in a positive light as it acknowledges the lack of adequate and non-uniform health care in South Africa and admits to the

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[116] *Ibid*.

[117] *Id.* 3.

[118] *Ibid*.

[119] *Id*. 2.

realities of South Africa's health care system. Another positive remark regarding the NHI is the fact that the NHI Fund is not unrealistic in thinking the implementation of this plan will have immediate effect, instead, a fourteen year plan has been instituted in terms of the implementation of NHI in South Africa. The Minister of Health's NHI plan can therefore be seen as a step in the right direction to once again spark health care reform and to attempt a system where South Africa will finally have universal health care.

The question asked in terms of this dissertation is why should the Locality Rule be implemented if South Africa is already undergoing major health care reform in terms of the NHI? The answer to this question lies in the fact that the proposed reform is still years away. As mentioned previously, the Locality Rule is not the solution to South Africa's health care problems but rather an interim suggestion to address the discrepancies between the public and private health care sectors. The NHI might be the ultimate solution and answer that the South African health sector has been waiting for all these years after its failed attempts at health care reform but, due to the fact that the complete implementation of the reform will take a minimum a fourteen years, the question beckons as to what the interim solution to South Africa's health care reality should be. The answer provided in this dissertation is that the Locality Rule can and should be used as an interim solution because it takes cognisance of the surrounding circumstances that South African physicians face daily and can therefore be used to determine if the negligence can be attributed to the physicians alone, or whether the physician's location and lack of available resources had an influence on the medical negligence that occurred.

8 Implementation of the Locality Rule in South Africa

The above case discussions together with the fact that the implementation of our main "saviour" to the current health care system will only take proper effect in more than a decade, affirms that the Locality Rule definitely has a place in the South African medical-law system. The question however becomes, how should the Locality Rule be implemented?

In the previous chapters it was established that the Rule originated in America, but was never applied, nor considered in England.[120] In the introduction to this dissertation it was mentioned that if it can be proven that the Locality Rule has been recognised in English law, then, through the development of our common law it will be fairly easy to incorporate the Rule in our medical law system. English law however discounts the Rule and therefore it cannot be strategically used for the Implementation of the Locality Rule in South Africa. The uniformity of health care in England negates the need for the implementation of a Rule with the sole purpose of admitting to discrepancies that exist in the private- and public-health sectors in order to effectively address these inconsistencies. It is exactly for this reason that the Locality Rule will never find recognition and/or application in the English law, and therefore the premise of incorporating the Locality Rule in the South African medical law through strategic use of English law is futile.

In order for the Locality Rule to be implemented in South Africa as an interim solution until full effect can be given to the long-awaited (and still awaited) NHI, the recent judgment of the SCA in *Tembani*[121] needs to be taken seriously not only by the judiciary, but more importantly also by the legislature and the executive. As it was stated in the conclusion to the first chapter of this dissertation, South Africa has fairly good legislative forms in place to address the discrepancies in the public- and private health-care sectors (as a result of the continuous attempts at health-care reform throughout the years). The a lack of enforcement, however, and tools such as policy documents and regulations assisting in the application and implementation of health-care legislation in South Africa, the judiciary, and its radical stance on the quality of health care in South Africa, will simply remain a judgment with words spoken by an Honourable Judge. In order for the Locality

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[120] Anderson AL "Standard of Care for Medical Practitioners – The Locality Rule" (1969) *South Dakota Law Review* 352; Bowden KR "Standard of Care for Medical Practitioners – Abandonment of the Locality Rule" (1972) *Kentucky Law Journal* 210; Flemming JG "Developments in the English Law of Medical Liability" (1959) *Vanderbilt Law Review* 640-641; Karlson HC & Erwin RD "Medical Malpractice: Informed Consent to the Locality Rule" (1979) *Indiana Law Review* 688; Nathan HL *Medical Negligence: Being the Law of Negligence in Relation to the Medical Profession and Hospitals* (London: Butterworth 1957) 21.

[121] *S v Tembani* 2007 1 SACR 355 (SCA).

Rule to therefore be implemented in South Africa we cannot simply rely on the support supplied by the courts and the legislature, unfortunately the implementation of the Rule lies in the hands of the executive in realising the true need for the Locality Rule currently in South Africa. Only once the three arms of government work together, will the true need for the Locality Rule be realised, and thereafter its implementation will effortlessly follow.

The suggestion made above is however very unrealistic, as it requires the three arms of government to work together as a perfect team and hold one another accountable, and therefore a more practical explanation of the implementation of the Rule in South Africa is required. Carstens & Pearmain discuss the Locality Rule in light of "South African medical realities, and makes a suggestion as to the practical implementation of the Rule".[122] They observe:

> It can be accepted that medical practitioners in South Africa today undergo uniform medical training, comparable with international standards. However it cannot be denied that South Africa is a developing country and in many respects even an emerging or Third World country. Although the physician may be well-qualified and equipped with all the subjective competence to be an excellent doctor, the fact that he/she is placed/practises in a remote rural district without the surrounding medical facilities or infrastructure available to a well-equipped modern practice in the larger city centres, must be a consideration when assessing the alleged medical negligence of such a medical practitioner.[123]

Carstens & Pearmain are of the opinion that the Locality Rule should be viewed as a "rule of special circumstance" meaning that locality of practice is one of the factors that must be taken into consideration when assessing the alleged medical negligence.[124] Therefore according to them the Rule cannot be disregarded in its entirety. The Rule does in fact come into play in South Africa, as a surrounding factor that must considered when medical negligence is assessed. What is important to note regarding their suggestion is the fact that through the

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[122] Carstens & Pearmain (2007) 637 – 638 – "In our opinion, a distinction is to be drawn between the subjective competence and the ability of the physician (ability with regard to training, experience and skill), and the objective circumstances of the particular locality where the physician practices or is employed."

[123] *Ibid*.

[124] Carstens & Pearmain (2007) 638.

implementation and recognition of the Locality Rule, the surrounding circumstances of a medical negligence suit will be considered in every case and it will no longer be a variable factor considered on occasion by the judiciary – it will form part of the basic test for medical negligence in South Africa.

Something worth mentioning is the fact that if the Locality Rule is not applied, it becomes substantially easier for the patient (usually the plaintiff) to prove that the conduct of the physician (usually the defendant) amounts to medical negligence.[125] This is not because the standard of care and skill of the physician is suddenly increased or assessed at a higher level but rather the fact that the plaintiff no longer has to find an expert in regards to the same or similar community.[126] This means that the chances that the defendant will be found guilty becomes more likely as the surrounding circumstances and the locality of practice is disregarded and each case involving alleged medical negligence is painted with the same brush. This is however currently the situation in South Africa. Independent Online posted an article entitled "Gauteng's Medical Negligence Shame" late last year confirming the abovementioned scenario.[127] The Gauteng Health Department has not had one medical negligence case decided in its favour since 2010, says writer Don Makatile.[128] A staggering amount of 176 medical negligence actions have been instituted against the Department between 2010 and 2015, where 168 of them were lost in court, and 8 settled out of court.[129]

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[125] It is generally accepted (and has been so for many years) that the (negligent) conduct of a physician is assessed in regards to the test of the "reasonable expert". If the physician is an expert the test will always be the reasonable physician (medical practitioner) in the same/similar circumstances. – See Carstens & Pearmain (2007) 619 – 621.

[126] Morrison (1996) 256.

[127] Makatile D, IOL "Gauteng's Medical Negligence Shame" 2015 www.iol.co.za/news/crime-courts/gautengs-medical-negligence-shame-1911421 Accessed 25 November 2015.

[128] *Ibid*.

[129] *Ibid* – "Health MEC Qedani Mahlangu revealed this week in the Gauteng Legislature that her department had forked out R544 million to date for medical negligence claims".

9 Conclusion

If it is said that "the test for negligence is a rule of circumstance",[130] then there can be no reason why the Locality Rule should not be implemented in a country like South Africa, where access to equal health care is clearly just a myth and the substantial increase in medical negligence actions is a fact.[131]

If the conduct of all medical physicians - regardless of their surrounding circumstances and resources - is assessed in the same manner, a public health care physician who might not be guilty of negligent conduct with regards to his standard of care and skill will be held to be negligent due to a lack of resources. The suggestion made by this dissertation is to implement the Locality Rule so that when medical negligence is assessed by the courts, the standard of care to which a physician is held is not only influenced by his or her locality of practice but is used as a determining factor in assessing the medical negligence.

By employing this Rule cognisance is taken of the reality of the conflicting health-care systems (private health care and public health care) we have in South Africa by allowing physicians exposed to inadequate circumstances to be held to a standard applicable to their locality of practice. This Rule would therefore allow health care in South Africa to be viewed for what it really is until a uniform health-care system – through the amendment of section 27 of the Constitution and the implementation of dynamic health care policies, such as the anticipated NHI – is achieved, where after the Locality Rule would no longer serve a purpose. Till then, however, the Locality Rule needs to be implemented in South Africa to afford

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[130] Carstens & Pearmain (2007) 638.

[131] Child refers in her article to medical negligence attorney Adele van der Walt who gives reasons for this substantial increase in medical negligence lawsuits in South Africa. Van der Walt says the increase can be linked to various factors, for example the under-qualification and poor training of nurses whose responsibilities far outweigh their capabilities. Another factor is the changes to the Road Accident Fund that occurred in 2008 this led to a decrease in work available for personal-injury attorneys who as a result started specializing in medical negligence claims - See Child K, The Times Live "Hospital Horrors Costing SA Plenty" 2014. www.timeslive.co.za/news/2014/01/17/hospital-horrors-costing-sa-plenty Accessed 8 October 2015.

medical practitioners the protection they deserve in order to compensate for the lack of resources available in the South African health care institutions.

The objective of this dissertation is to illustrate that even though section 27 of the Constitution provides access to health care, in South Africa there is no uniformity in the quality of health care exercised in the private and public spheres respectively. It therefore follows that medical physicians practising in these respective spheres cannot be held to the same standard of care when it comes to assessing alleged medical negligence. The Rule is therefore suggested as the alternative to the lack of uniform health-care system, which is not something featuring in South Africa's near future due to the long-term implementation of the proposed NHI.

The heading of this chapter states that the Locality Rule is suggested as an interim solution, the question becomes, why an interim suggestion? The purpose of this dissertation was not to suggestion the Locality Rule as a solution to the current health care system South Africa has but rather to find a way to deal with the lack of uniform health care we are currently facing. The Locality Rule is not suggested as a permanent incorporation into the South Africa medical law, but simply suggested as an interim solution which takes into account the lack of uniform health care and allows for physicians finding themselves in less favourable circumstances, due to their locality of practice, to be assessed by taking the locality of practice into account. As soon as South Africa can claim that it has uniform health care, therefore equal availability of resources, throughout the geographical boundaries of the country, like England and America claims to have, then the Locality Rule will fall into disuse. But South Africa is very far from making these allegations, and therefore the Locality Rule is the answer for the current health care system.

Chapter 6

Conclusion

In South Africa, until the Supreme Court of Appeal's decision in *S v Tembani*,[1] we were living under the false pretence that South Africa has a uniform health-care system with uniform training, resources and infrastructure. The reality of the health care system was suppressed and it was believed and portrayed that South Africa has uniform or national standard of health care but, with the increase in medical negligence suits in South African medical law as discussed in chapter 3 of this dissertation, the reality of the situation came to light. South Africa soon came to realise that avoiding the reality of the public health-care sector does not address the situation. Over the years there has been an attempt at health-care reform but none of these attempts have been sustainable and South Africa once again finds itself in the situation where it is attempting yet another health-care reform through the development and implementation of the NHI.

What proves interesting about the Locality Rule is that mention of the Rule (in contrasting opinions) has already been made in 1924 but never has the Rule actually been considered as a possible interim solution to the South African health care realities, even throughout the multiple attempts at health care reform. The aim of this dissertation was to do exactly this – to illustrate that the Locality Rule, as a rule of circumstance (as referred to by Pearmain & Carstens) can be the tool that South Africa needs to address the inconsistencies between the different health care sectors as have been finally identified. The Court in 1924 in *Van Wyk v Lewis*[2] illustrated this perfectly when it held:

> Not only must we take into consideration the practice of the profession, the place where the operation is conducted, the qualifications of the attendants, but the nature of the operation and the circumstances surrounding it. We cannot determine in the abstract whether a surgeon has or has not exhibited reasonable skill and care. We must place ourselves as nearly as possible in the exact

[1] *S v Tembani* 2007 1 SACR 355 (SCA).

[2] 1924 AD 438 461-462.

> position in which the surgeon found himself when he conducted the particular operation and we must then determine from all the circumstances whether he acted with reasonable care or negligently.[3]

Countries where the standard of health care is fairly equal and of the same quality do not require the Locality Rule. In those countries the standard of health care can be said to be standardised or uniform. Medical professionals have no reason to raise this Rule as a defence because all physicians obtained the same standard of medical training, they all have access to the same financial, infrastructural and medical resources and therefore when a medical negligence claim is assessed, the surrounding circumstances will not play a definite role because these surrounding circumstances are seen to be equal throughout the country. However, in a country such as South Africa - where access to equal health care is envisioned but merely constitutes a pipeline dream and a myth - the Locality Rule is required to protect the medical profession against medical negligent claims occurring due to the locality of practice and not necessarily the actions of the physician, in other words, the unequal access to health care and not malpractice itself.

In South Africa there is a goal to improve the overall quality of health care by implementing the NHI and therefore to finally ensure health care reform takes place. Until such a time that the NHI plan is fully implemented and operational, the objective of South African health care is simply to provide access to health care to as many South Africans as possible, neglecting the quality of the health care provided. The argument then follows that if the goal in South Africa is rather to afford everyone equal *access* to health care, and not to improve the *quality* of health, the Locality Rule *must* be implemented (to take cognisance of the lack of equal quality of health care) till a uniform level of health care can be achieved through the envisioned NHI. The Locality Rule will not improve the quality of health care, but if South Africa's focus rather lies with equal access throughout the geographical borders, then the Rule will at least ensure that cognisance is taken of the unequal quality (and lack of resources) in the public health sector.

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[3] 1924 AD 438 461-462.

This dissertation does not seek to protect medical physicians who have acted negligently, for example if the physician carelessly amputated the patient's leg but the patient came in for heart surgery the Locality Rule will not afford this physician protection. The dissertation simply seeks to suggest an interim solution to the fact that South Africa is a developing country that does not yet have uniform medical training, uniform medical resources or uniform medical infrastructure across the geographical boundaries of South Africa. The Locality Rule should therefore not be seen as a tool used as protection from the bench slanted in favour of the medical profession, but simply a factor that takes into consideration the fact that the ill fortune of a particular patient at hand might have ensued due to these surrounding circumstances the physician found himself or herself in at the time of attending to the patient, and that in the given scenario the physician had to make bricks with straw.

The Locality Rule will stand as an interim solution to make sure that the South African courts continue to realise the shocking reality of the public health care sector. The Rule will therefore ensure that in assessing medical negligence, the physician's surrounding circumstances are considered and not only the actions taken by the physician. The Locality Rue will guarantee that the presiding officer places himself or herself in the shoes of the physician during the time the medical negligence ensued. The Rule will ensure that for the next decade, as we are awaiting the development and implementation of the NHI, that South Africans not only have access to health care services throughout South Africa, but that the equality of the health care services are realised in the various locations and therefore addressed accordingly, especially if a medical physician seeks to assist in the given community but is not exposed to the necessary resources and/or infrastructure required to complete the procedure.

In conclusion, Professor Carstens, in his 1990 article published in De Rebus, sums up the position taken by this dissertation perfectly when he stated:

> In my opinion the locality where a medical practitioner operates will always be relevant in cases of medical malpractice until such time when it can safely be stated that the medical

facilities and equipment in this country are equally available and accessible, irrespective of whether the medical practitioner chooses to practice in the city or in the country.[4]

[4] Carstens PA "The locality rule in cases of medical malpractice" (1990) *De Rebus* 423.

Bibliography

Books

Amundsen DW "The Liability of the Physician in Roman Law" in *International Symposium on Society, Medicine and Law* by Karplus H (ed) (Amsterdam: Elsevier 1973).

Best A & Barnes DW *Basic Tort Law: Cases, Statutes and Problems* (Aspen Publishers Online 2007).

Brand D & Heyns CH (eds) *Socio-economic Rights in South Africa* (South Africa: PULP 2005).

Brennan WJ (ed) *Fundamentals of American Law* (Oxford: Oxford University Press 1996).

Brown S (ed) *Prenatal Care: Reaching Mothers, Reaching Infants, Volume 926* (National Academies Press 1988).

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

Casenotes *Torts: Case Note Legal Briefs* (Aspen Publishers Online 2009).

Cawthon EA *Medicine on Trial: A Handbook with Cases, Laws and Documents* (ABC-CLIO 2004).

Cohen AB *et al Technology in American Health Care: Policy Directions for Effective Evaluation and Management* (America: University of Michigan Press 2004).

Currie I & De Waal J *The Bill of Rights Handbook* (South Africa: Juta and Company 2013).

Danzon PM *Medical Malpractice: Theory, Evidence and Public Policy* (Harvard University Press 1985).

De Cruz P *Comparative Healthcare Law* (4th ed) (London: Routledge-Cavendish 2001).

De Cruz P *Nutshells: Medical Law* (1st ed) (London: Sweet & Maxwell 2002).

De Ville K & Freeman RB (eds) *Medical Malpractice in the Nineteenth-Century America: Origins and Legacies (The American Experience)* (America: NYU Press 1992).

Deutsch E & Schreiber HL (eds) *Medical Responsibility in Western Europe* (Springer Science & Business Media: 2012).

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

Dugard J *International Law: A South African Perspectiv*e (4th ed) (Cape Town: Juta Publishers 2013).

Ficarra BJ *Surgical and Allied Malpractice* (USA: Thomas Books 1968).

Furrow B *et al Health Law: Cases, Materials and Problems* (2nd ed) (St. Paul: West 1987).

Giesen ID *International Medical Malpractice Law* (1988).

Gordon I, Turner R & Price TW *Medical Jurisprudence (*Edinburgh: Livingston 1953).

Haavi EM *Holding Health Care Accountable: Law and the New Medical Marketplace* (USA: Oxford University Press 2001).

Hassim A, Heywood M & Berger J *Health and Democracy* (Siber Ink: 2007).

Healy J *Medical Negligence: Common Law Perspectives* (London: Sweet & Maxwell 1998).

Herring J *Medical Law and Ethics* (Oxford University Press 2008).

Herring J *Medical Law and Ethics* (Oxford University Press 2010).

Holder AR *Medical Malpractice Law* (2nd ed) (New York: John Wiley & Sons 1978).

Jones MA *Medical Negligence (*3rd ed*) (*London: Sweet and Maxwell 1991).

Kennedy I & Grubb A *Medical Law* (3rd ed) (London: Butterworths 2000).

Kennedy I & Grubb A *Principles of Medical Law* (Oxford: Oxford University Press 1998).

Martin R & Johnson L *Law and the Public Dimension of Health* (Routledge-Cavendish 2001).

Miller RD *Problems in Health Care Law* (Jones and Bartlett 2006).

Miller FH (ed) *Rights and Resources* (England: Dartmouth Publishing Company 2003).

Morreim EH *Holding Health Care Accountable: Law and the New Medical Marketplace* (Oxford: Oxford University Press 2001).

Morrison AB *Fundamentals of American Law* (Oxford: Oxford University Press 1996).

Nathan HL *Medical Negligence: Being the Law of Negligence in Relation to the Medical Profession and Hospitals* (London: Butterworth 1957).

Neethling J & Potgieter JM *Law of Delict* (Durban: LexisNexis 2010).

Neethling J & Potgieter JM *Law of Delict* (Durban: LexisNexis 2015).

Nolen WA *A Surgeon's World* (Random House Incorporated: 1972).

Pieterse M *Can Rights Cure?: The Impact of Human Rights Litigation on South Africa's Health System* (Pretoria: Pretoria University Law Press 2014).

Pegalis SE & Wachsman HF *American Law of Medical Malpractice* (New York: The Lawyers Co-operative Publishing Co. 1980).

Porter R *The Greatest Benefit to Mankind: A Medical History of Humanity from Antiquity to the Present* (London: Fontana Press 1999).

Potgieter *et al Law of Damages* (South Africa: Juta Publishers 2012).

Richards EP & Ratbun KC *Medical Care Law* (Jones and Barlett Learning 1999).

Shandell RE, Smith P & Schulman FA *The Preparation and Trial of Medical Malpractice Cases* (Law Journal Press 1990).

Slabbert MN *Medical Law in South Africa* (Kluwer Law International 2011).

Smith S "The History and Development of Legal Medicine" in *Legal Medicine* by Gradwohl RBH (Scotland 1954).

Spicker SF (ed) *The Law – Medicine Relation: A Philosophical Exploration* (London: D. Reidel Publishing Company 1981).

Stauch M, Wheat K & Tingle J *Sourcebook on Medical Law* (2nd ed) (Australia: Cavendish Publishing 2002).

Strauss SA *Doctor, Patient and the Law: A Selection of Practical Issues* (South Africa: Van Schaik 1980).

Strauss SA & Strydom MJ *Die Suid-Afrikaanse Geneeskundige Reg* (Suid Afrika: Van Schaik 1967).

Teff H *Reasonable Care: Legal Perspectives on the Doctor-Patient Relationship* (Oxford: Clarendon 1994).

Teitelbaum JB & Wilensky SE *Essentials of Health Policy and Law (Essential Public Health)* (Jones and Barlett Learning 2012).

Van den Heever P & Carstens PA *Res Ipsa Locquitur and Medical Negligence: A Comparative Survey* (Cape Town: Juta Publishers 2011).

Van den Heever P & Lawrenson N *Expert Evidence in Clinical Negligence: A Practitioner's Guide* (1st ed) (Cape Town: Juta Publishers 2015).

Van Rensburg HCJ *Health and Health Care in South Africa (*2nd ed) (Pretoria: Van Schaik Publishers 2012).

Walston-Dunham B *Medical Malpractice Law and Litigation* (Cengage Learning 2005).

Case Law - Domestic

Blyth v Van den Heever 1980 (1) SA 191 (A).

Carmichele v Minister of Safety and Security 2001 (10) BCLR 995 (CC).

CC Maynard et al v The Field Cornet of Pretoria (1894) 1 SAR 214.

Collins v Administrator, Cape 1995 (4) SA 73 (C).

Frankel v Ohlsson's Breweries 1909 TS 957.

Goliath v Member of the Executive Council for Health, Eastern Cape 2015 2 SA 97 (SCA).

Government of RSA v Grootboom 2001 (1) SA 46 (CC).

Khoza v Member of the Executive Council for Health and Social Development of the Gauteng Provincial Government 2015 (3) SA 266 (GJ).

Kruger v Coetzee 1996 (2) SA 428 (A).

Michael v Linksfield Park Clinic (Pty) Ltd 2001 (3) SA 1188 (SCA).

Mitchell v Dixon 1914 AD 519.

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 Kramer 1987 (1) SA 887 (W).

S v Makwanyane 1995 (3) SA 391 (CC).

S v Tembani 2007 1 SACR 355 (SCA).

Singh v Ebrahim (413/09) 2010 ZASCA 145.

Soobramoney v Minister of Health (KwaZulu-Natal) 1998 (1) SA 765 (CC).

Treatment Action Campaign v Minister of Health 2002 (4) BCLR 356 (T).

Van Wyk v Lewis 1924 AD 438.

Webb v Isaac 1915 EDL 273.

Case Law – International

Blair v. Eblen, 461 S.W.2d 370 (KY. 1970).

Bolam v. Friern Hospital Committee [1957] 2 All E.R. 118.

Bolitho v. City & Hackney Health Authority [1997] 4 All ER 771.

Brune v. Belinkoff 235 N.E.2d 793 (Mass. 1968).

Flock v. J. C. Palumbo Fruit Co., 63 Idaho 220, 118 P.2d 707 (1941).

Flock v. J. C. Palumbo Fruit Co., 63 Idaho 220, 118 P.2d 707 (1941).

Helling v. Carey (1974) 83 Wash 2d 514, 519 P2d 981, 67 ALR3d 175.

Hunter v. Hanley [1955] S. L. T. 213.

Lanphier v. Phipos (1838) 8 C. & P. 475.

Lanier v. Trammell 207 Ark. 372, 180 S.W.2d 818 (1944).

Leighton v. Sargent 27 N.H. 460 (1853).

Mahon v. Osborne [1939] 1 ALL ER 535

Pederson v. Dumouchel 431 P.2d 973 (Wash. 1967).

Regina v. Istan, 17 Cox C. C. 602 Engl.

Sheeley v. Memorial Hospital 710 A.2d 161 (1998).

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

Tatum v. Mohr, 21 Ark. 349 (1860).

Tefft v. Wilcox 6 Kan. 33 (1870).

Viita v. Dolan 155 N.W. 1077 (Minn. 1916).

Wilkinson v. Vesey, 295 A.2d 676 (1972).

Discussion Documents and Policy Papers

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

Harrison D "An Overview of Health and Health Care in South Africa 1994 – 2010: Priorities, Progress and Prospects for New Gains" Discussion Document by the Henry J. Kaiser Family Foundation (2010).

Internet Sources

ADMD Mavioglu & Alkan Law Office "Medical Malpractice: A Critique of the Turkish and American Approaches to Awarding Non-Economic Damages" Date Unknown. http://www.admdlaw.com/medical-malpractice-a-critique-of-the-turkish-and-american-approaches-to-awarding-non-economic-damages/#.VjccnZExGFI Accessed 2 November 2015.

B Domenech, Policy Documents "What the Constitution Says About Health Care" 2009. https://www.heartland.org/policy-documents/what-constitution-says-about-health-care Accessed 3 November 2015.

Child K, The Times Live "Hospital Horrors Costing SA Plenty" 2014. www.timeslive.co.za/news/2014/01/17/hospital-horrors-costing-sa-plenty Accessed 8 October 2015.

City Press, "SA ranks 8th on worst unemployment rate list". Date unknown. http://www.news24.com/Archives/City-Press/SA-ranks-8th-on-worst-unemployment-rate-list-20150429 Accessed 17 August 2015.

Crowe E, Study.com, "What is the Good Samaritan Law? – Definition, History and Cases". Date Unknown. http://study.com/academy/lesson/what-is-the-good-samaritan-law-definition-history-cases.html Accessed 27 November 2015.

Hall H, Science- Based Medicine "Paternalism Revisited" (2008) https://www.sciencebasedmedicine.org/paternalism-revisited/ Accessed 9 December 2015.

Health24 "How South Africa's NHI will work" 2015. www.health24.com/news/public-health/how-south-africas-nhi-will-work-2015121 Accessed 25 February 2016.

Kautzky K & Tollman SM, "A perspective on primary health care in South Africa" In: Barron P, Roma-Reardon J, editors. South African Health Review 2008. Durban: Health Systems Trust; 2008. URL:http://www.hst.org.za/uploads/files/chap2_08.pdf Accessed 19 August 2015.

Library of Congress "Medical Malpractice Liability: United Kingdom (England and Wales)" 2015. http://www.loc.gov/law/help/medical-malpractice-liability/uk.php Accessed 2 November 2015.

Medical Chronicle "Medical Litigation: A National Health Crisis Requiring Urgent Solutions" 2011. http://www.medicalchronicle.co.za/medical-litigation-a-national-health-crisis-requiring-urgent-solutions/ Accessed 7 October 2015.

Makatile D, IOL "Gauteng's Medical Negligence Shame" 2015 www.iol.co.za/news/crime-courts/gautengs-medical-negligence-shame-1911421 Accessed 25 November 2015.

"Medical Negligence Claims & Compensation in South Africa" Claim Help. Date unknown. http://www.claimhelp.co.za/medical-negligence/ Accessed 29 September 2015.

MedScape "The Verdict is in – The Locality Rule" Tony Francis 2013. http://boards.medscape.com/forums/?128@@.2a57045b!comment=1 Accessed 25 November 2015.

"Medical Ethics" Medical Dictionary. Date unknown. http://medical-dictionary.thefreedictionary.com/medical+ethics Accessed 27 August 2015.

"Minister of Health v Treatment Action Campaign (TAC) (2002) 5 SA 721 (CC)" ESCR-Net. Date unknown. https://www.escr-net.org/docs/i/403050 Accessed 25 August 2015.

Medical Protection "The End of Paternalism". Date unknown http://www.medicalprotection.org/uk/advice-booklets/mps-guide-to-ethics---a-map-for-the-moral-maze/chapter-1---ethics-values-and-the-law/the-end-of-paternalism Accessed 9 December 2015.

Naidoo S, Sunday Times, "Thousands of Doctors 'Negligent'". 2010. http://www.timeslive.co.za/sundaytimes/2010/06/06/thousands-of-doctors-negligent Accessed 7 October 2015.

News24, Health24, "SA's Shocking Medical Malpractice Crisis". March 2015. http://www.health24.com/News/Public-Health/SAs-shocking-medical-malpractice-crisis-20150309 Accessed 12 October 2015.

SouthAfrica.info, "Health care in South Africa". Date unknown. http://www.southafrica.info/about/health/health.htm#.VdGhF5ExGFI Accessed 17 August 2015.

South African Medical Research Council. Date unknown. http://www.mrc.ac.za Accessed 28 August 2015.

"The Influenza Epidemic" South African History Online. Date unknown. http://www.sahistory.org.za/article/influenza-epidemic Accessed 15 July 2015.

"What is the Human Right to Health and Health Care?" NESRI (National Economic and Social Rights Initiative). Date unknown. http://www.nesri.org/programs/what-is-the-human-right-to-health-and-health-care Accessed 24 August 2015.

Journal Articles - Domestic

Bateman C "Medical Negligence Pay-Outs Soar by 132% - Subs Follow" (2011) *South African Medical Journal*.

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

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

Chikte U "Health and Human Rights in South Africa" (2009) *Journal of the South African Dental Association*.

De Jager J & Du Plooy T "Measuring Tangibility and Assurance as Determinant of Service Quality for Public Health Care in South Africa" (2007) *Acta Commercii*.

Dhai A "A health system that violates patients' right to access to health care" (2012) *South African Journal of Bioethics and Law*.

Dhai A "Healthcare reform in South Africa: A step in the direction of social justice? (2011) *South African Journal of Bioethics and Law*.

Forman L, Pillay Y & Sait L "Health Legislation 1994 - 2003" (2004) *South African Health Review*.

Gaede B & Versteeg M "The State of the Right to Health in Rural South Africa" (2011) *South African Health Review*.

Howarth G *et al* "A Good Complaints System" (2015) *South African Medical Journal*.

Howarth G *et al* "Public Somnambulism: A General Lack of Awareness of the Consequences of Increasing Medical Negligence Litigation" (2014) *South African Medical Journal*.

Hugo JFM *et al* "Equity in Health Care: Does Family Medicine Have a Role?" (2010) *African Journal of Primary Health Care and Family Medicine*.

Kautzky K & Tollman SM "A Perspective on Primary Health Care in South Africa" (2008) *South African Health Review*.

Kramer E "'No One May Be Refused Emergency Medical Treatment' – Ethical Dilemmas in South African Emergency Medicine" (2008*) South African Journal of Bioethics and Law.*

Labuschagne D & Carstens PA "The Constitutional Influence on Organ Transplants with Specific Reference to Organ Procurement" (2014) *Potchefstroom Electronic Law Journal*.

Lalloo R et al "Access to Health Care in South Africa – The Influence of Race and Class" (2004) *South African Medical Journal.*

Langa P "Transformative Constitutionalism" (2006) *Stellenbosch Law Review*.

London L & Baldwin-Ragaven L "Human Rights Obligations in Health Care" (2006) *CME: Your South African Journal of CPD*.

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

McQuoid-Mason D "What Constitutes Medical Negligence? – A Current Perspective on Negligence versus Malpractice" (2010) *South African Heart Journal*.

Moyakhe NP "Quality healthcare: An attainable goal for all South Africans?" (2014) *South African Journal of Bioethics and Law*.

Naidoo K & Govender K "Compulsory HIV testing of alleged sexual offenders – a human rights violation" (2011) *South African Journal of Bioethics and Law.*

Naledi T, Barron P & Schneider H "Primary Health Care in SA since 1994 and the Implications of the New Vision for PHC Re-engineering" (2011) *South African Health Review*.

Ngwena C "Equity and the Development of the South African Health Care System: From the Public Health Act of 1919 to the Present Day" (2003) *Fundamina*.

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*.

Phaswana-Mafuya N, Peltzer K & Stevenson Davids A "Patients' Perceptions of Primary Health Care Services in the Eastern Cape, South Africa" (2011) *African Journal for Physical, Health Education, Recreation and Dance*.

Pieterse M "Health Care Rights, Resources and Rationing" (2007) *The South African Law Journal*.

Stulting A "Ethics in South Africa: New Challenges" (2000) *Medicine and Law.*
Zietsman JC "Medical Negligence in Ancient Legal Codes" (2007) *Akroterion*.

Journal Articles - International

Amundsen DW "The Liability of the Physician in Classical Greek Legal Theory and Practice" (1977) *Journal of the History of Medicine and Allied Sciences.*

Anderson AL "Standard of Care for Medical Practitioners – The Locality Rule" (1969) *South Dakota Law Review.*

Annas GJ & Healy, Jr JM "The Patient Rights Advocate: Redefining the Doctor-Patient Relationship in the Hospital Context" (1974) *Vanderbilt Law Review.*

Armstrong DD "Medical Malpractice – The Locality Rule and the Conspiracy of Silence" (1970) *South Carolina Law Review*.

Bach BJ "The Erosion of the Locality Rule and the Qualification of Experts Testifying in Medical Malpractice Suits in Virginia" (1981) *GMU Law Review*.

Bal BS "An Introduction to Medical Malpractice in the United States" (2009) *Clinical Orthopaedics and Related Research.*

Baldauf KE "Non-Resident Expert Testimony on Local Hospital Standards" (1969) *Cleveland State Law Review.*

Bowden KR "Standard of Care for Medical Practitioners – Abandonment of the Locality Rule" (1972) *Kentucky Law Journal*.

Buchanan DR "Autonomy, Paternalism and Justice: Ethical Priorities in Public Health" (2008) *American Journal of Public Health.*

Burcher P "The Patient-Doctor Relationship: Where are we Now?" (2015) *University of Toledo Law Review*.

Coetzee LC & Carstens P "Medical Malpractice and Compensation in South Africa" (2011) *Chicago-Kent Law Review*.

Cohen BR "The Locality Rule in Colorado: Updating the Standard of Care" (1980) *University of Colorado Law Review.*

Cowles DR "*Russo v. Griffen*: The Death of Vermont's Locality Rule in Legal Malpractice" (1987) *Vermont Law Review.*

Dworkin RB "Getting what we should from Doctors: Rethinking Patient Autonomy and the Doctor-Patient Relationship" (2003) *Health Matrix.*

Fagurland DE "Legal Malpractice: The Locality Rule and Other Limitations of the Standard of Care: Should Rural and Metropolitan Lawyers be Held to the

Same Standard of Care?" (1988) *North Dakota Law Review.*

Flemming JG "Developments in the English Law of Medical Liability" (1959) *Vanderbilt Law Review*.

Fox JE & Russell JF "The Locality Rule and Medical Malpractice: A Judicial Awakening" (1971) *Memphis State Law Review.*

Frenkel DA "Focus: Current Issues in Medical Ethics" (1979) *Journal of Medical Ethics*.

Gibson B "National Standard of Care – A New Dimension of the Locality Rule" (1983) *Arkansas Law Review.*

Giesen D "Vindicating the Patient's Rights: A Comparative Perspective" (1993) *Journal of Contemporary Health Law and Policy.*

Gillam S "Is the Declaration of Alma Ata Still Relevant to Primary Health Care?" (2008) *British Medical Journal*.

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

Goldberg R "Medical Malpractice and Compensation in the UK" (2011) *Chicago-Kent Law Review.*

Goodwin M & Song Richardson L "Patient Negligence" (2009) *Law and Contemporary Problems.*

Harris L "Tort Reform as Carrot-and-Stick" (2009) *Harvard Journal on Legislation.*

Human A "The Tale of Two Tiers: Inequality in South Africa's Health Care System" (2010) *University of British Columbia Medical Journal.*

Hyman DA & Silver C "Medical Malpractice and Compensation in Global Perspective: How does the U.S. Do It?" (2011) *Chicago-Kent Law Review.*

Kane WJ "Rural Health Care: Medical Issues" (1978) *Journal of the American*

Medical Association.

Karlson HC & Erwin RD "Medical Malpractice: Informed Consent to the Locality Rule" (1979) *Indiana Law Review.*

King JF & Coe WB "The Wisdom of the Strict Locality Rule" (1974) *Baltimore Law Review.*

Kong-lung HAU "Law and Ethics in Medical Practice: An Overview" (2003) *Medical Section.*

Kratz M "The Doctor-Patient Relationship" (1984) *Resource News*.

McKenzie Jr. FC "Torts – Willingness to Abrogate the Locality Rule in Medical Malpractice Suits Indicated" (1972) *Mississippi Law Journal.*

McK Norrie K "Medical Negligence: Who Sets the Standard?" (1985) *Journal of Medical Ethics*.

Michaud GL & Hutton MB "Medical Tort Law: The Emergence of a Specialy Standard of Care" (1981) *Tulsa Law Journal.*

MicCoid AH "The Care Required of Medical Practitioners" (1959) *Vanderbilt Law Review.*

Naidoo S "The South African National Health Insurance: A Revolution in Health-Care Delivery" (2012) *Journal of Public Health*.

Richardson Jr. JY "Virginia Abolishes Locality Rule in Medical Malpractice" (1979) *University of Richmond Law Review.*

Samantha A & Samantha J "Legal Standard of Care: A Shift from the Traditional Bolam Test" (2003) *Clinical Medicine*.

Schlender EL "Malpractice and the Idaho Locality Rule: Stuck in the Nineteenth Century" (2008) *Idaho Law Review.*

Scott SA "Torts – Evidence – Medical Malpractice: Locality Rule Abandoned in Alabama and Family Practitioner Held to National Medical Neighbourhood

Standard of Care" (1984) *Cumberland Law Review.*

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

Smerge R "Negligence – Medical Malpractice – the Locality Rule" (1968) *De Paul Law Review.*

Stewart WJ "The Locality Rule in Medical Malpractice Suits" (1969) *California Western Law Review.*

Stoia SJ "*Vergara v. Doan*: Modern Medical Technology Consumes the Locality Rule" (1993) *Journal of Pharmacy and Law.*

Thorpe KE "The Medical Malpractice 'Crisis': Recent Trends and the Impact of State Tort Reforms" (2004) *Health Affairs.*

Yamin AE "The Right to Health Under International Law and its Relevance to the United States" (2005) *American Journal of Public Health.*

Van Dokkum N "The Evolution of Medical Practice Law in South Africa" (1997) *Journal of African Law.*

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

Willis CJ "Establishing Standards of Care: Locality Rules or National Standards – A Commentary" (2007) *Journal of the American Medical Association.*

Willis CJ "Establishing Standards of Care: Locality Rules or National Standards" (2009) *American Academy of Orthopaedic Surgeons Journal.*

Wheat K "Is there a Medical Malpractice Crisis in the UK?" (2005) *Journal of Law, Medicine and Ethics.*

Legislation

Constitution of the Republic of South Africa, 1996.

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 16 April 1997.

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

National Health Act 61 of 2003.

Health Professions Act 56 of 1974.

Newspaper Reports

National Health Insurance – Commentary on the National Health Insurance White Paper, Pretoria News Newspaper, Separate publication, 17 February 2016.

Other

Budetti P & Waters TM *Medical Malpractice Law in the United States* (2005) Prepared for the Kaiser Family Foundation.

Guidelines on Ethical Medical Research of the Medical Research Council.

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.