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A critical Evaluation of the Locality Rule regarding the rural health care service in Public Sector

by

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DECLARATION

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1) I understand what plagiarism is and am aware of the University's policy in this regard.
2) I declare that this mini-dissertation is my own original work. Where other people's work was used (either from a printed source, Internet or any other source), this was properly acknowledged and referenced in accordance with departmental requirements.
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SUMMARY

The South African health sector encounters significant challenges of inequality in terms of access to health care services. A 'quadruplet burden of disease' does not make access to health any easier. Patient's access to health care can be hindered by the patient's residential area. Rural patients are faced with hospitals that do not have specialist care while urban areas are swamped with patient who need specialist care. Medical general practitioners' scope of practice is limited and that creates challenges when patients need specialised care in a resource constrained environment. The time it takes for the patient in public health sector to access health services may be affected by their locality. The same challenges may be experienced by patient in private sector with medical Aids who are residing in the rural areas. The state's impression is that demand is more than supply. On the other hand the court pursues justice for people who do not receive timeous access to healthcare. The study will be researching on locality issues that can jeopardise the standard of care. Although The Health Professions Council of South Africa is silent about the Locality Rule but it has unanimously adopted prerequisites and contraindications for using the Locality Rule as a defence. The Council has a duty in terms of Health Professional Act 56 of 1974 to uphold patient safety. The work seeks to understand the origin of the locality rule, its application in terms of the Constitution of the Republic Of South Africa, case law and relevant legislature. The work will also take into consideration the historical background of the South African health system and its responsibility in advancing socioeconomic rights for the citizens of South Africa. The prerequisite for using resource constrains and special circumstances will be discussed.

CHAPTER 1: INTRODUCTION

1.1 Research formulation and background

The history of Locality Rule draws a solid line between two health care systems, and that is: the urban and rural systems. The private health care system in many times is accessed in the urban areas while Public health care Services is largely in the rural areas. Rural health care systems are commonly observed as under-resourced hospitals, clinics and other related centres. This rule establishes the yardstick of standards of care and skills that doctors or health care professionals are expected to demonstrate in their specific locality. This creates a challenge for courts when adjudicating medical negligence related matters. The Constitution provides that all South Africans should be treated equally.[1] By extension, doctors should be held to the same degree of skill and diligence when treating their patients, regardless the hospital location where they practice. Even though the Constitution recognises the right to health care access and equality, it brings to bear the limitation rule, stating that rights can be limited.

This study evaluated the function of the Locality Rule in the broader South African health care context. The study aimed at assessing legal and medical implications of this rule, whilst evaluating whether it should be maintained, modified or entirely eradicated. The study endeavoured to emphasise the impact of locality on service delivery.

1.2 Assumptions

The study assumed the following in approaching the research problem:

- Medical doctors are professionally equal before the law, and as such are expected to comply with the same skill and care standard.
- All South Africans are entitled to higher quality health care products and services.
- The ability to discharge a higher standard of skill and diligence is enabled by adequate medical equipment and personnel in hospitals.

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[1] See section 9(2) of the Constitution of the republic of South Africa, 1996.

- Apart from the comprehensive defence of under-resourced facilities, doctors practising in public hospitals have a duty to discharge a higher standard of care and skill.
- There is an unequal distribution of health care services in South Africa.
- Health care services in the private and public sectors, are distributed according to the availability of resources, to such an extent that public hospitals are classified into district, regional and tertiary hospitals.

1.3 Research questions

In the subsequent chapters, this research addresses the questions listed below:

- What is the principle background history, modification and challenges?
- Does the Locality Rule have a place in the South African medical practice and health care sector?
- Does applying the Locality Rule across two health systems arbitrarily or unreasonably discriminate against other medical practitioners?
- Would eradicating the Locality Rule improve the practising standard amongst doctors in the broader South African health care systems?
- Should the Locality Rule be used as a defence in medical negligence related matters?
- Will the application of the rule make the health system any better or worse than what it is?

1.4 Study objectives and limitations

The research pursued to provide background history of the origin, modification and challenges of the principle. Public health care hospitals are severely under-resourced, leading to a crippled service delivery. Equally the private sector is reliant on funds. The resources of the later is limited by the affordability of the patient or community which is expected to service.

Although this study could provide some statistics concerning resources and hospital capacity amongst the two sectors, the objective was not to focus on resources. This study mainly focuses on the Locality Rule and its medico-legal implications in the South African health care context. No legal statute directly recognises the principle and thus the study will draw its argument from

common law. There is no literature in South Africa that explains the principle and that is the reason why most literature was sourced from other countries.[2]

The study did not pursue to approach individual medical practitioners and patients to reach its conclusion, nor did it aim to inspect certain hospital records to verify the capacity of institutions across the two health care systems. This study closely evaluated the Locality Rule, aspiring to reach a clear conclusion about its position in the practice of medicine in South Africa. The study was compiled from a general medical practitioner's perspective.

1.5 Research methodology

This research is an evaluation and as such, it adopted the critical analysis approach. The study strategy was to simplify the fundamental reasons behind the adoption of the Locality Rule. Whilst the rule can serve some specific purposes in establishing fairness in litigating medical negligence cases, it can also have its own weaknesses. One such weakness is the usage of geographic area as a test for negligence. The study looks into literature and case law from United State of America and United Kingdom. The professional experience of the study conductor as medical general practioner has influenced the structure of the research work.

[2] Section 39 of the Constitution of The Republic of South Africa allow the consideration of international law, foreign law and common law when need arises.

CHAPTER 2: THE ORIGIN AND MODIFICATION OF THE LOCALITY RULE

2.1 Introduction

The *locus classicus* of the Locality Rule in South Africa is observed in the following case:

In the case of *Van Wyk v Lewis*,[3] the Locality Rule was a dominant point of discourse. In this case, the patient (*Van Wyk*) sued the doctor (*Lewis*) after an operation, where a swab was left in the abdomen of the patient. The swab was only discovered after twelve months. The patient sued the doctor for medical negligence. In proceedings, it was argued that the operation was performed in a small town, at night time, in a poorly facilitated hospital. During the judgement, Wessels held that the doctor practising in a small rural town cannot be held to the same care and skills standards, equal to that of a practitioner in big cities. It is without doubt that Wessels's position places the Locality Rule at the centre of evaluating circumstances determining the presence or the absence of medical negligence.

In the same judgement of *Van Wyk v Lewis*, Innes held as follows:

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

Simultaneously, Wessels JA, in a minority concurring judgement, states:

> *"the contract between a patient operated upon in a hospital and operating surgeon is that the surgeon will perform the operation with such technical skill as the average medical practitioner in South Africa possesses an that he will apply that he will apply skill with reasonable care and judgement. The locality where the operation is*

[3] 1924 AD 348

performed is an element in judging whether or not reasonable skill, care and judgement were exercised. He stated he cannot expect the same level of skill and care of a practitioner in a country town as you can of one in a significant hospital in a large city. In the same way one cannot expect the same skill of surgeon practising in South Africa as of surgeon in London, Paris or Berlin."[4]

Other Countries, such as Idaho, Arizona, Washington, Virginia, New York and Tennessee went to the extent to define and modify the rule. In the U.S. during around 1880, the rule established its way.[5] The rule was created to exempt rural doctors from the same standard than that of urban doctors. Only physicians practising in the community, can testify. This made it difficult for the plaintiff to find expert witnesses, as doctors conspired against the patients. This was consistent with the original rule, classified as the 'strict Locality Rule'.

Carstens[6] observed that the "skill and care expected on medical practitioner is dependent on and influenced by the objective circumstances of the locality."

The case of Small vs. Howard is a case that occurred in 1880 in Massachusetts in USA where the geographic area where the doctor was practising was taken into consideration when determining professional standard.[7] The opinion that was driven by the Small case was that even though physicians often possess a thorough theoretical knowledge; they do not enjoy the opportunity of daily observations and practising medicine and surgery compared to those residing in metropolitan towns. The following classification and modification of the rule was observed:

[4] Ibid.

[5] Lewis MH, et al (2007) JAMA 2634

[6] Carstens PA (1990) De Rebus 421-423.

[7]. Ginsberg MD (2013) Drake L.R 323.

2.1.1 Strict Locality Rule[8]

The rule employs the geographic area where the physician resides to determine the medical care standard. The standard of the practitioner in question is evaluated on the standard of physicians in his own speciality in the same local area. The effect of the rule on the plaintiff is that it required the plaintiff to obtain an expert who practised in the defendant's 'community'.

The challenge of the rule is:[9]

- It restricts the plaintiff's right to access expert witnesses.
- Doctors in that area may decide not to testify against each other, called "conspiracy of silence."
- A possibility of a small group of physicians, by their laxness or carelessness, could establish a local standard of care below the law requirements.
- In Smothers v Hanks, the Supreme Court recognised that the standard of ordinary skills may vary even in the same state.[10]

In the Toth v. Community Hospital,[11]the paediatrician used rule as a defence after causing blindness to a preterm baby by using excessive oxygen. The court ruled against the defence as they indicated that the paediatrician was more informed of the risks and benefits of the treatment. The case indicates that the court will judge according to the actions of a specialist in the same field and in a similar situation. Giesen[12] indicates that "the practitioner may be held liable if he fails to apply established innovative methods, assuring greater success than an older method. The court regards it as *Lege artis."*

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[8]King JF (1974) University of Baltimore Law Review

[9] Ibid

[10] Ginsberg M.D(2013) Drake L.R 43

[11] Lewis MH, *et al* (2007) JAMA 297 (23):2633-2637

[12] Giesen D*(1988*) 113

2.1.2 Similar /same Locality Rule

The definition of this modified Locality Rule is that the physician will be judged on the same standard as the physician in the same or similar locality[13]. Under this classification, the doctor familiar with the standard of care in a small rural town can provide testimony to other doctors in similar small towns.

The leading case embracing the similar Locality Rule is Small v. Howard[14] where a physician in a small country village allegedly improperly treating a wound on plaintiff's wrist. The jury charge included an instruction that:

> "*Skill only which a physician and surgeon of ordinary ability and skill practising in similar localities with opportunities no larger expertise ordinarily possesses of ordinary ability and skill, practising in similar localities, with opportunities for no larger experience, ordinarily possessed; and he was not bound to possess that high degree of art and skill possessed by eminent surgeons practising in large cities, and making a specialty of the practice of surgery*."

The similar Locality Rule is also observed in the case of McClure v. Inova Medical Group.[15] The court ruled against the doctor for failing to routinely performing a Prostate Specific Antigen (PSA) without written consent**.** The court's argument was based on the fact that a clinician was not expected to take written consent for Prostate test in that town.

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[13] Giesen D*(1988)*2630

[14]Smerge R (1968) DePaul Law Review 329.

[15] Tan Law & Medical Locality Rule https://www.mdedge.com

Criticism to the rule:

The challenge in applying this rule is that it may disadvantage practitioners relocating from one state to another.

The rule does not consider the ethical duty of the practitioner to transfer or refer a patient if they are of the opinion that the condition needs more improved standards. If the rule is allowed, it may put patients at risk and lower the standard of care. Giesen[16]indicates that the question of whether the practitioner adhered to standards, cannot be limited to a community or group. The required standards are those demanded by the law.

2.1.3 Resource-based Locality Rule

Theodore Silver[17] describes locality as 'no more and no less' than a circumstance that naturally affects the reasonableness of a physician's knowledge and skill. Prof. McQuoid-Mason defines scarce resources as a "situation where health care providers are encountered with less than optimum human and material resources resulting from financial, administrative or personnel constraints. Such physician will be judged on the standard of a reasonable competent health worker in similar of resources."[18]

State hospitals in South Africa are divided into district, regional and tertiary. The blighted reason for the division is that the distribution of resources in hospitals differ. The report by the Office of Health Standards states:

> *"During 2016/17 OHSC advanced its efforts and inspected 696 public health facilities and 204 additional inspections were conducted. Of these additional inspections were conducted. Of these additional inspections, 155 were accomplished within [six] months from the first inspection. The number and effort of inspections will need to*

[16]Giesen (1988) 110.

17 Silver T (1992) Winscousin Law Review

[18] McQuoid-Mason JD (2011)359.

increase in the coming years to include inspections in the private health facilities. Inspected health facilities yield scores across seven domains of quality. The national average score was 59% in hospitals, 50% in community Health Centres (CHCs) and 47% in clinics. The highest average percentage outcome score amongst provinces was 61% from Gauteng while Eastern Cape and Limpopo provinces had the lowest average percentage outcome of 43%."[19]

The resource challenge is not only based in rural areas but are still noticed in urban areas. The Minister of Health is quoted saying that the demand is larger than the supply.

"The number of people who used to go to our clinics between 2004 and now has increased tenfold. But this was not met by a concomitant increase in the number of staff or even the number of facilities and equipment."[20]

2.1.4 Skills and equipment

Cancer patients at Dr Harry Surtie Memorial Hospital struggled to receive services in the hospital due to failure to procure mammography equipment[21]. Overcrowding is one of the factors that threatening the standard of care as observed at the Tembisa Hospital.[22] Overcrowding may be factors that influence the manner in which local doctors treat patients. The standard of care may be based on the availability of resources and not on the national standard, or global standard of care.

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[19]Office of Health Standard Safety Commission Annual report 2017/18 https://www.ohsc.org.za,publication

20 SA's Health System 'distressed' but not collapsing: Motsoaledi. https://www ewn.co.za/2018/06/05/minister-sa-healthcare-system-not-collapsing-despite-problems

[21] N Cape cancer patients affected by skills shortage www.sabcnews.com

[22] Tembisa Hospital Maternity ward overcrowding nightmare www.sowetanlive.co.za, overcrowding at Tembisa Hospital a cause for concern https://tembisa.co.za

2.1.5 Working conditions

The locality in which the healthcare worker operate in has great impact on the quality of care the patient receives.

Medical Register, medical officer and specialist in academic hospital are providing service to the public on a daily bases at the expense of compromising academic achievements. There is little room for academic supervision of inters and the registers.

It is documentaries such as Saving Soweto[23] that illustrate the challenges met by health provisional in the facilities while ensure patient are safe in the facility and proper standards are followed.

The failure to fill vacant post in health care is a nightmare to the clinicians as they end up working long hours and compromising on clinical care of patients.

The state has a duty as employer in terms of Occupational Health and Safety Act[24] to provide safe work environment.

Criticism of the rule

McQuoid-Mason[25] critically indicated that the Department of Health and private sector hospital bodies will be liable for wrongful conducts in their administration that result in intentionally or negligently harming patients by diverting funds from health care services. The burden of negligence is not only the responsibility of the clinician but also the administrators. The

[23] Saving Soweto https://www.news24.com

[24] Act 85 of 1993

[25]Prof McQuoid-Mason JD "Ethical and medico-legal consequences of healthcare rationing under budgetary constraints." 5 https://www.up.ac.za

administrators have the responsibility to qualify the reasons for failing to allocate resources. Tan[26] criticises the use of the rule, by indicating that it will create a 'slippery road' where people justify using out-dated models in order to provided substandard care.

The case of Palmer vs Biloxi,[27] held that it is necessary to consider the medical resource available in determining the standard of care. The availability of resource, especially human resources, should be intimately tied to medical decision-making and standard care.

2.2 Conclusion

Customary practices that threaten patient safety should be eradicated. Peter in the quiet demise of defence of two customs, indicates that doctors cannot rely on things always performed like that as a defence. Medical Professionals should act within the acceptable medical standards. Long working hours impact moods, performance, stress and anxiety level and patient safety. The state must take responsibility in improving the nurse doctor patient ratio.

Although the exclusion of the expert testimony may not be the best solution, it is of vital importance for the expert to be knowledgeable of the standard of care in the area, such as the referral system and the available medical equipment when providing an opinion. Clinicians have an ethical obligation to refer a patient, needing prompt resources that are not available.

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[26]Tan Law and Medicine: Locality Rule

https://www.mdedge.com/internalmedicinenews/article/.../law-medicine-locality-rule

[27] Stuart P et al (2014) AMJE

CHAPTER 3: A COMPARATIVE EVALUATION OF A LEGAL AND ETHICAL FRAMEWORK, INFLUENCING THE LOCALITY RULE

3.1 Delict

In the case of medical malpractice, the plaintiff has to prove that:

- The defendant had a duty to 'care'.
- The defendant breached the duty.
- The plaintiff incurred damages because of the defendant conduct.
- There is causal link between omission and the injury.[28]

The basic standard required in order to proof negligence in laypersons is that of a reasonable ordinary person. In medical malpractice or professional malpractice, the standard is slightly higher. It is the degree of care which would be exercised, representing a good degree of care, exercised by the physician in good standing in the same medical speciality in a similar community in comparable circumstances.[29]

The standard requires the doctor to maintain a level of competence, compared to others in the field, simultaneously considering resource constrains that may prevail during treatment. The definition is fair and comprehensive. It includes the use of the Locality Rule where it is fair, whilst in circumstances with constrains.

Prof. Carstens clearly explains it as 'nothing but a special circumstance principle'. Special Circumstances prevail in both private, public sector, urban or rural towns[30]. It would be unjust if circumstances that lead to a specific clinical judgement is not considered when preceding over medical negligence cases.

[28] Mello MM "Of swords and shield: the role of clinical practice guidelines in medical malpractice litigation." (2001) The John Marshall Law School 654

[29] Ibid

[30] Carstens & Pearmain *(2007)* 638.

The standard ensures that it does not preclude any doctor from the liability by virtue of ignorance. Doctors in similar fields are observed as equal, with equal capacities. The definition removes the original strict Locality Rule as it measures all doctors in similar fields with the same bench mark. The only aspect rendering a difference is 'circumstances'.

When the definition is read in full and not selectively, a balanced criterion can be established. In the resource constrained and shortage the test will be: "Has the healthcare practitioner conducted himself or herself in the manner that a reasonably competent practitioner in the same field encountered with the same shortage of resources would have acted?"

3.2 The standard of care as a determinant of negligence

The duty of an expert witness in a medical negligence case is to opine on whether the act of the peer meets acceptable standards in the field. Giesen[31] indicates that, "Standards of a practitioner who just qualified and that of an advanced practitioner are held to the same standards. They are both expected to keep abreast with the latest developments concerning treatment care and procedures".

Standards are objective and only become subjective when considering the circumstances of the conduct. The circumstances can be a medical condition[32] and/or the physical environment.

3.3 Challenges with judging on standards

3.3.1 Hindsight

When interpreting an expert report, it is important for the judge to protect the defendant from a disadvantage by hindsight[33].

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[31]Giesen D (1988) 96.

[32] Buthelezi v Ndaba (575/2012) (2013) ZASCA 72(29 May 2013).

[33]Montgomery J (1997)169.

3.3.2 Innovation

Innovative practice creates "*prima facie"* element of negligence. It remains the duty of the professional called upon, to justify novel therapy, or a procedure was pursued to improve standards and was conducted properly ensuring a balance between risks and benefits[34].

3.3.3 Various schools of thoughts

Occasionally professionals differ on standards to be used when embarking on patient treatment. In the case of Maynard v Midlands RHA, the House of Lords indicated that it will not choose amongst various bodies of competent opinions, but will decide on negligence of facts. The most important aspect is for the practitioner to ensure that the required standards are met, as established by the medical practitioners when subscribing to a particular school of thought.[35]

3.3.4 Emergencies

During an emergency situation, the practitioners may be more prone to errors than with less pressure; this is what Montgomery[36] defines it as the "battle condition". Montgomery continues, stating that this does not mean that standards are lowered but rather to consider standards of a reasonable practitioner in the same circumstances. This is conducted to ensure that standards are tailored to circumstances related to the immediate situation where the error occurs. It is also important to allude that the defence will not be valid if it is because of a cascade of negligence by the practitioner.[37] The clinical error of judgement because of failure to exercise the legally acceptable requisite level of care, will be regarded as negligence.[38]

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[34] Ibid,169.

[35] Carstens & Pearmain (2007) 641.

[36] Montgomery J (1997) 168.

[37]Giesen (1988) 97.

[38]Ibid, 95.

3.3.5 Involvement of more than one practitioner

The standard of the last practitioner may be compromised by the initial practitioner. It is important to indicate that the negligence of each practitioner will be attended to individually and not as a team. The doctrine of "the captain of the ship" was removed by the English courts.[39] The duties of a theatre sister is independent of the theatre surgeon.[40]

3.3.6 Standards during treatment

Standards are based on the care at the material time.[41] This is observed in the classical case of Van Wyk[42] of swab in the abdomen, and the Goliath v Member of the Executive Council for Health.[43] The two cases present a clear example of how circumstances and times can change the determination of a case, considering the time and circumstances of the incident.

3.4 Constitutional implication of applying the Locality Rule

Just like any rule in South African Law, the Locality Rule should be assessed to establish whether it will confront the constitutional scrutiny. Section 2 validated the supremacy of the Constitution and that any law inconsistent with the Constitution will be regarded as invalid.

3.4.1 Section 9: Right to equality

The strict Locality Rule pursues to differentiate doctors from rural areas from doctors from urban areas. This action is unjust as doctors from both areas have the same qualifications; Others even

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[39] Ibid, 95

[40] McQuoid-Mason (2011) 303.

[41]Ibid, 110.

[42] Ibid,3

[43] Goliath v Member of Executive Council of Health, Eastern Cape (085/2014)(2014) ZASCA 182 (25 November 2014).

went to the extent of writing the same exam. This can be observed as down-grading the standards of doctors in rural areas or as unfair discrimination.

3.4.2 Section 16(d): Freedom of expression

Limiting the choice of an expert witness because of their origin, may be observed as unfair discrimination and prejudicial to the plaintiff. This action is against the strictest form of the locality, or similar Locality Rule. Nationalising guidelines assist with uniformity and should not take away clinical autonomy.

3.4.3 Section 27(1)(a) Everyone have right to access to health care services including reproductive health

Healthcare is amongst the socioeconomic rights that the Government needs to protect in order for its people to live a dignified life.

Carstens[44] emphasises that the Constitution provides for access to healthcare. He further indicate that right to access to health care has various interpretations as compared to the direct right where people have right to health care. The access to health care has broader implication and flexibility such as creating room to allow those who can afford pay for the services to pay, ensuring that health care services must be placed within reach in terms of geographic, economic, social and physical factors. It may also include seeking alternative ways outside health care such as providing proper roads, infrastructure and in certain instances transporting patient to the health facility in rural areas where people cannot afford to pay for their transport and it is not feasible to construct health facility in their area. The state is also given the option of diverting services to the private sector and becoming the funder where possible.

The section reduces the bulk of issues of resource constrains as a defence as it provides the Government options and places the responsibility to the holder of the right to make effort to obtain the services.

[44] Carstens & Pearmain (2007) 37.

Section 27 (2)

The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of the rights.

"The Grootboom gave the executive important guidance with regard to the policy decisions". The case affirm the state's duty to adopt reasonable legislative and other measures to achieve the progressive realisation of socioeconomic rights. This implies that the policy must be:

Comprehensive- it must be inclusive of all segments of the society

Balanced and flexible – it must be able to adapt to changing needs and circumstances across interest groups and

Attentive to those who need most urgent and who have only the state to look to for assistance."[45]

McQuiod Mason[46] draws inference from the Constitution when he indicates that the Provincial Member of Executive Council can be held liable for failing to provide resources at the health facilities. The state has obligation to take reasonable steps to ensure that resources are put in place. The deliberate failure by the administrator to provide essential treatment can be as equivalent to act of *novus actus interveniens*. In such case if the element of murder can be elucidated through indirect intension then the MEC can be held liable for murder or to a lesser extend culpable homicide.

3.4.4 The National Health Act 61 of 2003

Section 44 recommends that patients be referred to another institution in the event that the institution cannot provide the services needed in an appropriate manner.

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[45] Carstens & Pearman (2007) 55.

[46] McQuoid-Mason JD (2016) SAMJ 83-85

The section can be used as an aggravating factor in the event where there was a failure to refer patient to an appropriate facility.

Section 47 recommends that the health establishment meet the standard requirements established by the National Health Counsel, The Office of the Health Standards concerning human resources, equipment, hygiene, premises, the delivery of health services safety and business services. This section holds administrators accountable for managing the health facilities. These are amongst the modern criteria legally considered, to satisfy before using the Locality Rule as a defence mechanism.

3.5 Scope of practice

Medical doctors are subdivided into intern student doctor, community services medical doctors, independent general practitioner, specialist and subspecialist. The subdivision assists in insuring that health care workers know their limits concerning prescripts.

Concerning common law, the regulation of the scope of practice is observed under the law of *Imperitia culpae adnumeratur* in the Locality Rule. The application of the principle means that a practitioner must not take an activity requiring expert knowledge, whilst lacking the prescribed expert knowledge[47]

In the case of McDonald,[48] the patient suffered an injury to the inferior alveolar nerve during extraction by a general practice dentist. The court ruled against the practitioner, stating that if the patient was operated on by a specialist, harm would have been minimised. This rule indicates that general practitioners will be judged by a standard specialist if they perform procedures of a specialist.

[47]Carstens & Pearmain (2007) 587.

[48] Ibid

The practitioner should have referred the patient to a specialist maxillofacial to treat the condition without risking the patient life. The doctor cannot rely on Locality Rule and the principle of *Imperitia culpae adnumeratur* was used.

The decision by the above case is reinforced by Montgomery[49] when he indicates that generalists should not be held liable for misdiagnosing a condition needing a specialist standard, but may be held liable for embarking on any inherently difficulty or specialist procedure, inferring a harmful result.

This is consistent with the Health Professions Council of South Africa's (HPCSA) requirements. The Council does not expect health worker to conduct a procedure that they are not competent to perform. The Nursing Counsel also emphasises the scope of practice of the nurses. It is of concern that the scope of practice of general practitioners is not clearly demarcated, creating a 'grey' field.

The Oppelt[50] case is a classic example where courts failed to understand Mr Oppelt's reason not to timeously access emergency reduction was due to circumstances of a hospital lacking an orthopaedic specialist with the necessary skill. These actions caused treatment delay. Efforts were made to ensure medical intervention was done by someone who is well trained in the procedure. This is a disadvantage of balancing skills and access to emergency healthcare with inadequate specialists. The question that remains unclear in this case is as to whether the judgement was made on the bases of the highest standard or reasonable standard.

The HPCSA clearly indicate that health workers must adhere to their scope of practice when caring for patients[51]. A challenge in context with the healthcare services is that health care workers might be confronted with an emergency situation where they are familiar with the medical intervention. The intervention might assist the person in need of emergency care. Prof. Carstens[52] indicates that

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[49]Montgomery J Oxford University Press (1997) 177.

[50] Ibid,88

[51] HPCSA Annexure 6 section 1 of Ethical rule of conduct

[52] Carstens & Pearman (2007) 591.

when health care workers exceed the scope of practice in an emergency situation, the extent to whether it will hold, remains unknown.

One must keep in mind that the practitioner has a duty to exhaust every possible option in the best interest of the patient when encountered with a medical diagnosis or treatment above their scope most importantly in the hospital setting calling for assistance or referring the patient.

In an unreported case of Sv Nel 1987 TPD [53] the general practitioner was found guilty of negligence and culpable homicide after delaying to call for assistance when the husband to the patient offered to call a specialist when the doctor was encountered with a massive bleeding when trying to remove the placenta from the uterus. This case clearly illustrate that a general practitioner has a legal duty to call for assistance when encountered with medical condition beyond the scope of practice.

Negotiorum Gestio allows for interference of one person in the affairs of another in the interest of the latter. This can be used as a defence where there was an emergency situation that provided the health care worker no alternative but to intervene. The principle can be used as a ground for justifying the action of health professional that exceeded their scope of practice when phased with a catastrophic event. Such performance should be in accordance with public policies and constitutional values[54].

3.6 Ethical issues surrounding the Locality Rule

South Africa encounters issues of unequal distribution of health care services.[55]It is thus difficult to critically analyse the Locality Rule in public sector without considering distributive justice in

[53] Oosthuizen W supervised by Prof Carstens "an analysis of Healthcare and Malpractice liability reform: aligning proposal to improve quality of Care and Patient Safety"(2014) Doctorate Faculty of Law 48

[54] Carstens & Pearman (2007) 592.

[55]Van Rensburg HC,et al (1994) S Afri Med J.

health care. If resources are not properly or equally distributed within the society, the state may be unreasonably exposed to health inefficiencies.

3.6.1 Distributive justice in health care

The principle of justice in healthcare refers to distributive justice and the fair allocation of scarce healthcare resources.[56] The ultimate universal health care access as advocated by the World Health Organisation (WHO) might eradicate the Locality Rule. South African Health Care Services employs the two-tier system, with a disparity in health care distribution. Benatar[57] raises the following comment concerning allocation of resources in the South African context: *"... comment about the private health sector servicing 16 per cent of our population but at the same time evolving into an expensive substitute and the largest challenge is to find balance between the rationality of private self-interest and public health interest."*

The South African Public Health encounters challenges, such as extended waiting periods, deficient quality of care, out-dated facilities, deficient disease control and prevention, opposed to the private counterpart. This was also observed in the public sector of other countries.[58] Distributive Justice is defined as "the equitable and appropriate distribution in society determined by justified norms that structure the term of social cooperation."

Prof. McQuoid indicates that in hospitals with limited resources available to repair or replace equipment or medical items, the hospital administrator may establish alternative referral systems and restrict the patient intake. Apart from emergencies, health care administrators would be negligent to allow patients to be accepted for procedures that cannot be performed properly at the concerned facility.[59]

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[56]Dhai & McQuoid-Mason (2011) 15.

[57] Benatar et al (2017) International Journal for Research,Policy and Practice 11.

[58] Mountgomery Y (2016) Western Michigan Universit 4.

[59] McQuoid-Mason (2010)SAMJ

This newspaper article can allude to the closing down of a neonatal unit in a hospital after several babies died of Klebsiella pneumonia in an overcrowded neonatal unit.[60]

- A Utilitarian approach in the case of a Locality Rule.

Most state facilities employ the Utilitarianism principle of right to ensure the greatest good for the greatest number, whilst the private sector employs the Libertarian distributive justice theory, based on the ability to pay for healthcare.[61]

The Treatment Action Campaign[62] the court established it as unfair discrimination when a drug is allocated to the few in the population who needs the drug.

The main challenge with allocating resources, is when patients receiving care are refused, or when a doctor is ready and willing to assist, but cannot conduct a procedure because of a lack of resources. Stauch[63] indicates that resources can be distributed according to merits, equally and/or according to needs.

The study further indicates that doctors care for groups of patients and are aware that using a bed or operating theatre for one patient may mean that treating another patient will be delayed or denied. For this reason, it is increasingly difficult to refer the elderly for surgery; infertility treatment was not always available. Those suffering from a mental illness could not always receive hospital care; kidney dialysis was available for only few people. Allocating resources can be performed through a triaging system where it is based on the probability of a successful medical outcome. For example, a smoker is refused heart surgery.

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[60]Gauteng Hospital under Scrutiny as more babies die from infection www.iol.co.za

[61]Moodley K (ed)(2014) 74.

[62] Minister of Health and Others v Treatment Action Campaign and Others (No. 2) 2002 (5) SA 721 (CC).

[63] Strauch M *et al(1998)* 45.

The fair inning arguments[64] indicate that failure to provide care to the elderly will lead to tragedy of prematurely ending the life of an elderly. They substantiate their argument by stating that they believe that when life is equally valued by the person whose life it is, it should be provided an equal chance of preservation.

Prof Carstens[65] also indicate that the Constitution acknowledges that there is limitation of socioeconomic rights by the availability of resources.

Dr Van den Bout[66] indicate that the practitioners be sensible about experimenting on their patient as this can amount to violation of Section 12 (2) (c) of the Constitution[67].

The article emphasises the danger of generalist performing skill work that they are not familiar with. The article further emphasise the generalist who is a specialist and the danger in performing procedures that he or she is not familiar with than if the procedure was performed by their counter subspecialist. These was seen in the Oppelt case as the patient could not be operated at Groote Schuur Hospital as the orthopaedic surgeon there did not have the skill to perform the close reduction for spinal injury.

The article advocate for generalist to know their boundaries when it comes to skill and to exercise caution in the best interest of the patient. The also advocate for practitioners to have Continuous Development when practising.

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[64]Ibid, 50.

[65]Carstens PA & Pearmain (2007) 37.

[66]Dr Van den Bout AH (2008) SAOJ

[67] Everyone has a right to bodily and psychological integrity which include the right not to be subjected to medical and scientific experiments without their informed consent

3.6.2 The influence of clinical autonomy by resources

Others aiming to reduce expenditure may endeavour second best treatment first and use best only if that fails. The British Medical Association[68] states: "*Wastage of resources is unethical because it diminishes society's capacity to relive suffering through the use that could be made of the waited resources*". Doctors working within the NHS, need to be aware of cost and clinical effectiveness in the care provided for the patient. General medical Council endorsed these views: "*The principle that doctors should always pursue to provide priority to the investigation and treatment of patient solely on the bases of clinical need*."[69]

3.6.3 The Health Professions Council of South Africa

Section 3 of Health Professions' Act[70] mandated the counsel to develop standards to ensure patient safety and fair and just distribution of healthcare. For a doctor to claim defence, they must ensure the Locality Rule, safeguarding reasonable ethical clinical solutions were exhausted, similar to emergency cases.

Prof. McQuoid indicates that in a resource starved health environment, ethical rules of health care professionals should not be compromised, except in emergencies.[71] Where the hospital limited resources to repair or replace equipment or medical items, hospital administrators may have to establish alternative referral systems and restrict the patient intake. Apart from emergencies, health care administrators would be perceived as negligent to allow patients to be accepted for procedures that cannot be properly performed at the concerned facility.[72]

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[68] Dr Van den Bout AH (2008) SAOJ

[69] Ibid.

[70] 56 of 1974

[71] Dada MA & McQuoid-Mason (2001) 43-45.

[72] McQuoid-Mason D(2010) SAMJ 574.

Before the doctor can claim defence of locality, the following prerequisite needs to be fulfilled, concerning the HPCSA code of conduct:

Booklet 1

- The practitioner must ensure that they are adequately educated and trained, with sufficient experience.
- Ensure that all procedures or interventions are taken under proper conditions and appropriate surrounding.
- (7) Act quickly to protect the patient from risks, attributable to any valid reason.
- (8.2.1) keep all equipment in a good working condition.

The study concluded that with this rule, a health care worker cannot embark on a duty that they are not experienced in or under unreasonable conditions, and then claim the Locality Rule.

Booklet 2

Practitioners are not allowed to receive fees and commissions from any company that has influence on clinical care. This is used to curb against standards influenced by the pharmaceutical companies.

Section 27A

- Obliges the practitioner to act in the best interest of the patient, unless it is an emergency.
- To maintain the highest standard of personal conduct and integrity.

Exposing patient to danger, incompetence and negligence are some of the charges that can be imposed on a practitioner in the event that patient suffers harm in their hands.

3.6.4 Complains and Inquiries

The council is invested with the powers to hold professional inquiries when a complaint is lodged through the council, protect the public and guiding the profession concerning Professional Health Act 56 of 1974[73]

The community can lodge complaint in line with regulation about the practitioner[74]

Poor performance[75] can be taken for enquiry by HPCSA. The Professional Conduct Committee may make finding of Poor Performance on the part of the respondent during an inquiry[76]. The matter can then where necessary be referred to Performance Assessment Committee[77]. If the performance committee is not satisfied that the practitioner has acquired the required skill to practice his/her profession, then the committee must determine the skill that the respondent requires to be able to practice his or her profession with reasonable skill. At the end of the inquiry the committee must make determination on the appropriate management of the respondent's deficient performance. The directive to be adhered to must be given to the respondent to improve his/her performance within the period as determined by the Committee

The committee may also direct the registrar to suspend the practitioner from practising his or her profession until such time he or she has complied with the directives.

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[73] Section 2(1)

[74] Regulation 2, Regulations relating to the conduct of inquiries into alleged unprofessional conduct under the health Professional Act 1974 published under Government Notice R102 Gazette 31859 of 6 February 2009

[75] Dr Oosthuizen supervised by Professor Carstens in his thesis *"An Analysis of HealthCare and Malpractice Liability reform: aligning proposal to improve quality of care and patient safety*" (2014) 29. Ibid fn(127) "Poor performance is referred to "negligence and conduct on the part of a practitioner which falls short of the required standards or generally acceptable norms in health care and which is found to be due to a lack of clinical or related skills or adequate knowledge of the management of patients or particular health condition."

[76] Ibid, 31. Reg 9(23)

[77]Ibid. Reg 10(1)-(8)

3.6.4 Patient safety in a resource scarce institution

Standards are there to safeguard patient care, considering how a facility can ensure patient safety, whilst complying with standards. Scarcity of human resources creates a flood gate for fatigue, professional error of judgements and systemic errors. When negligence occurs, it is unjust to observe an individual level, rather than contextualising on its systemic weakness. The article by the doctor in Eastern Cape indicates that resource scarcity is still pertinent in the current democratic South Africa.[78] Prof. McQuoid-Mason[79] stated that the following should be observed by practitioners when encountered with resource shortages:

- Respect patient autonomy by informing them of the limited options available.
- Acting to the best interest of their patients.
- Not harming patients, by best using the limited resources available to prevent harm.

Case Soobramoney[80] indicated that the court are willing to understand the policies, limiting health care distribution if the medical policy is just and reasonable. Mr Soobramoney was denied dialysis because he did not meet the criteria for dialysis in the state hospital after exhausting private funds of a private hospital.

[78]Talor D Inside South Africa's Rural Healthcare Crisis www.voanews.com

[79] Prof McQuoid-Mason ethical and medicolegal consequences of healthcare rationing under budgetary constraints www.up.ac.za

[80] Soobramoney v Minister of Health, KwaZulu-Natal 1998 (1) SA 765 (CC).

CONCLUSION

Knowing the extend and limits of the institution and practitioners' level of skill is important in ensuring that there is ethical limit as to how far one can go when it treating patients to protect them from harm and safe guard their constitutional right to bodily integrity. Their practitioners and institution must exercise options in the best interest of the patient when encountered with the condition above their scope and or lack appropriate skills and equipment.

Access to health care must be under conditions, upholding patient safety and quality healthcare services. The HPCSA activities fulfil an important function in reduce the issues of negligence when coupled with awareness programmes to the clinicians to ensure that professional know what their professional body expect from them. Ignorance by the practitioners cannot be reason to justify failure to adhere to professional standards.

CHAPTER 4: THE STATE OF SOUTH AFRICA'S HEALTH CARE IN CONTEXT WITH THE LOCALITY RULE

4.1 Introduction

South Africa is a two-tier health care system that is divided into private and public health care. The disparity of the two systems, creates an unequal distribution of health care services. More than 80% of the South African population depend on public health care. Patients residing in rural areas struggle the most to access the health care services**.** The rural community comprises over 40% of the South African population.[81]

> *"In 2010 an estimated 30% of South African's medical practitioners worked in public sector where they served an estimated 84% of the population. In the public sector the distribution of specialist to patients is 5.6 per 100 000. It is estimated that 46% of the population live in rural areas but are served by only 12% of doctors and 19% of nurses. Rural areas Northern Cape, Eastern Cape Mpumalanga and Limpopo had the lowest per 100 000 in 2014."*[82]

WHO recommends that the country should spend a minimum of 5% of its GDP on health care services and 1: 1000 physician patient ratio.[83] These numbers are unattained in South Africa. The health Minister Dr Aaron Motsoaledi, recently stated that the private sector spends 4.4% of the GDP on health services (16% of the population), whilst he public sector spends 4.1% of the GDP to service 84% of the population.[84] In 2010, it was reported that roughly R875 is spent on a patient in a year in the public sector, where roughly R6500 is spent on a patient in a year in the private

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[81] Cutting human resources for health. Who pays? An Eastern Cape case study www.rhap.org.za

[82] Mburu G *et al* (2017) Afri.j.of.Prim Heath Care & Fam. Med.

[83] De Bruyn Danielle. Lack of access to equal public healthcare and the locality rule in South Africa: a comparative study. Submitted in fulfillment of the requirements for the degree LLM in faculty of law, university of Pretoria, August 2016. 26.

[84] South Africa last in healthcare efficiency study https://www.fin 24.com>economy

sector.[85]It is this statistics and other factors that made the state to consider tabling the National Health Insurance Bill as a solution for the health system of South Africa. It proposes a universal health coverage, single purchaser single payer system. All though when going through the bill one start to realise that the voluntary Medical Scheme Insurance will still exist but the only difference is that the service will no longer be subsidised by the state.

The history of the health system should be considered when determining negligence starting from how the state of health care was prior 1994, then Reconstruction Development Plan and National Development Plan. This is also in the public interest as it does not make sense to implement a punitive measure above that, which the health care workers cannot change.

The implementation of Access care should be in line with the principle of distributive justice. The health care worker must find a way to evenly divide their ability to treat more patients in the public interest rather than individual interest.

The Tembani case[86] illustrate how the standard of care is compromised by resource constrains in public facility. Implementing an elusive perfect public health care system, instead of acknowledging that the health care workers are over stretched, creates injustice to the health care profession.

The leading injustice is when the legal sector uses the highest standard of care without exploring the South African economy's circumstances when putting judgement. These create a vicious circle in which the Government fulfil the interest of an individual at the expense of the community. The prevailing loser will be the patient. The Government has to manage health, food, water and shelter of the country; how will it function when all funds are to provide health care, whilst people are stranded without food, shelter and water? The judiciary should take into cognisance the economy and the demand of the country when applying the law.

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[85] Ibid, 27

[86] S v Tembani 2007 1 SACR 355 (SCA)

4.2 Case law

4.2.1 M.N. and Member of Executive Counsel for the Eastern Cape Province[87]

Facts of the case

The case involves a child who suffered from respiratory chest infection, dismissed at the Frere Hospital in East London. The child was under the care of specialist paediatric specialist who manages two hospitals. Both the plaintiff and defendant are experts witness , a cardiologist and paediatric cardiologist agreed in joint minutes that the child died because of a delay in diagnosing a cardiac condition. The defended ordered ultrasound. The investigation was incomplete. The argument of the plaintiff is that if the test was conducted earlier, the patient would have been diagnosed properly and provided appropriate medicine earlier.

Judgement

The court ruled in favour of the plaintiff, stating that the specialist is judged on the standard of a specialist and a reasonable specialist in the same circumstances would have done the investigation promptly, whilst treating the child differently.

[87] Unreported M.N and Member of the executive for health Eastern Cape Province case no 193/2011.

4.2.2 Oppelt v Head of Department Provincial Western Cape[88]

Facts

This is a case of a 17-year-old rugby player who sustained a C5/C6 dislocation, whilst playing rugby. An ambulance brought the patient to the Wesfleur Hospital. The doctor at this hospital, discussed the patient with an orthopaedic specialist, registered at the Groote Schuur Hospital that ordered the transferral of the patient to Groote Schuur with a helicopter. Attributable to the unavailability of a helicopter, the patient was transported by an ambulance instead, consuming six hours. On arrival he was observed by a specialist orthopaedic surgeon. X-ray confirmed the condition of cervical displacement. Unfortunately, the specialist was not what they call a reducer meaning a specialist in doing close reduction.

The patient was then transferred to a specialised spine hospital, the Conradie Hospital in Thornton, where a reduction surgery was performed 12 hours later. The procedure did not yield a good outcome. The patient was consequently, permanently paralysed.

Judgement

The majority judgement ruled in the patient's favour, dismissing the decision by the Supreme Court of appeal. The court held that the delay in treating the spinal injury, constituted in denying the patient access to emergency health care (Section 27 (3)) of the Constitution. The delay resulted in permanent paralysis of the patient.

The plaintiff expert specialist orthopaedic and spinal surgeon, provided evidence that the delay in transferring the patient was the cause for the bad outcome. He alluded that if the patient was treated within six hours of the injury, he would have had a 64 % chance of recovery. He also quoted an article, supporting his analysis. The expert also indicated that it was a known norm that spinal injury patients are treated in this hospital.

[88] Oppelt v Head of Department Provincial Western Cape (2015) ZACC 33

4.2.3 A critical discussion of M.N. Case in context with The Locality Rule

This is a case of special circumstances Locality Rule, based on the following:

- The child was referred by a specialist paediatrician and was observed by an intern doctor.
- There was delay in interpreting the Blood taken on 10 February indicated that the potassium content was high.

The study interpretation is that the usage of resource scares Locality Rule as a defence should be qualified.

In this case it is a specialist who fails to make a lifesaving decision to a child, whilst blaming the system. The specialist had an opportunity to review the x-ray, allowing a proper assessment, but that was never accomplished. The inefficiency of health care workers is also observed in failure to review the results promptly. The medical officer and student specialist who work with the specialist paediatrician, failed to follow up on the patient's results. The system uses intellectual property of one specialist and employ several hands to assist the specialist in facilitating the treatment plan.

It will be unjust on patients if the judges would apply the Locality Rule on the inefficiency of the health care workers. The omissions are most probably as a result of an unorganised hospital than resource scarcity. The health care workers failed to perform the core duties and review results promptly.

In the Tembani case[89] the defence claimed that the death of the patient was as a result of the negligence of the medical staff and the defence further suggested that the acceptance of the patient in the hospital created a new action or event that interrupted the initial one. The defence was found guilty of the murder. The study does not advocate covering the reason that the hospital was understaffed, without proof. Overcrowding is amongst the examples in South Africa that put a challenge onto the resource allocation of South African Government. The study believes that such circumstances should be considered with caution as the state and executive have legal duty to

[89] S v Tembani 2007 SACR 355 (SCA)

ensure that proper resources are put in place in the facilities. Institution that fail to provide reasonable standard of care due to resource constrains can be found liable for negligence under the principle of Novus Actus Intervenes.[90]

4.2.4 Critical discussion of Oppelt[91] in context with the Locality Rule

Oppelt

The study would like to divert the attention to the minority judgement by Judge Cameron. In context with the Locality Rule, there was no negligence, based on the grounds of justification:

A patient in the institution with a specialist orthopaedic surgeon present; attributable to the internal decision, the surgeon did not perform the procedure applicable to the patient. The decision not to perform the procedure, was in the patient's best interest.

The decision for the patient was by average doctors who are not specialists in that field. The concern of the special circumstances was also raised when the doctor indicated the pressure they encounter to establish a solution after two institutions were contacted and calls received. Established by the volume of doctors' work, they are less likely to make good decisions constantly.

Judge Cameron indicated that the doctor is not judged on performance excellence but on the performance of an average doctor. Quoting the case of "Michell v Dixon, A medical practitioner is not expected to bring to bear upon the case entrusted to him the highest possible degree of professional skill, but is bound to employ reasonable skill and care and he is liable for the consequences if he does not."

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[90]Unreported Member of Executive Counsel Eastern Cape and Ongezwa Mkhitha (1221/15) (2016)

[91] Ibid, 88.

The treatment must be evaluated, concerning the circumstances. The largest reality is that the judiciary tend to turn their back on the ratio of the specialist to patient being immense, possibly affecting the decision-making quality; that reasons why the Locality Rule should be considered in the cases of slow response to one patient in the interest of the public. What are the special circumstances in these cases?

The specialist at Groote Schuur Tertiary Hospital did not perform the procedure as the hospital did not hold skills needed by the patient. The decision by the speciality at Groote Schuur is consistent with the HPCSA ethical rules and legal principle of *Imperitia culpae adnumeratur* in the Locality Rule.

Judge Cameron indicated that the circumstances in this case prevailed that the time the patient was treated confirms the four hours cut-off theory of the specialist. Dr Newton's theory was not published yet and was thus not regarded as accepted by the medical professionals during the case

Mr Oppelt found himself in these circumstances. The situation holds resources, based on the locality at that time the service could be offered to him timeously. This is not perceived as negligence but as resource locality and/or similar circumstances where the Locality Rule was raised by the minority judges. The research supports the decision.

This is a case where it can clearly be established that the courts do not regard protocols as legislature. If the court believes that a process reasons injustice, it can regard the protocol as invalid. Conversely, the option that the practitioners chose, was consistent with another school of thought, supported by Prof. Carstens: "*Where there are more than one school of thought or medical opinion about the indicated procedure or technique to be applied to or inversion to be performed upon a patient, the attending physician is obliged to meet the required standard established by the practitioner who subscribe the particular school of thought of thought. The attend physician who opt out for a choice between different but*

acceptable school of thought is not negligent even though the school of thought might be of an acceptable or respectable minority in the medical profession."[92]

The following resource constrains were raised by the respondent: The helicopter was meant for the public and not for specific events. The patient on the road take precedence over the patient in the hospital.[93] The defence failed to adduce evidence to proof that the helicopter was busy elsewhere.

The Vermeulen[94] case is an example of special circumstances where the court ruled in favour of the hospital. It was said: *"Medical practitioners are facing on slaughter on medical negligence claims for unfortunately outcomes beyond their control because outcomes are caused by locality factor*."[95]

[92] Carstens & Pearmain (2007) 623.

[93] Ibid, 88 para15.

[94] Medi-Clinic LTD v Vermeulen 2015 (1) SA 241 (SCA)A.

[95] Bryn de Danielle, Carstens PA (2016) "*Lack of access to equal public health care and the locality rule in South Africa: a comparative study" 3.*

CHAPTER 5: CONCLUSION AND RECOMMENDATIONS

The Locality Rule encounters severe criticism in its formulation, differentiating standard of care and skill between medical practitioners in cities and those in rural locations. Provided the uniformity of training of doctors in the various institutions in the country, it is fair to submit that distinction medical professionals according to their geographical locality, is unjust.

The law cannot disregard similar circumstances of the Locality Rule when health care workers in South Africa still encounter immense challenges of inequality, whilst distributing health care in geographic areas and the patient ratio. Literature indicates that the South African Law and Ethics unanimously proposed prerequisites in using the rule as a defence. Failure to meet these prerequisites causes the likelihood of the courts to accept such as extreme.

It thus indicates that periodically, the rule can be used as a defence. It needs to be qualified, using HPCSA, National Health Act, the Constitution's guidelines and reasonable resources available in the institution. In conclusion, determining whether the decision is just, reasonable or logical, is the court's responsibility to assess.[96] The Locality Rule should be a rule of exclusion. Practitioners should be able to rely on this rule when encountering substandard care, attributable to resource constrains, but does not preclude the administrators. Administrators have an advanced function, ensuring hospitals are properly resourced. Failure to comply with this requirement, may hold them liable.

Alberts indicates that the Locality Rule in South Africa should not be classified according to geographic area[97] but rather suggests special circumstances as stated by Prof. Carstens.

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[96] Michael v Linksfield Park Clinic (Pty)Ltd 2001 (3) SA n88 (SCA).

[97] Alberts ANJD (2016) "Locality rule in the South African Public Health System. Observation and Application" 55.

Proper strategies should be put in place to minimise resource scarcity as suggested by the research work by facilitating recruitment strategies, creating conducive environment reasonable well equipped with relevant equipment managing the hospital administratively.[98]

The Locality Rule will only disappear with an equal distribution of health care services across the country. Disregarding the reality of the system, whilst applying punitive compensation, will cripple a system that is already on its knees. Concerns, such as an overused budget, corruption and maladministration influence negligence. South Africa realises that a wholesome vision for the country may be destroyed, despite aiming to ensure health care access, if stringent measures are implemented without recognising the history of the status of health care pre-1994 and post 1994.

If the number of patients, concerning the health care worker is restricted (based on standard requirements), fewer patients will have access to consultations, whilst more patients will die or suffer morbidities. Cases are judged without considering such difficulties. It is high time that the court judges cases on the reality and not on the textbook, presenting a perfect scenario.

Whilst considering the reality of health care services in South Africa, it is still the state's duty to ensure that inequality is addressed progressively. As Schutz JA indicates in the case of Durr v Absa Bank Ltd[99] "…in real life negligence it is not a mere legal abstraction but must be related particular facts".

> "*Every time the Locality Rule is used as a dense all relevant facts should be considered and from both clinical and administrative point of view as negligence could emerge from either [party].*"

The HPCSA should dedicate their time into drafting the regulation that addresses the scope of practice of general practitioners.

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[98]Moyimane MB et al (2017) PAMJ 71.

[99] 1997(3) SA 448 (SCA).

The STATE should take reasonable steps to ensure that people in rural areas obtain equal access to primary health care and specialised health care. This can be realised by advancing accreditation and financing of academic institutions within the provinces. Decentralisation of resources can assist with eradicating the influence of locality on access to health care.

CUSTOM LOCALITY is the danger that every practitioner must be aware of. The HPCSA has placed mitigation by requesting Health Care workers to have Continuous Professional Development. Access to media and internet mitigate against such. The custom Locality Rule brings about issues of school of thoughts. Certain customs make follow school of thought no longer recognised as standard because of advancing medicine or evidence-based medicine. For one to use custom Locality Rule as a defence they must ensure that the custom is still recognised as standard by their peers. As much as custom can be influenced by local challenges it must not be out of scope with standards, policies and patient safety regulations.

Custom that transgress standards of the profession put the professional at risk of negligence. I thus recommend that the practitioner do away with custom locality and embrace evidence-based medicine together with standards established by their professional bodies. Nothing stays the same and evolution of health care make health safe, effective and efficient.

STANDARD OF CARE

I recommend that the use of standard by the court be upheld. The courts are not there to create the health standard but all that they do is to reinforce the existing professional standards. Contributing factors such as school of thoughts, emergency, hindsight, location, should considered when presiding on a negligence case. Standards applies from the practitioner up to the administrators.

One must recognise the danger of stringent application of guidelines can be to the detriment to the community if is not modified to suit the needs of such community.

RESOURCES

An institution is expected to provide serviced that within standards that it is accredited for. The practitioner is expected to provide services to the standard and skill that they are trained for. It is important that the practitioner use their discretion based on the condition of the patient when deciding on the mode of transport and the area of referral. We should not use blanked method when interpreting institutional policies.

JUDGEMENT OF NEGLIGENCE CASES

Giesen[100] clarifies that no profession is above the law. The balance of probabilities must always be considered, when presiding over civil claims for medical negligence. The court is the final arbiter of what constitute reasonable [considering] the evidence leads and the expert opinion.

CONSTITUTION

It instruct the state to ensure that there is access to health care. This means that the state can be held to liable for failing to take reasonable steps to ensure that there is access to health care services in the rural areas. The Constitution does not state that all people can access health care for free but it gives the state the responsibility to develop policies that will make it easy for everyone who is in South Africa to be able access health care.

The wellbeing of the staff and their productivity depends on their working conditions. Some circumstances in the public localities are a breeding ground for professional error of judgement; failure to write legible notes, delay in administering emergency treatment due to staff shortage, long working hours and inadequate resources.

National Health Insurance (NHI).

This is a way of increasing health revenue in public health service. This will assist the health sector to escape the rat maze of inadequate funding. If funds received by NHI,

[100] Giesen (1988) 94.

are not properly managed it can have a ripple effect on the state of healthcare. More people will have to rely on state services, and that will add on more people with deficient quality of health who cannot afford private healthcare.

Private healthcare will still be a choice for patient. The service might be more expensive as it will be servicing smaller numbers than before. The efficiency of private health care ensure that services are provided faster to those who need efficient system to ensure that illness do not impact on productivity. The introduction of NHI might leave the system with more waiting times and more mandatory interdict to the state for service.

The NHI will expand healthcare services to everyone equitably and fairly. The state will no longer have to service the sicker with little budget. The health care GDP budget will be shared amongst everyone equitable, unlike the current status where haves are subsidised more than they have not.

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