

CHAPTER 4

Medical Negligence

1. Introduction

Strauss¹ explains with regard to the scope of medical malpractice law that it is not narrowly confined to the instances where liability flows from professional negligence only,² but also includes various other causes of action. He mentions that liability for assault;³ liability for the invasion of a patient's privacy;⁴ liability for the performance of an altogether unnecessary operation⁵ and also liability for breach of contract⁶ are all possible grounds for litigation. When malpractice liability is therefore considered, one should always keep in mind that a medical professional could principally be held accountable for damages based not only on delict but also on a contractual basis.⁷

Professional liability is therefore defined⁸ as an individual's accountability before a court of law which may take the form either of a civil judgement for delictual damages⁹ to compensate for harm wrongfully caused, or of a civil judgement compelling him to refrain from continuing with an unlawful course of action, or of a criminal conviction for an offence which was found to have been committed. The scope of the thesis, however, is restricted to civil liability.

¹ 1991. **Doctor, patient and the law** JL van Schaik (3rd edition), 243.

² as is often believed.

³ *ie* treatment/ performance of a medical intervention with proper skill and proficiency, but without the patient's informed consent - see ch 5 on liability for not obtaining an informed consent.

⁴ *eg* an unwarranted disclosure of medical information of a patient to outsiders, especially relevant in cases of genetic/ hereditary diseases where there are often relatives with vested interests in the results of genetic tests - see ch 11.

⁵ even though the physician was not negligent in performing the procedure.

⁶ a breach of contract that causes financial loss (non-patrimonial damages may not be claimed, based on contract) to a patient can constitute liability for such damages - see ch 2 where breach of contract is discussed and also **Administrator, Natal v Edouard** 1990 (3) SA 581 (A).

⁷ see ch 2.

⁸ Strauss *op cit* p 193.

⁹ or contractual.

McLean¹⁰ conveys her thoughts on the philosophy behind medical negligence law:

“Undoubtedly, medicine is seen as a valued social good. The law and society, therefore, might not unreasonably be expected to protect this good from unnecessary or inappropriate challenge. On the other hand, the rights of the individual are valued by law and society, and their vindication can also represent a social good.”

2. Physician-patient relationship

Concerning the precise relationship between doctor¹¹ and patient, Van Oosten¹² explains that it is primarily one of contract,¹³ but that it may also be based on a duty of care¹⁴ flowing from particular circumstances.¹⁵ Considering the fact that the physician and patient are involved in a contractual relationship and taking into account the basic principle of freedom of contract, one could say that both parties are free agents.¹⁶ This fact has the effect that a physician has neither a professional right,¹⁷ nor generally speaking,¹⁸ a legal duty to medically intervene in a patient's life.¹⁹

¹⁰ 1989. *A Patient's right to know - Information Disclosure, the Doctor and the Law* Dartmouth - Medico Legal Series, 7.

¹¹ or hospital - see vicarious liability discussed *infra*.

¹² 1991. The Legal Liability of Doctors and Hospitals for Medical Malpractice. *SAMJ* (80), 23.

¹³ *Correia v Berwind* 1986 (4) SA 60 (Z) 63 - the contractual relationship between physician and patient is discussed in ch 2 (in most cases the patient and doctor enter into a contract of letting and hiring of work, or *locatio conductio operis*).

¹⁴ if a physician fails to execute a medical intervention with professional , skill (see standard of care *infra*), delictual liability could follow.

¹⁵ eg where a seriously injured person in an unconscious condition is brought to a casualty ward for emergency treatment.

¹⁶ the unreported South African case of *Phillips v De Klerk* 1983 (T), has established the principle that a patient may refuse life-saving treatment.

¹⁷ a physician must obtain the valid consent from a patient to ensure lawful medical treatment - see ch 5 for a discussion on consent.

¹⁸ it is submitted that a physician does, however, have a legal duty to treat a patient in the following circumstances; where the doctor assumes control over a potentially dangerous situation /object; where a physician is under a statutory duty to act; where he is under a contractual duty to act; or where an emergency situation exists.

¹⁹ Strauss, *op cit* p 3.

Specifically in the field of genetic counselling²⁰ one can clearly see the contractual character of the physician-patient relationship.²¹ Parents who request procreative guidance and who are involved in these actions either consult their practitioner concerning birth control in general, or ask his opinion on sterilization options and procedures.²² Alternatively, concerned parents seek professional genetic advice from genetic counsellors or gynaecologists regarding possible genetic abnormalities in their future offspring.²³

Due to the fact that specific instructions are given by patients to the medical professional in terms of a contractual agreement, it is generally possible to base the subsequent action on breach of contract²⁴ or breach of guarantee.²⁵

It is reported²⁶ that whether health care services are provided by state or private hospitals in South Africa, " a doctor who, or hospital which, takes charge of a patient assumes a duty of providing reasonable care of the patient. The duty of care relates to the examination, diagnosis and treatment of patients, and a failure to exercise reasonable care may result in contractual and/ or delictual liability." What reasonable care entails has been established in a variety of local decisions.²⁷

²⁰ and therefore in the realm of wrongful life actions - see ch 5 for a discussion on the scope and general extent of genetic counselling.

²¹ it would be difficult to imagine a wrongful life type case where the physician-patient relationship is based on a *duty of care* not flowing from the contract, as discussed *supra*.

²² in a typical wrongful conception action.

²³ typical wrongful birth and wrongful life actions.

²⁴ in most cases in the form of positive malperformance - good example is found in the landmark South African case of **Edouard v Administrator, Natal** 1989 (2) SA 368 (D), where a provincial hospital has partially performed by conducting a Caesarian section on a patient, but neglecting to perform the desired sterilization operation altogether - see also ch 2 concerning suing for wrongful life on the basis of breach of contract.

²⁵ note the distinction that Berenson, M. A. 1990. The Wrongful Life Claim - The legal dilemma of existence versus nonexistence: "To be or not to be". **Tulane Law Review** (64), 895. reports on in French law, which recognizes a difference between the *obligation de resultat* (where an obligor promises to achieve a particular result) and the *obligations des moyens* (where an obligor promises merely to use appropriate means/ his best effort to achieve the promised result).

²⁶ Van Oosten, F.F.W. 1996. Patient Rights: A status report on the Republic of South Africa. **Law in Motion - International Encyclopaedia of Laws - World Law Conference**, 990.

²⁷ **Van Wyk v Lewis** 1924 AD 438; **Allot v Paterson & Jackson** 1936 SR 221; **Kovalsky v Krige** 1910 CTR 822; **Coppen v Impey** 1916 CPD 309; **Buls and Another v Tsatsarolakis** 1976 (2) SA 891 (T); **Applicant v Administrator Transvaal** 1993 (4) SA 733 (W); **Collins v Administrator Cape** 1954 (4) SA 73

Van Wijmen²⁸ is of the opinion that a patient's position is so special that it should be especially protected by the legislator,²⁹ which would have the additional benefit that the health care providers' position would also improve.³⁰

3. Medical negligence

The South African law of delict is based on a fault principle and in the medical malpractice arena it is usually negligent conduct³¹ that physicians are guilty of.³² If a physician's diagnosis, treatment or any other conduct carried out in his capacity as medical professional is performed negligently³³ and causes the patient physical or mental harm,³⁴ the negligent physician may in principle be held liable.³⁵ As the facts of every case are different, there is in principle no limit to the form negligent medical performance may take. According to Van Oosten,³⁶ negligence implies in any given context:

- that the defendant failed to foresee and guard against the possibility of harm to the plaintiff, and
- that the reasonable person in his position would have foreseen that possibility of harm

(C); *Clinton-Parker v Administrator Transvaal* 1995 (W) - unreported. see discussions on these cases *infra*.

²⁸ 1985. Hoe bijzonder is de rechtspositie van de patiënt? *Nederlands Juristenblad* (17), 541.

²⁹ *eg* by means of a special agreement.

³⁰ "De rechtspositie van de patiënt is bijzonder genoeg om zicht te laten beschermen door een eigen overeenkomst, die bovendien aan de bijzondere positie van de hulpverlener recht kan doen." *op cit* p 547.

³¹ it must be proved that defendant's reprehensible lack of foresight has caused harm to the plaintiff and to establish this, the court apply the test of the "reasonable man" - see *infra*.

³² intentional infliction of harm or loss by a physician is almost unthinkable.

³³ before the question of negligence is relevant, the wrongfulness of the conduct, (implicitly) should already have been established - see ch 2.

³⁴ note that the fact that harm or injury was caused does not *per se* constitute or lead to an inference of negligence and the onus to prove negligence still firmly rests on the plaintiff.

³⁵ Strauss *op cit* p 290: "The law on medical negligence is simple to state: the doctor must exercise reasonable care and skill. What is reasonable in a particular situation, is essentially a matter of expert medical evidence. It is the medical profession which lays down what the appropriate standard of care is."

³⁶ *op cit* p 25.

and would have guarded against it, by taking steps to prevent the harm from occurring.

He³⁷ writes with regard to the fundamental test for negligence:

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

Earle³⁸ reports that the benchmark case in medical negligence in South Africa remains to be **Van Wyk v Lewis**,³⁹ where the Appeal Court accepted that the degree of skill to be expected is the customarily adopted by the relevant branch of the profession concerned and not the highest possible degree.

The basic objective test of the reasonable person⁴⁰ is adjusted in cases where a person professes expertise in a particular field.⁴¹ In such cases the level of care and prudence is raised to the level that could be expected from a fellow professional in the same field, practising under the same circumstances. The test would therefore be that of the “reasonable expert”. It is important to note that a physician will not be compared to an exceptionally brilliant colleague or specialist in the same field, but rather on what could be expected from the average medical practitioner, bearing in mind that doctors are human beings.

If a doctor, however, professes himself to be a specialist in a particular field, his actions will be judged by that of the average specialist in the same field.⁴² Thus, a higher level of competence is expected from these professionals who venture in a particular field of speciality. The fact that a doctor engages in an undertaking that requires a certain degree of experience,

³⁷ Strauss *ibid.*

³⁸ 1995. 'Informed consent': Is there room for the reasonable patient in South African Law? SALJ (112), 639.

³⁹ 1924 AD 438.

⁴⁰ here one must be careful not to confuse the objective *ex post facto* test for wrongfulness, with the so-called ‘test of the reasonable man’ used to establish fault - see ch 2 for a brief discussion on basic tort principles.

⁴¹ *op cit* p 26.

⁴² 1999. Neethling, Potgieter and Visser. **Law of Delict** Butterworths (3rd edition), 135; **Van Wyk v Lewis**.

knowledge, skill or training has the effect that his actions will be judged by the higher degree of prudence⁴³ (whether he actually has the additional skill or not). In wrongful life cases, the defendant is usually a specialist in the field of gynaecology or genetic science, raising the appropriate standard of care and expertise by which his actions will be judged.

Schoonenberg⁴⁴ writes that the determination whether a particular physician acted below the applicable standard of care should be made with reference to the level of proficiency taken on a national level. Michiels van Kessenich-Hoogendam⁴⁵ refers to the Dutch Civil Code section 7:401 in determination of whether a physician has properly carried out his duty of care. He conveys that current circumstances will influence the decision. It is reported⁴⁶ that the *Hoge Raad* has formulated the criteria of “reasonably proficient” and “as a reasonable colleague” in a recent decision.⁴⁷ He explains that while the criterion established in the code is a general standard, the decision of the court could be deemed as the practical implementation thereof.

3.1 Error of judgement

It has been established in the English case of *Whitehouse v Jordan and Another*⁴⁸ that a physician’s mere error in judgement does not necessarily constitute negligence,⁴⁹ which principle is best summarised as follows:

“To say that a surgeon has committed an error of clinical judgment is wholly ambiguous and does not indicate whether he has been negligent, for while some errors or clinical judgment may be completely consistent with the due exercise of professional skill, others acts or omissions in the course of exercising clinical judgment may be so glaringly below proper standards as to make a finding of negligence inevitable.”

⁴³ on account of the rule “*imperitia culpa adnumeratur*” Gaius: Dig. 50.17.132; Inst. 4.3.7; - meaning that ignorance or lack of skill is deemed to be negligence (an excellent discussion on this topic is found in: T.J. Scott *Petere Fontes*: LC Steyn - Gedenkbundel (DJ Joubert, ed) 124).

⁴⁴ Gevers, J.M.K. and Leenen, H.J.J. 1986. *Rechtsvragen rond voortplanting en erfelijkheid* Kluwer - Serie Gezondheidsrecht no.19, 62.

⁴⁵ 1995. *Beroepsfouten* W.E.J. Tjeenk Willink, Zwolle (3de druk), 6.

⁴⁶ *ibid.*

⁴⁷ HR 9 November 1990, NJ 1991, 26.

⁴⁸ (1981) 1 All ER 267 (HL).

⁴⁹ the saying *errare humanum est* - to err is human, springs to mind.

This same principle has also been followed in South Africa courts and specific reference to the **Whitehouse** case was made in **Pringle v Administrator, Transvaal**.⁵⁰ It would therefore seem that where a physician does make an error in clinical judgement, his mistake does not constitute negligence as long as such a misjudgement could also reasonably have been made by any physician under the same circumstances. The conventional negligence test is therefore applied, with the effect that only misjudgements that are obviously/ exceptionally below the standard of care⁵¹ would be classified as negligent conduct.

3.2 Failure to inform

A physician's failure to adequately inform a patient does on the same account not necessarily constitute negligence.⁵² Strauss⁵³ states that such a principle would be anomalous in South African law, as our courts deal with non-compliance of the duty to obtain an informed consent on the basis of assault.⁵⁴ He conveys that "the essence of negligence in the medical context is unskilful treatment."⁵⁵ What is reported,⁵⁶ however, is that liability based on absence of informed consent is, apart from this "traditional medical negligence", the most important and prevalent basis of liability.⁵⁷ Strauss⁵⁸ conveys with special reference to the **Edouard** case:

"A doctor who undertakes a sterilisation and wants to protect himself against liability should take a proper informed consent, in writing, by which the patient and his/her spouse also waives any eventual claim."⁵⁹

⁵⁰ 1990 (2) SA 379 (W).

⁵¹ expected from medical professionals in the particular field of the defendant.

⁵² **Richter v Estate Hamman** 1976 (3) SA 226 (C), **Esterhuizen v Administrator Transvaal** 1957 (3) SA 710 (T) and **Lymbery v Jefferies** 1925 A 236 - ie failure to inform cannot be equated with negligence, as *culpa* entails a failure to foresee damaging consequences and accordingly take steps to avoid such occurrence.

⁵³ *op cit* p 268.

⁵⁴ see ch 5, where the legal consequences of treatment without consent is discussed.

⁵⁵ *ibid*.

⁵⁶ *op cit* p 289.

⁵⁷ it is submitted that this trend has developed as it is simpler to prove a cause of action based on lack of information, than proving negligence on the part of a physician.

⁵⁸ 1990. Unsuccessful sterilisation of woman: Doctor liable for child - raising costs. **South African Practice Management** (11), 16.

⁵⁹ *op cit* p 17.

He declares:⁶⁰ "It must be noted, however, that such a consent will be of no avail if the doctor has forgotten to perform the sterilization, (as was the case in **Edouard**.) The enforceability of a waiver in a case of negligence (in particular where the negligence was "gross") is also doubtful."

A different view has been taken by the English courts.⁶¹ In this case where the facts were very similar to that of **Richter's** case, the physician's failure to supply adequate information was found to have been negligent. *In casu* the patient-plaintiff based her claim for damages on trespass⁶² and negligence.⁶³ The court found that the plaintiff in this case was not only able to prove that the physician had in fact breached his legal duty to inform, but also that his failure has influenced her decision to consent to the medical treatment. Failure to inform a patient of the risks and the implications of a specific procedure, therefore, was deemed to constitute negligence.⁶⁴

Earle⁶⁵ conveys that the nature and extent of the duty to warn a patient of consequences of a surgical procedure as outlined in the **Richter** has been affirmed in **Castell v De Greef**⁶⁶ as embracing the normal and expected consequences.⁶⁷ Van Oosten,⁶⁸ reporting on the **Castell** decision explains that Ackermann J. found that there is not only a justification, but indeed a necessity for introducing the patient-orientated doctrine of informed consent into South African law. The learned judge also made it clear that "the issue of the doctor's duty of disclosure is in South African law... treated not as one of negligence, rising from the breach of a duty of care, but as one of consent to the injury involved and the assumption of an unintended risk. In the South African context the doctor's duty to disclose a material risk must be seen in the

⁶⁰ Strauss *ibid*.

⁶¹ **Chatterton v Gerson and Another** (1981) 1 QB 432 at 443 D.

⁶² no consent was obtained prior to the medical intervention.

⁶³ that the physician's provision of information was below the standard required from a reasonable physician.

⁶⁴ it is reported *ibid* that a similar viewpoint to that of the English has been followed in America.

⁶⁵ *op cit* p 639.

⁶⁶ 1994 (4) SA 408 (C) - see ch on informed consent.

⁶⁷ Earle *ibid* draws special reference to the fact that the **De Greef** court affirmed the English cases of **Sidaway** and **Bolam** - see previous fn.

⁶⁸ 1996, *op cit* p 995.

contractual setting of an unimpeachable consent to the operation and its *sequelae*.⁶⁹

It is further reported by Earle, regarding the duty to inform, that the important **Castell** case applied the principle laid down in **Lymbery v Jefferies** in that it is not necessary to inform a patient of *all* complications which could possibly arise from a procedure as informed consent implies a certain sophistication on the part of the patient which is an indeterminate factor. He summarises:⁷⁰

"The doctrine of informed consent suggests that a doctor's role is simply to inform, whereas knowledge of the patient should be the emphasis. In communication terms, this would mean that ideally the practitioner would take steps to become aware of how much information the patient requires for his or her decision to have been adequately informed."

Earle⁷¹ supports a middle ground approach between the strict American view on consent and the "physician-based gospel" followed in the English cases of **Bolam** and **Sidaway**. The correct perspective, according to Earle, would therefore be that the normal intelligent patient would want an objectively reasonable explanation of the risks involved according to a patient-based standard.

Pearson⁷² affirms the principle that increased knowledge involves greater responsibility. Physicians should take the duty to inform seriously and take note of the maxim: "the more information given, the less the scope for liability." It is once again commented that: "It is indeed the provision of information that is the central theme in the wrongful life (and, it is submitted, wrongful birth) cases".⁷³

3.3 Negligence in genetics/ birth control

In medical law therapeutic procedures⁷⁴ have traditionally been favoured above non-

⁶⁹ *ibid.*

⁷⁰ *op cit* p 642.

⁷¹ *ibid.*

⁷² 1997. Liability for so-called wrongful pregnancy, wrongful birth and wrongful life. **South African Law Journal**, 94.

⁷³ *op cit* p 106.

⁷⁴ *ie* medically necessary procedures, *eg* an abortion where the mother's life would be placed in danger if the pregnancy would continue, or where a sterilization operation is performed to prevent the conception of a seriously handicapped foetus.

therapeutic interventions⁷⁵ (where legal requirements of skill and care are generally more stringent).⁷⁶ It is therefore important that patients consenting to non-therapeutic interventions should adhere to all the requirements for legal consent.⁷⁷ As procreative interventions could mainly be classified as non-therapeutic, one could likely make the inference that a more demanding application of skill and care would be expected by the courts than would normally be the case.

An interesting aspect with regard to wrongful conception liability in South Africa is the diverse reasons⁷⁸ and motivations for which sterilization or abortion is requested. It has been pertinently decided⁷⁹ that only patients who have sought sterilization⁸⁰ for economic reasons would be entitled to institute a wrongful conception action locally. Although such procedure would therefore not technically be considered a therapeutic intervention, it is submitted that sterilizations for economic reasons should also be acknowledged as having a similar legally justifiable object.⁸¹

⁷⁵ ie interventions consented to for reasons other than medical necessity or benefit, eg abortion because of an untimely/ unplanned pregnancy.

⁷⁶ as illustrated by the requirements for abortion in the **Choice on Termination of Pregnancy Act**, Act No. 9 of 1996, see ch 3 - note that increasingly stringent prerequisites are demanded for termination as the pregnancy progresses. Initially so-called "eugenic" abortion on demand is acceptable, whilst therapeutic motivations are required for more advanced pregnancies.

- 2(1) A pregnancy may be terminated -
- a) upon request of a woman during the first 12 weeks of the gestation period of her pregnancy;
 - b) from the 13th up to and including the 20th week of the gestation, if:
 - (i) the continued pregnancy would pose a risk of injury to the woman's physical or mental health; or
 - (ii) there exists a substantial risk that the fetus would suffer from a severe physical or mental abnormality; or
 - (iii) the pregnancy resulted from rape or incest; or
 - (iv) the continued pregnancy would significantly affect the social or economic circumstances of the woman; or
 - c) after the 20th week of the gestation, if:
 - (i) would endanger the woman's life;
 - (ii) would result in a severe malformation of the fetus; or
 - (iii) would pose a risk of injury to the fetus.

⁷⁷ such as the requirement that the infringement must be legally justifiable and in accordance with the *boni mores*: non-therapeutic procreative procedures such as sterilization and contraception is undoubtedly acceptable in terms of current societal perceptions, as the importance of family planning and small families becomes increasingly compelling.

⁷⁸ therapeutic or non-therapeutic.

⁷⁹ **Administrator, Natal v Edouard** 1990 (3) SA 581 (A).

⁸⁰ the same principle applies to abortion.

⁸¹ falling in the same category as therapeutic procedures.

Strauss⁸² reports that a physician who is instructed to provide a specific task⁸³ is faced with a different mandate than the normal run-of-the-mill complaints of ailments. He explains that if the physician "departs from the patient's express instructions or fails to treat him in the manner tacitly agreed upon, the physician will be guilty of breach of contract and may be sued for damages".⁸⁴ It is obvious that a special risk of liability is assumed by the physician if he guarantees the successful outcome of the procedure.⁸⁵

3.4 Diagnostic errors

Medical science has developed much over the past few decades and especially in the field of genetic research, great breakthroughs have been achieved.⁸⁶ The knowledge of human genes and cells has increased dramatically, but in spite of this many experts believe that we now know only a fraction of what there is to know.⁸⁷ The importance of research in this field is magnified by the expected control that scientists could have⁸⁸ over general human weaknesses and genetically transferred diseases. All the medical prospects made possible by advanced genetic information are currently not even conceivable. Scientists believe that prenatal operations and treatment⁸⁹ for genetic impairments will be possible, as well as genetic manipulation of cells whereby unwanted characteristics or hereditary diseases may be

⁸² *op cit* p 288.

⁸³ such as plastic surgery or, it is submitted, genetic counselling/ birth control.

⁸⁴ *ibid.*

⁸⁵ see ch 2 for a discussion on guarantees.

⁸⁶ consider the recent debacle surrounding the first successful cloning of the sheep "Dolly" and also reports of planned human clones in the near future.

⁸⁷ see medical ch 11.

⁸⁸ if sufficient knowledge and expertise have been obtained (in the maybe not so distant future).

⁸⁹ If prenatal genetic treatment would be possible and successful in future, a new legal duty may be introduced in terms of which parents and physicians alike (and possibly even the state) will have to take positive steps in "curing" or "rectifying" the expected genetic disease detected in a foetus, in order to escape liability. Under these conditions wrongful life actions as we know them now will be outdated and the plaintiff-child will base his/her action on a real and feasible right "to be born with a sound mind and body". The difference between this type of action and the current wrongful life action would be that the plaintiff will not argue that it would be better for him not to have been born, but rather that he had the legitimate expectation (and real possibility of an attainable goal) to be born without any genetic impairment whatsoever. There would probably also be much less legal opposition and discussion in allowing these actions, since it would be based on traditional/ general delictual principles. These cases could in theory be treated like any other where a person is caused harm through the negligent or intentional conduct of another.

rectified.⁹⁰

Andrews⁹¹ reports on financial support by the United States Congress of \$3 billion for the "Human Genome Project". This project has the goal to establish the position and pattern of each of the 50 000 to 100 000 genes found in a single human cell. With the newfound knowledge derived from this project, scientists expect to be able to detect and cure up to 5000 genetic ailments.

Others⁹² have also made mention of this project and believe that the insights and technology which it has generated create new opportunities for the early diagnosis of patients and the identification of carriers of chromosome abnormalities and gene mutations. The next step would be to determine the function of each gene and also the composition of the protein produced by it. Such knowledge could then be used to develop new therapeutic techniques. To date, about 6 000 genes have been described and located. Associated hereditary disorders have been described for about 3 000 of these disorders which are associated with mutations in those genes.

The suggestions that extraordinary advancement in medical science has only exposed how little we actually know of the human body emphasises the fact that diagnosis of hereditary weaknesses and genetic aberrations is not a simple task and it is not uncommon that genetic malformations are overseen and an incorrect diagnosis accordingly made. It should be remembered that wrong diagnosis by itself does not constitute a cause of action and only once a patient has suffered loss or injury because of consequential incorrect treatment/ genetic advice and has succeeded in proving that the physician's conduct was negligent in the particular instance,⁹³ will liability follow.

3.5 In South Africa

In the South African case of *Mitchell v Dixon*⁹⁴ it was confirmed that a physician can only be

⁹⁰ liability flowing from actions that might arise from these medical advances, however, does not fall within the scope of this study.

⁹¹ 1992. Torts and the Double Helix: Malpractice Liability for Failure to Warn of Genetic Risks. *Houston Law Review* (29:1), 149.

⁹² Anon. 1994. Genetic screening. **Report: Health Council of the Netherlands: Committee Genetic Screening** (Publication no. 1994/22E).

⁹³ all elements of delict/ contract must be proved, depending on what basis the action is instituted - see ch 2.

⁹⁴ 1914 AD 519.

held liable if a diagnosis is so apparently/ obviously wrong that it not only encompasses a mistake, but also negligence.⁹⁵ Strauss⁹⁶ refers to other cases⁹⁷ of similar view and writes that:

"If a doctor were to fail in observing proper standards of care in examining a patient or if the doctor knows he is not properly equipped at all to make a proper examination, and fails to refer the patient to a colleague who is so equipped, the doctor may of course be held liable."⁹⁸

3.6 Accuracy of tests

An important aspect relevant to proper diagnosis involving modern genetic expertise, is the question whether genetic tests are "accurate enough"⁹⁹ to be used in detecting genetic anomalies. In **Simmons v West Covina Medical Clinic**¹⁰⁰ a physician was excused by the court for not suggesting the possible performance of a "AFP" test¹⁰¹ to the parents of a child later born with *Down's syndrome*. Although the test posed no risk to the foetus, the court found that there was no duty on the defendant to suggest such a test being carried out, because of the relative inaccuracy thereof. The court found that a mere 20% accuracy for detecting the disease was not sufficient and laid down a minimum of at least 50% accuracy for similar tests

⁹⁵ ie that the mistake is of such a nature as to imply an absence of reasonable skill and care, taking into account the ordinary level of skill and competence in the profession.

⁹⁶ *op cit* p 253.

⁹⁷ **Blyth v Van den Heever** 1980 (1) SA 191 (A), where the Appeal court held a physician liable for the losses caused by an incorrect diagnosis of an impending *ischemia* in the arm of the plaintiff - also **Dube v Administrator Transvaal** 1963 (4) SA 260 (T); **Buls v Tsatsarolakis** 1976 (2) SA 891 (T).

⁹⁸ this comment has an obvious application to wrongful life cases, where a general practitioner may not have the required expertise or specialised equipment to perform genetic tests, which could lead to an incorrect diagnosis - Strauss *ibid* continues his discussion on mis-diagnosis and explains that: "It must also be pointed out that a doctor may be held liable for failure to inform a patient of the diagnosis, where the circumstances are such that it would be reasonably necessary to inform the patient in order to bring to his attention the need of taking certain precautions or to take certain positive measures to protect his health."

⁹⁹ it is submitted that it would be fair to reason that if a certain test is too unreliable and inaccurate, its usefulness in the implementation of genetic diagnosis could be questioned and no action for wrongful birth or wrongful life could be based on it: the question remains, however, what precisely is "too unreliable".

¹⁰⁰ 260 Cal. Rptr. 722, 755 Ct. App. (1989).

¹⁰¹ alpha-feto protein test - see ch 11 where the so-called "triple test" is discussed which involves the measuring of the levels of *alphafoetoprotien*, hCG and *oestriol*.

in order to establish a duty¹⁰² on physician to apply it that would be recognized by the courts.¹⁰³

Strauss¹⁰⁴ discusses whether a gynaecologist would incur liability for damaging a foetus while performing genetic testing procedures, such as an amniocentesis with proper skill and care.¹⁰⁵ He is of the opinion that, because the risk to the mother and foetus is very slight¹⁰⁶ and since the objective sought is "scientifically, medically and socially recognized as not only fully justifiable, but indeed commendable", a physician would therefore not incur liability if the procedure was properly performed. Another factor that would support the view against liability would be the fact that there are no alternatives to a specific test that would enable the physician to make the same accurate diagnosis.

3.7 Incorrect prescription of medicine

Meyer¹⁰⁷ writes that in the light of present knowledge as to the possibly tragic consequences of the administration of drugs such as thalidomide to pregnant women, the holding as to foresee-ability in previous cases should serve as a warning to doctors and pharmacists to exercise the utmost caution when prescribing medicines to women whose status and condition are not known to them.

3.8 Prevalence of genetic disorders/ value of tests

The new/ extended information available to geneticists will probably also create an extended duty to inform patients and clients of additional risks of genetic disease or of a more accurate interpretation of tests done in the past.¹⁰⁸ The following questions will invariably arise: who will

¹⁰² a duty on defendant to suggest such a test from being performed or at least a duty to inform parents of the existence of such test.

¹⁰³ It is submitted that courts dealing with the science of genetics should realise that percentages are often minute, due to the extreme complexity of human genetic maps, emphasized by the relative little knowledge we currently possess. Calculations are therefore often not precise, but rather "informed guesswork." Some diseases are also very rare, but so serious that genetic screening is sometimes obligatory, eg tests for *phenylketonuria*, found only once in every 12 000 to 15 000 newborns - see ch11 for a discussion on this condition.

¹⁰⁴ *op cit* p 194.

¹⁰⁵ see medical ch 11.

¹⁰⁶ it is accordingly submitted that such a risk would be lawful.

¹⁰⁷ 1963. A Delictual Remedy for the Unborn Child. *South African Law Journal*, 449.

¹⁰⁸ refer to ch 5 on informed consent.

be expected to provide and communicate the newly interpreted genetic results and to what variety of groups of people with a legitimate interest to be informed? Andrews¹⁰⁹ is of the opinion that traditional health care workers are not the solution for this enormous task and suggests that societal mechanisms may be more effective in this respect.

Strauss¹¹⁰ agrees that liability involving negligence in respect of contraception, sterilization, genetic screening and abortion has become increasingly prominent. He believes that modern methods of genetic screening not only raise many difficult legal, but also ethical questions which are to be answered by ethicists and lawyers.¹¹¹

Fain¹¹² is of the opinion that because most genetic diseases and birth defects are from an individual viewpoint quite rather rare, their cumulative prevalence is not fully appreciated. He writes that over 3000 genetic diseases have been catalogued up to date and that approximately 5% of all newborns suffer from a major or minor malformation of some sort. The relevance of these statistics to wrongful life actions generally is emphasized by the fact that genetic disorders and diseases are so commonly found in society today, that of all the children admitted to pediatric wards, 25%-30% have an underlying genetic disease, chromosomal disorder or birth defect. Fain¹¹³ stresses that until the late 1960's, methods of detecting genetic disorders were very inexact but have fortunately improved drastically in the past few years.¹¹⁴ He writes that amniocentesis and karyotype analysis of foetal cells have made the detection of *Down's syndrome* and many other chromosomal abnormalities almost routine.

Fain¹¹⁵ is convinced that the modern tests available to concerned parents are accurate enough to be used and trusted with confidence. Amniocentesis tests, *fetoscopy* analyses and ultrasound probing head the list as most widely recognized prenatal examinations. Approximately 60 genetic disorders can at present be accurately detected through an amniocentesis and the number is ever increasing with each new application discovered by breakthroughs in technology.

¹⁰⁹ *op cit* p 151.

¹¹⁰ *op cit* p 196.

¹¹¹ *op cit* p 203.

¹¹² Fain, C.F. 1987. Wrongful Life: Legal and Medical Aspects. *Kentucky Law Journal* (75), 585.

¹¹³ *ibid.*

¹¹⁴ see ch 11.

¹¹⁵ *ibid.*

Medical workers and geneticists utilize an assortment of instruments and data bases to estimate the chances of a given couple parenting a child with a particular disorder: they could review old medical records; take comprehensive medical histories of both parents and blood relatives and finally do a battery of tests¹¹⁶ after which counselling, based on the total picture, follows.

It is extremely important that counselling, in whatever form it may be, should be based on the aggregate of all relevant facts discovered and that all facets of the patient's individual, religious, cultural and financial, as well as family interests should be taken into account.¹¹⁷

Although prenatal testing is usually safe for both the mother and the foetus, there have been isolated instances of needle damage to the foetus, miscarriages and bleeding where amniocentesis have been performed.¹¹⁸ For this reason it must be stressed, that in order to gather and analyse data properly, the physician should possess special/ superior skills in performing these potentially dangerous procedures.¹¹⁹

3.9 Medical standard of care

Much have been said about the appropriate standard of skill and care a medical professional should adhere to in practice. It should be noted that the standard of skill required is not the highest possible degree of professional skill, but rather "reasonable" proficiency.¹²⁰

Earle¹²¹ writes that if legal negligence is based on a professional standard, that standard might be prone to lowering in order to protect the profession from within against medical malpractice liability. For this reason, Earle states, proponents of the objective tests advocate a 'prudent patient' test.¹²²

3.9.1 Diagnostic errors

¹¹⁶ see p 11 where the various genetic test are discussed.

¹¹⁷ see ch 5 on informed consent.

¹¹⁸ see ch 11.

¹¹⁹ see *supra*, regarding medical negligence and the higher level of competence required from specialists.

¹²⁰ **Buls and Another v Tsatsarolakis** 1976 (2) SA 891 (T).

¹²¹ *op cit* p 641.

¹²² such as was introduced by the Richter case.

Fain¹²³ predicts that since parents rely more and more on genetic information to guide their procreative decisions, it seems likely that diagnostic errors will pave the way for increased litigation based on this tort. He writes that the St. Paul Companies (America's largest medical malpractice insurer) found that failure to properly diagnose patients was alleged in 25% of all malpractice cases filed. The American Department of Health, Education and Welfare similarly found that 25% of all claims filed and 50% of claims filed against internists and general practitioners, involved diagnostic errors.¹²⁴ In malpractice cases based on non surgical errors, claims involving insufficient testing were the highest in number. Fain¹²⁵ foresees that as new technology is developed, physicians will be forced to keep abreast of the times, by correctly applying the new techniques and procedures with the proper standard of care in order to escape liability.

Kortmann¹²⁶ gives various suggestions why more and higher claims are awarded against medical practitioners, some of them are: he believes patients have become more aware of their rights, and also more critical; the relationship between patient and physician has changed in the sense that it has become more business-like; he suggests that we live in a culture of "passing-the-buck",¹²⁷ where no one expects to carry his own losses.

3.10 In the United States of America

For physicians in the United States of America, the recognized standard of care has been the "standard of professional competence and care customary in similar communities".¹²⁸ An increasing number of courts in America, however, rule that a minimum national standard should be applied, especially in the case of specialists.

It is submitted that physicians should be up to date with current medical developments and aware of any new causes and forms of genetic diseases and other circumstances or conditions that could engender birth defects. This necessity is even more obvious in cases where the parents are existing patients of a particular physician requiring a medical opinion concerning the matter of family planning.

¹²³ *op cit* p 623.

¹²⁴ supporting the facts and trends found by the medical insurers.

¹²⁵ *ibid.*

¹²⁶ 1995. Beperking van de (verhaals-) aansprakelijkheid van de vrije beroepsbeoefenaar. *De Naamloze Vennootschap* (73), 14.

¹²⁷ "afwentelingscultuur".

¹²⁸ called the "locality rule".

3.11 In the Netherlands

Hondius¹²⁹ considers what the correct standard of medical care in the Netherlands should be. He refers to a decision of the *Hoge Raad*¹³⁰ which stated: “*De zorgvuldigheid die van een redelijk bekwaam en redelijk handelend specialist mag worden verwacht*”,¹³¹ or the care expected from a reasonably skilled specialist acting with reasonable proficiency. The statutory regulation on medical treatment agreements or “WGBO”¹³² states: “*De hulpverlener moet bij zijn werkzaamheden de zorg van een goed hulpverlener in acht nemen*” or a medical assistant should exercise his level of care in accordance with that of a good assistant. This standard seems to be in accordance with the globally expected level of professional proficiency.

3.12 Types of negligent genetic counsellors

Fain¹³³ mentions that it is difficult to classify the various possibilities of inappropriate conduct by geneticists into definite stereotypes and accordingly rather places the physicians themselves into varying classes of effectiveness to illustrate different possibilities of negligence. He does so, in the following manner:

3.12.1 “Out-of touch practitioners”

These are practitioners who have lost touch with modern techniques and procedures or who, in respect of a certain conduct, have acted below the current standard of competence by applying dated techniques or by prescribing obsolete medication or treatment. Under wrongful life circumstances, it could be possible that pertinent genetic data is not obtained because conventional/ outdated tests are utilized instead of applying more accurate modern tests. A physician guilty of such misconduct is more likely to be held liable for negligence, if damage should result, than a physician keeping up with medical science. Malpractice is determined

¹²⁹ 1995. De privaatrechtelijke positie van de patiënt in Europees perspectief. *Tijdschrift voor Privaatrecht* (32:4), 1687.

¹³⁰ 1990 (9 november) Hoge Raad (NJ 1991, 26).

¹³¹ and also: “*De hulpverlener moet bij zijn werkzaamheden de zorg van een goed hulpverlener in acht nemen.*” translated - an assistant should exercise his level of care in accordance with that of a good assistant.

¹³² “*Wettelijke regeling van de geneeskundige behandelingsovereenkomst.*”

¹³³ *op cit* p 624 90.

where the physician neglects to acknowledge an ever-changing standard¹³⁴ of medical practice. Physicians, for example, who fail to at least mention the possibility/ availability of a genetic evaluation because of mistrust in modern tests to a 35-year old¹³⁵ mother-to-be, should be found to have acted "below the standard of care expected from physicians in general".

3.12.2 "Reluctant practitioners"

They are physicians who are unwilling to embrace the relevant medical standard of care at any given time. An example of such conduct would be where physicians do not employ or advise the application of foetal monitors during childbirth even though monitoring is at that stage customary in the profession. This conduct could lead to legal responsibility, unless the court is convinced that foetal monitoring is not a standard procedure within the medical profession. Such physicians contest conformance with conventional practice by asserting that their refusal to employ such measures is reasonable. They might assert application of the "best judgement" rule¹³⁶ in support of their actions or inactions.

3.12.3 "Faithful followers"

This group of doctors embrace every medical procedure that exemplifies the prevailing current trend or direction in the medical profession. They generally adhere to acceptable practice and argue that others have laid the research groundwork necessary to support the particular current medical procedure. A problem might evolve where they depend so heavily on new/ breaking technology, that they abandon other more conventional, but effective and proven diagnostic checks and balances. Under such circumstances, for example, faulty laboratory tests may go undetected as in **Curlender** case.¹³⁷

3.12.4 "Innovative physicians"

This group of doctors is delighted and intrigued by all new techniques, equipment, diagnostic tools and procedures, even though these new developments have not necessarily yet been accepted by the mainstream medical profession. If a particular procedure has not garnered significant support in medical periodicals and in medical circles, these physicians might find

¹³⁴ as medical technology advances, the knowledge of diseases and conditions is broadened and new medicines/ treatments are accordingly developed as new research is done - a prudent physician is expected to keep in touch with these new developments.

¹³⁵ taking into consideration the (now) well established fact that the possibility of *Downs' syndrome* increases dramatically in mothers older than 30 years of age - for further information on this premise, see ch 5.

¹³⁶ see the discussion of medical paternalism v patient autonomy *infra*.

¹³⁷ **Curlender v Bio-Science Laboratories** 106 Cal. App. 3d 811 (1980), where personnel were not familiar with new testing procedures.

themselves liable if damage should result from the implementation of such new procedures. In such instances, physicians may not even be fully protected by complete disclosure of the experimental nature of the procedure, because of public policy¹³⁸ reasons.

3.12.5 Keep in pace

Leenen¹³⁹ acknowledges the fact that new methods for genetic diagnosis and therapy are constantly being developed. He warns that physicians must in this regard embrace the expected medical-professional standard, while patients' interests should be highly considered. Physicians should also conduct themselves in subjection to the current social norms. He believes that this application is primarily important for genetic counselling and genetic screening.

3.13 A Dutch perspective on medical negligence

Legemaate¹⁴⁰ writes with regard to wrongful conception actions for failed sterilization procedures that certain questions should be asked to determine the true basis of liability. He is of the opinion that these questions could assist in determining in what way the physician in question acted negligently:

- *Is de diagnose juist gesteld? Heeft er voldoende onderzoek plaats gevonden om op een verantwoorde wijze tot een diagnose te kunnen komen?*¹⁴¹
- *Welke behandeling is er, gegeven de diagnose, geïndiceerd?*¹⁴²
- *Is de geïndiceerde behandeling correct uitgevoerd? Heeft de hulpverlener de juiste methode of techniek gebruikt? Indien er complicaties zijn, zijn deze dan inherent aan de behandeling of gaat het om het gevolg van onjuist handelen?*¹⁴³
- *Heeft de hulpverlener in het traject na het onderzoek, de behandeling of de ingreep voldoende zorg en aandacht aan de patiënt besteed? Is voldoende*

¹³⁸ full disclosure is not a shield to legal responsibility for such innovation.

¹³⁹ 1984. Nieuwe wetenschappelijke ontwikkelingen rond het begin van het leven; problemen voor het gezondheidsrecht. *Tijdschrift voor Gezondheidsrecht*, 116.

¹⁴⁰ 1996. *Verantwoordingsplicht en aansprakelijkheid in de gezondheidszorg* W.E.J. Tjeenk Willink, 104.

¹⁴¹ has a proper diagnosis been made? has the physician conducted sufficient tests from which an accurate diagnosis could be made?

¹⁴² what treatment has followed the given diagnosis?

¹⁴³ has the treatment been effectively administered or procedure executed?

*gereageerd op complicaties en ontwikkelingen in het natraject?*¹⁴⁴

Gevers¹⁴⁵ emphasises the fact that medical negligence in the genetic testing and counselling arena could have serious consequences. He states that a physician could be negligent either in the failure to provide relevant information, such as making the patients aware of the possibility of prenatal diagnosis or in giving incorrect information, because of insufficient examination, a laboratory mistake, an inaccurate interpretation of test results or even a miscalculation in computing hereditary risk. He¹⁴⁶ indicates that an incorrect diagnosis could not only be prejudicial in the instance where a high risk couple is given the go-ahead for safe procreation,¹⁴⁷ but also where a healthy couple is prohibited from having children based on an erroneous report that their children would probably be affected by a dangerous hereditary disease.¹⁴⁸

Hondius¹⁴⁹ reports on the most important sections found in the statutory guidelines relating to model medical care are: Section 11 dictates that a physician should, in as far as it is his responsibility, make use of the appropriate and best materials and equipments available; section 12 directs that in instances where more than one physician is responsible for a patient, only one should be indicated as the contact person; section 14 restricts the cost factor for patients; section 27 has in view the attainability of physician guarantee; section 32 compels the physician to ensure an adequate observation; section 36 entitles a patient to a second opinion and section 38 obligates a physician to specification of any declarations. It is submitted that guidelines like these contribute much to clarify what conduct is expected from physicians, which will certainly extend the improvement of medical service, progress the physician-patient

¹⁴⁴ in summary:

- has a proper diagnosis been made and communicated?
- what treatment/ intervention has been indicated, based on the diagnosis?
- has the chosen treatment/ intervention been properly performed? have complications been caused by the inherent nature of the treatment or because of improper application of the physician?
- did the physician take necessary care in examining the patient or in performing the chosen intervention?

¹⁴⁵ 1987. Juridische aspecten van erfelijkheidsonderzoek en -advies. **Verlag: Vereniging voor Gezondheidsrecht** (10 April), 21.

¹⁴⁶ *ibid.*

¹⁴⁷ as is commonly found in the wrongful life sphere of litigation.

¹⁴⁸ liability for this type of injury will not be discussed in this work.

¹⁴⁹ *op cit* p 1688.

relationship and increase the protection of patient's rights.¹⁵⁰ It is my submission that similar legislative guidelines will in the same way address the wrongful life debate, clarify the various parties' legal positions and accordingly solve much of the contention currently experienced.

4. Related aspects

4.1 Disclaimer agreements

Lodeizen-Schoonenberg and Stein¹⁵¹ is of the opinion that disclaimer clauses in the medical negligence sphere is generally *contra bonos mores* and unenforceable. A contractual limitation of damages, however, should be valid and enforceable. They believe that medical professionals have a sufficient alternative to protect their interests, namely liability insurance.

"In onze gedachtegang vormt het verzekeringsaspect het sluitstuk m.b.t. de onderhavige problematiek. Wij zijn daarbij gekomen tot het aannemen van een algemene verkeersopvatting in onze sameleving, inhoudende dat ziekenhuizen en medici zich toereikend dienen te verzekeren voor medische aansprakelijkheidsrisico's, een verkeersopvatting die o.m. tot uiting komt in het thans gevestigd verzekeringsgebruik terzake. Hieruit leiden wij af, dat beperking van medische aansprakelijkheid tot een bepaald bedrag, namelijk het redelijkerwijs maximaal verzekerd bedrag per gebeurtenis, tegenover de patiënt wel toelaatbaar kan worden geacht."

4.2 Vicarious liability

Hospitals and provincial administrations¹⁵² often incur legal liability for the negligent exercise of professional duties by physicians under their auspice. Although South African hospitals could initially not incur liability for damage caused by the negligence of their professional personnel as they were deemed independent contractors, this position was eventually changed.¹⁵³ Plaintiffs often find this an attractive option, especially when the physician is

¹⁵⁰ it is suggested that a clear-cut understanding of expected conduct and a parameter of acceptable behaviour within clear bounds, will concomitantly protect physicians interests and will thereby reduce their possibility of medical negligence liability.

¹⁵¹ 1983. Uitsluiting van medische beroepsaansprakelijkheid. *Tijdschrift voor Gezondheidsrecht* (4:7), 184.

¹⁵² *Esterhuizen v Administrator Transvaal* 1957 (3) SA 710 (T); *Dube v Administrator Transvaal* 1963 (4) SA 260 (T).

¹⁵³ *Mtewa v Administrator Natal* 1989 (3) SA 600 (D).

financially incapable of paying the damages in full.¹⁵⁴ In wrongful life cases, hospital authorities or genetic laboratories are also frequently sued for negligent conduct by their employees.¹⁵⁵

The fundamental principle concerning vicarious liability is that a person¹⁵⁶ is not liable for the wrongful act of an independent contractor engaged by him, although circumstances may dictate that a legal duty is placed on an employer to take steps to prevent such harm to members of the public.¹⁵⁷ An important indication of a position of authority, is the existence of an employment relationship. A person can subsequently not be held accountable for damage caused by an independent contractor¹⁵⁸ engaged by him. One must therefore consider each case individually to establish whether a relationship of authority has in fact existed, before vicarious liability becomes applicable. These principles are applicable to hospital authorities *vis a vis* physicians, where in some instances an employment relationship exists between the parties¹⁵⁹ and in other cases an independently practising physician merely makes use of hospital infrastructure and equipment.¹⁶⁰

Schoonenberg¹⁶¹ discusses the possibility that a genetic laboratory be held liable for either the inaccurate performance of genetic tests or the incorrect calculation of risk percentages. Such liability has been recognized in the past¹⁶² and it is reported that in terms of Dutch law a physician would also be held accountable for such mistakes where he has chosen the particular facility, received the incorrect information and has applied faulty treatment based on this

¹⁵⁴ Van Oosten, 1991 *op cit* p 26: "Since hospitals are ordinarily in a better position to compensate patients for the harm they suffer as a result of the negligence of their professional personnel, this means that the patient is not simply left without a remedy where the doctor or nurse is financially incapable of footing the bill. It hardly needs any mention that there is nothing that prevents the patient from seeking his redress against the doctor or nurse concerned instead of against the hospital, but at least he now has a choice."

¹⁵⁵ see table of authority.

¹⁵⁶ or an institution/ legal person, such as a hospital.

¹⁵⁷ vicarious liability flows from the doctrine *respondeat superior* - where a person in a position of authority over another is legally capable of exercising control over the latter's actions, he is expected to exercise control in such a way as to prevent harm to others.

¹⁵⁸ executes an assignment in accordance with his own skill, proficiency and judgment.

¹⁵⁹ where vicarious liability could follow.

¹⁶⁰ where vicarious liability is not possible, although a hospital may be directly liable for its own negligence, eg provision of defective theatre equipment.

¹⁶¹ *op cit* p 65.

¹⁶² **Curlender v Bio-Science Laboratories** 106 Cal. App. 3d 811 (1980).

information. This opinion is based on section 6.1.8.3 of the Dutch Civil Code, whereby:

“...ene contractspartij tegenover de andere op gelijke wijze als voor eigen gedragingen aansprakelijk is voor gedragingen van degenen, die hij inschakelt bij de uitvoering van het contract.”¹⁶³

Vansweevelt¹⁶⁴ reports that some have rejected the concept that a hospital could be causally linked to a result-based agreement between a physician and patient. He conveys that the well-known “duty of care” found in Common law countries is very similar to the Dutch system's approach that a physician should act proficiently. Although the parties are free to expressly enter into a result-based agreement, this would not occur automatically.

It is suggested¹⁶⁵ that “fairness requires that the malpractice burden be borne by hospitals as well as physician's, because of their shared responsibility for medical mishaps that results from cost-cutting measures.” The following solution is proposed:

“In order to allocate this burden fairly while not depriving victims of compensation, lawmakers should create a rebuttable presumption of joint hospital-physician liability in cases in which malpractice claims arise from a failure to order tests, procedures, or hospitalization that may have been forgone because of cost-cutting concerns. Such legislation would encourage hospitals and physicians to cooperate in reducing health care costs without compromising quality, and would alleviate the conflicts engendered by the current system.”

4.3 Defensive medicine

In the Netherlands, professional liability is regulated by a system of obligatory insurance schemes. This system has the advantage that a plaintiff always will receive his award of damages because of the financial strength of these insurers.

In the United States of America, where extremely high amounts of damages are awarded in medical malpractice cases (compared to the position in South Africa and Europe), physicians

¹⁶³ or, where a contracting party is liable for any damage caused to the other contracting party in the performance of such sterilization for the conduct of another that has been introduced to the contract by himself.

¹⁶⁴ 1992. *De Civielrechtelijke Aansprakelijkheid van de Geneesheer en het Ziekenhuis* Maklu Uitgevers - Reeks Aansprakelijkheidsrecht.

¹⁶⁵ Anon. 1985. Rethinking medical malpractice law in light of medicare cost-cutting. *Harvard Law Review* (98:5), 1022.

and especially experts in medical science¹⁶⁶ suffer under the burden of exorbitant liability insurance premiums. This troublesome situation has led to fears that so-called “defensive medicine” practices will increase.

It is mentioned¹⁶⁷ that excessive damages awarded in medical negligence cases has various negative consequences: the high insurance premiums are eventually passed on to the patients;¹⁶⁸ physicians are possibly reluctant to be involved in unknown cases of accidental injury; physicians tend to become over-cautious¹⁶⁹ in an attempt to rule out any possibility of negligence whatsoever¹⁷⁰ and some physicians refuse to attend to “high risk” patients.

4.4 Response from physicians to wrongful life suits

Fain¹⁷¹ reports that although plaintiff’s have had only limited success with wrongful life actions against medical practitioners, compensation allowed for successful wrongful birth and wrongful conception actions has in fact increased liability-anxiety in medical ranks. He mentions possible negative consequences that might result from excessive liability for wrongful life:

- increase the number of diagnostic tests ordered by physicians in order to defend their conduct and rule out any possibility of negligent failure on their side to investigate even the most remote, but theoretically possible, abnormal condition;¹⁷²
- heightened malpractice insurance premiums;
- increased medical expenses; and
- unnecessary abortion of healthy embryos and fetuses, as a “precautionary measure”.

4.5 Increased litigation

It is reported that there is an increasing incidence of medical malpractice suits in all Western

¹⁶⁶ of all the medical specialists, the gynaecologists in America generally have to pay the most for liability insurance- of up to \$ 50 000 per year - Strauss *op cit* p 243.

¹⁶⁷ Strauss *op cit* p 243.

¹⁶⁸ or medical schemes that often cannot cope with increased medical costs.

¹⁶⁹ so-called “defensive medicine”, whereby totally unnecessary tests are done and preventative medication is administered.

¹⁷⁰ over-caution also leads to protracted consultations and excessive documentation of cases.

¹⁷¹ *ibid.*

¹⁷² so-called “defensive medicine”.

countries. Various reasons can be offered as explanation for this litigation lust that seems to be a characteristic of our time. It is suggested that one of the most important reasons is the technological development of medical science. People have great trust and high expectations in modern medicine and have become conditioned to demand more from their physicians. People seem to be fascinated with media coverage of malpractice trials and closely follow the papers to seek "how much the newest litigant got." There might yet be truth in the perception that plaintiffs in medical negligence cases do not take on the physician as such, but rather a professional insurance company, which are more than capable of footing the legal bill.

Another consideration why people might more easily decide to litigate is the awareness of human rights in modern-day society.¹⁷³ It is my submission that an informed people that are aware of their rights is a vast improvement on an obtuse society ignorant of their rights. One should not necessarily attach a negative stigma to increased cognizance of one's legal rights and focus on the adverse consequences of increased litigation. It is praiseworthy that wrongs are exposed and wrongdoers held accountable. It should also not be forgotten that the reality of professional accountability increases existing levels of proficiency and ensure that high standards of work ethics are maintained.

Verkruisen¹⁷⁴ calculates that medical negligence claims will greatly increase, despite a noticeable elevation in the quality of medical services. He explains that there are basically two main reasons for this prediction: the expected decrease of the number of avoidable medical injuries; but an improved percentage of successful claims.¹⁷⁵

Hondius¹⁷⁶ believes that although the current developments¹⁷⁷ in the European protection of patient rights will probably increase medical malpractice liability, he is adamant that it will not reach the excessive levels known to America. As reasons for his viewpoint he notes that the following aspects of American law accommodate abundant litigation: the differences in the law of obligations relating to plaintiff's entitlement to claim satisfaction and the application of

¹⁷³ in South Africa this is especially true.

¹⁷⁴ 1997. De medische aansprakelijkheidsexplosie in Nederland: de voorgeschiedenis en het te verwachten vervolg. *Nederlands Juristenblad* (19:72), 846.

¹⁷⁵ *"Op basis van het tegen elkaar inwerken van deze twee processen - vermindering van het aantal vermijdbare gevallen van gezondheidsschade, maar een groter percentage van deze gevallen dat zal worden verhaald - mag worden verwacht dat het aantal verhaalszaken van medische letselschades de komende jaren - ondanks de grote kwaliteitsinspanningen in de zorgsector - fors zal groeien."* op cit p 852.

¹⁷⁶ op cit p 1710.

¹⁷⁷ implementation of legislative guidelines for medical treatment agreements - see this ch *supra*.

punitive damages; the differences in procedural law, including pre-trial discovery and class actions and also the recognition of contingency fees. Hondius¹⁷⁸ suggests that plaintiffs in Europe have to a greater extent than their American counterparts, the additional advantage of alternative venues to redress their injuries such as effective social and also particular insurance.

4.6 Patient's challenges

Van Aller¹⁷⁹ mentions difficulties generally experienced by patients in medical negligence cases: difficulty in reconstructing the facts of the consultation and procedure; proving that the physician's conduct was below standard; deciding who to hold accountable - the physician or hospital; proving a causal link between conduct and damage and finally establishing damage.

4.7 Contributory negligence of patient

It has been found¹⁸⁰ that a patient's failure to carry out medical instructions does not necessarily amount to contributory negligence.¹⁸¹ Van Oosten¹⁸² writes in this regard: that once it is established that a physician has been negligent, the patient's contributory negligence is no defence to liability and can at best lead to an apportionment of damages or mitigation¹⁸³ of sentence. The degree of negligence also has no effect on liability, although it may influence the quantum¹⁸⁴ of damages.¹⁸⁵ It should always be kept in mind that the onus of proving the requirements of a particular cause of action,¹⁸⁶ as well as the damages claimed, rests on the plaintiff.¹⁸⁷

¹⁷⁸ *ibid.*

¹⁷⁹ 1989. **Schadevergoeding na medische fout: Geluk bij een ongeluk?** Koninklike Vermande BV. Lelystad, 20 ao.

¹⁸⁰ **Soumbasis and Another v Administrator of the Orange Free State and Another** (unreported - 1989 OPD).

¹⁸¹ note that plaintiff's contributory negligence is not taken into account when his action is based on contract, as the **Apportionment of Damages Act No. 34 of 1956** does not apply to breach of contract - see ch 2.

¹⁸² *op cit* p 26.

¹⁸³ reduction/ moderation/ easing of a judgement.

¹⁸⁴ quantity/ amount of damages.

¹⁸⁵ *op cit* p 26.

¹⁸⁶ whether liability is based on delict or contract.

¹⁸⁷ usually, the patient - **Blyth v Van den Heever 1980 (1) SA 191 (A)**.

5. Conclusion

Harrer¹⁸⁸ conveys, and rightly so, that the birth of a child is no longer considered an inevitable act of nature, but as a perfectly plannable enterprise. It is the task of physicians to act in accordance with the proper medical standards and thereby ensure that this goal is maintained. It is reported that¹⁸⁹ if we are to maintain high standards of care while lowering medical costs, current malpractice law should be modified to bring these conflicting incentives into alignment.

¹⁸⁸ 1994. Aspects of Failed Family Planning in the United States of America and Germany. *The Journal of Legal Medicine* (15), 89.

¹⁸⁹ Anon. 1985. Rethinking medical malpractice law in light of medicare cost-cutting. *Harvard Law Review* (98:5), 1004.