A PRELIMINARY INVESTIGATIVE SYSTEM TO PROFESSIONAL CONDUCT COMMITTEES OF THE HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA, WITH SPECIFIC REFERENCE TO MAXILLO-FACIAL AND ORAL SURGERY

by

IZAK FREDERIK REDELINGHUYS

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to

Annelie,

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"…The appointment of the new president of the HPCSA brings with it
the promise of additional persecution of medical practitioners.
A recent interview with the new HPCSA president was printed in
a local newspaper and makes for frightening reading.
One hundred legal firms have been engaged to ensure that those
doctors who have complaints lodged against them
will be expeditiously 'tried, judged and executed'.
And if found guilty, the penalties will be increased.
To quote,
"*They, the doctors are now going to pay R5 million for their legal fees.
And we are going to strike them off the roll, or suspend them.
Previously they dragged cases out while they
continued to practise and make fortunes*".
The interview continues to further exalt this great manifestation of wisdom,
understanding and compassion:
"*The majority, on panels investigating allegations of misdemeanours by doctors,
will be community representatives,
and they are going to be chaired by people who are not doctors*".

- AM Levin -
Medical Chronicle: Aug 2004

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‘n VOORLOPIGE ONDERSOEKSISTEEM NA PROFESSIONELE GEDRAGSKOMITEES VAN DIE RAAD VAN GESONDHEIDSBEROEPE VAN SUID AFRIKA, MET SPESIFIEKE VERWYSING NA KAAK-, GESIG- EN MONDCHIRURGIE

deur

IZAK FREDERIK REDELINGHUYS

PROMOTOR: PROF DR K.W. BüTOW

MEDE-PROMOTOR: PROF DR P.A. CARSTENS

DEPARTEMENT: KAAK-, GESIG- EN MONDCHIRURGIE

GRAAD: PhD

Die doel van hierdie studie is om die effektiwiteit van die komitee van voorlopige ondersoek (in die konteks van professionele gedragskomitees) van die Raad van Gesondheidsberoepe van Suid Afrika te evalueer, met spesifieke verwysing na kaak-, gesig- en mondchirurgie. ‘n Evaluasie is gedoen van sake wat deur die komitee van voorlopige ondersoek verwys is na hierdie spesifieke professionele gedragsondersoek komitee van die Mediese en Tandheelkundige Beroepsraad. Waar aangedui, is hierdie ondersoek uitgebrei en aangevul uit ander relevante professionele gedragskomitees.

Ten einde hierdie doel te verwesenlik, is ‘n breedvoerige literatuurstudie gedoen oor die breë konsep van geneeskundige en tandheelkundige wanpraktyk en nalatigheid. Spesifieke aandag is geskenk aan die beginsels van deskundige getuienis en toestemming tot operasies. ‘n Verdere studie is gemaak van die normale regsbeginsels waarbinne hierdie ondersoek-komitees behoort te funksioneer. In die gevalle waar dissiplinêre ondersoeke gevolg het op die optrede van praktisyns, is ‘n omvattende ontleding van die sogenaamde regsproses en daaropvolgende bevindinge (in die konteks van die professionele gedragskomitees) gemaak.

Die resultate van hierdie studie dui daarop dat daar tekortkominge is, veral in die meer komplekse gevalle, in die ondersoekprosedures van die komitee van voorlopige ondersoek wat dissiplinêre ondersoeke van die Raad van Gesondheidsberoepe voorafgegaan het. Die volgende aanbevelings is gemaak (in volgorde van belangrikheid):

1. Beide die komitee van voorlopige ondersoek en professionele gedragskomitee moet aan die normale juridiese reëls van natuurlike geregtigheid voldoen, soos vervat in die Grondwet van die Republiek van Suid-Afrika.
2. ‘n Forum van deskundige getuies moet gestig word om alle gevalle van beweerde onprofessionele gedrag en nalatigheid met betrekking tot die vakgebied van kaak-, gesig- en mondchirurgie wat deur die Ombudsman ondersoek en verwys is, te evalueer.

3. ‘n Kaak- gesig- en mondchirurgiese Ombudsman moet aangestel word om alle relevante gevalle wat voor die PRELIM gebring word, te evalueer.
4. Die sogenaamde ‘*redelike persoon’* toets, gesubjektiveer tot die ‘*redelike spesialis’*, moet as standaard dien vir evaluasie van beweerde gevalle van nalatigheid in die vakgebied van Kaak-, Gesig- en Mondchirurgie.
5. Die voorgestelde pasiënt toestemmingsvorm dien as voorbeeld vir die verkryging van ingeligte toestemming. Dit is voor die handliggend dat die normale juridiese voorskrifte, veral met betrekking tot uitbreiding en afwyking tydens operatiewe ingrepe, nagekom moet word.
6. Lidmaatskap van organisasies wat aspekte van vrywaring en skade-vergoeding hanteer (soos die Medical/Dental Protection Society) word aanbeveel ten einde enige aanklagte van onprofessionele/skandalige gedrag korrek te hanteer..

Die aanbeveling het dit ten doel om ‘n voorlopige ondersoeksisteem daar te stel wat meer vaartbelyn, koste- en tydseffektief is om klagtes van onprofessionele gedrag te ondersoek en te evalueer vir moontlike dissiplinêre optrede.

SUMMARY

A PRELIMINARY INVESTIGATIVE SYSTEM TO

PROFESSIONAL CONDUCT COMMITTEES

OF THE HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA,

WITH SPECIFIC REFERENCE TO

MAXILLO-FACIAL AND ORAL SURGERY

by

IZAK FREDERIK REDELINGHUYS

PROMOTOR: PROF DR K.W. BüTOW

CO-PROMOTOR: PROF DR P.A. CARSTENS

DEPARTMENT: MAXILLO-FACIAL AND ORAL SURGERY

DEGREE: PhD

The purpose of this study was to evaluate the effectiveness of the committee of preliminary inquiry (in the context of professional conduct committees) of the Health Professions Council of South Africa, with specific reference to maxillo-facial and oral surgery. An evaluation was done of cases that were referred by the committee for preliminary inquiry to this specific professional conduct committee of the Medical and Dental Professions Board. Where necessary, these cases were supplemented by relevant cases from other professional conduct committees.

In order to achieve this goal, a comprehensive literature study was conducted on the broad concept of medical and dental misconduct and negligence. Specific attention was paid to the issues of expert testimony and witnesses and consent. Furthermore, a study was conducted to determine the legal framework in which these committees are supposed to function. In the cases where inquiries into the complaints against the registered practitioners followed, a detailed evaluation of the so-called legal process was done, as well as the findings in each case (in the context of the professional conduct committees).

The results of this study have shown that the investigative system of the committee for preliminary inquiry preceding professional conduct inquiries into complaints against registered practitioners has certain shortcomings, especially in the more complex cases. The following proposals have been made (in order of most importance):

1. Both the committee for preliminary inquiry and professional conduct committee must abide by the rules of natural justice, as pertained in the Constitution of the Republic of South Africa.

2. Establishment of a Forum of Expert Witnesses that will evaluate all cases of alleged professional misconduct and negligence pertaining to the field of maxillo-facial and oral surgery, after it was evaluated and referred by the Ombudsman.

3. Appointment of a maxillo-facial and oral surgeon as Ombudsman to evaluate all cases brought before the committee for preliminary inquiry pertaining to the field of maxillo-facial and oral surgery.

4. Acceptance of the proposed test of medical negligence, i.e. the '*reasonable person's* test', subjected to that of the '*reasonable specialist*' as standard for evaluation of cases of alleged negligence in maxillo-facial and oral surgery.

5. The proposed patient's consent form serves as an example of a legitimate patient consent form. It follows that the legal requirements, especially in cases of extensions and deviations of medical interventions, must be adhered to.

6. It is advisable to belong to an organisation providing indemnity cover (such as Medical/Dental Protection Society) in order to receive proper assistance in the handling of these cases of alleged unprofessional/disgraceful conduct.

The recommendations consequential to this study would provide a more streamlined, cost- and time effective investigative system to investigate claims of unprofessional conduct for possible further disciplinary action.

CHAPTER 1

PROBLEM STATEMENT AND PRESENTATION OF STUDY

1.1. INTRODUCTION

It is common practice amongst professional organisations and societies to address issues affecting these bodies during their annual general meetings. It was during such a meeting that the author, then a student – member of the South African Society of Maxillo-Facial and Oral Surgeons, was disappointed at the ferocity that some of the senior members argued to strengthen their own diverse opinions on matters of mutual interest to the Maxillo-Facial and Oral Surgery profession. Such actions appeared not to be in the interest of the profession as a whole, and ultimately the patients as well. This was probably the single most important aspect that initiated this study.

1.2. PROBLEM STATEMENT

The first ten years of democracy in the new South Africa have emphasized the pluralism in values, principles and competing moralities that has dawned on us, bringing about several new grounds for moral and ethical controversies. As medico-legal actions are steadily increasing globally, it can be expected that South Africa will probably soon follow the international trends.

The Health Professions Council of South Africa (HPCSA) is responsible for the control of education, training, registration, practices and conduct of the medical and dental professions. In the instance of an unsolved medico-legal dispute arising between a patient and a practitioner, there is the possibility that the practitioner could either be reported to the HPCSA, or a civil case brought against him/her. On occasion a criminal charge is laid against a practitioner.

Investigations into allegations of alleged professional misconduct (with special reference to Maxillo-Facial and Oral Surgery) often reveal the following aspects, namely:

- Increasing, and often unrealistic expectations and claims by patients that can largely be attributed to one-sided, sensational media reports.
- Unrealistic expectations that are set by practitioners with limited insight and/or experience in certain complicated diagnostic and clinical issues.
- Diversity of expert testimony, mainly attributed to the many different schools of thought.
- Absence of adherence to legal guidelines and inconsistency with regard to the proceedings of the committee for preliminary inquiry (PRELIM).

The PRELIM is expected to conduct investigations into allegations of alleged professional misconduct in order to determine whether *prima facie* evidence exists to

justify a disciplinary investigation. The extent of the cases brought before the PRELIM is overwhelming. The rulings made in the vast majority of cases, such as fraud and false declarations/certificates, do not justify any further comment, as they were clearly based on sound judgement by the committee.

However, this study indicated that, especially in the more complex cases when the Dental PRELIM seemed to be in doubt, the responsibility was shifted to the relevant Professional Conduct Committee (PCC) of the Medical and Dental Professions Board (MDPB) for a decision. The South African Constitution assures freer access to the courts and although practitioners have always had the right to request a High Court to review the rulings by the HPCSA, they may now well challenge these proceedings and/or rulings more fiercely in a higher tribunal, as aggrieved practitioners have been granted a right to appeal against such decisions.[1]

An investigation was done at the legal department of the HPCSA regarding complaints that were lodged against Maxillo-Facial and Oral surgeons for various claims of alleged unprofessional conduct. These records (annexure 1) indicated that the Dental PRELIM investigated 78 complaints against 47 practitioners during the fourteen-year period from January 1992 to October 2004.

It appears that more than seventy percent of the claims focused on aspects pertaining to

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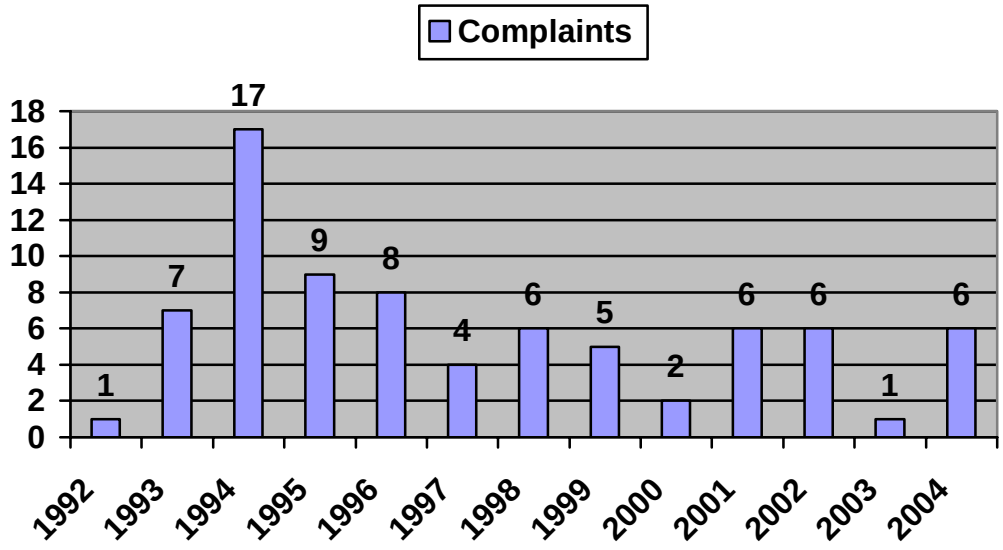
1. Taitz 1988: The basic distinction between review by and appeal to the High Court lies in the fact that the Court, in dealing with the remedy of review, is not concerned with the merits of the judgement, but only with the question whether judicially recognised irregularities were committed in the proceedings. On the other hand, appeal is the wider remedy. Appeal permits the court to reconsider the case on its merits, i.e. the substantive correctness of the decision based on the facts of the case and the law relevant to it.

the treatment of patients. This is also in accordance with the majority of complaints received by the Dental Protection Society against the dental profession as a whole in South Africa.[2] As there is often marked, albeit *bona fide* difference of opinion on various aspects of surgical treatment (some experts favour drastic interventions; others prefer more conservative options), it follows that there is a decided unease about the reliability and objectivity of expert witnesses.

The investigation done at the legal department of the HPCSA stipulated the annual amount of complaints as follows:



It is clear from this graph that the Dental PRELIM investigated an average of six complaints against Maxillo-Facial and Oral Surgeons annually during the thirteen-year period from January 1992 to October 2004.

2. Butterworth 2002

The cases are categorised as follows:

- Procedural	**57**		
Competence	35	Over-service	1
Insufficient care	7	Operation without consent	1
Bad communication	5	Supersession	1
Certificates/Reports	3	Discrimination	1
Covering	2	Impeding	1
- Administrational	**21**		
Fees/Accounts	18	Advertising	3

The records of the Dental PRELIM of the legal department further indicated that it took an average of 16,7 months for these cases to be resolved. There are still 12 cases that have not been resolved as yet – these cases are regarded as *sub judice* and can therefore not be discussed in this study. Up to this point in time the PRELIM has referred 6 cases (12,8%) of the initial complaints brought against the 47 practitioners to the PCC for disciplinary inquiry. In the evaluation of these cases it was noted with concern that an unacceptably high percentage of cases (50%) were eventually found not guilty. The reason for this can be two-fold: (a) the high acquittal rate may of course testify to the advantage of good-quality defence-lawyering, or, (b) questions must be raised with regard to the effectiveness of the investigative function of the PRELIM, as they apparently found *prima facie* evidence of professional misconduct in all of these cases and subsequently recommended that disciplinary inquiries be held. Considering the latter, it is very unfortunate and simply not fair towards the accused practitioner, as inquiries are time consuming and often very expensive.

1.3. PRESENTATION OF STUDY

The presentation of the study will be done as follows:

1. GENERAL INTRODUCTION

   An overview of professional ethics will be given, as well as public opinion on the broad concept of ethical practice and unprofessional conduct. This is followed by a discussion of the influence of current trends of malpractice litigation on patients' expectations of treatment-options and outcomes in South Africa, seen in the milieu of enormous progress in maxillo-facial and oral surgery.

2. SYNOPSIS OF THE LEGAL FRAMEWORK FOR THE PRELIM

   A discussion of the principles of natural justice, rules of evidence and judicial precedent is given, followed by an overview of the regulations relating to the conduct of enquiries by the PRELIM. The relevant sections of applicable Acts are presented, with emphasis on the prescribed procedural conduct.

3. AN OVERVIEW OF RELEVANT LEGAL PRINCIPLES IN THE CONTEXT OF UNPROFESSIONAL CONDUCT WITH REFERENCE TO MEDICAL NEGLIGENCE, THE CONSENT-ISSUE AND EXPERT TESTIMONY

   A definition of the meaning of unprofessional conduct as contemplated

in the applicable Act is given, with reference to improper/disgraceful conduct concerning patients and/or fellow practitioners. A selection of common juristic principles (in the context of unprofessional conduct) adopted from national and international (foreign) law is discussed. The concept of medical negligence (in context of unprofessional conduct), as well as the proof thereof, is discussed with specific reference to difference in opinion when treating patients.

With regard to consent to treatment, the rights of the patient as well as the duty of the doctor in this regard are explained. Reference is made to the paternalistic principles of the so-called *Bolam*-principle (emanating from English law) in comparison to the patient-orientated principles as pertained in the landmark case of *Castell*, that in turn was recently confirmed in the *Oldwage*-case, concluded by an overview on the concept of excessive information liability.

An overview of the utilisation of expert testimony in order to prove medical negligence is given, followed by a discussion regarding the legal opinion on expert evidence and the boundaries thereof. In this discussion reference will be made to specific principles relating to cases of medical negligence in the United Kingdom, United States of America, Australia and Canada.

4. CASE STUDIES

A critical evaluation of relevant cases in the context of the PCC of the MDPB of the HPCSA, relating to negligence in maxillo-facial and oral surgery, will be presented, with specific reference to the basic legal principles as set out in paragraph 2 above.

5. PROPOSALS CONSEQUENTIAL TO THIS STUDY

An analysis of the procedural conduct of all the cases is given and where applicable, the necessary recommendations are made according to the principles discussed above.

6. CONCLUSION

A summary of the recommendations resulting from the study is given.

This study, in essence, is not a juristic thesis *per se*, being centred on the specialty of maxillo-facial and oral surgery. The purpose of this study is to offer ethically and legally justifiable recommendations to the current investigative system of the PRELIM, as it can obviously only be in the best interest of all parties concerned that it casts objective decisions on all cases brought before them.

CHAPTER 2

GENERAL INTRODUCTION

2.1. INTRODUCTION

Complaints against doctors are not a new phenomenon, but it is unusual for an actual letter of complaint to have survived for over 360 years. This, however, happened to a letter sent by a patient to Dr John Hall, Shakespeare's son-in-law.[3] Hall's practice covered a wide area and he spent much time travelling to visit his patients in the surrounding villages and towns. He was also interested in local government, though he felt that he could not spare the time from his practice to accept election to the Town Council again. He would appear to have been right, because when he was elected for a third time in 1632 and accepted the post, he soon ran into difficulties, as shown by the following extracts from an irate letter from his patient:[4,5]

> *"Good mr Hall,*
>
> *I sent my boy to you this morning to carrie my water & acquaint you with what daunger & extremitie. I am faullen into in respect my shortness of breath & obstructions of my liver, that I cannot sleep nor take anie test, and although I have more need of yr pres this daie than to stay until to morrow ... about dynner this date I received a note from you howe that you cannot be*

3. Barton 1997
4. Joseph 1976
5. Lane 1996

here at Bushwood with me to morrow ... you saie you are warned to be there [Town Council meeting] & if you be absent you are threatened to be fined, I did not expect to receive such a kindle of excuse from you, considering the daugerous estate I am in …..... therefore I think it is not anie Towne business, that can hinder you but rather that you have promised some other patient & would put me off with this excuse ... I know my disease is pilous & procrastination is daungerous. I have relied on you I trust you will not faile me now. Therefore I pray you all excuses set a part that you wilbe here to morrow morning by 7 of ye clock ... thus with my best wishes & hartie love remember to yr self & ye rest of my good friends with you I ommit you Gods holie protection & ever remain.

Yor trewly loving friend & Servant

Sid Davenport

Bushwood. thursdaie 5 July 1632".

Thus alternately pleading, suspicious, insolent, demanding and finally convinced that his physician will not fail him, the tone of the letter obviously had the desired effect, as Hall went to see Davenport at Bushwood early on the morning of 6 July 1632. As a result of attending to his patient, Hall was indeed fined for not attending the Council meeting that day.[4]

2.2. PROFESSIONAL ETHICS – AN OVERVIEW

Medical and dental ethics have become fashionable. Hardly a day goes by without some mention of ethics or related terms in the popular media. Despite its omnipresence,

4. Joseph 1976

professional ethics is the subject of much confusion and discussion.[6] Most people will recognise the term and would have some vague understanding of its meaning, i.e. that it has something to do with right and wrong.[7]

One of the reasons why ethics is so much in vogue nowadays is that the moral certainties of previous times no longer exist. Whereas we previously had confidence in the moral consensus that was shared by many of our families, religious organisations, educational institutions, professional associations and justice system, recent events in South Africa, and elsewhere, have called into question many of the values and principles underlying this consensus. In its place is pluralism, as we live in a society of many competing cultures and moralities.[7]

Medicine and dentistry have always had a strong moral character, at least since the time of Hippocrates (5th century B.C.). The Hippocratic Oath stipulates moral requirements, legal liability and behaviour expected of health professionals over and above those normally binding on other people.[7,8] Health professionals have therefore traditionally enjoyed a very high status in many, if not most, societies.[7] Both the reputation of the medical and dental professions and its confidence in its moral rectitude received a severe jolt with the Nuremburg Trials revelations of atrocities by German health professionals under the Nazi regime. Despite the formulation and promulgation of the so-called *Nuremberg Code,* which stipulated the basic requirements for the ethical

6. Caplan 1998
7. Dental Ethics 2000
8. Van Oosten 1991

conduct of research on human beings, examples of clearly unethical research continued to surface.[7]

Closer to home, the death of the now well-known black activist, Steve Biko, in detention in South Africa (1977), has continued to generate debate in the international medical literature. The three doctors who examined him during his terminal illness made a diagnosis of malingering in spite of overwhelming evidence suggesting that he had suffered extensive traumatic brain injury while in detention. The inquest into his death scrutinised the failure of the major medical associations in South Africa to provide clear guidance and leadership to state-employed doctors, as it was argued that this increased the risk that individual doctors could continue to succumb to complex social and hierarchical pressures to condone acts of state-sanctioned violence against detainees.[9,10] It became obvious to the public, and even the medical and dental fraternity itself, that the medical and dental profession could not always be trusted to police themselves.[7,9]

The spate of new ethical issues occasioned by development in medical and dental science and technology in the 1960s and, subsequently, caused medical and dental ethics to enter an era of unprecedented change.[11] The process of change is more complicated today than in the past. The health professional of today must practise ethically in an environment of enormous technological complexity, where authority has

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7. Dental Ethics 2000
9. Pellegrino 1993
10 *Veriava and Others v President, SA Medical and Dental Council & Others* 1985
11. Norwell 1997

shifted to insurers and risk, to the profession; where ethnic, cultural and religious pluralism, especially in human life issues, divides the profession and the public; where moral scepticism is the order of the day; and where law, economics and patient autonomy demand to be heard at the bedside.[12]

2.3. PUBLIC OPINION ON DOCTOR-PATIENT RELATIONSHIPS

Once upon a time the doctor knew best - or thought he did. Doctors examined patients and decided in a rather paternalistic manner what treatment was in the best interest of their patients. Most important of all, to the benefit of the doctor, patients accepted this conduct and did what they were told.[13]

A hundred years ago doctors were held in high regard by their patients, although the patients' expectations of their doctors' performance were low. Today, however, practitioners are being held to account for sins of commission and omission, for their attitude towards patients, and for their belief in the miracles of medical technology.[14] The medical profession is being suspected more and more of concealing its own shortcomings, albeit less suspect than others. At the beginning of the 20th century, in the preface to his play *'The Doctor's Dilemma'*, George Bernard Shaw wrote that all professions are a conspiracy against laity. In 1964, Pedro Lain Entralgo, a Spanish historian of medicine, claimed in his classic book *La relación medico - infermo* [The

12. Bliznakov 2000
13. Silove 1990
14. Dunning 1999

doctor - patient relationship] that little of the elements in this relationship has changed during the preceding 25 centuries. However, some years later his successor had to acknowledge that in the last 35 years of the 20th century, the relationship between doctor and patient (along with the status of both) has probably changed more than during the preceding 25 centuries.[15]

The man in the street has probably become conditioned by the mass-media to demand more from the medical and dental profession. Romantic write-ups on the possibilities and capabilities of modern medicine, extensive publicity on medical mishaps and malpractice trials, undoubtedly serve as catalysts for other grieved patients to commence with legal action. For example, the *disciplinary procedure of the General Dental Council of the United Kingdom* is probably the one aspect that attracts the most attention, certainly as far as their national media is concerned.[16]

Concerns have been raised about the style of media reporting of cases where doctors face disciplinary proceedings, or civil or criminal actions in the courts. It is particularly hurtful when the complainant's viewpoint is explicitly portrayed in media reports highlighting the opening days of such hearings. By contrast the defence mounted on behalf of the doctor is rarely reported with such prominence and sympathy.[17]

Discussions at social gatherings are often centred around people's experiences during

15. Lázaro 1999
16. GDC Gazette 1996
17. Saunders 1996

visits to a doctor - everybody seems to have a '*bad doctor story*'. Claims that doctors are '*hiding true facts*' or that doctors are '*protecting one another*' are often made.[18,19] Public opinions are seldom objective about the profession as a whole, and it can be very difficult to change the image that patients have of our profession, as it is often accepted that common sense is only regarded as the selection of prejudices acquired by early adulthood.

Physical action in this regard is definitely no option: consider the following ruling by the HPCSA against a practitioner;

> "…a practitioner was reprimanded for using more persuasion than necessary by physically evicting a patient from his surgery...".[20]

in comparison to the following statement[21] which is probably much more acceptable:

> "…it is well for people who think to change their minds occasionally in order to keep them clean. For those who do not think it is best at least to rearrange their prejudices once in a while…"

Patients come to doctors because they have an illness, and they hope that the doctor can help to heal it. Doctors on the other hand, undertake the care of patients with the intent and the duty to make all reasonable efforts to help them. As all doctors are human and thus prone to making mistakes, errors are inevitable in the practice of medicine and dentistry.[22] The range of mistakes or mishaps is wide and could probably fill a book to compare with any textbook on how to do the right thing.

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18. *Lambrechts v INMDC* 1997
19. Saunders 1997
20. *Malan v INMDC* 1996
21. Saayman & Van Oosten 1994
22. Pickering 2000

Mistakes vary from minor ones to those of such magnitude and seriousness that they could result in a lawsuit or worse, the loss of a licence to practice. Sometimes mistakes result from medicine's inherent high-risk nature and uncertainty. Occasionally they are the result of mistakes or oversights on the part of the otherwise competent individual provider. Thus the topic of dental and medical indications, in addition to the clinical data that must be assessed, immediately raises two further questions in the medical mind:

- how much can we do to help this patient, and
- what risks of adverse effects can be tolerated when treating the patient?

Modern consumerism, in suggesting a more patient-centred approach, has brought under scrutiny many of the established principles in dental ethics.[23] Current ways of thought are increasingly rejecting medical and dental paternalism, as it is widely regarded as a *disregard* of the patient's moral and legal right of determining his/her own health status.[24] The doctor is no longer the paternal, prestigious, and powerful person who decided what was best for his patient; he is now required to inform his patients about the possible treatment options, leaving it to the patient to make the choice. Furthermore, the doctor is no longer judicially invulnerable, as he is increasingly being summoned by judges to reply to the claims of unsatisfied patients.[15]

One of the most vexing problems therefore which we as professional practitioners have to deal with is what to do when something goes wrong during the treatment of a patient.

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15. Lázaro 1999
23. Butterworth 1994
24. Hartshorne 1993

Thus, the practitioner will, sooner rather than later, have to address mistakes relating to his/her patient. The correct management of mistakes, once we have accepted that they do happen, is an essential part of quality practice.

2.4. THE INFLUENCE OF CURRENT TRENDS IN MALPRACTICE LITIGATION[25] ON PATIENTS' EXPECTATIONS IN SOUTH AFRICA, SEEN IN THE CONTEXT OF PROFESSIONAL CONDUCT COMMITTEES

During the past few decades enormous progress has been made in medicine. Continuous research has resulted in a wealth of new medicines, instruments and diagnostic and therapeutic techniques. Medical knowledge is expanding faster than man's ability to use it. This increase in medical knowledge is to the benefit of the patient but it also places additional responsibilities on the medical profession as a result of the concomitant increase in risks related to the new developments. The latter has resulted in a variety of new legal grounds on which a claim of negligence can be based.[26,27] Although this type of litigation, in principle, has no direct bearing on the inquiries of the PCC, it certainly serves as indication that the patients' expectations of the medical and dental profession are increasing. It follows that there is thus also the possibility of a subsequent increase in the number of complaints being reported to the HPCSA for investigation.

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25 This heading might appear slightly misleading with reference to the concept of medical malpractice. It is acknowledged that the main focus of the PRELIM's proceedings, and subsequent proceedings of the PCC's is on unprofessional conduct in the broad sense. (The definition of unprofessional conduct, as pertained in our South African legal system, is discussed in more detail in Chapter 4). However, the focus of this thesis will be on unprofessional conduct in the context of medical malpractice.

26. Strauss 1991

27. Claassen & Verschoor 1992

Medicine and law have since time immemorial been strange bedfellows. In the wide context of the almost manic pace of innovation and change in medicine and science and the comprehensive development and extension of legislation and case law, medicine, science and the law seem to be at a crossroads - in particular the latter, in its relationship

to the other two disciplines, and the role of all three in the context of a demanding and possibly not as well-informed-as-it-believes society. These strains have been manifest in the spate of medical negligence cases descending upon hospitals, with the doctors pointing their fingers at rapacious lawyers whom they consider may have bias motives and lawyers saying that doctors believe they should be above the law.[28]

Litigation is stressful, cumbersome and expensive for all those involved. The incidence of complaints and claims against general practitioners is rising inexorably, at a rate in excess of 10% per year.[29] The Medical Defence Union's (MDU) figures show an annual increase in malpractice litigation procedures of approximately 15%. The MDU paid out £67million during 1997 in defending members' claims - more than double the amount it spent at the beginning of that decade.[30]

There is no evidence of increasing negligence on the part of doctors. On the contrary, medical standards are generally very high. By the nature of their work doctors are probably more careful than members of other professions. However, the increasing incidence of malpractice litigation in Western countries seems to be a trend of

28. Goode 1996
29. Panting 1997
30. Maxwell 1998

our time.[26] In various countries physicians have increasingly become the target of litigation. This increasing incidence of malpractice litigation in Western countries without doubt recognises the United States of America (USA) as the unquestionable and undisputed leader in the field, with the number of claims against physicians having increased to such an extent that the USA faced a negligent malpractice crisis.[26,27] In 1983 16 out of every 100 physicians in the USA were sued for malpractice.[26]

In England there has also been a marked increase in claims for damages against practitioners over the past few years. A considerable rise in the number of suits brought against physicians and hospital authorities was experienced in West Germany as well over the last two decades of its existence.[26,31] Strauss pointed out that the number of claims against medical doctors in France has increased six-fold over a period of fifteen years. Figures supplied by the MDU has shown that the number of doctors in South Africa seeking legal assistance rose from 1 per 522 practitioners in 1968, to 1 per 22 in 1988.[26]

Although the situation in South Africa is hardly comparable to that of the USA, the new dispensation in South Africa enforces moral and legal adjustments upon us, as a definite growth in the number of medico-legal claims has been noted.[26,32,33,34,35] The country's Constitution and Bill of Rights have also ensured freer access to the Courts and the

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26. Strauss 1991
27. Claassen & Verschoor 1992
31. Giesen 1981
32. Simons 1978
33. Strauss 1987
34. Lewis 1996
35. Phillips 1996

rulings by the HPCSA are now often challenged in higher tribunals.[36]

The question may be asked – why the increase in litigation? It is believed that rising expectations and a growing tendency to litigate in the hope that the defendant may resort to an expedient settlement, may be significant factors. Medical negligence actions are extremely complex, and their complexity does not necessarily depend on how much the claim may be worth.[30] Experts are in agreement that this worldwide increase in malpractice suits cannot be ascribed to a single factor. The following divergent causes are mentioned:[26,27,30,37]

- In an era of consumerism the practitioner's traditional role as philosopher and adviser has been replaced by a cold contractual relationship between parties.
- The introduction of legal aid for needy patients can also be raised as one of the reasons for the increase in lawsuits against practitioners.
- A further possible reason is the enormous publicity given to any legal steps taken against the medical fraternity and the *quantum* of damages awarded by the courts in successful claims against physicians.
- The gradual transformation of the so-called doctrine of informed consent resulted in the criteria for legally valid consent by a patient, becoming more strict.

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26. Strauss 1991
27. Claassen & Verschoor 1992
30. Maxwell 1998
36. Heydt 1994
37. Harland & Jandoo 1984

- Strauss also pointed out that the *res ipsa loquitur* principle in law of evidence is certain to the advantage of the plaintiff-patient, because in some situations it effectively shifts the onus to the defendant-physician to prove that he did not act negligently.
- The plaintiff, or at least his attorney, knows that the real '*defendant*' in most cases is not so much the doctor in dispute, but rather an insurance company or protection society with a fistful of dollars.

2.5. PREVENTION BETTER THAN CURE?

2.5.1. High risk situations

One of the best ways to prevent litigation is to avoid obviously high-risk situations. Simply put, a high-risk situation is one that you are not fully trained to handle in every aspect. The chairperson of the MDPB of the HPCSA stated in his report[38] that:

> "It has been brought to the Medical and Dental Professions Boards attention that there are growing numbers of practitioners in dentistry who carry out surgical procedures on patients, even though they are not qualified to do so, such as the removal of impacted wisdom teeth … The PRELIM has pointed out that numerous complaints … in this regard are being received by the Committee. General practitioners are therefore reminded to refrain from performing procedures for which they are inadequately qualified or experienced..."

It is a serious mistake to let your ego convince you that you can manage any patient and any problem. Humility is not demeaning - when you are in doubt, refer the patient to

38. Becker 2000

someone more familiar with the problem. Failure to acknowledge one's own limitations in this regard can, and often does, result in the agony of medical disciplinary proceedings and the worry and expense of defending legal claims brought by patients for payment of substantial damages.[39]

2.5.2. Communication

There are doctors who make mistakes and never get sued for malpractice, yet others have caused no harm and still end up in court. Why is there a difference? The most strongly contributing factor is probably the type of relationship that is developed between the patient and the doctor. It is often said that patients will not sue someone they like. Most malpractice suits are based on a combination of patients perceiving a bad outcome and their disrespect for the treating doctor. Unfortunately, maxillo-facial and oral surgeons are often at a disadvantage because they see many patients for only one or two visits and have very little time to build a strong relationship. However, this does not mean that there is nothing that can be done to improve the situation. Time is not the only factor that determines the ability to develop positive patient relations.

Unless the doctor is aware of the patient's concerns before treatment, it may never be possible to achieve a result that will be satisfactory in their mind. We must always remain professional, respect the patient's dignity, and try to understand that nervousness, stress and worry about their illness can sometimes make their attitude less than pleasant.[20,40]

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20. Saunders 1997
39. Reilly's Solicitors 1994
40. Tomkins 1998

2.5.3. Defensive medicine

The practice of defensive medicine and dentistry has been envisioned as a possible response to this trend of increasing litigation.[29] It implies that the practitioner takes a decision not to offer or provide certain treatment options, not because the patient is not prepared to take the chance of an adverse outcome (however remote), but because the practitioner is not prepared to take the chance. A commonly cited example is the practice of ordering x-rays for every bump or bruise to avoid allegations of failure to diagnose a fracture.

Fear of complaints and litigation is said to induce doctors to convert to this kind of practice for their own protection rather than for the benefit of the patients. However, good medicine and dentistry involves establishing a trusty relationship with the patient in combating his/her illness. A doctor who takes precautions against justifiable concerns is not practicing defensive medicine.[29,34] Sound medicine is defensible, not defensive medicine.

2.6. THE NATURE AND SCOPE OF THE CLINICAL PRACTICE OF MAXILLO-FACIAL AND ORAL SURGERY – A SYNOPSIS

Too little emphasis has been placed on the range and quality of work undertaken by maxillo-facial and oral surgeons. Colleagues, in particular those in general medical practice, are frequently unaware of the extent of work being done by this specialty. By demonstrating the achievements of maxillo-facial and oral surgery, it would create an

29. Panting 1997
34. Lewis 1996

ideal opportunity to offer informed opinions on the best provision of care for patients with conditions affecting this area of anatomical expertise.[41]

The broad scope of maxillo-facial and oral surgery, a specialty that includes overlapping with several disciplines in both medicine and dentistry, can be subdivided into seven divisions:[42,43]

i. Dento-alveolar surgery includes peri-apical surgery; surgical removal of carious, fractured and impacted teeth and residual roots; and management of associated traumatic and/or pathological conditions of the *sinus maxillares.*

ii. Cranio-facial traumatology encompasses soft tissue and skeletal trauma of any kind to the head and neck region brought about by factors such as inter-person violence, motor vehicle accidents, gunshot wounds and sports injuries.

iii. Surgical pathology consists of treatment of infections, as well as management of a wide selection benign and malignant tumours of the head and neck region.

iv. Temperomandibular joint pathology and facial pain is a very complex aspect that is manifesting more and more in maxillo-facial and oral surgical practices, probably due to stress-related factors in modern business and households.

41. Baker, Carton & Dover 1996
42. Bütow 1996
43. Bütow *et al* 1988

v. Orthognatic and cranio-facial reconstructive surgery consists of the treatment of congenital/acquired dento-facial, skeletal and cranio-facial deformities, usually in conjunction with other dental (e.g.. orthodontists and prosthodontists) and medical specialties (e.g. neurosurgeons, plastic and reconstructive surgeons and ear-, nose- and throat specialists).

v. Pre-prosthodontic and implanto-reconstructive surgery includes all the possible surgical techniques that can be utilised to reconstruct minor defects such as a patient's missing teeth, as well as major defective parts of the oro-facial region.

vi. Facial cleft deformities require a multi-disciplinary approach to ensure optimal treatment of these very complex cases. Colleagues that are often consulted in this team-approach include several dental (orthodontics, pedodontia, prostodontics and oral hygienists), medical (pediatrics, plastic surgery, ear-, nose- and throat specialists and genetics) and para-medical personnel (speech therapy, community nursing, social work, clinical psychology and dental technology).

2.7. PROGRESS IN MAXILLO-FACIAL AND ORAL SURGERY

The changing field of Maxillo-Facial and Oral Surgery has given rise to the issue of whether this specialty's procedures fall only within the practice of dentistry. The scope of Maxillo-Facial and Oral Surgery has changed drastically over the last 20 years, and continues to change almost every day. From a dento-alveolar based specialty it has

developed into a complex regional specialty encompassing the whole of the oro-facial area.[44] Orthognathic Surgery has become routine in most maxillo-facial and oral surgery practices. Oncologic Surgery of the mouth and maxillo-facial skeleton has rapidly become the domain of the Maxillo-Facial and Oral Surgeon, whilst advanced reconstructive techniques including free and micro-vascular flaps and dental implants, allow us to reconstruct lost parts of the oro-facial area to a degree that these patients can no longer be considered dental cripples.[45,46] This has led to a revolution, in that patients with hitherto untreatable defects (such as mid-facial agenesis) or functional losses (due to tumour resections) can be brought back into their normal social life.

An interesting phenomenon in the USA is that the biggest increase in malpractice litigation is experienced in those areas where most progress has been made in developing new methods of treatment. It appears that the development of sophisticated technology, aimed at the improvement of the standard of medical care, has led to higher expectations by patients and a higher frequency of actions based on the negligence of the medical practitioner.[28,47]

The effect of the abovementioned increase in litigation against physicians resulted in the following:[28]

- Premiums for insurance against professional liability have risen sharply in most Western Countries and these extra costs have been passed on to

28. Goode 1996
44. Banks 1995
45. Stoelinga 1996
46. Stoelinga 1997
47. Barnard 1997

the patient.[48]

- Lawyers of dissatisfied patients have started to believe that physicians have formed a conspiracy of silence in reaction to the increasing number of lawsuits against them.
- Considerable problems are experienced in finding expert medical witnesses that are willing to testify against their fellow-practitioners in lawsuits based on negligent malpractice.[49]
- The increase in medical malpractice suits has further led to the development of so-called defensive medicine. To avoid possible future claims practitioners have begun to insist on additional diagnostic examinations, referrals to specialists and unnecessary follow-up procedures. These protective measures have increased the cost of medical services considerably.
- A growing unwillingness has developed among physicians to render assistance to victims of emergencies.[50]

Back then to the question - what determines the scope of a specialty? This is not an easy question to answer.[51] Although it is often based on purely anatomical divisions, regional

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48. In the USA premiums for insurance against malpractice claims increased during the decade 1960 to 1970 by the following percentages: for hospitals 262%; for general practitioners 540% and for surgeons an astronomical 949%. The situation has deteriorated to such an extent that certain progressive insurance companies were not able to keep up and succumbed. Others have withdrawn from this segment of the insurance market as a result of the extraordinary risks involved. These circumstances have even forced a number of physicians to abandon their practices in favour of less risky vocational options.
49. Strauss is of the opinion that although there exists an undisputable fellowship amongst physicians, the idea of a so-called conspiracy of silence deserves no serious consideration.
50. In an attempt to encourage physicians to stop at the scene of an accident and render the necessary medical assistance, nearly all the states in the USA have adopted the so-called *Good Samaritan legislation*. This legislation is aimed at limiting the liability of the doctor or paramedic who bona fide renders medical assistance in emergencies. The enforcement of Good Samaritan legislation is subject to certain qualifications. A physician who is grossly negligent in his treatment of an emergency victim will obviously not be protected by its enactments.
51. Laskin 1997

and functional interrelationships often lead to overlap and one then finds several specialties including similar procedures within their field. There does not appear to be one way in which scope can be established. Therefore, the solution to this problem probably lies in allowing unrestricted competition in areas of existing overlap, rather than trying to establish arbitrary rules about what one specialty can or cannot do.[51]

Unfortunately, in areas of controversy there is usually a strong polarisation of professional opinion.[52] Extreme views often result in aggressive and nasty litigation. Matters are often compounded with inexperienced practitioners offering advice and treatment in these complex cases.

2.8. CONCLUSION

The concept of medical and dental ethics have created immense confusion in the milieu of our plural society about what is right and wrong. Furthermore, progress in medicine and dentistry has created a spate of legal issues on which claims of medical negligence and misconduct can be based. Although this type of litigation, in principle, has no direct bearing on the inquiries of the PCC *per se*, it certainly serves as indication that the patients' expectations of the medical and dental profession are increasing. It follows that there is thus also the possibility of a subsequent increase in the number of complaints being reported to the HPCSA for investigation.

51. Laskin 1997
52. Wallman's Solicitors 1994

New technology raises the bar on patient expectations and the hopes of surgeons, while simultaneously (and temporarily) raising risk. In an unrelenting cycle, the more risk is mitigated, the more clinical practice advances, only to reveal a new set of risks. In this regard it is noted with concern that more and more doctors are practising defensive medicine in order to avoid the possibility of litigation. This is very sad, as sound medicine is always defensible, but defensive medicine not.

CHAPTER 3

SYNOPSIS OF THE LEGAL FRAMEWORK

FOR THE COMMITTEE FOR PRELIMINARY ENQUIRY AND

SUBSEQUENT PROFESSIONAL CONDUCT COMMITTEE

3.1. INTRODUCTION

The concept of natural law proposes that law also has a moral dimension – the law is not only that which is promulgated (legal positivism), but what ought to be, thus putting forward a set of moral principles regarded as higher than those against which human positive law can be judged. The principles and rules of natural justice embrace all the basic principles of any fair trial applicable in any court and are based on two simple rules: *audi alteram partem* (hear the other side) and *nemo iudex in sua causa* (no one should be a judge of his own case).[53]

The rules of any law are applied or interpreted by institutions of the state. The legislative authority therefore makes laws, and the judicial authority applies these laws

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53. Kleyn & Viljoen 1998
Audi alteram partem implies the following:
Someone accused or suspect of misconduct must be informed of the charge against him; Such a person must be afforded a reasonable opportunity to answer to the charges and to put forward his case; and, the tribunal must listen to both sides – it must hear all interested parties.
The *nemo iudex in sua causa* principle ensures an unbias hearing. It implies the following:
The tribunal must be free from any discriminatory motives arising from race, religion and so on. Someone who made it clear that persons of a certain race will 'over his dead body' be allowed to open a restaurant in a specific area may, for instance, not adjudicate an application for a business licence in such a case. No member of the tribunal may have an interest, such as a financial or personal interest, in the matter. A family member of the accused or of the applicant for a licence may not adjudicate the matter.

according to basic legal principles. Apart from the courts, there are quasi-judicial tribunals with administrative and disciplinary functions. Accordingly, the HPCSA exists by virtue of an Act of Parliament, functioning as a juristic person in terms of a statute as well as common law, which can grant or dismiss applications and impose disciplinary penalties, all of which can have a direct influence on the rights and interests of individuals.[53] If the principles of natural justice have not been complied with, the high court can review the matter and may set aside any decision.[53,54,55]

In this chapter the focus will be on the functioning of the HPCSA (including the PRELIM and PCC) as an administrative body within the legal regulations and parameters set by the South African law, in the context of the principles pertained in our Constitution.

3.2. ADMINISTRATIVE BODIES AND NATURAL JUSTICE

The history of the South African legal system links South Africa to various countries over the world, as it shares, to a greater or lesser extent, a common legal history with these countries. Because of this our law is found in various sources, which in fact means that our lawyers cannot turn to only one source when they search for answers to legal problems.[53] In this respect, section 39(1) of the Constitution[56] stipulates that a court,

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53. Kleyn & Viljoen 1998
54. *Castell v de Greeff* 1994
55. Judge H Daniels of the Transvaal High Court dismissed the review application (*Labuschagne v HPCSA* – unreported, 2002) involving a decision taken by the HPCSA regarding a complaint of improper or disgraceful conduct on the part of a practitioner, stating that the allegations were not substantiated. He also pointed out that the matter was not brought in terms of the Promotion of Administrative Justice Act 3 of 2000, nor was it argued on that basis.
56. Act No 108 of 1996 – Constitution of RSA

when interpreting the bill of rights, must take into account international law and may consider foreign law. In cases of medical negligence and unprofessional conduct it seems sensible to turn to other legal systems for guidance, as the medico-legal principles in these cases are often very similar in comparison with the South African scenario.

3.2.1. Rules of evidence

It would appear that in general terms statutory authorities exercising a quasi-judicial function, such as the HPCSA and its attendant PCC, is bound by the ordinary rules of evidence. In the case of *Dabner v SAR & H* [57] Innes CJ held:

> "Certain elementary principles, speaking generally, they (the authority) must observe; they must hear the parties concerned; those parties must have due and proper opportunity of producing their evidence and stating their contentions, and the statutory duties imposed must be honestly and impartially discharged. These elementary principles must be regarded as (being) embodied in the Act and regulations …. Running counter to them could not be upheld."

In *De La Rouviere v South African Medical and Dental Council*[58] the Supreme Court found that the HPCSA and its PCC should be held to the ordinary rules of evidence and accordingly, set aside the conviction and penalty imposed by the PCC against the practitioner on account of the failure by the PCC to apply the necessary rules of evidence. It was argued that the Council and the PCC are

57. *Dabner v SAR&H* 1920
58. *De La Rouviere v SAMDC* 1977

bodies that should be held more strictly to the rules of procedure and evidence than many other quasi-judicial bodies. In this respect the statement by Ramsbottom J in *McLoughlin v South African Medical and Dental Council*[59] was cited to emphasise this concept:

> "The (Medical) Council and the disciplinary committee are bodies of a very different kind. They are entrusted with the most important duties; they have the power to compel the attendance of witnesses; evidence is given on oath and any person who gives false evidence on oath before the Council to the committee or who refuses to answer commits an offence; the parties have the right to appear by counsel and witnesses are examined and cross-examined; a legal assessor may be appointed to advise on matters of law procedure and evidence….. In my opinion a body of this kind (the Medical Council) should be held much more strictly to the rules of procedure and evidence that a body such as … (the council of clubs, trade unions and the like)."

The case of *Jeffrey v President, SA Medical and Dental Council*[60] is also relevant. After a patient had lodged a complaint relating to his treatment with the SAMDC, disciplinary proceedings had been instituted against the accused practitioner who had been requested to explain his conduct in regard to the case. On the day before the hearing against him, the PCC had heard a case against a colleague, who had also been involved in the treatment of the patient. In the course of giving evidence this witness had materially contradicted the explanation initially given by the accused. These allegations made to the PCC were prejudicial to the accused. The court did not inform the accused of the allegations and accordingly he was unable to refute them.

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59. *McLouglin v SAMDC* 1947
60. *Jeffrey v President, SAMDC* 1987

After having been convicted the accused practitioner took the case on review to the Supreme Court. The court found that by not disclosing the prejudicial information to the accused the PCC had committed a gross irregularity in their proceedings and judge Berman set aside the conviction and sentence. In his judgment, he found it appropriate to cite the well-known phrase concerning fairness and justice in proceedings of a judicial or quasi-judicial nature:

> "Justice must not only be done …. But it must be seen to have been done."

It follows that the principles of natural justice will not only be of benefit to the defendant, but also to the HPCSA acting as the quasi-judicial body. In the case of *Volschenk v President, SA Geneeskundige en Tandheelkundige Raad*[61] the accused had been convicted by the PCC and it was recommended that the accused be suspended from practice for a period of six months, with such suspension to be suspended for three years subject to certain conditions. The accused was informed that the Council had the power to increase the sentence and in regard thereto he was advised by the court to submit written representations to the Council. The accused neither submitted written representations to the Council nor did he request a hearing before the Council. The Council confirmed the six-month period of suspension, but declined to suspend the suspension as recommended.

The accused sought a review of the sentence submitting, *inter alia*, that in amending the original sentence the Council had breached the *audi alteram*

61. *Volschenk v President, SAGTR* 1985

partem rule. The Court, however, held that the accused had been invited to submit representations to the Council, which he had not done. Further the Court pointed out that he had been legally represented at all the material times. It is trite law that, save where a party enjoys the specific right to give oral evidence, the acceptance of written representations by the authority is considered sufficient compliance with the *audi alteram partem* rule.

In conclusion, the necessity for the PCC to abide by the ordinary rules of evidence, at least in general terms, can be summarized by the following statement in *De La Rouviere v South African Medical and Dental Council:*[58]

> "These … rules are not obscure or technical rules of evidence but a matter of general common sense evolved from experience by courts whose daily task is to deal with matters of this nature. If a tribunal is untrained in tasks of this nature there seems all the more reason why it should be held more strictly to the rules."

3.2.2. Judicial precedent

Courts have to take into account their previous judgements in similar cases as they are bound to the approach followed in the past. The reason for this lies in the system of judicial precedent – the so-called doctrine of *stare decisis* (to stand by previous decisions). It is true that virtually no two cases are identical, as each and every case has its own unique features.[62] In comparison the same principle

58. *De La Rouviere v SAMDC* 1977

62. The role of legal assessors in the HPCSA PCC inquiries must not be underestimated. This body of lawyers are required by law to advise PCC's on matters of law, evidence and procedure. Although the PCC's are not legally bound by their advice, they often take notice of such advice, as many of the assessors have had long experience and are therefore in a good position to point out parameters of fair consideration of penalties to be imposed in an attempt to contribute towards reasonable consistency.

is found in our criminal courts. Many a convicted criminal would complain about excessively harsh sentences, while the public (who almost never know all the facts of a case) would complain of excessive leniency on the part of the trial judges. However, the concept of *ratio decidendi* (reasons for the decision) does create a definite precedent.[53]

In medical disciplinary hearings the peer judges should seek to balance the interests of the profession as a whole, the complainant, the accused practitioner as an individual, as well as society as a whole. An examination of penalties imposed on convicted practitioners from available sources revealed apparent inconsistencies in penalties, albeit the fact that the HPCSA as an administrative body is bound by the rules of natural justice.[1,10]

The following examples are presented to illustrate such inconsistencies:

i. Examples of cases of practitioners removed from the roll:

- For having committed adultery with a patient, whose husband was also a patient;[63]
- For commencing a private practice, after having been required by the Council to practise in the service of the Provincial Administration for five years on account of having only certain foreign qualifications;[64]

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1. Taitz 1988
10 Consider the fine judment by Boshoff JP in the *Veriava case* 1985
53. Kleyn & Viljoen 1998
63. *Groenewald v SAMDC* 1934
64. *Raad v MB* 1982 – cited in *T Verschoor: Uitsprake van die Mediese Raad (1985).* All attempts to find or obtain the specific detail of these records at the HPCSA were unsuccessful, as none of these records were available. Reference to these cases is therefore done according to references in Verschoor's book.

- For falsifying accounts and charging medical aid schemes for services not rendered;[65]

ii Examples of cases of practitioners suspended from practice for a period of time:

- For failing to properly examine a patient with a bullet wound in the back - the bullet had perforated the patient's internal organs and caused his death. Subsequently, the practitioner, acting as a District Surgeon, apparently conducted a post-mortem examination on the deceased in an improper manner and further failed to submit a true and correct post-mortem report. The practitioner was suspended from practice for a period of six months;[66]
- For obtaining payment on seven instances from a patient for professional services not rendered, a dentist was suspended from practice for nine months;[67]
- For allowing a dental technician to do alterations to a patient's denture, a dentist was suspended from practice for three months;[68]
- For extracting teeth, when at all material times a dentist was available, a medical practitioner was suspended for three months;[69]

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65. *Raad v MC* 1983
66. *Raad v GJDV* 1983
67. *Raad v GHSP* 1978
68. *Raad v BBK* 1978
69. *Raad v CJVZS* 1981

iii. Examples of cases of practitioners suspended from practice but where the suspension was itself suspended on condition that the practitioner was not again convicted of a similar or other offence before the Council:

- For refusing to disclose the contents of an injection and for prescribing drugs without examining the patient (twelve months suspension, suspended for three years);[70]
- For allowing his wife to cement two crowns on a patient (six months suspension, suspended for three years);[71]
- For claiming fees for services not rendered, as well as claiming according to the specialist fee-schedule, a dentist was suspended for three months, with the sentence suspended for three years;[72]
- For failing to visit a child whom he had hospitalised (the child subsequently died), and for failing to call upon certain patients after undertaking he would do so (four counts in all), in respect of which the practitioner was suspended for three months, which sentence was suspended for two years.[73]

iv Examples of cases of practitioners cautioned, reprimanded or cautioned and reprimanded:

- For prescribing (Schedule 1 and 2) drugs without examining the patient;[74]

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70. *Raad v DWS* 1978
71. *Raad v EJVB* 1978
72 *Raad v JK* 1981
73. *Raad v AM* 1983
74. *Raad v FFBG* 1983

- For extracting the patient's wrong tooth on two separate occasions;[75]
- For an improper and incomplete examination of an infant who had purportedly swallowed a two-cent coin and who died shortly thereafter of double pneumonia (not necessarily the result of having swallowed the coin);[76]
- For refusing to treat a badly injured and bleeding patient who had been transferred from another hospital, on account of the transfer papers being incomplete. The patient was returned to the initial hospital where he died shortly after admission.[77]

If these examples, on the face of it, show anything, it is a marked inconsistency in the penalties imposed by the HPCSA, albeit the fact that no two cases are in fact exactly the same.[1]

3.3. REGULATIONS RELATING TO THE CONDUCT OF PRELIMINARY INQUIRIES INTO ALLEGED UNPROFESSIONAL CONDUCT[78]

The HPCSA is the statutory body that has replaced the previous South African Medical and Dental Council (SAMDC), and later the Interim South African Medical and Dental

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1. Taitz 1988
75. *Raad v SML* 1983
76. *Raad v JV* 1984
77. *Raad v AIK* 1983
78. Government Gazette Vol. 434, Notice R765, 24 August 2001. The full text of the applicable regulations can be found in Annexure 2 attached to the end of this thesis.

Council (INMDC). Amended regulations of the HPCSA relating to the conduct of inquiries into alleged unprofessional conduct came into effect. Accordingly a PRELIM means a committee established by a professional board in terms of the regulations and functioning of the Professions Board under Government Notice No 979 of 13 August 1999[79] for the preliminary investigation of complaints.

3.3.1. Lodging of complaints

The accepted procedure that should be followed by the public if aggrieved by a person registered with the Council would be to direct all complaints to the Registrar of the HPCSA or to a specific Professional Board. Complaints must be in writing and signed by the complainant and/or his/her legal representative – the Council cannot deal with anonymous or confidential complaints.

3.3.2. Procedural conduct during the preliminary investigation[78]

On receipt of the complaint, the Registrar may:

(a) within seven working days after he or she received a complaint, call for further information or an affidavit from the complainant;

(b) within seven working days after he or she received a complaint, notify the accused of the complaint or forward particulars of the complaint to him or her:

(i) requesting a written response from him or her within 21 working

78. Government Gazette Vol. 434, Notice R765, 24 August 2001.
79. Devenish 1999

days after receipt of such notification or particulars, failing which the complaint will be forwarded to the preliminary inquiry committee without such written response; and

(ii) warning him or her that the written response referred to in subparagraph (i) may be used in evidence against him or her: Provided that a notification referred to in paragraph (b) shall be deemed to have been received:

(aa) on the day such notification is hand delivered to the registered address of the accused; or

(bb) if such notification is sent by registered mail, on the seventh calendar day following the date on which it was posted;

(c) refer the case directly to the committee of preliminary inquiry or the chairperson of such committee of the professional board concerned;

(d) direct that an inspection be held in terms of section 41A of the Act.

On receipt by the registrar of further information or a written response referred to in sub-regulation (1)(a) or (b), the registrar shall submit such further information or written response to the committee of preliminary inquiry and if no further information or written response is received, the registrar shall report this to the committee of preliminary inquiry.

The major function of the PRELIM is investigative. It has to decide whether or not a

prima facie case exists against a practitioner, in order to determine whether a disciplinary trial should be held or not. Accordingly the court has held that the PRELIM:[10,82]

> "… is not concerned to establish whether the charge can actually be proved. It is concerned only with the question whether there ought to be an inquiry (a disciplinary hearing) at all. Once there is to be an inquiry, it is charged with the duty of arranging to have the case heard by the Council or by a Disciplinary Committee appointed by Council…"

If the PRELIM decides, after due consideration of the matter, that there are no grounds for an inquiry, it shall direct the registrar to communicate in writing its decision to the complainant and the accused stating the reason(s) for such decision. However, if the PRELIM decides that an inquiry must be held into the conduct of the accused, it shall direct the registrar to arrange for the holding of an inquiry by the PCC.[1,83]

In an effort to effectively deal with complaints based on misunderstandings between doctors and patients relating to ethical matters, human rights, professional conduct and practice at an early stage, the MDPB of the HPCSA has resolved to appoint an Ombudsperson on a part-time basis to screen complaints, deal with minor and technical complaints, refer substantial complaints to the PRELIM for further attention, and assist in the formulation of charge sheets with regard to the professional aspects of complaints.[80,81]

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1. Taitz 1988
10. *Veriava and Others v SAMDC & Others* 1985
80. Becker 2001
81. Becker 2001
82. *Tucker & Another v SAMDC & Others* 1980
83. One sometimes gets the impression that, once the PRELIM is in doubt whether an inquiry should be held or not, especially in the more complex cases, the responsibility is shifted to the PCC with the resolution that an inquiry should be held. This is very unfortunate and simply not fair towards the respondent, as inquiries are time consuming and often very expensive.

3.4. HEALTH PROFESSIONS ACT (Act No 56 of 1974)[84]

This Act (commonly known as the principal Act) was adopted to provide control over the education, training registration, practices and conduct of health professionals, and to provide for matters connected therewith. In terms thereof the Registrar of the HPCSA is authorised to appoint an investigating officer to institute an investigation concerning alleged contraventions of the Act regarding the conduct of health professionals. Section 48 of this Act confirms that any professional board may enquire into any complaint, charge or allegation against any person registered in terms of the provisions of this Act in respect of his/her profession.[78,85]

The Minister of Health, in terms of section 49 of the Act, has approved certain ethical rules made by the then INMDC, specifying the acts and omissions in respect of which the Council may take disciplinary steps. The HPCSA has the final power to refuse or confirm the PCC's verdict and/or recommendation on sentence. Albeit the fact that there is no appeal against the Council's ultimate finding in disciplinary matters, it is not necessarily a case of *Roma locuta, causa finita* (Rome has spoken, case closed). There is still the possibility of taking the case on common-law review or appeal to the High Court.[10,26,55,58]

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10. *Veriava and Others v SAMDC & Others* 1985
26. Strauss 1991.
55. Judge H Daniels: Review application: *Labuschagne v HPCSA* (unreported) 2002 with his comments that the matter was neither brought nor argued in terms of the Promotion of Administrative Justice Act 3 of 2000.
58. *De La Rouviere v SAMDC* 1977
78. Refer also to the Regulations relating to the conduct of preliminary inquiries.
84. Act No 56 of 1974 (as amended by Act 89 of 1997)
85. Accordingly section 42 provides the procedural prescription for inquiries into complaints against registered persons and trials regarding cases of alleged improper and/or disgraceful conduct.

3.5. HEALTH PROFESSIONS ACT (Act No 89 of 1997)[86]

Certain amendments were made to the principal Act in order to provide for the establishment of the HPCSA and its functions. Further to the right to take any decision by the HPCSA on judicial review, the new Section 20 has now been inserted in the principal Act to make provision for and enabling persons aggrieved by any decision of Council, a professional board or disciplinary appeal committee, to appeal to the appropriate High Court against such a decision.

The insertion of section 42(1A) has far-reaching implications, as it clearly states that, in case of an appeal lodged against a penalty of erasure or suspension from practice, such a penalty shall remain effective until the appeal has been heard. It is common knowledge that these cases are sometimes time-consuming and extremely difficult to prove, often involving the doctor in considerable expense and prolonging his agony indefinitely.[26]

It is therefore of the utmost importance that the PRELIM conduct its investigations in such a manner that there is no doubt about the fact that *prima facie* evidence does indeed exist to support claims of improper and/or disgraceful conduct.

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26. Strauss 1991.
86. Act No 89 of 1997

3.6. NATIONAL HEALTH ACT (Act 61 of 2003)[87]

The new National Health Act has been signed into law. The 12 chapters, with its 94 sections, deal with numerous provisions of law. It is clear that the Act rests heavily on the Constitution, with some 50 sections of the Constitution[56] relating directly to what is contained in this Act. In particular, sections 6 – 9 deal extensively on the issue of consent. Section 6(1) provides definite prescriptions regarding the patient having to have full knowledge of the proposed treatment. It furthermore clearly states that the health care provider must inform the patient of the range of treatment options, as well as its benefits, risks, costs and consequences generally associated with each option. This includes the patient's right to refuse health services as well as the health care provider's duty to explain the implications, risks and obligations of such refusal. Section 6(2) requires the health care provider to convey such information, where possible, in a language that the patient understands and in a manner that takes into account the patient's level of literacy.

Provision has been made in section 7(1)(b) for the recognition of certain people (related to the patient) who are authorised to make medical decisions on his/her behalf. In this regard, where no person has been mandated or authorised to give consent on the patient's behalf, such consent can be given by the spouse or partner of the patient, or, in the absence of the spouse or partner, a parent, grandparent, an adult child or a brother or a sister of the patient (in the specific order as listed). It follows that such a person must,

56. Act No 108 of 1996 – Constitution of RSA
87. Act No 61 of 2003 (published in the Government Gazette, No 26595, 23rd of July 2004)

if possible, first consult with the patient before giving the required consent (see section 8(2)).[88]

3.7. CONSTITUTION OF THE REPUBLIC OF SOUTH AFRICA (Act No 108 of 1996)[56]

3.7.1. Supremacy of the Constitution

The new constitutional context has an impact on the interpretation of all statutes. Section 2 emphatically states the supremacy of the Constitution:

> "This Constitution is the supreme law of the Republic; law or conduct inconsistent with it is invalid, and the obligations imposed by it must be fulfilled."

The Constitution therefore has a direct influence on all legislation in the sense that any legislation in conflict therewith it can be struck down by the Courts. It is applicable to all law and binding on all natural and juristic persons and legislative bodies, such as the HPCSA. Everyone is regarded as equal before the law and has the right to equal protection and benefit of the law. Accordingly, any court, tribunal or forum must promote the values that underlie a democratic society, while also taking into consideration international and/or foreign law. Although the rights of individuals are covered extensively, provision has been made for limitation of such rights in terms of law, provided that it is reasonable and justifiable.

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56. Act No 108 of 1996 – Constitution of RSA
88. The impact of the constitutional principles regarding informed consent, as pertained in the new National Health Act is discussed in more detail in Chapter 4.

3.7.2. The right of access to information and fair administrative action

According to section 33 of the Constitution everyone has the right to administrative action that is lawful, reasonable and procedurally fair. Accordingly, anyone whose rights have been adversely affected by any administrative action, has the right to be given written reasons thereof. National legislation regarding effective access to information and fair administrative action have recently been amended by the Promotion of Access to Information Act, Act No 2 of 2000 ("Proatia Act")[89] and Promotion of Administrative Justice Act, Act No 3 of 2000[90] respectively.

3.7.2.1. Promotion of Access to Information Act, Act No 2 of 2000 ("Proatia Act")[89]

Further to section 32 of the Constitution, this Act came into action with the purpose of giving effect to the constitutional rights of access to any information required for the exercise or protection of any rights. This Act establishes mechanisms to give effect to the right of information, enabling persons to obtain reasonable access to records of public and private bodies and thus promoting transparency and accountability.

3.7.2.2. Promotion of Administrative Justice Act, Act No 3 of 2000[90]

Administrative action includes any decision taken, or any failure to take a decision by a quasi-judicial body, such as the HPCSA, when

89. Act No 2 of 2000
90. Act No 3 of 2000

exercising a public power or performing a public function in terms of any legislation which adversely affects the rights or has a direct external legal effect on any person.

The purpose of this Act is to give effect to the right to administrative action that is lawful, reasonable and procedurally fair. The principal Act (Act56, 1974) has not provided for the furnishing of reasons. Section 5 of the Administrative Justice Act emphasises the procedural acts with regard to the right to be given written reasons for administrative actions. It is clear that the reasons furnished must be those that actually influenced the administrator in effecting the decision. The reasons must therefore not only be adequate, but also relevant to the decision in question.[80,91,92]

Any person may institute proceedings in a Court or Tribunal for the judicial review of an administrative action. Such a Court or Tribunal has the power to judicially review an administrative action if the administrator taking it was biased or reasonably suspected of bias (section 6(2a)(iii)), or where the action was materially influenced by an error of law (section 6(2)(d)). Accordingly, the court will set aside any

80. Becker 2001

91. Compare the English case of *Re Poyer & Mills Arbitratum the Queens Bench*, in interpreting and applying the word reasons in section 12 of the Tribunals and Inquiries Act of 1971 that stipulates that certain tribunals must furnish reasons for decisions taken.

92. The PCC always meets *in camera* after having heard evidence regarding alleged misconduct by practitioners. It is noted with concern that this committee was initially not required to give any reasons for their decisions taken *in camera*, thus in fact defying the rights of both the respondent and/or complainant to access to information and fair administrative action. However, by the mid-1990s the then SAMDC resolved to advise its disciplinary committees to furnish reasons for all its decisions.

decision by the HPCSA or PCC where a member of that body *inter alia*:

- is related by blood or affinity to the complainant patient or to the accused practitioner;
- has a pecuniary interest in the case, either directly or indirectly, e.g. is a partner of the accused practitioner;
- is a witness to any material aspect of the case;
- has instituted or caused the proceedings to be commenced;
- has expressed his opinion on the merits of the case or the untruthfulness of one of the parties, either before or during the relevant proceedings.[93]

3.8. CONCLUSION

There are clear and definite prescriptions with regard to conduct of preliminary inquiries into alleged unprofessional conduct. However, an examination of penalties imposed by the HPCSA on convicted practitioners revealed inconsistencies in penalties, thereby indicating that the HPCSA, although bound to the rules of natural justice as a

93. See Currie & Klaaren 2001:
As defined by the Administrative Justice Act (Act3, 2000), a decision must be final, in the sense of decisive or determinative, before it can be considered administrative action. It is important to take note of the fact that standing under the Administrative Justice Act is co-extensive with section 38 of the Constitution that provides the right for a person/s to approach a competent court, alleging that the right in the Bill of Rights has been infringed or threatened. However, one should also take note of the fact that no court or tribunal shall review an administrative action in terms of the Administrative Justice Act unless any internal remedy provided for in any other law has first been exhausted. Furthermore, there is a significant limitation of the constitutional rights of the Administrative Justice Act that places time limits on such judicial review proceedings. Accordingly, such proceedings must be instituted without reasonable delay and not later than 180 days after the date of finalisation of any internal remedies. Finally, the applicant must also demonstrate '*sufficient interest*' in the remedy that he or she seeks. This requirement of '*sufficient interest*' allows a court some control over the grant of standing and can be used to prevent the type of '*busy body*' litigation that has traditionally justified narrow standing rules.

quasi-judicial body, might in fact not have abided by those rules in these particular cases.

Roma locuta, causa finita – this can only be the accepted if the principles of natural justice and evidence have been adhered to by the HPCSA. It therefore implies adopting basic legal principles as stipulated in the relevant Acts that were discussed, as well as the doctrine of *stare decisis*, whilst ultimately considering the supremacy of the Constitution in each and every case brought before the PRELIM.

CHAPTER 4

AN OVERVIEW OF RELEVANT LEGAL PRINCIPLES IN THE CONTEXT OF UNPROFESSIONAL CONDUCT, WITH REFERENCE TO MEDICAL NEGLIGENCE, THE CONSENT-ISSUE AND EXPERT TESTIMONY

4.1. INTRODUCTION

It is acknowledged that the proceedings of the PRELIM have to focus on unprofessional conduct in the broad sense of the word. As the focus of this thesis is on unprofessional conduct in the context of medical malpractice, the discussion of unprofessional conduct in this chapter will be done in the context of interactions with patients and other practitioners, with reference to medical negligence, the issue of consent to treatment and expert testimony according to a selection of common juristic principles (in the context of unprofessional conduct) adopted from national and international (foreign) law.

4.2. UNPROFESSIONAL CONDUCT

Section 1(g) of the Health Professions Act (Act No 89 of 1997)[86] states as follows:

- *"**unprofessional conduct"** means improper or disgraceful or dishonourable*

86. Act No 89 of 1997

or unworthy conduct or conduct which, when regard is had to the profession of a person who is registered in terms of this Act, is improper or disgraceful or dishonourable or unworthy -

The HPCSA is the custos morum of the medical and dental professions and is accordingly empowered by the Health Professions Act to conduct disciplinary inquiries into allegations of improper/disgraceful conduct against practitioners. The term 'improper/disgraceful behaviour' is intended to cover any reprehensible act committed by a practitioner in the exercise of his/her profession (which is the more usual form of disciplinary action by the HPCSA) and other acts, which may have nothing to do with their practice as such, but which may reflect on their integrity as a practitioner.[1]

Improper or disgraceful behaviour may be viewed under four separate headings:[1]

- medical malpractice that covers treatment of patients which may be regarded as negligent, improper or not in accordance with accepted practice;
- improper or disgraceful behaviour concerning patients that are contrary to accepted behaviour by members of the profession, such as breach of confidentiality or indulging in sexual relationships with patients;
- improper or disgraceful conduct concerning fellow practitioners, such as supersession or discussing colleagues and their ability with laymen in a

1. Taitz 1988

scandalous manner;

- other improper or disgraceful conduct unbecoming to a practitioner not necessarily directly related to their practice, patients or colleagues, such as convictions for common law crimes like fraud and murder.

It is of considerable importance to distinguish between improper and disgraceful conduct/behaviour, as the latter is considered to be more serious. However, in general terms what is improper or disgraceful conduct is not subject to simple description *per se*. It is conduct which, in the opinion of the HPCSA as custos morum of the profession, is improper or disgraceful. It also means that each complaint to the HPCSA will have to be considered on its own individual merits.

4.3. MEDICAL NEGLIGENCE

4.3.1. INTRODUCTION

The fact that a patient's consent has been obtained for a specific procedure, or that an emergency situation exists, does not rule out any civil and/or criminal liability for the practitioner. A negligently performed intervention that wrongfully causes the patient's death or which harms the patient in any way whatsoever, may render the practitioner civilly or criminally liable for his/her

actions.[54,94,95,96,97,98]

It appears that the concept of medical malpractice liability cannot be narrowly confined to liability for damages flowing from professional negligence.[99] It also embraces other causes of action, such as liability for assault in the form of an operation performed with proper skill on a patient without his/her informed consent,[100] or liability for invasion of a patient's privacy by unwarranted disclosure to outsiders of medical details pertaining to the patient.

As far as private law is concerned, the classic test for negligence of medical practitioners is described as follows in *Van Wyk v Lewis*:[27,94,95,101,102]

> "a medical practitioner is not to bring upon the case entrusted to him the highest possible degree of professional skill, but he is bound to employ reasonable skill and care. And deciding in 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."

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27. Claassen & Verschoor 1992
54. *Castell v de Greeff* 1994
94. Van Oosten & Strauss 2002
95. *Coppen v Impey* 1916
96. *Kovalsky v Krige* 1910
97. *Dube v Administrator Transvaal* 1963
98. *Castell v de Greeff* 1993
99. Compare with the report on medical malpractice and negligence by Hayes Solicitors 1994 - there appears to be no common accord as to the concept of medical negligence mainly because of materially different interpretations by experts of the uncertainty on the predictability of eventual treatment outcomes in the milieu of the rapidly developing medical science and technology.
100. Although this type of litigation, in principle, has no direct bearing on the inquiries of the PCC, it certainly serves as indication that the patients' expectations of the medical and dental profession are increasing. It follows that there is thus also the possibility of a subsequent increase in the number of complaints being reported to the HPCSA for investigation.
101. *Van Wyk v Lewis* 1924
102. Our courts regard negligence as a form of fault and use an objective test in the ascertainment thereof. In *S v Ngubane* the court ruled as follows concerning the nature of negligence:
> "*Culpa* (negligence), it would seem, may entail no state of mind at all. The mere labelling of culpa as form of *mens rea* (fault) does not necessarily and decisively point to the contrary. The view generally held by our courts is that culpa is constituted by conduct falling short of a particular standard, viz that of the reasonable man."

4.3.2. TEST FOR MEDICAL NEGLIGENCE

A failure to cure does not ordinarily constitute medical negligence.[95,96,101] Factual situations underlying medical negligence litigation[103,104] include the following:

- wrongful diagnosis, e.g. failure to detect dislocation of the jaw,[105] failure to detect a wrist fracture[106], an incorrect diagnosis of cancer[107]
- incorrect or incompetent technique or procedure resulting in injury to the patient's arm and shoulder during extraction of his tooth during general anaesthesia[108]
- failure to refer the patient or to call in a specialist[109]
- failure to adequately inform or instruct the patient[97,98,105,110]
- relying on a colleague's opinion or on hospital records, or knowingly making use of incompetent or inexperienced fellow health care workers (*culpa in eligendo*).[103,104,111]

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95. *Coppen v Impey* 1916
96. *Kovalsky v Krige* 1910
97. *Dube v Administrator Transvaal* 1963
98. *Castell v de Greeff* 1993
101. *Van Wyk v Lewis*1924
103. Strauss & Strydom 1967
104. Schwär, Loubser & Olivier 1984
105. *Prowse v Kaplan* 1933
106. *Buls & Another v Tsatsarolakis* 1976
107. *Fowlie v Wilson* 1993
108. *Allot v Paterson & Jackson* 1936
109. *S v Nel* 1991
110. *Broude v MacIntosh* 1998
111. Carstens 1996

4.3.2.1. Reasonable care and skill

Fundamentally the test for negligence is an objective one insofar as the hypothetical person sets the standard, but it also contains a subjective element inasmuch as it requires that the reasonable person be placed in the same situation as the defendant found himself or herself at the time of the incident in question.[94,101,106]

A classic formulation of the test for medical negligence is found in the case of *Mitchell v Dixon*:[112]

> "A medical practitioner is not expected to bring to bear upon the case entrusted to him the highest possible degree of professional skill, but he is bound to employ reasonable skill and care; and he is liable for the consequences if he does not."

Although the *Mitchell*-case was decided in 1914, the Cape High Court recently held in *Oldwage v Louwrens*[113] that *'medicine is still not – and probably will never be – an exact science comparable to mathematics'*. Accordingly the court reaffirmed the principles laid down in the *Mitchell*-case.

Obviously a physician's alleged negligence must be proven against the background of the particular circumstances in which he had to perform

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94. Van Oosten v Strauss 2002
101. *Van Wyk v Lewis*1924
106. *Buls & Another v Tsatsarolakis* 1976
112. *Mitchell v Dixon* 1914
113. *Oldwage v Louwrens* 2004

his duties. As AJ Wessels put it in *Van Wyk v Lewis*:[101]

> "We must place ourselves as nearly as possible in the exact 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."

To determine what a reasonable practitioner's conduct would have been, consideration must be given to the existing knowledge and methods of treatment at the time in question. This implies that where an action against a physician is instituted in 1992 and the trial stage is only reached in 1995, the court will only take into account the knowledge which existed in 1992 and disregard any expansion of medical knowledge since the alleged incident.[114] This rule is strikingly illustrated in the English case of *Roe v Ministry of Health and Others*,[115] when on appeal Lord Justice Denning remarked:

> "We must not look at the 1947 incident with 1954 spectacles."

The standard of the reasonable practitioner implies that the physician will reasonably acquaint himself with developments in medicine. If a physician fails to employ a recently developed but widely acknowledged method of treatment and his patient is prejudiced by the outdated method of treatment used by him, then the physician can be held liable for the consequences.[114]

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101. *Van Wyk v Lewis* 1924
114. Giesen & Fahrenhorst 1984
115. *Roe v Ministry of Health* 1954

The law does not require that a practitioner be infallible in his conduct, and an error of clinical judgment will not constitute negligence where the proper standard of care has been followed. A practitioner may be aware, after the occurrence of an incident, that his judgment was wrong, but as long as his conduct was reasonable, he will not be held liable.[116] Whether error of clinical judgment will constitute negligence therefore depends on the particular circumstances. The comments of Lord Fraser in the House of Lords on the case of appeal of *Whitehouse v Jordan*[117] illustrate the point:

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

4.3.2.2. Reasonable person's test

The norm of the reasonable person is no absolute measuring instrument but serves as a standard in relation to which a Court can make a finding and through which a court can place itself in the same position as the defendant with due allowance for all the circumstances of the particular

116. Holder 1978
117. *Whitehouse v Jordan* 1981

case.[118,119,120,121,122] The term '*reasonable person*' thus embodies an objective criterion. In *S v Burger*[123] Holmes AJ describes the reasonable man as follows:

> "One does not expect of a *diligens paterfamilias* [literally a 'diligent father/head of a family – used as synonym for 'reasonable man'] any extremes such as Solomonic wisdom, prophetic foresight, chameleonic caution, headlong haste, nervous timidity, or the trained reflexes of a racing driver. In short, *diligens paterfamilias* treads life's pathway with moderation and prudent common sense."

It appears that, despite all attempts to define the meaning of the term '*reasonable person*', the particular finding in a given case will be closely bound to a specific Court's interpretation and discretion.[122,124] In Southern Africa's heterogenic society an absolute enforcement of the objective test may be problematic, as strikingly illustrated by the statement in *R v Nkomo*:[125]

> "In England with its relatively homogenous population, the test of the '*reasonable man*' has caused enough difficulty in attempting to define the standard. In a country such as this, with its diverse, multi-racial community, whose social and educational standards vary over almost the widest possible range, the task is wellnigh impossible. To strike a mean between the Batonka fisherman living his primitive life in some remote spot on the Zambezi and the

118. Boberg 1984
119. Labuschagne 1985
120. Burchell, Milton & Burchell 1983
121. Van der Walt 1979
122. Claassen 1984
123. *S v Burger* 1975
124. Morkel 1977
125. *R v Nkomo* 1964

> professor at the University College of Rhodesia, is to set a task which even an arch-exponent of the *'reasonable man test'* would shrink from attempting."

From the abovementioned authorities it is clear that when an accused possesses above average knowledge or experience he will be judged by the standard of what the reasonable man with he same knowledge or experience would have foreseen or done. Thus, in our law a person is judged to be negligent where:[111]

- he should reasonably have foreseen the possibility of the occurrence of the consequence or the existence of the circumstances in question, and,
- he should reasonably have guarded against that possibility: and,
- he failed to take steps which he should reasonably have taken to guard against it.

4.3.2.3. Specialist treatment

Imperitia culpae adnumeratur - Lack of skill is reckoned as fault. A practitioner will therefore be blamed for being negligent where he performs an operation or embarks on the treatment of a patient well knowing that he does not have the necessary knowledge or experience, and the patient is prejudiced thereby. In such instance his ignorance is equal to negligence.[126] Giesen and Fahrenhorst[114] argue that a physician

111. Carstens 1996
114. Giesen & Fahrenhorst 1984
126. Hosten 1969

cannot defend himself by averring that he tried his best in accordance with his abilities and professional knowledge. If he is not competent to treat a patient's specific illness he is obliged to refer the patient to a specialist. This principle, however, is not applicable when specialist procedures are done in an emergency situation.[103]

A specialist is required to employ a higher degree of care and skill concerning matters within the field of his specialty than a general practitioner, therefore it is expected of him to act as the reasonable specialist would have done under similar circumstances.[33,127] However, if a practitioner presents himself as a specialist in the sense that he manages a case from a specialist point of view, or he insists on specialist tariffs, or he professes to treat a patient with a special degree of knowledge, care, skill and experience, the law will hold him to this pretext. His performance will then have to comply with the standard of conduct of a reasonable specialist belonging to the same specialty of which the practitioner professes to be a member.[27]

In the event of a person presenting himself as an expert in a specific field, the traditional standard of a reasonable man is therefore raised to the standard of the reasonable expert. The test for negligence of an

27. Claassen & Verschoor 1992
33. Strauss 1987
103. Strauss & Strydom 1967
127. Snyman 1982

expert was stated as follows in *R v Van Schoor*:[128]

> "Coming to the case of a man required to do the work of an expert, as e.g. a doctor dealing with the life or death of his patient, he too must conform to the acts of a reasonable man, but the reasonable man is now viewed in the light of an expert: and even such an expert doctor, in the treatment of his patients, would be required to exercise in certain circumstances a greater degree and caution than in other circumstances."

In context of this thesis, applied to maxillo-facial and oral surgery, the test for negligence would be determined with reference to the reasonable maxillo-facial and oral surgeon in the same circumstances.

4.3.2.4. Difference in opinion

4.3.2.4.1. Locality rule

In *Van Wyk v Lewis*[101] it was argued that the same degree of care and skill expected from a practitioner in a big city hospital could not be required from a rural physician. Chief Justice Innes, however, explicitly rejected the argument that locality should play any role in deciding a practitioner's negligence:

> "I desire to guard myself from assenting to the principle ... 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, in one place or the other.

101. *Van Wyk v Lewis* 1924
128. *R v van Schoor* 1948

The fact that several incompetent or careless practitioners happen to settle in the same place cannot affect the standard of diligence and skill which local patients have a right to expect."

In view of modern developments of communication it appears that there is little justification for the retention of the so-called locality rule. Even in the USA where the locality rule had its origin, its influence has weakened considerably and it is no longer considered the only decisive factor in determining a practitioner's negligence.[129] Carstens, however, argued very convincingly that a distinction must be made between subjective (capability, training and knowledge) and objective (inferior equipment and infrastructure) influences of the environment in which a practitioner is working and that this should be taken into account when evaluating his/her conduct.[130,131]

4.3.2.4.2. Different schools of opinion

In instances where practitioners differ on diagnostic and therapeutic techniques, expert evidence must be led to show that difference of opinion exists and that there are physicians, apart from the defendant, who support his methods.[129] McNair, in his judgment in favour of the defendant in the English case *Bolam v*

129. Potgieter 1985
130. Carstens 1990
131. *Collins v Administrator Cape* 1995

Friern Hospital Management[132], said the following:

"[A doctor] is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art ... Putting it the other way round, a man is not negligent, if he is acting in accordance with such practice, merely because there is a body of opinion who would take the contrary view. At the same time, that does not mean that a medical man can obstinately and pig-headedly carry on with the same technique if it has been proved to be contrary to what is really substantially the whole of the informed medical opinion."

Where different schools of thought exist as to the method of treatment to be employed, a practitioner does not act improperly where he makes use of a method favoured by a respectable minority.[32,96,133] Each case should be evaluated according to its own unique circumstances. Only then can new and better techniques come to light. It follows that such developments should be medically justifiable.[134]

4.3.2.4.3. Customary practice

Where a practitioner acts according to the general and approved practice of his profession, he will normally have a good defence against an allegation of negligent conduct.[116,135] On the other

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32. Simons 1978
116. Holder 1978
132. *Bolam v Friern Hospital Management Committee* 1957
133. *Pringle v Administrator Transvaal* 1990
134. Carstens 1991
135. *Sidaway v Bethlem Royal Hospital Governors & Others* 1984

hand, the application of accepted customary medical practice is not necessarily indicative of careful conduct.[116,117] It seems that employing customary practice will therefore not always be a solid defence, as it remains a controversial legal principle.

In the well-known case of *Van Wyk v Lewis*[101] the defendant, a surgeon, performed an urgent and difficult abdominal operation on the plaintiff. After completing the operation one of the swabs used by the defendant was overlooked and it remained inside the plaintiff's body until it was excreted after a period of twelve months. The evidence proved that, in accordance with customary practice in that particular hospital, the defendant depended on the theatre nurse to keep count of and check the swabs used. At completion of the operation on this critically ill patient, both the defendant and the theatre nurse were convinced that all swabs used were accounted for.

The plaintiff's claim for damages in the Trial Court was refused and the case was taken to the Appeal Court. Sufficient evidence was led during the court proceedings to show that the said practice was a common one in hospitals and was approved of.

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101. *Van Wyk v Lewis* 1924
116. Holder 1978
117. *Whitehouse v Jordan* 1981

The appeal was dismissed and the decision of the Trial Court confirmed. In passing judgment in favour of the defendant the following comments were made on customary practices:

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

However, with regard to American law it appears that employing customary practice will not always be a solid defence. In *Darling v Charleston Community Memorial Hospital*[136] the Supreme Court of Illinois summarized the position with regard to customary practice as follows:

"Custom is relevant in determining the standard of care because it illustrates what is feasible, it suggests a body of knowledge of which the defendant should be aware, and warns of the possibility of far-reaching consequences if a higher standard is required….But custom should never be conclusive."

In another case, *Helling v Carey*[137], the American Court again deviated from the customary practice principle. The defendant had, in accordance with the common practice amongst ophthalmologists concerning patients under the age of 40 years of age, failed to execute on the plaintiff a routine pressure test for glaucoma. As a result of the omission the plaintiff suffered

136. *Darling v Charleston Community Memorial Hospital* 1965
137. *Helling v Carey* 1974

permanent damage of sight and subsequently sued the defendant for damages. She alleged that earlier diagnosis would have improved her chances of successful treatment. The court held that the defendant was liable and said:

"Under the facts of this case reasonable prudence required the timely giving of the pressure test to the plaintiff. The precaution of giving this test to detect the incidence of glaucoma at patients under 40 years of age is so imperative that irrespective of its disregard by the standards of the ophthalmology profession, it is the duty of the courts to say what is required to protect patients under 40 from the damaging results of glaucoma."

In the English case of *Hunter v Hanley*[138] it was decided, though, that deviation from a customary practice *per se* will not necessarily constitute negligence. Three requirements were mentioned that would make a deviation from customary practice negligent:

"First of all if must be proved that there is a usual and normal practice; secondly it must be proved that the defender has not adopted that practice; and thirdly (and this is of crucial importance) it must be established that the course the doctor adopted is one that no professional man of ordinary skill would have taken if he had been acting with ordinary care."

138. *Hunter v Hanley* 1955

4.3.2.5. Innovation and experimentation

Deviations from established principles and methods of treatment will most probably lead to claims of negligence. When the liability of a practitioner for experimental procedures come to the fore, two opposing interests existing within an experimental situation must be balanced, i.e. firstly, the interest of the patient who is not to be exposed to any abuse that may result from uncontrolled experimentation and, secondly, the interest of the practitioner as well as those of society that relate to furtherance of knowledge of illnesses and their treatment. However, if all practitioners were to be strictly limited to existent procedures, all development and progress in the medical sphere would come to a halt, with disastrous results for society.[139]

4.4. THE CONSENT-ISSUE

4.4.1. INTRODUCTION

The doctor-patient relationship being primarily contractual by nature and, hence, one which presupposes *consensus ad idem* (a meeting of minds) as to the proposed medical intervention, it follows that the patient's effective consent is fundamental to lawful medical interventions.[8,94] Indeed there are exceptional

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8. Van Oosten 1991
94. Van Oosten & Strauss 2002
139. Cantrell 1984

circumstances, such as emergency situations. However, to simply allow doctors to administer medical treatment against a patient's will on the basis of the '*doctor-knows-best'* and '*in-the-patient's-best-interest'* criteria, would be tantamount to practising medical paternalism at the expense of patient autonomy.[8]

There are dangers attached to all operations and medical interventions. A doctor whose advice is sought about an operation to which certain dangers are attached is therefore in a real dilemma. If he fails to disclose even the extremely uncommon risks, and it does happen, he may render himself liable for medico-legal action, whereas if he does disclose them, he might very well frighten the patient into not having the operation at all, even though he knows full well that the planned procedure is only in the patient's interest.[8] However, an undertaking by a health professional to treat or operate upon a patient does not include a guarantee that the patient will be cured or that the intervention will be a success. The practitioner undertakes no more than to treat or operate upon the patient with the amount of competence, care and skill that may reasonably expected from that particular branch of the profession. Hence, a mere therapeutic reassurance is not to be construed as a guarantee of cure or success.[26,94,96,101]

Claims are increasing, and informed consent is becoming a major issue for

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8. Van Oosten 1991
26. Strauss 1991
94. Van Oosten & Strauss 2002
96. *Kovalsky v Krige* 1910
101. *Van Wyk v Lewis* 1924

practitioners defending themselves in court. These cases had little effect on how surgeons operate - what it did was to change what doctors said to patients. The law effectively made it necessary for doctors to obtain informed consent in a certain way. It moved from *doctor-led* to *lawyer-led*, as they argued that, while a patient may not be entitled to know everything, neither is the doctor entitled to decide everything.[8,13]

4.4.2. PATIENT UNDERSTANDING OF CONSENT

Consent, and a patient's right to self-determination, is the root of many important problems in medical ethics.[141] The requirement to obtain consent is imposed by law, not by the practices of the profession. The fact that the treatment might be safe and effective and given with the best interest of the patient in mind, is irrelevant to the question of whether in fact the patient consented.[142]

The amount of information that patients expect to be given before a medical procedure varies according to circumstances, but one thing is clear and that is that the patient must receive sufficient information to help him make a decision. The procedure for obtaining informed consent is often poorly appreciated by patients.[142] They think the primary aim is to provide legal protection for the

8. Van Oosten 1991
13. Silove 1990
141. Jones 1995
142. Osuna *et al* 1998

doctor.[142,143,144]

Some authors have pointed out that detailed information does not, contrary to many doctors' beliefs, increase a patient's anxiety.[145,146] It has also been shown that adequate information not only increases patient satisfaction but also reduces subsequent claims even when complications arise.[145,147]

The results of the study undertaken by Osuna *et al*[142] have shown that, although patients had signed the required consent documents, they did not feel they had really understood the risks involved in the surgery they had undergone. The patients who underwent surgery did so with a sufficient knowledge of the greatest risks they faced, but a less profound understanding of the minor risks. In general, the patients were not happy with the information they had received concerning their pathology and treatment. It is precisely the appearance of an unexpected complication that can have such a psychological effect on the patient, even when this complication is of no great importance for the patient's overall health.

142. Osuna *et al* 1998
143. Muss *et al* 1979
144. Byrne, Napier & Cushiery 1998
145. Kerrigan & Dennison 1993
146. Tabak 1995
147. Waisel & Troug 1995

4.4.3. THE DOCTOR'S DUTY OF DISCLOSURE IN SOUTH AFRICA

4.4.3.1. Introduction

The principle to consent to treatment by a doctor should surely imply that a patient fully understands the nature and risks of the procedures involved. There appears to have been an initial paucity of authority in South African case law on the question as to the extent that a medical practitioner is obliged to furnish patients with information about medical diagnosis and treatment. The provision of only some broad indications of the scope of information by medical practitioners appeared adequate in our earlier court decisions.[148] In the case *Lymbery v Jefferies*,[149] Judge Wessels remarked:

> "All the surgeon is called upon to do is give *some general idea* of the consequences. There is no necessity to point out *meticulously all the complications* that may arise."

The leading case at that point in time on compliance with the consent requirements is probably *Stoffberg v Elliot.*[150] The patient had contracted cancer of the penis and he was admitted to a hospital where he underwent surgery. Upon regaining consciousness he discovered that his penis had been amputated. In an action for damages for assault, Judge Watermeyer commented as follows:

> "[A] man, by entering a hospital, does not submit himself to such surgical treatment as the doctors in attendance upon him may think necessary ... unless his consent to an operation is expressly obtained, any operation performed upon him without his consent

148. Van Oosten 1998
149. *Lymbery v Jefferies* 1925
150. *Stoffberg v Elliot* 1923

> is an unlawful interference with his right of security and control of his own body, and is a wrong entitling him to damages if he suffers any."

The obligation to at least inform a patient of possible serious effects of any medical intervention was later emphasised more specifically in the statement by Judge Neser in *Rompel v Botha*:[151]

> "There is no doubt that a surgeon who intends operating on a patient must obtain the consent of the patient. In such cases where it is frequently a matter of life and death I do not intend to express any opinion as to whether it is the surgeon's duty to point out to the patient *all the possible injuries* which might result from the operation, but in a case of this nature, which may have *serious results* to which I have referred, in order to effect a possible cure for a neurotic condition, I have no doubt that a patient should be informed of the *serious risks* he does run. If such dangers are not pointed out to him then, in my opinion, the consent to treatment is not in reality consent – it is consent without knowledge of the possible injuries."

Endorsing these remarks and rejecting the contention on behalf of the medical practitioner in *Esterhuizen v Administrator Transvaal*,[152] that it would render the position of the medical profession intolerable if it were to be held that they owed a duty to patients of having to inform them, prior to any operation or treatment, of all the consequences, dangers and details of the risks accompanying the operation or treatment, Judge Bekker said:

> "I do not pretend to lay down any such general rule; but it seems to me, and this is as far as I need to go for purposes of a decision in the present case, that a therapist, not

151. *Rompel v Botha* 1953
152. *Esterhuizen v Administrator Transvaal* 1957

called upon to act in an emergency involving a matter of life or death, who decides to administer a dosage of such an order and to employ a particular technique for that purpose, which he well knows beforehand will *cause disfigurement, cosmetic changes* and result in *severe irradiation* of the tissues to an extent that the *possibility of necrosis* and a *risk of amputation* of the limbs cannot be excluded, must explain the situation and resultant dangers to the patient – no matter how laudable his motives might be – and should he act without having done so and without having secures his patient's consent, he does so at his own peril."

4.4.3.2. *Castell v Bolam:* A paradigm shift

4.4.3.2.1. The *Castell* case: Determination of material risk

In South Africa the traditional approach in determining the duty of a practitioner to disclose to a patient the expected risks and complications relating to the particular proposed course of treatment, changed dramatically after the landmark case of *Castell v de Greeff*.[54,98]

In this case it was determined that the plaintiff's mother, and possibly also her grandmother, died of breast cancer. After undergoing surgery for the removal of lumps in her breasts, further lumps were later diagnosed. In view of her family history, the patient's gynaecologist recommended a mastectomy as prophylactic treatment and referred her to the defendant, a plastic and reconstructive surgeon. What was proposed was a surgical procedure involving removing as much breast tissue as possible, with

54. *Castell v de Greeff* 1994
98. *Castell v de Greeff* 1993

simultaneous reconstruction of the plaintiff's breasts using silicon implants. The operation was initially a success in the sense that upon completion all seemed well. However, complications occurred regarding the possibility of impaired blood supply to the left areola, as well as possible infection.

The plaintiff's left areolar complex worsened and at the time of her discharge from hospital, the defendant advised her that she would have to undergo further surgery, but that it would first be necessary to wait and see what the extent of the necrosis would be. She also received oral antibiotics. When the plaintiff's dressings were changed at home, a discharge with an offensive odour was noted from both the left and right areolar areas. She began to experience pain and also became feverish. She visited the defendant and the antibiotics were changed. One week later she consulted a colleague of the defendant, as he had gone away for the weekend. He admitted her to hospital, where debridement of the necrotic tissue were done and swabs taken for microbiological analysis. She subsequently lost the entire areolar complex on the left side and an area of skin (including the areola) on the right side. According to the pathologist's report the organisms present in the tissue were resistant to both courses of antibiotics prescribed by the defendant. She eventually had to undergo other reconstructive procedures to her breasts.

Precisely what was said at the pre-surgical consultation was in dispute. The plaintiff alleged that the defendant deviated from the particular procedure, as well as the size of the breast implants that they had agreed upon, while the defendant claimed that he had stuck to the proposed treatment-plan and that he did inform the patient of the risks involved in the almost an hour consultation. Accordingly, Judge Scott dismissed the allegations of the plaintiff:

> "...the plaintiff was unable to recall a number of things that had been discussed at the consultation on 14 June and in certain respects seemed uncertain to what had transpired. Indeed, at one stage in her evidence she explained that there had been 'an awful lot of facts to absorb', implying that she had not absorbed them at all..."

The real importance and value of the judgement in this case, however, relates to the issue of the duty of a medical (and dental) practitioner towards to warn his/her patient about the risks involved in a proposed treatment. Judge Scott cited the statement by Watermeyer J in the case of *Richter and Another v Estate Hamman*:[156]

> "It may well be that in certain circumstances a doctor is negligent if he fails to warn a patient, and, if that is so, it seems to me in principle that his conduct should be tested by the standard of the reasonable doctor faced with the particular problem. In reaching a conclusion a Court should be guided by medical opinion as to what a reasonable doctor, having regard to all the circumstances of the particular case, should or should not do. The Court must,

156. *Richter and Another v Estate Hamman* 1976

> of course, make up its own mind, but it will be assisted in doing so by medical evidence."

In this regard Scott J stated that this '*reasonable doctor's*" test is one that is well established in our law and is applied to both medical diagnosis and treatment, affording the necessary flexibility, and, if properly applied, does not leave the determination of a legal duty to the judgement of doctors. He concluded that it does not follow that a doctor is obliged to point out meticulously each and every complication that may arise:

> "To do so could well result in the risk of complications and their possible further sequelae assuming an undue and even distorted significance in the patient's assessment of whether to proceed with the operation or not. Nor is the doctor obliged to educate his patient to the extent of bringing him up to the standard of his own medical knowledge of all the relevant factors involved. What he must do, it seems to me, is present his patient, in such circumstances, with a fair and balanced picture of the material risks involved."

Judge Ackerman ultimately reversed the decision by Scott J in part on appeal, awarding compensation to the plaintiff for the period of pain, suffering, illness, discomfort and anxiety she had to endure because of the defendant's failure to treat her infection properly and timeously. However, he confirmed the guidelines by Scott J regarding consent to medical treatment and therefore dismissed the plaintiff appeal in that regard. He cited the requirements for consent to operate as a lawful

defence:[157]

> "...the following requirements must, inter alia, be satisfied:
>
> (a) the consenting party must have had knowledge and been aware of the nature and extent of the harm or risk;
>
> (b) the consenting party must have appreciated and understood the nature and extent of the harm or risk;
>
> (c) the consenting party must have consented to the harm or risk;
>
> (d) the consent must be comprehensive, that is extend to the entire transaction, inclusive of its consequences."

Judge Ackerman concluded his ruling regarding consent by referring to the Australian case of *Rogers v Whitaker*:[155]

> "In my view we ought, in South Africa, to adopt the ... formulation laid down in Rogers v Whitaker, suitably adapted to the needs of South African jurisprudence. It is in accord with the fundamental right of individual autonomy and self-determination to which South African law is moving. ... I therefore conclude that, in our law, for a patient's consent to constitute a justification that excludes the wrongfulness of medical treatment and its consequences, the doctor is obliged to warn a patient so consenting of a material risk inherent in the proposed treatment; a risk being material if, in the circumstances of the particular case:
>
> (a) a reasonable person in the patient's position, if warn of the risk, would be likely to attach significance to it; or
>
> (b) the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it"

155. *Rogers v Whitaker* 1992
157. Set out in van Oosten's detailed review of informed consent in South African, English and German law 1991

This judgment introduced a radical departure from the traditional approach to the question of consent, as the emphasis was placed on what a reasonable patient would require rather than the information considered necessary by the practitioner.[54,98,158,159]

4.4.3.2.2 Criticism of the *Bolam* principle

An understanding of the nature, scope and application of the doctrine of informed consent enunciated in *Castell v de Greeff*, as discussed, leads one to briefly examine the said doctrine in English law, as a point of departure for the development of the South African law. A brief comparison of English and South African law on this point is indicated, not only for historical reasons, but also on account of the provisions in the South African Constitution. The doctrine of informed consent strikes, amongst others, at one's constitutional right to bodily integrity (autonomy) and privacy. Interms of section 39(1)(c) of the Constitution of South Africa, a court, tribunal or forum, when interpreting the Bill of Rights, *may consider foreign law*. It is in this context that a brief comparison is made to the English law.

In the United Kingdom the issue of consent to treatment was tested in the case of *Bolam v Friern Hospital Management Committee*.[132] Mr Bolam

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54. *Castell v de Greeff* 1994
98. *Castell v de Greeff* 1993
132. *Bolam v Friern Hospital Management Committee* 1957
158. MacRoberts *et al* 1997
159. *C v Minister of Correctional Services* 1996

was suffering from a manic-depressive disorder. As was common practice at the time, he was offered a course of electro-convulsive therapy. However, he was neither informed of the risks inherent in this therapy, nor that these could be minimised by the use of restraints or muscle relaxants. Bolam, not knowing that the risks could be minimised, did not ask his doctors about possible use of safeguards. He agreed to the treatment, and in the second course of the treatment suffered severe pelvic fractures. Not surprisingly, Bolam sued the hospital.

The decision about whether sufficient information has been given to him was tested against the then current opinions of an informed body of medical practitioners. In this regard Justice McNair stated:

> "[the doctor] is not guilty of negligence if he has acted in accordance with the practice accepted as proper by a reasonable body of medical men skilled in that particular art…Putting it the other way round, a man is not negligent if he is acting in accordance with such a practice merely because there is a body of opinion which would hold a contrary view."

This became known as the controversial *Bolam* principle.

English law was given the opportunity to look again at the *Bolam* principle in the case of *Sidaway v Bethlem Royal Hospital Governors & Others.*[135] In this case the patient had an operation on her spinal cord and

135. *Sidaway v Bethlem Royal Hospital* 1984

was not informed that there was a risk of damage to the cord, which was less than 1%. The House of Lords upheld the *Bolam* principle although Lord Scarman criticised its application:[132,135]

> "The implications of this view of the law are disturbing. It leaves the determination of a legal duty to the judgment of doctors. Responsible medical judgment may, indeed, provide the law with an acceptable standard in determining whether a doctor in diagnosis or treatment has complied with his duty. But is it right that medical judgment should determine whether there exists a duty to warn of risk and its scope? It would be a strange conclusion if the courts should be led to conclude that our law, which undoubtedly recognizes a right in the patient to decide whether he will accept or reject the treatment proposed, should permit the doctors to determine whether, and in what circumstances, a duty arises requiring the doctor to warn his patient of the risks inherent in the treatment which he proposes."

The English case of *Thake & Another v Maurice*[153] is also relevant, as it dealt with broadly similar issues. The patient won his case against the surgeon who carried out his vasectomy, because the judge considered that the surgeon was negligent in failing to warn that the vas may recanalise. The numerical risk was irrelevant — it was the practice of other surgeons that was the deciding factor. The duty was on the doctor to tell the patient, not on the patient to ask. Thus consent had to be patient-led rather than doctor-led.

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132. *Bolam v Friern Hospital Management Committee* 1957
135. *Sidaway v Bethlem Royal Hospital* 1984
153. *Thake & Another v Maurice* 1985

Quite clearly, if the *Bolam* principle were to be adhered to, the doctors would claim to '*know best*' and set their own standards. Judge Michael Kirby,[154] of the Court of Appeal and Supreme Court in Australia, also expressed his concern in this regard as follows:

> "The test stated in the *Bolam* case was criticised roundly in the United Kingdom itself, and in other countries of the common law which have inherited the English legal system. In fact, it was suggested that the test was simply a hangover from Victorian age when "Nanny" was supposed to "know best". In Australia, it was sometimes irreverently said that it grew out of the class system and the hierarchical nature of English society and reflected the unwillingness of one profession (the law, represented by the Judge) to countenance ordinary people challenging the rules laid down by another profession (medicine). It was also said that, effectively, it allowed the medical profession to set its own standards of care."

The law in Australia has put the *Bolam* principle to its final test in the case of *Rogers v Whitaker*.[155] In this case, the patient had had a penetrating injury to her right eye at an early age and was referred to a practitioner for treatment to remove the scarring from that eye and to reduce the risk of glaucoma later in life. As is known to any practising ophthalmic surgeon, whenever operating on one eye, there is always a risk of sympathetic ophthalmitis, which will cause a deterioration in the functioning of the healthy eye. This is a very uncommon complication, estimated in this case at 1:14 000, but nonetheless one which is widely

154. Kirby 1995
155. *Rogers v Whitaker* 1992

recognised. Despite the patient's concern that her sight in her good eye could in some way be affected during the operation, the doctor did not raise with her the possibility of sympathetic ophthalmitis.

Unfortunately, she developed this condition after the operation and became blind in her good eye with only some improved residual sight in her damaged eye. Not surprisingly, she sued, saying that she should have been warned. The High Court dismissed the doctor's appeal, preferring Lord Scarman's[135] dissent to the *Bolam* test:

> "The law should recognise that a doctor has a duty to warn a patient of material risk inherent in a proposed treatment: a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that a particular patient, if warned of the risk, would be likely to attach significance to it."

4.4.3.3. The *Oldwage*-case: Affirming the constitutional principles relating to informed consent

In a recent decision by the Cape High Court in *Oldwage v Louwrens*[113] the issue of informed consent as pertained in South African law was again discussed in great detail.

The defendant, a surgeon, performed vascular surgery on the plaintiff following

113. *Oldwage v Louwrens* 2004
135. *Sidaway v Bethlem Royal Hospital* 1984

complaints by the plaintiff of severe pain in his right leg. Following the vascular surgery, the pain of which the plaintiff complained was not relieved. In fact, the plaintiff then suffered from claudication after the operation by the defendant, which impeded the plaintiff from enjoying the lifestyle to which he was accustomed prior to the vascular surgery. The plaintiff then consulted a further specialist who performed a laminectomy on the plaintiff, which relieved all the pain symptoms. The plaintiff consequently instituted a claim in the Cape High Court for damages, who in turn decided upon in favour of the plaintiff.

The court had to examine closely issues pertaining to the reasonable medical intervention required in order to address the plaintiff's complaint regarding pain. This question also required the court to examine the principles of informed consent in South African law, as it had to decide whether the defendant misrepresented to the plaintiff that the specific procedure would in fact relieve the plaintiff of his severe pain. After due consideration the decision by the Cape High Court in the *Castell*-case was affirmed by the court. It ruled that the principles set out by the Cape High Court in the *Castell*-case set the standard for determining whether or not informed consent by a patient existed prior to a the performance of a medical procedure by a practitioner. The court also found that these principles were consistent with the rights presently enshrined in the Constitution of the Republic of South Africa, more particularly, those to individual autonomy and self-determination.

It is accepted in South African law that a medical procedure performed on a person without his/her informed consent constitutes assault. Therefore the question of whether or not proper informed consent was provided is one of fact. The principle of informed consent is based on '*substantial knowledge of all material risks*' inherent to the planned procedure, which must exist on behalf of the patient. The court found in this case that the defendant had, in fact, assaulted the plaintiff. This determination was made on the basis that the defendant misrepresented to the plaintiff that the procedure proposed would relieve the plaintiff of the pain of which he complained, and therefore did not, in fact, obtain informed consent from the plaintiff.

4.4.4. LEGAL REQUIREMENTS

4.4.4.1. Informed consent

Ordinary, lawful consent is out of the question unless the consenting party knows and appreciates what it is that he/she is consenting to. Although the Roman maxim *volenti non fit injuria* (no harm is done to someone who consents thereto) is generally applicable, there are important legal requirements to be met and exceptions to be considered.[27,94,103,160] It also implies that the patient has been given sufficient information regarding the risks of the procedure. It is widely believed that knowledge gives freedom. One is unable to choose the

27. Claassen & Verschoor 1992
94. van Oosten & Strauss 1991
103. Strauss & Strydom 1967
160. Van Oosten 1999

most appropriate course of action without appreciation of all aspects of the situation and all the possible alternatives.

The nature and scope of information that must be disclosed has initially caused immense confusion amongst the legal and medical professions. However, the judgement by Ackerman J in the now landmark case of *Castell v de Greeff* has provided clear guidelines regarding the patient's right to knowledge of the material risk or danger of the treatment in question. Accordingly, the requirements of effective consent in the medical context must include the following:[8,26,27,160,161]

- it must be recognized by law (factual consent by a philanderer to undergo castration to save his faltering marriage, or by a kleptomaniac to have his hands amputated so as to render future thefts by him virtually impossible, will not be legally recognized)
- it must be given by someone who is legally capable of consenting;
- it must be informed consent;
- it must be comprehensive;
- it must be clear and unequivocal;
- it must be free and voluntary.

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8. Van Oosten 1991
26. Strauss 1991
27. Claassen & Verschoor 1992
160. Van Oosten 1999
161. Refer also to the MDPB's guidelines for good practice in medicine, dentistry and the medical sciences: SEEKING PATIENT'S CONSENT: THE ETHICAL CONSIDERATIONS (Booklet 15), July 2002. This booklet sets out the principles of good practice which all doctors, dentists and medical scientists are expected to follow when seeking patients' informed consent to investigations, treatment, screening or research. The contents of this booklet is an adjusted version of a booklet under the same title issued by the General Medical Council, London, November 1998, revised to comply with South African circumstances, obviously with the written permission of the President of the General Medical Council.

Furthermore, the new National Health Act[87] deals extensively with the issue of consent. Section 7(3) states that *'informed consent'* means consent for the provision of a specified health service given by a person with legal capacity to do so and who has been informed as contemplated in section 6. Accordingly, section 6 provides definite prescriptions regarding the patient having to have full knowledge of the proposed treatment and clearly states that the health care provider must inform the patient of the range of treatment options, as well as its benefits, risks, costs and consequences generally associated with each option. It must also be noted that the health care provider is required to convey such information, where possible, in a language that the patient understands and in a manner that takes into account the patient's level of literacy.

In the event of a patient being unable to give consent or where no person has been mandated to give consent on the patient's behalf, provision has been made in section 7(1)(b) for the recognition of certain people (related to the patient) who are authorised to make medical decisions on his/her behalf. In this regard, such consent can be given by the spouse or partner of the patient, or, in the absence of the spouse or partner, a parent, grandparent, an adult child or a brother or a sister of the patient (in the specific order as listed).

87. Act 61 of 2003

4.4.4.2. Deviations and extensions

As a general rule no practitioner is entitled to deviate from or extend an agreed intervention.[94,103,107,152,162] Hence the question arises whether or not consent to the agreed operation also covers medically indicated deviations therefrom or extensions thereof. This will obviously depend on the nature of the consent given pre-operatively by the patient. Deviations or extensions will be legally justified provided it:[26,27,94,103,104,150,160]

- is in accordance with recognised and accepted medical practice
- is performed in good faith to alleviate the patient's complaint
- does not materially increase the risk and danger in question
- is in the patient's best interest to proceed with the deviation or extension rather than to allow the patient to recover from the anaesthetic for the purpose of obtaining an express consent to the deviation or extension
- is an emergency intervention justified by statutory authority
- is an emergency intervention justified by unauthorised administration (*negotiorum gestio*) or necessity. Supposing a man is found unconscious in the street, and one cannot get his consent, and

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26. Strauss 1991
27. Claassen & Verschoor 1992
94. Van Oosten & Strauss 2002
103. Strauss & Strydom 1967
104. Schwär, Loubser & Olivier 1984
107. *Fowlie & Wilson* 1993
150. *Stoffberg v Elliot* 1923
152. *Esterhuizen v Administrator Transvaal* 1957
160. Van Oosten 1999
162. *Verhoef v Meyer* 1975

it is necessary for one to perform some operation to save his life, then clearly one could do so without consent.

4.4.4.3. Excessive information liability

A novel phenomenon that has reared its head is legal liability for excessive disclosure, or over-information. According to this a fundamental medico-legal principle in defining the scope and limits of a doctor's duty to inform, is that a medical practitioner, in fulfilling his obligation to inform, should refrain from causing the patient too much anxiety and distress by unnecessary disclosure of adverse consequences of medically indicated interventions.

It is within this context that the problem of over-information liability has arisen.[163] Most patients, when being over-informed, are not capable of objective assessment of their case due to lack of medical training, their prejudices or their personality. This legal liability for excessive disclosure or over-information which causes the patient psychological harm, brings the potential conflict between the doctor's obligation to inform the patient and his obligation not to harm the patient to a head by rendering the dividing line between liability for too little and liability for too much information, a very thin one.

163. Van Oosten 1992

However, it seems that the question of legal liability for over-information in the South African system leaves one in no doubt as to their acceptance of the principle in cases where excessive disclosure on the doctor's part has the effect of causing the patient physical and/or emotional harm. For example, an overdose of therapeutic information may result in the patient's incorrectly following the relevant instructions because he/she lacks the necessary understanding of their content and purpose The view is taken that over-informing a patient may be tantamount to not informing him/her at all and, hence, that the doctor may be held legally liable on the same basis as in non-disclosure cases.[163]

4.5. EXPERT EVIDENCE AND WITNESSES

4.5.1. Introduction

This is the era of the expert witness. An expert differs from other witnesses in that he is entitled to state his opinion in relation to some matter lying within his field of expertise.[164] Writing reports for use in court and giving expert evidence from the witness box demand skills different from those that most experts acquire during the course of their professional careers, and there is growing support for the idea of formal training in these skills. Experts registered in the United Kingdom's *Register of Expert Witnesses* have reached agreement on the

163. Van Oosten 1992
164. McDermott 1997

fact that better training was needed for a number of reasons:[165]

i. to assist first-time expert witnesses;

ii. to improve the skills of all expert witnesses in report-writing and giving oral evidence;

iii. to give instructing solicitors a recognized measure of expert witness skills; and

iv. to improve knowledge of court procedures.

There is no threshold test of reliability. If a witness is apparently qualified and can give relevant evidence on a matter in issue in the proceedings, the evidence becomes admissible in the proceedings. The trier of fact (be it judge or jury) is then expected to weigh up often competing expert opinions, thus having the task of:

> "…ensuring that an expert's testimony both rests on a reliable foundation and is relevant to the task at hand. Pertinent evidence based on scientifically valid principles will satisfy those demands"[164]

There are, however, generally accepted guidelines in this regard. To be admissible as 'expert opinion' evidence:[166]

- the alleged expertise of a witness must relate to a recognised field of expertise or knowledge;
- a witness must be qualified as an expert by experience or

164. McDermott 1997
165. Pamplin 1997
166. *Daubert v Merrell Dow Pharmaceutical Inc* 1993

training; and

- an evidence must relate to the determination of the facts in issue.

The United States Supreme Court emphasised the obligation of the trial judge to act as a '*gatekeeper*', screening out both irrelevant and unreliable expert testimony. Although the Court did not purport to set forth a specific test of reliability, it indicated that it involves scientific validity based on the following:[167]

- whether the reasoning or methodology underlying the testimony has been tested;
- whether it has been subjected to peer review in publications;
- its potential rate of error;
- whether it has been generally accepted or rejected in a relevant scientific discipline.

Certainly, in a wider context, medicine, science and the law seem to be at a crossroads, in particular the latter in its relationship with the other two disciplines, with doctors pointing their fingers at rapacious lawyers whom they consider may have base motives, and lawyers claiming that doctors should not be above the law.[28]

Whatever the case, expert evidence remains an important element in the judicial

28. Goode 1996
167. Collins, Waldron & Pavlakis 1997

process that, when properly assembled and fairly given, can greatly assist in the court's decision-making process. Albeit the fact that judges are often confronted by conflicting expert opinions on various technical and scientific issues upon cases they must adjudicate, they are generally schooled by long experience, and, with an imbued sense of equity, and inherent integrity and objectivity, will hopefully arrive at as fair a verdict as is humanly possible.

4.5.2. Exceptions to the need for expert evidence

As the presiding judge has normally no medical training, it cannot be expected of him/her, without the submission of medical evidence, to judge the correctness of facts not falling within his/her domain. As a rule the patient will have to present expert evidence to support his allegations of negligence against a practitioner. The reason for this is that proof of the origin of even minor injuries or prejudice to health can be extremely complicated.[27]

There are, however, two exceptions to the rule that expert evidence should be led in order to prove deviation from normal practice guidelines.[27]

4.5.2.1. The case speaks for itself (*res ipsa loquitur*)

The maxim *res ipsa loquitur* is based on the fundamental principle that the mere evidence of the detrimental occurrence, as well as that it was caused exclusively by the defendant, constitutes a *prima facie* factual

27. Claassen & Verschoor 1992

presumption that the defendant had been negligent. The damage must be of such kind that it would normally not have taken place in the absence of negligence.[168] This does not necessarily imply that the onus of proof has automatically shifted from the plaintiff to the defendant. However, if the defendant does not succeed in giving an acceptable explanation for the incident, the court may find that he was negligent.

The *res ipsa* principle is readily applied in England and virtually all the jurisdictions in the United States of America, and finds its most frequent application in cases where some or other foreign object was left behind in the body of a patient. In *Mahon v Osborne*[169] the English Court of Appeal decided that the principle was applicable where a swab was left in a patient's stomach after an abdominal operation:

> "There can be no possible question but that neither swabs nor instruments are ordinarily left in the patient's body, and no one would venture to say that it is proper, although in particular circumstances it may excusable, so to leave them. If, therefore a swab is left in a patient's body, it seems to me clear that the surgeon is called on for an explanation, that is, he is called on to show not necessarily why he missed it, but that he exercised due care to prevent it being left there."

South African courts have as yet been unwilling to adopt the maxim in medical cases albeit its application abroad.[27] In the case of *Mitchell v*

27. Claassen & Verschoor 1992
168. Jackson & Powell 1982
169. *Mahon v Osborne* 1939

Dixon,[112] it was alleged that the physician had failed to use an appropriate instrument during treatment. The Court found that there was no evidence on which this allegation could be based. There also appeared no reasonable grounds to find that the defendant negligently inserted the needle in the wrong place. From the evidence it would also have been unreasonable to find that the actual breaking of the needle could be blamed on the physician's negligence. For these reasons the defendant's appeal was upheld. In his judgment, lnnes ACJ again rejected the *res ipsa* principle:

> "The mere fact that the incident occurred was not in itself prima facie proof of negligence. Because the needle might have been fractured by cause beyond the control of the operator — by movements of the patient for instance. So that the maxim res ipsa loquitur could have no application."

In another well-known South African case, that of *Van Wyk v Lewis*[101] the maxim was again explicitly rejected. The Court found that it could find no application in matters where the presence or absence of negligence depended on something relative and non-absolute. The Court stressed that in determining the existence of negligence all circumstantial facts should be investigated and considered and seen as a whole. The nature of the incident is an important element, but it must be considered in context with other evidence. In rejecting this principle. Wessels AJ said:

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101. *Van Wyk v Lewis* 1924
112. *Mitchell v Dixon* 1914

> "The mere fact that a swab is left behind in a patient is not conclusive of negligence. Cases may be conceived where it is better for the patient, in case of doubt, to leave the swab in rather than to waste time in accurately exploring whether it is there or not, as for instance where a nurse has a doubt but the doctor after a search can find no swab, and it becomes patent that if the patient is not instantly sewn up and removed from the operating table he will assuredly die. In such a case there is no advantage to the patient to make sure that the swab is not there if during the time expended in exploration the patient dies. Hence it seems to me that the maxim *res ipsa loquitur* has no application to cases of this kind."

Strauss and Strydom criticise this unequivocal rejection of the *res ipsa loquitur* principle and argue that equity demands that a patient need only show a casual nexus between the physician's conduct and the highly unusual result. The physician should then be compelled to supply a reasonable explanation for the incident.[103] This is in accordance with Constitutional principles and there are substantial grounds to argue that the majority judgement in *van Wyk v Lewis*[101] should be overruled and that the general application of the *res ipsa loquitur* principle be extended to inquiries into complaints against registered practitioners of the HPCSA.[170,171]

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101. *Van Wyk v Lewis* 1924
103. Strauss & Strydom 1967
170. Carstens 1999
171. Van den Heever 2002

4.5.2.2. Common knowledge

The doctrine of common knowledge, which was developed in American law, postulates that certain facts are so commonly known that a court or jury could take notice thereof without evidence having been led.[27,172] It is, for example commonly known that a careful physician would make use of x-ray examination when investigating a possible fracture, or the facts are usually very clear where there was failure to sterilise surgical instruments, or where the wrong leg was amputated.[173]

The difference between the common knowledge doctrine and the *res ipsa loquitur* principle is that in cases where the latter is applied, it is expected of the plaintiff only to prove the alleged *iniuria* or damage and not also the standard of care of a specific act. In contrast hereto the doctrine of common knowledge is applied after damage as well as the *commissio* or the *omissio* of the professional person has been proved.[174] The application of the common knowledge doctrine actually changes a claim of negligence based on professional malpractice to one based on '*ordinary negligence*'.

4.5.3. Legal opinion on expert evidence

It is somewhat astounding to the layman in the field of medicine to hear how eminent medical men put forward clinical opinions that differ quite materially

27. Claassen & Verschoor 1992
172. Strauss 1984
173. Dornette 1972
174. Cohen & Mariano 1982

— and they do so utterly convinced of the correctness of their views.[167]

One might reasonably ask how it is possible that a rule of law has evolved which actively encourages the obfuscation of the truth? Experience has shown that such a manipulation of reality often results in expert testimony failing to achieve the truth, the whole truth and nothing but the truth. Central to this dilemma is the expansion of the principle of attorney-client privilege. As such, the defence is free to shop around, tearing up one '*unhelpful*' expert report after another, until at last it finds the person who is ready to say what it wants the court to hear.[175]

The quality of expert evidence has therefore been the subject of many a comment in the legal press, with much being said about the battle of the experts.[167,175,176,177,178,180] This scepticism about the use of '*expert*' evidence in trials has been voiced as long ago as 1858:[180]

> "Perhaps the testimony which least deserves credit with a jury is that of skilled witnesses. These gentleman are usually required to speak, not to facts but to opinions: and when this is the case, it is often quite surprising to see with what facility, and to what extent, their views can be made to correspond with the wishes or the interests of the parties who call them."

There is some recognition of the fact that expert evidence can add significantly to cost and delay in litigation. Accordingly, present thinking favours cases being

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167. Collins, Waldron & Pavlakis 1997
175. Manarin 1999
176. Strauss 1997
177. Samuels 1994
178. Orr 1995
180. Taylor 1858

subject to judicial management, so that positive efforts be made to determine what, if any, points of difference exist between the experts engaged in a case – this could be done by an early exchange of reports and/or meetings between experts. The situation was summarised as such in a detailed examination of the civil justice system in England and Wales:[168]

> "The area of expert witness is one in which current unmanaged adversarial approach to litigation has had adverse consequences in terms of both excessive cost and avoidable delay. To redress this effectively will require co-operation by legal advisers, in the interest of their clients. It will also require a robust approach by the court."

Unfortunately it is true that some expert witnesses are showing a tendency to be less than impartial or objective: they are becoming partisan. An important judicial function is therefore to ensure that experts do not stray beyond the limits of their expertise and seek to give their opinion on credibility or the very issue on which the judge had to decide.[175] Adaptations by the courts in this regard have enabled trial lawyers to exploit these developments:[164]

> "Expert witnesses used to be genuinely independent experts. Men of outstanding eminence in their field. Today they are in practice hired guns: there is a new breed of litigation hangers on, whose main expertise is to craft reports which will conceal anything that ought be to the disadvantage of their clients. The disclosure of expert reports, which originally seemed eminently sensible, has degenerated into a costly second tier of written advocacy. Costs of experts have probably risen faster than any other element of litigation costs in the last 20 years. This deplorable development has

164. McDermott 1997
168. Jackson & Powell 1982
175. Manarin 1999

> been unwittingly encouraged by a generation of judges who want to pre-read experts' reports before coming into court, and by practice directions stipulating that the reports be lodged in court to enable them to do so. What litigant can ignore an opportunity to implant his case in the judge's mind before the hearing begins?"

The foregoing commentary has created a lot of uneasiness and suspicion, probably because we have come to realise that the expert is ripe for exploitation, particularly when the expert is willing to abdicate control over his or her own evidence to a second party – the lawyer.

4.5.4. Setting the boundaries for expert evidence in the South African law[181]

The assessment of expert evidence is crucial to a finding of fault on behalf of a medical or dental practitioner. The primary function of the medical expert is to guide the court to a correct decision on questions falling within the expert's specialised field. The value a court should attach to expert medical evidence with regard to the proof of medical negligence is contentious, especially in those cases where the court will find it difficult to draw its own reliable inferences due to the technical nature of the testimony. This is particularly the case where medical experts have conflicting opinions or represent different but acceptable schools of thought in medical practice.[26,27,54,95,133,134,182]

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26. Strauss 1991
27. Claassen & Verschoor 1992
54. *Castell v de Greeff* 1994
95. *Coppen v Impey* 1916
133. *Pringle v Administrator Transvaal* 1990
134. Carstens 1991
181. Carstens 2002
182. *Webb v Isaacs* 1915

Although the approach to expert evidence has been the subject of judicial scrutiny in various medical negligence cases, the Supreme Court of Appeal in the case of *Michael & Another v Linksfield Park Clinic (Pty) Ltd*[183] had the opportunity to authoritatively enunciate the general applicable considerations in assessing expert medical evidence. According to Carstens, the approach to expert evidence followed by the Supreme Court of Appeal in this case can be summarised as follows:[181,183]

i. In delictual claims the issue of reasonableness or negligence of a defendant's conduct, is one for the court itself to determine on the basis of the various and often conflicting expert opinions presented;

ii. As a rule, that determination will not involve considerations of credibility but rather the examination of the opinions and the analysis of their essential reasoning, preparatory to the court reaching its own conclusion on the issues raised;

iii. In the case of professional negligence, the governing test is the standard of conduct of the reasonable practitioner in the particular professional field, but that criterion is not always itself a helpful guide to finding the answer;

iv. What is required in the evaluation of expert evidence bearing on the conduct of such persons is to determine whether and, to what extent, the opinions advanced are founded on logical reasoning;

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181. Carstens 2002
183. *Michael & Another v Linksfield Park Clinic* 2001

v. The court is not bound to absolve a defendant from liability for allegedly negligent professional conduct (such as medical treatment or diagnosis) just because evidence of expert opinion, albeit genuinely held, is that the conduct in issue accorded with sound practice;

vi. The court must be satisfied that such opinion had a logical basis, in other words that the expert has considered comparative risks and benefits and has reached a defensible conclusion. If a body of professional opinion overlooks an obvious risk which could have been guarded against, it will not be reasonable, even if almost universally held;

vii. A defendant can be held liable despite the support of a body of professional opinion sanctioning the conduct in issue, if that body of opinion is not capable of withstanding logical analysis and is therefore not reasonable. However, it will very seldom be correct to conclude that views genuinely held by a competent expert are unreasonable;

viii. The assessment of medical risks and benefits is a matter of clinical judgment which the court would not normally be able to make without expert evidence, and it would be wrong to decide a case by simple preference where there are conflicting views on either side, both capable of logical support;

ix. Only where expert opinion cannot be logically supported at all, will it fail to provide the benchmark by reference to which the defendant's conduct fails to be assessed;

x. Finally, it must be borne in mind that expert scientific witnesses tend to assess likelihood in terms of scientific certainty and not in terms of where the balance of probabilities lies on a review of the whole of the evidence.

In principle, the court has set the boundaries for expert evidence in support or defence of medical negligence. In essence, the court also affirmed the generally applicable principles already enunciated in leading South African medical case law, that the proof of medical negligence has to be determined with reference to expert evidence of members of the medical profession, but that such determination in the final instance is for the court which is not bound to adopt such testimony.[54,95,101,133,182] The court correctly stated the rule that such determination will involve the examination of the expert opinions and the analysis of their essential reasoning preparatory to the court reaching its own conclusion on the issues raised.

The court further reiterated the governing test for professional medical negligence being the standard of conduct of the reasonable practitioner in the particular field. In this regard the court clearly recognised the interdependency of the test for medical negligence and the proof thereof by means of expert evidence. The analysis of the judgement of the nature of the expert evidence in

54. *Castell v de Greeff* 1994
95. *Coppen v Impey* 1916
101. *Van Wyk v Lewis* 1924
133. *Pringle v Administrator Transvaal* 1990
182. *Webb v Isaacs* 1915

relation to the test for medical negligence in this case is, with respect, problematic in the sense that the context of its application by the court is somewhat clouded. This is also true with regard to the court's assessment of conflicting schools of thought in medical practice.[181] In this regard the Supreme Court of Appeal[183] accepted the '*principle of* logical reasoning':

> "The court is not bound to absolve a defendant from liability for allegedly negligent medical treatment or diagnosis just because the evidence of medical opinion, albeit genuinely held, is that the treatment or diagnosis in issue accorded with sound medical practice. The court must be satisfied that such opinion has a logical basis, in other words that the expert has considered comparative risks and benefits and has reached 'a defensible conclusion'."

It is conceivable that expert medical opinion based on logic is not necessarily indicative of reasonableness or unreasonableness within the realm of accepted medical practice. Logic refers to a process of reasoning/rationality based on scientific or deductive cause and effect. Therefore a given result or inference is either logical or illogical. Reasonableness on the other hand is a value judgement indicative of, or based on an accepted standard or norm. While it is true that logic more often than not is an integral part of reasonableness, it does not necessarily follow that logic can be equated to reasonableness. The distinction is illustrated with reference to the concepts of '*medical misadventure*' and '*professional errors of judgement*' within medical practice where even '*illogical*' medical mishaps/errors of judgment have been held to

181. Carstens 2002
183. *Michael & Another v Linksfield Park Clinic* 2001

have been reasonable in terms of accepted medical practice.[26,103,115,116,117]

The true test for expert medical opinion in medical negligence actions rests upon the fact that all factual information has been presented to him/her in order to present an objective and clinical reflection of the standard or norms of accepted medical practice in the particular circumstances. In the event of conflicting expert opinion or different schools of thought in medical practice, it appears that even a conflicting and minority school of thought or opinion will be acceptable provided that such opinion accords with what is considered to be reasonable by that branch of the medical profession. In this regard clear guidance was given in the case of *Van Wyk v Lewis*[101], where the following was said:

> "The court cannot lay down for the profession a rule of practice. It must assume that the generally adopted practice is the outcome of the best experience and that which is best suited to attain the most satisfactory results … The general rule of law is that where a reasonable trade usage is of universal application in a community where a form of professional practice is generally adopted by a particular profession, a person who deals with the trade of profession is impliedly bound by the usage or practice of the profession. The court can only refuse to admit … a universal practice if in its opinion it is so unreasonable and dangerous that it would be contrary to public policy to admit it".

The court's concern that it would be wrong to decide a case by simple preference where there are conflicting views on either side, both capable of

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26. Strauss 1991
101. *Van Wyk v Lewis* 1924
103. Strauss & Strydom 1967
115. *Roe v Ministry of Health* 1954
116. Holder 1978
117. *Whitehouse v Jordan* 1981

logical support, could be overcome by strictly applying the ordinary rules of evidence. If both conflicting views on either side are capable of logical support (or rather are indicative of accepted or reasonable medical practice) the question arises whether the plaintiff has proven his or her case against the defendant medical practitioner on a preponderance of probabilities. The judgment then depends on the credibility and reliability of the expert witnesses. If the scales are evenly tipped on a review of the whole of the evidence, then absolution from the instance should be ordered. It is submitted that difficulties in assessing expert medical testimony should not erode the application of the ordinary rules of evidence.

Albeit the fact that the principles pertaining to the approach to expert medical evidence generally have been reaffirmed, it is specifically the approach to conflicting opinions representing different but acceptable schools of thought in medical practice that still remains open ended.

4.6. CONCLUSION

In general terms what is improper or disgraceful conduct is not subject to simple description *per se*. It is conduct that, in the opinion of the HPCSA as custos morum of the profession, is improper or disgraceful. It also implies that each complaint to the HPCSA will have to be considered on its own individual merits. In this regard the Cape High Court recently held in *Oldwage*-case that

medicine is still not – and probably will never be – an exact science. Accordingly the court reaffirmed the principles laid down in the *Mitchell*-case.

Consent with regard to medical and dental treatment, including maxillo-facial and oral surgery, has become a major issue globally. Clear and definite legal guidelines in this regard have been provided in the landmark-case of *Castell.* These principles have been reaffirmed in the very recent *Oldwage*-case.

The quality of expert evidence, as well as the acceptance thereof by the court, remains a controversial issue. However, it still remains a very important factor in order to provide substantiation, and subsequent proof, of charges of alleged professional negligence and misconduct. Accordingly, the South African law has set clear boundaries for the acceptance of expert testimony in the *Michael*-case.

CHAPTER 5

CASE STUDIES

5.1. INTRODUCTION

The extent of the cases brought before the PRELIM is overwhelming. The rulings made in the vast majority of cases, such as fraud and false declarations/certificates, do not justify any further comment, as they were clearly based on sound judgement by the committee and are actually a matter of *res ipsa loquitur*, which seldom create difficulty of interpretation.[84,184,185]

The Dental Protection Limited has rated consent/communication (2nd), complications related to minor oral surgery (4th) and implant surgery (7th) amongst the '*Top Ten*' complaints in South Africa over a five-year period that ended in 2000.[2] It is therefore interesting to note that it is also in these more complex aspects (in particular with regard

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2. Butterworth 2002

84. Act No 56 of 1974:
With regard to the issuing of medical certificates it is necessary to refer to the acts mentioned in rule 17 of the principal Act – it prohibits the granting of a certificate by a practitioner in his professional capacity unless he is satisfied from personal observation that the facts are correctly stated therein, or has qualified the certificate by the words "*As I am informed by the patient*".

184. *Sitlu v INMDC* 1996:
A charge of improper and/or disgraceful conduct was brought against a dentist on the basis of the fact that he claimed to have performed surgical procedures, for which he was reimbursed, while in fact the procedures was never done. It was alleged that he claimed a fee for surgical removal of residual roots on a child, while in fact the two upper deciduous incisors were only extracted, and also claimed a fee for surgical exposure of a tooth for orthodontic reasons whilst only performing an extraction. He was subsequently found guilty of improper conduct.

185. *Duafrie v INMDC* 1996:
A charge of improper and/or disgraceful conduct was brought against a foreign dentist with limited registration, on the basis of the fact that he put forward false documentation in order to be considered for appointment in the South African Medical Services (National Defence Force), well knowing that it had been forged. It was proved during cross-examination that he was not even registered with the Medical and Dental Council in his country of origin. He was found guilty of disgraceful conduct.

to expert evidence on peri-operative complications) that there appears to be a void to some extent in the investigative system that precedes the PRELIM's findings and its recommendations to the PCC.[186]

In the evaluation of the cases with regard to maxillo-facial and oral surgery that was referred by the PRELIM to the PCC for formal disciplinary inquiry it was noted with concern that an unacceptably high percentage of cases were eventually found not guilty. The reason for this can be two-fold: (a) the high acquittal rate may of course testify to the advantage of good-quality defence-lawyering, or, (b) questions must be raised with regard to the effectiveness of the investigative function of the PRELIM, as they apparently found *prima facie* evidence of professional misconduct in all of these cases and subsequently recommended that disciplinary inquiries be held. Considering the latter, it is very unfortunate and simply not fair towards the accused practitioner, as inquiries are time consuming and often very expensive.

A total of seventy-eight complaints were lodged at the HPCSA against maxillo-facial and oral surgeons (Annexure 1). More than seventy percent of these complaints focused on the alleged unprofessional conduct of practitioners (in the context of medical negligence) when treating their patients. In this regard it appears that two issues are becoming very relevant to the patient: (a) did the doctor inform him/her of all the relevant aspects of the treatment, and, (b) in the event of an unfavourable outcome, who will testify whether the doctor's conduct was unprofessional or not. Cases confined to

186. Verschoor 1986

the specialty of maxillo-facial and oral surgery, as well as relevant dental cases where appropriate, will therefore be presented under the following headings: expert testimony; informed consent and post-operative complications.

5.2. EXPERT TESTIMONY

The majority of standards set by professional organisations still require an expert to explain and assess adherence to those standards to the court. The continued use of experts to help interpret and apply practice parameters is likely to be preserved and therefore the legal profession will be continuously confronted by conflicting opinions of experts.[187,188]

Six cases that were heard before the PCC of the MDPB of the HPCSA will be discussed to illustrate the quality of the expert testimony that was accepted by the PCC in each case.

5.2.1. *Klopper v SAMDC*[189]

In this case the respondent (maxillo-facial and oral surgeon) chose to conduct his own defence despite advice to the contrary by both the chairman of the

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187. The British Medical Association (BMA) became a founding sponsor of the so-called *Expert Testimony Institute* early in 1997. The Institute was intended to offer training and education for professionals who were interested in this particular field. However, they decided in December 1997 to sever all links with the Institute because of continuing problems and the BMA is now looking at providing in-house medical expert witness training.

188. Unfortunately it appears that a similar situation exists in South Africa. The Ethics Institute of South Africa (EISA) is an independent, South African, non-profit Institute focusing on health care and organisational ethics. There appears to be a lack of transparency regarding EISA's workings, and the South African Dental Association (SADA) has expressed its disappointment at the lack of response from EISA to letters directed to them in this regard. (See Campbell 2002 - Report of the Executive Director: SADA's Annual Report 2001 – 2002)

189. *Klopper v SAMDC* 1992

committee and the attorney for the complainant. During the course of the proceedings his interpretation and lack of knowledge of the legal proceedings were very evident, as he was reprimanded several times about his conduct and ordered to confine his questions and statements to the relevancy of the particular case. Sadly his following comment after being found guilty of disgraceful conduct:

> "Mr Chairman, I ask you to give me another chance. From the time when I started practice back in 1952, I have never been before this Council, and thus it was all a bit strange to me. I wasn't aware that I could make use of my Medical Defence Union's rights, and therefore could have had an attorney to help me with my case. So I plead with you to restart this case and allow me to have an attorney present."

This case serves as an excellent example of the value of sufficient legal representation with regard to claims of unprofessional and/or disgraceful conduct. It is therefore advisable to belong to an organisation providing indemnity cover (such as Medical/Dental Protection Society) in order to receive proper assistance in the handling of these cases right from the start.

5.2.2. *Bux v INMDC*[190]

A charge of improper and/or disgraceful conduct was brought against a dentist (Dr B[1]) on the basis of the fact that he had performed surgical procedures in an incompetent and negligent manner not in accordance with acceptable standards. It was also alleged that he claimed to have performed a successful extraction of his patient's lower third molar, for which he claimed a professional fee, whilst in

190. *Bux v INMDC* 1998

fact he in fact displaced the tooth into the lingual soft tissue. The patient later consulted another dentist, who referred the patient to a maxillo-facial and oral surgeon (Dr B^2) for evaluation and treatment. The committee was however concerned about some inconsistencies in the expert-evidence given by the surgeon:

> "Now, did you know that Dr B^1 had been the dentist who had originally treated the patient? --- *No.*
> You didn't? --- *No, I never required in that regard.*
> Were you not told? --- *No.*
> Did you ever make a record that Dr B^1 had originally treated the patient? --- *No, because I did not know that Dr B^1 had treated the patient.*"

The expert witness was handed a copy of his own records that clearly indicated that he had documented the fact that he was aware that Dr B^1 did indeed treat the patient. He was also questioned about the fact that he did not take his own records into account in this regard:

> "You didn't look at these notes before you came here today? --- *No, I didn't.*"
> "Do you recall writing that letter of the 19th of May to Dr B^1? --- *No, I don't offhand.*
> That was not a true statement. --- *No, it wasn't.*"

The closing questioning by the attorney for the complainant finally points out the lack of credibility of this expert witness:

> "You were talking about the care with which you prepare your records, Dr B^2, and my attention was directed to the paragraph of your report on page 8 which commences with the words 'shortly thereafter'. --- *Page 8?*
> Was it the left muscle… --- *No, it was the right one.*
> Thank you."

In the statement on its finding the Committee simply dismissed the quality of his

evidence as statements and commented as follows:

> "… in respect of Dr B[2]'s evidence the Committee was concerned about a number of inconsistencies."

The practitioner was found guilty of disgraceful conduct and suspended from practice for six months, with operation of the penalty suspended for five years.

5.2.3. *Jaga v INMDC*[191]

A charge of improper and/or disgraceful conduct was brought against a dentist (Dr J) on the basis of the fact that he had performed surgical procedures in an incompetent and negligent manner not in accordance with acceptable standards. It was also alleged that he failed to establish the existence of post-operative complications, i.e. a fracture of the maxillary tuberosity, as well as an oro - antral communication. Furthermore it was alleged that he apparently provided treatment not indicated and failed to properly assist his patient during the post-operative course. The practitioner was subsequently found not guilty.

The expert testimony (by a maxillo-facial and oral surgeon) on behalf of the respondent is relevant in the context of this discussion – especially his expression of personal philosophical views on the treatment given by the respondent rather than giving unbiased scientific testimony, claiming, for instance, that if a patient receives any treatment whatsoever (albeit not indicated) for a specific condition and it causes no harm, it cannot necessarily be regarded as wrongful conduct:

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191. *Jaga v INMDC* 1998

> "Why do you think [Groote Schuur] gave [Otrivin]? --- *Because they thought to give it. But that doesn't necessarily mean they have to."*
> "Did they have nothing in mind that they aimed at nothing when they gave it? --- *No, they were basically covering themselves ..."*
> "You see, I just find it, Dr D … advocates it, Groote Schuur gives it, and you say well, it doesn't mean a thing."
> "Now doctor, … why do you think Dr J gave Konakion? --- *Well, from what I'm told, he wanted to give Cyclocapron, it was not available and the pharmacist offered him Konakion, you know, as an alternative …"*
> "But you say it was just worthless? --- *No, I don't think anybody can say it was worthless."*
> "Well, you said for the first three days it does nothing. --- *No. Yes, absolutely."*
> "That is why the other doctors say I wouldn't use Konakion, it is not the thing. --- *I also wouldn't use Konakion, Sir."*
> "It is not indicated … --- *But giving it won't do a patient any harm."*
> "Yes Dr H, so would giving an aspirin also, or a bit of water, it wouldn't do any harm, but it wouldn't help either. --- *But I mean, why run the man down because he has given vitamin K. Vitamins are good for you, it doesn't do you any harm."*
> "I have difficulty just in passing with your philosophy of medicine, as I understand it. --- *You have difficulty? … Well, I am in practice for ten years now, and know lots of people who don't have that difficulty. Are you actually querying my competence?"*
> "But let's logically look at it. Your evidence is that for three days Konakion doesn't do anything. --- *But I'm not going to say it was wrong to give it."*

When questioned about his elusiveness in giving a clear opinion on the treatment that was given for the post-operative complications that occurred, the witness offered an emotional defensive response of his own reputation and competence:

> "… just this one aspect, Dr, … the words that you used about his dealing with the bleeding – he did fairly well … are you trying to convince the Committee that Dr J did an exemplary piece of work? --- *I wouldn't say that. I didn't say he would do a job as well as I could. What I'm saying to you is that taking into consideration that he is a general practitioner, I think he did fairly well, and using the word fairly, I submit as a specialist, I am giving him credit."*

"Yes. --- *I am also not going to run him down."*
"All right --- *I don't run, I don't run down my colleagues."*
"All right. Yes, I understand you quite clearly. --- *Otherwise I won't be in business."*
"What would you have done, had you encountered the identical circumstance? --- *Well, I would have done exactly the same thing as the general practitioner, except being a bit smarter …"*

"Are you saying that there didn't exist [an oro-antral communication] in this case? --- *I am saying that more than likely it didn't."*
"That's not what Groote Schuur says --- *I don't care what they say, Sir …"*
"Fine --- *I can take on the whole Groote Schuur as far as this case is concerned."*
"And if they say it was there, is it not so? --- *Where do they say it was there, Sir …How did they confirm that, because it doesn't correspond with the referral note"*

With regard to the findings and evidence of the specialist-clinic at Groote Schuur Hospital, the repeated attempts by this witness to stress his own personal viewpoint were dismissed by the final questioning by the chairman of the committee:

"Dr H, can I just ask you a question – I mean, given the evidence that Groote Schuur has given, I take it that you disagree with them completely? Of their diagnosis. ---*I think …*
"No, just wait, just answer, no long story, yes or no, cut the story short, and just tell us, very clear and concisely. Groote Schuur on its front page says, diagnosis, problem or procedures, fractured maxillary tuberosity, right? --- *Right.*
Number two, oral antral communication. That is what it says. ---*Okay.*
Is that the matter of fact that we have seen here? --- *Yes.*
Okay, that's fine, thank you very much. --- *And all I'm saying is that …*
No, that is fine, thank you, Dr H."

The defendant was found not-guilty on all charges against him.

5.2.4. *Shevel v SAMDC*[192]

A charge of improper and/or disgraceful conduct was brought against a maxillo-facial and oral surgeon on the basis of the fact that he had claimed an improper fee for a certain surgical procedure. His surgical technique regarding the suturing of wounds was also questioned. Although expert testimony in this regard showed several shortcomings and proved to be unsubstantiated, it was still accepted by the PCC. The practitioner was subsequently found guilty of disgraceful conduct and suspended from practice for a period of three months.The expert witness called to testify on behalf of the complainant presented his testimony as being representative of the maxillo-facial and oral surgery fraternity as a whole:

> "Doctor, would you say the view expressed by you here as far as these procedures that that is generally shared by other members of your specialty? --- *Yes, I do feel that."*
>
> "Is this common practice amongst oral surgeons to have small incisions and remove impacted teeth without suturing afterwards? Is this described in the literature? ---
>
> *Mr Chairman, no, I think the academic approach to this is in fact to raise a full muco-periostal flap ..."*
>
> "Are you aware then of surgeons, of your colleagues, of a tendency not to suture these wounds? In discussions with them have you heard this mentioned? --- *Mr Chairman, that is a difficult question, but I would say no. I don't recall having heard of surgeons in fact not suturing."*

A further interesting aspect arose in this case, as the expert witness called to testify on behalf of the respondent, made several contradicting statements, therefore in actual fact disqualifying himself as an expert on the case at hand:

192. *Shevel v SAMDC* 1982

> "Prof P, what are your qualifications? --- *I have got a BDS Dentistry and I then did a Master's degree in Dentistry, but in Orthodontics. I have been affiliated with the School of Dentistry for the past 17 years, or 14 – 15 years.*"
>
> "Now, during the course of your experience, have you been present at and assisted in the removal, surgical removal, of wisdom teeth? --- *I assisted in the theatre for approximately 6 years on three or four sessions a week so I think I have seen the removal of about 12 000 or so wisdom teeth in that.*"

His expertise is severely questioned during cross-examination by the attorney for the complainant:

> "Professor, do you feel yourself equipped to express any explicit views as far as the field of maxillo-facial and oral surgery is concerned? --- *Well, in fact it is strange that I do, because I take a particular interest in surgery, having been associated in my earlier career in being much with surgeons, but I do have to run a department of orthodontic surgery at this time and I do have to play a part in a large number of surgical procedures. With the surgeons we had meetings two or three times a week and we had one this morning for instance. So I feel a very, very close affiliation with the surgeons and I think I have got a relatively in-depth insight into surgery although I am not a practicing surgeon.*"
>
> "Would you dispute the evidence that was given here by Dr M, also the reference made to the views of other maxillo-facial and oral surgeons that in instances such as this, no fee should be charged for the closing of the antro-oral fistula; would you dispute those views? --- *I would find it very difficult to give an answer to that question, because I am not a surgeon. I don't really know how they go about this.*"
>
> "Is that your answer, Professor? You are not a surgeon and you are not aware of what the customs in the usages in surgery are. --- *In this instance I wouldn't really be able to give an opinion.*"
>
> "You don't know, in other words you don't work with it and you have no knowledge of how it it's dealt with…"

The chairman of the committee strangely continues to ask this witness for further '*expert opinion*' on this case, during which he again disqualifies himself

as an expert on the particular subject at hand:[193,194]

> "Prof P, just one question regarding the closure of the wounds. You heard the evidence this morning regarding the suturing of the wounds and could you give me an idea in this roughly 12 000 impactions that you were involved in or attended, what percentage of those were or was not necessary to suture the wound? --- *Most of my work was done with one surgeon. I have also worked with other people that don't suture. I personally prefer my surgeons that I work with to suture the wounds. I suppose I don't know enough about surgery really to give an opinion, but my own patients… I assisted all my own cases and I insist that they do in fact suture them.*"

5.2.5. *Erasmus v INMDC*[195]

A charge of improper and/or disgraceful conduct was brought against a maxillo-facial and oral surgeon on the basis of the fact that he had performed surgical procedures in an incompetent and negligent manner not in accordance with acceptable standards. Implants were placed in the patient's mouth. It was alleged that the prosthodontic reconstruction was made extremely difficult, if possible at all, due to sites of implant placement, as well as non-parallelism of the implants. The expert evidence led on behalf of the complainant revealed some bias with regard to available implant-systems in use throughout the world. It was also pointed out (on the witness' own account) that he had little experience in the system that was used:

> "Do you often make use of compression screws which we see in the mouth of mr R.? --- *I don't use compression screws at all.*
> What is the reason for that? --- *Well, it strays away from the original protocol laid down by Branemark…*"

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193. Ironically this technique that was used by the defendant was apparently a globally accepted technique. Furthermore, a scientific paper was later published on the results of a study done by the University of Pretoria that indicated that this particular technique was definitely acceptable in indicated cases.

194. See also Shevel, Koepp & Bütow 2001

195. *Erasmus v INMDC* 1996

> "Are you suggesting that it's, that's to some extent at least, the prosthodontist's privilege to stipulate those things? --- *I would have told the surgeon where I wanted the implants and which implants I wanted him to use ... Generally speaking, under the Branemark protocol that is how it works and unfortunately the Branemark protocol at this stage is the one, the only one we have and the one that we follow.*
>
> Well, who's we? Because on the same hand you indicate that this isn't followed as a matter of general practice --- *Well, I would say the University of the Witwatersrand Dental School … as a teacher at the University of the Witwatersrand Oral and Dental School this was the protocol that we have taught all of the students that have passed through that university. I don't know what happens at the university of Pretoria or the University of Brussels …"*
>
> … in relation to the protocol which you referred to, the Branemark protocol. You know there, you would agree with me, are other systems available, manufacturers throughout the world. Are you aware that any of these systems will advocate the procedures whereby similar sort of protocol is not followed? --- *No, I think that most systems will follow that exact protocol."*[196,197,198,199,200]

However, concern was raised about the pre-operative evaluation and planning of the case in the sense that there was some question about the level of expertise of the restorative dentist. The committee also felt that the pre-operative planning was inadequate and suggested the possible involvement of a prosthodontist. It is noteworthy that, during the course of the hearing, the attorney for the respondent referred to the rules of administrative action, as stipulated in the Constitution, questioning the fact that the PRELIM had decided to refer this case for a disciplinary inquiry. The defendant was found not guilty on the charges brought against him.

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196. The fact that the technique and system utilised by the respondent had already been described and published in national and international literature several years before [and after] this disciplinary hearing, clearly demonstrates the bias of the expert witness towards the [only] system that he is used to working with.
197. See Bütow, Potgieter & Bürkel 1991
198. See Bütow & Duvenage 1993
199. See Bütow & Benninghoff 1995
200. See Bütow *et al* 2000

5.2.6. *White v SAMDC*[201]

A charge of improper and/or disgraceful conduct was brought against a maxillo-facial and oral surgeon on the basis of the fact that he had performed surgical procedures in an incompetent and negligent manner not in accordance with acceptable standards. Implants were placed in the patient's maxilla and the patient was referred back to her dentist for the prosthodontic phase. The dentist decided to rather refer the patient to a prosthodontist, who experienced some difficulty in the reconstruction of the implant-supported prosthesis due to the positioning of the implants. Conflicting expert evidence on behalf of both the complainant and defendant again indicated the diversity of approaches to the same clinical problem:

> "[in this regard] *I think that you will get as many different answers as to how many different experts you consult…"*
>
> " As I understand the evidence given here today, it might be that some doctors might have followed a different treatment plan, but none of them are prepared to say 'I think what Dr W did was wrong'…"

The chairman of the committee expressed concern at the apparent lack of communication between the surgeon, restorative dentist and patient during the pre-operative planning phase, and also suggested the possible involvement of a prosthodontist in future.[202] The defendant was found not guilty on the charges

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201. *White v SAMDC* 1994

202. The case of *Hendricks v SAMDC* (1990) is very similar in principle, illustrating the difference in opinion as a result of different schools of thought. A charge of improper and/or disgraceful conduct was brought against a maxillo-facial and oral surgeon on the basis of the fact that he had performed surgical procedures in an incompetent and negligent manner, not in accordance with acceptable standards. Bimaxillary osteotomies were performed on the patient and surgical relapse occurred. The patient subsequently underwent corrective surgery by another surgeon. The disciplinary hearing extended over a period of almost six months, during which expert evidence on behalf of both the complainant and respondent indicated the diversity of approaches to the same clinical problem. However, although severe criticism was expressed to the fact that the patient was not adequately monitored during the post-operative period, the Committee still had doubts about the events that led to the patient's problems and the defendant was found not guilty on the charge brought against him.

brought against him.

5.3. INFORMED CONSENT

The signing of the consent form is one standardised ritual throughout the medical world, albeit from a healthcare perspective, often simply regarded as a bureaucratic instrument for obtaining and recording the patient's written agreement prior to certain medical procedures. However, as one Canadian commentator has put it, a '*piece of paper is nota substitute for the rapport of doctor and patient which should precede the obtaining of consent*'.[203]

Most of the cases heard before the PCC of the HPCSA provide little difficulty as the gross negligence on behalf of the practitioner/s to obtain informed [any] consent is very evident. Consider the following:

5.3.1. *Klopper v SAMDC*[189]

A charge of improper and/or disgraceful conduct was brought against a maxillo-facial and oral surgeon on the basis of the fact that he had not obtained the necessary informed consent before performing a surgical procedure on his patient. It was also alleged that he did not do a proper pre-operative examination of the patient. On admission to hospital this patient deleted certain oral surgical procedures indicated on the consent form, as she had not been examined by

189. *Klopper v SAMDC* 1992
203. Faunce 1997

anyone in this regard and was under the impression that she was only to have a sinus operation. However, she did sign the consent form on a later occasion on the insistence of the maxillo-facial and oral surgeon but, unfortunately, also after having had her pre-medication administered.

The operation was performed and no proper explanation of the events was given to the patient during the post-operative period despite her enquiries in this regard. No follow-up appointments were made. The evidence presented provided the necessary substantiation for all the allegations that were made.

The practitioner was subsequently found guilty of disgraceful conduct and suspended from practice for a period of three months, with operation of the penalty suspended for a period of three years on condition that he was not found guilty of any offence committed during that period.

5.3.2. *Berman v INMDC*[204]

A charge of improper and/or disgraceful conduct was brought against a dentist on the basis of the fact that he had performed surgical procedures without obtaining the necessary informed consent. It was alleged that he had consulted the patient and booked her for two extractions and three fillings to be performed under general anaesthesia. Without the knowledge of the patient, his partner performed the treatment. However, he did not do any fillings, but extracted all five teeth.

204. *Berman v INMDC* 1998

The committee pointed out the bias of the respondent's expert witness, who attempted to justify the actions of the respondent.

> "The complainant also called an expert witness, prof T. He testified that the extractions of the teeth … were not indicated and not in the best interest of the patient. His evidence was not seriously challenged and is accepted by the committee without reservations. You yourself admitted that at least four extractions were not indicated and not in the best interest of the patient. This was also confirmed by your expert witness, Dr C, although he did attempt to justify your actions, based on the premise that your version would be accepted by the Committee."

The practitioner was subsequently found guilty of disgraceful conduct and suspended from practice for a period of three months, with operation of the penalty suspended for a period of three years on condition that he was not found guilty of any offence committed during that period.

It is, however, the more complex cases that prove to create a lot of difficulty both in interpretation and decision-making with regard to the legitimacy of allegations against practitioners. The following case is an excellent example of illustrating the conflicting perceptions and guidelines with regard to the concept of material risk.

5.3.3. *Grotepass v HPCSA*:[205]

A charge of improper and/or disgraceful conduct was brought against a maxillo-facial and oral surgeon on the basis of the fact that he had not obtained the necessary informed consent before performing a surgical procedure on his patient. The patient suffered from permanent lingual and mental paraesthesia

205. *Grotepass v HPCSA* 2000

after the procedure. Although it was proved that the patient had not been informed pre-operatively of the possibility of the complication, evidence was led that justified the practitioner's decision not to inform the patient, as it was proved that this was an extremely rare complication. The practitioner was subsequently found not guilty. However, concern was expressed regarding the guidelines in respect of consent.

With regard to the post-operative complication that occurred in this case, the chance of this complication occurring was estimated at 1 in 400 000 cases, or 0,0025%. In his address on the merits of his case, the attorney for the respondent questioned the concept of informed consent, and more particularly what the extent thereof should be:

> "… I have asked the following: 'Are there any ethical rule, regulation, law or finding whatsoever on the norms and standards that the Council proposed with regard to informed consent?' The answer was only: *'Habitual law and authority as would be argued.'* In other words there is no rule or regulation. Thus in the absence thereof you cannot make any case of unethical behaviour against a practitioner unless clear evidence is provided as such. Where does one stop? There might even be two and a half thousand possible complications that may occur after an injection."

He also refers to remarks in the *Castell*-case[54,98] regarding the concept of material risk and raises concern about the uncertainty to what it in fact encompass:

> "...the bottom line is would it be professional or not professional for a practitioner to warn a patient of this or that. *Castell v de Greeff* says the following:
>
> 'I therefore conclude that in our law [*and he is now dealing with the civil*

54. *Castell v de Greeff* 1994
98. *Castell v de Greeff* 1993

> *claim*] for a patient's consent to constitute a justification that excludes the wrongfulness of medical treatment and its consequences, the doctor is obliged to warn a patient consenting of a material risk [*and those were his words*] inherent in the proposed treatment. A risk being material, if in circumstances of the particular case [*and this takes into account the practitioner, the circumstances, the nature of the procedure, a whole lot of things*] a reasonable person in the patient's position if warned of the risk, would be likely to attach to it or the medical practitioner is or should reasonably be aware that the particular patient would be likely to attach a significance if warned of the risk."
>
> "So if I sum up, there is no evidence before you as to what a practitioner should do in these circumstances, and as to what the norm is."

He elaborates further on this issue by further quoting from the case of *Broude v McIntosh and others.*[110] In this case the plaintiff, a medical doctor, suffered from deafness, tinnitus and protracted bouts of giddiness. He was operated upon in Germany and although the operation left him permanently deaf in the one ear, all other symptoms were alleviated to such an extent that he did not require further surgical interventions for about 20 years. When there was a recurrence of vertigo, a cochlear vestibular neurectomy was performed on him by the defendant. The plaintiff suffered facial palsy and afterwards underwent corrective surgery at an overseas institution which restored some motor function. He subsequently sued the defendant for negligent conduct, alleging that he had not obtained proper informed consent.

The fact that any decision by the PCC (and thus the HPCSA) can be overruled and dismissed by the Supreme/Appellate Court was clearly illustrated by the

110. *Broude v McIntosh* 1998

attorney:

> "Most certainly in this case he had not given the patient a list of all 2 000 possible complications but apart from anything else the case never got off the ground and in terms of the judgement he was exonerated. But what is important about the case is, that it is the judgement of the Supreme Court of Appeal, a case that in other words has the highest authority in this country. The judgement called to question the test laid down by Judge Ackerman in *Castell v de Greeff*, but said because that issue wasn't pushed any further, it wouldn't give a pronouncement on its correctness. But it certainly indicated that the Appeal Court has doubts as to this so-called patient orientated approach that was set out in *Castell v de Greeff*."

The defendant was found not guilty on the charge brought against him.

5.4. POST-OPERATIVE COMPLICATIONS

Two cases that are very similar in nature where complications related to the surgical removal of impacted third molars occurred, are discussed.

5.4.1. *Essop v INMDC*[206]

A charge of improper and/or disgraceful conduct was brought against a dentist on the basis of the fact that he had performed surgical procedures in an incompetent and negligent manner not in accordance with acceptable standards. It was also alleged that he did not inform his patient about the extent of the complications that occurred. The charge arose after the dentist booked his patient for surgical removal of four impacted teeth under general anaesthesia.

206. *Essop v INMDC* 1998

After a prolonged intra-operative period (almost three hours), only the two lower teeth had been removed successfully and one of the upper teeth had been dislodged into the infra-temporal fossa. The patient was not informed about the complications and was only referred to a specialist maxillo-facial and oral surgeon after the patient complained of continuous pain and discomfort a few days later.

Criticism was expressed about his level of experience in performing the procedures, as well as the handling of the case after the complications occurred. The practitioner was subsequently found guilty of disgraceful conduct and suspended from practice for a period of three months, with operation of the penalty suspended for a period of three years on condition that he is not found guilty of any offence committed during that period.

5.4.2. *Erasmus v INMDC*[207]

A charge of improper and/or disgraceful conduct was brought against a dentist on the basis of the fact that he had performed surgical procedures in an incompetent and negligent manner not in accordance with acceptable standards. It was alleged that he failed to take any pre-operative x-rays, failed to evaluate his patient's condition post-operatively and also, before discharging him from hospital the next day, failed to diagnose complications that occurred intra-operatively.

207. *Erasmus v SAMDC* 1995

The charge arose after the dentist booked his patient for surgical removal of four impacted teeth under general anaesthesia, informing the patient that it would only be a minor procedure. After a prolonged intra-operative period (almost three hours) and also after a colleague was called in to help with the case, it was decided to hospitalise the patient for that night. The patient was discharged the next day without the doctor evaluating his condition at all during that post-operative period. The patient complained of persisting pain and discomfort, and was later referred by his medical practitioner to a maxillo-facial and oral surgeon. A residual root was diagnosed and removed by the surgeon, whereafter all symptoms cleared up.

An important aspect came to light in the address on mitigation by the attorney for the complainant, in that concern was raised about the effect the practitioner's actions would have on the profession as a whole.

> "…I think the most important aspect in this case is that the image of the dental profession as a whole might have been affected. Especially with regard to post-operative actions, or lack thereof, by the respondent in that he did not visit and evaluate the patient himself and discharged him telephonically. It might have created the impression that this is the way dentists act, a type of apathetic attitude. And it is in fact the complainant's argument that the doctor's post-operative management of the patient was disgraceful with regard to the image of the profession as a whole."

Criticism was expressed regarding his level of experience in performing the procedures, as well as the handling of the case after the complications had occurred. The practitioner was found guilty of improper conduct and subsequently reprimanded and warned.

These two cases that are very similar in nature yet again illustrate the inconsistent rulings of the PCC of the HPCSA.

5.5. CONCLUSION

The evaluation of the cases revealed that an unacceptable high percentage of these cases were found not guilty by the PCC. The inevitable, albeit justifiable question must therefore be asked whether these cases should have been referred to the PCC at all, and whether the PRELIM could not have finalised the matter itself. It also raises concern about the effectiveness of the investigative function PRELIM, as it is the PRELIM that has to thoroughly investigate all complaints and, only when *prima facie* evidence of professional negligence and/or misconduct is found, recommend that a disciplinary inquiry be held.

It appears that the PRELIM, when in any doubt, is referring questionable cases to the PCC for a decision rather than instituting a proper investigative process to base its recommendations on.

CHAPTER 6

PROPOSALS CONSEQUENTIAL TO THIS STUDY

6.1. INTRODUCTION

The situation in South Africa with regard to malpractice litigation is hardly comparable to other developed countries, such as the USA. However, increased consumerism and the introduction of new legislation demand adjustments in our current systems, as a definite growth in the number of medico-legal claims has been noted, albeit the fact that there is no evidence of increasing negligence on the part of doctors.

Although this type of litigation, in principle, has no direct bearing on the PRELIM and inquiries of the PCC, it certainly serves as indication that the patients' expectations of the medical and dental profession are increasing. It follows that there is thus also the possibility of a subsequent increase in the number of complaints being reported to the HPCSA for investigation. The HPCSA, through its PRELIM, is therefore in a unique position to play a fundamental role in this expected rise in complaints against doctors.

6.2. TEST FOR NEGLIGENCE

DEFICIENCY:

The broad concept of unprofessional conduct needs no further explanation in the context of Annexure 1, especially with regard to issues such as fees and/or accounts. However, the difficulty lies in the interpretation of the concept of medical negligence in the context of the specialty of Maxillo-Facial and Oral Surgery.

There appears to be no common accord as to the concept of medical negligence mainly because of materially different interpretations by experts of the uncertainty on the predictability of eventual treatment outcomes in the milieu of the rapidly developing medical science and technology.[99,101] Some are of the opinion that it also embraces other causes of action, such as liability for assault in the form of an operation performed with proper skill on a patient without his/her informed consent, or liability for invasion of a patient's privacy by unwarranted disclosure to outsiders of medical details pertaining to the patient. To the contrary, referring to the judgment in *Castell v de Greeff*,[54,98] the consensus in South Africa appears to be quite the opposite, namely that treatment in the absence of consent is not regarded as a form of negligence, but rather as a form of assault.

It is of considerable importance to distinguish between improper and disgraceful conduct/behaviour, as the latter is considered to be more serious. However, in general

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54. *Castell v de Greeff* 1994
98. *Castell v de Greeff* 1993
99. Compare with the report on medical malpractice and negligence by Hayes Solicitors 1994
101. *Van Wyk v Lewis* 1924

terms what is improper or disgraceful conduct is not subject to simple description *per se*. It is conduct which, in the opinion of the HPCSA as custos morum of the profession, is improper or disgraceful.

PROPOSAL:

The '*reasonable person/reasonable expert test*' embodies an objective criterion.

DISCUSSION:

As far as private law in South Africa is concerned, the so-called '*reasonable person's test*' has been widely accepted and adopted.[27,94,101,102] Although the norm of the reasonable man is no absolute measuring instrument it does make provision for the Court to place itself in the position of the defendant with due allowance for all circumstances of that particular case, whilst considering all aspects to come to its ruling.[94,101,106,112,114,115,116,117,118,119,120,121,122,123] In this regard Scott J stated that this '*reasonable doctor's*" test is one that is well established in our law and is applied to both medical diagnosis and treatment (including surgery), affording the necessary flexibility, and, if properly applied, does not leave the determination of a legal duty to the judgement of doctors.

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27. Claassen & Verschoor 1992
94. Van Oosten & Strauss 2002
101. *Van Wyk v Lewis* 1924
106. *Buls & Another v Tsatsarolakis* 1976
112. *Mitchell v Dixon* 1914
114. Giesen & Fahrenhorst 1984
115. *Roe v Ministry of health* 1954
116. Holder 1978
117. *Whitehouse v Jordan* 1981
118. Boberg 1984
119. Labuschagne 1985
120. Burchell, Milton & Burchell 1983
121. Van der Walt 1979
122. Claassen 1984
123. *S v Burger* 1975

A classic formulation of the test for medical negligence is found in the case of *Mitchell v Dixon*:[112]

> "A medical practitioner is not expected to bring to bear upon the case entrusted to him the highest possible degree of professional skill, but he is bound to employ reasonable skill and care; and he is liable for the consequences if he does not."

Although the *Mitchell*-case was decided in 1914, the Cape High Court recently reaffirmed those principles in *Oldwage v Louwrens*[113] by stating that *'medicine is still not – and probably will never be – an exact science comparable to mathematics'*. Accordingly the court reaffirmed the principles laid down in the *Mitchell*-case.

In the event of a person presenting himself as an expert in a specific field, the traditional standard of a *'reasonable person'* is obviously raised to the standard of the *'reasonable expert'*.[27,33,103,114,126,127,128]

The concept of customary practice is widely accepted, although there appears to be global hesitance to always employ it as a solid defence, as application of such practices

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27. Claassen & Verschoor 1992
33. Strauss 1987
103. Strauss & Strydom 1967
112. *Mitchell v Dixon* 1914
113. *Oldwage v Louwrens* 2004
114. Giesen & Fahrenhorst 1984
126. Hosten 1969
127. Snyman 1982
128. *R v van Schoor* 1948

is not necessarily indicative of careful conduct.[101,116,117,135,136,137,138] Albeit the fact that the difficulty of applying the '*reasonable person's test'* in a heterogenic society such as South Africa was pointed out, it is common knowledge that, in view of modern developments in communication, there is no justification for future acceptance of the so-called locality rule.[101,129]

6.3. PROCEEDINGS OF THE PRELIM, AND SUBSEQUENT PROFESSIONAL CONDUCT COMMITTEE

DEFICIENCY:

The HPCSA, as a quasi-judicial body, can apply its disciplinary powers to great effect on the individual rights of its members. However, greater transparency in judicial proceedings and freer access to courts due to legislative prescriptions has led to many a case that was heard by the PCC's of the HPCSA, being taken to higher tribunal for review and/or appeal, and possible rejection of their findings.[26,27,29,30,31,32,33,34,35,37]

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26. Strauss 1991
27. Claassen & Verschoor 1992
29. Panting 1997
30. Maxwell 1998
31. Giesen 1981
32. Simons 1978
33. Strauss 1987
34. Lewis 1996
35. Phillips 1996
37. Harland & Jandoo 1984
101. *Van Wyk v Lewis* 1924
116. Holder 1978
117. *Whitehouse v Jordan* 1981
129. Potgieter 1985
135. *Sidaway v Bethlem Royal Hospital & Others* 1984
136. *Darling v Charleston Community Memorial Hospital* 1965
137. *Helling v Carey* 1974
138. *Hunter v Hanley* 1955

PROPOSAL:

The HPCSA and its attendant PCC, in its capacity as statutory authority exercising an administrative function, is obliged to discharge its statutory duties by PRELIM, as its primary function is to establish whether *prima facie* evidence exists to justify a disciplinary inquiry into the conduct of a practitioner. It follows that these parameters and protocols must be consistent with appropriate standards in order to be credible and acceptable to all parties concerned.

DISCUSSION:

The PRELIM has been charged with the responsibility to determine whether *prima facie* evidence does exist that would support a claim of misconduct on the part of a practitioner.[10,78,79,82] It is therefore on their recommendation that the whole disciplinary process is started. The importance of an objective and legally justifiable investigative/evaluation system can therefore not be emphasised enough. Unfortunately one sometimes gets the impression that, once the PRELIM is in doubt whether an inquiry should be held or not, especially in the more complex cases, the responsibility is merely shifted to the PCC for decision in that regard, with obvious great expenses and agony to all involved.

The PCC's procedure is akin to that of a Court of Law and, therefore to the accused doctor, to all intents and purposes a court with a formal trial in every sense of the word.

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10. *Veriava & Others v President, SAMDC & Others* 1985
78. Government Notice R765 2001
79. Devenish 1999
82. *Tucker & Another v SAMDC & Others* 1980

Senior members of the Council often chair these disciplinary meetings. Despite the fact that they do not have any formal legal background, their integrity and knowledge of [most] rules, as well as their natural sense of justice, are very seldom, if ever, disputed. However, the principle of the Committee to discuss a case *in camera* does not pose a problem *per se* anymore, as the HPCSA resolved to advise its PCC's to furnish reasons for all its decisions in an attempt to state the logical reasoning behind all decisions, in writing, for future reference.

It is also accepted that the disciplinary process is also of a quasi-criminal nature, requiring stricter adherence to ordinary rules of procedure and evidence if justice is to be done to all involved. Criminal courts have the advantage of availability of findings in reported cases, and are bound by these preceding findings in respect of similar current cases.[1,53,57,58,59,60,61] The Council, however, appears not to be bound by any such findings, and reference to any similar preceding cases is very seldom made. It therefore raises the concern about whether the Council did in fact make an unbiased, legally-valid ruling in each and every one of their disciplinary hearings.

During the evaluation of cases that were referred by the PRELIM for formal disciplinary investigation, the inconsistent nature of the penalties eventually imposed by the Council was noted with concern. This is in fact in direct contrast to legal

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1. Taitz 1988
53. Kleyn & Viljoen 1998
57. *Dabner v SAR&H* 1920
58. *De la Rouviere v SAMDC* 1977
59. *McLouglin v SAMDC* 1947
60. *Jeffrey v President, SAMDC* 1987
61. *Volschenk v President, SAGTR* 1985

prescriptions. *Roma locuta, causa finita* – It therefore implies adoption of the so-called doctrine of *stare decisis* that will create an objective and legally justifiable system for reference purposes in order to adhere to the natural rules of evidence, whilst ultimately considering the supremacy of the Constitution in each and every case brought before the PRELIM.[1,10,63,64,65,66,67,68,69,70,71,72,73,74,75,76,77]

6.4. OMBUDSMAN IN MAXILLO-FACIAL AND ORAL SURGERY

DEFICIENCY:

The recent approval of the appointment of an Ombudsman in the MDPB to deal with some of the ever-increasing complaints of patients, is accepted with appreciation. However, with specific reference to maxillo-facial and oral surgery, the main concern is that the professional skill of the Ombudsman and the accused physician is very often poorly matched, with disadvantage to both parties, It follows that there is a considerable risk that the main performance of the Ombudsman could only be to suggest that the patients simply accept the points of view presented by the accused specialist due to the complex nature of the scope of this specialty.

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1. Taitz 1988
10. *Veriava & Others v President, SAMDC & Others* 1985
57. *Dabner v SAR&H* 1920
61. *Volschenk v President, SAGTR* 1985
63. *Groenewald v SAMDC* 1934
64. *Raad v MB* 1982
65. *Raad v MC* 1983
66. *Raad v GJDV* 1983
67. *Raad v GHSP* 1983
68. *Raad v BBK* 1978
69. *Raad v CJVZS* 1981
70. *Raad v GJDVl* 1983
71. *Raad v EJVB* 1978
72. *Raad v JK* 1981
73. *Raad v AM* 1983
74. *Raad v FFBG* 1983
75. *Raad v SML* 1983
76. *Raad v JV* 1984
77. *Raad v AIK* 1983

PROPOSAL:

The MDPB of the HPCSA must appoint a maxillo-facial and oral surgeon to act as an Ombudsman to evaluate all cases in respect of this specialty, as well as assist in selecting and obtaining the services of surgeons for expert evidence.

DISCUSSION:

It is difficult to find the ideal model that can ensure both the practitioner's and the patient's rights. Exactly how does one ensure autonomy, and how impartial is the person dealing with the complaint with regard to the complaint system? It is certain that the attitude, openness and professionalism of the various persons handling complaints differ, but it is important that they consider themselves as a real '*third*'-party. Therefore, with regard to an Ombudsman, at least four elements are important to elucidate, firstly, his/her impartiality, secondly, his/her professional skills, thirdly, his/her leading commissions to improve communication and ensure both the patients' and the practitioners' rights and, fourthly, his/her specific knowledge of medicine and dentistry, as applicable to maxillo-facial and oral surgery.

It follows that such a person should be amongst the more senior members of the profession. Ideally, he/she should be a retired Head of an Academic Department who can provide great insight into cases reported to the HPCSA, based on both his academic and clinical experience. He/she should also have the necessary skills in writing reports and giving oral evidence and, with his/her experience, should have an inherent integrity, sense of equity and objectivity. Furthermore, all relevant cases brought before the

PRELIM should first be referred to this Ombudsman for evaluation in order to help in limiting the so-called '*nuisance*' cases, with the purpose of streamlining all aspects of investigation into alleged professional misconduct and negligence. Only the more "*credible*" cases will then be forwarded to a higher expert-forum for evaluation.

6.5. EXPERT EVIDENCE

DEFICIENCY:

Doctors with sufficient seniority and professional standing are often requested by legal representatives to write reports and give expert evidence on the care of patients with whom they have previously had no clinical involvement. Whilst not the only evidence considered, their views are often crucial to the final decisions.

The records of the PRELIM indicate that, since January 2000, twenty-one cases have been investigated against maxillo-facial and oral surgeons. It took an average of 8,4 months (1–18months) to resolve twelve of these cases. The remaining nine cases are still under investigation (2000 [1]; 2001 [2]; 2002 [1]; 2003 [1], 2004 [4]). There are also another three cases (1996 [2]; 1999 [1]) that have apparently not been resolved as yet (Annexure 1).

Against this background it is highly significant to note that the newly elected President of the HPCSA has already publicly admitted that the current procedures of the conduct

and preliminary committees are inadequate. Accordingly, designated private legal firms and external agencies have been appointed to investigate the backlog of complaints against practitioners, as well as the expected rise in complaints that have been noted by the HPCSA.[208] One can only speculate about the additional amount of time and money that will be needed to eventually complete these investigations.

PROPOSAL:

The solution to the problem should come from the profession itself. All cases of alleged professional negligence must be referred to a Forum of Expert Witnesses with the purpose of streamlining and promoting expert testimony. Panellists of this Forum must include the Academic Heads of Department of all the Training Institutions in South Africa, as well as at least two credible, practising clinicians in full-time private practice. In fact, invitations should be extended to all practising clinicians to join the panel on a rotational basis, based upon collegial relationships and clinical excellence. The selling point of this service will be that this panel consists of practising physicians acting as *diligens paterfamilias*, and not only as professional witnesses. It follows that, where applicable, appropriate training should be provided in order to assure a high quality of expert evidence.

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208. Refer to the public statement by prof N Padayachee in the *Sunday Times*, 03 October 2004, p29:
"...We have also seen a steady increase (27% during the last financial year) in the amount of complaints, which is indicative of the public's awareness of Council's grievance procedures and there ability to exercise their rights.....We have outsourced a number of matters to firms of attorneys and external agencies and are also tightening the sentencing dispensation so that only penalties that are deserved are meted out. **We are however cognisant of the current limitations in our processes that sometimes lead to long drawn out procedures and delays in dispensing with justice**, whilst also cognisant of the perception that practitioners seem to protect each other. We have, for this reason, instituted a process of reviewing our procedures as well as the composition of the conduct and preliminary committees of our professional boards in order to reflect the needed balance of opinion in the consideration of disciplinary matters..."

DISCUSSION:

Perjury is giving false evidence which is material to a case, under oath. Witnesses in fact run the risk of being convicted of perjury if they do not tell the truth. On the other hand, expert witnesses give opinion evidence. Moreover, expert witnesses give evidence on complex and often controversial specialist issues. The restraint on the South African Courts is usually the expert evidence before it, with judges usually limiting their findings to what can be based on the expert evidence presented to them, albeit the fact that they are not bound to adopt such views. It is often difficult to decide whether a doctor's evidence has been biased or not. It has been suggested that the legal procedures should be changed to allow both parties to agree on which expert witnesses to use at the outset – too often too many experts are involved, resulting in the inordinate delay of the legal process in some cases.[164,168,175,180,209]

The quality of expert evidence has been the subject of many a comment in legal circles, with much being said about the so-called '*battle of the experts*'. An important judicial function, therefore, is to ensure that expert witnesses stay within their limits of expertise and give unbiased opinions on all aspects on which the Court has to decide in a specific case. The legal representatives have the choice of calling those expert witnesses who will be most helpful to their client's case. Unfortunately, it is true that some experts show a tendency to be less than impartial or objective, often being ripe for exploitation

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164. McDermott 1997
168. Jackson & Powell 1982
175. Manarin 1999
180. Taylor 1858
209. *Albrighton v Royal Prince Alfred Hospital* 1980

by the lawyers.[139,164,167,168,175,176,177,178,179,180] Hence, the expert reports and evidence that are presented in court may not always be representative of the general opinion of the profession as a whole. Moreover, these expert witnesses are often involved in highly specialised services, and may not be the best witnesses to give opinions on accepted practice by '*less specialised*' practitioners.

In instances where there is a difference of opinion on the course and/or type of treatment, expert evidence must be led to illustrate the different schools of thought. Practitioners often have reservations about the fact that how the judge, who is not a doctor, can determine what the standard and extent of medical care should be. In this regard, however, the Court has confirmed that the approach to conflicting opinions representing different but acceptable schools of thought in medical practice, still remains open ended.[26,27,54,94,103,115,116,117,133,134,182]

The assessment of cases of alleged medical and dental professional misconduct

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26. Strauss 1991
27. Claassen & Verschoor 1992
54. *Castell v de Greeff* 1994
93. *Coppen v Impey* 1916
103. Strauss & Strydom 1967
115. *Roe v Ministry of Health* 1954
116. Holder 1978
117. *Whitehouse v Jordan* 1981
133. *Pringle v Administrator Transvaal* 1990
134. Carstens 1991
139. Cantrell 1984
164. McDermott 1997
167. Collins, Waldron & Pavlakis 1997
168. Jackson & Powell 1982
175. Manarin 1999
176. Strauss 1997
177. Samuels 1994
178. Orr 1995
179. Leopard 1996
180. Taylor 1858
182. *Webb v Isaacs* 1915

(inclusive of maxillo-facial and oral surgery) is really a matter of clinical judgement the Courts would not normally be able to make without expert evidence. It is therefore of the utmost importance that the expert opinions advanced are based on sound logical reasoning rather than simple preference where there are conflicting views.[181,183]

The true test for expert testimony rests upon its objective and clinical reflection of the standard and norms of accepted practice, with consideration of comparative risks and benefits of all treatment options in the particular circumstances. Because of the inherent antagonism between doctors and attorneys, such an objective Forum of Expert Witnesses will be the obvious key to the satisfaction of both sets of customers – doctors and attorneys.

6.6. INFORMED CONSENT

DEFICIENCY:

The doctor-patient relationship being primarily contractual by nature and hence, one that presupposes *consensus ad idem* as to the proposed treatment, implies that the patient's consent is fundamental to lawful medical interventions. There is a definite paradigm shift from traditional medical paternalism to modern views of patient autonomy. Despite the commonly accepted and clear guidelines set out in the *Castell*-case, the PRELIM amazingly enough decided to refer the *Grotepass*-case[205] to the PCC

181. Carstens 2002
183. *Michael & Another v Linksfield Park Clinic* 2001
205. *Grotepass v HPCSA* 2000

for disciplinary inquiry.

PROPOSAL:

There are obvious legal requirements in regard to effective consent in the medical and dental context that must be adhered to. Similarly, there are definite legal prescriptions with regard to deviations or extensions in this regard. A legitimate patient consent form should preferably be included in all patients' files for medico-legal purposes. An example of such a document (see annexure 3) has been designed that could be used for this purpose. However, the design of such a form might change from time to time, based on facts evolving from new cases brought before the PCC due to unforseen and unknown complications that might have arisen. In an inevitable, unrelenting cycle, the more risk is mitigated, the more clinical practice advances, only to reveal a new set of risks.[210,211,212,213]

DISCUSSION:

The traditional grounds of justification for lawful medical interventions are the following:[8]

- the patient's consent;
- in the absence of consent, the existence of an emergency situation;
- statutory authority;
- Court Order.

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8. Van Oosten 1991
210. Striling 1995
211. Gasparini *et al* 2004
212. Kirby 2004
213. Assael 2004

It is now reality that the South African Courts have introduced a more patient-orientated approach to the issue of consent after the landmark case of *Castell v de Greeff*. Accordingly, there is a duty on the practitioner to warn a patient consenting to a particular treatment/procedure, of a material risk inherent in the proposed treatment. The judgement by Ackerman J in the *Castell*-case has provided clear guidelines regarding the patient's right to knowledge of the material risk or danger of the treatment in question. Therefore the requirements of effective consent in the medical context must include the following:[8,26,27,160,161]

- it must be recognised by law;
- it must be given by a lawful person;
- it must be informed consent;
- it must be comprehensive;
- it must be clear and unequivocal;
- it must be free and voluntary.

The Cape High Court recently reaffirmed the principles set out in the *Castell*-case as the standard for determining whether or not informed consent by a patient existed prior to a the performance of a medical procedure by a practitioner. The court also found that these principles were consistent with the rights presently enshrined in the Constitution of the Republic of South Africa, more particularly, those to individual autonomy and self-determination.[212]

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8. Van Oosten 1991
26. Strauss 1991
27. Claassen & Verschoor 1992
160. Van Oosten 1999
161. Refer to HPCSA's Guidelines regarding consent.
212. Kirby 2004

Furthermore, the new National Health Act[87] deals extensively with the issue of consent. Section 7(3) states that '*informed consent*' means consent for the provision of a specified health service given by a person with legal capacity to do so and who has been informed as contemplated in section 6. Accordingly, section 6 provides definite prescriptions regarding the patient having to have full knowledge of the proposed treatment and clearly states that the health care provider must inform the patient of the range of treatment options, as well as its benefits, risks, costs and consequences generally associated with each option. This includes the patient's right to refuse health services as well as the health care provider's duty to explain the implications, risks and obligations of such refusal. It must also be noted that the health care provider is required to convey such information, where possible, in a language that the patient understands and in a manner that takes into account the patient's level of literacy.

In the event of a patient being unable to give consent or where no person has been mandated to give consent on the patient's behalf, provision has been made in section 7(1)(b) for the recognition of certain people (related to the patient) who are authorised to make medical decisions on his/her behalf. In this regard, such consent can be given by the spouse or partner of the patient, or, in the absence of the spouse or partner, a parent, grandparent, an adult child or a brother or a sister of the patient (in the specific order as listed). It follows that such a person must, if possible, first consult with the patient before giving the required consent (see section 8(2)).

87. Act 61 of 2003

Provision is also made for deviations or extensions to planned procedures, provided that it:[8,26,27,94,103,104,150,160]

- is in accordance with recognised and accepted practice;
- is performed in good faith to alleviate a patient's complaint;
- does not materially increase the risk and danger in question;
- is in the patient's best interest to proceed with a deviation or extension rather than to allow the patient to recover from the anaesthetic for the purpose of obtaining express consent to the deviation or extension;
- is an emergency intervention justified by statutory authority;
- is an emergency situation justified by *negotiorum gestio.*

Still, the exact nature and scope of material information that must be disclosed may cause confusion amongst both the medical and legal professions, as pointed out in the cases of *Broude v MacIntosh*[110] and, more recently, *Grotepass v HPCSA.*[205]

If the medical and legal professions are genuine in their desire to promote a therapeutic alliance of shared decision-making and mutual trust, promoting individual self-determination in the health care context, then they should agitate for such positive structural changes to the system for delivery of risk information. In other words, in

8. Van Oosten 1991
26. Strauss 1991
27. Claassen & Verschoor 1992
94. Van Oosten & Strauss 2002
103. Strauss & Strydom 1967
104. Schwär, Loubser & Olivier 1984
110. *Broude v McIntosh* 1984
150. *Stoffberg v Elliot* 1923
160. Van Oosten 1999
205. *Grotepass v HPCSA* 2000

relation to disclosure of material risk, all parties involved should be prepared to undertake a thorough investigation of the system in which those medical practitioners work.

6.7. LEGAL REPRESENTATION vs OWN REPRESENTATION

DEFICIENCY:

The case of *Klopper v SAMDC*[189] illustrates the value of sufficient legal representation when charges of alleged unprofessional/disgraceful conduct is brought against a practitioner. In this case the practitioner (maxillo-facial and oral surgeon) chose to conduct his own defence despite advice to the contrary by both the chairman of the PCC and the attorney for the complainant. During the course of the proceedings his interpretation and lack of knowledge of the legal proceedings were very evident.

PROPOSAL:

The value of sufficient legal representation with regard to claims of unprofessional and/or disgraceful conduct is self-explanatory. It is therefore advisable to belong to an organisation providing indemnity cover (such as Medical/Dental Protection Society) in order to receive proper assistance in the handling of these cases right from the start. Such assistance should preferably be in person by the aforementioned indemnity organisation.

189. *Klopper v SAMDC* 1992

6.8. CONCLUSION

The cases that were evaluated revealed certain deficiencies in the proceedings of the PCC of the HPCSA. By implication it also appears that the PRELIM's investigative function is not effective, especially in the more complex cases (as discussed), as a very high percentage of these cases were eventually found not-guilty. The proposals that were made serve as purpose to provide a cost-effective and time-effective system for the PRELIM in order to limit the so-called '*nuisance'* cases that are brought before the PCC for evaluation and, finally, rejection.

CHAPTER 7

CONCLUSION

An evaluation of the investigative system preceding inquiries into complaints against registered practitioners of the HPCSA has revealed certain shortcomings. The following proposals have been made (in order of most importance):

1. Both the Committee for Preliminary Inquiry (PRELIM) and Professional Conduct Committee (PCC) should abide by the rules of natural justice.
2. Establishment of a *Forum of Expert Witnesses* (with the required skills) that will evaluate all cases of alleged professional misconduct and negligence pertaining to the field of maxillo-facial and oral surgery after being evaluated and referred by the Ombudsman.
3. Appointment of a maxillo-facial and oral surgeon as Ombudsman to evaluate all cases pertaining to the field of maxillo-facial and oral surgery brought before the PRELIM.
4. Acceptance of the proposed test of medical negligence, i.e. the '*reasonable doctor's / expert's test*'.

5. Introduction of the proposed Patient's Consent Form as the minimum requirement for effective consent. It follows that the legal requirements, especially in cases of extensions and deviations of medical interventions, must be adhered to.

6. It is advisable to belong to an organisation providing indemnity cover (such as Medical/Dental Protection Society) in order to receive proper assistance in the handling of these cases of alleged unprofessional/disgraceful conduct.

ANNEXURE 1

INVESTIGATIONS BY THE PRELIM WITH REGARD TO COMPLAINTS LODGED AGAINST MAXILLO-FACIAL AND ORAL SURGEONS.

(January 1992 – October 2004.)

Date received	Complaint no.	Description	Date resolved
1992:			
1992/09/17	1034/92	Incompetence	1999/07/02
1993:			
1993/01/18	78/93	Competence	1993/06/24
1993/01/29	90/93	Fees	1993/06/02
1993/05/11	558/93	Refuse assistance	1993/09/24
1993/06/07	667/93	Accounts incorrect	1994/05/30
1993/06/24	763/93	Accounts incorrect	1995/05/24
1993/09/24	1288/93	Competence	1994/03/24
1993/12/24	1697/93	Covering	1994/06/01
1994:			
1994/01/10	18/94	Bad communication	1994/07/22
1994/01/18	70/94	Competence	1995/02/08
1994/02/14	193/94	Fees	1994/05/04
1994/03/02	278/94	Bad communication	1994/07/22
1994/04/13	471/94	Competence	1996/10/15
1994/04/18	498/94	Secrecy	1994/08/12
1994/04/20	518/94	Accounts incorrect	1994/07/05
1994/06/21	748/94	Competence	1996/08/06
1994/06/21	748*/94	Competence	1996/08/06
1994/07/18	859/94	Competence	1994/12/15
1994/08/01	922/94	Competence	1998/08/13
1994/08/18	987/94	Competence	1995/04/07
1994/09/14	1099/94	Competence	2003/08/18
1994/09/30	1159/94	Bad communication	1997/09/05
1994/10/05	1185/94	Insufficient care	1995/01/11
1994/10/26	1274/94	Fees	1996/03/18
1994/10/31	1290/94	Competence	1995/10/24
1995:			
1995/01/26	92/95	Competence	1995/07/24
1995/02/03	126/95	Insufficient care	1995/08/01
1995/02/09	150/95	Competence	1995/07/31
1995/02/21	197/95	Competence	1996/10/08
1995/08/24	963/95	Competence	1998/03/03
1995/09/21	1097/95	Advertising	1997/07/07
1995/09/27	1111/95	Competence	1998/05/29
1995/10/12	1167/95	Bad communication	1997/05/22
1995/10/13	1177/95	Accounts incorrect	2003/03/07

1996:

1996/01/03	13/96	Competence	1998/08/17
1996/03/27	438/96	Advertising	NULL
1996/03/20	406/96	Insufficient care	1997/07/22
1996/04/11	481/96	Advertising	NULL
1996/05/21	769/96	Competence	2003/03/07
1996/07/04	995/96	Accounts incorrect	1998/07/24
1996/10/10	1422/96	Accounts incorrect	1997/01/22
1996/10/15	1442/96	Supersession	1997/03/25

1997:

1997/02/04	208/97	Competence	1997/07/21
1997/05/23	651/97	Covering	1997/08/13
1997/08/15	907/97	Competence	1997/11/11
1997/12/15	1248/97	Competence	1999/08/26

1998:

1998/04/30	328/98	Fees	1999/01/07
1998/06/03	407/98	Competence	1998/08/21
1998/06/03	408/98	Reports	1998/07/27
1998/08/18	616/98	Insufficient care	2000/04/12
1998/10/06	742/98	Certificates	1999/01/26
1998/10/19	777/98	Accounts incorrect	1999/01/26

1999:

1999/03/03	133/99	Competence	NULL
1999/03/10	153/99	Competence	1999/07/29
1999/05/31	369/99	Bad communication	1999/07/22
1999/07/29	587/99	Competence	1999/11/22
1999/11/30	1021/99	Competence	2001/02/02

2000:

2000/04/05	248/00	Fees	NULL
2000/06/29	473/00	Fees	2001/12/10

2001:

2001/01/25	69/01	Competence	2001/04/18
2001/01/31	99/01	Over-service	2001/12/10
2001/03/05	181/01	Competence	2002/09/18
2001/07/12	495/01	Reports	NULL
2001/07/18	507/01	Secrecy	NULL
2001/11/13	817/01	Operation without consent	2002/11/20

2002:

2002/01/25	71/02	Fees	NULL
NULL	623/02	Impeding	2002/11/20
2002/08/14	633/02	Refuse assistance	2003/10/08
2002/11/28	957/02	Fees	2003/07/30
2002/12/02	971/02	Competence	2003/03/28
2002/12/19	1042/02	Racial discrimination	2003/10/08

2003:

2003/09/29	761/03	Insufficient care	NULL

2004:

2004/01/02	4/04	Accounts incorrect	2004/02/03
2004/02/24	145/04	Fees	NULL
2004/06/14	504/04	Competence	NULL
2004/07/08	604/04	Accounts incorrect	NULL
2004/09/09	833/04	Competence	NULL
2004/09/13	843/04	Competence	2004/10/08

ANNEXURE 2

GOVERNMENT NOTICE

DEPARTMENT OF HEALTH

No. R765 24 August 2001

HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA

REGULATIONS RELATING TO THE CONDUCT OF INQUIRIES INTO ALLEGED UNPROFESSIONAL CONDUCT UNDER THE HEALTH PROFESSIONS ACT, 1974

The Minister of Health has, in consultation with the Health Professions Council of South Africa, under section 61(1)(h), read with section 61(4) of the Health Professions Act, 1974 (Act No. 56 of 1974), made the regulations in this Schedule.

SCHEDULE

Definitions

1. In these regulations "**the Act**" means the Health Professions Act, 1974 (Act No. 56 of 1974), and any word or expression to which a meaning has been assigned in the Act shall bear such meaning, unless the context otherwise indicates;

"**accused**" means a person registered under the Act whose conduct is the subject of an inquiry under Chapter IV of the Act and these Regulations;

"**appeal committee**" means a committee established by a professional board under section 10(2) of the Act for purposes of conducting an appeal against the finding of an inquiry conducted by a professional board or a committee established for such purposes;

"**appellant**" means an accused or pro forma complainant who is aggrieved by a decision of an professional conduct committee or a professional board and who appeals to the appeal committee;

"**committee of preliminary inquiry**" means a committee established by a professional board in terms of the Regulations relating to the Functions and Functioning of Professional Boards under Government notice No. 979 of 13 August 1999 for the preliminary investigation of complaints;

"**complainant**" means any person, group, professional body)including a professional association or society, teaching or training institution, or any other health care or related facility), or the registrar who lodged a complaint against any registered person pertaining to possible unprofessional conduct;

"**complaint**" means any information regarding the alleged unprofessional conduct by a person registered under the Act, which comes to the attention of the registrar, the council, or a professional board, or a complaint, charge or allegation of unprofessional conduct against such a person;

"**inquiry**" means an inquiry held by a professional board or a professional conduct committee under Chapter IV of the Act and these Regulations to inquire into a complaint against a person registered in terms of the Act;

"**preliminary inquiry**" means an inquiry held in terms of these regulations by a committee appointed by a professional board under section 15(5) of the Act to consider a complaint against a registered person for whom that professional board is responsible in order to resolve on the holding of an inquiry in terms of section 41 of the Act or any other appropriate manner in which to deal with such a complaint;

"**professional conduct committee**" means a committee established by a professional board under the Regulations relating to the Functions and Functioning of Professional Boards published under Government Notice No. R979 of August 1999 to conduct an inquiry;

"**pro forma complainant**" means a person appointed by a professional board to represent the complainant and to present the complaint to a professional conduct committee.

Lodging of complaints

2. (1) A complaint shall be in writing and be addressed to the registrar or to the council or to a professional board.

(2) Where a complaint is addressed to and received by the council or a professional board, the council or such professional board shall submit it to the registrar within 24 hours.

Preliminary inquiry

3. (1) The registrar may:

(e) Within seven working days after he or she received a complaint, call for further information or an affidavit from the complainant;

(f) within seven working days after he or she received a complaint, notify the accused of the complaint or forward particulars of the complaint to him or her:

(i) requesting a written response from him or her within 21 working days after receipt of such notification or particulars, failing which the complaint will be forwarded to the preliminary inquiry committee without such written response; and

(ii) warning him or her that the written response referred to in subparagraph (i) may be used in evidence against him or her: Provided that a notification referred to in paragraph (b) shall be deemed to have been received:

(aa) on the day such notification is hand delivered to the registered address of the accused; or

(bb) if such notification is sent by registered mail, on the seventh calendar day following the date on which it was posted;

(g) refer the case directly to the committee of preliminary inquiry or the chairperson of such committee of the professional board concerned;

(h) direct that an inspection be held in terms of section 41A of the Act.

(2) On receipt by the registrar of further information or a written response referred to in subregulation (1)(a) or (b), the registrar shall submit such further information or written response to the committee of preliminary inquiry and if no further information or written response is received, the registrar shall report this to the committee of preliminary inquiry.

(3) If a committee of preliminary inquiry decides, after due consideration of the matter, that there are no grounds for an inquiry, it shall direct the registrar to communicate in writing its decision to the complainant and the accused stating the reason(s) for such decision.

(4) If a committee of preliminary inquiry decides, after due consideration of the matter, that an inquiry must be held into the conduct of the accused, it shall direct the registrar to arrange for the holding of an inquiry.

Inquiry

4. (a) On receipt of a directive referred to in regulation 3 (4), the registrar shall issue a notice, which is attached hereto and essentially in the form of Annexure A and addressed to the accused, stating where and when the inquiry will be held and enclosing a charge sheet as formulated by the pro forma complainant.

(b) The notice referred to in paragraph (a) shall be served on the accused or mailed to him or her at his or her registered address by registered mail at least one month prior to the date of the aforesaid inquiry.

Request for further particulars

5. (1) A request by the accused for further particulars to the charge sheet referred to in regulation 4(a) shall be served on the pro forma complainant at least three weeks before the date of the inquiry.

(2) The pro forma complainant shall furnish his or her written reply to a request referred to in subregulation (1) to the accused within one week after receipt thereof.

Discussion prior to inquiry

6. In order to determine the issues in dispute at an inquiry, the parties shall, at least seven days prior to the inquiry, arrange a conference with each other at a mutually convenient time and venue, where -

(a) the accused and/or his or her legal representative shall indicate what exceptions, objections (including the objection to jurisdiction of a professional conduct committee to inquire into the matter) or points in limine he or she intends raising;

(b) the accused and/or his or her legal representative shall indicate how he or she intends pleading to the charge sheet;

(c) copies of all documents, reports, notes, X-rays and any other exhibits which a party intends using at the inquiry are furnished to the other party;

(d) perusal of the originals of the documents, reports, notes, X-rays and other exhibits referred to in paragraph (c) is allowed;

(e) admissions are made by both parties with regard to allegations and/or exhibits;

(f) a summary of the opinion of an expert witness that a party intends using at the inquiry is furnished to the other party; and

(g) any other aspect concerning the inquiry is resolved.

Procedure at inquiry

7. (a) The accused or, if he or she is not present, his or her legal representative shall be asked by the chairperson of the professional conduct committee to plead to the charge, which plea shall be so recorded.

(b) If the accused, or his or her legal representative, refuses or fails to plead directly to the charge sheet, this shall be recorded by the chairperson and a plea of not guilty shall be entered.

(c) The pro forma complainant may address the professional conduct committee and he or she may lead evidence in support of his or her case.

(d) The accused or his or her legal representative may apply for his or her discharge after the pro forma complainant has closed his or her case. The pro forma complainant may then reply.

(e) The professional conduct committee shall then consider the application and may grant or refuse such application.

(f) After the pro forma complainant has closed his or her case, the accused or his or her legal representative may address the professional conduct committee and her or she may lead evidence in support of his or her case

(g) The professional conduct committee may allow the pro forma complainant or the accused or his or her legal representative to lead further evidence or to recall a witness after their cases have been closed.

(h) After evidence of a witness has been given, the opposing party may cross-examine the witness.

(i) The chairperson of the professional conduct committee may examine a witness who has given evidence and allow other members of the professional conduct committee to examine the witness.

(j) Further cross-examination shall be allowed arising from the examination by the chairperson and other members.

(k) The person who led the evidence may there after re-examine the witness, but shall confine his or her re-examination to matters on which the witness was

cross-examined or on which the chairman or other members examined the witness.

(l) After the parties have closed their cases the professional conduct committee may call and examine further witnesses or recall and re-examine a witness where after the pro forma complainant and the accused or his or her legal representative shall also be entitled to examine the witness.

(m) After all evidence has been adduced, the pro forma complainant and the accused or his or her legal representative may address the professional conduct committee on the evidence and the legal position.

(n) The pro forma complainant may reply on any matter of law raised by the accuse in his or her address and may, with the leave of the professional conduct committee, reply on any matter or fact raised by the accused in his or her address.

(o) If the accused or his or her legal representative is not present at the inquiry after having been duly informed, the inquiry shall proceed in the accused's absence and a plea of not guilty shall be entered, unless the accused has in writing pleaded guilty. If the accused's absence is however due to bona fide circumstances, the professional conduct committee will consider the postponement of the inquiry.

(p) All oral evidence shall be taken on oath or affirmation administered by the chairperson of the professional conduct committee.

(r) Evidence on affidavit shall be admissible: Provided that the opposing party may require the deponent of such affidavit to be present for purposes of cross-examination.

(s) (i) The record, or any portion thereof, of a lawfully constituted court, inquest court or statutory body from any jurisdiction shall be accepted as prima facie evidence if it has been certified to be a true copy by that court and/or jurisdiction.

(ii) If it is practicable and appears just the professional conduct committee may, for the purpose of cross-examination, order the presence of a witness whose evidence appears in such record and is presented as prima facie evidence.

(t) Upon the conclusion of a case the professional conduct committee shall deliberate thereon in camera and shall thereafter announce its finding.

(u) The professional conduct committee may make a finding of not guilty even if the accused has pleaded guilty.

(v) (i) If the accused is found guilty the pro forma complainant shall furnish details to the professional conduct committee of previous convictions of the accused under the Act, if any.

(ii) The pro forma complainant may address the professional conduct committee and lead evidence regarding a suitable penalty to be imposed.

(iii) The accused or his or her legal representative may thereafter address the professional conduct committee and adduce evidence in mitigation of the penalty to be imposed where after the pro forma complainant may reply.

(iv) The professional conduct committee shall deliberate in camera upon the penalty to be imposed where after the chairperson of the professional conduct committee shall inform the accused of the penalty decided on.

(v) The finding made and penalty imposed by the professional conduct committee shall be of immediate force and effect

Appeal

8. (1) The accused or pro forma complainant may appeal against the finding and/or penalty of the professional conduct committee to the appeal committee.

(2) The appellant shall inform the registrar by notice within three weeks from the date of the professional conduct committee's decision of his or her intention to appeal against the finding and/or penalty.

(3) The registrar shall provide the appellant with a copy of a transcript of the proceedings at the inquiry within one month from the date on which the registrar received a written notice of appeal.

(4) The appellant shall file six copies of his or her papers setting out the grounds for appeal and containing heads of argument with the registrar within one month from the date on which he or she received a copy of the transcript referred to in subregulation (3).

(5) The appeal shall only be heard on the papers referred to in subregulation (4).

(6) The other party shall file six copies of his or her reply to the appellant's papers referred to in subregulation (4) with the registrar within one month from the date on which the appellant filed his or her papers with the registrar.

(7) The appellant shall file six copies of his or her reply to the other party's reply referred to in subregulation (6) with the registrar within two weeks from the date on which the other party filed his or her reply.

(8) If no reply is filed by the appellant within the period referred to in subregulation (7), the registrar shall after the aforesaid period has lapsed advise both parties in writing of the date on which the matter will be heard by the appeal committee.

(9) After the appellant and the other party addressed the appeal committee on the merits and/or grounds of appeal at the hearing, the appeal committee shall deliberate, in camera, on the matter and advise the parties of its findings.

(10) Each party shall be responsible for his or her own costs occasioned by the preparation for and/or the finalisation of the appeal.

(11) The decision of the appeal committee shall be of force and effect from the date determined by such committee, unless set aside by the appropriate high court.

Continuation of inquiry

9. (1) If one or more member(s) of the professional conduct committee is unable to serve at any time after a plea has been lodged, the inquiry shall proceed provided that not less than two of the original members are available to continue with the inquiry.

(2) If a chairperson is unable to serve at any time after a plea has been lodged, the matter may proceed with a new chairperson provided that such a chairperson be granted the opportunity to re-examine witnesses who had already testified if he or she deems it necessary.

Accessibility of an inquiry

10. (1) The proceedings at an inquiry shall be open to the public.

(2) Notwithstanding subregulation (1) -

(a) any decision of the professional conduct committee in respect of any point arising in connection with, or in the course of an inquiry may be arrived at in camera;

(b) any evidence adduced during an inquiry may on good cause shown in the discretion of the professional conduct committee be heard in camera.

(c) The professional conduct committee may on good cause shown order that no person shall at any time and in any manner publish

any information which will likely reveal the identity of any particular person other than that of the respondent.

(3) Any person who infringes or fails to comply with an order made in terms of subregulation (2) shall be guilty of an offence and liable on conviction in a court of law to a fine not exceeding R5 000.

(4) Typed recordings of all inquiries shall be kept by the council and upon written request, a typed written copy of such recording shall be made available to the complainant, accused or any other party who in the opinion of the registrar has a substantial interest in the matter upon payment of the actual cost for making such a written copy.

Subpoena

11. A summons for attendance as a witness before a professional conduct committee to give oral evidence or to produce any book, record, document or thing shall substantially be in the form prescribed hereto.

Repeal

12. (1) The regulations published under Government Notice No. R 2303 of 28 September 1990 and Government Notice No. R.874 of 26 April 1991 are hereby repealed

(2) An inquiry in terms of the Regulations referred to in subregulation (1) pending before a professional conduct committee of the council or a professional board immediately prior to the commencement of these Regulations shall be conducted and finalized under the procedures prescribed by those regulations as if such regulations had not been repealed.

MINISTER OF HEALTH
Date: 12/08/2001

ANNEXURE 3

CONSENT FORM TO OPERATION

A. PERSONAL DETAIL.

Name of patient: _____

Address: _____

_____

_____

ID & Date of birth: _____ / _____

B. DECLARATION BY THE DOCTOR RESPONSIBLE FOR TREATMENT.

1. I have explained the nature and extent of the following operation to the patient and/or parent/guardian:

_____

_____

_____

_____

2. I have explained the following known material risks of the operation:

_____

_____

_____

_____

_____

_____

3. I have ensured that this consent form is properly witnessed and signed.
4. NAME: _____
5. SIGNATURE: _____
6. DATE: _____ TIME: _____

C. DECLARATION BY PERSON WHO SIGNS CONSENT FORM.

1. I have been informed and I understand the nature of the planned surgical procedure.
2. My doctor has examined me and explained alternatives to this treatment.
3. I have been informed of the possible risks and complications involved with the surgery, as well as the fact that the exact duration may not be determinable and may be irreversible.

4. My doctor has explained to me that it is not possible to accurately predict the healing capabilities in each patient. I therefore understand that no guarantees or assurances as to the outcome of the treatment and/or surgery can be made, as the practice of Maxillo-Facial and Oral Surgery is not an exact science.
5. I agree to follow my doctor's home care instructions and to report for regular examinations as instructed.
6. To my knowledge I have given an accurate report of my medical and dental health history.
7. I consent to the use of all my medical and dental records to be used for education, research, professional consultations and publications, provided my identity is not revealed.
8. I fully understand that during the surgical procedure deviations or extensions to the planned procedure might be necessary, provided is in my best interest and in accordance with accepted and recognized practice, without materially increasing the risk and danger in question.
9. NAME: _____
10. SIGNATURE: _____
11. DATE: _____ TIME: _____

D. EMERGENCY OPERATION ON PATIENT THAT IS CONTRACTUALLY INCOMPETENT.

1. The patient suffers from the following:

   _____

   _____

2. Declaration by attending doctor (Mark the applicable)
   a. The patient is under the age of 18 and needs an urgent operation to protect and preserve his/her health, but all reasonable efforts to trace the parent or guardian have failed.
   b. The patient is above the age of 18 and urgently needs the proposed procedure to protect and preserve his/her health.
   c. I have discussed the case with a colleague who agrees that the intervention mentioned above is necessary.

      Name of colleague: _____

      Date: _____ Time: _____

      Signature of colleague: _____

E. WITNESSES.

Name of witness 1: _____

Signature : _____

Name of witness 2: _____

Signature : _____

Date: _____ Time: _____

REFERENCES

Note: *The references are presented in alphabetical order for easier reference.*

A

Act No 56 of 1974: Health Professions Act, 1974.

Act No.108 of 1996: Constitution of the Republic of South Africa, 1996.

Act No 89 of 1997: Health Act, 1997.

Act No 2 of 2000: Promotion of Access to Information Act, 2000.

Act No. 3 of 2000: Promotion of Administrative Justice Act, 2000.

Act No 61 of 2003: National Health Act, 2003.

Assael LA. Editorial: Risk avoidance in surgical practice: Mitigating the inevitable. *J Oral Max-Fac Surg*. 2004; 62: 1053 - 1054.

B

Baker N, Carton A & Dover S. The future of Oral and Maxillofacial Surgery in the UK: the trainee's perspective [Editorial]. *Brit J Oral Maxfac Surg*. 1996; 34: 141 – 142.

Banks P. Internationalism in Oral and Maxillofacial Surgery. *Brit J Oral Maxfac Surg*. 1995; 33: 273 – 275.

Barnard JT. Indemniteitseise en kommunikasie [JT's Column]. *J Dent Ass S Afr*. 1997; 52: 540 – 543.

Barton N. a Midsummer Night's Call – Shakespeare's Son-in-Law accused of neglect. *Int J MDU*. 1997; 11: 28 – 29.

Becker LH. Complaints about general practitioners in dentistry who perform surgical procedures. *Meddent News*. 2000; 1(2): 4.

Becker LH. Chairperson's Review. *Meddent News*. 2001; 2(2): 4.

Becker LH. Appointment of an Ombudsman. *Meddent News*. 2001; 2(2): 8.

Bliznakov EG. Medical ethics [Correspondence]. *Lancet*. 2000; 356(9240): 1522.

Boberg PQR. The Law of Delict – Vol I. 1984; Cape Town: Juta.

British Medical Association. Expert Witness Institute. *Br Med Ass Ann Rep of Council*. 1997 - 1998; 18.

Burchell EM, Milton JRL & Burchell JM. The South African Criminal Law and Procedure – Vol I, 2nd Ed.: 1983; Cape Town: Juta.

Burchell JM. Non-therapeutic research on children. *S Afr Law J* 1978; 95: 193 - 216.

Bütow K-W, Potgieter PJ & Bürkel H. Osseointegrated compression screw Implant: Preliminary report. *Hands-On*, 1991; 3(4): 11 – 14.

Bütow K-W, Boshoff JFS, Duvenage JG, Edgar AS, Grotepass FW, Harmse JF, Jacobs FJ, De V Joubert JJ, Van der Merwe GG & Van Vuuren N. Kaak-, Gesig- en Mondchirurgie vir die algemene praktisyn – 1st Ed.: 1988; Cape Town: Juta.

Bütow K-W. Editorial. *Hands-On*, 1996; 8(1): 2.

Bütow K-W & Duvenage JG. Implanto-orthognathic reconstructive surgery: A preliminary report. *J Cranio-Maxfac Surg*, 1993; 21: 326 – 334.

Bütow K-W & Benninghoff W. Osseointegrated compression screw implant: Implant improvement and Prosthetics. *Hands-On*, 1995; 7(1): 20 – 24.

Bütow K-W, Duvenage JG, Dintcheva PM & Benninghoff W. Bone resorption and/or osteogenesis of the mandible in implanto-orthognathic reconstructive surgery. *J S Afr Dent Ass*, 2000; 55: 615 – 620.

Butterworth M. Ethics: Patient or Dentist first? *Ann Rep MPS*. 1994; 17 – 18.

Butterworth M. 'Top ten' cases in South Africa – Dental Protection. 2002; Letter: personal communication.

Byrne DS, Napier A & Cushiery A. How informed is signed consent? *Br Med J*. 1998; 296: 839 – 840.

C

Campbell N. Report of the Executive Director. *S Afr Dent Ass Annual Report 2001 – 2002*. December 2002: 25 - 41.

Cantrell C. a Physician's liability for experimental procedures. *Med & Law*. 1984; 3(4): 339 – 344.

Caplan Al. Insiders and Outsiders. *Ann Intern Med*. 1998; 128: 569 – 571.

Carstens PA. The locality rule in cases of medical malpractice. *De Rebus*. 1990; 421.

Carstens PA. Nalatigheid en verskillende gedagte-rigtings binne die mediese praktyk. *Tydskr Hedendaagse Rom Holl Reg*. 1991; 54: 673.

Carstens PA. Die strafregtelike en deliktuele aanspreeklikheid van die geneesheer op grond van nalatigheid. (Unpublished LLD thesis, UP 1996).

Carstens PA. Setting the boundaries for expert evidence in support or defence of medical negligence: Discussion of *Michael & Another v Linksfield Park Clinic (Pty) Ltd. Tydskr Hedendaagse Rom Holl Reg*. 2002; 430.

Claassen JY. Toets vir toerekeningsvatbaarheid en nalatigheid van kinders in die deliktereg. *J Jurid Sci*. 1984; 9(1): 90 – 94.

Claassen NJB. Verschoor T. Medical Negligence in South Africa - 1st Ed.; 1992: Pretoria: Digma Publications.

Cohen J. Mariano WE. Legal Guidebook in Mental Health. 1982; New York: The Free Press.

Collins A, Waldron BD & Pavlakis J. Determining the standard of care in medical negligence litigation in Australia. *Med & Law*. 1997; 16: 201 – 207.

Conduct cases reviewed. *Gen Dent Council Gazette*. 1996/1997; 6 – 7.

Currie I & Klaassen J. The Promotion of Administrative Justice Act Benchbook – 1st Ed.; 2001: Cape Town: Creda Communications (Pty) Ltd.

D,E

Dental Ethics. The Foundation for Professional Development. 2000; 7 – 8.

Devenish GE. A commentary on the South African bill of rights. 1999; Durban; Butterworths.

Dornette WHL. Legal aspects of anaesthesia. 1972; Philadelphia: FA Davis Company.

Dunning AJ. Status of the doctor – present and future. *Lancet*. 1999; 354.

F

Faunce TA. Medical disclosure and consent forms: Proposal for international standard. *Med & Law*. 1997; 16: 381 – 391.

Fenwick P & Beran RG. Informed consent – should Bolam be rejected? *Med & Law.* 1997; 16: 215 – 223.

G

Gasparini G, Boniello R, Longobardi G & Pelo S. Orthognathic surgery: An informed consent model. *J Cran-Fac Surg.* 2004; 15(5): 858 – 862.

Giesen D. Arzthaftungsrecht: Medical malpractice law. 1981: Bielefeld: Gieseking.

Giesen D & Fahrenhorst I. Civil liability arising from medical care – Principles and Trends. *Int J Legal Pract*. 1984; 9(3): 80 – 85.

Goode AW. Editorial. *Med Science & Law*. 1996; 36(1): 1.

Government Gazette. Vol. 434. Notice R.765: Health Professions Council of South Africa – *Regulations relating to the conduct of inquiries into alleged unprofessional conduct under the Health Professions Act, 1974. 24 August 2001*.

H,I

Harland WA & Jandoo RS. The medical negligence crisis. *Med Science & Law.* 1984; 24(2): 123 – 129.

Hartshorne JE. Principles of valid informed consent to treatment in Dentistry [Practitioner's Corner]. *J Dent Ass S Afr*. 1993; 48: 465 – 468.

Hayes Solicitors. Malpractice and Negligence – a Distinction? *Dent Protect Ann Rep*. 1994; 4.

Heydt H. A new Era. *Dent Protect Ann Rep*. 1994; 6.

Holder AR. Medical malpractice law. 2nd Ed.: 1978; New York: John Wiley.

Hosten WJ. Imperitia culpae adnumeratur. *J Contemp Roman-Dutch Law*. 1969; 32(4): 394 – 396.

J

Jackson RM & Powell JL. Professional Negligence. 1st Ed.: 1982; London: Sweet and Maxwell.

Jones MA. A fundamental problem of consent – the legal position (Comment). *Br Med J*.1995; 310: 46 – 47.

Joseph H. Shakespeare's Son-in-Law: John Hall, Man and Physician. 1976; Published privately.

K

Kerrigan DD & Dennison AR. Who's afraid of informed consent? *Br Med J*. 1993; 306: 298 – 300.

King JY. Practice guidelines and medical malpractice litigation. *Med & Law*. 1997; 16: 29 - 39.

Kirby M. Patients' rights - Why the Australian courts have rejected "Bolam". *J Med Ethics*. 1995; 21: 5 – 8.

Kirby N. When all is not well in Rome. *Mediwerks*. 2004; 3: 1 – 5.

Kleyn D & Viljoen F. Beginner's Guide for Law Students. 2nd Ed.: 1998; Kenwyn; Juta & Co.

L

Labuschagne JMT. Dekriminalisasie van nalatigheid. *SA J Crim Law & Criminol*. 1985; 9(3): 213 – 222.

Lane J. John Hall and his patients. Shakespeare Birth Trust, 1996.

Laskin DM. Dividing up the territory [Editorial]. *J Oral Maxfac Surg*. 1997; 52(3): 150.

Lázaro J. Doctors' status: Changes in the past millennium. *Lancet*. 1999; 354.

Leopard P. Are Oral and Maxillofacial Surgeons an endangered species? [Editorial]. *Brit J Oral Maxfac Surg*. 1996; 34: 345 – 347.

Lewis K. Defensive dentistry: Do claims influence the way dentists practice? *Ann Rep DPS*. 1996; 8: 31 – 32.

M

MacDermott J. A judicial point of view with regard to the testimony of medical experts. *Med & Law.* 1997; 16(3): 635 – 642.

MacRoberts, de Villiers, Lunnon & Tindall Inc Attorneys. Developments in South Africa regarding consent. *Dent Protect Ann Review*. 1997; 15.

Manarin B. Of puppets and puppeteers: The role of the expert witness in a criminal prosecution in Canada. *Med & Law*. 1999; 18: 93 – 98.

Maxwell W. Malpractice trends in the USA. *Int J MDU*. 1998; 12(2): 6 – 7.

Mitchell JA. A fundamental problem of consent. *Br Med J*. 1995; 310: 43 – 46.

Morkel DW. Nalatigheid as grondslag vir strafregtelike aanspreeklikheid. Unpublished LLD – thesis. 1977; Bloemfontein: University of the Orange Free State.

Muss HB, White DR, Michielutte R, Richards F, Cooper MR, Williams S & Stuart JJ. *Cancer*. 1979; 43: 1549 – 1556.

N

Norwell N. Paternalism is dead! *Int J MDU*. 1997; 11(3): 45 – 46.

O

Orr S. Clinical language for expert witnesses [Editorial]. *Med Science & Law.1995*; 35(1): 2.

Osuna E, Pérez-Cárcalez MD, Pérez-Moreno JA & Luna A. Informed consent: Evaluation provided to patients before anaesthesia and surgery. *Med & Law*. 1998; 17: 511 – 518.

P,Q

Pamplin C. Do experts need training as witnesses? [Letter to Editor]. *Brit J Oral Maxfac Surg.* 1997; 35: 299 – 300.

Panting G. Defensive medicine – Who wins? [Editorial comment]. *Update*. 1997; 12(5) 19.

Pelligrino ED. The metamorphosis of medical ethics – A 30 year study retrospective study. *J Am Med Ass.* 1993; 269: 1158 – 1163.

Phillips D. Secretary's Report. *Ann Rep Dent Protect Soc*. 1996; 8: 5.

Pickering WG. Single medical errors [Correspondence]. *Lancet*. 2000; 356(9245): 1933.

Potgieter JM. *Professionele aanspreeklikheid.* Research report: Department of Private Law, University of Pretoria, 1985.

R

Reilly's Solicitors RSA. *Ann Rep MPS – Dent Protect.* 1994; 6: 11.

S

Saayman G & Van Oosten FFW. Forensic Medicine in South Africa – Time for a Change? *Med & Law*. 1994; 13: 129 – 132.

Samuels A. Forensic Science and the miscarriages of justice. *Med Science & Law.* 1994; 34(2): 148 – 154.

Saunders M. Don't be afraid to apologize. *Int J MDU.* 1997; 11(2): 17.

Saunders M. It's not fair. *Int J MDU*. 1996; 12(2): 1.

Schwär TG, Loubser JA & Olivier JD. Die ABC van Geregtelike Geneeskunde. 1984; Pretoria: Haum.

Shevel E, Koepp WG & Bütow K-W. A subjective assessment of pain and swelling following the surgical removal of impacted third molar teeth using different surgical techniques. *J S Afr Dent Ass*, 2001; 56: 238 – 241.

Silove D. Doctors and the State: Lessons from the Steve Biko case. *Social Science & Med*. 1990; 30: 417 – 429.

Simons KL. The legal pitfalls of medical malpractice and how to avoid them. *De Jure*. 1978; 11(1): 123 – 133.

Snyman JL. Die dilektuele aanspreeklikheid van die psigiater vanweë nalatige behandeling van die geestesongestelde pasiënt. *J Jurid Science*. 1982; 7(1): 1 – 19.

Spur CL. Written informed consent in patients with breast cancer. *Cancer*. 1979; 43: 1549 – 1556.

Sterling VJ. Informed consent: Patient education through the Consent consultation. *Oral Max-Fac Clin North-America.* 1995; 7(4): 665 - 670

Stoelinga PJW. The next 25 years [Editorial]. *Int J Oral Maxfac Surg*. 1996; 25: 2.

Stoelinga PJW. Maxillofacial and Oral Surgery and Dentistry [Guest Editorial]. *J Dent Ass S Afr*. 1997; 52(3): 150.

Strauss SA & Strydom MJ. Die Suid Afrikaanse Geneeskundige Reg. 1967; Pretoria: van Schaik.

Strauss SA. Doctor, patient and the law. 2nd Ed.: 1984; Pretoria: Van Schaik.

Strauss SA. Geneesheer, die pasiënt en die reg: ‘n delikate driehoek. *J S Afr Law*. 1987; 1: 1 – 11.

Strauss SA. Doctor, Patient and the Law – a Selection of Practical Issues. 3rd Ed.;1991: Pretoria: JL van Schaik.

Strauss SA. SAMDC Disciplinary Inquiries: Assessment of Evidence. *S Afr Pract Managem*. 1997; 18(3): 8 – 10.

T,U

Tabak N. Doctor’s policy on explaining the implementation of novel experimental treatment to cancer patients. *Med & Law*. 1994; 13: 331 – 355.

Taitz J. The disciplinary powers of the South African Medical and Dental Council, in Law and Medicine. 1988; Cape Town; Juta & Co.

Taylor A. Treatise on the Law of Evidence. 3rd Ed.: 1858: 69.

Tomkins C. Tough defense for our members. *Int J MDU*. 1998; 12(1): 1.

V

Van den Heever P. The application of the doctrine of *res ipsa loquitur* to medical negligence cases: a comparative survey. (Unpublished LLD thesis, UP 2002).

Van der Walt JC. Delict: Principles and Cases. 1979; Durban: Butterworths.

Van Oosten FFW. Informed consent: Patients' rights and the doctor's duty of disclosure in South Africa. *Med & Law*. 1989; 7: 443 – 456.

Van Oosten FFW. The legal liability of doctors and hospitals for medical malpractice. *S Afr Med J*. 1991; 80: 23 – 27.

Van Oosten FFW. The doctrine of informed consent in medical law. 1st Ed. 1991; Frankfurt: Peter Lang.

Van Oosten FFW. The doctor's duty of disclosure and excessive information liability. *Med & Law*. 1992; 11: 633 – 639.

Van Oosten FFW. Some reflections on emergencies as justification for medical intervention. In: Ahrens HJ, ed. Festschrift für Erwin Deutsch zum 70 Geburtstag. Köln: Heymanns Verlag; 1999: 673 – 684.

Van Oosten FFW & Strauss SA. Legal liability. *Clin For Med & Med Jurisp*. 2002; 1 – 88.

Verschoor T. Uitsprake van die Mediese Raad. 1st Ed. 1986; Roodepoort: Digma.

W,X,Y,Z

Waisel DB & Troug RD. The benefits of explanation of the risks of anaesthesia in the day surgery patient. *J Clin Anaesth*. 1995; 7: 200 – 204.

Wallman's Solicitors Australia. Controversial Practice. *Ann Rep MPS – Dent Protect*. 1994; 6: 10.

ALPHABETICAL LIST OF CASES

A

Albrighton v Royal Prince Alfred Hospital. 1980 2 NSWLR 542 (CA).

Allot v Paterson & Jackson. 1936 SR 221 224.

B

Berman v INMDC. 1998 Proc. Discipl. Comm..

Bolam v Friern Hospital Management Committee. 1957 1 WLR 582 UK.

Broude v McIntosh. 1998 (3) SA 60 (SCA) 67.

Buls and Another v Tsatsarolakis. 1976 (2) SA 891 (T) 893.

Bux v INMDC 1998 Proc. Discipl. Comm.

C

C v Minister of Correctional Services. 1996 (4) SA 292 (T) 300.

Canterbury v Spence. 1972 464F 2d 772, 150 US App. DC 263.

Castell v de Greeff. 1993 (3) SA 501 (C).

Castell v de Greeff. 1994 (4) SA 408 (C).

Collins v Administrator Cape. 1995 (4) SA 73 (C).

Coppen v Impey. 1916 CPD 309 314.

D

Dabner v SAR & H. 1920 AD 583

Darling v Charleston Community Memorial Hospital. 200 NE 3rd 149, 211 NE 2nd 253 III 1965 USA.

Daubert v Merrell Dow Pharmaceutical Inc. 1993 113 S.Ct 2786.

De la Rouviere v SA Medical and Dental Council. 1977 (1) SA 85 (N).

Duafrie v INMDC. 1996 Proc. Discipl. Comm.

Dube v Administrator Transvaal. 1963 (4) SA 260 (W) 266.

E

Erasmus v SAMDC. 1995 Proc. Discipl. Comm.

Erasmus v INMDC. 1996 Proc. Discipl. Comm.

Essop v INMDC. 1998 Proc. Discipl. Comm.

Esterhuizen v Administrator, Transvaal. 1957 (3) SA 710 (T).

F

Fowlie v Wilson. 1993 (N) (unreported, discussed by Strauss (1994)).

G

Groenewald v SA Medical and Dental Council. 1934

Grotepass v HPCSA. 2000 Proc. Discipl. Comm.

H,I

Helling v Carey. 83 Wash 2d 514, 519 P 2d 981 1974 USA.

Hendricks v SAMDC. 1990 Proc. Discipl. Comm.

Hunter v Hanley. 1955 SLT 213 UK.

J

Jaga v INMDC. 1998 Proc. Discipl. Comm.

Jeffrey v President, SA Medical and Dental Council. 1987 (1) SA 387 (C).

K

Klopper v SAMDC. 1992 Proc. Discipl. Comm.

Kovalsky v Krige. 1910 (20) CTR 822 823.

L

Labuschagne v Chairman of the Preliminary Enquiry of the HPCSA. Review Application Case 26129/2001 (unreported, judgement of Daniels J (2002)).

Lambrechts v INMDC. 1997 Proc. Discipl. Comm.

Lymbery v Jefferies. 1925 AD 236.

M

Mahon v Osborne. 1939 1 A 11 ER 535, 2 KB 14 UK.

Malan v INMDC. 1996 Proc. Discipl. Comm.

McLoughlin v SA Medical and Dental Council. 1948 (2) SA 355 (W).

Michael & Another v Linksfield Park Clinic (Pty) Ltd. 2001 (3) SA 1188 (SCA).

Mitchel v Dixon. 1914 AD 519.

N

Nell v Nell. 1990 (3) SA 889 (T) 895.

O

Oldwage v Louwrens. 2004 (1) SA 532 (C)

P,Q

Pringle v Administrator Transvaal. 1990 (2) SA 379 (W).

Prowse v Kaplan. 1933 EDL 257.

R

Raad v EJVB (March 1978) cited in *T Verschoor: Uitsprake van die Mediese Raad* (1985), 63.

Raad v BBK(Oct 1978) cited in *Verschoor,* 63.

Raad v DWS (Oct 1978) cited in *Verschoor,* 70.

Raad v GHSP (Oct 1978) cited in *Verschoor,* 76.

Raad v CJVZS (Apr 1981) cited in *Verschoor,* 101.

Raad v JK (Oct 1981) cited in *Verschoor,* 77.

Raad v MB (Apr 1982) cited in *Verschoor,* 103.

Raad v AIK (Apr 1983) cited in *Verschoor,* 95.

Raad v AM (Apr 1983) cited in *Verschoor,* 98.

Raad v FFBG (Apr 1983) cited in *Verschoor,* 91.

Raad v GJDV (Oct 1983) cited in *Verschoor,* 97.

Raad v MC (Oct 1983) cited in *Verschoor,* 75.

Raad v SML (Oct 1983) cited in *Verschoor,* 99.

Raad v JV (Apr 1984) cited in *Verschoor,* 94.

R v Nkomo. 1963 (3) SA 128 (SR).

R v van Schoor. 1948 (4) SA 349 (C).

Roe v Ministry of Health. 1954 2 A11 ER 131 (CA).

Rogers v Whitaker. 1992 175 CLR 479.

Rompel v Botha. 1953 TQD Unreported.

S

S v Ngubane. 1985 (3) SA 677 (A).

S v Nel. 1987 (T) (unreported, discussed in Strauss (1991)).

S v Burger. 1975 (4) SA 877 (A).

Schloendorff v Society of New York Hospital. 1914 211 NY 125.

Shevel v SAMDC. 1982 Proc. Discipl. Comm.

Sidaway v Bethlem Royal Hospital Governors & Others. 1984 1 All ER 1018 (CA).

Sitlu v INMDC. 1996 Proc. Discipl. Comm.

Stoffberg v Elliot. 1923 CPD 148.

T,U

Thake & Another v Maurice. 1985 2 WLR 215 (CA).

Tucker & Another v SA Medical and Dental Council & Others. 1980 (2) SA 207 (T).

V

Van Wyk v Lewis. 1924 AD 438.

Verhoef v Meyer. 1975 (T); 1976 (A) (unreported, discussed in Strauss (1991)).

Veriava & Others v President, SA Medical and Dental Council & Others. 1985 (2) SA 293 (T).

Volschenk v President, SA Geneeskundige en Tandheelkundige Raad. 1985 (3) SA 124 (A).

W,X,Y,Z

Webb v Isaacs. 1915 EDL 273.

White v SAMDC. 1994 Proc. Discipl. Comm.

Whitehouse v Jordan. 1981 (1) All ER 267 (HL).

Curriculum Vitae

Izak Frederik Redelinghuys

AUGUST 2005

PERSONAL DATA

21/03/63	Date of birth	
	Place of birth	Rustenburg
13/04/85	Married	Annelie Loots B.(Bibl)
	Children	Esteé (16 yrs) Erik (15 yrs) Alicia (11 yrs)

SCHOOL EDUCATION

1980		Transvaal Senior Certificate Nelspruit High School

UNIVERSITY EDUCATION

1. Courses completed:

1986	**BChD**	University of Pretoria
1990	**MSc(Odont)**	University of Pretoria
1991	**Dip(Odont)**(*Cum Laude*)	University of Pretoria
1991 - 1992	**Dentistry: Special Postgraduate** (as for MChD-MFOS)	University of Pretoria
1997	**MChD (endos. Chir.Max-Fac.Dent)**	University of Pretoria

2. Current course:

1999 -	**PhD** (Maxillo-Facial and Oral Surgery)	University of Pretoria

ACADEMIC APPOINTMENTS

10/1991- 12/1992	**Dentist/Lecturer (Part time)** Department of Maxillo-Facial and Oral Surgery	University of Pretoria
01/1993 12/1997	**Registrar** Department of Maxillo-Facial and Oral Surgery	University of Pretoria
01/1998- 04/1999	**Senior Lecturer/Senior Specialist** Department of Maxillo-Facial and Oral Surgery	University of Pretoria/ 1 Military Hospital
04/1999 - 10/2001	**Senior Specialist (Full/Part time)** Department of Maxillo-Facial and Oral Surgery	MEDUNSA Polokwane Campus

PRIVATE PRACTICE

1990 - 1997	General dental practitioner	Pretoria

1998 - 1999	Maxillo-Facial and Oral Surgeon	Pretoria
1999 -	Maxillo-Facial and Oral Surgeon	Polokwane

MILITARY APPOINTMENTS

1986/07/01- 1998/06/30	**Dentist** and Head: Dental clinic: Air Force Gymnasium	South African Military Health Service
1988/07/01- 1990/03/31	**Senior Dentist** and Head: Dental clinic: Air Force Base Waterkloof	South African Military Health Service
1994/04/15- 1997/12/31	**Principle Dentist/Registrar**: 1 Military Hospital	South African Military Health Service
1998/01/01- 1999/03/31	**Senior Specialist:** Maxillo-Facial and Oral Surgery 1 Military Hospital	South African Military Health Service

MILITARY COURSES

1986	Basic Training	South African Military Health Service
1986	Officer's Course	South African Military Health Service

MERIT AWARDS

1981	Bursary of Achievement	University of Pretoria
1989	Certificate of Recommendation	Northern Medical Comm. SA National Defence Force
1992	Honorary Colours: Academic	University of Pretoria
1993	Dean's Award for Postgraduate Achievement	University of Pretoria
1994	General Service Medal	SA National Defence Force
1996	Certificate of Recommendation Casualty Unit: Pretoria Academic Hospital	Faculty of Medicine: University of Pretoria
1996	Certificate of Recommendation	Mpumalanga: Dept of Health, Welfare & Gender
1999	Bursary for Postgraduate Study (Doctoral study)	University of Pretoria

PUBLICATIONS

1. Redelinghuys, I.F. Kemp, A.J. (1992) The effect of tenoksikam after surgical removal of impacted third molars *[Afrikaans]*. ***Hands-on***, 4, 26 - 27.

2. Redelinghuys, I.F. Mazarakis, E. (1993) Child abuse – Dental Aspects *[Afrikaans]*. ***J Dent Ass S Afr***, 48, 123 - 128.

3. Redelinghuys, I.F. Bütow, K-W. (1993) Pedicled temporalis muscle flap in bilateral ankylosis repair: a case report. ***Hands-on***, 5(2), 32 - 35.

4. Redelinghuys, I.F. De Witt, T.W. (1994) Demarquay-Van der Woude Syndrome: Incidence, Variation and Surgical treatment of the lower lip. ***Hands-on***, 6(1), 37 -40.

5. Bredell, M.G. Redelinghuys, I.F. (1994) Three-dimensional computerized tomography in the evaluation and treatment of severe cranio-facial trauma. ***Hands-on***, 6(1), 19 - 21.

6. Redelinghuys, I.F. Mazarakis, E. (1994) Child abuse – Identification and reporting. ***Nursing RSA***, 9(4), 10 - 13.

7. Redelinghuys, I.F. Bredell, M.G. (1996) A broken dental needle: The surgical recovery. ***Hands-on*** 8(1), 5 - 7.

8. Redelinghuys, I.F., Lindeque, B.G.P. Bütow, K-W. (1996) Liquid nitrogen cryosurgery for keratocyst with soft tissue envolvement. ***Hands-on*** 8(1), 19 - 21.

9. Redelinghuys, IF. du Preez, LA. (1998) Lipoma of the floor of the mouth: An unusually large lesion. ***J Dent Ass S Afr*** 53(5), 245 – 246.

ABSTRACTS

1. Redelinghuys, I.F. Bütow. K-W. (1994) Van der Woude Syndrome: Incidence, Variation and Treatment. ***J Dent Res*** , 73(4), 998.

2. Redelinghuys, I.F., van Schalkwyk, S.J.F. Bütow, K-W. (1995) Three-dimensional Computerized Tomographic Reconstruction in Maxillo-Facial and Oral Surgery. ***J Dent Res*** ,74(3) 1018.

3. Redelinghuys, I.F. Bütow, K-W. (1995) Demarquay-van der Woude Syndrome (D-VWS): Incidence, Variation and Surgical treatment of the lower lip. ***Ann Congr Ass Plast Reconstr Surg (incl cleft lip and palate and microsurgery)*** Ses. III, No. 4.

4. Redelinghuys, I.F., Bütow, K-W. Duvenage, J.G. (1996) Implanto-Orthognathic Reconstructive Surgery: A Follow-up report. ***Int Triang Maxfac Oral Surg Congr*** , 65.

5. Redelinghuys, I.F. Bütow, K-W. (1996) Improved patency of the Eustachian tube in cleft palate patients after veloplasty by means of a tensor sling. ***Int Triang Maxfac Oral Surg Congr*** , 83.

6. Redelinghuys, IF. Bütow, K-W. (1997) Liquid nitrogen cryotherapy for benign, locally aggressive bony lesions. ***S Afr Soc Max-Fac Oral Surg Congr*** (Sun City).

7. Redelinghuys, IF. Bütow, K-W. (1997) Liquid nitrogen Cryotherapy after enucleation of benign aggressive bony lesions. ***J Dent Res*** , 77(5),1280.

8. Bredell, MG. Redelinghuys, IF. Bütow, K-W. (2001) Treatment modalities for Ameloblastomas at the University of Pretoria. ***Int J Oral Maxfac Surg*** , 30(Suppl A) June 2001, S106.

POPULAR PUBLICATIONS

1. Redelinghuys, I.F.(1989) Removal of wisdom teeth – Is it really necessary? *[Afrikaans]* ***MILMED***, 5, 14.

INTERNAL PUBLICATIONS

1. Dental aspects of child abuse *[Afrikaans]* (1990) – Dissertation presented to the Department of Oral Pathology and Oral Biology: University of Pretoria, as partial requirement for the degree MSc(Odont).

2. Cryotherapy with immediate bone transplant after enucleation of benign, locally aggressive bony lesions. *[Afrikaans]* (1997) – Dissertation presented to the Department of Maxillo-Facial and Oral Surgery: University of Pretoria, as partial requirement for the degree MChD(Chir. Max.-Fac. Dent).

SCIENTIFIC PRESENTATIONS

1. Redelinghuys, I.F. Bütow, K-W. (1993) *Van der Woude Syndrome: Incidence, Variation and Treatment*. Int Ass Dent Res (SA-Division) 27th Congr. Cape Town.

2. Holtzhausen, E.F., Winstanley, T.D. Redelinghuys, I.F. (1994) *The use of hyperbaric oxygen therapy in the prevention and healing of osteoradionecrosis (ORN)*. 11th Fac Day: Fac Dent, Univ Pret. Pretoria.

3. Mazarakis, E. Redelinghuys, I.F. (1994) *Child abuse – Dental aspects (Poster presentation)*. 11th Fac Day: Fac Dent, Univ Pret. Pretoria.

4. Redelinghuys, I.F. (1994) *Three-dimensional computed tomographical reconstruction in Maxillo-Facial and Oral trauma and pathology*. Refresher course, Max-Fac Oral Surg. Pretoria.

5. Redelinghuys. I.F., Van Schalkwyk, S.J.F. Bütow, K-W. (1994) *Three-dimensional Computerized Tomographic Reconstruction in Maxillo-Facial and Oral Surgery*. Int Ass Dent Res (SA-Division) 28th Congr. Pretoria.

6. Redelinghuys, I.F., Holtzhausen, E.S. Winstanley, T. (1994) *The role of hyperbaric oxygen therapy in the management of osteoradionecrosis in Maxillo-Facial and Oral Surgery*. 11th Nat Conf: S Afr Soc Aerosp Environm Med. Banana Beach.

7. Redelinghuys, I.F. Bütow, K-W. (1995) *Demarquay-van der Woude Syndrome (D-VWS): Incidence, Variation and Surgical treatment of the lower lip*. Ann Cong Ass Plast Reconstr Surg (incl cleft lip and palate and microsurgery), Berg en Dal.

8. Redelinghuys, I.F., Bütow, K-W. Duvenage, J.G. (1996) *Implanto-Orthognathic Reconstructive Surgery: A Follow-up report.* Int Triang Maxfac Oral Surg Congr (RSA, Britt., Netherl.) Cape Town.

9. Redelinghuys, I.F. Bütow, K-W. (1996*) Improved patency of the Eustachian tube in cleft palate patients after veloplasty by means of a tensor sling*. Int Triang Maxfac Oral Surg Congr (RSA, Britt., Netherl.) Cape Town.

10. Redelinghuys, IF (1996) *Complications related to Exodontia*. Mpumalanga: Dept Health Welfare Gender Affairs Ann Gen Meet. Witbank.

11. Redelinghuys, IF. Bütow, K-W. (1997) *Liquid nitrogen cryotherapy for benign, locally aggressive bony lesions.* Congr S Afr Soc Max-Fac Oral Surg. Sun City.

12. Redelinghuys, IF. Bütow, K-W. (1997) *Liquid nitrogen cryotherapy after enucleation of benign aggressive bony lesions* Int Ass Dent Res (SA-Division) 31st Congr. Cape Town.

13. Redelinghuys, IF (1997) *Emergency treatment of Facial Trauma patients*. Mpumalanga: Dept Health Welfare Gender Affairs Ann Gen Meet. Witbank.

14. Redelinghuys, IF. (1999) *New advances in Maxillo-facial and Oral Surgery*. North Prov Branch S Afr Dent Ass. Pietersburg.

15. Redelinghuys, IF (2000) *Maxillo-facial Trauma*. College Emerg Care: North Prov. Pietersburg.

16. Redelinghuys, IF (2001) *Maxillo-facial Trauma*. College Emerg Care: North Prov. Pietersburg

17. Redelinghuys, IF (2001) *Surviving a risky business – Ethical assessment of cases and litigation.* MFOS & Radiol Refresh course – Univ Pret. Pretoria.

18. Bredell, MG. Redelinghuys, IF. Bütow, K-W. (2001) *Treatment modalities for Ameloblastomas at the University of Pretoria (Poster presentation).* 15th Int Conf Oral Max.Fac Surg , Durban.

19. Redelinghuys IF (2002) *Maxillo-facial Trauma*. College Emerg Care: North Prov. Pietersburg

20. Redelinghuys, IF (2003) *Maxillo-facial Trauma*. College Emerg Care: Limpopo Prov. Polokwane

21. Redelinghuys, IF Bütow, K-W Carstens, PA. (2003) *Informed consent – What do I need to tell my patient?* Limpopo Branch S Afr Dent Ass. Polokwane.

22. Redelinghuys, IF Bütow, K-W, Carstens, PA (2004) *The Consent-issue – What do I need to tell my patient?* Soutpansberg Branch S Afr Med Ass. Polokwane.

COURSES AND CONGRESSES

1. Courses/Conferences (38)

2005	Feedback on the World Conference and newest technology in implantology	SA Society of Dental Implantology
2005	"Taking control" – Dental Leadership programme	SADA Limpopo

2005	15th International Dento-Maxillofacial Radiaology Congress Pre-Congress Course in Head and Neck Imaging	Cape Town
2004	Digital Imaging and Diagnostic Maxillo-Facial Radiology	University of Western Cape
2004	Designated service provider contracts	SPESNET
2004	Nobel Biocare's Team Day	Nobel Biocare
2003	Facial trauma – Where first and third worlds meet	WITS University
2002	Nobel Biocare's Team Day	Nobel Biocare
2001	15th International Conference on Oral & Maxillofacial Surgery ***(One presentation)***	SASMFOS
	MFOS and Radiology Refresher course ***(One presentation)***	University of Pretoria
2000	Towards greater aquity in Orthognatic Surgery: An advanced approach (Four courses)	Centre for Orthognatic Surgery Carstenhof Clinic
	Implants Hands-on Course	Nobel Biocare
	Basic Prosthetics for Dental Implants	Southern Implants
	Practice Management Course - Human Resource Management in the Medical Practice - Structuring of Professional Practices	SADA – Northern Province
1999	Ethical aspects in Dentistry	SADA – Northern Province
	International Course in Recent Advances in Cranio-Maxillofacial Surgery	Glasgow, Scotland
	Risk management in Dentistry	SADA – Northern Province
	New advances in Maxillo-facial and Oral Surgery ***(One presentation)***	SADA – Northern Province
	Quarterly meeting of Vascular Malformation Study Group ***(One presentation)***	Pretoria
1998	Annual meeting of SADA	SADA - Mpumalanga
	Quarterly meeting of Vascular Malformation Study Group	Pretoria
1997	Bone Source: Hydroxyapatite cement for Cranio-maxillofacial surgery.	Leibinger
	Brånemark system – From Science to Practice	Nobel Biocare
1995	Orthognathic surgery	SA Societies: MFOS & Orthodontists
1994	Advanced Trauma Life Support (American College of Surgeons)	Trauma Society of SA
	Eleventh National Conference: SA Society for Aerospace and Environmental Medicine ***(One presentation)***	SASAEM
	Refresher course in Maxillo-Facial and Oral Surgery ***(One presentation)***	University of Pretoria
	Symposium on Current Concepts in Facial Trauma	WITS University
1993	Refresher course: Oral Pathology for MFOS	University of Pretoria
1992	General Refresher course in Dentistry	University of Pretoria
1991	Facial deformities in children	MASA: Eastern Tvl branch

1990	Temperomandibular Joint disorders	SA Academy for Cranio-mandibular deformities
	Interpretation of panoramic X-rays	SA Society for Maxillo-Facial Radiology
1988	Infection control and Sterilisation Interpretation of panoramic X-rays	SADA Northern Transvaal
	Refresher course: Maxillo-Facial and Oral Surgery/Diagnostics and Radiology	University of Pretoria

2. Congresses (13)

2004	Annual Congress of SA Society for MFOS (The Science and the Art)	Kwa-Maritane
2003	Annual Congress of SA Society for MFOS (TMJ – Yesterday, Today and Tomorrow)	Cape Town
2002	SADA / IDEC	Durban
	Annual Congress of SA Society for MFOS	Durban
2000	Annual Congress of SA Society for MFOS	Magaliesburg
1998	Annual Congress of SA Society for MFOS	Pretoria
1997	IADR ***(One presentation)***	Cape Town
	Annual Congress of SA Society for MFOS **(*One presentation*)**	Sun City
1996	International Triangular Congress for MFOS **(*Two presentations*)**	Cape Town
1995	Annual Congress of the Society of Plastic and Reconstructive Surgery (including Cleft lip and palate and Microsurgery) **(*One presentation*)**	Berg en Dal
1994	IADR **(*One presentation*)**	Pretoria
1993	IADR **(*One presentation*)**	Cape Town
1988	Congress of the Society for Forensic Odontostomatology	Durban

SOCIETIES/COMITEES

1986 -	South African Dental Association
1997	South African Society for Maxillo-Facial and Oral surgeons (Student member)
1998 -	South African Society for Maxillo-Facial and Oral surgeons (Full member)
1999 - 2002	General Dental Council – UK
1999 -	South African Sporthunting Association
2000 - 2002	Medics Golf Club – Limpopo Province (Chairman - Ex-Co)
2002 -	Pietersburg Vryburgers (Chairman: 2004)
2003 -	School Governing Body – Hoërskool Pietersburg
2004 -	SA Hunters and Game Conservation Association

SPORT

Golf
Hunting