THE MEDICO-LEGAL PITFALLS OF THE MEDICAL EXPERT WITNESS

by

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This dissertation is dedicated to all doctors and their families, who adhere to the highest ethical principles of answering the call of duty towards the ill, sick, infirm and injured, but who had to suffer litigation and disciplinary proceedings in an undignified, unfair, unreasonable and unjustified way. It is trusted that this dissertation would bring some form of legal reasoning to bear upon the medico-legal processes and the quality of the medical expert's witness, opinion and testimony. Thus it is trusted to contribute to maintaining the high standards of medical care and to emphasize that the wellbeing of the ill is still the supreme law.

Salus Aegroti Suprema Lex

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This dissertation is in remembrance of my father, Emilio Willi Scharf, who was a lawyer and known to be a wise, kind and gentle man, who I unfortunately due to his untimely early death (due to cancer), never could know and also to my dedicated mother Eileen, who had to raise two small sons alone as a widow, who had always wished that I would also study law one day.

PREFACE

This writer as a doctor, surgeon and legally qualified person, has seen the abuse of medical expert witnessing in many spheres of legal medicine, court and disciplinary cases. Most of this writer's colleagues agree and had found themselves embittered victims of hostile and in-appropriately wrongly interpreted medical expert witnessing. This has caused severe psychological trauma, loss of self-esteem and respect for the legal and the medical professions.

As Justice has to be served with the inevitability of ever increasing litigation for professional negligence, proper guidelines and knowledge must be available. This dissertation is then such an attempt at improving the dire shortage of guidelines and knowledge to avoid the dilemmas and pitfalls of the Medical Expert Witness and contributing to improving medico-legal guidelines and knowledge.

In this dissertation emphasis is placed on ethics and medico-legal knowledge as the mainstays for acceptable medical expert witnessing. This writer will therefore often and inevitably repeat arguments and statements but for the continuity of the broad message this is considered necessary.

To keep a dissertation short and readable, the writer refers to third persons in an open discussion unfortunately in the male form. No intent to subject or insult women/feminism is meant with this word choice and apology is given if found offensive. Likewise the abbreviation of MEW is used for medical expert witness or witnesses and the plural form must kindly be deducted from the main sentence. The words opinion and/or testimony are preferably used instead of witnessing.

It is sincerely hoped and trusted that the readers of this dissertation will find it a pleasure and most informative, as much as this writer excitedly discovered newly found knowledge and argumentation in the many books and articles read in the process of writing this dissertation.

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ABSTRACT

THE MEDICO-LEGAL PITFALLS OF THE MEDICAL EXPERT WITNESS

The fastest growing field of law is undoubtedly that of Medical Law with the civil and disciplinary cases flowing from it. Globalization, international communication, development and evolution of Law as well as Medicine, cause this worldwide rising medical litigation.

Humanitarian rights, post-modern scepticism and even iconoclastic attitudes contribute to this phenomenon. Medico-legal litigation and disciplinary complaints rise (in South Africa) up to 10 per cent per year.

To assist the courts and legal profession, in medico-legal issues, helping the parties where the plaintiff has the burden of proof and the defendant for rebuttal, a medical expert witness must be used.

The dilemmas and pitfalls arise, in that although knowledgeable medical experts could be used to guide the courts to the correct decision, the lack of a legal mind setting, court procedure and legal knowledge could affect the relevance, credibility and reliability, making the medical evidence of poor quality.

The legal profession, deliberately, could “abuse” medical expert witnesses with demanding and coercion of results, which have unrealistic and unreasonable expectations. “Case building” occurs, especially in the adversarial systems of law, making the medical expert vulnerable under cross-examination, when it is shown that the witness has turned into a “hired gun” or is unfair. Thus, *lacunae* develop, making reasonable cases difficult and a quagmire of facts have to be evaluated for unreasonableness, credibility and appropriateness, compounded by the fact that seldom, cases are comparable.

The danger is that the presiding officer could be misled and with limited medical knowledge and misplaced values, could reach the wrong findings. Several cases arguably show that this has led to wrongful outcomes and even unacceptable jurisprudence.

The desire to “win” a case, can make a medical witness lose credibility and reasonableness with loss of objectivity, realism and relevance. With personality traits and subjectivity, the case becomes argumentative, obstinate and could even lead to lies. The miasmatic, hostile witness emerges, leading to embarrassing, unnecessary prolongation of court procedures.

The medical expert witness should be well guided by the legal profession and well informed of the issues. Medical witnesses should have legal training and insight into the legal and court procedures. At the time of discovery of documents, via arbitration or mediation, medical experts should strive to reach consensus and then present their unified finding, helping the parties fairly and expediting the legal procedure and processes.

Keywords: Medical Law, Medical Malpractice, Professional Negligence, Medical Expert Witness, Ethics, Medico-Legal Knowledge, Medico-Legal Training, Improvement of Medical Expert Witnessing

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CHAPTER ONE

INTRODUCTION, DELIMITATION, PROBLEM STATEMENTS AND HYPOTHESES

"Knowledge without justice should be called cunning, not wisdom,…and if prompted by greed and not the common good, warrants the description 'brazen', not 'courageous'".[1]

1.1 Background to the dilemma of the Medical Expert Witness

Law and Medicine, being of the oldest professions, influence one another, within an established relationship of law, health and ethics.[2] Medical law, being a comparatively young discipline, has developed over the past 20 years academically into a distinct legal subject field.[3] It is formed and cast out of a melting pot of laws, including those of tort or delict, criminal law, civil procedure, the law of contracts, constitutional law and family law.[4]

Medical law acknowledges *inter alia* autonomy, consent, truth, confidentiality, privacy, the person and his or her dignity, as well as the respect for justice. With emerging human rights forming a foundation, medical law encompasses a coherent approach to medico-legal problems in the health sector.[5] It is of value to have medical law as an acknowledged field, so that when medical negligence is for instance suspected, justice should be applied in the correct context, as not to be irrational or unfair. Here the role of the knowledgeable medical expert witness (MEW) must be acknowledged to ensure that justice is done.[6] It is also perceived that as scientific health knowledge and interventions are advancing, so too health

1 Habinek *Cicero – On Living and Dying Well* 129.
2 Geston Medical *Law Review* 11, as a foreword in honouring Prof Margaret Brazier, retiring as Professor in Medical Law at the University of Manchester, where she had established the field of Medical Law 25 years ago.
3 Kennedy and Grubb *Medical Law* 1.
4 Freckelton and Petersen *Disputes and Dilemmas in Health Law* 3.
5 Kennedy and Grubb *Medical Law* 4. Medical Law, including a Right to Autonomy, to Dignity and to Life is founded in Humanitarian Law, enshrined in the Human Rights Acts of 1998, based on the guidelines of the ECHR (European Charter of Human Rights).
6 Carstens and Pearmain *Foundational Principles of South African Law* preface.

law and common law will develop, with patients becoming more aware of their rights, to impose regulations and constraints.[7]

1.1.1 Defining the medical expert witness

The MEW can be defined, as anyone (by implication in medicine - a medical practitioner) with special knowledge, skill, experience, training or education in a particular field or discipline, that permit him or her to testify to an opinion that will aid a judge in resolving a question that is beyond the understanding or competence of lay persons.[8] With this MEW knowledge available to a court, it will help the court to understand the issues of a case and reach sound and just decisions.[9] In South Africa the definition and value of a medical witness had been referred to in various cases for instance *Van Wyk v Lewis* (1924), *Mohammed v Shaik* (1978) and *Michael and Another v Linksfield Park Clinic and Another* (2001).[10]

1.1.2 The Duties of the medical expert witness

It is the expected role of the expert not to be concerned as such with the law as he/she does not argue matters of the law, but argues technical matters and medical expertise. In the case of *S v Huma and Another*,[11] it was stated that an expert witness is not to further the cause of a particular party, but to assist the court to come to a proper decision and finding on technical and scientific matters. This assistance to court does not revolve around the "opinion", but indeed the witnesses' competency whilst also considering knowledge, experience, and expertise.[12]

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7 Freckelton and Petersen *Disputes and Dilemmas in Health Law* 3. Examples would be organ transplantations, experimental protocols for cancer treatment, minimal invasive operations etc.

8 Knoetze 2008 *De Rebus* 26. In the USA, a jury must be helped by a medical expert witness to reach a correct finding. Hookman *Medical Law and Ethics* 219.

9 Grobler 2007 *SAGR* 11.

10 *Van Wyk v Lewis* 1924 AD 438; *Mohammed v Shaik* 1978 (4) SA 523 (N) para 528G; *Michael and Another v Linksfield and Another* 2001 (3) SA 1188 (SCA) para 1189G.

11 *S v Huma and Another* 1995 (2) SACR 407 (WLD) para 409d-e. In this case mainly involving ballistic expert witnesses it was mentioned that especially in *pro deo* cases, that if necessary medical and psychiatric expert witnesses for the defendants must be appointed in the interest of justice (para 409f).

12 Knoetze 2008 *De Rebus* 26.

1.2 Purpose and problem statement

1.2.1 General background and the rise of medico-legal litigation

The purpose of this dissertation is to state the problems around and encountered by the MEW and the quality of the MEW, so as to help all parties and the court to achieve fair and reasonable judgements, especially in cases of medical negligence litigation. The main problem seems to be the lack of MEW's insights into medico-legal aspects, like the "duty of care", "notion of proximity", the criteria of "remoteness of damage", the concept of legal "causation" and the constituting elements of negligence.

The MEW must know that medical mishaps have multivariate causes and there is always a question of causal complexity, which often cannot be satisfactorily addressed. The MEW must be aware of a tendency to seek sufficient evidence, opinion and a human factor for attribution of blame, feeding a desire to punish. The lay mentality, causing a pitfall for the MEW is then, if something "went wrong", somebody must be blamed. It is argued, that by exposing "medical accidents" and "blaming the doctor", the purpose should be to lower the incidence of inadequacies in a system, altering the specific circumstances so that it could produce better medical results.[13]

MEWs must know that once blame is levelled at a doctor, it is rarely a simple matter as allegations are often misplaced. Lessons (for the medical doctors) are then not learned from a tragedy, simply because all focus is on the blame. An opportunity for constructive intervention, in improving medical care and prevention of adverse events, is then lost. Medico-legally, there should be sufficient understanding of causes of iatrogenic harm and a sophisticated appreciation of how things go wrong.[14] Best practice must be seen in juxtaposition of realism with medicine's pressing needs and limited resources. Lawyers and medical doctors,

13 Merry and McCall Smith *Ethics, Medicine and the Law* 8.
14 Merry and McCall Smith *Ethics, Medicine and the Law* 8.

especially expert witnesses, are "normally blind about their own blindness (implying lack of knowledge)".[15]

Professional people are generally overconfident in their opinions, impressions and judgements. Exaggeration could then take place.[16] The dilemma and pitfall arises where a MEW, will support a bogus claim, the challenge being that it is then difficult to defend against such a claim.[17]

Another dilemma occurs in that medical practitioners with seniority and professional standing are requested by various legal representatives to write reports, give opinions for possible litigation and then to give "expert" evidence on the care of patients, with whom they have had no clinical knowledge other than an unknown doctor's notes, statements and records of management. Often their views, albeit not well considered and often judgementally prejudiced are then used as crucial to the final decisions.[18] The MEW should be aware of the pitfall that it is difficult to single out any cause for the increase of medical negligence actions.[19] The most common explanations would be that more medical accidents are occurring due to increased pressure on hospitals and doctors, to falling standards of professional conduct and due to the ever increasing complexity of therapeutic and diagnostic methods.

According to the Medical Protection Society,[20] the increase in medical litigation in South Africa rose more than 30 per cent over the last four years whilst the rise in the claim costs was over 132 per cent. Out of court settlements and the potential incurred, but not reported cases, have probably also doubled.[21] In the Gauteng province the medical malpractice/negligence litigation claims against the provincial hospitals are presently far over R 573million.[22] The recent amendments of the

15 Daniel Kahneman (Nobel Prize winner, psychologist and economist), referring to economists, applicable to all professions. This writer then quotes Donald Rumsfield, former US Secretary for Defense "we do not know, what we do not know". Kahneman 2011 *Time* 5 December 56.
16 Kahneman 2011 *Time* 5 Dec 56.
17 Schwikkard *et al Principles of Evidence* 450.
18 Redelingshuys *et al* 2006 *SADJ* 136.
19 Mason and McCall Smith *Law and Medical Ethics* 191.
20 The Medical Protection Society is a member driven medical indemnity insurance scheme in the United Kingdom, South Africa and several other commonwealth countries.
21 Howarth 2012 *SA Medical Chronicle* 1.
22 Howarth 2012 *SA Medical Chronicle* 1.

Road Accident Fund (RAF) Act,[23] as well as the implication of contingency fees are contributory, in that as the RAF claims and income decrease for the legal practitioner, many are now willing and available to do medico-legal work.[24] To illustrate the dilemma of rising medical law incidences, is that in the United States of America, 10 per cent of annual healthcare expenditures go for liability and defensive medicine and that malpractice litigation costs rise 7.5 per cent annually, of which 50 per cent alone go for legal fees and administration.[25] This increase of medico-legal litigation creates a rising need for guidelines, standards, training and accreditation of witnesses.[26]

The concern is raised whether a medical malpractice litigation storm is brewing. The dramatic rise in litigation and its impact on the medical fraternity is indeed considered to be a looming disaster.[27] Data shows that South Africa is following the United States and global trend of increased medical negligence cases. Presently the discipline of obstetrics and gynaecology is most affected, followed by neuro and spinal surgery, trauma, orthopaedic surgery, plastic-reconstructive surgery, bariatric surgery and fertility procedures.[28]

Runaway negligence pay-outs are fuelling this phenomenon and "cherry picking" occurs of potential cases on a contingency basis, encouraging the hunt for medical malpractice/ negligence cases. This then promotes defensive medicine.[29] It seems not so much that the doctors are more negligent, as it is that the patients are more demanding of their "rights".[30]

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23 *Law Society of South Africa and Others v Minister for Transport and Another* 2010 CCT 38/10.
24 Pepper and Slabbert 2011 4 *SAJBL* 29.
25 Hookman *Medical Malpractice Expert Witnessing* 4.
26 Grobler *The South African Gastroenterology Review* 11.
27 Howarth 2012 *SA Medical Chronicle* 1.
28 Pepper and Slabbert 2011 4 *SAJBL* 29.
29 Bateman 2005 *SAMJ* 376. Defensive medicine is where a doctor, afraid of litigation, over services a patient to eliminate a risk of misdiagnosis as well as ordering many more and unnecessary tests to make sure and the over treating a patient as to (falsely) consider himself at low risk for litigation.
30 Bateman 2005 *SAMJ* 376.

An adverse event occurs in at least 10 per cent of all medical treatment cases. [31] Of these cases, 20 per cent have severe consequences. About 50 per cent of these were preventable and fewer still are really due to negligence. The doctor-patient communication and attitude before and after the event have an influence. With an adverse event occurrence, the doctor must attend to the clinical and psychological need of the patient and the family, to minimize the "blame and shame" rebound reaction. Lessons must be learnt in order to improve patient safety.[32] Doctors, lawyers, lay patients and their families must remember also that an expression of regret is not an admission of liability.[33]

The question is whether defensive medicine, practiced by litigation wary doctors, actually prevents professional liability suits. The main effect it seems, at the increased cost for all, is that physicians protect themselves, *inter alia* by ordering superfluous tests. Thus defensive medicine transforms the malpractice crises into a vicious circle. This enhances risk, which without medical scientific rationale results in the potential litigation increase.[34]

This can result for instance in higher malpractice insurance premiums. "Negative" defensive medicine ensues, which is characterised by avoidance, shying away from difficult cases with potentially poor results. Doctors for instance, won't see emergencies, do no new procedures or prescriptions, avoid obstetrics and orthopaedics, and choose early retirement.[35] Experienced staff are then lost.

1.2.2 The effects of litigation on doctors

Although it is not the focus of the research of this dissertation, cognisance should be taken of the effect of litigation on a medical practitioner. MEWs should be aware of this, so that they could conduct themselves in a manner as an aid to the court and not act as a "hired gun" for the plaintiff or the defence.

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31 Hookman *Medical Malpractice Expert Witnessing* 6. An adverse event is described as any event in medical practice where the treatment, against expectations, had to be adjusted to meet a changing scenario and where a patient suffers permanent damage.

32 Hookman *Medical Malpractice Expert Witnessing* 6.

33 Writer's emphasis. An expression of regret has been found to be a common factor amongst lay people that it demonstrates possible blame against or guilt by the attending doctor.

34 Hookman *Medical Malpractice Expert Witnessing* 6.

35 Howarth 2013 Sept *Medical Chronicle* 11.

Physicians indicate that their primary anxiety about litigation is the traumatic experience of being sued for malpractice, which is often interpreted personally as embarrassing and an affront against their professionalism, resulting in psychological trauma. Doctors then experience a sense that they have already "lost" the case. The legal process is intimidating, seen against the background that physicians, in good faith, practice medicine competently and ethically.[36]

The constant state of vigilance exhausts doctors, rendering them dysfunctional, causing physical illness and even suicides due to the Malpractice Stress Syndrome, a variant of the Post-Traumatic Stress Disorder.[37] Schooled in the pursuit of excellence, a summons fuels anger, frustration, isolation and difficulty to distinguish between bona fide and negligent errors, deviations from professional standards and blameless misfortune for a doctor.[38] Pressures from liability insurance carriers to settle a case for financial reasons are upsetting and exacerbate the situation.[39]

Although advised not to take it personally, the emotional toll is extreme as malpractice claims are experienced as a personal "assault". Legal terms like negligent, reckless, careless, unskilled, unfaithful, and unprofessional are difficult to keep in perspective. The confusing and lengthy legal processes count emotionally. A successful defence and trial could be a pyrrhic victory. Cases become "character assassinations" and any physician's practice can be faulted, "after the fact", by a MEW. Pressures from liability insurance carriers, to settle a case for financial reasons, are upsetting and exacerbate the situation.[40]

A worrisome effect which seems to be occurring more often is that reimbursements and compensation pay-outs are based on personal economics, sympathy or whim and not on legal fault and harm caused. To accomplished fairness to patients and physicians and to be treated justly, could be the end effect to strive for, facilitated by a knowledgeable MEW.[41]

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36 Marshall and Kapp *Our Hands are Tied* 1.
37 Marshall and Kapp *Our Hands are Tied* 13.
38 Marshall and Kapp *Our Hands are Tied* 14.
39 Hookman *Medical Law and Ethics* 2.
40 Hookman *Medical Law and Ethics* 2.
41 Marshall and Kapp *Our Hands are Tied* 28.

1.2.3 The relevance of the Medical Expert Witness

It must be accepted that there are medico-legal issues that simply cannot be fairly decided upon without expert guidance, as a presiding officer probably has little or no medical knowledge. As in other professional fields like engineering, chemistry and accounting, medical expert opinion is well received. There is a practical test, namely that the opinion of a skilled witness is admissible, when it could help the court appreciably in reaching a fair, reasonable, just and justifiable finding.[42]

This statement is supported by previous judgments. In the case *S v Melrose*[43] the court found the *viva voce* evidence of medical practitioners relevant. In medical cases, it is important that the witness should not express an opinion on hypothetical facts, which would have no bearing on a specific case, or which cannot be reconciled with the other evidence and facts of a case.[44] However, an overreaction is found in the case of *Mohamed v Shaik*.[45] In this case it was considered necessary to decide whether an expert had the necessary qualifications and experience to express reliable opinions. Paradoxically, it was held that a qualified medical practitioner, with the MBChB degree[46] and four years of experience was not an adequately qualified authoritative figure, under doubtful circumstances and facts, to discuss a (specialist) pathologist's report.

Formal qualifications are not always so essential and thus especially when highly qualified academic professors are called upon, they are in fact "expert medical witnesses" instead of the reasonable and fair "medical expert witness".[47] Here the practical experience and expertise should be more decisive to accept a professional person as a MEW. Obviously, greater credibility and weight must be given to evidence on what had actually happened than to the opinion of an expert

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42 Schwikkard *et al Principles of Evidence* 93.
43 *S v Melrose* 1985 1 SA 720 (Z) para 724I.
44 Schwikkard *et al Principles of Evidence* 96.
45 *Mohamed v Shaik* 1978 4 SA 523(N) para 528G.
46 *Medicus Baccalaureus; Chirurgus Baccalaureus* degree as the accepted medical degree at most universities with health and medical faculties.
47 An "Expert Medical Witness" would in this writer's opinion be a highly qualified professional (i.e. a professor) with a niche interest and expertise that would emphasise and discuss exceptional medical knowledge (i.e. a rare syndrome), whereas "Medical Expert Witness" the emphasis would be on the reasonable professional's standard of skills and knowledge and opinion on an acceptable course of action to be used in medical negligence and malpractice litigation.

witness who attempts to reconstruct events on the basis of experience and scientific training. Caution must be exercised in accepting expert witness opinion as evidence when it is in conflict with the probabilities which arise.[48]

There is also a perpetual dilemma of hearsay evidence. An expert witness may not, as a rule, base his or her opinion on statements made by a person not called as a witness. This could be a problem with quoting journal articles, as many of these articles (even in prestigious journals) are proven to be false and fraudulent.[49] However, experts may refer to textbooks and be allowed to do so provided conditions are met as set out in *Menday v Protea Assurance Co Ltd*.[50] It must be shown that the expert witness, by his own training and knowledge, can confirm the correctness of statements in a textbook. The textbook must also be reliable as it must have been written by a person with an acceptable reputation and experience. This rule seems to be disregarded, in especially the preliminary legal consultations, when a legal representative uses an expert witness to encourage a settlement. The court however, can rely upon publications referred to and adopted by a credible and trustworthy expert witness.[51]

1.3 Choice of legal systems

The systems with which the South African legal system would be compared would be mainly adversarial systems which would be comparable with the South African system. The choice is then mainly English Law and then also from various Commonwealth countries like Australia and Canada, from which many lessons could be learnt. As most literature advising the MEW originates in the USA some reference to cases in the USA need to be made as well.

1.4 Research methodology

The research is based on a need of personal experience that as a medically and legally qualified MEW, large gaping *lacunae* were noted in the medical negligence and expert witness roles in medical litigation. It was surmised that many MEWs

48 Schwikkard *et al Principles of Evidence* 99.
49 Ruiz M "Credibility of Science Journals under Scrutiny" http://wwwguardian/v.com/2013/10/ credibility-of-science- journals-under-scrutiny. (Date of use: 20 October 2013).
50 *Menday v Protea Assurance Co Ltd* 1976 1 SA 565 (E) para 569D.
51 Schwikkard *et al Principles of Evidence* 101.

are ill prepared and often incorrect as far as procedure and ethics were concerned. Extensive literature studies were done with the available literature and personal communication. The medico-legal dilemma and pitfalls of the medical expert witness was presented at the 19th World Congress on Medical Law.[52]

The concept of the unfair, unreasonable and "hired gun" MEW and the problems caused by their testimonies were well received and it was acknowledged that this must be prevented by giving MEWs some form of legal training. Over 60 high court cases and personal MEW experience also forms the foundation of this study. The referencing and bibliography is based on the academic guidelines as given by the College of Law, University of South Africa.

1.4.1 Point of departure and assumptions

The point of departure for this research is that the need for qualified and ethical medico-legal witnesses is high. This is especially so in South Africa where medical negligence and litigation cases are rising. The average MEW has no or very limited specific knowledge of legal thinking, reasoning as well as of the legal system. The knowledge and practice of medico-legal ethics is arguably the corner stone for effective medical expert witnessing to help a court reach a finding ensuring justice. The legal representatives and the so-called medical legal expert, as an assumption, must therefore be aware of the pitfall and dilemma regarding the ethics, credibility and relevance of the expert witness. These pitfalls are exacerbated by mainly irrelevant or wrongly interpreted facts and the building of cases by "trawling"' "fishing" or when the MEW becomes a case of the "hired gun". This could lead to an unsatisfactory finding and outcome of a case. Contributing factors to this phenomenon would be and is a conflict of goals between the legal and medical fraternity as well as the adversarial court procedures.

1.4.2 Court rules

The following court rules need to be taken note of and continuously kept in mind. These should then serve as the legally sanctioned mandate for the role of the

52 Scharf The Medico-Legal Dilemmas and Pitfalls of the Medical Expert Witness www.2012wcml.com (Maceio, Brazil – August 2012)

MEW. Rule 24(9) of the rules of the Magistrate's Courts and rule 36(9) of the rules of the Supreme Court (virtually the same) provide as follow:

> *No person shall, save with the leave of the court or the consent of all the parties to the suit, be entitled to call as a witness any person to give evidence as an expert upon any matter upon which the evidence of expert witnesses may be received, unless he shall*
>
> *(a) not less than 15 days before the hearing, have delivered notice of his intentions to do so; and*
>
> *(b) not less than ten days before the trial, have delivered a summary of such expert's opinion and his reasons therefore.*

The above rules are confined to civil cases. In criminal cases prior disclosure may be demanded – and should generally be granted on constitutional grounds. In both civil and criminal cases there are certain statutory provisions which permit expert evidence by way of affidavit or certificate. These provisions do not however, preclude the calling of the witness in person.[53]

1.4.3 Acts relevant to medical expert witnessing

It must be accepted that virtually every medico-legal case is indeed a variant of the *sui generis* rule, as every case is under the circumstances one of its kind and peculiar in the approach. Medical expert witnesses and legal advisors must be aware of this fact and thus use the applicable laws to facilitate litigation and argumentation processes. The Constitution is the most important fundamental act in the present Post-Apartheid South Africa and all the human rights that are enshrined in it form the basis on which all subsequent acts as well as the common law must adhere and be subjected to. Insight into the Constitution and the relevant Acts must therefore be obtained by a MEW.

The Constitution of the Republic of South Africa, 1996, has in it the Bill of Rights[54] guidelines that must be used in medical malpractice litigation and which

53 Criminal Procedure Act 51 of 1977 s 212, Civil Procedure Evidence Act 25 of 1965 s 22.
54 Chapter 2 of the Constitution of the Republic of South Africa, 1996 to be referred to as the "Constitution of the Republic of South Africa".

would be applicable to all parties. The following sections are highlighted as important to take note of, namely:

- Section 9: refers to equality and subsection (1) states that everyone is equal before the law, and has the right to equal protection and benefit of the law.
- Section 10: refers to human dignity where everyone has inherent dignity and the right to have their dignity respected and protected.
- Section 11: everyone has the right to life.
- Section 12: freedom and security of the person especially subsection (2) where everyone has the right to bodily and psychological integrity, which includes the right-
  (a) To make decisions concerning reproduction;
  (b) To security and control over their body; and
  (c) Not to be subjected to medical or scientific experiments without their informed consent.[55]
- Section 14: everyone has the right to privacy, which includes the right not to have the privacy of their communications infringed.
- Section 27: health care, food and water and social security including that everyone have the right to have access to health care services, including reproductive care and very important that no one may be refused emergency treatment. Thus with possible medical litigation it is expected that if a facility, or any medical practitioner, could and can be able to help a person in an emergency, it will be expected to do so.
- Section 28: concerning rights of children. Subsection (2) states unambiguously that a child's best interests are of paramount importance in every matter concerning the child. The court is the ultimate supreme guardian of all children (applicable to those younger than 18). It should be taken note of that legal procedures and action could be taken against parents who refuse lifesaving treatment to their children.

55 This subsection is therefore important to bear in mind when evaluating informed permission, consent as well as therapeutic privilege aspects in medico-legal litigation.

- Section 32: access to information. A patient and also thus a doctor have the right to have access to information on request, especially what would be needed to exercise a right.
- Section 33: just administrative action. Here everyone under subsection (1) has the right to administrative action that is lawful, reasonable and procedurally fair.[56]
- Section 39: interpretation of the Bill of Rights. Here it should be noted under subsection (1) that a court, tribunal or forum, when interpreting the Bill of Rights, must promote the values that underlie an open and democratic society based on human dignity, equality and freedom; ***must consider international law: and may consider foreign law.***[57]

With this Constitution in place, the developing and maturation of medical law in South Africa, must use proper and applicable foreign law cases, especially when research and study shows tremendous scientific legal development of medical jurisprudence in other countries. The role of international law cannot be ignored and the development of International Law and especially following the mandate of United Nations Charter on Human Rights (UNCHR)[58] over the last sixty years, dealt the death knell for medical paternalism, inappropriate applications of therapeutic privilege, the "wall of silence" and the "veil of secrecy"! However, the same rights enshrined into the Constitution must also at all costs be used to defend a medical practitioner in fairness, equality and reasonableness.[59]

The Constitution is considered to have mainly a vertical effect, interpreted as the State versus the individual, but it also implies so-called horizontal application between private and/or juristic persons, enhancing the three principles of law namely constitutional supremacy, justiciable application and entrenchment. All laws and litigation must be subjected to constitutional scrutiny and the Constitution

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56 This is most applicable in disciplinary hearings against doctors in Health Professions Council of South Africa (HPCSA) cases, which has a status of a high court. The burden of proof in these cases are "on the balance of probabilities" and not "beyond reasonable doubt". The MEW must be very aware of this pitfall of possible unreasonableness as virtually every doctor and his legal team admit to dissatisfaction with HPCSA procedures.

57 Writer's italics to emphasise that in the development of Medical Law in South Africa, also especially pertaining to medical expert witnessing, many lessons and findings need to be taken from international and foreign law.

58 United Nations Charter on Human Rights at https://www.un.org/rights/50/declaration (Date of use: 11 April 2013).

59 Currie and De Waal *The Bill of Rights Handbook* 7.

must be applied to all legal proceedings, directly or indirectly.[60] This is then the foundation of modern South African Medical Law, where first and foremost the constitutional obligations must be fulfilled.

The following acts[61] are also most important for the MEW to be considered in the appropriate aspects of medical litigation:

- **The Road Accident Fund Amendment Act 19 of 2005**. Note must be taken of the implications and limitations (capping) of claims and the narrative test allowed where a medical expert witness could argue for appropriate special and general damages.[62]
- **The National Health Act 61 of 2003**. This act provides the foundational structure of the national, provincial and district health care systems, including forming relationships between public and private care regulating the minimum acceptable standards. It provides for the statutory Health Professions Council, academic complexes and human resources regulations. Criticism has been levelled at a Draft Amendment for the establishment of the Office of Health Standards Compliance, where there is no clarity of the role of an appointed Ombudsman in relation to the HPCSA and the Council of Medical Schemes.[63]
- **The Medical Schemes Act 131 of 1998**. It could be envisaged that future "third party" financers would become more embroiled into medical litigation for instance the failure to provide for the payment of cancer medication, honouring patient agreements and exercising member rights. MEWs will be needed to determine fairness of paying for the prescribed minimal benefits.
- **Medicines and Related Substances Control Amendment Act 90 of 1997**.
- **Compensation for Occupational Injuries and Diseases Act 130 of 1993**.
- **Promotion of Equality and the Prevention of Unfair Discrimination Act 4 of 2000**. To note that this act prohibits unfair denial of access to healthcare services.

60 Currie and De Waal *The Bill of Rights Handbook* 32.
61 SAPPF publication 2011 *Healthcare in South Africa* 170.
62 Slabbert and Edeling 2012 *PER* 267.
63 Kahn 2011 *Business Day* January 26.

- **Promotion of Access to Information Act 2 of 2000**. Here it must be noted that information could be accessed that is required for the exercise or protection of any rights. This then has an impact to access medical records and a patient's medical history.
- **The Children's Act 38 of 2005**. The most important aspect here is that the age of majority has been reduced from 21 to 18 years, which is now the age of consent for medical procedures, and even to twelve years for the use of contraceptives.[64]
- **The National Credit Act 34 of 2005**.
- **The Consumer Protection Act 68 of 2008**. This act promotes social and economic welfare of consumers by promoting fair business practices.[65]

1.5 Overview of chapters

This dissertation is divided into seven chapters, which will be so set up in an effort to flow into one another to reach arguments after problem statements, which could be used in a summary and conclusions. The chapters are the following:

- Chapter one: this is an introductory chapter where the problems encountered by the MEW, the legal teams and the courts will be set out. The problems are elucidated which would be more addressed in detail in other chapters.
- Chapter two: in this chapter applicable historical aspects are discussed. Strategically the vision is that when it is known where aspects of litigation have come from, the future adaptation for the dynamic evolution of legal aspects in medical law will be better formulated and understood. Emphasis is also placed on ethics and certain philosophies influencing a MEW.
- Chapter three: medical negligence in litigation is defined and several applicable definitions of concepts given.
- Chapter four: in this chapter the many dilemmas and pitfalls of the medical expert witnesses are defined and by way of literature studies, advised how to avoid these dilemmas and pitfalls. In so doing better focus could be obtained

64 The Children's Act 38 of 2005, S 129 (2)(a)(b) and S129 (3)(a)(b)(c)
65 Pepper and Slabbert 2011 4 SAJBL 29.

in expert testimonies and opinions, which again could ensure that the courts are helped by applying sound principles furthering the cause of justice.

- Chapter five: this chapter entails aspects of other commonwealth and other legal systems which the South African legal system should take note of, especially under the Constitution section 39, that international law must be considered and that foreign law may be used.[66] Traditionally English Law has a very vast experience of medical law as well as the legal systems of Canada and Australia. Many dynamic changes regarding the norms, ethics and qualifications of a MEW in the USA system were noted which could be of use here in South Africa.
- Chapter six: Here the emphasis on the present medico-legal expert witnessing and its dilemmas in South Africa. On comparison it is the opinion of this writer that the South African system is fair, reasonable and just, but that the true quality of a MEW, by way of case reports, shows that it could be substandard. This could lead to wrong court findings. Norms and values as well as ethics need to be more refined and matured into a MEW and that there should be some form of training as well as a "code of conduct".
- Chapter seven: is the concluding chapter with a summary and conclusions.

1.6 Hypothesis

As law develops with the course of time, especially with the number of medico-legal cases increasing, there would be a need for knowledgeable and qualified medical expert witnesses and that the quality of medical expert witnessing should increase. This would have the effect that medical litigation would on the advice of a MEW become more streamlined, facilitating the conclusion of meritorious cases in settlements outside the courts. Furthermore the litigation processes will be more fair and reasonable and the courts, plaintiffs and defendants helped in an ethical and professional environment.

66 The Constitution, section 39: interpretation of the Bill of Rights. Here it should be noted under subsection (1) that a court, tribunal or forum, when interpreting the Bill of Rights, must promote the values that underlie an open and democratic society based on human dignity, equality and freedom; ***must consider international law: and may consider foreign law.***

MEWs should have to undergo some training in the “principles of medical law” as well as ethics.[67] Round table discussions at the time of discovery of documents and the reaching of MEW consensus under the supervision of the various legal teams would prevent unnecessary long, psychologically traumatic appearances in court and being subjected to cross examination and other adversarial systems of court procedures.[68]

The medico-legal profession as well as the various professional bodies of Law and Medicine should then endeavour, with the help of concerned societies and academic institutions, to educate, train and advise the legal profession as well as the MEW. It will be most necessary that a “Code of Conduct” be established.[69]

1.7 Value contribution

Through an overview of the causal and contributing aspects of medico-legal litigation, the knowledge gained will be used and valuable to educate and train lawyers as well as medical personnel in matters to improve medical expert testimonies. This will be to the immense help of courts but hopefully litigating parties would be able to settle cases out of court, saving money and time. In this dissertation aspects will be highlighted which could enhance the quality and fair, reasonable and justifiable testimonies, which will not cause any insult, humiliation or disgrace to any party. Thus the main value contribution of this dissertation could be to enhance the legally acceptable standard of the MEW and the opinion and testimony which could be used to every party’s advantage.

1.8 Motivation

A lot of problems are encountered with the MEW in various litigation cases. Close scrutiny of these problems show that many MEW's, do not understand their role and have very little insight into exactly what a legal team needs, due to a lack of legal knowledge. Many witnesses are false, hide facts, do not attend to the real material problems and often seem to have an unethical attitude and even start to

67 Hookman *Medical Malpractice Expert Witnessing* 270.
68 Theophilopoulos C et al *Fundamental Principles of Civil Procedure* 267.
69 Meintjes-Van der Walt 2000 *The South African Law Journal* 790.

do the argumentative adversarial role of the advocate, causing confusion and complicating the issues.

The writer has interviewed (informally) over 200 doctors and surgeons about their experiences in various Health Professions Council of South Africa cases or high court cases and it is astounding how the majority feel that the various medical witnesses were extremely unfair as well as unreasonably hostile and acted as “hired guns”.

At the same time it was noted that the legal profession browbeats the medical profession with legal terms, threats and imposing knowledge which fill the medical profession with submission and fear. By knowing some aspects of law, this intimidating role of the legal profession could be neutralised.

In attending over 102 high court case as a Medical Expert Witness and with obtaining a legal degree, it became obvious that the MEW could be a very valuable team member and could give insights, not thought of by legal persons, which could win a case or at least not pursue a case that would have no chance of being won.

For the benefit of all parties in the field of medical litigation it could be motivated, albeit more out of an altruistic and ethical point of view, that there must be medical doctors, who endeavour to learn more aspects of the law of medical litigation, thus avoiding the dilemmas and pitfalls of a MEW, which could nobly and honourably benefit all fair and reasonable parties.

CHAPTER TWO

HISTORICAL AND ETHICAL DEVELOPMENT OF THE MEDICAL EXPERT WITNESS

"Quod ego praetermitto et facile patior sileri" – [If] I make no mention of this, [I will] readily allow it to be passed over in silence.[1]

2.1 Introduction

The earliest records of medical negligence litigation are found in for instance, the Code of Hammurabi (*circa* 1 750 BCE) which provided penalties for "medical negligence", by amputating a physician's hand when having had caused a death.[2] The Greeks in 500 BC made medicine more scientific, where close observations and astute conclusions had led to acceptable good diagnoses and treatment for the time.[3] The Hippocratic Oath was formed and would set ethical standards which are still adhered to today by most doctors (who often see the Oath as a prohibitive factor in not (unnecessarily) testifying against fellow doctors), taking the Oath or similar undertaking at graduation.[4] The Romans frowned upon the medical profession, by employing Greek doctors (albeit as slaves), to do this "undignified" medical work. Medical malpractice was however already then divided into "intentional", "negligent" and "ignorant".[5] The concept of *culpa* was introduced, denoting the absence of intention, but the presence of negligence through a *commissio* or an *omissio*.[6] The concept of *imperitia culpae adnumerator* was introduced following the description of negligence by Gaius.[7]

The notion of causation, since Roman times, is pivotal to law as in medicine. However it was being understood that causation could be due to other origins of a

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1 Haynes *Ancient Guide to Modern Life* 52. The writer quotes Cicero, admitting to an historical murder he knows about.

2 Johns http://www.comonlaw.com/Hammurabi.html (Date used: 28 August 2012). Referring to "paragraph" 218. "If a surgeon has operated with the bronze lancet on a patrician…,and has caused his death,… his hands shall be cut off. For a slave…he shall render a slave for a slave.

3 Carstens and Pearmain *Foundational Principles of South African Medical Law* 609.

4 An example would be that many doctors would not want to testify against another doctor, especially for a considered reasonable error of judgement.

5 Freckelton and Mendelson *Causation in Law and Medicine* 57.

6 Hiemstra and Gonin *Trilingual Legal Dictionary* 165. *Commissio* in delictual offence meaning to commit, and *omissio* emphasizes an offence due to failure to act.

7 Carstens and Pearmain *Foundational Principles of South African Medical Law* 613. *Imperitia culpae adnumerator* meaning here that the lack of or want of skill is reckoned as a fault.

phenomenon or the consequential effects between two events, one which is claimed to have brought the other.[8] Likewise, legal causation developed from the Roman Law of Delict, namely the *Lex Aquilia* (286 BCE).

In due course a chain of causation had developed (especially now in present time medico-legal practice), because it is really seldom if ever that one single action or omission is the sole cause of damage.[9] The notion of fault was the determining criterion of liability. Fault would be attributed to someone who negligently performed services under a contract or for a fee.[10]

If patients died in the Roman-Greek times, medical culpability was considered, and if negligence was present action could be undertaken.[11] Fault, meant in terms of a defendant's actions against foreseeable risk of harm, was always determined first and then causation was established between the culpable conduct and the alleged harm.[12]

Medical negligence cases after the Roman-Greek periods are obviously, as part of the dark ages, rare. If a physician caused a death, he would be at the mercy of the deceased's family. In early Roman-Dutch law the *imperitia culpa adnumerator* rule survived. However, it was considered that it could be wrong to hold a physician liable for a death, as the fact that a patient died is not in itself any indication of medical negligence. On the continent, Europe came under the C*onstitutio Criminalis Carolina* of Emperor Charles V, influenced by the humanistic school of Roman Law in 1530.[13] This unified the legal systems of Europe, giving courts the chance to examine a case on its own accord, finding judgement based on facts and opening the way of the expert witness. Abandonment as cause of liability emerged and the payment of compensation for bodily injuries came to the fore.[14]

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8 Freckelton and Mendelson *Causation in Law and Medicine* 58.

9 This is still very true in present time and astute lawyers and advocates must continuously bear this in mind when planning a defence or representing a plaintiff. The role of the medical expert witness here is most critical.

10 Freckelton and Mendelson *Causation in Law and Medicine* 76.

11 Freckelton and Mendelson *Causation in Law and Medicine* 77.

12 Even now in modern times the defendant's lawyer while accepting a client's fault, can deny liability on the grounds of causation.

13 *Constitutio Criminalis Carolina* http://www.latein-agina.de/explorer/hexen1/carolina.htm (Date of use: 12 March 2012). Emperor Charles V was the emperor of the Holy Roman Empire in the 1500's, also being the King of Burgundy, the Germanic states and Spain.

14 Carstens and Pearmain *Foundational Principles of South African Medical Law* 617.

In early English Law the tort of negligence was introduced, with the first reported case in 1374, under the reign of Henry IV in England.[15] Note was taken of where people were injured by unintentional harmful conduct. The concept of "legal duty of care" entered the common law in England. Thus, due to the lack of care, diligence and foresight, as well as skill and honesty, patients could suffer damage.[16] Although the causal link was not yet conceived, damage had to be demonstrated.[17]

2.2 Roots of legal medicine development

The roots of legal medicine could be traced to sixteenth century Italy and the later eighteenth century in Britain, then also being developed in Germany, France and the United States. The French term *Médecine légale* appeared for the first time in the late eighteenth century.[18] In due course the term "medical jurisprudence" was introduced into America, following the lead from Britain.

2.2.1 The development of legal medicine in Britain

In 1788 Dr. Samuel Farr published the Elements of Medical Jurisprudence. Since then the systematic study and teaching of forensic medicine took place. In 1789 Dr. Andrew Duncan[19] emphasised that the term Medical Jurisprudence should also encompass "medical police" and "juridical" medicine.

Professional malpractice in England became rooted in the publication of Sir William Blackrose's (1723-1780) writing "Commenting on the Laws of England". Here the term *mala praxis* has been used for the first time under humanistic expressions. In 1917 it was stated that mere mental pain and anguish are too vague for legal address where no injury is done to a person, property, health or reputation. This would have to be medico-legally challenged over the next several decades up to the present time where for instance post-traumatic stress syndrome is acknowledged. [20]

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15 Carstens and Pearmain *Foundational Principles of South African Medical Law* 617.
16 Mendelson *The Interfaces of Medicine and Law* 8.
17 Mendelson *The Interfaces of Medicine and Law* 10.
18 Hookman *Medical Malpractice Expert Witnessing* 14.
19 University of Edinburgh, Scotland.
20 Mendelson *The Interfaces of Medicine and Law* 31.

In due course the question of the "reasonable man" and the want of due care according to the circumstances arose.[21] The notion of "duty of care" has been part of common law for a long time. Its practical effect is the restriction of freedom of conduct. Thus a doctor must not create actionable risks to the protected interests of a plaintiff, which fall in the ambit of the duty. However, there is no general test which would determine the existence or otherwise of the duty to care. The boundaries are vague and often there was no prior relationship between a plaintiff and the defendant. The decisions of remoteness of damage and the reasonable care to avoid damage, as well as the "egg-shell skull" type of cases complicate this insight. The concept of the measure of reasonableness was stated by the Chief Justice Tindal in the High Court of England 1838 that a reasonable care and skill must be determined of the person who has entered a learned profession.[22]

Judge Atkin formulated the so-called **Atkinian formula** of, a person from whom an action had sprung forth, who could reasonably have foreseen the result, should then be directly affected. The duty of care is then closely related to this concept. Medical scientific truth forms another element to be considered. Thus such dicta must be considered in the light of contemporaneous knowledge.[23]

The concept of a physician giving an opinion on the defendant's demeanour and facts produced in evidence in a court goes back to 1760.[24] Even then a warning was made that over eagerness may cause extravagant statements and injury to the scientific standards of proof. Nowadays it is accepted, with the contribution of more scientific psychological and psychiatric standards, that with most illnesses and afflictions, that it is not possible to isolate emotional from physical factors. Here the Atkinian principle comes to the fore again in what is reasonably foreseeable. Thus "close" proximity in emotional shock translates into "causal" proximity. Post-Traumatic Stress Disorder (PTSD) has become defined since the 1960's.[25] Although it could lead to over and misuse, the PTSD studies made the

21 Hookman *Medical Malpractice Expert Witnessing* 19.
22 Meagher, Marr and Meagher *Doctors and Hospitals: Legal Duties* 192.
23 Meagher, Marr and Meagher *Doctors and Hospitals: Legal Duties* 193.
24 Mendelson *The Interfaces of Medicine and the Law* 156.
25 Defined as a prolonged state of anxiety and psychological arousal following emotional trauma episodes, together with concomitant emotional disturbances. Proven with EEG, CT, MRI, PET scans (positron emission scans) and is typical found with intrusive thoughts, nightmares, flashbacks.

claim for emotional shock more scientific. The "once and for all rule" might not cover this phenomenon in later stages.[26]

Once *culpa* had been established, there will be an acceptable duty in English law to compensate. The law of torts proceeded on the assumption that the duty to compensate was based on a moral duty to provide reparation for the consequences of faulty conduct (that was foreseeable and preventable). In the legal history it is interesting to note that there were so-called compurgators or "oath swearers",[27] where formalistic procedures were followed. Although they did not testify, a set form of oath was made, provided they had personal knowledge of the case, in defence of the doctor or defendant. Initially, other witnesses were considered inferior to compurgators. However, echoes of compurgation are still present in modern law, and no much more that in the field of the MEW, in defending a respectable colleague.[28]

Since the 1990's it has become evident in Britain that MEWs could be lying or be giving false information. To counter this phenomenon Royal Court rulings have been given, strengthened as well as by General Medical Council findings, that a MEW can be held liable for negligence where false or misleading opinions and evidence was given.[29]

2.2.2 The development of legal medicine in the United States of America

The concept of medical jurisprudence was transferred into America by one Dr. James Stringham, who had studied for his medical degree at Edinburgh, elaborating upon the definition as "that science which applies the principles and practices of the different branches of medicine to the elucidation of doubtful questions in courts of justice".[30]

The first Medico-Legal Society was formed in 1867 in New York. This society emphasised that no physician or surgeon could be a satisfactory expert witness,

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26 Mendelson *The Interfaces of Medicine and the Law* 36.
27 Present in the Law of Ancient India and in English Law before King Edward I.
28 Murphy *Murphy on Evidence* 401.
29 *Levine v Wiss* 478A, 2ed 397 (NJ 1984), also *General Medical Council v Meadow* (2006) EWCA Civ 1390.
30 Hookman *Medical Malpractice Expert Witnessing* 15.

without knowledge of the law. Eventually the American College of Legal Medicine was formed, by a group of doctors qualified in the law.[31]

The first USA malpractice case was in 1794, where a surgeon was fined for the death of a woman due to a result of surgery "that was unskilful, ignorant, cruel, contrary to all known rules and principles". This was seen as breach of contract. Benjamin Rush, a signatory of the Declaration of Independence, called for lectures that would bring medicine and legal professions closer together.[32]

In 1892 the *Journal of the American Medical Association* (JAMA) lashed out at the disgrace of medical experts who were hired for theories and opinions. It was apparent that winning a case became paramount, resulting in jumbled cases with confused collections of half-truths and facts that are open to question.[33] It was also stated that concern about the credibility of a medical expert testimony in malpractice litigation is nothing new. It stated:

> …disgraceful exhibition of medical experts who are hired… paid for theories and opinions… led then to conflict enthused with the idea that truth is the great object. In reality both sides care nothing for the truth, winning the case is paramount. The expert witness is seductively drawn up to make statements, then driven to retract or qualify them, even pressed to perjury and then this expert ends up to a jumbled confused mass of half-truths and facts open to discussion. [34]

In 1942 Dr. Alan Moritz described legal medicine as "the application of medical knowledge to the needs of justice". Although meant to be interpreted broadly, the term was more applicable to forensic law or pathology. Later, in 1975, the Harvard professor of legal medicine defined it as "the specialty areas of medicine concerned with relations with substantive law and with legal institutions, including clinical medical areas, such as treatment of offenders and trauma medicine related to law, would be included herein".[35]

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31 Hookman *Medical Malpractice Expert Witnessing* 15. This prestigious organisation is still devoted today to address problems at the interface of the law and medicine.
32 Hookman *Medical Malpractice Expert Witnessing* 11.
33 Hookman *Medical Malpractice Expert Witnessing* 13.
34 Hookman *Medical Malpractice Expert Witnessing* 292.
35 Hookman *Medical Malpractice Expert Witnessing* 21, quoting the American College of Medicine and the Law (ACML) - In 1877 the Harvard University established a separate professorship in legal medicine.

Since 1972 the American Society of Law, Medicine and Ethics evolved, presently set as basic curriculum goals that medical students must:[36]

- Have the ability to identify the legal moral aspects of medical practice.
- Understand and have the ability to obtain a valid informed consent or accept a refusal.
- How to act where a patient is incompetent to consent or refuse treatment,
- How to proceed if a patient refuses treatment.
- Legally morally justification to withhold information from a patient.
- When it is justified to breach confidentiality.
- Knowledge of the legally moral aspects of care of terminally ill patients with a poor prognosis.

2.2.3 The South African scenario

It could be argued that the South African scenario arises out of the Roman-Dutch teachings of the common law, thus having also a great influence in the eventual development of medical law in South Africa.[37] The Dutch concepts for fault were repetitions of the Roman law. The *imperitia* rule was also carried over.[38] The Roman-Dutch law sanctioned physicians most harshly for medical negligence, originating from the *Constitituo Criminalis Carolina* of 1532.[39] Apart from medical negligence the Roman-Dutch law emphasised that a physician has a "duty to care" for a patient and must undertake to complete the treatment and not abandon the patient. Roman-Dutch Law also influenced legal and moral convictions regarding the liability of physicians.[40]

In Southern Africa the first medico-legal case was noted in 1877 where it was mentioned that a medical practitioner, like any professional man, is called upon to bring to bear a reasonable amount of skill and care in any case.[41] This was

36 Hookman *Medical Malpractice Expert Witnessing* 21.
37 Carstens and Pearmain *Foundational Principles of South African Medical Law* 616.
38 *Imperitia culpae adnumerator* – Loosely translated that the lack of skill will be held against the physician.
39 *Constitutio Criminalis Carolina* http://www.latein-agina.de/explorer/hexen1/carolina.htm (Date of use: 12 March 2012).
40 Carstens and Pearmain *Foundational Principles of South African Medical Law* 617.
41 *Lee v Schonnberg* (1877) 7 Buch 136 – de Villers CJ.

followed by the *Kovalsky v Krige* case where permanent damage followed a circumcision and it was stated:

> A surgeon… undertakes to bring a fair, reasonable and competent degree of skill to his case.[42]

Since 1994, the Constitution plays a decisive role. The term of "professional negligence" is preferably used as opposed to "medical malpractice", the latter being a very broad term.[43] The essential legal elements of a medical negligence, namely (1) an act, which was performed with (2) negligence, which (3) had caused harm or injury, at which (4) there is fault and a (5) provable nexus between cause and the harm, remained basically unchanged. Yet, technological development altered these standards of the levels of these elements dramatically, like complications of X-ray examinations, anaesthetics and organ transplantations to mention but a few.[44]

With these paradigm shifts, the nature of the doctor-patient relationship and understanding of professional negligence, changed. Paternalism gave way to patient autonomy, brought about by constitutional and human rights considerations. Consumerism, impersonality and financial constraints emerged adding other dimensions to this complicated doctor-patient relationship formula.

To establish professional negligence, a test for medical negligence has evolved. The test or criteria to be answered is basically that of a medical professional, having failed to foresee the possibility of harm (physical or mental) occurring to a patient in circumstances, where a reasonable person (*diligens paterfamilias*)[45] in the professional's position, would have foreseen the possibility of harm occurring and would have taken steps to avoid or prevent it, is then negligent!

This basic test revolves around foreseeability and preventability. Although fundamentally objective, it has elements of subjectivity when the negligence is assessed. The standard of negligence is graded according to the case of a

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42 Carstens and Pearmain *Foundational Principles of South African Medical* 619. *Kovalsky v Krige* (1910*),* the plaintiff lost his case.

43 Carstens and Pearmain *Foundational Principles of South African Medical* 599.

44 Carstens and Pearmain *Foundational Principles of South African Medical* 602.

45 Figuratively from Latin as the "reasonable man", who would be prudent, diligent, careful and circumspect, just like a caring head of a family.

medical practitioner, where the standard would be of a reasonable medical practitioner under the same circumstances. It is stressed that it is not the standard of an exceptionally able doctor, but that expected of an ordinary or average doctor and his levels of knowledge, skill, ability, experience and diligence.[46] By studying the historical aspects of the MEW mainly by the English (and by implication also the Commonwealth laws), the legal systems of the USA and then the reciprocated and developing medico-legal law in South Africa, it is interesting to note how mature refined legal reasoning had been promoted in its development. This in itself is the proof why a legal representative and a medico-legal expert witness should have insight to this historical development, to understand better the argumentation revolving around medico-legal cases. Understanding the historical background, would give enough reason to evaluate and appreciate the value of the philosophy and ethics involved in preventing the pitfalls of a medical expert witness as discussed in the next chapter.

2.3 The role of ethics and selected applicable philosophies in the development of the present day medical expert witness

"To certain people, even educated ones, the whole business of philosophising is distasteful. Others have no objection, as long as it's conducted informally, but don't think too much effort should be devoted to it."[47]

The knowledge a MEW should have about ethics, amplified by a "code of ethics", would help to lessen the overwhelming burden of medico-legal litigation and also enhance the satisfactory outcome to all parties concerned.[48] As lessons are learnt from history it could be argued that a "Code of Ethics / Conduct" for MEWs must be endorsed by the medico-legal community and ethical guidelines should be contained in this "Code", as lessons learnt from the historical development.[49]

46 *Van Wyk v Lewis* 1924 AD 438. This case is quite well referred to and quoted from after having been referred to in English, Canadian and Australian legal literature and court cases.
47 Cicero (*circa* 45 BCE) *On Living and Dying Well* – Habinek 1
48 Mason and McCall Smith *Law and Medical Ethics* 3.
49 Meintjes-Van Der Walt 2003 *Child Abuse Research SA* 42

Jean-Martin Charcot stated that everyone is aware of the common human need to tell lies, whether for no reason at all or to create an impression to accrue pity.[50] Physicians and MEWs for instance, reciprocally distrust patients especially when no lesions or injuries could physically be demonstrated, believing it an act for "compensation neurosis".[51]

The psychology of "moral panic" threatens fundamental values and fuels the need for punishment which should be reserved for those whose actions reveal morally relevant wrongdoing. The philosopher Jean Hampton (1990) reasoned that accusing, condemning and avenging are part of our daily life, but it is poorly understood. The term *mens rea*,[52] referring to the state of mind to be culpable, creates a refined system, to distinguish between being blameworthy or blameless. However, as often experienced, there is a continuing tension between subjectivism and objectivism. Society's practice of "blaming" creates a danger of losing moral values. MEWs can falter, for instance becoming "hired guns" when losing the values of ethics. This opens the full complexity of faults of human behaviour of all concerned parties.[53]

Insights into the fields of psychology and accident causation theories are often ignored by the medico-legal team. It must be realised that there is a belief by the patient and the family, in individual accountability and then they become and develop into an autistic,[54] self-centred, self-interest responsive person in scapegoating. They then have an inability to accept the inevitability of human loss.[55] Fallibility is, alas, a condition of human existence. Doctors, like ordinary people of all walks in life, will at times err through ignorance or misadventure, but these errors in medicine can be fatal.

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50 Jean-Martin Charcot (1825-1893), world renowned "father" of neurology, but also developed psychology and worked with hypnosis on hysteria. Worked at the famous Salpetriere Hospital, Paris, France for 33 years. http://www.en.wikipedia.org/wiki/Jean-Marin_Charcot (Date of use: 28 January 2013).

51 Mason and McCall Smith *Law and Medical Ethics* 5.

52 Mason and McCall Smith *Law and Medical Ethics* 5. "Guilty mind doctrine".

53 Mason and McCall Smith *Law and Medical Ethics* 8.

54 The term used here with the litigious patient and family having impaired social interaction and communication and having restrictive self centered persistent behaviour, refusing to listen and consider the doctor's side of events.

55 Durand "Responsibility" www.durand.org.za/tuis/medies/responsibility (Date of Use: 31 July 2012).

2.3.1 Doctors as culprits, victims and witnesses

From a medico-legal point of view, a MEW when asked to give an opinion or even a testimony is confronted by many ethical questions. The doctors have to do an evaluation whether their colleagues must be seen as culprits or victims and whether they should be prepared to testify for a particular party in medical litigation. It is an encountered problem that doctors are not willing to testify against colleagues – the so-called "conspiracy of silence".[56] Most reasonable doctors feel that any doctor can make a mistake or an error of judgement and when it comes to negligence, no intent was meant. All doctors know that the practice of good medicine is not easy, often complicated by difficult unreasonable patients. Biological sciences can also have a large degree of unpredictability. A question that begs to be asked is whether the doctor is a culprit or a victim of the circumstances of a particular case. Furthermore the witness doctor is placed under stress as the classical Hippocratic Oath has an undertaking which could be interpreted to keep silent, when encountering a situation that could reflect adversely on a colleague.[57] The reasons could also be fear of losing hospital privileges, that malpractice insurance could be cancelled and fears of vulnerability in future litigation against a particular doctor that would want to act as a MEW against a fellow medical doctor or specialist. This creates a dilemma for the "professional witness". The consequences of any litigation against a doctor where a MEW has stated or defined negligence are patient-family anger, self-centeredness and "autism changes" in the litigious patient or family.[58] The defendant doctor, inadvertently but understandably, invariably reacts with hostility, can become inattentive and abruptness can follow, challenging his own ethical principles and a vicious circle could develop.[59]

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56 Bateman 2005 *South African Medical Journal* 378.

57 The original Hippocratic Oath, although not pledged as such any more, is usually still taken note of and the appropriate sentence is here which could enforce silence is "*all that may come to my knowledge in the exercise of my profession or in daily commerce with men, which ought not to be spread aboard, **I will keep secret and never reveal**"* (own emphasis).

58 With "autism changes" is meant that patients and their family become extremely self centered, with loss of contact to reality, inappropriate reactions to the situation and showing most unreasonable and unrealistic expectations.

59 Durand "Responsibility" www.durand.org.za/tuis/medies/responsibility (Date of use: 28 January 2013).

However, the “suit prone” physician (as a “culprit”), often has faulty working habits, personality faults and weak communication skills. This person often cannot admit his limitations, dismisses complaints and fails to defuse an upset patient. He fails to realise that patients can react with hostility and anger, especially if ill, fearing malignancies in uncomfortable, painful and embarrassing circumstances, resulting in loss of trust and faith. The doctor lacks empathy, failing to understand that this is a form of communication, by ways of actively experiencing the feelings and thoughts of patients. This then loads the scenario against the doctor and these weaknesses should be taken note of by an ethical medical witness so as to fairly evaluate a case in which he deems it appropriate to testify, because this type of doctor must be brought back to order, even by using extreme measures like the law and medical litigation.[60]

The effect of a summons initiates a period of disequilibrium in a doctor’s life. With unfair litigation this is an extremely heavy emotional burden for a doctor to carry. There is invariably shock, disbelief, shame, anxiety, anger, depression and physical symptoms. Self-blame could be excessive, lasting up to two years. This could, uncontrolled and under stress, cause that the defendant doctor will likely accept unwarranted guilt. Thus, a MEW must take care, also from an ethics and philosophical point of view, not to pressure the defendant doctor to assume unwarranted blame, adding to a phenomenon where a good doctor otherwise could become guilt ridden, more dysfunctional and contributing to miscarriage of justice.[61]

Using a holistic approach, it must be borne in mind that psychologically, a doctor has residual feelings following medical litigation for up to two years. Furthermore angry patients undergo emotional maturity regression under stress and vent their anger with a malpractice suit, often unnecessarily complicating the issue. Once litigation has started, an apology will probably not stop it, and this long course of stress for especially an innocent doctor to bear must be prevented by means of a MEW using a well-considered ethical approach.[62]

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60 Hookman *Medical Malpractice Expert Witnessing* 198.
61 Hookman *Medical Malpractice Expert Witnessing* 179.
62 Hookman *Medical Malpractice Expert Witnessing* 179.

As most professional organisations and societies have codes of ethics and professional rules, more attention should be given to ethical and professional aspirations and obligations. It must be prevented that the MEW, "as a victim", will be abused or forced to act unfairly without any integrity, by unreasonable, emotional and probably "compensation greedy" patients and their lawyers.[63]

2.3.2 The philosophical role of autonomy and confidentiality

For many centuries doctors were in a comfort zone of paternalism, domineering patients into treatment regimens which the doctor thought was right and appropriate. With the emergence of human rights and the post-modern era were patients, as independent responsible persons, would want to decide on their own terms which treatment and its implications they would consider, the concept of patient personal autonomy emerged. This encompasses to be able to rule oneself, and not be under the control and interference of others. Limitations to inadequate understanding and information to make a meaningful personal choice are thus rejected in this concept.[64] Four types of autonomy applicable to the medical professional - patient relationship can be described. This is important to know, as any litigation could actually be enhanced by how this interaction develops namely,

- A paternalist relationship[65]
- A relationship of mutuality.[66]
- A consumerist relationship.[67]
- A relationship of default, which basically amounts to no sensible relationship having been established.[68]

Above emphasises that an efficient and ethical doctor-patient relationship should be a fiduciary relationship. This is defined in terms that it arises when the beneficiary (patient) entrusts the fiduciary (doctor) with power which may affect the

63 Meintjes-Van der Walt 2003 *Child Abuse Research SA* 42. Meintjies-Van der Walt emphasises that not enough attention is given to the ethical aspirations and obligations of professionals involved with expert evkidence.
64 Beauchamp and Childress *Principles of Biomedical Ethics* 99.
65 The physician controls the relationship and decides for the patient.
66 The doctor and the patient are equal partners engaged in a sharing of information designed to produce the best treatment for the patient.
67 The patient is the active dominant party, demanding treatment from a doctor who must meet the requests of the patient.
68 Here neither party takes a leading role. This encounter leads to a non-productive result.

beneficiary's interests and to the patient's exclusive benefit. However, the reality is that the medical professional has the power of knowledge and thus the authority in relationships. This must then always be considered when evaluating the ethical angle as a MEW of a doctor-patient relationship. An advantage is that it would then also improve communication between the doctor and the patient.[69]

A dialogue could then follow, abolishing the fear, lack of control and feelings of abandonment, which patients could experience, enhancing the concept that a patient has autonomy and in confidence, can make informed choices of treatment with an empathy sensitive and sympathetic doctor. The patient's integrity is thus protected. This then forms an important concept of consent. Patients' rights could be neglected if too little attention is given to autonomy. However doctors must guard against ending up submitting to a patient's arguments, when the patients have no understanding of medicine or the issues for instance, giving the confused and frightened "no" to ideal or appropriate treatment or surgery. The argument which courts will have to settle in medico-legal cases is the question of whether a doctor, ethically speaking, was indeed acting in the best interests of the patient, so that proper and informed consent could have been given by a patient![70]

More and more cases, especially at disciplinary hearings arise where issues of transgression of confidentiality are encountered. Every such case must be decided on its own merits, as confidentiality is very important. This should ethically be taken very seriously, especially with computerisation nowadays which could cause loss of privacy. Insurance companies also seek forever more and more information about patients, infringing on the autonomy of a patient. Some medical commentators have described patient confidentiality as a "decrepit concept", because often in reality it does not actually and realistically exist, infringing also on the autonomy of a patient.[71] Thus reaffirmation of the importance of confidentiality

69 Hookman *Medical Malpractice Expert Witnessing* 179.

70 Herring *Medical Law and Ethics* 206. The rights in Medical Law, including a Right to Autonomy, to Dignity and to Life is founded in Humanitarian Law, enshrined in the Human Rights Acts of 1998, based on the guidelines of the ECHR (European Charter of Human Rights).

71 Carstens and Pearmain *Foundational Principles of South African Medical Law* 948.

could ethically be seen as one way of restoring patient-doctor trust and show respect for the patient's autonomy.[72]

2.3.3 The effects of legal dictates on the ethics of a medical expert witness

Legal dictates (for instance avoiding litigation by the practice of defensive medicine and "over servicing") often act in opposition not only to cost containment, but also to good clinical judgement and also the accepted principles of medical ethics.[73]

In the 4th century BC, Hippocrates, had the concept of *primum non nocere* - "above all, do no harm".[74] Questions from an ethical aspect must be posed by every MEW of what is right, what is justice and what it means to act correctly, by which way all parties could benefit. Every MEW must be evaluated in each witness session as to his level of practice regarding ethics and the basic philosophies, setting the standard in how a particular MEW would and could assist the court. In recent times, following transplant surgery and the changing relations between all in healthcare, important ethical questions are raised. Patient confidentiality and justifying being a MEW are examples of these changes.[75]

Every MEW should, prior to being an expert witness, undergo self-examination, whenever ethics and morality are involved, thus ensuring that there is an ethical and moral base, for instance studying case reports and having group discussions. Flowing from this, ethical concepts in medicine and law, what is good, bad, right and wrong will be better defined. Ethics, could force the evaluation in situations about what ought to be done and whether the right thing is being done in a particular medico-legal case.[76]

Morality refers to actual human practices enforced by values and legal practice. Thus morality is what people factually do, whereas ethics is what they think,

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72 Herring *Medical Law and Ethics* 255.

73 Marshall and Kapp *Our Hands are Tied* 1. This leads to "deprofessionalisation" of medicine, forfeiting medical judgement for legal protection. (Doctors are often reminded by their defence lawyers, that one cannot use an excuse of too expensive costs, when having thought about special tests and examinations).

74 Both as philosopher and physician, in the oath, written by him or one of his students. This principle is more known in the Latin phrase instead of the original Greek.

75 Moodley *Medical Ethics, Law and Human Rights* 9

76 Moodley *Medical Ethics, Law and Human Rights* 9.

reflectively and systematically, they should do. Here the two main pillars (Utilitarianism and Kantian Deontology) of medico-legal philosophy should also be understood by the MEW.[77]

2.4 Utilitarianism and Kantian Deontology

It is most important that any MEW must understand the two most accepted philosophical theories so as to formulate and justify the basis of rendering an opinion and testifying, thus assisting the court with his medical knowledge (either for or against the plaintiff or the defendant).[78] It will be noted that it is perhaps more acceptable to have and use both theories as a background so that the one theory's strong points could compensate for the other's weak points.

2.4.1 Utilitarianism refers to an ethics theory that forms a subgroup of consequentialism. This is a moral approach theorising that the consequences of actions are exclusively taken, as the only concern in terms of which the moral status ("rightness" versus "wrongness") of the actions is the way in which it is decided. The specific consequentialist theory, based on the argument that the relative amount of happiness or pain, that is brought about by actions is the most important indicator of moral worth.[79] The following three claims to utilitarianism are formulated, and must be considered by a MEW who intends to give expert testimony in court, thus justifying his action:

- Actions are to be judged right or wrong solely by the virtue of their consequences; nothing else matters.
- In assessing consequences, what matters is the amount of "happiness" or "unhappiness" that is created; everything else is irrelevant.
- Each person's "happiness" counts the same. Thus, right actions are those that produce the greatest balance of "happiness", with each person's "happiness" equally important.[80]

In medico-legal issues all parties should have an intuitive sense that the consequences of the actions of lawyers, doctors and especially MEWs, count in a

77 Moodley *Medical Ethics, Law and Human Rights* 11.
78 Moodley *Medical Ethics, Law and Human Rights 20*.
79 This is known as utilitarianism.
80 Moodley *Medical Ethics, Law and Human Rights* 23

moral sense. If doctors as a MEW harm another person by their slanted or faulty, unfair and unreasonable opinion or testimony, it is wrong. The quality of a good MEW is that no unfair or unjustifiable "harm" should occur against the party against whom he or she testifies.

This makes the utilitarianism quite radical, weighing up one party's right to "happiness" with another party's right not to have unfair and unjustifiable "unhappiness". The greatest balance of "happiness" over "unhappiness" (fairness and reasonableness) is sought. A MEW could have to answer whether it is right, for instance, to lie or manipulate the truth, to bring about the most happiness/satisfaction for the most people involved, relying on the adversarial system and the other party's legal team to let the law arrive at the correct finding, by means of a "check and balance" mechanism.[81] Thus, this balance of bringing greater "happiness" over "unhappiness" can be at odds with the demands of justice, especially if the MEW is weak, ill prepared, has no strong integrity and lacks ethical values and insight. In countering this phenomenon MEWs must not be placed in an unbearable position, in that they cannot act with integrity. The MEW must be placed in a position to give a balanced opinion.[82]

2.4.2 Kantian Deontology is the second significant and influential moral theory, with close association with the modern world. The term "Kantian" comes from the German-Lithuanian philosopher, Immanuel Kant (1724-1804). This philosophy emphasises the role of strict behaviour to rules in conferring moral status on any action. Deeds have inherent moral worth. Acts would be wrong, regardless of justification, by having no possible advantageous consequences. It is by being human, that insight is developed in good moral characteristics like honesty, integrity and altruism. By being rational, right and wrong can be distinguished.[83]

Kant's concept of morality comes from the capacity to reason and for freedom to act autonomously. Here autonomy means to act according to a "law" that an individual imposes on himself. For Kant, the right motive is to always do one's

81 Presuming that all parties have excellent advocates who through their training, knowledge and skill would ensure inbuilt automatic safety factors like checks, balances and counter checks to ensure truth and accuracy.
82 Moodley *Medical Ethics, Law and Human Rights* 23
83 Moodley *Medical Ethics, Law and Human Rights* 25.

duty. It is a "duty" to do the right thing to fulfil the inalienable sense of duty. This is a categorical imperative or unconditional demand, a role of "good will" in morality.[84]

This emphasises that acts are based on rationality and that moral action is based on freedom which in turn is based on autonomy, which then invites unconditional respect. It is important that Kant meant it to be respect also for all individuals. This imperative forbids "abusing" anybody (like a MEW) as a "means" to something else.[85]

Kantianism also explains the role which moral rules play in life. The sense of duty springs from the morally obliged respect for all autonomous human persons. In Kantianism acts are not from self-interest or for optimal consequences, but only for the sake of duty.[86] Obviously there will be inflexibility, but it should be tempered by a concept of greater value or duty. There is thus a duty to prevent harm to people and respect autonomy and confidentiality, which every MEW should bear in mind, rather than being a virtuous person and not for instance a "hired gun".[87] This then leads to the ethical concepts of virtue ethics and principlism.

2.5 Virtue ethics and Principlism

2.5.1 Virtue Ethics: this is the oldest form of ethics in the Western Tradition.[88] It is also called character ethics, as it is focused on the character traits of people.[89] The fundamental point of a virtue approach is that moral status is conferred on acts, not because of the characteristics of the act[90] or its consequences,[91] but for the character traits of the actor. What makes an act right or wrong, is the character of the actor, since it is the virtuousness of the character that confers a moral status on what is done. To act right is to act with virtue. By dealing with good people,

84 Moodley *Medical Ethics, Law and Human Rights* 26.
85 Moodley *Medical Ethics, Law and Human Rights* 27.
86 Moodley *Medical Ethics, Law and Human Rights* 27.
87 This could be used as a counter argument against doctors for not accepting MEW requests, for instance when it is considered that harm due to fault of a callous doctor had occurred to a patient.
88 Moodley *Medical Ethics, Law and Human Rights* 29.
89 Aristotle is the most prominent philosopher associated with this. It was rekindled in the 20th century.
90 Concept from deontology.
91 Concept from utilitarianism.

there will be a guarantee of righteous deeds, producing goodness and preventing harm. Virtue is a character trait that is "good for a person to have".[92]

There must be good intentions and motives with which people embark on moral action. Although virtue ethics have excellent qualities, it cannot actually stand on its own. Apart from care, virtues that are important to support one another are compassion, trustworthiness, integrity and conscientiousness. It would be useful if a MEW, would evaluate the actions of a doctor under these headings to reach a sense of fairness of his professional view in the medical-legal process.[93]

2.5.2 Principlism. This theory refers to the approach to moral argumentation developed by Beauchamp and Childress, worldwide acknowledged experts in biomedical ethics.[94] The basic idea is that moral problems, in accepting and evaluating a case, must apply one or more of the four basic moral principles.[95] These principles are (a) **autonomy**, (b) **non-maleficence**, (c) **beneficence** and (d) **justice**.[96] The approach is to use these as "basic" beginnings of addressing an ethical, moral and medico-legal problem.[97]

By using the four principles as a basic point of departure, consensus could be achieved. All other theories, alone, could not always be applied in medico-ethical situations, but they can fit into one or more of the basic four principles. This creates a form of common morality and it is pluralistic, as two or more principles form the basis of a normative statement.[98]

In every situation the principles must be individually weighed. Thus each case must be analysed for principle application.[99]

The emphasis is more on a process than a final product. The downside of principlism is that intuition (which could be wrong) plays a bigger role, but it is balanced out eventually with the consensus achieved by the built-in common

92 Moodley *Medical Ethics, Law and Human Rights* 30.
93 Beauchamp and Childress *Principles of Biomedical Ethics* 38.
94 Moodley *Medical Ethics, Law and Human Rights* 37.
95 Beauchamp and Childress *Principle of Biomedical Ethics* 12.
96 Moodley *Medical Ethics, Law and Human Rights* 39.
97 Dhai and McQuoid-Mason *Bioethics, Human Rights and Health Law* 14
98 Kennedy and Grub *Medical Law* 23.
99 Moodley *Medical Ethics, Law and Human Rights* 39.

morality. Principlism, as a point of departure is very popular, as people could identify with it, because of simplicity and versatility.[100]

Principlism should be used by all medical lawyers and MEW's as a background to each case as follows namely by the principles of:

- **Respect for Autonomy** – respect is related to individual autonomous choice and decision making by patients. This principle takes into consideration self-determination and is the basis of informed consent and respecting confidentiality in healthcare practice.[101]
- **Non-maleficence**. This revolves around avoiding or doing as little harm as possible. False or distorted testimony against a doctor or for the interpretation of a patient's case, fall under this heading!
- **Beneficence** – this principle means doing good for others and promoting their interests and well-being.[102] In healthcare practice this principle expects practitioners to act in the best interests of their patients and to promote their welfare.
- **Justice**. In healthcare it refers to distributive justice and the fair allocation of scarce healthcare resources. The principle of justice also considers whether the individual is properly treated and whether society's benefits and burdens are distributed fairly.

Criticism against this system is that to use above as a single system providing a framework for dealing with all moral problems, is that it does not actually provide a unique solution to every moral problem.[103]

By using principlism, the outdated doctrine of paternalism is then being eliminated. Paternalism however can still remain a comfort zone for many doctors. It could be argued that often patients trust a doctor to make the right decision for them, but at least then it must be at the informed will and consent of the patient.[104]

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100 Moodley *Medical Ethics, Law and Human Rights* 39.
101 Dhai and McQuoid-Mason *Bioethics, Human Rights and Health Law* 14. Respect for autonomy of the MEW should therefore also be borne in mind.
102 It differs from benevolence which is "wishing good "for others.
103 Gert, Culver and Clouser *Bioethics: A Systemic Approach* 26.
104 Kennedy and Grub *Medical Law* 25.

Paternalism in medico-legal law is ethically juxtaposed to informed consent. It could be argued that doctors are victims of legal paternalism by lawyers encouraging pleas of guilty of malpractice charges, to prevent costly prolonged litigation. Medical and legal practitioners must also not make themselves guilty of paternalism.[105]

Current ethical approaches tend to value a patient's autonomy and rights of choice. The move from paternalism to patient centred decision-making is at the heart of many recent cases like *Rogers v Whitaker* (1992) 175 CLR 479.[106]

2.6 The post-modern era's effects on medical ethics

In the post-modern era,[107] it must be accepted that doctor/patient relationships are also much affected by economic interests. Traditional subjects, processes and (Western) ideologies are abandoned, promoting diversity and discourse. Moral insights can thus be gained through a diversity of perspectives. A form of pragmatism has thus developed, born out of frustration with the old orders and dominance of power. There is a danger in post-modernism, in that the study of other philosophies is neglected. It stands to reason that doctors and patients will view one another differently when one is a State patient, treated free, compared to being treated on a private commercial basis. Although a consumerist philosophy applies, it does not or should not really have any impact on the altruistic ethical care of a patient.[108] However it could lead to costly over-servicing, unnecessary referral and over-investigation, especially in facilities owned by doctors. Money's corrupting role is difficult to avoid and this could lead to doctor/patient conflict. Patients inevitably see themselves as victims who could only fight back with litigation, and this pathway is fuelled by the patient's ignorance of medical matters. The public should be educated in the broader picture of medicine and its costs. However, these polarised opposing attitudes between doctor and litigious patients

105 Dhai and McQuoid-Mason *Bioethics, Human Rights and Health Law* 15.

106 Freckelton and Petersen *Disputes and Dilemmas in Health Law* 4. Here the doctor did not warn the patient about a rare eye immunological reaction which could cause the loss of sight in the healthy eye, as he considered "paternalistically" that the patient need not, as well as would not have wanted to know.

107 In this writer's view since from the United Nations Declaration of Human Rights 1948-1953 or from 1945 onwards.

108 The exception here is probably cosmetic and plastic surgery.

can be reconciled, where a knowledgeable, qualified MEW could play a role based on respect and trust, fulfilling a main function of medical witness jurisprudence![109]

Human rights are always at the centre of any potential litigation where justice, information, access to health services, dignity and privacy are at the forefront. There is a continuous need for policy makers, judges and legislators to seek a balance between individual rights and the community's interests.[110] Because advances in technology and knowledge cause dilemmas which could be ubiquitous, health law has a very strong international global aspect.[111] Admittedly it is difficult to define ethics, in the post-modern era.[112] Ethics is defined as a study and practice relating to morals and addressing moral questions. Although most people will maintain that there is a difference between ethics and morals, both concepts can refer to character, behaviour patterns, custom, legal sanction and the distinction between right and wrong. [113]

Ethics seek principles of overriding importance, of universal application, concerning human well-being, with a rational approach to morality and should be prescriptive.[114] Thus by putting ethics of medicine first and foremost in the practice not only of medicine but also in the practice of medical litigation, the MEW would then by maintaining this standard with integrity, give honest, fair and reasonable medico-legal opinions and testimony that would help a court and all parties involved to reach a fair and justifiable outcome. This type of practice of medicine and medical law, especially in post-modern times, could be a tool for improving the practice of health care and thus the role of ethics here as a positive factor, should be acknowledged.[115]

In practice, many doctors express their concern that many so-called MEW's do however lie. This is to sound extremely authoritative and knowledgeable to create

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109 Mason and McCall Smith *Law and Medical Ethics* 17.
110 *Soobramoney v Minister of Health, KwaZulu-Natal* 1998 (1) SA765 (CC) .
111 Freckelton and Petersen *Disputes and Dilemmas in Health Law* 4. Comment: Thus focus must be maintained on the health law development in other countries, especially for South African purposes, from other common law jurisdictions like the United Kingdom, New Zealand, Australia , Canada and the Netherlands.
112 Freckelton and Petersen *Disputes and Dilemmas in Health Law* 17.
113 The words "Ethics" and "Morals" originated respectively from Greek *ethikos* and Latin *morales.*
114 Freckelton and Petersen *Disputes and Dilemmas in Health Law* 18.
115 Montgomery 2012 *Journal of Med Law Review* 8.

the impression that they are better and more superior to the defendant doctor. This is a rising phenomenon and is now addressed as a new and rising aspect and threat of medico-legal practice.[116]

2.7 The ethical dilemmas of a medical expert witness.

Considering all the factors contributing to finding a MEW as fit, proper and competent, the most important are the reliability, being capable of clearly explaining and presenting the facts, and being knowledgeable.[117]

From a plaintiff's point of view a dilemma is that a MEW must evaluate issues like malingering, vindictiveness, behaviour akin to childlike regression and autism, histrionic behaviour, hysterics and the so-called "compensation neurosis" which is motivated by the lure of pecuniary damages.[118]

The ways in which the standard of care is assessed are themselves subjected to limitations creating further dilemmas, as "expert" evidence may be a poor indicator of what should reasonably be expected in a particular case. Legal and disciplinary procedures should be properly founded on firm moral and scientific grounds. There should also be a conviction that patients will be better served if the real causes of harm are properly identified and appropriately acted upon, thus eliminating unrealistic and unreasonable expectations.[119]

Quite minor cases may present a dilemma in that it has consequences completely out of proportion to their moral culpability. On the other hand, a major departure from the required standard could even result in a criminal case, but many fall into the civil /common law jurisdictions.[120] The pitfall could occur that a tendency has evolved to blame the last identifiable element in the chain of causation and the person "holding the smoking gun" is then mostly blamed. It is a mistake to concentrate on a single discrete act, without paying adequate attention to the overall performance of the individual in the context of the entire event. By not

116 Durand "*The Mechanism of the Lie – Mendaciology*" www.durand.org.za/tuis/medies/mendaciology (Date of use: 12 February 2012)
117 Knoetze (2008) *De Rebus* 28.
118 Durand "Responsibility" http:www.durand.org.za/tuis/medies/responsibility (Date of use : 3 July 2012).
119 Murphy *Murphy on Evidence* 51.
120 Merry and McCall Smith *Errors, Medicine and the Law* 11.

doing so, the pendulum can swing unfairly against the defendant. It is most important that the cause of a problem be properly identified, as it could then from a medical point of view act as a lesson to prevent a recurrence. At the same time there must be caution against and no deliberate choice, to falsify evidence by any party, which would be a criminal act.[121]

There must be resistance to the temptation to and it must be factually accepted, that there is no rational justification for judging culpability of an act by the severity of its unintended consequence. Likewise legal action against a doctor would focus on an isolated failure and discount many successes.[122] It is therefore also important that the myth should be dispelled that in medical expert witnessing, especially in the adversarial system, that autonomy, certainty and real objective scientific knowledge actually and really fully exist.[123]

2.8 The phenomenon of lies as a threat to medico-legal ethics

Mendaciology is a new field to ethical study involving the mechanism and effects of the lie.[124] The MEW to avoid embarrassment, to enhance his own image and to control a threatening situation (like losing his status as an expert), could lie deliberately, trusting that the lies and false information would not come out in the cross examination. This is a prevalent issue as nearly 60 per cent of doctors have personally seen and experienced a MEW in court whom they believed to have been inaccurate or who have based their witnessing on questionable science.[125] Another factor which could fuel mendaciology is that by being "famous", that it could be addictive. Thus to maintain this "famous" status, false testimony could be conjured up by doctors who have some form of a character defect, to impress and gain accreditation, thriving on the attention.[126]

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121 Merry and McCall Smith *Errors, Medicine and the Law* 14. Chain of causation: legally and during evaluation and analysis of the events it is realized that seldom if ever, just like in an aircraft crash, that one single person or incident precipitated an adverse event or harm and injury due to negligence in a patient. There are usually many small but leading incidences and events eventually culminating into the sum of a catastrophe. This must be evaluated.

122 Merry and McCall Smith *Errors, Medicine and the Law* 15.

123 Meintjes-Van Der Walt 2000 *The South African Law Journal* 790.

124 *Mendacium* definition: Latin for "lie", also "mendacious" adjective in English for "untruthful".

125 Publication of the Centre for Survey Research and Analysis, University of Virginia, October 2006. On commission of the American Tort Reform Association.

126 Youngson and Schott *Medical Blunders* 233. The case is described of a certain Dr. William McBride, who triumphed by discovering the Thalidomide (anti-nausea pill in pregnancy)

The fine art of these lies is when there is truth in the semantics of the spoken text being essentially true, but in context of the situation and the circumstances, it is false. This type of lie is picked up by a knowledgeable person, who recognizes this deviation and knows the right answer. Medical professionals can control this form of lie, masquerading self-confidence and honesty as well as sincerity, knowing well that the truth is being misrepresented and so could lose or win a case.

In the same sense a witness could "lie" by withholding the truth. This is well known in criminal law as misrepresentation by omission. The expectation is not met that the liar, as a MEW, could take steps to remedy the misrepresentation, but does not do it. The paradox and dilemma could however arise, by applying Kantian deontology,[127] that focus on what is forbidden to say where obligations to tell the whole truth, could create many contradictions.[128]

Most doctors have become aware of this phenomenon in especially HPCSA cases, where the MEW of the disciplinary council is an assertive professor with a niche interest and no reasonable experience in the private or clinical practice. However, if Beauchamp and Childress' principles, especially that of non-maleficence, are used by these witnesses, these scenarios could be avoided, enhancing moral reasoning and reaching proper moral decisions.[129] It is thus obvious, that the solution to proper, fair, reasonable and justifiable medical jurisprudence must be a commitment to adhere and follow the philosophy of mainly the above mentioned as ethical and moral behaviour. [130]

2.9 Conclusion

It is unacceptable that doctors should have to work in a legal vacuum, in which they are fearful that they could face civil, disciplinary or criminal action following risks that they take with every patient. Doctors know that an astute lawyer and a

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disaster in 1961 and who received many accolades (*i.a.* Commander of the British Empire) for this, found that several other drugs also had similar effects, but when confronted no evidence could be provided. After millions of Pounds were spent on litigation, McBride admitted publishing false data. Dr. McBride was found guilty of scientific fraud and erased from the General Medical Council (UK) medical register.

127 Davis *A Companion to Ethics* 205.

128 Durand "*The Mechanism of the Lie – Mendaciology*" www.durand.org.za/tuis/medies/mendaciology (Date of use: 12 February 2012)

129 Beauchamp and Childress *Principles of Biomedical Ethics* 399.

130 Moodley *Medical Ethics, Law and Human Rights* 193.

naïve or hostile unethical MEW, could conjure up a case, even when only a *bona fide* error of judgement had been made.[131]

For this reason, for proper judicial process, clear and general rules and qualifications must be in place, even by means of a statutory process. A check and balance mechanism must be built in. After necessary proof had been given of malicious or careless testimony by a MEW, the MEW could also be charged for "malpractice" or criminally for perjury.[132]

There must be a commitment to only appoint an experienced and qualified MEW, by whom the professions and the public could be adequately represented. The dilemma is that once rules have been formulated, they eventually acquire a narrow meaning which allows no room for manoeuvring and then these rules could become more restrictive than originally intended.[133]

The legal profession is drawn into this complex situation, leading to distress, emotions and even judicial hostility. This could influence the proper judicial processes, unless these situations are defused by knowledgeable expert witnesses.

The long term effect, now that damages claims are colossal, is that experienced practitioners are refusing patients for fear of being accused of negligence. Young doctors are deterred to enter the high risk disciplines of the profession because of the risks involved. The dilemma here is the classic problem of doing justice to all parties.[134] This is all amplified by the *legio* dilemmas a MEW must know of and consider when trying to give an opinion about a medical negligence claim that should be fair, reasonable, justified and justifiable, with ethical considerations of beneficence and non-maleficence to be obligatory.[135]

131 Hookman *Medical Malpractice Expert Witnessing* 15.
132 Freckelton I (2007) Expert Witness Immunity and the regulation of experts: *General Medical Council v. Meadow Psychiatry, Psychology and Law* 185.
133 Mason and McCall Smith *Law and Medical Ethics* 150.
134 Mason and McCall Smith *Law and Medical Ethics* 16. Quoting the statement of Lord Denning in the case *Whitehouse v Jordan* (1980) 1 All ER 650.
135 Beauchamp and Childress *Principles of Biomedical Ethics* 371.

CHAPTER THREE

DEFINING AND UNDERSTANDING MEDICAL NEGLIGENCE IN LITIGATION

"We must not take what is unknown as known and rashly assent to it. Anyone who wants to avoid this mistake, as all should, will devote time and effort to careful observation"[1]

3.1 Introduction

For meeting the requirements for patient care, a doctor is understood to bring forth a fair, reasonable and competent degree of skill.[2] This has been shown as one of the most basic requirements for the doctor-patient relationship to develop (chapter one). The historical oversight showed that this tradition from a medico-legal point of view has been well established and is amplified in the practice of medical-legal ethics in ensuring that a doctor adheres to his side of this relationship (chapter two).

The causes of litigation revolve around the breakdown of this relationship due to perceived judgements of error, or real and factual medical negligence or malpractice. It is therefore important to define and understand the concept of medical negligence and to conceptualise this factually, so that potential litigation or defence could follow if necessary. Definitions and concepts must be clarified so that no room for error is given that under a misunderstanding, a wrongful path will be taken causing real cases to be dismissed or findings made which are erroneous.[3] The MEW and the legal team must therefore define and understand medical negligence, as set out in this chapter.[4]

3.2 Definitions in medical litigation

As much confusion exists amongst physicians around the various definitions widely used in medical litigation some clarification is needed.

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1 Habinek *Cicero- On Living and Dying Well* 115.

2 Moodley *Medical Ethics, Law and Human Rights* 143.

3 Carstens and Pearmain *Foundational Principles of South African Law* 19. It is stated here: "*For Law is beautiful – it has a certain elegance of logic, a certain rightness of reason, which when correctly understood and applied, is no less entrancing than the constructs of higher mathematics – this is certainly also true of medical laws*".

4 Grobler 2007 *The South African Gastroenterology Review* 11 refers to MEWs that are held in low esteem. This is mainly due to their lack of defining and understanding negligence as well as their lack of ethics. Terms of "jukebox experts", "hired guns" and "plaintiff's whores" are used.

3.2.1 Medical malpractice: Where professional negligence resulting from improper discharge of professional duties or failure to meet the standard of care of a professional, resulting in harm to another. The legal standard of care for malpractice requires (a) a physician-patient relationship that establishes the duty of care, (b) an adverse outcome with actual injury or harm, (c) negligence by the provider (often interpreted as failure to provide the standard of care) and (d) direct causality between negligence and outcome.[5] The term are often loosely used and interrelated with medical negligence, confusing many medical practitioners. Medical malpractice is used were medical negligence has taken place. Factual as well as legal causes have to be considered.[6] Negligence refers to a blameworthy unlawful conduct in the context of how a reasonable doctor would have acted. The issue of criminal medical negligence then comes to the fore where foreseeability and preventability would be measured normatively by the "reasonable doctor in the same circumstances", and found to have been extremely unacceptably and even deliberately below standard (creating a sense of horror and abhorrence as well as disbelief by the reasonable professional person).[7]

3.2.2 Adverse incident: an adverse incident occurring in medical practice is mainly unexpected due to rareness but if argued, could have been foreseen as a possibility. This incident has a potential of permanently harming the patient and the doctor must take appropriate action. This leads to the adverse advent described as any event in medical practice where the treatment, against expectations, had to be adjusted to meet a changing scenario and where a patient suffers permanent damage. The dilemma is whether a reasonable careful diligent doctor would have foreseen such an event and have taken appropriate steps to prevent it. If the adverse incident is considered an accident, the dilemma arises that the event was not preventable and would be interpreted medico-legally as exculpatory, mitigating, unintentional and unforeseeable. Thus the definition and the meaning of such a broad definition must be placed in boundaries by the MEW and legal teams![8]

5 Hookman *Medical Malpractice Expert Witnessing* 283.
6 Hookman *Medical Malpractice Expert Witnessing 283* .
7 Carstens and Pearmain *Foundational Principles of South African Medical Law* 846.
8 Merry and McCall Smith *Errors, Medicine and the Law* 27.

3.2.3 Medical misadventure, mishap or error: is considered as a personal injury arising from medical error or medical mishap. Medical mishap is defined as an adverse consequence of treatment by (or at the direction of) a registered health professional, given if:

(a) The likelihood of the adverse consequence of treatment is rare; and
(b) The adverse consequences of the treatment are severe.

With some caveats, "rare" is defined as something that would not occur in more than one per cent of cases.[9] The severe is dealt with "arbitrarily". Medical error is also here defined as the failure of a registered health professional to observe the standard of care and skill reasonably to be expected in the circumstances.[10] The short definition of a medical error could be drawn through to civil negligence. However, the definition fails to recognise the nature of human error and its distinction from a violation, or to recognise a body of science underpinning this concept.[11]

3.2.4 "Act of God" (*vis major*) is often used loosely and should be defined as a direct, sudden and irresistible action or the operation of uncontrollable natural forces, which could not humanly have been foreseen or prevented. When many of these cases are closely scrutinised, often tell-tale signs are picked up like uncorrected electrolyte imbalances, which could have caused sudden heart arrest.[12]

3.2.5 A medical accident is an unplanned, unexpected and undesired event, usually with an adverse outcome. An adverse outcome, following an error, must be construed to be an accident as "no one plans, expects or desires an error".[13]

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9 Strauss. Paper delivered at the Surgical Controversies Symposium, regarding Informed Consent 2006.
10 The New Zealand Accident, Rehabilitation and Compensation Act (1992) definitions.
11 The New Zealand Accident, Rehabilitation and Compensation Act (1992) definitions
12 Green http://www.expertlaw.com/library/malpractice/medical_error.html 9. (Date of use: 12 July 2011).
13 Green http://www.expertlaw.com/library/malpractice/medical_error.html 3. (Date of use: 12 July 2011).

3.3 The "medical negligent act"

As a negligent act is the basis of medical malpractice litigation and the leading element of a delict, the elements of a delict, must be evaluated, to avoid dilemmas especially at cross examination. These elements are conduct, which was wrongful, at which there is fault that caused injury or harm, and that there is a causal connection or nexus with the harm or injury (own emphasis). Thus a delict is an act, that wrongfully and in a culpable way, caused harm to another, and that there is fault as well as a connection between the causation and the harm. All elements must be present before a plaintiff could, via a delictual action, pursue liability.[14]

The most common causes of action, of which a MEW must be well acquainted with, are:[15]

- Negligence.
- Breach of contract, meaning the guaranteeing a specific result.[16]
- Divulgence of confidential information.
- Insufficient informed consent. A claim is possible even at a low risk of one to two per cent because failure to have warned could have deprived the claimant of a choice.[17]
- Failure to prevent foreseeable injuries.

3.3.1 Determining the cause – to prevent cause "confusion"

Legally it is important to establish and confirm the cause generally and specifically of an incident of professional medical negligence. Confusion exists and pitfalls develop so that lay people and doctors confuse factual causes with juristic and

14 Neethling, Potgieter, Visser *Law of Delict* 4.
15 Hookman *Medical Malpractice Expert Witnessing* 280. Hookman uses "Black's Law Dictionary's" definition of negligence.
16 Plastic and reconstructive surgery cases especially, as well as sterilization operations that have failed.
17 Cameron and Gumbel *Clinical Negligence – A Practitioner's Handbook* 12.

judicial causes.[18] Legally speaking, the proximate cause seems to be a good approach and the MEW should be knowledgeable about it.[19]

The principle for the proximate cause is explained as the closest related cause or sequence of causes that produces the undesirable or catastrophic event. Note should be taken by not choosing exaggerated descriptive words like "catastrophic or disastrous", as a court's opinion could be unfairly influenced! It also must be emphasised that a medical complication is not the same or synonymous as medical negligence.[20]

The MEW should understand that a plaintiff's attorney has to, pending the circumstances of the litigation, demonstrate that:

- The physician departed from commonly accepted standards.[21]
- The physician failed to keep abreast with changes in medical practice.
- The physician employed a new, unproved and unacceptable method of treatment.
- The physician did not take proper precaution against risks.
- The physician did not perform to the standards expected of a reasonably competent and "prudent" specialist.

In short, to obtain compensation the patient must show that the doctor was at fault causing an injury. Thus to find that a doctor is at fault, the judges must rely on the opinion and views of a doctor as a MEW. The accepted view of the medical profession will seldom be challenged by a judge. As both sides can call their own MEW, a clash of eminent medical opinion could however unfortunately occur, also in the adversarial court procedures.[22]

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18 Neethling, Potgieter and Visser *Law of Delict* 175. This revolves around the *conditio sine qua non* or the question of "but for…"?

19 Neethling, Potgieter and Visser *Law of Delict* 190. Also known as the flexible approach with emphasis on the direct consequences of an act and reasonably foreseeability.

20 Hookman *Medical Malpractice Expert Witnessing* 295.

21 Although not necessarily the majority's use of standard, but at least should have followed respected minority's standards.

22 Kennedy and Grub *Medical Law* 397.

3.3.2 Assessing the plaintiff's "harm" or "damage"

The medical profession as a whole is most prone, unlike other professions, to make irreversible mistakes, often committed as an error done in an unguarded moment.[23] It could also be problematic to prove harm, as a doctor can only undertake to do his best and can never guarantee a cure. The patient will only have a legal remedy if it can be shown that **"but for"** the doctor's carelessness or lack of skill, it had caused the patient injury, that would otherwise not have been suffered. The plaintiff must prove that had the doctor acted acceptably and properly, the harm would have been avoided. To maintain an action in negligence, the plaintiff must establish that the doctor owed **(a) a duty to care, (b) that the duty was breached, (c) that harm was suffered due to the breach** (own emphasis).[24] The MEW must understand this to assist the legal teams.

Furthermore the plaintiff's attorney must prove, with considered MEW advice, that:

- The physician had a duty to care for the plaintiff.
- The physician failed this duty.
- This failure resulted in damage.
- The damage must be measured for monetary compensation.

However, the plaintiff must first establish the appropriate medical standard of care (by using a MEW), so the court can determine whether the defendant's conduct was a deviation which then constitutes negligence.[25]

The most common complaints against doctors are:

- Deserting patients.
- Devaluing patient and family views.
- Poor communication, failing to understand patient and family prejudice. This is the most important contributing factor.[26]

23 Kennedy and Grub *Medical Law* 398.
24 Kennedy and Grub *Medical Law* 398.
25 Hookman *Medical Malpractice Expert Witnessing* 80.
26 Hookman *Medical Malpractice Expert Witnessing* 110.

The decision to litigate is precipitated by perceived lack of caring and collaboration in the delivery of health care:

- Perceived unavailability.
- Discounting patient and family concerns.
- Poor delivery of information.
- Lack of understanding the patient and family perspective.

Communication failures contribute to many medico-legal mishaps. Unfortunately these communication failures can be very complex. It has been shown that positive communication increased patient perception of physician competence and decreased malpractice claim intensions up to 50 per cent.[27]

Although effective communication shows a doctor as caring, diagnostic errors that harm patients, result in multiple communication break-downs.[28] It is important though to take note of patients contributing to errors, like not providing complete and appropriate clinical history information. Interpersonal relationships can complicate effective empathy and sympathetic communications.[29]

An informed patient is an understanding patient.[30] In the diagnosis and treatment, the elements needed to be covered are the options, benefits of treatment, possible harm, the seriousness of this harm, probabilities, factors influencing outcome and difficulty in avoiding harmful incidents. By informing the patient, the important medical ethic of autonomy, is fostered. If this could not be achieved, it would be wise to refer the patient. Lawyers, but also plaintiffs, don't realise that the complete elimination of risk is simply not possible. What would be considered a tolerable risk is dependent on values, beliefs and scientific information. Risk management will continue to be a balancing act of competing priorities and needs.

27 Howarth 2012 *SA Medical Chronicle* 1.

28 The prevalent aspects most consistent in prevention of litigation are compassion, communication, competence and proper charting according to most authors.

29 Freckelton and Petersen *Disputes and Dilemmas in Health Law* 81.

30 A typical case law example would be the case of *Castell v De Greef* 1994 (4) SA 408 (C). Here a patient was not warned that her breast areola could become devoid of blood supply causing necrosis, following a subcutaneous mastectomy.

By being flexible and by using good judgements are the key factors to make appropriate risk decisions.[31]

Most common reasons for patient dissatisfaction are:

- Failure to diagnose, inordinate delay and failure to consult other doctors. If doctors negligently fail to diagnose and treat an illness, it will have to be shown, apart from the disease worsening, that had it been treated earlier it would have prevented worsening, at least for the interim period.[32]
- Negligent prescriptions and invasive procedures.
- Failure to obtain and document informed consent:
    - Must contain expected outcome, potential risks and reasonable alternatives.
    - The principle decisions in what the doctor advised and which the patient chose.[33]

Good clinical notes should contain the patient's subjective complaints, the objective clinical findings, the appraisal/diagnosis and plan, as well as the options, the opinions and the agreement. Records were considered the sole property of the doctor, prior to the present (RSA) Constitution.[34] With the new Constitution this has changed, reminding doctors to have good quality notes, realising that it could be read by a judge in court! The procedure of discovery would also allow the other party to inspect the records. Records should not be given to other parties without obtaining own legal guidance, especially when it seems that the records are wanted by parties contemplating litigation.[35] Refusal to give records after obtaining legal guidance would however only arouse excessive suspicion and paranoia.[36]

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31 Choctow *Avoiding Medical Malpractice* 27.
32 Cameron and Gumbel *Clinical Negligence – A Practitioner's Handbook* 27.
33 Hookman *Medical Malpractice Expert Witnessing* 175. Stating in documentation that the "patient understands and agrees".
34 The Constitution of the Republic of South Africa, 1996 s 32 Access to Information and s 33 Right to Just Administrative Action would apply.
35 For purposes of building a case by "fishing" or "trawling" expeditions.
36 Strauss *Doctor, Patient and the Law* 291.

3.4 The delictual concept of causation

The defendant's lawyer, while accepting fault, can deny liability on the grounds of causation. This is because legal liability will be attributed only to the defendant if it could be shown on a balance of probabilities, that the action or omission caused or materially attributed to a risk of injury.[37] The decision of liability is reached on the basis of legal policy considerations rather than seemingly logical extrapolation of facts.[38]

The shift is from factual causation[39] to legal (judicial) causation.[40] Modern law has also now incorporated foreseeability **of risk** of harm, as against foreseeability of harm, making it inchoate.[41] Factual causation, following inductive reasoning and established by the *condition sine qua non test*, could thus become superfluous. Judicial causation has then to be established as well and this could be a pitfall for a MEW to understand. A foundational case in South African medical law is *Silver v Premier Gauteng*.[42] Here the patient developed bedsores and claimed from the Premier, but the factual causation could not be satisfied, and thus a judicial causation could also not be established.[43]

It is important for legal credibility, for achieving justice, that following a careful analysis, it must be shown how a defendant's conduct is causatively linked to the plaintiff's harm. The task of courts is to determine whether some harm has indeed been caused by a particular wrongful act. The classical example here, bordering perhaps from the viewpoint of the MEW on a travesty of justice, is the *Rogers v*

37 Khoury *Uncertain Causation in Medical Liability* 22.
38 Freckelton and Mendelson *Causation in Law and Medicine* 81.
39 Neethling Potgieter and Visser *Law of Delict* 177. Determined on the basis of the evidence and probabilities, whether there is a causal link between an action and the damage. The obvious method is to establish whether one fact followed from another expressed in terms of the *conditio sine qua non* "test".
40 Neethling Potgieter and Visser *Law of Delict* 187. Legal causation must be determined by criteria after factual causation has been established. There are many opinions and theories are formed. The favourite is the so-called "flexible approach", which considers policies, reasonableness, fairness and justice. Others are "adequate causation", "direct consequences" criteria," theory of fault" and "reasonable foreseeability" criteria.
41 Here meaning that this concept is not fully developed, confused and incoherent. The Main question to be asked here was whether the risk and also its cause was reasonably foreseeable.
42 *Silver v Premier, Gauteng Provincial Government* 1998 (4) SA 569 (W) para 570 E.
43 ` Carstens and Pearmain *Foundational Principles of South African Medical Law* 828. *Silver v Premier, Gauteng Provincial Government* 1998 (4) SA 569 (W) para 570 H.

Whitaker case of Australia.[44] In this case it was considered that a complication which only occurs in a one in fourteen thousand chance should have been mentioned in the process of informed consent, as it was, though remotely, still foreseeable. It should have been foreseen that it was material to the patient (own emphasis) to have been warned. A South African case is *Castell v De Greef*, in which similar arguments had been produced, in that a practitioner had to incur liability for negligent failure to warn of (foreseeable) material risks.[45]

The concept of harm and thus also injury must also be understood in this context. Harm as a term has both a normative and a non-normative use. To harm someone need not imply a violation. In medico-legal terms harm is construed in the sense of thwarting, "defeating" or negatively influencing somebody's interests. Acts of harming is then considered a *prima facie* wrong. The concept of harm should however be interpreted narrowly as a wide conception would include discomfort, humiliation, offense and annoyance or setbacks of reputation and privacy. Harm in this context should be limited to physical and mental harm including pain, disability, suffering and death.[46]

The concept of causation is a vague area for a MEW. To define and identify it, the elements of a delict must be evaluated by the legal team with the medical witness giving input on what would be reasonable and a proper standard of care under the circumstances. If the MEW cannot understand the concepts of factual and judicial causation, the MEW's opinion and testimony could be misunderstood and would be of a questionable standard making the MEW very vulnerable under cross examination. Causation, responsibility and legal liability must be evaluated together.[47]

Causation must then be seen as a tool for inquiring into the relation between one event and another. It must be borne in mind that doctors cannot predict an

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44 Here the *Rogers v Whitaker* (1992) 175 CLR 479 High Court case and (1993) 67 ALJR 47 Appeal Court case of Australia found that the risk of sympathetic ophthalmia (loss of sight in the healthy eye, through the action of antibodies, formed from the diseased eye) that may occur in 1: 14 000, rarely performed procedures was foreseeable! *This is an extremely unreasonable, if not unfair finding against a doctor (Doctor Rogers).* (Writer's italics and opinion).

45 *Castell v De Greef* 1994 (4) SA 408 (C) para 408I. The defence of *volenti non fit iniuria* was rejected (para 409A).

46 Beauchamp and Childress *Principles of Biomedical Ethics* 152

47 Freckelton and Mendelson *Causation in Law and Medicine* 4.

outcome, as patients could react differently to various treatments. Medical judgements, being dependent on many interlinking factors in medicine, therefore differ from other "predictable" exact sciences like mathematics and physics.[48]

3.4.1 The role of a novus actus interveniens *in medical litigation.*

Novus actus interveniens is also described as *nova causa interveniens*, which is interpreted as a new cause that is intervening and also a later additional occurrence (complicating a medico-legal issue). However it must be very well interpreted, and the role of the MEW here is to help establish *novus actus interveniens* from the normal or expected course that develops in the progressive evolving clinical situation of a specific condition, i.e. as complications of the specific condition.[49]

Its occurrence is then vested in the break or interference of the continuation of a chain of events, flowing from a cause and another intervening, unrelated occurrence. This is an often hidden major pitfall of which a MEW must be aware of, exacerbated by the withholding of important and material facts by a plaintiff or a legal team.[50]

3.4.2 Remoteness of damage

Three conditions must be met, before a person who caused harm, could be held liable for it, these being the following:[51]

- The person must have had knowledge that by taking an action (or by omission), which caused harm, they could be held liable.
- The sanction must be proportional to the conduct.

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48 Freckelton and Mendelson *Causation in Law and Medicine* 5.

49 Strauss *Doctor, Patient and the Law* 323.

50 Another example is a case (*Van Der Merwe v Workman's Compensation Fund*,2008 Gauteng North, unreported) of where a person who fell down a set of stairs (the fall being caused by broken floor tiles) fracturing his neck, developed bowel distension due to the turning of the large bowel on itself (volvulus). The patient had to undergo a permanent colostomy. This is a well-known and acknowledged complication of quadriplegia but the Workmen's Compensation Fund refused to pay for this, viewing it as a *novus actus interveniens*. This writer had to sternly advise the court that it was not fair and a settlement was reached, compensating the patient appropriately. Had the medical witness no insight into this concept, the patient would probably have been legally bereft of fair payment and compensation.

51 Freckelton and Mendelson *Causation in Law and Medicine* 10.

- The connection between the action or conduct and harm must be proved.[52]

By satisfying these legal criteria in civil procedures, liability could be excluded for harm that was unforeseen, even if it was caused by wrongful conduct.[53] Here the "umbrella term" of "remoteness of damage" applies, where secondary damage or harm sets in by later intervention and not directly flowing forth from the original injuries or harm. When proving that the damage caused was due to an unlawful conduct, lawyers and the MEW could misunderstand one another. Here the onus of proof will lie with the victim, and although legal minds would argue for a standard of proof, most medical doctors act on probabilities that often fall short of the standard of proof required by a court.[54]

Biological processes, like Post-Traumatic Stress Disorder (PTSD) are difficult to prove, especially in the context of "remoteness of damage". This could be circumvented if a court puts the onus of proof on the defendant to rather prove why a certain trauma or harm could not have caused PTSD, for example following a bullet wound injury. By insisting either way on the proof of a causal connection, the law will be aligned with the values that prevail in society, creating dilemmas and pitfalls for the MEW. Courts must emphasise, that lawyers as well as MEW, must at the inquiry stage (when a *prima facie* case exists), properly evaluate historical involvement and relevance, to determine liability for harm or remoteness of damage.[55]

3.4.3 A failure to warn

A dilemma could occur if the test for causation is taken to the level of a "failure to warn". Whether a plaintiff was not warned and even if warned would not have been subjected to medication, to a point where if the patient still went on with the recommended treatment which caused harm, the plaintiff must show as the reasonable person, sharing reasonable beliefs, fears, desires and expectations, that the plaintiff would then not have agreed to the medical procedure. The question that arises is whether the plaintiff's harm should be held to be within the

52 Neethling, Potgieter and Visser *Law of Delict* 186. It is emphasized that in South African Law of Delict, a causal nexus can only exist between actual events.
53 Like burn wounds obtained in theater, because the patient was not properly "earthed".
54 Freckelton and Mendelson *Causation in Law and Medicine* 12.
55 Carstens and Pearmain *Foundational Principles of South African Medical Law* 859.

appropriate scope of liability. This could also be valuable for a defence argument.[56]

Perplexing questions arise regarding which factors should be considered relevant, in terms of responsibility, especially with intervening events occurring.[57] *Chappel v Hart* is an important case quoted to evaluate "medical causation"[58] within a failure to warn context. In this case a throat ailment was operated upon which caused damage to the nerve leading to the vocal cords. This is a common complication for neck operations and this risk, as part of obtaining informed consent, should be explained. The patient was not warned and although the surgery was professional, the vocal cord nerve was damaged. The patient claimed, had she been warned, she would have gone elsewhere for surgery. However, because the defendant did not foresee damage and as the patient needed the operation, there was no reasonable way to establish whether other doctors, would have had no greater risk of injuring the nerves. Failure to have warned did not expose the plaintiff to any greater risk, than what she would have faced elsewhere, but the patient's autonomy was neglected. Had the plaintiff asked about this risk, different reasoning would apply. It was argued by the defence that had she gone elsewhere, she would not have had this injury. This was impossible to prove. In this case the plaintiff was compensated. The neglect of or ignoring foreseeability, is thus a contributing focal point in causation and the incidence of materially relevant, possible complications should be well explained in layman's terms to a patient. However, severe misunderstandings by any average patient could still occur.[59]

The notion of causation is pivotal to medical law, but paradoxically often does not meet the accepted legal standard. The two faceted legal notion of causation may be the reason as causation could medically be due to other origins of a phenomenon or the consequential effects between two events, one which is

56 Freckelton and Mendelson *Causation in Law and Medicine* 26.
57 Examples could be *inter alia* medication given causing an allergy which kills an orthopaedic patient, or due to negligent treatment, gangrene sets in and a limb is amputated.
58 *Chappel v Hart* (1998) 195 CLR 232.
59 Carstens and Pearmain *Foundational Principles of South African Medical Law* 860.

claimed to have brought the other.[60] It is seldom if ever that one single action or omission is the sole cause of damage, especially in medico-legal practice.[61]

The MEW must understand the shift from factual causation to legal causation.

The legal system places a greater apportionment upon responsibility, whereas in medical settings generalisations are made.[62] In the various medical disciplines, perceptions about the causation may differ. MEW's may display a degree of being unsure, especially when having to give explanations for the causation. Intrinsic subjectivity of the MEW can then subsequently cloud the issue.[63]

Judges should only bring closure to the question determining medical causation, when the different MEW's agree to an acceptable extent, as exemplified in the South African case of *Michael and Another v Linksfield Park Clinic Ltd and Another.*[64] If the experts still have disagreement, closure is considered, if there would be no further significant implications.[65] Emphasis is placed on substantial and significant harm or damage, thus to exclude "*de minimus non curat lex*" cases, as opposed to cases where medical negligence had materially contributed to cause damage.[66]

Use of "common sense" must be tempered by a personal sense of wisdom and reasonableness by a MEW in his opinions and testimony, when causation is evaluated. This must also remain normative as liability must be determined on the broad grounds of moral responsibility for the damage which has occurred. Presently in order for the MEW to avoid pitfalls and gaps in his testimony as far as causation is involved, he needs to be advised that ultimate questions must be

60 Neethling, Potgieter and Visser *Law of Delict* 175. The two notions being 1. Factual causation (*conditio sine qua non*) and 2.Legal causation.

61 To quote a favoured quotation by advocates in medico legal hearings or trials : "just like an aircraft accident seldom happens "suddenly" due to one cause, so does a chain of events and omissions add up to an eventual medical adverse event and a case of medical malpractice negligence".

62 Freckelton and Mendelson *Causation in Law and Medicine* 83.

63 Freckelton and Mendelson *Causation in Law and Medicine* 85.

64 *Michael and Another v Linksfield Park Clinic Ltd and Another* 2001 (3) SA 1188 (SCA) para 1200C. Here the judge emphasized he will not be misled by council eliciting expert opinions but will listen to believable (*sic*) opinions of various experts to determine whether the conduct of the respondents were reasonable. Para 1198I.

65 Freckelton and Mendelson *Causation in Law and Medicine* 89.

66 Khoury *Uncertain Causation in Medical Liability* 25. "*De minimus non curat lex*" meaning figuratively that the law will not concern itself with trifle minimal frivolous cases.

answered like, “was there a breach”, “did it affect the plaintiff” and “did it indeed cause the damage claimed”. Here objectivity will then penetrate and solve uncertainty regarding culpability and compensation, making the focus for the MEW and the legal teams at least a bit clearer. This will help a court then to reach a fair, reasonable and justifiable decision. [67]

3.4.4 Loss of chance and hypothetical future scenario’s

The loss of chance concept has internationally (especially in the USA) now also become a popular lateral way for litigation against medical malpractice. Especially *inter alia*, doctors’ prognosis statements could be used with the necessary caution.[68] It is seldom easy, but provided it is well thought out with the aid of a knowledgeable MEW, this could provide a fair avenue for just compensation, where a harmed patient might have received no compensation at all. In the RSA this doctrine at the time of writing had not really yet been used (and thus not reported) although it had been mentioned in *Oldwage v Louwrens*.[69] Several cases in the RSA had the potential for this doctrine (for instance the loss or misinterpretation of histology, leading to non-curative action) and thus the MEW, although it could be a difficult concept, must have some understanding of it. This doctrine has been described in the Supreme Court of Canada and defined as – “…the plaintiffs may be compensated where their only loss is the loss of a chance of a favourable opportunity, or of a chance of avoiding a detrimental event”.[70]

The “Loss of Chance” concept for harm prevention is poorly understood. To illustrate, a case needs to be discussed.

Hotson v East Berks Area Health Authority (1987) AC 750[71]

> In this case, a child who fell out of a tree developed necrosis of the injured hip. This hip was not immobilized and it was claimed that he was treated negligently, thus necrosis followed, even if accepted that 75% of children with this type of injury would develop this

67 Freckelton and Mendelson *Causation in Law and Medicine* 151.
68 Carstens and Pearmain *Foundational Principles of South African Medical Law* 833.
69 *Oldwage v Louwrens* (2004) 1 SA 532 (C) para 562C.
70 *Athey v Leonati* (1996) 3 SCR 474.
71 Freckelton and Mendelson *Causation in Law and Medicine* 25.

> complication. If this is taken as the view statistically and allowing for probability, this child could not claim for harm, but if a claim is made for a "loss of chance" then a 25 % claim for damages could be made. Thus the concept of "loss of chance" came as a developed remedy, were the court adopts a "competing fiction" asking: "was the defendant party's fault, part of the sequence of this case's history by which the plaintiff lost a chance of avoiding complications with its resultant harm?" The court must choose which rules are appropriate where there are evidentiary *lacunae* in a case. However in this case the plaintiff's case was not entertained (arguably unfairly and unreasonably) on the principle of the "all or nothing" approach by the House of Lords.

The theory is put in practical terms as a patient presenting for treatment with symptoms of cancer, but the practitioner negligently fails to recognize these symptoms and then does no tests to confirm this cancer. The correct diagnosis is then made after several months when the patient has advanced cancer. In retrospect using the size of the growth and spread, it could be deducted that the earlier consultation should have been so to have made the diagnosis provided a proper examination and tests had been done. It then could have been presumed that had the earlier diagnosis been made, the cancer would have been detected and treated. It could then be argued that the patient would for instance, have had a better survival for five to ten years. Now, after the lapse of time, the patient's life expectancy would be a couple of months.[72]

Assuming there had been a contract between the patient and the doctor, the patient would probably be entitled to nominal damages for breach of implied terms requiring the exercise of reasonable care and skill. There could also be compensation for pain suffered, until the diagnosis was made, as well as for loss of earnings. The question is whether loss of chance of survival could be claimed for, as on probability any such cancer patient would have died naturally on the balance of probabilities, unless this could also be proportionally compensated. Loss of chance should be compensated appropriately, even if the chances are

72 De Raedt Q "Loss of a Chance in Medical Malpractice" http://www.2012wcml.com 145 (Date of use: 19 August 2012).

less than even (proportionally) for a predictable course of the disease. It should be recognised as such rather than as an "all-or-nothing" proposition.[73] Alternatively, as it is not to be a drastic change of the traditional views in the RSA, defendants could still be held accountable for the proportion of damages that they are liable for.[74]

Another pitfall that could develop under loss of chance is the distinction between past facts and future hypothetical facts. In the court's assessment of damages it could hinge on what will be and what would have been, contrasted by determining what was. Hypothetical events on what might or might not have occurred have since been applied almost daily, where a plaintiff is suffering from an underlying natural condition that might have affected the plaintiff, if an injury or a missed diagnosis had not occurred.[75]

This raises questions in relation to causation, since any causal questions would involve the hypothetical scenario of what would have happened had the defendant not been negligent. The acceptable course would be that proof on the balance of probabilities would be required in the relation to causation. Evidential onus placed on the defendant, can show what would have been the effects of an underlying condition, if the plaintiff had no injuries. The ultimate onus still rests on the plaintiff, to prove that the defendant caused the harm for which damages are sought. Thus the plaintiff must prove on the balance of probabilities that a defendant's negligence contributed materially to the present symptoms. Alternatively, it might be easier to convince a court and "prove" that there is now a loss of survival chances, bypassing the proof of causality to an extent.[76] Pending the evidential proof and the defendant's case, a court could reduce the plaintiff's claim appropriately, bearing contingencies and imponderables in mind.[77]

So-called open and closed cases must also be touched on briefly. The open cases is where a plaintiff has been exposed to a risk, which may or may not occur and is confronted with the dilemma of "the once and for all rule" of assessment of

73 Freckelton and Mendelson *Causation in Law and Medicine* 154.
74 Carstens and Pearmain *Foundational Principles of South African Medical Law* 839.
75 Freckelton and Mendelson *Causation in Law and Medicine* 166. Scenario's that come to mind are obesity, heart and lung conditions.
76 De Raedt http//www.2012wcml.com 145 (Date of use: 19 August 2012).
77 Freckelton and Mendelson *Causation in Law and Medicine* 168

damages. If the patient waits for the risk occurrence, the limitation period may have passed. If the plaintiff sues before the risk occurrence, damages may be awarded only on the chance basis. The plaintiff will probably be undercompensated if the risk does eventuate. Here provisional damages should be compensated and rules be developed in the so-called chance and "forecast" cases. If the risk realizes or occurs at a later stage another court appearance could be scheduled.[78]

"Closed" cases are linked to the discovery of the fact of negligence and there are no reasons for waiting or expecting the eventuation of a risk. At trial, the facts will already have been evident. All personal injury litigation has the inevitable uncertainty of what would have happened and what will happen.[79]

It is important to establish at the time of harm or death, whether a disease or condition contributing to it, was present. Weaknesses will be present to help define whether these factors fall in the remoteness of cause, but should be mentioned to show that consideration was given to these factors in evaluating the case for a loss of chance. The court could then have the final say.[80]

Other dilemmas contributing to negligence in loss of chance case that must be taken note of could be:

- The absence of a good and comprehensive history of an incident that caused harm or death. It might be unreliable and not accessible, creating unique challenges.
- The absences of a thorough examination, where the patient may have been abusive, threatening, uncooperative, agitated, confused or have intellectual disabilities.
- Unreasonable and unrealistic expectations.
- Review of cases may assist and must be considered where possible to observe delayed appearances or the permanent evolution of injuries.

78 This has been introduced in England in 1985 by Rules of Court and Supreme Court Act 1981 s 32A, following recommendations by the Law Commission.
79 Freckelton and Mendelson *Causation in Law and Medicine* 176.
80 Freckelton and Mendelson *Causation in Law and Medicine* 305.

- Medical practitioners have limited medico-legal knowledge which creates problems. Factually incorrect information is then given. No appreciation is given on how much weight would be placed on an opinion by a court, which may influence a charge or a verdict.
- Impartiality is a critical component to the provisions of medico-legal services. Immense pressure could be brought on a defendant medical practitioner to resolve an issue, compromising fairness.
- Objectivity must be maintained, as its absence could lead to inappropriate expectations and observations.[81]

In the *Rogers v Whitaker* case, [82] where a complication ensued following loss of sight, which was stated to be a "one in 14 000" risk of occurring, the lesson is that it was found that a doctor has a duty, even if it is onerous, to warn a patient of a material risk inherent in the proposed treatment – a risk is considered material if in the circumstances of the particular case, a reasonable patient, if warned of the risk, would be likely to attach significance to it, or if the practitioner is aware that the particular patient, if warned of the risk, would be likely to attach significance to it. This is however subject to therapeutic privilege.[83] In South African case law a similar case is found, namely *Verhoef v Meyer*[84] of an ophthalmologist of whom the patient claimed did not give adequate informed consent, in that both her eyes had to be operated for retinal detachment instead of only the right eye. The case was dismissed against the doctor, even on appeal, as the doctor could professionally defend himself against the charges. Comparing the two cases, it does seem that the South African Law would be more tolerant to the action of a doctor when he acts in the true interest of the patient.[85]

It must also be accepted that all surgery and medical treatment involves risk which could precipitate loss of chance and other litigation. Routine hospital admissions can for instance carry risks of infection. Material risks might really be remote but a

81 Freckelton and Mendelson *Causation in Law and Medicine* 310
82 *Rogers v Whitaker* (1992) 175 CLR 479,
83 Carstens and Pearmain *Foundational Principles of South African Medical Law* 984.
84 *Verhoef v Meyer 1976* AD, (T) unreported.
85 Strauss *Doctor, Patient and the Law* 35.

doctor must consider what a reasonable person would think, considering the specific patient's anxiety and concerns.[86]

3.5 The possible role of imputed knowledge in negligence

The level of imputed knowledge, which a reasonable patient should have, can and should be a defence against medical negligence claims. Just like in the law of enterprises and commerce, if a person goes into a contractual relationship, he must make sure of the facts and have some additional knowledge. By using the principle of *caveat emptor*,[87] the reasonable and knowledgeable patient must by study, asking questions and reading up, gain extra background knowledge and information, especially of the facts, effects and complications of medical procedures.

However, there will be many unresolved issues and as long as those could be covered by the imputed knowledge concept, it would be significantly useful. The rest of the complications, which have an under 1/100 chance of occurring, should be viewed if not materially important to a specific patient, as unlikely or a remote possibility.[88]

A balance has to be maintained between the impacts of advice regarding significant risks, versus the patient's fear. It is very important for a doctor to mention at the outset, what would happen if no treatment is given and then to mention various courses of action with the advantages and disadvantages. The patient's own wishes and quality of life must be taken into account. Prospects of success and likely outcomes are also important. A point will be reached which will define that the doctor has done what is reasonable, albeit not easy to obtain or recognise in practice, regarding informing the patient appropriately accepted as the optimal treatment regimen decided upon, as well as the possible adverse

86 Smith and Maddern *The Surgical Litigation Crises* 36.

87 *Caveat Emptor* – from Latin literally meaning "buyer beware", or in medical case in these modern times "patient beware".

88 Strauss *Doctor, Patient and the Law* 36. Here examples could also be to warn a singer or telephonist that after a thyroid operation the voice could be hoarse, or an athlete, that he would not be able to train for six weeks,

effects that could occur. It must be realized that the complete elimination and discussion of most risks, are simply not possible![89]

Should the information given, had led to other opinions or the consulting of another surgeon, it does not imply that there would have been any reduction of risk but that note should be taken that the patient is a "statistically significant risk case".[90] This risk should be explicitly addressed in these cases. It is important to consider absolute as well as relative changes in outcome. Then secondly, the severity and permanence of injury must be taken into account. Finally the particular concerns and circumstances of the patient involved must be considered.[91]

Imputed knowledge should lead to the issue that statistical errors are important in the confusing ways of expressing probabilities. One such idea is if data falls outside of the 95 per cent confidence limit, it is "unworthy" to be considered. The legal team must then also understand MEW reasoning. Reasoning is a process of moving through a chain of arguments from premises to a conclusion. This should be a cognitive process. Scientific cognitive findings suggest that humans, irrespective of training, can be "blind".[92]

Although probabilistic information is processed and acted upon, intuitive responses to it are flawed. Naivety could set in, causing errors even for trained professionals. Wrong answers "that seem right" are produced, even consciously avoiding other answers that could be "more" right.[93]

Problematic information could become over simplified. Risk evaluation is biased in terms of where the risks are great, and is avoided as much as possible to preserve "false" gains. Statements are often only put in the positive, where negatively framed ones could lead easier to legal responses at a later stage. The feeling of reasonableness becomes very subjective and is linked to the events and the plausibility of the narrative. Thus the events are fitted into a likely ''story''. This

89 Hookman *Medical Malpractice Expert Witnessing* 172.
90 Freckelton and Mendelson *Causation in Law and Medicine* 392. *Chappel v Hart* (1998) 195 CLR 232 John Doyle (Chief Judge, Southern Australia).
91 Freckelton and Mendelson *Causation in Law and Medicine* 396.
92 Kahneman *Thinking, Fast and Slow* 8.
93 Freckelton and Mendelson *Causation in Law and Medicine* 410.

then becomes a powerful force on how these events will be judged and could manipulate a court's opinion.[94]

These factors must be mentioned and openly examined in a court so that the influence on decision making could be tempered. Plaintiffs and defendants can become most upset if the "reasonable expected result" is disrupted. Intuition, on which many untrained people rely, has a probability of more than 50 per cent of being wrong.[95] A MEW presenting reasoned statistical information, must use a simple framework and endeavour to ensure that the evidence is comprehensible, credible and of use to a court.[96]

3.6 The meaning of proof in medical negligence

The meaning of proof revolves around the key word "certainty". Proof might not incriminate a person absolutely, but must also be thought of as an instrument to exonerate a person absolutely. Words like "proved absolutely" must be used with utmost caution. The proof of medical negligence represents the formal law of procedure and evidence. A MEW should have insight in how this fits into a legal case so as to avoid pitfalls where wrongly interpreted facts could lead to weak or even false evidence.[97] The presumption of innocence until proven guilty should be remembered at all times. Care must be taken that elaboration of facts should not take place. A statement must preferably be made so clear, that confusing repetition would be avoided. A MEW should be well prepared or read from carefully constructed notes, as spontaneous lectures and presentations are unlikely to be understood. Jargon should be avoided. The MEW should practice expected cross examination so that the information would be advisory, accurate and understandable.[98]

A dilemma in the proof of causation is that as it is often described as a matter of common sense, it is too simplistic and unhelpful when proper legal advice needs to be given, where there are issues where causation must be proved. It beguiles a

94 Hookman *Medical Malpractice Expert Witnessing* 10.
95 Kahneman *Thinking, Fast and Slow* 234.
96 Freckelton and Mendelson *Causation in Law and Medicine* 411.
97 Carstens and Pearmain *Foundational Principles of South African Law* 854.
98 Hookman *Medical Malpractice Expert Witnessing* 405.

MEW as to whether a breach of duty has or will cause an adverse outcome. [99] "Wisdom" and "intuition" in a sense of mysticism are used often by decision makers using difficult factors in making connections, establishing the influences, determining the aetiologies and assessing causalities.[100]

The "common sense test" has a danger that proof of causation could be difficult and unpredictable.[101] Consistency and correctness could have variable results. Proof is however fundamental for any resolution in all forms of litigation, even when it is afflicted by many theoretical and practical conundrums, also influenced by the complex rules of shifting burdens of proof, as well as conceptually objective and subjective tests, that could be used. Decision makers, though they value expert objective opinions, are still too often confronted by opinions that are complex, conflicting and demanding, but are also partisan and subjectively based. Causation evidence demands high quality reasoning of expert witnesses but the opinions must be tested by effective cross-examination. "Observations", "generalisations" and "explanations" must be clearly distinguished to weed out conceptual difficulties and inconsistencies. Here the South African case of *Michael and Another v Linksfield Park Clinic and Another* could be used as an example.[102]

To prevent such scenario's in future, the aim in the long term must be to have clearer tests and for greater synchronicity between medical and legal criteria for proof of causation. [103]

Obviously, in the criminal law, the need to establish the guilt of the accused, such as causing a victim's injuries, must be beyond reasonable doubt. Essential, primary, crucial facts are difficult to distinguish from non-essential, secondary, background facts. In the civil law, the proof lies in the balance of preponderance of probabilities, thus causation must be established to that level, except where the

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99 Freckelton and Mendelson *Causation in Law and Medicine* 429.

100 Kahneman *Thinking, Fast and Slow* 235.

101 Neethling, Potgieter and Visser *Law of Delict* 190. The "common sense test" (preferred term used in Australian Law)is where a judicial officer uses all the tools to relate the given evidence to the causation which would include the flexible approach, the adequate theory and direct consequences approach but where it must be acceptable, believable and logical. The MEW must therefore help to connect the evidence to logical reasoning to help the court to accept the presented evidence.

102 *Michael and Another v Linksfield Park Clinic and Another* 2001 (3) SA 1188 (SCA) para 1189G.

103 Freckelton and Mendelson *Causation in Law and Medicine* 431.

allegations are so serious that it could become a criminal charge or have serious consequences for a defendant. Future implications of adverse events are always a matter of chance and are less certain objects of knowledge. There is also then more speculation and experts, like actuaries and epidemiologists, could be needed to interpret circumstantial evidence and facts to conduce toward suspected causes and its outcome.[104]

The line between an expert witness opinion and conjecture can be grey. Burdens of proof can also shift as where failure of standard of care has been proven and the injury followed shortly thereafter, as well as *res ipsa loquitur* cases. Often proof is arrived through circumstantial evidence or by expert evidence expressed in terms of possibility and probability. This could allow for unacceptable case building and must be guarded against.[105]

Evidence and the opinion by a MEW in the same field of the defendant, obviously carry much more weight. The legal proceedings as far as proof and influencing the opinion is concerned, is mostly additionally complicated by the plaintiff's claim that he would never have undergone a procedure had he been properly advised of risks, often with obvious hindsight knowledge and even with conscious self-interest.[106]

It must be noted that the most disagreement and difficulty in giving appropriate weight or credibility to evidence, are related to the interpretations of observations, generalizations and explanations. The MEW must be most cautious of these terms and their interpretations, as well as deductions and conclusions flowing form it.[107] Causation can be scientifically regarded as explanatory if it is possible that an precipitating action can show up in the consequent injury and damages.[108]

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104 Freckelton and Mendelson *Causation in Law and Medicine* 432.

105 Carstens and Pearmain *Foundational Principles of South African Medical Law* 861. These authors emphasize the fact, quoting Innes CJ in *Van Wyk v Lewis.* "The testimony of experienced members of the (medical) profession is of the greatest value in questions of this kind. But the decision of what is reasonable under the circumstances is for the Court; it will pay high regard to the views of the profession, but it is not bound to adopt them." This writer would want to add and emphasize that this is the main reason why by explaining the medical facts and evidence it must be made as logical as possible for the Court to accept.

106 Freckelton and Mendelson *Causation in Law and Medicine* 434. Here especially psychiatric patients and cosmetic procedures patients who are dissatisfied with the results of treatment.

107 Freckelton and Mendelson *Causation in Law and Medicine* 435.

108 To be seen as an *ex post facto* prediction of the consequences of an act.

Circumstantial evidence, with proof being needed at trial, does not itself bear directly upon an issue, i.e. the causation of a death could be quite influenced by other background circumstances, leading to "legal fallacies".[109] The real issue is the degree of probative value to this form of evidence. In the famous Australian case of *Chamberlain v The Queen*,[110] where the parents were accused of murdering their baby, whose body was never found, serves as an example. The theory by the defence was that a dingo wild dog carried off and killed the baby. There were no eye witnesses and only circumstantial evidence was evaluated, *heavily supported by wrong, inappropriate assumptions and deductions in the absence of scientific evidence.*[111]

Expert evidence of the possibility of causation can create the danger that assumptions and reasoning about probabilities become too mathematical,[112] which must be tempered with the contention that some judgements of probability can be justified by non-mathematical criteria.[113] Presiding officers could become overwhelmed by statistics, creating a pitfall that other important evidence, could be held at a lower level or become marginalized.[114]

Another problem for a medical witness is the distinguishing of what could have occurred naturally or would not have occurred, "but for" exposure to a substance.[115] Flowing from this the phenomenon of "association fallacy" is created

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109 Hookman *Medical Malpractice Expert Witnessing* 3. *Post hoc, ergo propter hoc* applies as a legal fallacy, "after this; therefor in consequence of this".

110 *Chamberlain v The Queen* (1984) 153 CLR 521.

111 Writer's italics to emphasize that this was an absolutely unallowable finding and sentence on the balance of probabilities and even beyond all reasonable doubt. Surely a trauma surgeon as a MEW could have prevented the jail term of 8 years which Mrs Chamberlain had to do. In 2012 the Australian Supreme Court formally apologized to a freed Mrs Chamberlain.

112 Referred to the Pascalian model where mathematical proof is given, named after mathematician Pascal.

113 Freckelton and Mendelson *Causation in Law and Medicine* 437, refers to the Baconian model where for example in the identification of a guilty or not guilty rapist via DNA testing, counts more than a witness/victim's (did she consent to sexual intercourse?) testimony.

114 Chances that an HIV person could knowingly, heterosexually, infect another unknowingly person during sex is 1:200, but should this person become infected the consequences are dire. The question that could be asked is whether the connection between the intercourse and infection is too remote, and could it have been foreseen by the perpetrator.

115 In *re* Agent Orange product liability litigation. This argument seems to have been settled in Re Agent Orange Liability findings, where Vietnamese citizens and USA veterans of the Vietnam war (1966-1973), could not prove that these substances, used as a defoliant and herbicide in the Vietnam War, caused diseases like lymphoma. The normal incidence of these lymphomas where not found to be significantly increased and as far as skin lesions were concerned, no biopsies had been done to prove the link to Agent Orange. Although admittedly this contained "dioxin", a toxic substance that could cause skin afflictions and

– the confusion of "association with a cause".[116] Thus, to prevent the wrong assumptions and findings there must be an algorithm or formulae to use:

(a) A statistical association, the stronger (in magnitude) the more likely, and
(b) Temporality, meaning a cause must precede its effect. The closer the temporality, the stronger it should count in weight.
(c) There must be a cause and effect relationship between exposure, harm or disease that should be biologically plausible and consistent with other information.
(d) Dose-response effect where causation is likely if greater amounts of a (putative) cause are associated with increasing harm.
(e) Consistency – similar findings elsewhere would support causation.
(f) Analogy – substantiation of relationships, increases likelihood of causation.
(g) Experimental evidence, *i.e.* removal of a cause results in decrease of harm or injury.
(h) Specificity – single putative cause supports causation.

These criteria must be rigorously scrutinised. Meta-analysis enabling the combination of several similar studies enhances the value and weight of the overall conclusions. These criteria could be most important in cases for claims for damages following acts precipitating medical complications.

It is important that the MEW must help and guide a legal team to establish whether a *nexus* is found at an observational, generalisation or a real explanatory level, the last being the desired level.[117] In *Seltsam Pty Ltd v McGuiness*, the Australian High Court emphasized that the common law test of the balance of the preponderance of probabilities, is not satisfied by evidence that only establishes a

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possibly tumours, this substance also occurs naturally, thus it would be most difficult to prove a link and nexus, between exposure and tumours. Harvard University, Faculty of Law publication www.law.harvard.edu/publications/evidenceiii/cases/agent.htm (Date accessed 18 August 2012).

116 Kahneman *Thinking, Fast and Slow* 222.

117 Examples would be claims against where asbestos caused cancer, brain damage followed pertussis inoculation, which emphasize that the "observational level" did not meet the "explanatory level" for proof of causation. Strokes following contraceptive medication (*Vadera v Shaw* (1998) 45 BMLR 162, Lexis-Nexis p13) – which claims were found not to be true and at that time there was no relationship proven between the pill and strokes, thus data was at a "generalization level" and not at an "explanatory level".

possibility of a *nexus*.[118] This still seems a major issue in court testimonies in the SA where expert witnesses confuse "possibilities" with "probabilities".[119]

Proving causation of injuries is fundamental to success for plaintiffs in personal injury litigation, not only in that there had been a failure to adhere to a proper standard of care by the defendant, but indeed whether the failure had caused the injuries.[120]

The claimed impact of non-provision of information (during the informed consent stage) can be used by a plaintiff to strengthen a case, but interestingly in the USA and Canada, the test is objective, focusing on what a reasonable or prudent patient would have done in the circumstances of the plaintiff. What the individual plaintiff would have done is of little relevance, while in England the test is subjective *i.e.* what would the reasonable person have done in the plaintiff's position. The danger created here is that the plaintiff could be viewed as an untrustworthy witness, because of having hindsight into an artificial situation. The emphasis should therefore be on whether a particular plaintiff, had the plaintiff known the (adverse and harmful) outcome was possible, would still have undergone the procedure. Objective facts could however support a plaintiff's claim, as well as the court's assessment of the patient's character and personality.

The so-called **Briginshaw standard test**[121] could be used, being that "the seriousness of an allegation made, must be weighed up against;

(a) the inherent unlikelihood of an occurrence of a given description, and/or
(b) the gravity of the consequences flowing from a particular finding" and
(c) "the petitioner must satisfy the court that his story is true".[122]

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118 *Seltsam Pty Ltd v McGuiness* (2000) NSWCA 347

119 *Michael and Another v Linksfield Park Clinic and Another* 2001 (3) SA 1188 (SCA) para 1190B.

120 Freckelton and Mendelson *Causation in Law and Medicine* 457. Examples here would be the *Chappel v Hart* case *supra* and also *Wilsher v Essex Area Health Authority* 1988 AC 1074 – here too much oxygen for a premature baby was given, resulting in retro-lental (behind the lens of the eye) fibrosis causing blindness, where discharge of the burden of proof could not be attained – it was wrongly based on an observational level, but not on the explanatory level in the threefold typology.

121 Especially with advance directives ie living will or refusal for treatment,

This could then support the common law notion in civil matters generally that "he who alleges must (prove) carry the burden of proof".[123]

3.7 Conclusion to Chapter Three

It is most important for a MEW and the legal teams to reach consensus on defining and understanding negligence in medical litigation. Every case should quite rightly be viewed as a *sui generis* case and thus in every case a medical witness should be called to assist the legal profession and the court, establishing whether there was negligence or to verify negligence. To help in this endeavour concepts must be taken note of getting the facts right even using the criminal law's principles if need be. To evaluate the burden of proof the *res ipsa loquitor* concept must be understood and realised that it could not stand alone and must be supported by logical arguments. The RIL is a form of circumstantial evidence but must be based on logical reasoning where certain facts may be inferred from other acts, thus forming a premise that a harmful result speaks of negligence.[124]

With negligence evaluation the "center of gravity", so to speak, revolves around the true causation of an alleged incident. Care must be taken by a MEW to really establish whether an occurrence which could be construed as negligence really did materially contribute to a patient's harm and injury. The potential problems must be avoided by evaluating the factual cause against the judicial cause. Complicating concepts must be taken note of like the *nova actus/causa interveniens* phenomenon, to realize that some evolving concepts have nothing to do with the original cause. Likewise, this begs consideration in the concept of "remoteness of damage", when assessing a case and effects flowing forth from it.

Foreseeability (by the doctor) of any harm or injury would play a pivotal role in confirming negligence and must be agreed upon by a medical witness. Recently the "loss of chance" has come to the fore and could be a valuable tool to get compensation, where statistically the compensation would have been denied. This concept is at times very difficult to understand, but a MEW can play a major role

122 Freckelton and Petersen *Disputes and Dilemmas in Health Law* 42. *Briginshaw v Briginshaw* (1938) 60 CLR 336. Originally a divorce case where adultery was alleged but could not be proven. The test has been used freely since in Australian court cases.
123 Carstens and Pearmain *Foundational Principles of South African Medical Law* 855.
124 Van Den Heever and Carstens *Res Ipsa Loquitor and Medical Negligence* 5.

here in providing most likely clinical courses of a particular patient. For the defence of a doctor, especially where there could be a lack of proper informed consent, the concept of imputed (or general) knowledge could also be advised, but society as such would expect that the doctor should have taken more care, with arguments carefully advanced, if any information, would not have been important to a specific patient under the circumstances.

Finally it must be borne in mind that the line between an expert witness's testimony and conjecture (thus manufacturing evidence and building a case) can be grey.[125] Thus negligence must be proven and such contributing facts must be made known to the MEW, as to give proper and acceptable logical testimony. To enable this to occur, the requirements needed and the expected qualities of a MEW must be evaluated, at least by the contracting legal team, to ensure the avoidance of abovementioned pitfalls. This leads then to a critical stance on the requirements and expected qualities of the medical expert witness.

125 Hookman *Medical Malpractice Expert Witnessing* 8.

CHAPTER FOUR

THE DILEMMAS AND PITFALLS FOR THE MEDICAL EXPERT WITNESS

"Wer einmal lügt dem glaubt Mann nicht, auch wenn er die Wahrheit spricht."[1]

4.1 Introduction

Knowledge of due legal processes is the best antidote for encountering the fear of litigation. By understanding Medical Law, a MEW should then meet certain requirements and then also have valuable expected qualities. This is achieved amongst other factors, by understanding the ethics involved, the formation of thinking patterns and by having some knowledge of the history of how Medical Law has evolved.

By understanding and defining the concept of medical negligence, the MEW could be a very valuable member of a legal team. Medical Law is built up mainly by the field of contract law and the field of tort/delictual law. There is mostly a negligence aspect involved with a breach of trust, emphasising the fiduciary role and confidentiality in the doctor-patient relationship. The requirements for a MEW towards a plaintiff or defendant must be the same as the relationship of the doctor and a patient, which is then naturally one in which trust and confidence must be placed in the doctor as a MEW.[2]

This trust must be founded in the medico-legal knowledge which the MEW could be expected to have. An effective, credible and reasonable MEW should therefore also meet exacting requirements in that he or she should have qualifications and insight into medical-legal procedure protocols and have acceptable qualities of fairness, objectivity and reasonableness with exemplary medical practice standards and a fair reputation.

Many concepts will be discussed in this chapter, of which insight and knowledge is paramount to help define a path for the MEW and the legal team to follow

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1 Coetzee LC *Medical Therapeutic Privilege* (LLM Dissertation University of South Africa 2001) German proverb: "He who has lied once, will never be believed, even so when he speaks the truth!" Quote used in LLM thesis of Dr L Coetzee.

2 Judge Hodgkins in the Canadian case of *Kenny v Lockwood* (1932) OR 141.

enforcing fairness, reasonableness and equitability as well as justice. This could perhaps only be achieved by the MEW with further studies and an interest in Medical Law.[3]

4.2 When is a doctor an expert and the appointment of an appropriate medical expert witness

The term "expert" should not be interpreted as a person with above average and exceptional knowledge, but rather a competent and knowledgeable person who can aid the court and the presiding judicial officer, with professional insight into the medical science, so that proper, fair and equitable findings and deductions as well as conclusions could be made.[4] Medico-legal knowledge is a dire necessity, because with proper analysis of a case, correct guidance could be given. As it is commonplace for a MEW to be used by either the plaintiff or the defendant, some unknowledgeable and unethical experts could in due course, transgress boundaries of acceptable medico-legal practice and undermine a court with unacceptable and falsely interpreted testimony to possibly reach an unfair decision.[5] The common duties of an expert witness, as set out in the case *National Justice Compania Naviera S.A. v Prudential Assurance Co Ltd* could be set out as:

- Expert evidence should be the independent product of the expert who was not influenced by the exigencies of litigation.
- The expert witness should provide independent assistance to assist a court. The opinion must be objective and unbiased. The role of an advocate must not be assumed.
- Facts and assumptions upon which the opinion and testimony is based should be stated. All material facts, even those causing detractions of the opinion, must be considered.

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3 Carstens and Pearmain *Foundational Principles of South African Medical Law* 19.

4 Knoetze *'n Regsvergelykende Studie van Deskundige Getuienis in Straf- en Siviele Verhore* 54.

5 *General Medical Council v Meadow* (2006) EWCA Civ 1390. In this case it was shown that the testimony of a Professor in Paediatrics was false due to the ignorant interpretation of statistics, which let a Court to unfairly sentence a woman to a jail term (For "murdering" her two infants boys, who as was shown later died of an inherited metabolic disease which was incompatible with life after infancy. Although released after two years, the mother, a solicitor, committed suicide) http://www.bailie/ew/cases/EWCA/Civ/2006 (Date of use: 30 March 2012).

- The expert witness must state clearly if a particular issue falls outside his expertise.
- If insufficient data was available it must be emphasised that the opinion is provisional. If the truth could not be ascertained without some qualification, it must also be stated.[6]

It is highlighted in this case that it is the function of the court to base its inferences and conclusions on all the facts placed before it. The opinion of an expert witness is admissible only due to their special skill and knowledge. These expert witnesses are thus better qualified to help draw inferences than the judicial officer.[7] However, the expert's witnessing will be irrelevant and unallowable when intruding on the legal or general merits of a case or the interpretation of a statute.[8] The principle is that an expert witness's opinion should be acceptable if it could appreciably help the court and only the court shall finally determine whether a question demands an expert's evidence.[9] The qualification to be an expert witness, as well as the value and acceptance of the form and probative value of the evidence will also be the prerogative of the court to decide upon.[10] The MEW especially should be well aware to bear in mind the principles and rules for the admissibility of his expert opinion.[11]

It could also be stated that a MEW should also possess an acute insight into ethics and morals of being an expert witness, respecting the Bill of Rights regarding the dignity of a patient and doctor, respecting their privacy and also their rights of fair administrative actions and access to the legal system. This broader and extended definition of the expert witness must be respected especially in the medical litigation field.[12]

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6 Nondwana http://www.legalcity.net/Index.cfm (Date of use: 26 January 2012). The case *National Justice Compania Naviera S.A. v Prudential Assurance Co Ltd* 1993 (2) Lloyds Reports 68-81 sets out these duties.

7 Zeffert and Paine *The South African Law of Evidence* 321.

8 Zeffert and Paine *The South African Law of Evidence* 322.

9 Zeffert and Paine *The South African Law of Evidence* 323. Referring also to the case of *Michael and Another v Linksfield Clinic (Pty) Ltd and Another* para1189G, where four expert witnesses were allowed to testify, all with differing opinions!

10 Zeffert and Paine *The South African Law of Evidence* 326.

11 Zeffert and Paizes *Essential Evidence* 103.

12 Swanepoel M http://www.puk.ac.za/opencms/expert/pul/html/2009volume12no4 (Date of use: 25 February 2014). Prof M Swanepoel, of the Department of Jurisprudence, Unisa

The concept of expertise must be understood in that it is formed in a novice witness, with acquired knowledge and skill, bearing in mind that even a top expert can be proven wrong. The inevitability of human error is not only due to human weakness, but rather an inevitable concomitant summation of our cognitive ability and development. Even though a medical practitioner in clinical practice can have a relentless dedication to achievement, the medical profession is the foremost culprit in perpetuating the myth of professional infallibility.[13]

The effect is that the courts take the lead from these "expert" doctors themselves and then would treat any kind of failure in medical practice as unacceptable, creating a dilemma in medico-legal practice, resulting in wrongful findings.[14]

A legal team must make an effort to select a fit and appropriately qualified, knowledgeable and experienced MEW. The ideal MEW must be appropriately qualified, must be selected on eminence in the appropriate field and should have some research and academic status. A paradox could be that a junior person in the same department could be a more realistic and acceptable MEW, as he will think more laterally than a senior colleague with fixed ideas and values, creating pitfalls and dilemmas for a legal team by having wrongly selected a MEW who is very rigid and inconvincible in his opinions. A MEW must have the ability to communicate and think appropriately under pressure. The MEW must have adequate knowledge to potentially counter an opposing expert's "outstanding" superior specialist knowledge. Following the Canadian case of *Arland v Taylor*,[15] it was found that judges could discount certain experts. Guidelines have been spelt out and emphasised, that medico-legal and court expertise be developed as a rule and skill-based behaviour must be taught. Therefore the expert must ideally possess a substantial medico-legal and procedural knowledge base. The MEW should ideally also be a teacher, preferably have contributed to textbooks, published articles in journals, have personal experience and interact well with colleagues.[16]

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emphasises this extended definition of a MEW in the LLD thesis, *Law, Psychiatry and Psychology: A selection of Constitutional, Medico-Legal and Liability Issues*.

13 Herring *Medical Law and Ethics* 38. In the form of "Medical Expert Witness".

14 Herring *Medical Law and Ethics* 38.

15 *Arland v Taylor* (1955) OR 131 (CA) 142.

16 Merry and McCall Smith *Errors, Medicine and the Law* 185.

The *voir dire*[17] principle must be upheld by a medico-legal panel to establish an individual's fitness to act as an expert witness. It could be argued that a MEW should also be a *fit and proper person for this role* (own emphasis) and meet the requirements to be capable and qualified to be a MEW. The MEW must have acceptable concepts of integrity, defined as having such high levels of professionalism, that the client's interest is put first, within reasonable and realistic professional boundaries. Cognitive illusions are pitfalls that must be guarded against, which could be anchoring, framing, hindsight bids, dominating heuristics and egocentric biases.[18]

The expert witness must assist the court and therefore the opinion of such an expert is admissible if the expert is better qualified than the judicial officer. The parameters cannot be defined with certainty mainly due to the expanding fields of medico-legal knowledge. Furthermore categories of expert evidence like evidence of opinion, technical expert evidence, evidence of fact and the admissible hearsay can also include those persons considered an "expert", emphasising the importance of an expert's knowledge, rather than his qualifications.[19] It could be argued that as a paid witness, an expert might be tempted to become a professional witness with perfected courtroom performances.[20]

A biased MEW can sway a court's finding, by choice of words, manner of explanation and body language. Most medical cases would stand or fall on the quality of the available expert evidence. The MEW should bear in mind that the courts will have the final say about the reasonableness or even "negligence" of a medical witness, as well as to determine which opinions have a logical reasoning as foundation. The court can still find a defendant guilty, despite good professional support if the opinion will not withstand logical analysis. By having the intent on being objective, independent, uninfluenced and unbiased, the MEW would create a good and credible impression. The MEW should also qualify his opinions, if

17 *Voir dire* – from French and Latin meaning, figuratively to "speak the truth" and literally, to "see to speak". In common law countries this is a principle whereby a board of panellists or a presiding officer, could determine whether a witness (or juror in the USA) is biased or would not deal with the issues fairly, for instance having knowledge of the facts or having acquaintance with a party. (dictionary.law.com) (Date of use: 12 June 2012).

18 Hookman *Medical Malpractice Expert Witnessing* 302. Heuristics, meaning here to find solutions by trial and error or by loosely defined rules.

19 Meintjes –Van der Walt 2000 *The South African Law Journal* 773.

20 Meintjes –Van der Walt 2000 *The South African Law Journal* 775.

there is a possibility that insufficient data had been given or that there could be an element of truth lacking.[21]

The MEW must remember that a judge can and will see through dishonesty and insincerity. Thus the conduct of the MEW is very important and must be professional, courteous, sincere, honest and human. The MEW must conscientiously avoid being garrulous, impolite, pompous, arrogant, sarcastic, cynical or overconfident. The demeanour should be that of a calm teacher. The MEW must bear in mind that he is being consulted as a consultant expert. The MEW must be impartial and thus unable to perceive any promise of personal advantage from espousing either side of a controversy.[22]

The MEW must be knowledgeable and trained in the skill to appear before a court. The MEW must have full qualifications in the area where his opinion is given. Credibility amongst peers must be present by *inter alia* peer reviewed research or publishing in journals, on-going education and by academic activities.[23] If the expert opinion cannot be logically supported, it can fail the test of "the benchmark by reference to which (the defendant's) conduct fails to be assessed".[24]

The medical witness selected must know or be informed of pitfalls like that technical terms are to be avoided and that language, intelligible to laymen, should be used. The MEW may consult notes to refresh memory and may refer to medical treatises. Books as such, are not admissible as authoritative. It could be misinterpreted, just like journal articles.[25] Questions directed to elicit an opinion

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21 Carter 2011 *MPS Africa Case Book* 7.

22 Hookman *Medical Malpractice Expert Witnessing* 305. Judges also follow a precedent and doctors should bear this in mind. A guide is to stick to "common sense" as the Latin phrases could emphasize – *ab honesto virium bonum nihil deterret* – nothing deters good people. *Experto credite* – accepted believe / assumption that an expert is speaking from experience.

23 Lecture "A Lawyer's Perspective" given by Adv. Emiel van Vuuren at Medical Malpractice Litigation Seminar, University of Pretoria 29 September 2012.

24 Referring to the case of *Michael and Another v Linksfield Park Clinic (Pty) Limited and Another* 2001(3) SA 1188 para 1190E.

25 *HPCSA v Van Almenkerk* (2006) (Not reported) – here a general practitioner who practiced as a plastic surgeon doing liposuctions quoted articles that in the USA cosmetic surgeons do the procedures in their rooms, thus he could quite safely do it in his rooms, here in the RSA. This disciplinary case was about a patient that died following this procedure. However it was pointed out by an expert witness that in the USA, the cosmetic surgeons usually have their consulting rooms in clinics and thus have theatre and resuscitative equipment and cannot be compared to his (sub-standard) facilities. Van Almenkerk was found guilty and suspended from practicing plastic and cosmetic surgery. www.legalbrief.co.za/articles.php (Date of use 13 October 2013).

from a defendant are proper when a doctor's conduct is in issue. If no personal knowledge of facts is in dispute, an opinion may be given on a hypothetical question. If a selected doctor as a MEW is called to testify, the lawyer and advocate must:

- Research the subject to understand the discussions with a doctor.
- Remember that experience, knowledge and skill, weigh more than qualifications.
- Get the MEW to testify in a narrow field rather than generally.
- Know that the doctor cannot be a partisan, but must make concessions.
- Insist on clear communication.
- Be in possession of medical reports and conclusions as documented.
- Stress the importance of MEW's ability to support an opinion.
- Prevent contradictions.
- State the MEW's qualifications (and possibly *curriculum vitae*) at the start.

A MEW actually expresses more opinion than establishing facts, due to his base of special knowledge and specialist training in the subject. For clarity, it is then customary to ask for an opinion based on hypothetical questions.[26]

A test which indirectly would influence the choice of a MEW, similar to many common law jurisdictions was formed in the Supreme Court of Appeal (SA) in the *Michael and Another v Linksfield Park Clinic*.[27] Here the judge was not deviated from his decision-making role, noting that the question of reasonableness and negligence is for the court to determine, evaluating the basis of the varying, conflicting expert opinions. This determination does not involve credibility so much

26 Hookman *Medical Malpractice Expert Witnessing* 307.

27 *Michael and Another v Linksfield Park Clinic (Pty) Ltd and Another* 2001 (3) SA1188 (SCA) para 1200C. In this case a 19 year old patient having a post trauma nasal bone repair by a plastic surgeon, had been administered cocaine via the nose as a local vasoconstrictor, which could give a bloodless view for the surgeon, but as a side effect could give heart arrest. Whilst the patient developed a fast pulse rate, the anaesthetic level was deepened and a beta-adrenalin blocker administered. The patient decompensated and had heart arrest. The patient had permanent brain damage and survived in a sad vegetative state. As negligence could not be proved the consequent claim was dismissed.

but by examining the opinions, the essential reasoning must be analysed for the court to reach a conclusion on the issues raised.[28]

Evidence from "second hand" sources is admissible only if the use of such sources is a normal and acceptable practice. Evidence of accepted practice or custom may be given. The court must subsequently determine whether a doctor conformed to the legal standard of reasonable conduct in the light of the apparent risk existing at the time. A MEW must generally be from the same specialty, but the "locality" rule is not generally followed. A MEW may express an opinion whether care or treatment provided, was consistent with the ordinary care and skill of a similar practitioner. A MEW can state that a certain course may have produced a result, but never emphatically say did[29] (own emphasis).

The medical report of a MEW should include:[30]

- Preliminary data, date and place of examination.
- The plaintiff's or defendant's version of the events.
- History of plaintiff's health prior to and at the time of accident and examination.
- Physical and mental state of health and avoid exaggerations.
- Doctor's / defendant's report of the diagnosis and proposed treatment.
- Details of tests.
- Opinion whether incapacity is temporary or the degree of permanent incapacity.
- Not comment on the amount of compensation which should be the responsibility of the court, except for expected medical expenditures in future.

28 Letzler "Choosing the Right Expert in a Medical Negligence Case" http://www.derebus.org.za/nxt/gateway.dll/4rnla/k(wmc/r9wmc/laxmc (Date of use: 27 March 2012).
29 Hookman *Medical Malpractice Expert Witnessing* 219.
30 Hookman *Medical Malpractice Expert Witnessing* 219.

- The medical report must have the patient's consent for the records.[31]

As journal or book texts are actually "hearsay evidence", the courts have considerable discretion in controlling the issue of use. In principle, nothing may be given from a textbook other than as an opinion of a witness who gives it.[32]

The advocate must also then ensure at cross examination that no hostile abuse or efforts to contradict the MEW presentation would be tolerated. It is important that the MEW must determine on his own that a physician, had a duty and that it was breached, that harm had occurred and that this was indeed caused by the physician's breach of duty. It is most important, to view the larger picture and not to get lost in details. The MEW will thereby be reasonable also in evaluating a plaintiff's case against the assumption of a risk, contributory negligence, comparative fault, the Good Samaritan clause (USA), "sudden" emergency, the opinion of a respectable minority, the opinion and teachings of different schools of thought and the necessity of clinical innovation.[33]

A MEW if chosen, could excuse himself from a case when it is embarrassing or if healthy relationships with colleagues, friendship, incrimination, collegiality and impartiality would be threatened and the excuse is raised as a "conflict of interest".[34] By implication it must be realised that the adversarial system would in itself create problems with conflicting opinions of expert witnesses, for which all parties must be prepared to deal with, emphasising that to prevent this conflict the MEW also owe duties in giving professional evidence to their respective discipline and professions.[35]

Medical expert witnessing will be most needed in the following three categories of medical negligence claims which could influence the choice of a MEW, namely:

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31 Hookman *Medical Malpractice Expert Witnessing* 230. Based also in the RSA under the Constitution s14 "Privacy – Everyone has the right to privacy".Hookman emphasizes the inclusion of what he refers to as "magic words". These are: "all the opinions expressed herein are the product of reliable principles and methods developed as a result of professional knowledge, experience, education and training in the fields of medicine (surgery or trauma) and law; furthermore the said principles and methods were reliably and ethically applied".

32 Meintjes-Van Der Walt 2000 *South African Law Journal* 777.

33 Hudson, Moore (2011) *J Emergency Med* 598.

34 Cameron and Gumbel *Clinical Negligence – A Practitioner's Handbook* 149.

35 Meintjes-Van Der Walt 2000 *South African Law Journal* 778.

- Breach of Duty: This revolves mainly around the standard of care. A doctor would be considered to be negligent if a patient was treated in such a way where a reasonable body of fellow practitioners would not have done (Bolam test). If so the doctor would have been considered to have breached his duty. The MEW must evaluate the treatment as well as that which should have been given. A statement will be made whether the standard of treatment was that of a reasonable person, assessed in what the doctor knew or should have known at the time of the event. The MEW must be of the same specialty as the defendant, except when the defendant practiced outside his specialty.
- Causation: Even if there has been a breach of duty it must still be demonstrated that the negligence led to harm. The MEW must demonstrate a causative link between the standard of care and the eventual outcome. This is done preferably from several opinions to establish on a balance of probabilities, whether a causative link exists.[36] This entails the study of the history and the analyses of a chain of events, bearing the natural progression of a disease in mind. An opinion must be given on the effect the negligence had made. If the course would not have been altered, the defence could be that a correct diagnosis at the time of the event would not have made a difference or created a "loss of chance".
- Quantum: Here the MEW assists in the size of the claim and the financial settlement. This must be realistically assessed in various details of general and special claims. Educated guesses must be tolerated and chances of deterioration or improvement must be considered. Occupational therapists, psychologists and actuarial calculations might be needed to assess the quantum. The final settlement must for example include daily care requirements, loss of amenities compensation and future employment prospects.[37]

Legal practitioners can be in an untenable situation if it is found that their choice of a MEW testimony and opinion do not carry much weight resulting in an unsuccessful result in a case for either the plaintiff or the defendant. It is

36 Important *not possibilities*, as it is the *probability* that must be above 50 per cent chance.
37 Grobler 2007 *The South African Gastroenterology Review* 13.

imperative that above mentioned facts in the choice of a MEW must be considered very seriously.[38]

The level of agreement between doctors can be very low due amongst others, to conflicting information, different interpretations and substandard personal experience. Therefore clinical studies to be quoted must be well designed, prospectively randomised and "double blind". This leads to evidence based medicine, based on structured and systematic review, making it acceptable, more respectable and it would have better status than textbooks.[39]

A threat is that some experts, on account of senior positions, spend more time on research and administration than in actual clinical practice, creating a gap between the theoretical and the actual situation. Their testimony could generally be irrelevant and unreliable.[40]

MEWs must not (over) rationalise a case, attempting to justify an action with inappropriate logical reasoning. Valuable facts could then be overlooked. A MEW must be prepared to advocate for the patient, but must not take the argumentative role of the advocate.[41] Conflict of interest like testifying against a colleague must be avoided. By promoting the truth, the MEW must also be a careful gatekeeper. There must be awareness that insurance or medical aid organisations could employ "business tools", raising ethical issues. By paying physicians in unethical ways, these organisations could impose conflict of interests, and then "regulate" the physician's clinical judgement, decision making and behaviour. To prevent this pitfall, MEW doctors must seize the initiative, convert potential weaknesses into strengths, learn from mistakes, seek advantages and not overextend themselves.[42]

Concepts should be taken note of by MEW, in conjunction with lawyers, for instance possible punishment, as this will apply if the action of the defendant was unacceptable to society. Undue emphasis on blame in relation to such incidents is

38 Letzler "Choosing the Right Expert in a Medical Negligence Case" http://www.derebus.org.za/nxt/gateway.dll/4rnla/k(wmc/r9wmc/laxmc (Date of use: 27 March 2012).
39 Merry and McCall Smith *Errors, Medicine and the Law* 186.
40 Merry and McCall Smith *Errors, Medicine and the Law* 187.
41 Hookman *Medical Malpractice Expert Witnessing* 271.
42 Hookman *Medical Malpractice Expert Witnessing* 117.

unjustified and counterproductive. Culpability would only be aired if substandard antecedent conduct had been deliberate. The "**reasonable person test**" is on hand to address the reasonable expectations, but has progressively failed to take into account the inherent human limitations of actual "reasonable" situations and people. There has been a shift of what "could reasonably have been expected" to "what ought to have been done".[43] The better question would be "could other people in this position reasonably have made the same error". This demonstrates the inherent tension and trends in law of delict. A teasing question is whether somebody that did his best, but still fell short of a reasonable person's expected performance, must still be held liable, for instance under the *imperitia culpae adnumerator* rule?[44] Here then an appropriately appointed MEW must take the lead in proper, fair, reasonable and justifiable decision making.[45]

4.3 Legal processes and the medical expert witness

It is in the interest of the MEW to understand relevant issues of the law and litigation, especially so that their testimony could influence the fair decisions of judges. The following, although not necessarily complete, will help if it is also understood by all MEWs.

4.3.1 The Stare Decisis rule

From the common law the *stare decisis* rule had developed. This rule means that a proper finding by a judge or judges in another court case would be taken to also apply in similar court cases in future. A judge should abide and adhere to a finding in already well decided cases. The MEW should understand this concept that a court's finding could be binding as a rule in similar court cases. But, it must be emphasised that in medical negligence litigation it is seldom if ever that one case is like another, this is a factor a MEW could help to explain.[46]

43 Merry and McCall Smith *Errors, Medicine and the Law* 244.
44 Hiemstra and Gonin *Legal Dictionary* 201. The *imperitia culpae adnumerator* rule here would imply that the want of skill is reckoned as a fault.
45 Merry and McCall Smith *Errors, Medicine and the Law* 244.
46 Thomas, Van Der Merwe and Stoop *Historical Foundations of the SA Private Law* 111.

4.3.2 Importance of an objective evaluation of a case

It must also be accepted that factors in a system may contribute to an error, and must so be presented that a court could make the decision about it. [47] A call for mature reflection and a more detailed examination of the facts need to be made by the MEW, evaluating all material facts in the right order to correctly advise the legal team. No matter how competent a medical or legal person could be, there will always be challenges that exceed his or her ability to react adequately and in time under specific circumstances. The desire to blame must not and should not prevent a proper and objective evaluation of what went wrong.[48]

Ideally the medico-legal consultation must be done with the patient or plaintiff present as well as a review of all relevant documentation applicable to the case to make sure of all the relevant and applicable facts, and only then could an informed, unbiased opinion be given by the MEW.[49]

4.3.3 The Imperitia Culpae Adnumerator *rule*

The MEW must be aware of a serious phenomenon, especially involving surgeons that they would continue procedures in the face of persistent poor results.[50] Likewise the problem of technical competence of doctors should be addressed and if a surgeon, without warning a patient, except in an emergency, is not sufficiently skilled, and not supported by colleagues, the common law rule of *imperitia culpae adnumerator*[51] should be the basis of litigation or disciplinary action. The MEW could advise the legal team if this rule would be applicable for instance in a case where a specialist exceeded his bounds of speciality in the absence of an emergency, which caused a patient harm (for instance a general practitioner removing complicated tonsils resulting in the patient's death by persistent bleeding).

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47 For instance nursing errors, instrument failures, hospital administration errors.
48 Strauss *Doctor Patient and the Law* 249.
49 Beran R.G. http://www.2012wcml.com (Date of use: 12 August 2012).
50 Bristol case – cardio-thoracic surgery services suspended. It was noted that regardless of cardio-thoracic operations having dismal survival figures for the Bristol hospital, the staff carried on performing the operations, until stopped by a court order. See Lloyd-Martyn 1998 *BMJ* 816.
51 Hiemstra and Gonin *Trilingual Legal Dictionary* 201. *Imperitia culpae adnumerator* is translated as "a want of skill is reckoned as a fault .

4.3.4 The adverse event

To describe an adverse event as an accident, which by a medico-legal definition should be an incident largely if not completely unintentional, unforeseeable and harmful, is taken by lawyers and lay people as a matter of choice. However, any element of foreseeability makes the situation non-accidental.[52]

A genuine error must be accepted as unintended and unavoidable, synonymous with the true meaning of "accident". Meaning the event was unintended and either was reasonably unforeseeable or was indeed foreseeable, but realistically could not have been prevented. It is often seen, that an adverse event is the end result of a series of developments which are dependent upon one another.[53]

It should be taken into account in terms of the overall picture and the reaction to each stage which is affected by what had preceded the adverse event and boundaries must be defined. What might have been considered preventable at the beginning of a sequence of events, can become inevitable by human limitations confronted with informational and emotional overload which develops at a greater speed as a crisis unfolds. To prevent this dilemma and pitfall, more training in the sophisticated analytic reasoning is needed and adherence to standard proven drills and procedures taken.[54] The full sequence of events must be evaluated, as well as the nature of antecedent factors, evaluation of the cognitive processes, examination of the contributory role of other players, as well of the system factors (machines, equipment, hospital setting etc.).[55]

It must be realised that as soon as a finding is made of a non-accidental injury, accident or adverse event, that it in itself implies an element of culpability. There may be grey zones and a question of interpretations, but it depends on proper insights of psychology and understanding the limitations of human behaviour. By implication, errors are never deliberate and if it is a violation, it should be defined in terms of rules, norms and principles. It must be shown that there was a "deliberate" deviation and that this involved "choice". Violations are avoidable,

52 Mason and McCall Smith *Law and Ethics* 27.
53 Mason and McCall Smith *Law and Ethics* 27.
54 Kahneman *Thinking, Fast and Slow* 71.
55 Merry and McCall Smith *Law and Medical Ethics* 32. A lawyer and MEW should then force themselves to "look through the haze and beyond the smoking gun"!

pending on difficult circumstances and the system. If a MEW does not have the above working knowledge, the "expert" witness actually becomes nothing more than a lay person regarding a specific case of an adverse event.[56]

4.3.5 The concept of vicarious liability

It must also be accepted by a MEW that there is a concept like "respondent superior" where an employer could be involved by vicarious liability. Negligence should further be defined here to extend to other role players, as a contributory failure by other role players like a hospital authority, to act with reasonable and prudent care.[57] Doctors in private practice are independent contractors, but the impaired standard of care could be due to other role players like the hospital or nursing levels deemed below an acceptable standard. Standard of care could then be defined as the degree of care that a prudent person should exercise under the same or similar circumstances. The reasonable person is defined as a prudent person whose behaviour would be considered appropriate under the circumstances. In the case of *Riff v Morgan Pharmacy* a finding was made that every member of a health team: "has a duty to be, to a limited extent, his brother's keeper".[58]

4.3.6 The doctrine of **Res Ipsa Loquitor**[59]

Negligence in medical malpractice, at first implies that there was no intent to harm or injure, but actually means "not doing what a reasonable man would do in similar circumstances".[60] The facts of a case would indicate whether a reasonable man had performed an act of negligence. An expert witness, who must come from the same profession, is required to testify in a court, to set a standard for a defendant, which should have been met. The question here would be whether the conduct was acceptable to the majority or to an acceptable minority of professional opinion. The doctrine of *res ipsa loquitor* (RIL) must also be set by a MEW,

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56 Meagher, Marr and Meagher *Doctors and Hospitals: Legal Duties* 27.

57 Strauss *Doctor, Patient and the Law* 301. It is emphasised that a hospital need not necessarily be held responsible for the negligence of staff. *St Augustine Hospital (Pty) Ltd v Le Breton* 1975 (2) SA 530 (D).

58 Freckelton and Mendelson *Causation in Law and Medicine* 91. *Riff v Morgan Pharmacy* 508 A.2d 1247 (Pa1986).

59 Hiemstra and Gonin Legal Dictionary 280. *Res ipsa loquitor* : "the case speaks for itself" or "it stands to reason – also known as *res ipsa docet* meaning the case teaches by itself.

60 Freckelton and Mendelson *Causation in Law and Medicine* 92.

provided that this could be motivated above all reasonable doubt, by the defendant not being able to give a logical explanation and that all contributory facts are proven.[61]

The questions that need to be answered here is whether in the normal course of events, the accident would not have occurred if reasonable care had been used, or that the plaintiff did not contribute to the occurrence of the accident.[62] Thus the maxim or doctrine of RIL should only be considered if (a) that the occurrence must be of such a nature that it would not normally happen, unless there had been negligence and (b) this occurrence of the "instrumentality" should be within the exclusive control of the accused negligent person.[63] This maxim as stated in the case of *Macleod v Rens* 1997(3) SA (ECD) is no "magic formula" but has a place in the scheme of and the search of causation.[64] There must be an absence of other facts and evidence so that it would be self-evident that the defendant would be at fault.[65] The inference of finding a defendant at fault must however be consistent with all other proven facts, and also that the proven facts should be such that this inference drawn is the most probable one.[66]

To establish negligence in civil litigation of medical malpractice, the elements of a civil malpractice suit should consists of:

- A relationship (which had existed) between the physician and patient.
- An established duty by physician to the patient.
- Duty had to be upheld at a professional standard of care.
- The physician had breached this duty to the patient.
- This breach had resulted in harm.

61 Zeffert and Paizes *The SA Law of Evidence* 221.
62 Freckelton and Mendelson *Causation in Law and Medicine* 92. The r*es ipsa loquitor* principle is not primarily accepted as such anymore in South African Law, but must be argued in full as a secondary issue. However, in the working stages of evaluating a case it still helps to classify facts that could be used in argumentation.
63 Van Den Heever and Carstens *Res Ipsa Loquitor and Medical Negligence* 9.
64 *MacLeod v Rens* 1997 (3) SA (ECD) para1046D.
65 *MacLeod v Rens* 1997 (3) SA (ECD) para 1052E-F.
66 *MacLeod v Rens* 1997 (3) SA (ECD) para 1049B-C.

- The physician's breach was the proximate cause of a patient's injury. This is then more refined into this element by asking the question whether the injury would have occurred "but for" the breach of the physician.[67]

4.3.7 The concept of the "burden of proof"

The MEW, in preparing his testimony and in consultation with the lawyers must understand and know how to address the burden of proof. The plaintiff bears the burden of proof and the elements to argue against must be thought through, "applying the mind". In civil cases it rests on the preponderance of evidence, by implication a weight in favour of 51 per cent. Thus the MEW for or against must appear and impress the court to be knowledgeable, objective, and credible.[68]

The criteria for standard of care should also be assessed by defining it as "that degree of care, which a reasonably prudent person should exercise in the same or similar circumstances". It implies "that reasonable and ordinary care, skill and diligence as physicians and surgeons in good standing in the same locality, in the same general line of practice, would have exercised the same prudent care in similar cases". Thus the MEW must:

- Establish standards of care applicable to the case.
- Evaluate whether the factual testimony provided indicates any deviation from acceptable standards.
- When care has been deemed "substandard", the MEW may be asked whether the deviation from the standard of care could be the proximate cause of harm.
- Because courts depend on a MEW to make medical standards understandable, the testimony should be clear, coherent and consistent with the standards at the time of the incident.
- The MEW must know of and consider alternative standards, which could be raised under direct testimony or under cross-examination.

67 Freckelton, Mendelson *Causation in Law and Medicine* 101.
68 Schwikkard et al *Principles of Evidence* 23.

- The MEW should not define the standard so narrowly that it only emphasizes their opinion on the standard of care, to the exclusion of other acceptable options.[69]
- The MEW must know that a negative outcome does not necessarily indicate medical professional negligence.
- The MEW must be able to concede to other acceptable treatment a prudent physician would pursue.[70]

4.3.8 Evidence of journals

To supplement and boost their testimonies, many MEW and legal teams prefer to quote professional journal articles. A major pitfall to avoid when medical journals are quoted, is that a MEW must be mindful that editors usually only publish "good news" articles where results, as part of a research project are inflated so as to look good and are exceptional. To set a standard of care against an article published by top experts and having itself highly set standards, would therefore not be generally fair for a defendant, except when used in defence.[71] Thus, before published material is put forward, it must adhere to the so-called **Daubert rules**, where the published evidence must be peer reviewed by random controlled studies and meta-analysis, the error rate must be known, the article must be widely accepted by the medical community and must meet tested guidelines.[72]

In fact, the Daubert rule empowers the court or legal team to be a gatekeeper of expert testimony. This must also be interpreted like as it was at the time of the alleged malpractice. The common guideline in medicine of *primum non nocere* should also be borne in mind here. A comparative faults doctrine should be

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69 This occurs very commonly in most doctors' opinion in especially disciplinary cases and a dilemma is when lawyers pressure a MEW to be "narrow" in his opinion.

70 Hookman *Medical Malpractice Expert Witnessing* 285.

71 Hookman *Medical Malpractice Expert Witnessing* 298.

72 Daubert rule from *Daubert v Merrill Dow Pharmaceuticals Inc* 509 US 579, 1135 (1993) Knowledge of the Daubert rule should be obtained and can be used by the MEW and the legal team in rebutting the opponent's testimony. Based upon a case of wrong medication that was wrongly prescribed and issued and who would be the negligent person in this chain of events. The rule that follows from this case is that the judge becomes a "gatekeeper" of expert testimony and the acronym is used of PEAT and especially if literature is to be quoted that it should be **p**eer reviewed material with knowledge of **e**rror rate, generally **a**ccepted by the medical community and must be **t**ested.

followed and other factors identified which could have contributed more to the adverse outcome.[73]

Coupled with the above, note should also be taken of the so-called **Frye rule** which states that an expert witness' testimony must be based upon a reasonable degree of acceptance within the specialised field.[74] Obviously this necessitates that the parties should do a greater effort to agree on the submitted evidence, opinion and testimonies and thus the need for alternative dispute resolution has developed and will be discussed later.

4.3.9 Pre-trial discussions

Pre-trial expert discussions are most important and the ideal is that the experts should reach a consensus and note their difference for the court. Although it could be argued that the attendance of the lawyers at such a deposition would influence the MEW, it still seems very important that the lawyers should attend. Factors which should influence this are the importance of the case, the factual complexity, the status of the experts, the extent of legal issues relevance and costs. It is however recommended that the lawyers attend but only intervene in helping in aspects of the law.[75]

If a deposition is requested, which is a discovery of documents in the form of oral testimony, it must be taken by the attorney appearing in advance of the trial. The opposition has the right to dispose of the other party's MEW. However if this occurs there should be insistence on a conference with the client's attorney. The MEW must also be very well prepared. Erroneous claims must be rebutted and for the defendant's case the merits must be demonstrated by a fair MEW.[76]

73 Hookman *Medical Malpractice Expert Witnessing* 299.
74 Hookman *Medical Malpractice Expert Witnessing* 294.
75 Campbell, Callum and Peacock *Operating Within the Law* 249.
76 Hookman *Medical Malpractice Expert Witnessing* 270

4.4 Dilemmas for medical expert witnesses

4.4.1 The "conspiracy of silence"

It could be "that all professions are then indeed a conspiracy against the laity".[77] Lawyers and lay people find it irksome that the doctors, ostensibly at least, do have a "conspiracy of silence". This is often understood as an obligation under the ethics of the Hippocratic Oath, where a fellowship status is established amongst doctors.[78]

Doctors then simply have an aversion to testify or acknowledge mistakes outside the "fellowship" knowing that there is a chance that an incident could also happen to and with anyone. However, many doctors do feel that medical opinion regarding the conduct of a colleague, in whether he was negligent, cannot fit into the perceived dogmatism in the law, which the doctors feel would be impossible and unfair.[79]

The MEW would perhaps be more available to give a medical opinion report regarding so-called medical negligence, when his report could be discussed with the opposing MEW for the other party when the exchange of the discovery of documents take place, with facilitation followed by the focussed expeditious testimony and cross examination of the MEW in a court. This undertaking and re-assurance by the legal team would then probably break down this "conspiracy of silence" phenomenon, and avoiding the pitfall of "hitting the wall of silence".[80]

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77 Concept from George Bernard Shaw's play "The Doctor's Dilemma". Ross *George Bernard Shaw* 111.

78 Hookman *Medical Malpractice Expert Witnessing* 258. In the Classic Hippocratic Oath "What I see or hear in the course of treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep myself holding such things shameful to be spoken about". A modern version states 'I will remember that I remain **a member of a society with special obligations to all my fellow human beings**, those of sound mind and body as well as the infirm." For senior colleagues "to hold him who has taught me this art as equal to my parents and to live my life in partnership of him" or more modernly stated "I will respect the hard-won gains of those physicians in whose steps I walk…" Also *en.wikipedia.org/wiki/Hippocratic_Oath* (Date of use: 12 July 2012).

79 Hawkins *Mishap or Malpractice* 161.

80 Hawkins *Mishap or Malpractice* 164.

4.4.2 The dilemma of a "duty to give evidence"

When requested to give evidence, every doctor should recognise his responsibilities to assist the court in arriving at a just decision.[81] Although doctors will testify only to facts within their knowledge, usually medical opinions will be offered based upon assumed facts as well. The lawyer must prepare the MEW and make him aware when this potential pitfall could be encountered and that there are procedural rules, as well as rules of evidence that must be adhered to. Conflict of opinion between an assessor and a MEW is a source of great embarrassment. Lay people could get the impression that a MEW would be prejudiced in favour of their fellow defendant practitioner. It is essential, not only that justice should be done as far as possible in every case, but that even the appearance of partiality or unfairness should be avoided. Doctors should be properly interviewed and must give proper and full honest pre-trial discovery and basically stay with this when on trial. The doctor to testify must make sure, that the qualifications are established, that note is taken of the medical experience, the details of specialisation and the doctor's attachments to any hospital, clinical teaching, writing and research. Conflict of interest must also be ruled upon.[82]

The MEW must also be made aware of the *subpoena duce tecum* procedure.[83] Leading questions are also generally confined to cross examination by opposing counsel. The judge may ask leading questions to clear issues for himself. The court has the final decision and discretion to accept and reject evidence, to determine its reliability, weight and credibility and its relevance.[84]

Objections can be raised if basic rules of procedure generally followed are not adhered to and that the evidence must be material and relevant to the issues involved. Here the MEW must be made aware of the facts that evidence on prior facts must be excluded and that hearsay is normally excluded. The MEW cannot testify directly as to the truth of the statement of a witness but may support it by showing for instance that the patient's symptoms appeared to confirm the

81 Hookman *Medical Malpractice Expert Witnessing* 215. A "Code of Ethics" should be required.
82 Hookman *Medical Malpractice Expert Witnessing* 309.
83 Theophilopoulos et al *Fundamental Principles of Civil Procedure* 294. According to the rules of the Civil Procedures Evidence Act 25 of 1965.
84 Theophilopoulos et al *Fundamental Principles of Civil Procedure* 299.

statements. The MEW should only answer questions, as volunteering new or additional information, which is perhaps immaterial, could give rise to new aspects to the embarrassment of all.[85]

The question of the reasonable skilful doctor will need to be addressed. There are many judicial pronouncements on the standard of care which is expected of the doctor.[86] The Bolam test could also be applied here in that the defendant doctor must sufficiently show that he exercised the ordinary skill of an ordinary man exercising that particular profession or art.[87] At least, he follows practices that would not be disapproved of by the responsible opinion within the profession. This doctor has a reasonably sound grasp of medical techniques and is as informed of new medical developments as the average competent doctor would be.[88]

Obviously the circumstances under which a doctor treats a patient will have to be taken into account. It has been eluded that when a doctor has worked under severe pressure and made a mistake forced by an emergency, that this incident should not be lightly taken as negligence.[89]

The MEW could need to testify about so-called "usual practice". This is also known as the "**custom test**" where a defendant doctor's conduct is tested against the normal usage of his profession. This should be applied in all areas of medical negligence litigation. Three facts are needed to establish liability: First the normal and usual practice must be established and proven, secondly it must be proved that the defendant had not used that practice and thirdly it must be established that the course that was adopted is one which no professional man of ordinary skill would have taken if he had been acting with ordinary care. The dilemma here is that there will always be obvious disagreement as to what the appropriate course would have been to follow. Here the **"modified" Bolam test** could establish the perspectives in that a doctor would not be negligent, if he had acted in accordance

85 Meagher, Marr and Meagher *Doctors and Hospitals: Legal Duties* 315.

86 Mason and McCall Smith *Law and Medical Ethics* 199. As early as 1838 Tindall CJ ruled that every person who enters a learned profession undertakes to exercise a reasonable degree of care and skill. This echoed in the *R v Bateman* in 1925 (1925) 94 LJKB 791 (CCA), that a court or jury in this case should not exact the highest or very high standard, nor be content with a very low standard.

87 *Bolam v Friern Hospital Management Committee* (1957) 2 All ER 118.

88 Mason and McCall Smith *Law and Medical Ethics* 199.

89 Mason and McCall Smith *Law and Medical Ethics* 200. In the case *Wilsher v Essex Area Health Authority* (1986) QB 730,

with an acceptable practice used by a responsible group of doctors in that particular field. This is provided that this medical practice is rightly regarded as tenable and acceptable, even if contrary to another view, pending upon the court's decision.[90]

The MEW will have to confront the sentiment of "the law will not allow the medical profession to play God". In the *Rogers v Whitaker* 1992 109 ALR 625 the custom test was excluded, by stating that the standard of care is not determined solely by reference to the practice followed by a responsible professional body. Expert evidence of professional custom will be needed and will be used in the majority of suits, but a defendant must not rely on this. A doctor has a duty to keep himself informed of major developments, but it cannot be expected that he should have read every article or know everything and the MEW must emphasise this point. However, a doctor should be aware of a series of articles and/or appropriate warnings in the medical press. A MEW must know that innovative techniques must also be approached with the necessary caution. Untried procedures would not be legally endorsed if patients were exposed to considerable and unreasonable risk of damage. Other factors should be taken into account here like the patient's response to conventional treatment, the seriousness of the patient's condition and the patient's attitude following fully informed consent. The standard of care to be applied would be expected to be the same of a doctor competent in the provision of such treatment.[91]

The MEWs work could be made quite difficult as contesting parties have no obligation to present all relevant evidence. They are entitled to present selected and potentially favourable evidence to the court. The vision the court and the MEW have, is then often limited by the material presented by the adversaries. Thus to obtain the "truth", depends on the issue whether the party has discharged the burden of proof. MEWs could deliberately then be specifically chosen to present favourable opinions. Thus the views could be made to correspond with the wishes of the party who calls them. Problems could arise when MEW extrapolate from the general experience to a particular case. Another dilemma is that the

90 Mason and McCall Smith *Law and Medical Ethics* 200. As set out in the Scottish case *Hunter v Hanley* (1955) SC 200.

91 Mason and McCall Smith *Law and Medical Ethics* 202.

emphasis in court is more about the MEW's qualifications and status, rather than the quality of the expert evidence. The MEW with foresight might fear this aspect and wish not to become involved, thereby side stepping the "duty to give evidence".[92]

Accordingly the role of the MEW must be re-emphasised and is twofold;

- To furnish basic scientific and technical medical facts or data,
- To present inferences and conclusions from the facts which the judge, for the lack of specialised knowledge, cannot draw.

The expert is therefore introduced to carry the proof to a conclusion for which the party presenting the evidence contends. This evidence should give the scientific medical basis and if appropriate, the statistical likelihood, but the presiding officer can decide whether this is satisfactory.[93]

However the unethical, miasmatic MEW can compensate for the lack of scientific authority and facts with aggressive and assertive vehemence, falsely and misleadingly superseding the level of satisfaction of presented evidence necessary in a legal proceeding.[94] These differences in views could be resolved by:

- Accepting the variation of current approaches to causation.
- Beware of the process of "framing" of influential stakeholders.
- Defining the role of the "medical expert witness".
- Evaluating the quality of evidence, distinguishing between facts and opinions.
- Improving communication between all groups.

It is a concern amongst lawyers that a culture of "forensic" objectivity must be developed for the MEW. Naïve, straightforward, dichotomous answers are regularly given by a sole MEW, to resolve complicated issues. Any disciplinary

92 Freckelton and Mendelson *Causation in Law and Medicine* 52.
93 Freckelton and Mendelson *Causation in Law and Medicine* 53.
94 Freckelton and Mendelson *Causation in Law and Medicine* 54.

hearing will not result in financial compensation, but a finding against a doctor could streamline further civil litigation, "boxing in" the MEW.[95]

The principles of a*udi alteram partem*, i.e. listening to the other party, must be practiced with objectivity by a MEW. Likewise the principle of *nemo iudex in sua causa*, where no-one should be the judge in his own cause must be upheld. Furthermore, the MEW must support the doctrine of Common Knowledge, which postulates that certain (medical) facts, are so commonly known that pending the education and profession of lay people or the court, that cognisance could be taken of it without evidence being led. This could be applied after damage occurred and where obvious commission or omission negligence occurred. This is then to a certain extent the opposite of the *res ipsa loquitur* principle and where "professional malpractice" becomes "ordinary" negligence.[96]

A dilemma that could occur is that a MEW (under professional, status and psychological pressures) could become utterly convinced of the "correctness" of his views. It is most important for the MEW not to give any misleading evidence and must not guess or create suspicion. All evidence must be relevant.[97] Here formal training of an MEW is most important. When a MEW's evidence, testimony or opinion is rejected, it is usually due to the fact that these were not well presented and explained.[98] Criteria, to prevent the dilemma of a MEW rejection that will lead to acceptance of the legal findings of scientific facts are:

- Theories are to be established, confirmed and must be relevant.
- The MEW must understand the theory and science around it.
- Medical scientific principles must be correctly applied to the facts of the case.
- It must be understandable in and to the court.
- Correctness of the witness' presentation is essential.
- Credibility. Here the *Daubert v Morrell Dow* Pharmaceutical case must be taken note of where scientific data must be used with guidelines of (a)

95 Freckelton and Petersen *Disputes and Dilemma in Health Law* 10.
96 Redelinghuys, Butow, Carstens 2008 *South African Dental Journal* 151.
97 Knoetze 2008 *De Rebus* 29. Relevance : testimony that confirms the existence of a fact or the conclusions of the facts.
98 *Mohammed v Shaik* 1978 (4) SA 523 (N) para 528 (G). Here it was found that the MEW's (a general practitioner giving evidence over the fertility tests of a man) evidence fell severely short of proving on a balance of probabilities that the appellant was sterile.

credibility of the theory, with valid results, which were (b) published and (c) generally accepted.[99] This must be presented in pre-trial meetings. The emphasis must however be on answering the legal questions and not the factual questions![100]

4.4.3 Understanding the concept of error

Errors should, in contrast to violations, be viewed to be both understandable and inevitable, even for highly trained and regulated professionals. Thus it must be distinguished between unintentional errors and deliberate unsafe acts or violations. In cases where a standard of practice has knowingly fallen short, the act in question would be a violation, even when there was no intent to harm. An error is an unintentional failure in the formulation of a plan which is intended to achieve a goal, or an unintentional departure of a sequence of activities that was intended, except where such departure is due to chance intervention. Errors are not necessarily automatic acts, as there is some intended aspect of the procedure which goes wrong or a failure of the planned treatment.[101]

Errors are therefore skill based and most often a result of a distraction. Knowledge based errors, can be due to faulty deliberation, errors of judgement and technical errors. Knowledge based errors are actually driven and enforced by the error and faulty subjectivity assessments. Skill based errors could be due to unintentional actions or omissions, and are probably unavoidable. The remedy to prevent this must be in the design of the system. It is a misconception that expertise, incentives or threats could prevent errors on the basis of choice alone, to avoid unintended actions. Doctors cannot be expected to be superhuman and thereby never make an error. Prevention lies *inter alia* in double checking a protocol and not to put expectations unrealistically high. There is also the group of technical errors which would depend on patient and doctor variability, the last mentioned in terms of skill, knowledge, as well as the levels of fatigue. The phenomenon of “rule based” errors, also typically made by experts, often occurs in the presence of heavy workloads. A course of action is chosen according to “a rule”, following a

99 *Daubert v Merrell Dow Pharmaceuticals Inc* 509 US 579 (1993).
100 Knoetze 2008 *De Rebus* 29.
101 Merry and McCall Smith *Errors, Medicine and the Law* 88.

sequence that has worked previously. Further investigation into the diagnosis or case is halted due to failure to apply "a rule" at the right time. [102]

Errors of judgement, where there must have been thought processes, are clearly a subset of deliberative errors. This is compounded by the fact that a perfectly rational outcome could follow a poor quality decision. The basis of facts known at the time may in analyses, not prove to be the correct one in terms of result. Many decisions in medicine also have an element of uncertainty and that the outcome is unknown. The phrase "Error of Judgement" has much use normatively so as to suggest that an individual takes risks different from what is thought to be appropriate.[103]

When a crises or emergency happens during medical treatment, doctors should force themselves to take essential cognisance in alternatives available, make a time frame for decisions and realize their limitations of the cognitive processes and thus get help. These steps should also influence a MEW, in defending a case.[104]

The dilemma of the egregious error exists, where unacceptably low standards are applied. If it is major, it could be argued that it is gross negligence which in severe cases could precipitate a criminal case, especially where there is a loss of life. [105] Poor training, failure of examination systems and non-existent mechanisms for screening incompetent doctors contribute to this dilemma.[106]

Above can become a true violation where the moral implication of an injury is quite different, when some element of choice was involved in the actions which led to the adverse event's causation. This is to be differentiated from an error, because the actor believes that the action is an appropriate way of achieving an objective, but fails. Here the expression to be used is "acting in good faith", or "doing the best possible thing". Thus where an element of choice is involved in relation to an action, which falls short of some identifiable standard, only then can it be deemed

102 Merry and McCall Smith *Errors, Medicine and the Law* 89. Example here which often occurs in diagnosing influenza instead of malaria or meningitis, because of "frequency gambling".
103 Merry and McCall Smith *Errors, Medicine and the Law* 89.
104 Merry and McCall Smith *Errors, Medicine and the Law* 93.
105 Merry and McCall Smith *Errors, Medicine and the Law* 93. Egregious, meaning outstandingly bad, shocking error.
106 Carstens and Pearmain *Foundational Principles of South African Medical Law* 847.

to be a violation. This action is the "deliberate – but not necessarily reprehensible", deviation from standard practices.[107]

Boundaries could be very vague and cognitive processes are to be used, for instance: "was there an element of choice?" The relation to established rules must be determined and the violation of these rules would tend to make errors more likely and dangerous. The perpetrator of these violations could then be morally responsible for the con-sequences. Deliberate violations could be regarded as recklessness and would carry a greater measure of opprobrium. This would lead to the censure of a medical action, which knowingly was done where an action or omission will involve an unacceptable level of risk. It has to be determined by the MEW that an action was correct and appropriate. The violation is to be tested for appropriateness with a "**substitution test**", namely: "whether a different person, in the same circumstances and with the same events unfolding in the same way, would have likely behaved any differently, assuring that this hypothetical person came from the same general field of activity and had similar experience, abilities and qualifications". If this "test" is positive, it could form the basis of "defence of necessity". [108]

Exceptional violations, usually occurs in emergency situations but could under the circumstances, be appropriate, like a junior doctor doing an emergency tracheotomy in the ward. Routine violations could be neglecting mundane procedures, like not checking an anaesthetic machine prior to use, failing to follow-up blood tests or taking a proper history. Violations could eventually become embedded as "bad habits". Violations created by antecedent actions and errors, may involve culpability.[109]

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107 Merry and McCall Smith *Errors, Medicine and the Law* 100. Standard practices deemed as standard are SOP's – Standard operational procedures, Standard Rules and necessary measures to maintain the safe operation of medical practice.

108 Merry and McCall Smith *Errors, Medicine and the Law* 101. This **substitution test** is then known as the Johnson test, where Johnson was a legal writer.

109 Merry and, McCall Smith *Errors, Medicine and the Law* 120. An example could be a doctor working while fatigued or under the influence of alcohol. Also failing to take a proper history from a patient, where there is no privacy. An additional purpose of these procedures and following the above criteria, is to prevent (good) doctors from harming their patients! The majority of doctors work longer hours than considered safe and healthy. This must be weighed up to the continuity of care. The culture of medicine is to gain competence through experience, that hours worked translates into money earned and the average, especially junior doctors have extraordinary levels of motivation.

When causation of errors is questioned, it is initially the factual causation *sine qua non*, that should be considered by the MEW with the reasoning of the "but for" principle or the question "if the consequence would have occurred without the conduct – then there's no blame". The legal causation is evaluated on a normative basis and needs to be answered whether the actor deserves to be held accountable. This could lead to compare the violation with five levels of blame, to ascertain liability. These are:

- Pure causal blame: the defendant acted reasonably, no rule was broken, and has done nothing wrong in moral terms.
- Blame by means of unintentional deviation or where normative standards are set. Here is a human error and the defendant must be viewed as a "human being".
- Blame for deviation what could reasonably be accepted. An empiric decision about what is reasonable and although no intention was to cause any harm, the doctor can be held accountable for performing chosen acts.
- Recklessness – defendant had knowledge of existence of a risk, but proceeded with an action.
- Blame where it could be demonstrated that there was not an ambiguous intention to harm. Antecedent activity could contribute like consumption of alcohol, fatigue and omission (whilst still in training, inexperienced or failure to do a checklist).[110]

4.4.4 The unethical expert

It is important to avoid the pitfall of being labelled as an untrustworthy and unethical MEW whose testimony would not be credible. The unethical expert would have testimony variability, an untenable view and will develop certain fundamentally dishonest lines of evidence.[111] The *pro-veritate* witness, as an independent witness for the court and the so-called miasmatic witness are then

110 Merry and McCall Smith *Errors, Medicine and the Law* 130. If it could be shown that there had been a failure to take all reasonable steps to ensure safety or minimize risk, culpability may exist in the last four levels of blame.

111 Boyce http://www.proz.com/kudoz/italian_to_english/law (Date of use: 01 April 2012). A witness must be impartial and truthful (pro veritate "for the truth"), guiding a court which needs authoritative guidance. **However this could be abused and by (deliberately) missing essential elements, could be misleading**.

typically examples of the unethical witness.[112] This results in profound injustice, equally affecting the plaintiff or a defendant. There are then often subtle nuances of complex evidence, that pending on the presentation, assertiveness and choice of words, could hold the danger to swing a court's sympathy and findings.[113]

Emotional aspects benefitting the plaintiff's side are often over-exploited. The defendant's MEW has the disadvantage of having to convey facts which are difficult to grasp and uninteresting. Gatekeeping of the testimony should be appropriate and relevant. Experts, at the time of discovery, should confer and try to agree on certain points even only to agree to disagree.[114]

"Personal opinion" should rank low in weight of evidence. Patient factors contributing to an adverse outcome must be emphasised. It must be realised that medical evidence is an inevitable concomitant of human limitations, especially in the face of demanding situations.[115]

To compound the dilemma of the unethical witness, there is a lack of legal and lay understanding of what the standard of care and the role of an expert witness must be. The courts also seldom act against an expert witness whose testimony is improper and untruthful. It is emphasised that ethical issues and obligations should outweigh legal expectations and duties. The medical boards and organisations should monitor this and act against such expert witnesses. Alleged abuses by expert witnesses must be studied by the various boards, undertaking appropriate action. However, this will not improve the standard of expert witnessing and testimony. The medical profession must monitor the medical testimony and the manner it is presented. There should be more participation by the medical associations and boards, strengthening the presentation of such testimony. Legal professional education will then have to play a major role. The medical profession should correct misrepresentations and assist in the encouragement of thoughtful and informed consideration of medical testimony and

112 Berlin 2003 *American Journal of Radiology* 25. Pro-veritate witness, in international literature referred to but coming from Italian Law, translated into English as a witness called in for an independent witness. This witness has no connection otherwise with the case.
113 Berlin 2003 *American Journal of Radiology* 25. The skilled and arresting speaker could use this technique.
114 Hoving 2012 *Nederlands Juristenblad* 873.
115 Merry and McCall Smith *Errors, Medicine and the Law* 190.

the interpretation of medical literature.[116] Due to the court's adversarial system, it is also often difficult to distinguish a simple medical disagreement from a false medical representation.[117]

To prevent the excessive use of the unethical witnesses, reforms including the role of society, should be introduced. No-fault compensation and quick settlement must be emphasised. This allows the defendant to avoid a vigorous defence, will protect his reputation and prevent feelings of resentment. It will emphasise that harm or injury is not necessarily due to incompetence, but rather no more than an inevitable concomitant complication of an inherently high risk procedure.[118] The emphasis should be on the "Burden of Illness" of the patient which must be enlightened, in that every ill and unhealthy person will have a larger background risk to life and harm, beyond the reasonable, fair and realistic control of a treating doctor.[119]

The unethical MEW ignores the fact that the management of medical injuries and its avoidance creates special cases, deserving special treatment. This will cause the practice of so-called "defensive medicine" to increase. Better and improved record keeping must also therefore be implemented to prevent the unethical MEW gaining a threshold to build a case.[120]

An unethical witness, as a colleague, worsens the effects of litigation on the doctor and his morale is adversely affected. It affects the doctor's psychological health and ability to work. This could result in denial and blind reasoning, leading a vicious circle of confusion of events, self-blame, anger, unworthiness, hesitancy, insecurity and a grief reaction. This results in a climate of fear, excessive stress on performance, trauma of litigation and can affect the families and colleagues, with demoralising effects. The remedy should be to curtail the unethical MEW

116 Kassirer and Cecil 2002 *JAMA* 1387.
117 Berlin 2003 *American Journal of Radiology* 1521.
118 Typically the unethical and miasmatic, hostile witness will be very personal in his attack on the defendant. Terms like unbelievable, incredulous, unethical, aggressive, arrogant, flamboyant, unacceptable and "weak standards" are emphasized by these witnesses.
119 Conditions precipitating complications like obesity, hypertension, diabetes mellitus, kidney failure, previous sepsis, urinary tract infections, smokers and cortisone therapy to mention a few conditions.
120 Merry and McCall Smith *Errors, Medicine and the Law* 210.

aggressively and strive for a timeous out of court settlement, thus avoiding a flood of unmerited claims, reputation damage and unnecessary punishment.[121]

4.4.5 Manufactured evidence and the concept of "trawling".

The MEW should also be aware of the dread of manufactured evidence. As this seems to prevail itself the MEW must be most critical and avoid so-called "trawling", "fishing" and "building" of a case. The MEW must be aware of perjury, fabrication of and attempts to obscure or prevent knowledge of pertinent facts and evidence. Generally, although doctors and lawyers could easily be convinced by the patient's version of events, the MEW must be aware that it is mostly hearsay and usually hearsay is not actually admissible evidence.[122]

Evidence must be understood as oral evidence, documentary evidence and real evidence. It is most important to ascertain and keep to the facts of the issue. Facts must form part of the *res gestae*,[123] as well as facts surrounding the event (i.e. drunkenness, with assault, that led to a death). *Facta probanda*, are the facts related to each other contributing to the material facts of issue, and must be identified and proved to amongst others to establish the cause of the action.[124]

This is important to make the determination whether an action is more or less probable, thus they have probative value. The golden rule of evidence, with the expert witnesses' opinion, is whether it is admissible and carries weight, by being relevant and credible.[125] In malicious prosecutions, violations of these principles are usually well camouflaged and a MEW must be able to help discover it, to help prepare counter arguments![126]

In medical law it is often advised that a defendant doctor should get character evidence especially when having to plead for leniency in sentencing. This is most difficult and controversial, with limited application in civil cases. However, it could have a role in the disciplinary or defamation cases. In cases of real reprehensible

121 Merry and McCall Smith *Errors, Medicine and the Law* 211.
122 Meagher,Marr and Meacher *Doctors and Hospitals: Legal Duties* 315.
123 Hiemstra and Gonin *Legal Dictionary* 278. *Res Gestae* literally means "things done" but here in the law of evidence "all facts concomitant with, illustrating and forming part of the matter in question".
124 Hiemstra and Gonin *Legal Dictionary* 189.
125 Zeffert and Paizes *The SA Law of Evidence* 321.
126 Murphy *Murphy on Evidence* 139.

behaviour, the MEW must realise that a judge must decide whether it is a case of *contra bonos mores*, which could lead to a criminal case being founded. By giving character evidence a medical witness might be giving (allowable) hearsay testimony.[127]

4.4.6 The concept of the evaluation of informed consent.

Characteristics and elements of informed consent decisions include accurate assessment of information about the relevant alternate options and their consequence in relation to a patient's priorities. Options need to have been outlined. This must include the consequences for the patient if it is decided to have no treatment.[128]

Where the value of informed consent is appraised, it is accepted that if a patient decides that he places his confidence in the surgeon (thus paternalism), to act in the patient's best interests, it must then at least be the patient's choice. In court the **subjective approach test**,[129] would determine what the individual patient would have decided, if the necessary information had been given. This is followed by **an objective test** on what the reasonable person would have decided and this is where the onus to state this, rests on medical evidence.[130]

A pitfall to be avoided is that an informed consent (or informed choice) must never be violated. If a patient seems confused and cannot decide, more visits, gaining information by reading or a second opinion, is advised. Informed consent must contain effects of ideal treatment, the purpose of the treatment, the side-effects of the treatment, complications and these are then critical elements of which medical law must take note of if it was discussed.[131] These norms have been set out in the case of *Castell v De Greef*.[132] In this case it was stated that a practitioner could incur liability for failure to warn a patient of material risks (in this case the necrosis

127 Murphy *Murphy on Evidence* 139.
128 Hookman *Medical Malpractice Expert Witnessing* 117.
129 The patient's testimony would emphasise this approach.
130 Meagher, Marr, Meagher *Doctors and Hospitals: Legal Duties* 70. The guideline of Chief Justice Laskin could be of help as in *Riebl v Hughes* (1980) 114 (DLR 3rd) 1. This case takes into consideration what decision a reasonable person might make in the patient's particular position.
131 Neethling, Potgieter and Visser *Law of Delict* 106.
132 *Castell v De Greef* 1994 (4) SA 408 (C).

of tissue with a mammoplasty (sub-cutaneous mastectomy),[133] that the defence of *volenti non fit injuria* would then not be allowed,[134] that a doctor has a duty to disclose material risks "under certain circumstances".[135]

Requirements for informed consent / choice is that it is to be given freely, by a patient capable of volition, having full knowledge, appreciating fully the nature and (relevant and realistic) risks, also subjectively consenting to the act. This consent must be allowable by legal order or not be *contra bonos mores*.[136] The same applies not only to surgical procedures but also to the administration of medication. [137]

4.4.7 The concept of therapeutic privilege

The excuse of therapeutic privilege could and although these days the use of it is less, it would be used in defence of a doctor. The doctor especially if he feels that the whole explanation of a disease could upset an individual so, that that he or she might refuse very necessary treatment, might prefer not to mention the risks or prognosis of a disease, thus withholding information as "therapeutic privilege"[138] When TP is used, the doctor must state it clearly in the notes, documenting the reasons and underlying psychological profile. The MEW in court would need to evaluate the risks and dangers of a particular diagnosis and intervention, thus evaluating the practitioner's reasons, clinical notes and the nature of the non-disclosure.[139] The Court would have to decide whether the practitioner's conduct conformed to the standard of the speciality.

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133 *Castell v* De Greef 1994 (4) SA 408 (C) para 408I.
134 *Castell v* De Greef 1994 (4) SA 408 (C) para 409A. *Volenti non fit inuria* is then a defence argument implying that "those who had given permission cannot claim for harm".
135 *Castell v* De Greef 1994 (4) SA 408 (C) para 416J.
136 Neethling, Potgieter and Visser *Law of Delict* 108. The dictum of Innes CJ from the case of *Waring and Gillow v Sherborne* 1904 TS 340-344 must be borne in mind namely: "It must be clearly shown that the risk (of injury) was known, that it was realised, and that it was voluntary undertaken. Knowledge, appreciation, consent – these are the essential elements; but knowledge does not invariably imply appreciation, and both together are not necessarily equivalent to consent".
137 Hookman *Medical Malpractice Expert Witnessing* 280.
138 Carstens and Pearmain *Foundational Principles of South African Medical Law* 984. It is difficult to really define therapeutic privilege as it is a wide concept. Therapeutic privilege is defined as where a medical professional will keep secret to himself information aspects of a disease or treatment that otherwise would cause unnecessary anguish influencing a patient's correct acceptable consent.
139 Van Oosten 1993 *Medicine and the Law* 651.

Furthermore as seen above, the TP undermines the patient's right to self-determination. TP could be paternalistic and the patient's right to self-determination is the principle of the informed consent doctrine. Underlying the concept of therapeutic privilege is the classical Hippocratic ethic, according to which doctors should do what in their judgement, would lead to the greatest good (or least harm) for the patients. Therapy becomes the ultimate goal, but what is told to the patient must be carefully planned and communicated with skill. The information given must correlate with the patient's need for information. This attitude should not slip into the realms of paternalism.[140] Care must be taken not to leave a patient with an unrealistic picture for permission for an operative procedure, based on deceptive and unbalanced information whilst obtaining "informed consent".[141]

The privilege could undermine the patient's trust in doctors. The real danger and potential cause for litigation is that a patient who finds out the truth after having been deceived for instance by way of second opinions, materialisation of undisclosed risks, discomfort, lack of benefit or awareness of approaching death, is the loss of faith against the doctor and the medical profession. The perplexed patient is left in a state of anxiety. If possible, a patient must never be deceived by non-disclosure. A vicious circle could develop and a communication gap can develop. Significant harm can thus ensue, should the patient learn the truth. Shielding a terminal patient, even a child, from "bad news" is often futile, as most patients intuitively know that they are dying![142]

The TP can be open to abuse. There is very little proof, that a patient after receiving bad and upsetting news about their diagnosis and prognosis, actually do plunge into severe depression, suffer health problems, refuse sensible and reasonable treatment or commit suicide.[143]

It is concluded that TP could have been overused as an excuse for not giving patients sensitive information. It is likely the TP abuse is inconsistent with the

140 Van Oosten 1995 *Medicine and the Law* 164. Quotes that therapeutic privilege is: "a continuing locus of medical power".
141 Van Oosten 1995 *Medicine and the Law* 164
142 Meagher, Marr and Meagher *Doctors and Hospitals: Legal Duties* 71.
143 Hookman *Medical Malpractice Expert Witnessing* 306. According to the United States President's Commission on Ethical and Legal Implications of Informed Consent (1982),

patient's right to know and to decline "informed" treatment. The doctor therefore "forces" the patient into consent. The counter argument is that if patients were to be informed of all the extreme complications and risks of an operation, no patient would ever undergo any operation.[144]

It must be guarded against by the MEW and legal teams, that TP must not be allowed for defence where a dishonest doctor concealed the truth under circumstances where non-disclosure amounts to abuse. The TP may afford an easy defence to present "after the fact", and thus may shield negligence. The TP may be used by doctors who have fear and aversion to disclosing unpleasant information, like causing pain, having misplaced sympathy, fearing blame, hiding incompetency and deficient training, eliciting unpleasant reactions, having to say "I don't know", showing emotions, fearing of own illness / death and fearing the medical hierarchy. Cost implications of non-disclosure could be that of lost or missed chances, having a worse prognosis and suffering indignity. A conclusion could be made that therapeutic privilege could rest on false medical assumptions and therefore if TP is to be used, it must be done with the utmost thought, reasoning and communication skill.[145]

Issues are often raised whether a patient would or would not have refused the offered treatment if the doctor had informed the patient more fully of the treatment, arguing if the patient had refused, there would have been no injury. Here for the plaintiff to succeed, the court must be made to decide whether a reasonable patient would have accepted the treatment on advice of the doctor. There is the subjective view (patient's view) and objective view ("reasonable" patient's view) factors which must be considered here. Apart from whether the risk had been material, the plaintiff has the onus of satisfying the court, on a balance of probabilities, that a patient would have refused treatment had the risk of a procedure, like "air embolism" (a remote risk not mentioned by a doctor under defence of therapeutic privilege), been explained. Subjectively it is determined whether the patient would still have undergone the procedure and objectively,

144 The author, when confronted by anxious patients, reminds them that risks must be weighed, very much in the same way like buying an airplane ticket. We all know the airplane could crash, be hijacked, suffer mechanical failure and that the pilots and ground air traffic controllers could make judgement errors or other mistakes, but we all deem it necessary, under the circumstances, most practical to fly.

145 Meagher, Marr and Meagher *Doctors and Hospitals: Legal Duties* 72.

what a reasonable patient would have done if there had been a full disclosure of remote risk. Here further examples of remote risks would be the like of perforation of the colon by colonoscopy, or permanent paraesthesia of the lower jaw, upon extraction of impacted wisdom teeth.[146]

If a risk is material, special and unusual but possible, it must be discussed and as a guideline all temporary effects with more than a seven per cent chance of occurring and all permanent effects more than one per cent chance of occurrence must be mentioned as far as reasonably possible.[147]

Only in exceptional cases can inadequate disclosure be justifiably accepted, pending a real threat to a patient's mental or physical health, or where the patient cannot make a rational decision due to an emotional state. The defendant must bear the onus to prove that the TP was based on good clinical judgement, and that the patient's autonomy was not unduly restricted. The main object for TP, is that of achieving the best medical treatment, *under the prevailing circumstances,* for the patient.[148]

Cognisance should be taken that a doctor could set up defences by:[149]

- Waiver – preferably, a document should be provided, signed by the plaintiff, which specifically lists the disclosed risks.
- Consent form – must mention that the plaintiff had been informed of the risks.
- Usual practice – it is claimed that it is practice to warn of certain risks. If credible, it should be acceptable.
- Other sources of information - could have found out by asking doctor, friend or relative. Here the concept of imputed knowledge becomes important.
- Common risks as average knowledge should make one aware of possibility, albeit small, of death, bleeding, pain, scars, infection, discomfort, gangrene and whether a specific centre would not be capable of dealing with complications. Care must be taken against misconceptions as well as

146 Meagher, Marr and Meagher *Doctors and Hospitals: Legal Duties* 73.
147 Strauss *Controversies of Surgery, Medical Jurisprudence Symposium,* University of Pretoria 2006.
148 Van den Heever 2005 *SAMJ* 421. Writer's italics and addition.
149 Meagher, Marr and Meagher *Doctors and Hospitals: Legal Duties* 80.

unrealistic and unreasonable expectations, like in cosmetic surgery, that it is "scarless".

- Emotional factors (therapeutic privilege).
- Risk of complications.
- Standard of knowledge – the defendant did not know whether a certain event would occur, as it was not reasonably foreseeable.
- Too remote too mention. If a complication is too remote there is no need to normally mention it. The risk has possibly less than one per cent chance, fellow doctors would also not warn and the risk effect is not serious enough. Here expert MEW testimony is important.
- The law of percentages – this is a very effective defensive tool. For instance the incidence of air embolism[150] is less that 1/100 000 cases (unless deliberately negligent like central venous line left open to air), perforation of the bowel with laparoscopic sterilizations is 1/1000 (unless there was previous abdominal surgery or pathology that could have caused adhesions), and perforation of the colon is zero in an average of 5 000 – 8 000 cases of routine colonoscopies (provided there are no lesions like diverticulitis).[151]
- Opinion of experts – considering that there would be a continuous clash between the court and the medical profession, to dictate a standard for disclosure of risk.
- Material risks – like voice loss following a thyroidectomy, necrosis of bone, facial numbness following surgery, numbness and hypersensitivity of the breasts after cosmetic surgery. There is a duty to warn against unnecessary elective surgery and the patient's apprehension must be noted.

4.4.8 Determining the standard of care: documentary proof

A dilemma could be that documents, describing appropriate clinical practice in defined situations could be (and indeed usually is) viewed as a source of evidence on whether there was a departure from acceptable practice. The danger is that this could be accepted on face value as the norm in all cases. The guidelines from

150 Air embolism is where air enters the venous system and could as air bubbles prevent the passing of blood to the lungs, thereby causing death. It can also accidently land in the arteries and could cause a stroke by the same mechanism.

151 Small bag-like pouching of the inner mucosa lining of the bowel through to the muscle layer and with infection, especially in the large bowel, is known as diverticulitis.

academic institutions will have considerable authority, but these institutions will tend to represent only a particular section of medical opinion.[152] A danger is created and exacerbated in that experts tend to be selected from those working in leading academic institutions.[153] These MEW's, if they have strong autocratic and narrow minded views, their set expected standard of care presented to a specific court will be unreasonably high, differing from that accepted by a substantial if not the majority group of experts not associated with these institutions.[154] The Bolam test (*i.e*. what would be still acceptable even if it is a minority of reasonable and acceptable medical opinion) should therefore be applied in all these potential cases. Doctors must always therefore give reasons and document it, when there is a deviation of the standard form of treatment. Any deviation must preferably be done with the advice of a second opinion. Another danger is that guidelines can become so numerous that even the most conscientious doctor would not be able to keep abreast of them.[155] The academic miasmatic expert could then also set standards that not even he himself could obtain![156]

Using documentary proof, the MEW should determine what should have been done, rather than what is usually done, where the latter concept would reflect which most competent practitioners in the defendant's positions could have reasonably be expected to have done. Due to the changing nature of professional knowledge, any reasonable practitioner should not be out of date.[157] Judgements must be made according to the acceptable knowledge and practices prevailing at the time of the adverse accident, like the attitude to internal and intimate examinations that have changed.[158] It must be accepted that every MEW can and will have an outcome bias, thus eventually creating a dilemma in being professionally not objective. Eventually the emotional will to win a case could

152 Redelinghuys, Bütow, Carstens *South African Dental Journal* 148.
153 Hookman *Medical Malpractice Expert Witnessing* 305.
154 Grobler *The South African Gastroenterology Review* 11.
155 Van Den Heerver and Carstens *Res Ipsa Loquitor & Medical Negligence* 146.
156 Hookman *Medical Malpractice Expert Witnessing* 291. Although it could be flattering to be called as a MEW, the emphasis on "expert" is not an honorary qualification as such but rather a legal technical term and the word "expert" should be changed to say "appropriately qualified witness".
157 Thus one of the main reasons why documentary proof of actively staying up to date must be given by earning continuing professional development points.
158 Merry and McCall Smith *Errors, Medicine and the Law* 189. In the case of *Roe v Ministry of Health* (1954) Lord Denning is quoted: "do not look at the 1947 accident with 1954 spectacles".

become overriding. The MEW could subliminally be influenced by the fact, that the more serious the possible harm that could have been caused, then the higher the standard of care would have been expected. MEW should not focus solely on individual factors, but also be led by other general and systemic factors, within an institution, albeit that it is easier to prove a doctor negligent, than for instance an institution like an academic hospital.[159]

4.5 The concept of acceptability of expert evidence

The MEW must know the effect and impact, acceptance and weight of opinion evidence. Factors that will lead to a MEW opinion, to be accepted as evidence, is the MEW's composure that will signal special knowledge and technical presentation. It is emphasised that an expert's opinion is actually reasoned conclusions based on certain facts which are common cause, established on evidence or obtained from another competent witness.[160] The admissibility is allowed where the court is unable to draw proper inferences, or make its own opinion and judgements. The court will realise it needs an expert witness, who acquired specialised knowledge by study or practice, to help evaluate the evidence. Expert opinion evidence may be contradicted and subject to cross examination. The facts are evaluated for admissibility and weight.[161]

Independence and objectivity of the MEW will carry a lot of weight (and respect), even if the MEW had been retained by the other party. Thus the main function of an expert witness is to give an opinion that ultimately could assist the court by making a fair finding in matters regarding specialized knowledge. The opinion must be credible or must be rejected if the scientific validity is not acceptable or logical.[162]

4.6 The dilemmas created by Health Professional Committees or Councils

Once medical malpractice occur health councils or committees must examine, classify and clarify a complaint or accusation, using acknowledged definitions and

159 Merry and McCall Smith *Errors, Medicine and the Law* 190.
160 Zeffert and Paizes *The SA Law of Evidence* 327. Proper evaluation of the expert opinion can only be done if the process of reasoning, the proper premises and the conclusion reached, are disclosed by the expert witness.
161 Knoetze 2008 *De Rebus* 29
162 Schwikkard et al *Principles of Evidence* 437.

respond to the various parties in writing. However it is accepted and there is a perception, that doctors could have been denied their rights to natural justice.[163] The blocking by the professional councils of the patient's right to sue, must be counterbalanced and accompanied by acceptable alternatives to ensure that reasonable complaints against doctors can be heard and dealt with. There are many real and perceived instances where mistakes / errors involving little or any moral culpability, resulted in findings of "conduct unbecoming" in a hearing of a health professions council.[164] The opprobrium of such a finding is then unduly harsh. Professional over self-regulation and protection however, will lead to patient frustration realizing that "closing of professional ranks" could lead to extreme cases being overlooked and condoned.[165]

It should be accepted that doctors are well placed to judge aberrant and unethical behaviour by colleagues. Preventative measures should be controlled by MEW doctors by re-registrations, proof of continued professional education and development, as well as programs of clinical governance. The costs will be offset by savings on court cases and of iatrogenic harm, in financial and human terms.[166]

The dilemma also arises that with different and various diagnostic techniques or therapy, that it may be difficult to defend a particular regimen if an untoward outcome occurs. Thus alternative dispute resolution procedures must be established and followed *i.e.* mediation or depositions. Another dilemma is the want for punitive damages. Here a third party (like a Medical aid or Medical Care Organization) could also sue, if unnecessary or when preventable costs occurred.[167]

If a finding could be made of "guilty of conscious disregard" of patient safety, the punitive rewards in addition to compensatory damage should be considered – an MEW can contribute to this process, at the request of the plaintiff's lawyer.[168]

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163 Strauss *Doctor, Patient and the Law* 369.
164 Strauss *Doctor, Patient and the Law* 369.
165 Merry and McCall Smith *Errors, Medicine and the Law* 236. The so-called Dr H Shipman cases refers, where this British general practitioner killed his aged patients with an overdose of pain medications.
166 Merry and McCall Smith *Errors, Medicine and the Law* 237
167 Hookman *Medical Malpractice Expert Witnessing* 152.
168 Hookman *Medical Malpractice Expert Witnessing* 153.

The dilemma is that when a case is built by a series of questions leading to a summation, it could be found (perhaps unreasonably), that the defendant "deliberately and intentionally", consciously contributed to this "adverse outcome", proving that there was a disregard for the plaintiff's safety. To prevent this most doctors would practice forms of defensive medicine. Defensive medicine could then be "over practiced" which could be,

(a) Positive (Assurance Behaviour) – more measures, albeit of little or no real value from an objective medical point of view) taken to help with the diagnosis, or aiming to reduce litigation risks or,

(b) Negative (Avoidance behaviour) – avoiding high risk patients.[169]

An alternative could be so-called moderated settlement conferences where the lawyers are neutral and a panel of experts reports merits on either sides.[170]

4.7 Diverse aspects of medical witnessing

As there are many small pitfalls that could grow into cumbersome problems, the MEW should also be aware of many diverse aspects of medical witnessing. The most common and often awkward ones would be fees to be asked for and the undertaking of practising a "code of ethics". If not sorted out early, it could ruin a medico-legal partnership and cause a justifiable case to be lost. An important aspect, as unpleasant as it seems is that fee contracts must be drawn up and a memorandum of understanding issued with the legal team. It must be noted to NEVER negotiate fees on a contingency basis, as it could "build a case", thus developing an unreasonable and unethical desire to "win", in order to get remunerated. The MEW must insist on a right to abide by a "code of ethics", the right to receive adequate and fair compensation for services rendered, to consult, to all relevant data, to be kept informed of all new developments, to be free from all undue influence, to have depositions within a reasonable time and to have adequate endorsement.[171]

169 Howarth 2013 Sept *SA Medical Chronicle* 3.
170 Hookman *Medical Malpractice Expert Witnessing* 153. As shown in the Wisconsin State, it expedites resolution, settlements and avoids lengthy litigation. This can also be described as early neutral evaluation.
171 Hookman *Medical Malpractice Expert Witnessing* 210.

4.7.1 The dilemma of the "Designation without Permission Syndrome"

A MEW must be aware of the so-called "Designation without Permission Syndrome", where a lawyer intentionally forces a case on a potential MEW. Acceptance of a case must be provisional at first and then later confirmed in writing, after the specific lawyer had provided **all the relevant facts** (own emphasis) of the case. Often the request is urgent just to "see" whether a case can be made. If the opinion of the MEW would support this *prima facie* case, without further agreement, appointment, contract or letter of undertaking, this case is thrust upon the (unwilling) MEW.[172]

Closely related to this is the "attorney's shopping syndrome", where lawyers deliberately build a case with opinions and "fish" for a favourable MEW. Once a potential MEW has become involved in such cases, the MEW's credibility could be lost as his opinions would be interpreted by knowledgeable lawyers and other MEW as insincere, artificial, deceitful and the witness could be caught out "under oath" of not telling the truth. The question that could be asked is whether a MEW's opinion "is also the truth".[173]

It is the judge's perception of the MEW's truthfulness that will be critical. The phenomenon of the miasmatic expert, who through opportunism and greed exploits the judicial system, is typically found out by a judge in the scenario of a court case. Doctors should not let an attorney write the report or when conforming to local statutes or court rules, put other words into the report that could construe a different meaning. Reports must conform to civil procedures.[174] Thus the MEW's report must be prepared by the witness and contain a complete statement of all opinions to be expressed plus the basis of the reasoning. [175]

4.8 Conclusion to Chapter four

Knowledge of Medical Law will empower a medical expert witness and enable him to be a credible and reliable witness, thus helping a legal team and the courts to reach a fair finding. With additional knowledge and skill, a MEW would be trusted

172 Hookman *Medical Malpractice Expert Witnessing* 268.
173 Hookman *Medical Malpractice Expert Witnessing* 269.
174 Theophilopoulos et al *Fundamental Principles of Civil Procedure* 139.
175 Hookman *Medical Malpractice Expert Witnessing 270.*

to do the correct thing, thus avoiding many mishaps and pitfalls. The basic definitions must be known and checked with the legal team, i.e. for instance if one is dealing with medical malpractice, medical negligence and when an error of judgement is possibly also a cause of medical negligence. The aspects of foreseeability versus also the risk must be understood. To evaluate these factors fairly, ethics must be a guiding principle like “at first do no harm”, often used in the practice of medicine but in a medico-legal opinion it is also very applicable.

Legal principles must be known like the use of *stare decisis* and objectivity. Other rules and concepts like *imperitia culpae adnumeratur* and the adverse event must be understood and properly evaluated. These concepts could encourage a hesitant MEW to avoid the “conspiracy of silence”. Understanding the concept of an error and its analyses could contribute to proper legal procedure. Thus there must be cognisance taken of criteria which play a role in the appointment of a medical witness. Medical witnesses must not rationalize a case or help by building, or manufacturing the case. The MEW should know of the considerations that a court could use when evaluating the acceptability of the expert evidence. The MEW should also play a role in evaluating the informed consent process to establish if it had been reasonable. Likewise the pitfall of quoting journals must be taken note of and qualified in court by the Daubert rules. Post-graduation training in the field of the MEW seems to be quite essential and will have to be enforced in future as medical law will inevitably change with changing times. This will contribute to selecting an appropriate medical witness ensuring that such a witness is just like a lawyer or advocate in their respective professional fields, “a fit and proper person” for this role.

In this chapter many of the most obvious and common dilemmas are discussed which act as pitfalls for an unwary medical witness. It is thus most important that the MEW should be creatively aware of these potential dilemmas which could affect the standard, fairness, reasonableness and justifiability of his opinion and testimonies. By not addressing as many medico legal and dilectual elements specifically and objectively, the medical expert opinion could become useless and be rejected in a court of law. Definitions should be understood so as not to complicate reasoning or confound the issues, for instance when is a medical complication due to an error of judgement or really due to a wrongful negligent act.

The medical witness must know the pivotal role of proof. Likewise the legal team and the MEW for a party must be able to evaluate their own and the other party's MEW in terms whether his testimony measures up to acceptable standards. Case studies reveal that a judge is seldom, if ever, fooled by these witnesses, but a legal team must be actively prepared to raise doubtful issues at cross examination. The unethical MEW must thus be eliminated from legal procedures. Reforms in the legal process could help to eliminate the threat of unethical witnesses in Medical Law.[176] Mediation and arbitration meetings could defuse patient and family generated dilemmas of unrealistic expectations in term of compensation, accountability and punitive actions.[177]

Definitions must be well understood and uniformly used by the legal team as friction could develop, if the same understanding and definition of a concept is not used like using the term "adverse event" loosely as "medical malpractice". Medico-legal dilemmas are actually also created by controlling statutory bodies where doctors are charged for "conduct unbecoming" and "failing in the care" following naïve, unreasonable and unrealistic complaints of patients. Here an ethical knowledgeable witness on a committee could defuse many situations and via feedback, allay the plaintiff's concerns.

A major dilemma is where a case in thrust upon a MEW by an over demanding and aggressive legal team. The weak and unprepared MEW could fall for this assertiveness and should guard his professional independence fiercely even if it could mean losing the client. Specific dilemmas that virtually occur in every medical legal court case are that of proper informed consent. Thus all aspects of present accepted informed consent must be known and accepted.[178]

Although it is virtually impossible to address all the dilemmas that could lead to severe pitfalls in the role of the MEW, those mentioned above has been found to be virtually consistent in all the case studies and the personal experience of most MEWs. Thus it must be taken note of and properly pro-actively addressed when every case is evaluated and assessed by the MEW.

176 Berlin 2003 *American Journal of Radiology* 1521.
177 Hookman *Medical Malpractice Expert Witnessing* 102.
178 Van Oosten 1995 *Medicine and the Law* 167.

CHAPTER FIVE

THE MEDICAL EXPERT WITNESS EXPERIENCE IN OTHER LEGAL SYSTEMS

"*Fools learn from experience. I prefer to learn from the experience of others*" –
Count Otto von Bismarck, Chancellor of Germany *circa* 1885

5.1 Introduction

By evaluating other international MEW experiences and systems could help to improve the position in South Africa, bearing in mind that the Constitution encourages this action.[1] Medical litigation had prominently taken place and had been debated in English speaking common law countries for many years, therefore a comparison of medical litigation should be made with these countries. [2] As South African Law is mainly mixed Roman-Dutch Law with extrapolation of English law, this would make sense. Because the worldwide tendency for medical litigation is rising, English speaking countries make up the vast part of this litigation and thus should have the most collective experience of acceptable medical litigation that would be applicable for the South African experience.[3]

5.2 Facilitation by use of rules and tests in foreign medical law

To facilitate argumentation in law, the appearance of several objective "tests" were noted in the USA. [4] As it is important to reach a fair outcome on the balance of probabilities, courts actually invite physicians in the role of "clairvoyants" to foretell of conditions, presumably on scientific speculation in the absence of verifiable medical predictions, or in hypothetical situations during argumentation, to determine an outcome.[5]

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1 Section 39(1)(c) of the Constitution of the Republic of South Africa, 1996.
2 Thomas, Van der Merwe en Stoop *Historiese Grondslae van die Suid-Afrikaanse Reg* 8.
3 Howarth 2012 *Medical Chronicle* 12. This article acknowledges the steeply rising claims being awarded to patients.
4 *Potter et al v Firestone Tire and Rubber Co* (1993) California. This case emphasizes the use of acceptable scientific knowledge as given by an expert witness.
5 Mendelson *The Interfaces of Medicine and Law* 258.

In due course it was also accepted in English law, regarding the MEW's role in the law of tort, that the scientific validity of a subject or methodology must be accepted by the scientific community.[6] By applying this guideline, it must be borne in mind, historically and factually, that it is a MEW's opinion testimony, which must be based upon a reasonable degree of acceptance within the specialised field.[7]

More recently, internationally, the testimony of the MEW must adhere to the guidelines from the case of *Daubert v Merrell Dow Pharmaceuticals Inc*,[8] where it was suggested that evidence had to be relevant, reliable, would not mislead the court and that this evidence should not make a case more complicated.[9] Thus testimony must be based on sufficient facts or data, must be a reliable product and must demonstrate that the witness has applied methods applicable and relevant to the facts of the case.[10]

In English law two important tests have been devised and have the recognition and approval of the high courts. These tests are the so-called **Bolam** and the **Bolitho** tests.[11]

The **Bolam principle** could apply in medical testimony, which seems to be used extensively in English Law, and was upheld for use in court on four occasions in the House of Lords (by 2001).[12] The Bolam principle states that it allows for the difference in opinion between doctors and that it is a sufficient defence to have the support of a reputable body of medical opinion (regardless of the size of that body). A doctor and especially a MEW should bear in mind that consulting with a colleague is a powerful tool, not only in preventing litigation but also to form a united front in litigation. At the time of discovery of documents, it could prevent unpleasant adversarial procedures or prolonging the case unnecessarily.[13]

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6 *Frye v US* 293 F 1013(1923). This case emphasised the scientific validity of expert evidence.
7 Hookman *Medical Malpractice Expert Witnessing* 294.
8 *Daubert v Merrell Dow Pharmaceuticals Inc* 509 US 579 (1993). "Daubert" pronounced "Dowbert", seem to be used extensively in the USA.
9 Knoetze 2008 *De Rebus* 29.
10 Gomez 2005 *The Journal of Legal Medicine* 391.
11 Campbell, Callum and Peacock *Operating Within the Law* 29.
12 Campbell, Callum and Peacock *Operating Within the Law* 29.
13 Merry and McCall Smith *Errors, Medicine and the Law* 90.

Objectively, the Bolam test and the **Bolitho test** would help to set a standard to meet, before appropriation of blame. The **Bolitho test** demonstrates that if a professional opinion is not capable of withholding logical analysis, the body of opinion is unreasonable or irresponsible and must be rejected.[14]

In the South African case of *Michael and Another v Linksfield Park Clinic and Another*, the Bolitho test (as well as the *Daubert* principle) was actually followed thus setting the precedent of usage in South African Law.[15]

5.2.1 Determining the standard of care: the Bolam test

The test is based on the case of *Bolam v Frien*.[16]

In this case the defendants were vicariously held liable for harming a psychiatric patient who had undergone electroconvulsive therapy without a muscle relaxant. In the convulsions that followed, the plaintiff fractured his hip. In this case it became an issue whether negligence is involved when a respectable body of opinion would have supported the mode of action of the defendants. This could be qualified by the words "in all circumstances". A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of appropriately skilled

14 Merry, McCall Smith *Errors, Medicine and the Law* 165. *Bolitho v City and Hackney Health Authority* (1997) 4 All ER 771. www.publications.parliament.uk/pa/ld199798/ldjudmt/jd971113/boli02,htm. (Date of use: 10 September 2012) The test is based upon this case where a two year old child died following episodes of respiratory distress after being admitted for Croup. Although the child did well on the consultant's round, he deteriorated and the senior registrar was called. She did not come to see the child and sent her junior doctor to assess. After initial improvement, the child once more deteriorated and was then also again not seen and developed respiratory failure ensuing in brain death and eventually died. The question was whether this child should have been intubated and respiratory supported. The expert opinions were opposing and the judgement was in favour of the defended doctors who were not found negligent. The fact was emphasised, **that if an opinion differed from another, it had to withstand logical analyses by the court to be accepted**. However, this finding has attracted a lot of academic criticism. It is realised had more assertive medical expert testimony been given, the finding could have been that of guilty of negligence and the appeal upheld.

15 *Michael and Another v Linksfield Park Clinic Ltd and Another* 2001 (3) SA 1188 (SCA) para 1189G. It is mentioned that in the presence of various and often conflicting expert opinions presented, the court must decide using guidelines like credibility, examining, and logical analysis. If the expert opinion cannot be logically supported it will fail to be the reference to which a defendant's conduct is assessed (para 1198 I).

16 *Bolam v Friern Hospital Management Committee* (1957) 1 WLR 582. In this case a patient underwent electro-convulsive therapy for a psychiatric condition, without a muscle relaxant anaesthesia. Muscle contraction due to convulsions were so severe that the patient suffered a femur (upper leg) fracture. The majority MEW concurred that this was negligence but an authoritative minority group stated it was accepted practice not to give a muscle relaxant and thus the hospital and treating doctors were acquitted.

medical practitioners, of a contrary body of medical opinion and view. Obviously the doctor must work within acceptable borders and not carry on in an obstinate fashion, and thus the Bolam test could be "modified" that under the circumstances the action was reasonable! The Bolam test must be presented where there is a defence of acceptable, but different practice. This leads to the dictum quoted as from Lord Denning: "*we must say and say firmly that in a professional man*, ***an error of judgement is not negligence***" (own emphasis).[17]

The Bolam principle may be formulated as a rule that a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a respectable responsible body of medical opinion, even though other doctors adopt a different practice. In short, the law imposes the duty of care, but the standard of care is a matter of medical judgement.[18]

The Bolam test sets the standard of the ordinary, medically qualified, skilled professional man. This person need not possess the highest expertise or skill, but it will be accepted that sufficient ordinary skill is exercised by an ordinary competent man. There may be other perfectly proper standards and if the professional person conforms to one of the acceptable standards, there will be no negligence. A personal belief whether a particular technique is best, is no defence unless it is based on reasonable and logical grounds.[19]

Differences of opinion exist and even if one body of opinion is preferred, it is not necessarily fair or reasonable for a specific opinion to be a basis for a conclusion of medical negligence.[20]

In any case the claimant / plaintiff, in establishing that harm or injury has occurred due to the negligence of a medical practitioner, carries the burden of proof. To counter the Bolam test, the plaintiff must show that the treatment fell below the proper standard expected of a practitioner at his level of skill in his field of

17 Kennedy and Grubb *Medical Law: Texts with Material* 443. *Whitehouse v Jordan* (1980) 1 All ER 650.
18 Lord Scarman in *Sidaway v Governors of Bethlehem Royal Hospital* (1985) AC 871.
19 Cameron and Gumbel *Clinical Negligence – A Practitioner's Handbook* 7.
20 Cameron and Gumbel *Clinical Negligence – A Practitioner's Handbook* 8. House of Lords (1985) approved the Bolam Test as being a rule that a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by an acceptable body of medical opinion, even though other doctors adopt a different practice.

expertise on the specific date the treatment was carried out. It must also be shown that the damage or harm was indeed caused by this negligent act (causality). A professional man is required by law of negligence (delict or tort law) or by the law of contract to display care and skill.[21]

The Bolam test was moderated to some extent in the House of Lords in 1997 in *Bolitho v City and Hackney Authority*[22] where it held:

> In cases of diagnoses and treatment there are cases where, despite a body of professional opinion sanctioning the defendant's conduct, the defendant can be held liable for negligence. That is because in some cases, it cannot be demonstrated to the judge's satisfaction that the body of opinion relied upon is reasonable or responsible.

The Australian High Court rejected the Bolam test, unless "modified", i.e. it must be logical, reasonable and responsible, as well as the assessment of a breach of duty and focused more on the need for information, rather than the practices and attitudes of the majority or minority of practitioners.[23] It was held that the law imposes a duty on a medical practitioner to exercise reasonable care and skill in the provision of both professional advice and treatment.[24]

It seems that the application of the Bolam test could be rejected in a particular case. Professional advice to a patient depends on the provision of information, except in cases of emergency or necessity, ensuring that action is preceded by the patient's choice to undergo it. It is therefore important to realise that the decision of whether the required standard of care had been met is a matter for the court, based on the opinion of the MEW.[25]

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21 Cameron and Gumbel *Clinical Negligence – A Practitioner's Handbook* 11. Comment : in the RSA this could extend also to the Consumer Protection Act, although not yet tested in a court.

22 *Bolitho v City & Hackney Health Authority* (1993) 13 BMLR 111 (CA)

23 Freckelton and Petersen *Disputes and Dilemmas in Health Law* 382. In *Rogers v Whitaker*, the rare risk of losing vision in the healthy eye (sympathetic ophthalmia 1:14000 chance) where the patient had expressed anxiety about her risks to her vision, many ophthalmologists stated that they would not have warned a person of such a risk.

24 Including a covering examination, diagnosis and treatment.

25 Freckelton and Petersen *Disputes and Dilemmas in Health Law* 383. The Australian law committee concluded that if the Bolam rule is strictly applied, it could give rise to results that would be unacceptable to the community.

The main weakness of the Bolam rule is that it allows a smaller amount of medical opinion, to set the requisite standard of medical care, even in instances when a substantial majority of medical opinion would disagree. Thus the Bolam rule is not a reliable guide to acceptable medical practices, bearing in mind the varying aspects of medical practice like the varying size of opinion, different training, circumstances and locations.[26]

The **Bolam principle** could apply in other legal systems,[27] as it allows for the difference in opinion between doctors and that it is a sufficient defence to have the support of a reputable body of medical opinion (regardless of the size of that body). At the time of discovery of documents, the use of the Bolam principle could prevent unpleasant adversarial procedures or prolonging a case unnecessarily.[28]

5.2.2 Determining the standard of care: the Bolitho test

To solve the Bolam test dilemma of varying opinions, the implementation of the **Bolitho approach is recommended**, by considering that in the public interest, that the chance that an opinion which is widely held by a significant number of respected practitioners could be held irrational is very small. If the expert opinion in the defendant's favour were held to be irrational, the defendant should not be allowed to rely on it.[29]

This approach contains sufficient safeguards to satisfy the reasonable public, patient and medical practitioner. The recommended rule suggests that there must be more than one opinion widely held in the field. Provided a court does not find it irrational (or unscientific and / or unreasonable), thus **most logically and scientifically acceptable**, a defence can be provided. This is with the presumption, by peer opinion, that a provided service was acceptable at the time,

26 In the writer's view this criticism is over exaggerated as there would not necessarily be disagreement, but more acknowledgement that there are other opinions, which pending the circumstances could in the hands of a specific doctor be allowable and acceptable.
27 Campbell, Callum and Peacock *Operating Within the Law* 29.
28 Merry and McCall Smith *Errors, Medicine and the Law* 90.
29 The Bolitho test was used i.a in the well-known *Michael and Another v Linksfield Park Clinic Ltd and Another* 2001(3) SA para1198 I, where four MEW had to testify about the indication and dosage of medication given during an anaesthetic which could have caused heart arrest.

as competent professional practice. Professional peer opinions need not to be universally accepted to be considered acceptable in a particular court case.[30]

The MEW must make an effort when using the Bolam or the Boltho tests, to establish that there is or was a duty by the treating doctor / defendant to give advice of **material risks in the process of informed consent**.[31] If this had been done, it would enforce the point that the defendant doctor had been reasonable and his treatment regimen most "acceptable".

5.3 Solutions to the escalating medical litigation "crises" in other countries

The escalating costs of litigation have forced several other countries to reform. The MEW must be aware of this so that future unrealistic support to outrageous claims could be withdrawn using the lessons gleamed from foreign law.[32] In Ireland, well known for its high rate of medical litigation, and due to rising costs, a Clinical Indemnity Scheme was introduced in 2002 where the Irish government assumed full responsibility. In 2004 damage compensation "caps" were introduced and it now stands at R 6.8million in Ireland, where the State takes responsibility for the excess of this. Limitation rulings to initiate claims have also been lessened to two years.[33] Similarly, the USA has been capping general damage claims in 28 states since 2006, giving an average saving in total compensation amounts of 20-30 per cent.[34] In Australia it has been recommended, following the collapse of a general insurer in 2001, that damages for loss of past and future earnings are capped at two to three times average weekly earnings over a year and non-patrimonial losses at three million Rand. Reforms also set minimum thresholds of permanent injury, to make sure claims are proportionate when seeking damages for non-patrimonial losses. In New Zealand a "no-fault" system is run by the Accident Compensation Corporation, where patients could receive compensation without liability being placed on the involved doctor. The emphasis here also shifts to proof of causation, rather than proof of fault. The claimant/plaintiff must prove that the medical error caused the injury and harm directly, irrespective of who is to

30 Freckelton and Petersen *Disputes and Dilemmas in Health Law* 386.
31 Carstens and Pearmain *Foundational Principles of South African Medical Law* 314.
32 The Constitution of South Africa allows for this under section 39(1)(c). When interpreting the Bill of Rights, a court, tribunal or forum – may consider foreign Law.
33 Howarth 2012 *Medical Cronicle* 12.
34 Howarth 2012 *Medical Cronicle* 12.

blame.[35] However, what works in other countries might not work here in SA, as each country has social, legal and governmental factors to consider.[36]

In Britain the membership fees to belong to a Medical Defence Society have increased so much, that for doctors in the employment of the National Health Service (NHS) it is unaffordable and thus Crown indemnity has been extended to all professional health care workers since January 1990.[37] The entire costs of negligence litigation against a NHS doctor are now borne by the NHS. The other dilemma that could result, though it has not been properly assessed, is that the Health Authorities would now feel obliged to settle cases as this would be considered the "cheapest" way. However, this is money for compensation that will be at the expense of already limited State treatment facilities. It is recommended, even if the NHS doctors are covered, they should retain cover for any private, "good Samaritan" work and also now for medico-legal activity.[38]

The Australian Federal Government (in 2002) appointed a panel of Eminent Persons (the so-called Ipp Committee) to review the country's laws of negligence. This was because the awards for damages had become unaffordable and unsustainable. It was concerned that methods have to be examined to reform the common law thereby limiting liability and quantum of damages arising from personal injury and death and with stricter control, the insurance companies had re-introduced acceptable medical indemnity insurance.[39] Furthermore, recommendations were made and seem to be accepted, including the introduction of the **modified form (*i.e.* it must be logically acceptable)** of the Bolam test, changes relating to the laws of causation, restrictions on recovery, limits on

35 The term "claimant" is used in English Law and the term "plaintiff" is used preferably in all other English speaking common law countries.

36 Howarth 2012 *Medical Chronicle* 12. However, some examples of reform has inevitably been introduced by the RAF amendment act where in 2008, over R 50 million was paid to a Swiss tourist who had lost an arm and leg in a motorcycle collision. This was obviously a precedent for unrealistic and unsustainable costs. Although it is obvious that transposing models to SA might not be practical, some reform for the law of delict and damages for medical claims cases must be urgently implemented.

37 Mason and McCall Smith *Law and Medical Ethics* 32, quoting Ministry of Health circular.

38 Mason and McCall Smith *Law and Medical Ethics* 32.

39 Freckelton and Petersen *Disputes and Dilemmas in Health Law* 391.

damages for personal injuries, compensation and statutory recognition of apologies and expressions of regret. [40]

The High Court of Australia found that *prima facie* harm is regarded as a tort or delict, if the harm ensues in the immediate aftermath of the act.[41] This can create open arguments by health professionals as MEW *i.e.*:

- The link between the breach of duty and the damage was temporal and coincidental.
- The damage was inevitable and probably would have occurred regardless of breach of duty.
- The breach of duty was irrelevant to the damage.
- The event was the immediate result of the plaintiff's action.
- The event was not the cause of damage as this event which occurred would have happened in the same way even had there not been a breach.

By answering these questions, more opportunity is brought into litigation for fairness to be reasoned by debating the causation. Such reasoning seems absent in the SA medical litigation. The Australian court has accepted that had there been a foreseeable risk, of loss of an opportunity to undergo surgery at the hands of a more experienced surgeon, there is a duty to inform the patient that there were more experienced surgeons practicing in a particular field. This must be evaluated against a balance of probabilities knowing that intuition and common sense would suggest that the greater the skill and more frequent the performance of a specific surgical procedure, the less risk of complications will occur.[42]

The question to be asked in a court according to Australian practice is what a patient would have done, in terms of a procedure or treatment, if given a proper warning. The courts do not have to unquestionably accept the ostensible position of a patient claiming that they would not have had a (complicated) procedure if warned of the risk.[43] Here it seems that imputed knowledge plays a major role,

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40 Freckelton and Petersen *Disputes and Dilemmas in Health Law* 392. Recommended "modified" Bolam test.

41 Freckelton and Petersen *Disputes and Dilemmas in Health Law* 392.

42 Freckelton and Petersen *Disputes and Dilemmas in Health Law* 393.

43 Freckelton and Petersen *Disputes and Dilemmas in Health Law* 393. In the case of *Rosenberg v Percival* (2001) HCA 18 223, the patient as a doctorate in Nursing, her plea

while in the RSA medical malpractice litigation this concept seems to be absent or not emphasized.

Following the Australian reforms, a two tier test for causation is put forward namely,

(a). Negligence must be a necessary condition of the occurrence of the harm (factual causation) and,[44]

(b) It must be appropriate for the scope of the negligent person's liability to extend to the harm so caused (scope of liability).

The Australian emphasis on factual causation is regrettable as it shown that there must also be judicial causation to be verified. [45] Here the South African Law of Delict with its ***elements of a delict would be better suited in the final analysis of the better legal system for medical professional negligence litigation.***[46]

Recent rulings in the USA and UK have redefined the court's role in ensuring the quality of expert testimony. In Australia a MEW has to undergo training and accreditation.[47] In English Law it is held that medical expert evidence is only admissible as to matters outside the ordinary human knowledge or experience.[48] Awareness of broader causes for adverse outcomes, like system factors, a patient's health problems and deficiencies of skill and competence, is important, especially so as to be able to adhere to the real material and relevant issues of a case.[49]

Doctors, in most English speaking countries, are generally not legally required to provide expert testimony in legal proceedings. It could be argued that the adversarial system is found to be against professional collegiality but as a profession, doctors should with ethics as a basis (of which sincere honesty and

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was rejected that she, if warned, would have sought treatment elsewhere. (Example of imputed knowledge).

44 Here then acceptable complications of a treatment would thus be automatically excluded as grounds for litigation. Obviously the MEW would have to emphasise this.

45 Freckelton and Petersen *Disputes and Dilemmas in Health Law* 393.

46 Writer's conclusion and emphasis in italics. The elements of a delict being an act or conduct, which was wrongful and negligent, of which fault is proven, causation proven and that harm or damage had occurred and that there must be a nexus between the harm and causation.

47 Freckelton and Petersen *Disputes and Dilemmas in Health Law* 395.

48 Meintjes-Van Der Walt 2000 *The South African Law Journal* 773.

49 Merry and McCall Smith *Errors, Medicine and the Law* 110.

integrity would be most important), have a professional obligation to serve the public in settings where expertise is needed by a court. In the USA, supported by the American Medical Association, a witness can be qualified by knowledge, skill, experience, training and education. In future some form of legal education and training will have to take place to set a minimum standard. Guidelines must then also be given for acceptable testimony, ensuring that it is conducted fairly, reasonably and in good faith.[50] This must still be more enforced in the RSA. In the United Kingdom, medical witnesses must preferably do a course and be registered as a medical witness.[51]

In the UK a MEW must take note of the question that seldom seems to be answered in the RSA, in that what effect has the natural history of a disease of a patient scenario to an unfortunate outcome. This is seen to be a problem when patients write most emotionally charged sensational and upsetting statements. Lawyers are then not eliminating the subjective interpretation from facts in their summaries, before asking MEW's to give an opinion. It is emphasised that there must be an obligation to objectivity and material facts,[52] when doctors respond to requests to serve as MEW. Such testimony must embody the relevant facts as well as the expert's knowledge, experience and best judgement of the case.[53]

A MEW must be familiarised in the rules of evidence with a mixture of logic, epistemology, sociology, psychology and the forensic sciences. Whereas in medical malpractice litigation, negligence is the predominant factor, it must be borne in mind not to confuse it with complications or medical "mal-occurrence". These would include an unfavourable outcome of medical intervention and is not necessarily related to negligence or the unreasonableness of the provided care.

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50 American Medical Association. *Report of the Council on Ethical and Judicial Affairs* 2004 2

51 General Medical Council. "Acting as an Expert witness" www.gmc-uk.org/static/documents/content//Acting as an expert.pdf (Date of use: 20September 2012).

52 Silver *The Signal and the Noise* 57. The author emphasizes that aggressive type A personalities as "experts" fail, because they create a blurry fusion between facts and values which are lumped clumsily together. A prejudicial view is taken towards evidence "seeing or hearing what they (the retaining party) want to see or hear" and ***missing*** what is real.

53 Richards "Guidelines for Expert Witness Testimony in Medical Liability Cases" http://biotech.law.lsu.edu/map/GuidelinesforExpertWitnessTestimoney . (Date of use: 17July 2011). This could be most exasperating if lay people could make false statements like "they wanted to do a post mortem so that the medical students could do experiments on my husband's corpse", "the doctor wanted to stop the bleeding by putting in towels in the pelvic cavity – have you ever heard about such rubbish!", "the staff caused the bed sores because they did not move him enough" (while not mentioning that the patient weighed 180kg, with ischaemic skin ulcers having smoked over 80 cigarettes/day).

However it seems to be especially in the USA, that "mal-occurrence" is compensated, where there was no real "malpractice". [54]

The American Medical Association stated in 1992 that a physician has an ethical obligation to assist in the administration of justice. This must be done without becoming an advocate for the case or by being a partisan in the case.[55] It is considered unethical in the USA to accept compensation for being a MEW on a contingency basis.[56]

5.4 The medical expert witness' role in preventative strategies

The role MEW's play in English common law countries in the preventative goals of risk management is quite prominent. This concept is already statutory in a few States of the USA with educational programs that teach about lawsuit reduction. Medical law education for medical students is now compulsory in all US medical faculties. This educational course is useful, would reduce physician anxiety and provide strategies for prevention and resolution of potential problems. There should be ethics committees and risk managers in all major hospitals and universities, lying emphasis on risk management education.[57] In South Africa, although mooted, it is still not well developed.

To enforce the status of preventative goals, it should be compulsory in any tort/delictual reform, that mediation and arbitration must be done before any court procedures.[58]

To monitor preventative strategies the standard of care must be evaluated. The standard of care can often be evaluated by the Bolam or "modified" Bolam tests.[59]

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54 Murphy *Murphy on Evidence* 21. This should be cautioned against in the RSA as an increasing occurrence, the reasoning also being that it is cheaper to settle than to have a finding (with costs) against a defendant in a high court.

55 The desired yardstick for objectivity and fairness is that a testimony must be so prepared that it could be used by the plaintiff's or defendant's party, without any changes or embarrassment!

56 Richards "Guidelines for Expert Witness Testimony in Medical Liability Cases" http://biotech.law.lsu.edu/map/GuidelinesforExpertWitnessTestimoney . (Date of use: 17 July 2012).

57 Marshall and Kapp *Our Hands are Tied: Legal tensions and Medical Ethics* 56.

58 Marshall and Kapp *Our Hands are Tied: Legal tensions and Medical Ethics* 148.

59 *Bolam v Friern Hospital Management Committee* (1957) 2 All ER 118.

Regarding the defence of inexperienced doctors in the prevention strategies, it must be noted as emphasized in the Canadian Tort Law, that the definition of negligence for inexperienced doctors is not diluted or considered sympathetically (except in a true emergency situation)! *Thus a novice inexperienced surgeon who has not yet performed a particular operation, can and will be held liable, if harm due to a negligent act takes place, like the severance of a nerve.* One of the qualities a junior or inexperienced doctor must have **is an appreciation of his own limitations**. A standard is set, below which no doctor must fall regardless of his knowledge and degree of skill. However, public hospitals are so organized that young doctors and health care staff inevitably have to "learn on the job". If this was not the case to hold them liable, *inexperience would always be rendered as an excuse in the defence to an action of professional negligence*. If a junior doctor sought the advice and help of a senior in the treatment management it would be considered satisfactory. An inexperienced junior doctor should only be held liable for the acts or omissions, which a careful doctor with his qualifications and experience would not have done or omitted. [60]

Junior inexperienced doctors will be judged by the reasonable skill test but the danger still exists that these doctors do not realize their own incompetence. Reasonable supervision should temper this risk but only constant supervision would minimise it. In the context of medical treatment, the law will probably reflect a court's unwillingness to accept that an agreement by the patient (for treatment by an inexperienced doctor) is voluntary rather than reached under duress of the circumstances. The (inexperienced) professional will be held to the standard of care he possesses or professes to have. It is most important for the MEW, that it is the medical profession who must set the legal standard of care, but also to determine what a doctor ought to have done.[61]

English Law has numerous case examples. This controversy was addressed in *Maynard v West Midlands Regional Health Authority*[62] where doctors were

60 Kennedy and Grubb *Medical Law: Texts with Material* 447. *Wisher v Essex AHA* (1987) QB 730, (1986) 3 All ER 801 (CA).

61 Kennedy and Grubb *Medical Law: Texts with Material* 448.

62 *Maynard v West Midlands Regional Health Authority* (1985) 1 All ER 635 (HL). The vocal cord nerves were damaged by means of a biopsy done via a so-called mediastinoscopy, where by placing an optic steel tube into the central part of the chest, lymph glands are

charged with negligence for recommending a diagnostic procedure which caused vocal cord paralysis when the diagnosis of tuberculosis was obvious, but as defence argued, needed confirmation. The Bolam test was applied and it was accepted that an error of judgement was made, as a substantial body of opinion would have condoned this diagnostic procedure. However, in the case of *Sidaway v Board of Governors of Bethlehem Royal Hospital,*[63] it was stated that the definition of care must not be handed over to the medical profession. This definition rests as a matter for the law and the courts. It was argued that the medical professionalism displays an excess of paternalism and the law must not permit "the medical profession to play God". The *caveat* here is that the doctor should have had "due regard" in the exercise of his judgement, whether another professional opinion was obtained. The Bolam test could be rejected in certain cases by defining it as that "the duty is fulfilled, if the doctor acts in accordance with a practice rightly accepted as proper, by a body of skilled, experienced men".[64]

The *Hucks v Cole*[65] trial set a standard where the Bolam test was limited. This involved a case of negligence because a doctor did not give his patient penicillin for a susceptible germ timeously, which resulted in septicaemia. It was shown that the doctor took the risk knowingly and that the fact that others would have done the same thing could, however be an excuse. The *lacuna* which formed between the diagnosis, risks and effective treatment was so large, that it was considered unreasonable. This case demonstrates that courts should play an assertive role.[66]

This leads to the *Bolitho v City & Hackney HA* [67] where the medical opinion of one group of doctors could be rejected on the grounds that the reasons of a specific group *do not really stand up to analysis*. It is emphasized that it borders on the unfair for the plaintiff to demonstrate the "unreasonableness" of an "accepted practice". The court must play a meaningful role of setting a legal standard of care. Reasonable action must be evaluated in terms of the doctor and the

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removed for analyses. With tuberculosis severe adhesions could ensue and with surgery of this kind, the vocal nerves could be damaged and torn.

63 *Sidaway v Board of Governors of Bethlehem Royal Hospital* (1984) 1 All ER 1018 (CA).

64 Kennedy and Grubb *Medical Law: Texts with Material* 457.

65 *Hucks v Cole* (1993) 4 Med LR 393 (CA).

66 Kennedy and Grubb *Medical Law: Texts with Material* 458 .

67 *Bolitho v City & Hackney HA* (1993) 13 BMLR 111 (CA).

circumstances. This could shift the burden of the proof in asking "what is to be done" into "what ought to have been done" in a specific case.[68]

In English and US medico-legal practice it is found that medical personnel are reluctant to testify or participate in legal proceedings, which testimony could be considered a preventative strategy by forcing litigation prone doctors to positively adapt their methods in preventing litigation as much as possible.[69] There is in any doctor, continuous tensions weighing up a duty to testify in a court as an expert witness, versus the medical ethics of maintaining silence resulting in the "medico-legal silent wall" phenomenon. The cost-risk benefit, lost friendships, loss of respect from colleagues, loss of referrals and guilt, could be simply too high for doctors to testify voluntary. It is inevitable that doctors that are prepared to testify are attached to academic institutions and have the time to do medico-legal activities. In the case of specialists it is expected that there must be at least five years of experience. However, if all doctors have some medico-legal knowledge they would understand the litigation process and as long as a medical witness follows ethical principles, the legal MEW should not be despised, begrudged or feared. Proper education is needed to increase the numbers of a desirable larger pool of medical experts. This will address the problem of marked deficiencies in the medico-legal knowledge and formal courses in medical testimony could be advocated. MEWs must remind colleagues professionally, that a "cover-up" often has worse consequences than the initial mistake. If a MEW knows about a cover-up he could also be litigated against as a vicarious liability process.[70]

5.5 Controlling the medical expert witness

Frustration is experienced especially in the USA and England, in that the "hostile", unethical and miasmatic MEW should be controlled, especially when the witness so slants his testimony as to unfairly and unreasonably benefitting his retaining party. This is also encountered when a "hired gun" or a miasmatic witness deliberately tells a lie or withholds the truth. Incompetence, mental and personality defects of the MEW could play a major role. This problem of false testimony being proffered remains especially in the English speaking countries that use the

68 Kennedy and Grubb *Medical Law: Texts with Material 458.*
69 Hookman *Medical Malpractice Expert Witnessing* 270.
70 Hookman *Medical Malpractice Expert Witnessing* 8.

adversarial system (especially in the USA). Little progress to stop this outrageous practice has been made even though the American Medical Association had announced that the MEW testimony must also be of such a high standard, that it is effectively also the practice of good medicine![71]

The American Association of Orthopaedic Surgeons revised the Standards of Professionalism applicable to all expert opinions of its members. Instead of using the expression "Expert Witness" the emphasis is on "Expert Opinion and Testimony", [72] to ensure less pressure on being the MEW, but more on the quality of the evidence.[73] In the USA over 30 states have expert witness laws, specifically to control the expert witness preventing indifference to the truth, the use of unethical tactics and combating the phenomenon of the "hired-gun". Medical associations and various State Medical Boards have created standards for proper testimony and would act against a MEW who violates the rules.[74] To prevent severe distortions of the truth, facts and testimony, all medical associations and boards should have a programme to deal with the irresponsible expert witness and his testimony.[75]

For many years in English Law the witness was protected by the "Witness Immunity Rule". However, following the case of *General Medical Council v Meadow*,[76] where on appeal, the English Court of Appeal found that the principle

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71 Milunsky 2003 *J Child Neurol* 413.

72 Merry and McCall Smith *Errors, Medicine and the Law* 176. When an MEW testifies around the facts of a case it will be considered testimony. Once these facts, with assumption and perhaps hypothetical scenario's are reconstructed to explain an incident, that would be considered an opinion.

73 Young http://www.aaos.org/news/aaosnow/jan11/managing6.asp (Date of use 24: Oct 2011).

74 Gallegos http://www.ama-assn.org/amednews/m/2011/08/01/psa0801.htm (Date of use 24: October 2011).

75 Feld and Carey 2005 *The American Journal of Gastroenterology* 991.

76 *General Medical Council v Meadow* (2006) EWCA Civ 1390. This case was prominent where the UK General Medical Council investigated the conduct of Professor Sir Roy Meadow, a professor in paediatrics (Prof Meadow was knighted for his work on the "Munchausen Syndrome by Proxy" and against child abuse 1977). The GMC ruled that he acted unprofessionally and on appeal the Supreme Court, although upholding an appeal that Prof Meadow must not be struck off the role, held that a Medical Expert Witness must stand trial for alleged false testimony and also perjury if necessary. In this case the Professor gave misleading evidence, based on wrong and faulty interpretation of statistics, against a certain Mrs Sally Clark, a lawyer, for being responsible for her children's cot deaths at different times and ages, respectively at 11 and eight weeks *post partum*. She was handed down a jail sentence of which she served three years. It was later shown that both these children had an inborn error of metabolism causing their deaths as babies. Although acquitted and freed, Mrs Sally Clark became an alcoholic and sadly committed suicide.

of witness immunity does not protect the MEW from accountability to the regulatory bodies for unacceptable substandard work, resulting in that the expert witness immunity is abolished.[77] Professor Meadow could have prejudged the issue making statistical errors after being famous and knighted for his campaign to limit child abuse and coined the infamous blunder "dictum" of:

> one sudden infant death is a tragedy, two is suspicious and three is murder, until proved otherwise.[78]

Following this case it was realized the there was a lack of security and safeguards to prevent miscarriages of Justice in medical litigation. It was emphasized that all evidence must have a logical base.[79] A MEW could be reported to a regulatory body for poor professional performance. More so because if litigants were to be unhappy with witness evidence, they cannot litigate and sue the witness, but can make a professional disciplinary complaint.[80]

In 2012 and following up to present time, the press, family law experts and concerned paediatricians have launched a campaign (*LB of Islington v Al Alas and Wray*) against the findings of family courts of England, where children are removed from their natural parents for "battered baby syndrome".[81] It was found that in many of these cases the children suffered from nutritional (lack of Vitamin D) and congenital (nephrotic or malabsorption syndrome) diseases, causing rickets and thus are prone to spontaneous rib and long bone fractures.[82] A

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77 Nash http://www.blm-law.com/2114/11296/objects/news/expert-witness-immunity-abolished (Date of use: 9 September 2011). This was precipitated by the case of *Jones v Kaney* (2011) UKSC 13, where the witness for the plaintiff stated that the victim (Jones) suffered post- traumatic stress disorder (PTSD). After conflicting reports from the defence a joint state-ment was set up and signed by Dr. Kaney. Here Mr Jones was described as deceptive and it was then denied that he had PTSD. Dr. Kaney admitted that this statement was not read. As Mr. Jones received less compensation than he could, he instituted action against the doctor. Dr. Kaney was subjected to proceedings for negligence.

78 The "Rule" of Meadow" also referred to as "Meadow's Law".

79 Brown 2005 *The Lancet* 16. Quoting Lord Woolf, Master of the Rolls 1995.

80 Groves 2007 *J Law Med* 306.

81 *LB of Islington v Al Alas and Wray* (2012) EWHC 865 (Fam) para 233. Here after a lengthy trial and long findings, a need was expressed that when evaluated accurately using the appropriate levels and burdens of proof, death due to rickets should not be confused with signs of the baby battering as subdural haemorrhage (brain bleeding beneath brain covering) could be a peri-mortal finding due to death of rickets.

82 Ricketts in children occur with lack of vitamin D, due to lack of sunshine and nutritional intake, especially in rainy countries where children are kept mostly indoors like the UK. In rare cases it could be inherently congenital. As these could lead to fractures, doctors could

radiologist who claims to be an expert witness, then falsely diagnosed "battered baby syndrome" instead of giving the benefit of the doubt, by enquiring about the vitamin D levels in the child's blood, which would have indicated rickets as the cause of the bone fractures (following minor trauma). The critique in the press is then how such findings of a so-called medical expert witness could be allowed, apart from it causing a travesty of justice, also making a mockery of the so-called "UK register of Medico-legal Expert Witnesses".[83]

The MEW therefore needs more security and support from the profession and there should be some form of vetting of MEW via an "Academy of Experts". Courses for the MEW and a registration programme has been initiated in the UK, but due to low numbers an effective MEW Register would not be practically achievable in the RSA. Even in the UK, there are no real entry requirements, except to pay an annual registration fee and attend a (two day) course, to be a so-called MEW. In the UK it is recommended that a MEW must take time and make an effort to get some medico-legal training and courses in ethics, as lawyers would expect better quality and knowledge. To improve the standard of the MEW, the courts must set and demand higher standards. Cases have also faltered where lawyers relied on expert witnesses drawn from different ends of the range of opinions. It is much more appreciated by the courts if a MEW is able to see and comment professionally on both sides of an argument.[84]

Although this process to improve the standard of the MEW is being implemented in the UK, more definitive work in this area must be done in the RSA. However it could be emphasized and consideration must be given that not so much accreditation of disciplinary measures are needed, but more measures are to be taken to prevent the MEW getting the witnessing and testimony wrong! Focusing inappropriately on qualifications, status and presumed credibility takes the attention away from the quality, logic and reliability of the MEW evidence. The questions of the allowable evidence must be engaged before and not during the

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mistakenly suspect the "battered baby syndrome". The lack of skin bruising could help to distinguish from the battered baby syndrome.

83 Taylor http://www.theguardian.com.news 9 May 2012 (Date of use 31 January 2014)

84 Brecker 2009 *Heart* 763.

trial![85] Due to the smaller number of MEW readily available in the RSA, these measures would be more pragmatic and realistic.

5.6 Conclusion

Although detailed comparisons of the laws and rules affecting the MEW in the RSA and other common law countries, like England is a vast subject in itself, it could be stated that the RSA have strong and weak points. However, by studying case reports somehow, mainly because of the stricter adherence to and element definitions of the law of Delict in the RSA, it does seem that philosophically and by jurisprudential use, good findings are made. By and far, the RSA court findings seem to be fair, realistic, reasonable and equitable. However, it is the opinion of this writer that as stated in the RSA Constitution, more use could and should be made of Foreign Law.[86] The various "tests" used like the Daubert, Bolam and Bolitho tests should be used more applicably, MEW training must be done to ensure the ethical use and enhance the quality of the MEW and deviant, dishonest, unprofessional miasmatic MEW must be reported and possibly prosecuted by the various professional boards.

85 Brown 2005 *The Lancet* 17. Quoting: "the worst doctor might be right and the best doctor might, for once, be wrong". Therefore the quality of the evidence presented is much more important than the qualifications of the MEW.

86 S 39(1)(c) of the Constitution of the Republic of South Africa,1996.

CHAPTER SIX

MEDICAL EXPERT WITNESSING IN SOUTH AFRICA

"Even if someone lacks the ability to practice law…he will still be obliged to excel at things under his control, such as justice, good faith, generosity, restraint and temperance…recognizing that one's best inheritance – superior to any fortune- is virtue and achievement".[1]

6.1 Introduction

It seems that the first recorded case of professional medical negligence in Southern Africa was the case of *Lee v Schönnberg* which was heard in the Cape Province during 1877.[2] There is no reference that a MEW had to help guide the court, but the judge (de Villiers CJ) did mention that a medical practitioner, as any professional man, is called upon to bear a reasonable amount of skill and care to a case which he has to attend to. Surely the learned judge must have obtained at least some form of advice to have made this comment which is still most relevant and applicable more than 130 years later! A general principle thus developed with the help of English case law that in a proposed medical negligence case a medical expert witness must be used to help assess to determine the "reasonable man or expert".[3]

6.2 Legislation

There is at present no legislation qualifying a doctor to be a medical expert witness, apart from being registered as a medical practitioner at the Health Professions Council of South Africa. The selection of who could be a medical expert mainly rests on the choice or recommendation of the plaintiff's legal team and that of the defendant doctor and his legal team. Those medical practitioners who would be prepared to act as expert witness are then approached either by the plaintiff, the defendant or their legal teams.[4]

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1 Habinek *Cicero – On Living and Dying Well* 147.
2 Carstens and Pearmain *Foundational Principles of South African Medical Law* 619. The case is quoted as to have been heard in 1877.
3 Carstens and Pearmain *Foundational Principles of South African Medical Law* 620.
4 Letzler M *Choosing the Right Expert in a Medical Negligence Case* http://www.deebus.org.za/nxt/gateway (Date of use: 27/03/2012).

It also seems apparent that it is mainly academic personnel who are readily available and sought after for their academic "expertness", which often is biased for instance, against the realism of private and/or peripheral non-academic practices.[5]

More often than not these medical expert witnesses have no or very little knowledge of the legal concerns and evaluating process for instance the reasonableness, fairness and objectivity principles as well as evaluating the true causality of a specific and apparent professional negligence case.[6]

There are many facts that must be considered and also assessed in the right context, to be able to be considering whether a particular medical practitioner had attained the acceptable standard of treatment. Each case, being unique, should then be assessed with reference to its particular facts.[7]

It should stand to reason that a medical expert witness should have some form of training and preferably some legal qualification, must belong to a medico-legal professional body and undertake to adhere to the principles of professional ethics, fairness and objectivity.[8]

This would prevent MEWs from being "boxed-in" by legal teams and unwittingly forced to testify along certain argumentations in the adversarial system.[9]

6.3 Case studies and the role of the medical expert witness

Case studies must be used as a departure and reference point for guidelines for the quality, qualification and use of the MEW in litigation. The following cases with comments highlight the role of the MEW and how they could help the courts to reach fair, reasonable, justifiable and justified findings under the auspices of the Constitution. The following case studies are presented with the emphasis on the role of the MEW.[10]

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5 Redelinghuys, Butow, Carstens 2008 *South African Dental Journal* 151.
6 Meintjes-Van der Walt (2003) *CARSA* 47.
7 Carstens and Pearmain *Foundational Principles of South African Medical Law* 623.
8 Moodley *Medical Ethics, Law and Human Rights* 4.
9 Meintjes-Van der Walt (2003) *CARSA* 49.
10 Carstens and Pearmain *Foundational Principles of South African Medical Law* 619. It is emphasised here that a doctor's negligence should be assessed with reference to the "reasonable expert", confirmed (since the earliest times) with case law as compared to also

6.3.1 Van Wyk v Lewis[11]

Facts of the case:

The facts appear from the judgement of Innes CJ. The patient's appendix was removed and gallbladder area had to be drained due to inflammation. Operation swabs had been placed in the abdominal wound to pack it, ostensibly to stop the spread of sepsis and bleeding. As the anaesthetist was anxious to stop the operation, these swabs were removed and the wound sutured. The patient, being 26 years old, made a satisfactory recovery but over the course of a year drained purulent material from the wound appeared. The plaintiff claimed to have recovered a swab which had "presumably" eroded through her intestinal wall; she consequently launched an action for damages.

As judgement had been given to the defendant in the court *a quo*, the plaintiff appealed. Although it was thought by medical evidence, as given by medical expert witnesses, that it was improbable that the appellant could pass a swab with relatively few symptoms, it was not impossible. The point was made that a practitioner could not be expected to bring the highest degree of skill to a patient, but is only required to apply reasonable skill, regardless of the locality. It was held that it is the duty of the theatre sister to count, check and report on the swab status, the reasonable surgeon could not be expected to concentrate on the count of swabs in a critical operation. Even when a swab had been admittedly left behind, this could not be seen as negligence under the *prevailing circumstances*.

English case law. Carstens states that there is even exclusive reliance on comparable English case law by the courts of the RSA even in present times! This is then significant.

11 *Van Wyk v Lewis* 1924 AD 438. Although an old case, this case demonstrated the weighing of the reasonable man test, the maxim, causality and the weighing up of the factual versus the judicial cause. This South African case is widely in Canadian, English and Australian literature. This case, regardless of its age, is still a landmark case to be studied, its relevance to the MEW from a historical point of view, being the touchstone realization and definition of the reasonable man, that allegations must be proven, that the diligence and skill applied must be reasonable and the concept that "no human being is infallible". This case is quite well referred to and quoted from after having been referred to in English, Canadian and Australian legal literature and court cases. Freckelton and Mendelson *Causation in Law and Medicine* 80. Meagher, Marr and Meager *Doctors and Hospitals: Legal Duties* 194.

The role of the MEW:

The court had to consider whether the appellant's evidence was credible and could be accepted, as this course of events of passing an old retained swab with minimum symptoms could be doubtful. The role of medical expertise here is that it was found that although highly improbable it was not impossible. The court accepted the plaintiff's version of passing the swab. With the help of the MEW's and their opinion, the level of skill and diligence of the surgeon had to be determined. It was stated that the testimony of members of the profession is of the greatest value, but although highly regarded, the court is not necessarily bound to it. Following expert opinion, the judge found that a surgeon could not be accountable for the swab and although much sympathy was expressed, the judge found the surgeon not guilty of negligence.

Comments:

As "no human being is infallible", the standard is that of accepted practices, provided that these are not unreasonable and/or dangerous. The standard of the test of medical negligence is the same in civil as in (medical negligence) criminal cases namely, on the balance of probabilities, but is more difficult proven in criminal cases.[12]

However, in retrospect this finding on the balance of probabilities was with respect, probably wrong, as the swab, could not be produced in court as evidence. If there was a swab it should have eroded and tunnelled through a bowel wall that would have caused so much pain, discomfort, fever and obstructive signs that this patient would most likely have presented within three months with dire complications, as seen in most present day cases.[13] With a more experienced MEW, this case would have had a different outcome, in that a finding would have been made regarding the staff and hospital also not guilty of negligence.

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12 Van Oosten 1986 *Medicine and the Law* 22. See also *R v Van der Merwe* 1953 (2) PH H124 (W). Here it was found that a reasonable doctor should/must know the medication, its side effects and dosage when administering it. Here the test of negligence was also determined to be the same for civil and criminal cases.

13 Grassi, Cipello, Torciva et al *JMed Case Reports* www.medscape.com/viewarticle/51247-3 (Date of use: 30 October 2013)

In the recent case (unpublished) of *Goliath v MEC for Health in the Provence of the Eastern Cape*,[14] it was found, due to difficulty of a procedure that neither the doctor nor the hospital staff could be held negligent for having left one swab in the abdomen of a patient. A simplified view was used to judge negligence referring to a "three element test" namely, the reasonable foreseeability of harm; the taking of reasonable precautions against the occurrence of foreseeable harm; and then the failure to have taken these reasonable precautions.[15]

6.3.2 Castell v De Greef [16]

Facts of the case:

This case concerned a plastic surgeon being sued for damages on account of an unsuccessful subcutaneous mastectomy.[17] The patient had a strong family history of cancer of the breast as well as several previous breast operations. The patient's operation complicated with necrosis of breast tissue and sepsis. It was stated that the defendant surgeon breached his duty to warn the patient of these complications (insufficient informed consent).[18] The defence was also based around the principle of *volenti non fit iniuria*.[19]

The defence held that the reason for insufficient informed consent was therapeutic privilege, (a MEW was justifying the withholding of information which could cause unnecessary anguish for the patient). This argument was rejected in that the "reasonable doctor" would have warned the patient and that the defendant was therefore unduly "paternalistic". The defendant was consequently found negligent, not so much for the deficient informed consent,

14 *Goliath v MEC for Health Eastern Cape* (1084/2012)[2013]ZAECGHC.
15 *Goliath v MEC for Health Eastern Cape* (1084/2012)[2013]ZAECGHC para [49].
16 *Castell v De Greef* (1994) 4 SA 408 (C).
17 Subcutaneous mastectomy is where all the breast glandular and connective tissue is removed as much as possible but the skin and nipple area is left intact for reconstruction of the breast for instance with a prosthetic implant. The danger, especially in women who smoke is necrosis of the central skin area due to insufficient blood supply.
18 *Castell v De Greef* 1994 (4) SA 408 (C) para408I and also para409D.
19 *Castell v De Greef* 1994 (4) SA 408 (C) para409D. *Volenti non fit iniuria* – Whoever consents cannot receive an injury.

but more in the duty of care, for not acting appropriately to the control of the subsequent infection.[20]

Role of the MEW:

It was emphasised in this case that realistic risks of the operation which a reasonable person in the patient's position, if warned of in the proper informed consent process, would likely have attached significance to it, and/or the doctor, should have been aware that the particular patient, if warned of the risk, would be likely to have attached significance to it.[21] The delineation of such risks would simply not have been possible realistically without proper MEWs. In this case the MEW had played a role emphasising that the patient indeed did know more that the reasonable patient would have known about the risks of such operations. It was stressed that that no surgeon can guard against every incident or, as it should be common knowledge, that all surgical operations will have a risk and mishaps despite proper exercising of skill by a surgeon. Therefore as far as the occurrence of the direct surgical complications were concerned, on the evidence that was especially led at the court *a quo* the medical witness had played a significant role in excluding the many complications as fault and blame of the surgeon.

Comments:

In this case the view was expressed that expert evidence is relevant in determining the risks, results and the materiality of the risks of an operation for the court. However, it was found, that the plaintiff's case was weak, as she was indeed pre-operatively aware of the risks.[22]

For the doctor and the MEW, it is important to be advised of the duty to make reasonable disclosure of real material risks of treatment, unless there are sound medical reasons for not doing so (*i.e.* causing unnecessary anguish), exercising the right to therapeutic privilege.[23] Misrepresentation can occur when an error due to a risk is pertinent to the proper care of the patient, and not made known

20 *Castell v De Greef* 1994 (4) SA 408 (C) para 413 G-F.
21 *Castell v De Greef* 1994 (4) SA 408 (C) para 421G.
22 Van Oosten 1995 *Medicine and the Law* 167. *Castell v De Greef* 1994(4) SA 408 (C) para 424E.
23 Carstens and Pearmain *Foundational Principles of South African Medical Law* 984.

to the patient. Doctors are considered to have a duty to report the full relevant and real material medical facts, as non-disclosure prevents a patient from consenting, or consenting under the wrong impression. A plaintiff cannot succeed in action for negligence *i.e.* breach of the duty to inform, unless it is shown that the breach caused injury and financial loss.[24]

A medico-legal dilemma can arise out of the concept of therapeutic privilege, where critical evaluation of the principle must be done.[25]

The legal teams must be able to realise these concepts as, if unprepared, the case could be lost. Unfortunately the guidelines are not clear, could be abstract and therefore reasonableness must be the standard guideline.[26] Therapeutic privilege (TP) as a legal phenomenon is fairly new, and case law pronouncements are therefore scarce.[27]

Any discussion on TP usually lacks depth, differentiation and detail. The usual interpretation of therapeutic privilege is that it must be narrow and limited as not to impair the duty of disclosure. As many medical negligence claims are based on allegations that informed consent was not procured properly, TP has become an important defence. However, whether informing patients is more hasardous to their health than not, it is experienced when mentioning material complications that the patient could inappropriately overreact to a risk, by refusing an operation or demanding a second opinion.[28]

If the second opinion "downplays" the risk, the patient would be more comfortable and acquiesce that the second opinion should take over the treatment. However TP must still be subject to a proper examination, diagnosis

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24 Meagher, Marr and Meagher *Doctors and Hospitals: Legal Duties* 72.

25 Coetzee *Medical Therapeutic Privilege* 36.

26 Carstens and Pearmain *Foundational Principles of South African Medical Law* 198. In *Castell v De Greef* 1994 (4) SA 408 (C), para 421G, the court seemed dubious about this privilege.

27 However, especially in German Litterature (Giesen 1990:163-164 – Artzhaftungsrecht: Die Zivilrechtliches Haftung aus Medischer Behandlung in der Bundesrepublik Deutschland, in Osterreich und der Schweiz (3rd Ed)), of all exceptions to informed consent, the TP has received the most attention.

28 Carstens and Pearmain *Foundational Principles of South African Medical Law* 989. Therapeutic privilege in closely intertwined with informed consent and even The Promotion of Access to Information Act 2 of 2000, s30(1) and s61(1). The art to balance this conundrum would be to assess the capacity of a normal patient of sound mind to understand and accept the medical risk but if the patient would not psychologically cope there will be a risk for emotional shock damages if this was not communicated well.

and an acceptable treatment plan. If a patient considers it material to have a diagnosis before submitting to a procedure, there will be a duty to disclose, where non-disclosure vitiates prior consent and TP could then not be used as a defence.[29]

6.3.3 Richter and Another v Estate Hammann [30]

Following from the reasoning above, a dilemma of therapeutic privilege in the informed consent process could easily ensue, creating a problem also for the MEW giving an opinion. Here the question could be asked whether a failure to have warned or informed the patient could constitute negligence.[31] The case study *Richter and Another v Estate Hammann* must be taken note of, as the role of the MEW comes to the fore in this case.

Facts of the case:

This case raises many points regarding informed consent and the undertaking of treatment but the supposed negligence, which does appear credible at first glance, is rejected on the advice and testimony of good and well qualified MEWs. Judge Watermeyer emphasised at the outset of his findings that a doctor "is not under a duty to have warned a patient of a remote possibility of complications". It was also acknowledged by the judge that notwithstanding above, a doctor could on the one hand be held liable if there was a failure to discuss risks and on the other side could scare a patient off.[32]

Litigation was instituted, four years later, after the treating doctor had died. The case for negligence was made in (a) being negligent in advising a phenol block (for persistent and acute exacerbation of coccyx pain, where phenol that binds with the nerves is inserted via a lumbar puncture into the nerve cover, a procedure done with great care and concern by neurosurgeons), (b) negligent in the manner in which it was administered, (c) failure to have warned the

29 *Vitiate*: derived from Latin meaning "to impair", implying the destruction or impairment of legal validity.
30 *Richter and Another v Estate Hammann* 1976 (3) SA 226 (C).
31 Strauss *Doctor, Patient and the Law* 267.
32 *Richter and Another v Estate Hammann* 1976 (3) SA 226 (C) para 227A.

plaintiff of the inherent dangers of the procedure and (d) failure to have enquired into the past medical condition and medical history.[33]

Role of the MEW:

Here, although the MEWs did say that this patient should have been treated conservatively for a longer period, all conceded that this complication of nerve fall out was "very uncommon", for a procedure that was considered acceptable, reasonable and safe.[34]

As the defendant was deceased, the plaintiff's evidence was carefully scrutinised. However the Court found that not one of the three MEWs could specifically say whether the procedure and the way it was done was negligent.[35]

The grounds for a case of negligence failed. Because the patient did suffer damage with loss of bladder and bowel control as well as sexual sensation, it was found that there was an element of a failure to warn. However, it was in the patient's interest to have had the procedure and according to the MEWs, the discussion of the risks should have been minimised as the complaints were severe, or it was felt that there was no need to mention the risks and another opinion was that the chances of complications were so remote that it was not necessary to warn. Regardless of the opinions, it was found that the patient had an adverse event which caused significant harm and an award was made for specific as well as general damages.

Comments:

It should be borne in mind that at that time frame, certain aspects of therapeutic privilege (TP) such as a strong element of "medical paternalism" were prominent. This case, considering the circumstances, could be an example how three MEWs could agree and concede on various points, making a fair judgement possible, but also being fair towards the plaintiff (who did receive some compensation). At present (40 years later), it would have been more

33 *Richter and Another v Estate Hammann* 1976 (3) SA 226 (C) para 227F.
34 *Richter and Another v Estate Hammann* 1976 (3) SA 226 (C) para 229G.
35 *Richter and Another v Estate Hammann* 1976 (3) SA 226 (C) para 230B.

appropriate under informed consent to have discussed these rare but significant complications, but pleading TP here, would perhaps have been unacceptable in present times!

It follows that there is now presently, a "therapeutic" duty to warn, which would also rule out TP. The MEW therefore should know that basically TP could presently only be used where:

- There is a case of psychiatric illness.
- Mental incapacity complicates the scene.
- Where disclosure could be life-threatening, detrimental to physical and psychological wellbeing.
- Where a patient's rational decision-making skill is influenced and is preventing treatment.
- Where there will be precipitated anxiety and stress, influencing outcome.
- Where it would be insensitive or inhuman to a moribund patient and prejudice third parties.[36]
- The risks of full disclosure must not equal or exceed the dangers of the proposed intervention.[37]

6.3.4 Oldwage v Lourens and Lourens v Oldwage[38]

A prerequisite for a MEW testimony to be considered in a court is that it must be obvious that the testimony is unbiased, fair and reasonable but should also satisfy the presiding officer's quest for truth in that the reasoning is scientifically sound and **logical**. The MEW must concentrate to establish the basis of logical reasoning. The following case study should illuminate this concept. At first the finding was in favour of the plaintiff, but on appeal the defendant applicant was acquitted, due to the fact that the original testimony by MEWs had been flawed and illogical.

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36 Van den Heever 2005 *SAMJ* 420. Here the psychological profile of the patient would play a major role. The patient's susceptibility to anxiety should be assessed and recorded, preferably by a psychologist.

37 Van den Heever 2005 *SAMJ* 420.

38 *Oldwage v Lourens* (2004) 1 All SA 532 (C) and *Lourens v Oldwage* 2006 (2) SA 161 (SCA).

Facts of the case:

This case study could actually directly and indirectly contain virtually all the elements of the typical pitfalls and dilemmas of being a MEW. In this case the plaintiff probably had a double pathology in the aspect of vascular occlusion of his pelvic and femoral arteries, as well as a spinal disc protrusion causing pain. It is clear that a treating vascular surgeon did not do a proper examination and assessment, had very sparse notes and did not take the patient through an accepted informed consent process.[39]

An operation on the vascular system was done followed by a later spinal operation and then another vascular operation, where a rare vascular complication known as the "steal" syndrome occurred. This is where a healthy arterial system, which is supposed to feed an undersupplied system (in this case a so-called femoro-femoral (leg to leg) arterial bypass), was done from the "good" right leg to the impaired left leg in order to supply it with blood, but then in fact the "good" leg, "steals" even more blood from the ill side. The patient could hardly walk and had severe pain on walking scarcely 30 meters after the operations, where before he could do cycling, walking and mountaineering.

The surgeon was found negligent and liable for this course of events. Substandard management and flaws in the "contract" were found, as well as that deficient informed consent was supplied. The defendant appealed and the Appeal Court reversed the High Court's finding, emphasising that the benefit of the doubt had to be given to the doctor regardless of all the factors, in that the expert witnesses and their opinions were to have been better evaluated **on the founding of logical reasoning**, as well as the relation of the various evidence of the MEWs to each other, viewed in the light of the probabilities.[40]

Role of the MEW:

This case also demonstrates that by sound reasoning, what seems to be an obvious finding, when applying a reasonable and fair (legal) mind to the matter,

39 *Lourens v Oldwage* 2006 (2) SA 161 (SCA) para 173C-D.
40 *Lourens v Oldwage* 2006 (2) SA 161 (SCA) para 175C-E.

is that a quite unexpected outcome could occur.[41] Yekiso J in the court *a quo*, noted that misrepresentation of medical facts and course of action by the defendant could have misled the patient. It was emphasised as Yekiso J wanted to determine if the defendant's preoperative conduct, the performing of the operation and the post-operative care was culpable and if the defendant would be liable. The evidence from the MEWs was conflicting. The judge then followed the ruling that the varying opinions of MEWs would be advanced when founded on logical reasoning. The MEWs would then be evaluated if by logical reasoning "a defensible conclusion" could be made. It then seemed that Yekiso J came to the (wrong) conclusion, based on the views of the MEWs, that misdiagnoses were made, that the proper diagnosis and evaluations therefore were wrong, even when conceding that to practice over-regulated medicine is difficult. He faulted the record keeping of the defendant. Yekiso J found based on eschewed and wrongfully concluded MEW opinions, that no proper consultations and informed consent processes had taken place. The defendant was then found, apart from assault that he was in breach of his contractual obligations. The defendant lodged an appeal, which succeeded, as the Appeal Court found that the MEWs had not allowed for any benefit of doubt and had not applied their minds properly to the case.[42]

Comments:

Expert witnesses and their evidence must be properly evaluated, especially when quoting articles to support their testimony and pitfalls must be avoided by reasoning scientifically sound and logical. Whilst understanding that "anything" is possible in medicine, it must be evaluated to help the court by stating whether it is probable.

The dilemma of the medical expert witness and the logical cause of real negligence must be addressed by a MEW. The test for negligence cannot be disentangled from the particular facts or circumstances. Thus the degree of skill used or required, will be dependent on the circumstances of each particular case. Allegations of medical negligence cannot be assessed in isolation and

41 Carstens and Pearmain *Foundational Principles of South African Medical Law* 470.
42 *Lourens v Oldwage* 2006 (2) SA 161 (SCA) para 175E.

should only be evaluated with objective, proven facts in each case. This is then the construed principle of "**concrete negligence**", translated into practical terms as the rule of circumstances, facilities, financial resources and nature of the intervention, *i.e*. whether emergency or difficult conditions prevailed where and when the medical act / intervention was performed. Patient factors also come into consideration like a particular predisposition, idiosyncrasies and susceptibility for hidden complications.[43]

Considering the *Lourens v Oldwage* case, the "degrees of negligence" can elicit debate. It is stated, albeit as a reminder, that whether negligence is gross or slight makes no difference to liability, but is could affect the quantum of awarded damages.[44] However, lawyers try to enforce MEW participation by exaggeration of a case as that of "gross" negligence, hoping that a case could then be built up, overwhelming the other party's defence. The term "gross" should then rather only be applied to where it would really be abhorrent to any other professional person or *contra bonos mores,* forcing perhaps a criminal case against the defendant medical personnel.[45]

The concept of contributory negligence must also always be evaluated by a MEW as it could be used in defence. The patient also has duties to himself and his doctor. A patient could also be expected to meet the standard of a reasonable patient.[46] If the patient causes a breach which is the factual and proximate cause of his injuries, he could be contributory negligent and the compensation reduced accordingly, or if the negligence is exclusively due to his own action, the charges must be dismissed. The relatively rare application of this concept in medical law is due to factors comprising of a patient's illness, submissive attitude, incapability of acting in own best interest and the seemingly unequal position. In addition, the standard of care which patients should meet and be responsible for, is then perhaps kept at an unreasonably low level.[47]

It is not easy to show that a patient was contributory negligent. In medical parlance there is also reference to patient non-compliance. This refers to when a patient

43 Carstens and Pearmain *Foundational Principles of South African Medical Law* 639.
44 Carstens and Pearmain *Foundational Principles of South African Medical Law* 639.
45 Carstens and Pearmain *Foundational Principles of South African Medical Law* 639.
46 Carstens and Pearmain *Foundational Principles of South African Medical Law* 640.
47 Kennedy and Grubb *Medical Law:Texts with Materials* 492.

may not follow the instructions given by his or her doctor.[48] The availability of contributory negligence defence could be limited because of the disparity in medical knowledge and of the patient's right to rely on the doctor's knowledge and skill in the treatment. An example was seen in the case *Schliesman v Fisher*[49] of an overweight diabetic who did not keep to his diet or blood sugar control, eventually losing his leg due to sepsis. Overwhelming opinion, as well as MEW contradictions, supported that the patient was responsible for his own fate, due to excessive contributory negligence by being over 50 kilograms overweight.

The case of *Dube v Administrator, Transvaal*[50] reminds that a patient is generally not guilty of contributory negligence, if the conduct of the defendant which induced or misled the patient to believe, to assume that his action or inaction would not be dangerous.[51]

Closely linked to the above concept, especially when a patient is treated by a State Hospital, a defence could be based on the "voluntary assumption of risk", by the plaintiff. Generally, this rule applies in the law of torts where in effect it means that the plaintiff has agreed to waive the duty owed by the defendant to observe the required standard of care. There is amongst doctors a strong sympathy that such a rule should apply in legal reasoning. It need not be an express agreement although the courts are reluctant to accept that this is implied. Lack of equality in power in the doctor-patient relationship, would lead a court to accept that no patient if he had known better, would ever voluntary waive his rights due from a doctor except in the most exceptional or emergency circumstances. The question of imputed knowledge can perhaps also be implied here.[52]

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48 For example like taking prescribed medication.

49 *Schliesman v Fisher* (1979) 158 Cal Rptr 527 (Cal CA).

50 *Dube v Administrator, Transvaal* 1963 (4) SA 260 (W) para 270C-F.

51 Carstens and, Pearmain *Foundational Principles of South African Medical Law* 639. Question of role of "Imputed Knowledge". In the *Dube* case the patient contracted an ischaemic Volksman's contracture. The defence held that the plaintiff should have reported to hospital earlier but out of ignorance did not. It was found that the hospital staff had been negligent for not warning the plaintiff to report earlier to hospital when severe pain occurred, although this probably would not have made a difference.

52 Carstens and, Pearmain *Foundational Principles of South African Medical Law* 640. It must be borne in mind that the Constitution would also protect patients signing a waiver against prosecution for professional negligence.

6.3.5 Motswai v Road Accident Fund [53]

Often it seems in South African litigation that MEWs are "boxed" in and then are gently coerced by a persistent adversarial legal team in giving a faulted expert testimony. This could be a dilemma and the MEW must be conscious of this unethical practice and even under pressure, not to relinquish his objectivity and trustworthiness. The following can serve as an example.

Facts of the case:

In this case lawyers have claimed an excessive amount (R 390 000) on behalf of a road accident victim who had injured his right ankle as a pedestrian in an accident in 2008. It was noted that the ankle was injured and bruised with tenderness, but no ligamentous tears or fractures were found. The patient was not admitted and within a couple of months no permanent significant injuries could be noted and the ankle recovered completely. No compensation was granted by the judge.

Role of the MEW:

In spite of this and the medical expert witnesses confirming that there were no serious permanent injuries, large voluminous opinions were written including the effect on the psyche and social function of the victim. The lawyers then presented this case. The roles of the MEWs were therefore unacceptable and unethical and morally indefensible. The judge in this case expressed concern and dismay that this case had been presented and that it was then deducted that there had been collusion between two doctors and the legal team to present this claim with the sole intention to earn fees for services in an unacceptable and unprofessional way. No compensation was granted (as there were no serious injuries causing permanent harm), the costs of the court were awarded against the plaintiff's legal team and the legal team, as well as the doctors, had been reprimanded and warned respectively, that they would be reported to the legal and medical professional boards.[54]

53 *Motswai v RAF* (2010/17220) 2011 SGHC. (At the time of writing unreported).
54 *Motswai v RAF* (2010/17220) 2011 SGHC. Satchwell J in para [68], [72], and the order page 25 para [4].

Comments:

This case is most upsetting in that obvious irregularities and "false" testimony were given with the intention to mislead the court. The MEWs should have warned the legal team that here was no case for compensation, which would have shown integrity and high ethical and moral principles. This is then actually a case which could demonstrate that legal action and professional board action against untrustworthy and indeed miasmatic MEWs could be instituted. Perjury charges could also be instituted and all MEWs should be warned by their legal teams that it is imperative now also in the South African context, that a high standard of professionalism must be upheld.

6.3.6 Buthelezi v Ndaba[55]

In medical negligence cases, it is further most important, that when a MEW has to give his opinion, that all factors be objectively considered to determine whether in a particular case, albeit in the mind of a lay person or lawyer that the doctor has to be found negligent, that the cause of the harm, in fact is not due to the doctor's alleged negligent conduct. The MEW must then play a dominant role to let the court consider the real causality and fault.[56] A recent unreported appeal case of *Buthelezi v Ndaba* can serve as an example.[57]

Facts of the case:

This case was an appeal case under a full bench led by Brand JA, where the applicant, a Dr Buthelezi, lodged an appeal against a finding of negligence for performing a hysterectomy (removal of the womb) in allegedly such a negligent manner that the patient (Ndaba), developed a vesico-vaginal fistula (the bladder being then connected via a "tunnel" due to surgical trauma to the vagina above the sphincter muscles, which give urinary control, causing the free flow of urine through the vagina).[58]

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55 *Buthelezi v Ndaba* (575/2012) [2013] ZASCA 72 (29 May 2013)
56 Carstens and Pearmain *Foundational Principles of South African Medical Law* 509.
57 *Buthelezi v Ndaba* (575/2012) [2013] ZASCA 72 (29 May 2013). SAFLII "*Buthelezi v Ndaba*" http://www.saflii.org/za/cases/ZASCA/72html (Date of use: 23 October 2013)
58 *Buthelezi v Ndaba* (575/2012) [2013] ZASCA 72 (29 May 2013)para [1].

Role of the MEW:

Two MEWs gave opposing views whether the appellant would have been negligent and in the court *a quo*, the appellant was to pay the patient damages. Note was taken in the appeal case that Dr Buthelezi was a gynaecologist with over 20 years of experience and had done over 1 000 hysterectomies. In addition it was found that the MEWs had areas which proved to be common ground in accepting the size of the fistula and that it probably developed progressively over the period following the operation and was probably not caused at the time of the operation! The development was however triggered by the hysterectomy. Both MEWs agreed that contributing factors were the HIV sero-positivity of the patient, that she had diabetes, that she had previous surgery in this area and that she had a chronic pelvic infection at that stage. Both MEWs agreed that the patient respondent had an increased and higher risk for forming the fistula![59]

Due to adhesions which needed to be cut through between the bladder and the uterus, some damage, not noticeable at the operation could have occurred, according to the respondent's MEW. This MEW emphasised that had reasonable precautions been taken at the time of surgery this would not have happened and thus the doctor was indeed negligent.[60] Although the appellant's notes were poor referring only to the operation as a "standard total abdominal hysterectomy", it was admitted in the court *a quo* that he could have been negligent. However the MEW for the appellant emphasized that factually, **no one really knew for sure how the fistula developed!** This was therefore pure speculation that the gynaecologist caused the fistula! Furthermore the fact that a fistula developed, did not in itself prove that there was any negligence involved on the part of the gynaecologist. This MEW emphasised, with authority that fistula development after hysterectomies can occur, no matter how diligent or careful the surgeon would be.[61]

59 *Buthelezi v Ndaba* (575/2012) [2013] ZASCA 72 (29 May 2013) para [4].
60 *Buthelezi v Ndaba* (575/2012) [2013] ZASCA 72 (29 May 2013) para [7].
61 *Buthelezi v Ndaba* (575/2012) [2013] ZASCA 72 (29 May 2013) para [13].

The judge then emphasized that the court must determine on the analysis of the reasoning which would be most credible, criticising that the court *a quo* neglected this aspect. The judge quoted from *Hucks v Cole*:[62]

> *a doctor was not to be held negligent simply because something went wrong,*

and stated that the test, just like in *Castell v De Greef,*[63] revolved around the fact whether the practitioner exercised reasonable skill and care and whether or not, it was below the acceptable standard of a reasonably competent practitioner. Thus the judge found that if the fistula was due to the gynaecologist's action, an error had occurred, which any reasonably competent practitioner could also have made.[64]

The Judge found that the MEWs testimony for the appellant was more acceptable as it was supported by international journals, emphasizing that fistula type of injuries to the bladder and vagina are inherent risks of all hysterectomies. The doctor appellant had the appeal upheld with costs and the order of the court *a quo* was rejected.[65]

Comments:

It is the opinion of this writer that this case could be the most exemplary case to show the true role of a knowledgeable and ethical MEW, in that the facts were portrayed accurately, scientifically correct and logical. The emphasis here is that the exact cause of the fistula was not really known but that many other factors played a role as well as the fact that it was a difficult operation under the circumstances.

The reasonable man test was used here and found that this delayed complication could have happened to any other reasonable surgeon. The opposing MEW was unfortunately rather miasmatic, but had to concede to this argument of the appellant's MEW. The legal parties must give their respective

62 *Hucks v Cole (1968)* (reported 1993) 4 Med LR 393 (CA).
63 *Castell v De Greef* 1994 (4) SA 408 (C).
64 *Buthelezi v Ndaba* (575/2012) [2013] ZASCA 72 (29 May 2013) para [15]. Here quoting the cases of *Hucks v Cole* [1968] 118 LJ at 496, and also *Castell v De Greef* 1993 (3) SA 501 para 512A-B.
65 *Buthelezi v Ndaba* (575/2012) [2013] ZASCA 72 (29 May 2013) para [17,18].

MEWs room to think laterally outside the "frame" in which legal argumentation would take place and thus in the interest of justice and fair findings, causality and fault must really be accurately established. If questions of causality are truthfully solved by ethical MEWs, the legal liability of a defendant and his rebuttal burden will be greatly lightened.[66]

6.3.7 S v Mokgethi[67]

The dilemma of *novus actus interveniens* or *novus causa interveniens,*of which a MEW must take note of, is that this concept should not be seen as a break in the continuity of events, but rather a break in the original chain of events.[68]

Many legal teams and MEW are confused with the definition and application of this concept. The following case study would clearly demonstrate the dilemma, which outcome, in this writer's opinion, a knowledgeable MEW could have influenced.

Facts of the case:

The victim, a bank employee, was shot during an armed robbery. This victim was paralyzed, but rehabilitated so much that he (wheelchair bound) could resume his work at the bank. To prevent *decubitus* ulcers,[69] he had to change his position regularly, by shifting his weight. It was claimed that due to his failure to comply, he developed complicated skin pressure sores. In due course these developed into septicaemia, resulting in death. Although the respondents were convicted of murder, it was argued that there was not sufficient causal connection between the harm done by the bullet wound and the deceased's death.[70]

Van Heerden AJ found in favour of the respondents that the pressure sores formed due to the patient's own negligence.[71] The bullet wound causing the paraplegia was a c*ondition sine qua non*, but that the complication causing death could not be directly coupled to the original wounding. It was thus

66 Carstens and Pearmain *Foundational Principles of South African Medical Law* 509.
67 Snyman *Criminal Law Case Book* 69.
68 Freckelton and Mendelson *Causation in Law and Medicine* 10.
69 Decubitus referring to "lying down" meaning development of bedsores, pressure sores.
70 *S v Mokgethi* 1990 (1) SA 32 (A) para 38A.
71 By not changing his position often enough, hampering the blood supply to the skin, due to occlusive pressure on the blood vessels caused by body weight.

considered that the patient's own negligence was the real cause of his death, causing a "break" in the causal chain, thus too far removed to be criminally liable for the death (it thus being a *causa nova interveniens)*.[72]

Role of the MEW:

The judge based his finding on a single medical "expert" witness testimony, that due to proper medical care, the mortal potential of the wounding was prevented. It was argued that, provided the patient adhered to medical advice, he would have survived. [73] The MEW implied that the decubitus ulcer forming and complicating was then due to the patient's own negligence and lack of care as well as failure of preventing contributory negligence.

Comments:

Here is an example that had the medical opinion been fair to mention, that even for an intelligent and educated person, being a high paraplegic in the thoracic area, that it is most difficult for these patients to prevent their own bedsores. These patients have an involuntary slumped attitude with body crumpling, leading to excess weight on the pressure areas. Even in attempting to be reasonable and fair to the respondents, it is deemed that it was most unfair and unreasonable that the medical witness could not state that this patient could not have been responsible for developing his deadly bedsores. Alternative medical testimony was not given to what could have led to a different finding, in that these complications could still have been flowing directly from the bullet injury and thus a finding of guilty of murder, instead of attempted murder, should have been made.

The respondents were only sentenced to 10 years imprisonment, to run concurrently with other sentences culminating in 18 years, where they could have, at that time, have been sentenced to death or alternatively to life imprisonment.

72 *S v Mokgethi* 1990 (1) SA 32 (A) para 45E.
73 *S v Mokgethi* 1990 (1) SA 32 (A) para 47D.

6.3.8 Pringle v Administrator of the Transvaal[74]

In medical practice it would be natural to accept that there could always be more than one correct opinion of the course of action decided upon. It could be argued by prominent MEWs that pending the experience, knowledge and skill of a doctor, that one opinion could be as good as the other and in determining causation and fault MEWs would have to concede and concur on the common grounds, weighing up the various advantages and disadvantages of the various options. In the case of *Pringle v Administrator of the Transvaal*[75] an example of a good balance and decision by a judge is found.

Facts of the case:

In *Pringle v Administrator of the Transvaal*, an accident occurred where a mediastinoscopy was done, which entails that the chest cavity between the lungs are opened and a rigid tube passed through the incision with a light source to evaluate and biopsy suspicious lesions and in the process, caused life threatening haemorrhage from a large vein. The presiding officer was Blum AJ. The judge emphasized that the test of foreseeability should be applied in that the doctor should have foreseen that excessive force used to gain tissue for analysis could have caused damage.[76]

Role of the MEW:

Although the MEW who testified for the plaintiff, said that he would have used another (implying more safe) approach, the court found that the plaintiff had not discharged the onus of proving that the procedure was incorrect or inappropriate.[77] This MEW admitted that the approach used is as such also not really incorrect. Furthermore, even though the doctor stated that he could have pulled too hard or have used, due to inexperience, excessive force (*sic*), the court warned against the "*insidious subconscious influence of ex post facto knowledge*".[78] The judge emphasised that negligence is not established merely by occurrence of what had happened or showing how it could have been

74 *Pringle v Administrator of the Transvaal* 1990 (2) SA 379 (W).
75 *Pringle v Administrator of the Transvaal* 1990 (2) SA 379 (W).
76 Carstens and Pearmain *Foundational Principles of South African Medical Law* 706.
77 *Pringle v Administrator of the Transvaal* 1990 (2) SA 379 (W) para 395B.
78 *Pringle v Administrator of the Transvaal* 1990 (2) SA 379 (W) para 394B.

prevented. However, the plaintiff received damages on the court's finding, on the weight of MEW opinion, that the applicable skill and diligence was not exercised by the members of that particular branch of the profession.[79] Thus the major lesson here is that the MEW must think laterally and must dissect the legal questions in detail to help support these types of findings to aid the legal profession.[80]

Comments:

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 and the principles of fairness, reasonableness, justice and justifiability must be honoured. The MEW must remember that courts do not make findings *in vacuo*, but base their interpretation and findings on the facts before the court.[81] This case serves the purpose that all sides must be heard and that more than one opinion might be acceptable and right. It is also enlightening to note that a warning was issued not to use *ex post facto* knowledge in "building" a case.[82] The use of hindsight knowledge by many unwary MEWs could be a weak point in defending a doctor.

It must be borne in mind (as set out in the case *Pandie v Isaacs*),[83] when there are disputed issues in a court, the credibility, reliability of the witnesses and their explanations of the probabilities must be considered. Here the witness' attitude, candour and demeanour will play a part. Bias, in whatever form must be absent, there must be no contradictions, and the probability or improbability of aspects must be explained logically. Reliability will be dependent on a witness' experience and observations as well as the quality, integrity and independence during the testimony.[84]

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79 *Pringle v Administrator of the Transvaal* 1990 (2) SA 379 (W) para 397B.
80 Strauss *Doctor, Patient and the Law* 284.
81 Strauss *Doctor, Patient and the Law* 290.
82 *Ex post facto* here to mean with "hindsight, retrospectively.
83 *Pandie v Isaacs* (A135/2013, 1221/2007) [2013] ZAWCHC (4 September). In this case a gynaecologist sterilized a patient after her fourth delivery by Caesarean section without her consent, when he putatively thought he had it.
84 *Pandie v Isaacs* (A135/2013, 1221/2007) [2013] ZAWCHC para [48]. Here the judge had quoted from the case *Stellenbosch Farmer's Winery Group & Another v Martell et Cie & Others* 2003 (1) SA 11 (SCA) para [5], regarding the correct approach in how to solve the various factual disputes and irreconcilable versions in a particular case.

A dilemma, which can broaden the field of argumentation for a MEW, is that an error of judgement is judged to be an error by those who would have done something different. This was addressed in the *Pringle* case.[85] It is thus defined as an error of judgment when a doctor has made a decision which any other similar reasonable doctor under the same circumstances would have made.[86] This is an acceptable principle which could be used in a defence.[87] However, due to the various inherent risks of medical practice, it is now accepted that legal liability for an error of judgement will also depend upon the reasonableness of such an error under the same circumstances.[88] It is obvious that this opinion must be made by using a very experienced and knowledgeable MEW.

6.3.9 Goliath v MEC for Health in the Provence of Eastern Cape[89]

It is important, though much present controversy surrounds the maxim of r*es ipsa loguitor*, that the MEW must be made aware of its possible use. The Bolam test, or similar argumentation, addresses the expected standards of the medical profession in setting the medico-legal acceptable standards of care required from a doctor. Exceptions, at least in theory, could be *res ipsa loquitor* (RIL) cases, like amputating the wrong leg.[90] The essentials for RIL are quite easy to state, but the application could be complicated. The doctrine should only apply when, there is no evidence as to how or why the litigious incident occurred, the occurrence being such that it could not have occurred without negligence and the defendant is proven to have been in control of the situation either personally or vicariously. The purpose of the RIL could lighten the plaintiff's burden of proof, especially if proof is not available, with the necessary justification in that there is most probably a high

85 *Pringle v Administrator of the Transvaal* 1990 (2) SA 379 (W) para 395B
86 Carstens and Pearmain *Foundational Principles of South African Medical Law* 640.
87 Hawkins *Mishap or Malpractice* 107.
88 Carstens and Pearmain *Foundational Principles of South African Medical Law* 640.
89 *Goliath v MEC for Health in the Provence of Eastern Cape 89* (1084.2012) [2-13] ZAECGHC 72 (14 June 2013)
90 Kennedy and Grubb *Medical Law: Texts with Material* 465. The question is, how must a plaintiff prove this is not acceptable. The emphasis should be on that the incident speaks of negligence, rather than it "speaks for itself", *i.e.* ***res ipsa neglegentia versus res ipsa loquitor***.

chance of negligence.[91] However, it is stated that common law courts are largely reluctant to accept that RIL has much, if any, primary place in medical law.[92]

In the case of *Pringle v Administrator of Transvaal* it was stated that the RIL maxim could only be used where the negligence involved depends on absolutes.[93] There is always a possibility of a judicial error due to conjecture and speculation, which must be avoided and here the MEW can play an important role. The MEW must help to establish that the claim of RIL must be consistent with the proven facts and that these proven facts could not be explained by any other logical cause or action.[94]

In South Africa the *res ipsa loquitor* principle, would not readily be applied to a medical legal situation, but the tendency in opinion is that it should be a "rule of sympathy".[95] The onus should still lie on the plaintiff to convince a court that there was indeed negligence, and that the damage which was suffered, was (causally) in the consequence there-of and not in the natural course of the illness or natural complications.[96] It was also emphasised in the *Pringle v Administrator of Transvaal* case that the plaintiff must still prove that a substandard of diligence and skill was applied before relying on RIL.[97] Thus the posture of RIL in medical negligence is limited, but it should be introduced provided that it could be derived and supported by an absolute fact, which is not depended on the surrounding circumstances of a particular case.[98] The "requirements" for this in negligence cases could be:

- This injury or harm does not occur ordinarily without negligence,
- If injury occurred, there would be a high probability of negligence,
- The facts of the issue is based on inference derived from the occurrence alone,

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91 Van Den Heever and Carstens *Res Ipsa Loquitor and Medical Negligence* 10.
92 Kennedy and Grubb *Medical Law: Texts with Material* 465.
93 *Pringle v Administrator of Transvaal* 1990 (2) SA 379 (W) para 384G.
94 Van Den Heever and Carstens *Res Ipsa Loquitor and Medical Negligence* 13. Here it is important not to camouflage conjecture with terms like "in ordinary human experience" or "common sense dictates" and "obviously". **It is also the writer's view that when considering the "absolutes" to justify RIL maxim usage, that medicine and the practice of medicine is not an exact science!** This the MEW must bear in mind.
95 Especially by inexperienced legal representatives and MEW,
96 Strauss *Doctor, Patient and the Law* 290.
97 *Pringle v Administrator of Transvaal* 1990 (2) SA 379 (W) para 395B.
98 Van Den Heever and Carstens *Res Ipsa Loquitor and Medical Negligence* 33.

- The presence of injury due to negligence must depend on an absolute and thus not by only considering surrounding circumstances.
- The RIL maxim should be permissible only in the absence of other acknowledged or known causes. It is important that there must be no contributory negligence from the plaintiff's part.[99]
- The control of preventing the injury (the instrumentality) must have been under the exclusive control of the defendant for whom the responsibility or right to control exists.[100]

In a recent case, *Goliath v MEC for Health in the Provence of Eastern Cape*, still unreported at the time of writing a discussion of the use of the r*es ipsa loquitur* maxim is given and of its use and value in medical litigation.[101]

Facts of the case:

The main issue in this case, presided by Lowe J, was that a swab or operation towel had inadvertently been left in the abdominal cavity following a hysterectomy at an Eastern Cape hospital.[102] The plaintiff claimed that that there was a duty of care and that she had suffered and had pain until her second operation to remove the retained swab. It was argued that she had at least a 20 per cent chance of needing a further operation in the unforeseeable future for intestinal obstruction following inevitable adhesions.[103] It was emphasised that the facts of a case could be so that negligence could be inferred compatible with the RIL doctrine.[104] It is further emphasized that in appropriate situations that it be used as an aid by the plaintiff. This was then

99 Van Den Heever and Carstens *Res Ipsa Loquitor and Medical Negligence* 125.
100 Van Den Heever and Carstens *Res Ipsa Loquitor and Medical Negligence* 34.
101 *Goliath v MEC for Health in the Provence of Eastern Cape101* (1084.2012) [2-13] ZAECGHC 72 (14 June 2013). Southern Africa Legal Information Institute "Goliath v MEC for Health of the Provence of Eastern Cape" http://www.saflii.org/za/casa/ZAECGHC/2013/72.htm (Date of use:3 November 2013)
102 Jaffary S, Asim S, Anwar S et al 2010 *JLUMHA* (09) 2 page 58. In this article it is mentioned that the term medico-legally of a retained operating device or towel should be "*gossympiboma*" (Latin for cotton is "gossympinus") or "*textiloma*". It is admitted the majority are due to gynaecological or obstetrical operation (because of deep recess areas and bleeding). The majority present within three months with bowel obstruction.
103 *Goliath v MEC for Health Eastern Cape* (1084/2012)[2013]ZAECGHC para [10].
104 *Goliath v MEC for Health Eastern Cape* (1084/2012)[2013]ZAECGHC para [51].

argued with the *van Wyk v Lewis* case,[105] that although rejected as applicable in the medical negligence, that the use of RIL should be reconsidered.

Following then the case of *Pringle v Administrator Transvaal* it was argued by the judge that the RIL maxim has application value, provided that the alleged negligence will be deducted from an absolute fact and that the mishap could not have taken place in reasonable terms, without the alleged negligence.[106] By implication its use would be exceptional. On the other hand it must be borne in mind that if all possible and true circumstances are considered the absolute could become "relative", and then the maxim could not really be applicable.[107] Once the cause of the foundation of an incident in known the RIL maxim can be discarded and in this case it was found that the mere fact of a swab left behind in a patient is the not necessarily conclusive of negligence.[108]

Role of the MEW:

With the role of a strong and knowledgeable MEW for the defence, a surprising case ensued, where the treating doctor and facility were not found liable for damages for a retained swab. This revolves also where the MEW (Prof. L. Snyman)[109] for the defendant, specifically stated that this was a very difficult case and thus it would have been any reasonable surgeon that could have left a swab in the abdomen in such a case like this case. This would also apply more to emergency situations and where the risk of long term harm is limited; it would be a fair finding. The plaintiff clearly still has the onus of proving negligence and thus a MEW could emphasize this to block a RIL maxim use.[110] The plaintiff's expert was found faulted because he did not deal with relevant factors at the operation where the swab was retained.[111]

105 *Van Wyk v Lewis* 1924 AD 438.
106 *Goliath v MEC for Health Eastern Cape* (1084/2012)[2013]ZAECGHC para [59].
107 *Goliath v MEC for Health Eastern Cape* (1084/2012)[2013]ZAECGHC para [65].
108 *Goliath v MEC for Health Eastern Cape* (1084/2012)[2013]ZAECGHC para [79].
109 Prof. L Snyman - Head of the Department of Obstetrics and Gynaecology, Kalafong Hospital, University of Pretoria. Personal interview.(Date: 7th February 2014).
110 *Goliath v MEC for Health Eastern Cape* (1084/2012)[2013]ZAECGHC para [87].
111 *Goliath v MEC for Health Eastern Cape* (1084/2012)[2013]ZAECGHC para [113].

Comments:

The RIL should however be applied to limited but meritorious cases of medical negligence cases, which are within the common knowledge which a MEW could support, after the medical evidence had been evaluated.[112] However, pending the circumstances this case which was wisely led by a MEW experience and insight, established a case where the perpetual legal problem of a retained swab could be addressed by considering the circumstances prevailing in a specific case, and that the RIL would not automatically be used in such cases in future.

Note is taken that though perhaps exceptional, that a South African court had in 2012, given judicial recognition to the application of the *res ipsa loquitor* maxim.[113] In this specific case *Lungile Ntsele v MEC for Health Gauteng Provincial Government*,[114] a baby was born with brain damage, where it could be proven that a prolonged neglected birth process had been the one and only **absolute**, cause for this brain damage.[115]

6.3.10 Michael and Another v Linksfield Park Clinic and Another.[116]

The handling of conflicting and variant expert opinions has been quite strictly addressed and objectivity used in the important case of *Michael and Another v Linksfield Park Clinic and Another*.[117] Objectively, the English Law tests of the Bolam test and the Bolitho test helped to set a standard to meet, before appropriation of blame. The Bolitho test demonstrates that if a professional opinion is not capable of withholding logical analysis, the body of opinion is unreasonable or irresponsible and must be rejected.[118] In the case of *Michael and Another v*

112 Van Den Heever and Carstens *Res Ipsa Loquitor and Medical Negligence* 183.
113 Carstens 2013 *Orbiter* 348.
114 *Lungile Ntsele v MEC for Health, Gauteng Provincial Government* 2009/52394 (GSJ) 24 October 2012.
115 Carstens 2013 *Orbiter* 357. The emphasis here being on "absolute", and not relying on any circumstantial evidence.
116 *Michael and Another v Linksfield Park Clinic and Another* 2001 (3) SA 1188 (SCA)
117 *Michael and Another v Linksfield Park Clinic and Another* 2001 (3) SA 1188 (SCA)
118 Merry, McCall Smith *Errors, Medicine and the Law* 165. *Bolitho v City and Hackney Health Authority* (1997) 4 All ER 771. www.publications.parliament.uk/pa/ld199798/ldjudmt/jd971113/boli02,htm. The test is based upon this case where a two year old child died following episodes of respiratory distress after being admitted for Croup. Although the child did well on the consultant's round, he deteriorated and the senior registrar was called. She did not come to see the child and sent her junior doctor to assess. After initial improvement,

Linksfield Park Clinic and Another, the Bolitho test was actually followed thus setting the precedent of usage in South African Law.[119]

Facts of the case:

This case came to the Supreme Court of Appeal whilst dealing with the alleged negligence of an anaesthetist. Here the judge also deliberated on how to handle and asses the medical expert evidence, setting limitations for the medical expert evidence.[120] This is rather a sad case as the patient was a talented young scholar, who broke his nose during a sporting event. A rhinoplasty (surgically correcting the fracture deformity) was recommended. The patient developed heart arrest after cocaine was administered to control bleeding from the surgical site, probably in conjunction with the anaesthetic gasses and Inderal, a heart rate blocker, which could have been given erroneously. Furthermore, when it was decided to give cardio-conversion to resuscitate the patient and normalise the heart, the cardio-convergence (defibrillator) machines did not work, although the staff of the hospital claimed that it was examined and tested earlier the day as per protocol. The patient suffered permanent brain damage.

The court was faced with the dilemma to evaluate the individual views of all the expert witnesses, to determine which testimonies and opinions would be reasonable. It was acknowledged that as often occurs, various and conflicting expert opinions are expressed.[121] Analysis of the essential reasoning would be

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the child once more deteriorated and was then also again not seen and developed respiratory failure ensuing in brain death and eventually died. The question was whether this child should have been intubated and respiratory supported. The expert opinions were opposing and the judgement was in favour of the defended doctors who were not found negligent. The fact was emphasized, **that if an opinion differed from another, it had to withstand logical analyses by the court to be accepted**. However, this finding has attracted a lot of academic criticism. It is realized had more assertive medical expert testimony been given, the finding could have been that of guilty of negligence and the appeal upheld.

119 *Michael and Another v Linksfield Park Clinic Ltd and Another* 2001 (3) SA 1188 (SCA) para 1189G. It is mentioned that in the presence of various and often conflicting expert opinions presented, the court must decide using guidelines like credibility, examining, and logical analysis. If the expert opinion cannot be logically supported it will fail to be the reference to which a defendant's conduct is assessed (para 1198 I).

120 Carsten and Permain *Foundational Principles of South African Medical Law* 785.

121 *Michael and Another v Linksfield Park Clinic Another* 2001 (3) SA 1188 (SCA) para 1189G.

considered more important before the court decides and reaches its own conclusion.[122]

Role of the MEW:

It was noted in the during the appeal that in the court a quo, that none of the MEW witnesses could express, even collectively, what the acceptable and reasonable anaesthetic practice entailed.[123]

It was emphasised that a doctor cannot be absolved on the MEW's opinion, but must have his conduct evaluated in accordance with sound practices. The court must be satisfied that an opinion had a logical basis, and the MEW, has "to apply his mind" in considering comparative risks and benefits in reaching a defensible conclusion. The court was forced to evaluate each MEW's evidence and then to determine whether and to what extent these were based on logical reasoning. If obvious risks had been overlooked, the opinion would not be reasonable even if it was an opinion universally held.[124] It was held that a decision of the court could be swayed if a body of opinion is not able to withstand logical analysis.[125] Although the court found that the anaesthetist presented false evidence to exonerate him, the appeal did not succeed and that it was found that the trial judge was right to dismiss the claim.[126]

Comments:

This case is a landmark case in South African medical law, as this case emphasised that although the four medical expert witnesses did not present a joint or collective view, the court using the English rules of the Bolam and Bolitho tests, stated that even if an opinion is held by the minority, it will still be considered. Eventually the view was accepted to consider only such evidence

122 *Michael and Another v Linksfield Park Clinic Another* 2001 (3) SA 1188 (SCA) para 1189G.
123 Carstens and Pearmain *Foundational Principles of South African Medical Law* 788.
124 *Michael and Another v Linksfield Park Clinic Another* 2001 (3) SA 1188 (SCA) para 1189I. This is where reference was made to the Bolitho case i.e. *Bolitho v City and Hackney Health Authority* 616 [1998] AC 232(HL), implying that the expert's testimony must be scientifically correct and logical.
125 *Michael and Another v Linksfield Park Clinic Another* 2001 (3) SA 1188 (SCA) para 1190A. The court did mention that MEWs tend to asses a case in terms of scientific certainty and not in terms of a balance of probabilities.
126 *Michael and Another v Linksfield Park Clinic Another* 2001 (3) SA 1188 (SCA) para 1190E. Costs were awarded for the plaintiffs, and the anaesthetist was reported to the Health Professions Council of South Africa for a disciplinary finding.

which was scientifically correct and logical. It was also stressed that there is a difference regarding scientific and judicial proof. Although the medical profession sets the standard for the reasonable man, the court need not be bound to it. If the reasoning is not logical it is not reasonable evidence.[127] The true test therefore for expert medical opinion should be that the opinion is objective and must reflect the standard of accepted medical practices in the specific circumstances. The MEW must realise therefore that a judgment is dependent on the credibility and reliability of the MEW, which is paramount.[128]

6.3.11 Silver v Premier Gauteng Provincial Government.[129]

It seems that a problem often encountered by a MEW is that there is confusion, exacerbated by the legal team's inset, regarding the cause of the harm a patient would claim for. This could lead to a severe miscarriage of a judgement if not identified and corrected. The MEW must play a leading role in these circumstances. A case that could be used as an example here is the case of *Silver v Premier Gauteng Provincial Government*.[130] The emphasis on factual causation is also highlighted to facilitate the assessment is such cases.

Facts of the case:

The plaintiff was admitted to a general hospital with the diagnosis of pancreatitis, which in itself could over the course of a few days, become a life threatening situation. After being admitted to an intensive care unit he was put on a ventilator respiratory support for facilitation of respiration. For this he had to be sedated, but he also had diabetes and kidney failure needing dialysis from kidney machines as life support. For practical reasons he was so sedated that he could not move him and as he was in a low blood pressure (hypotensive) state he had under perfusion of his skin. With all these factors he inadvertently developed a bedsore of his sacral (lower back and gluteal) areas. The plaintiff eventually recovered but could hardly walk and blamed the bedsore that he claimed was caused by an omission, which was considered negligent in that he

127 Carstens and Pearmain *Foundational Principles of South African Medical Law* 790.
128 Carstens and Pearmain *Foundational Principles of South African Medical Law* 791.
129 *Silver v Premier, Gauteng Provincial Government* 1998 (4) SA 569 (WLD).
130 *Silver v Premier, Gauteng Provincial Government* 1998 (4) SA 569 (WLD).

was not moved enough to ensure sufficient blood perfusion of the skin.[131] The defendant countered that this was mainly due to complications flowing forth from the pancreatitis, and thus in the course of such a disease there was a risk of pressure sores occurring irrespective of any reasonable treatment.[132] The presiding officer Cloete J said that if the defendant's legal team was correct, the plaintiff cannot succeed in his claim, as the factual test of causation would not be satisfied.[133]

Role of the MEW:

It is obvious then that the presiding officer had to rely on the scientific explanation regarding the causation, as set out by MEWs. The factual causation then had to be emphasised using the "but for" test and any other unlawful conduct was eliminated, that the event causing the harm would have occurred probably in any case, and thus the *sine qua non* test needed detailed application.[134] Because the damage could not be determined to have flowed naturally and directly from the defendant's breach of contract, the factual causation cause here had carried the weight and the court was satisfied.[135] The court held that, despite adequate care, the patient would have had on all probabilities, still have developed a bedsore.[136] This served as a portal of germs, and the patient regardless of ideal treatment regimens would have suffered such complications irrespectively of any negligence and the case was dismissed.[137]

Comments:

Although much emphasis is placed on judicial cause, this case serves to demonstrate that fair and reasonable findings would not have been made, without proper testimony and opinion of a knowledgeable MEW. The plaintiff, who had the burden of proof, could not succeed in the claim based on delict,

131 *Silver v Premier, Gauteng Provincial Government* 1998 (4) SA 569 (W) para 569H.
132 *Silver v Premier, Gauteng Provincial Government* 1998 (4) SA 569 (W) para 569 I.
133 Carstens and Pearmain *Foundational Principles of South African Medical Law* 828.
134 *Silver v Premier, Gauteng Provincial Government* 1998 (4) SA 569 (W) para 570E.
135 *Silver v Premier, Gauteng Provincial Government* 1998 (4) SA 569 (W) para 570H.
136 *Silver v Premier, Gauteng Provincial Government* 1998 (4) SA 569 (W) para 570I.
137 *Silver v Premier, Gauteng Provincial Government* 1998 (4) SA 569 (W) para 571D.

(although the claim was found in contract) as the factual *sine qua non* test for causation was not satisfied.[138]

The plaintiff emphasised that in terms of implied agreement and duty to care the nursing staff should have exercised due care, skill and diligence. Although remoteness of damage was mooted by the defence, the factual test also still had to be satisfied.[139] Because the patient would have, due to faecal contamination of the area, still had developed this complicated bedsore irrespective of any negligence, this case was dismissed. Thus the MEW must bear in mind in similar cases that delictual liability for alternate causes of complications of a debilitating illness must be based on factual causation, before judicial causes can be applied. A MEW must use his medical knowledge acutely and with lateral thinking to bear important facts in mind which must be discussed, regardless of criticism, as the law cannot be divorced from its factual context.[140]

6.3.12 S v Kramer and Another[141]

When an operating team goes into action with an operation, all members of this team work in conjunction with one another, but if a negligent act causes harm, injury or death, it is necessary to really determine what amount of negligence every individual, *i.e.* the surgeon, the anaesthetist or the nursing staff, had contributed in the sum of the total effect. The case of *S v Kramer and Another* establishes the significance and importance to this principle and also highlights the role of the *imperitia culpae adnumerator* maxim.[142]

Facts of the case:

The accused No 1 was an ear, nose and throat (ENT) specialist who had an ostensibly junior inexperienced general practitioner (accused No 2) as a designated “anaesthetist”. In an anaesthetic adverse event a ten year old girl died, during a tonsillectomy, when the endotracheal tube had apparently not

138 Carstens and Pearmain *Foundational Principles of South African Medical Law* 828.
139 Carstens and Pearmain *Foundational Principles of South African Medical Law* 829.
140 Carstens and Pearmain *Foundational Principles of South African Medical Law* 833. The italics part is the dissertation writer’s own opinion!
141 *S v Kramer and Another* 1987 (1) 887 (W).
142 *S v Kramer and Another* 1987 (1) 887 (W).

been correctly inserted into the airway. Dark blood, encountered with the surgical procedure in progress, signified that the airway and oxygenation was compromised and in due course heart arrest ensued. The anaesthetist "froze" and the ENT surgeon then re-intubated the patient, but resuscitative measures were unsuccessful, also because the theatre was ill equipped and had no heart monitor. Because accused No 1 had then left the theatre and accused No 2 "froze" and did nothing, both were found guilty of culpable homicide in a Magistrates Court. This case was then heard as an appeal case in a high court with Van der Merwe J being the presiding officer.

Role of the MEW:

The MEW had to assist in the various aspects of negligence of both the accused as well as in the defence. It was stated that accused No 1 failed to ascertain whether accused No 2 had adequate experience and training to administer anaesthetics for a tonsillectomy.[143] The court *a quo* found that the combined acts or omissions of both doctors caused the death but accused No 2 failed to properly assess, monitor and to begin resuscitative measures.[144]

Although it was granted that accused No 1 should have known that the anaesthetist was relatively inexperienced and that the endotracheal tube could have been placed wrongly, he was not faulted and it was quoted that:

> A medical practitioner is not expected to bring to bear upon the case entrusted to him the highest possible degree of professional skill, but he is bound to employ reasonable skill and care; and he is liable for the consequences if he does not.[145]

Reasonableness as well as reasonable skill and care were emphasized. Thus it was stated that if a mishap should occur during the operation, it would be of importance to ascertain who was responsible and to what extent any other member of the operating team can be held liable for the actions of that person.[146]

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143 *S v Kramer and Another* 1987 (1) 887 (W) para 889D.
144 *S v Kramer and Another* 1987 (1) 887 (W) para 889I.
145 *S v Kramer and Another* 1987 (1) 887 (W) para 893F. The quote used here, comes from the case of *Mitchell v Dixon* 1914 AD 519 at 525.
146 *S v Kramer and Another* 1987 (1) 887 (W) para 895C.

The MEW emphasised that a trained anaesthetist would have, even with limited facilities, found that the tube in the airway was incorrectly placed and would have taken immediate action. The MEW was instrumental to have drawn the line, facilitating the correct judgement regarding the omission and delayed action of the untrained inexperienced doctor.[147]

The court found that, generally speaking, neither the surgeon nor the anaesthetist is liable for the other's negligence, subject to exceptions like where the surgeon or anaesthetist is totally incompetent.[148] It was found that as the "anaesthetist" was an inexperienced general practitioner, that this fact created a sense of shock and thus the appeal failed. The surgeon was dismissed as his appeal succeeded.

Comments:

It is demonstrated in this case that each and every practitioner is to be judged individually and his relevant actions scrutinised. Although this case never directly referred to the *imperitia culpae adnumerator* rule,[149] the principle of this rule was held against the general practitioner who was untrained and inexperienced in ENT anaesthetics.

A dilemma can be confronted when more than one doctor / professional person is involved in complicated cases. This is demonstrated in the sad case of *S v Nel* 1987 TPD (unreported) where a general practitioner failed to timeously consult a specialist obstetrician when he had encountered problems during a delivery. The patient eventually died. It was mentioned that the anaesthetist, whilst administering Pentothal and Halothane,[150] could have caused the death of this exhausted and shocked patient. This argument was rejected by the court with the statement that "anything can happen, but whether it was probable". It was mentioned that a MEW would have helped the court better with real objective scientific contributions, by explaining how real the possibility had been

147 Carstens and Pearmain *Foundational Principles of South African Medical Law* 762

148 *S v Kramer and Another* 1987 (1) 887 (W) para 895E.

149 Hiemstra and Gonin *Trilingual Legal Dictionary* 201. Latin phrase *imperitia culpae adnumerator* here meaning "for the want of skill as reckoned as a fault".

150 Pentothal, a long acting phenobarbitone used as an induction agent for anaesthetics in conjunction with Halothane, a main anaesthetic gas, in a shocked exhausted patient could give heart arrest. These products are presently not in general use anymore.

that administration of the substances could have caused the death. The MEW must, as the judge observed, "*avoid to simply take a shot in the dark*". Likewise in the case of *De La Rouviere v SA Medical Council*[151], where the appellant was sentenced to suspension and erasure had lodged an appeal in a high court, the appeal was upheld. It was found that the quality of the evidence was lacking and that the doctor did not have a proper trial. The shocking finding was that on a question of the standard of proof, namely distinct balance of probabilities, some members (and MEWs) unwittingly failed to apply their minds properly to the evidence.[152]

MEWs must strive to be as objectively as possible with logical scientific reasoning.[153]

The most practical way of addressing such problems is to separate and divide the fields and the actions of the individual doctors and specialists and then to go through their actions to ascertain each his own, if any, role in a medical negligence claim.[154]

6.4 The role of the Medical Expert Witness in Special Courts and alternative dispute mechanisms

Reform measures in the medical professional litigation in South Africa should be implemented like in New Zealand, Australia and the UK *inter alia* to limit the legal costs and amounts awarded to claimants. Presently both the South African medical and medical insurance industries as well as the government realise that the claims situation needs to be urgently changed.[155]

Special courts to expedite valid medico-legal claims, via mediation and arbitration, should be made available. Capping of amounts to be awarded must be implemented especially for State patients, as the claims payments are indeed spiralling out of proportion. The fees of medical malpractice lawyers should also

151 *De La Rouviere v SA Medical Council* 1977 (1) SA 85 (N).
152 *De La Rouviere v SA Medical Council* 1977 (1) SA 85 (N) para106A.
153 Strauss *Doctor, Patient and the Law* 181.
154 Merry and McCall Smith *Errors, Medicine and the Law* 44.
155 Malherbe 2013 *SAMJ* 84.

be limited, thus preventing inflated claims.[156] This could prevent the channelling away of funds that could be better spent on patient care.[157]

As the risk of medical negligence litigation could never be totally eliminated, the rate of claims will keep on rising, especially as patients become more aware of their rights.[158]

6.4.1 The role of alternative dispute resolution mechanisms

To counter the increasing litigation alternative forms have litigation should be sought. Although the method known as Alternative Dispute Resolution (ADR) in medical negligence litigation is gaining international favour,[159] it is still poorly understood amongst doctors and legal teams in South African medical law. ADR is then an alternative of a formal civil procedure litigation trial, attempting to resolve legal disputes in this case arising out of the allegations of medical professional negligence.[160] There are three main structures of ADR consisting mainly of negotiation (involving a structured bargaining and debate), mediation (here a neutral impartial third party, who could be a professional medical person or a legal person would assist the parties to reach a settlement) and arbitration (being more formal in that an impartial arbitrator will adjudicate and make a final as well as binding, decision after hearing evidence and arguments from all parties).[161]

It would be ideal if parties in medical litigation, at the consent stage, would agree contractually, that if a dispute would occur that they would subject it to arbitration. This would be under auspices and regulations of the Arbitration Act,[162] which presently is used elsewhere in the RSA.[163]

The advantages of ADR is first and foremost that cases could be expedited, avoided long delays as cases are put on the roll for high courts and civil

156 Freckelton and Mendelson *Causation in Law and Medicine* 115.
157 Malherbe 2013 *SAMJ* 84. This is especially necessary as the highest claim to be paid at the time of writing in SA was over R 24million, and for a State patient, R 15million.
158 Malherbe 2013 *SAMJ* 83.
159 Freckelton and Mendelson *Causation in Law and Medicine* 115.
160 Greer 2009 AAOS http://www.aaos.org/news/aaosnow/jul09/managing7.asp (Date of use: 3 March 2014)
161 Theophilopus, Rowan, Van Heerden *et al Foundational Principles of Civil Procedure* 5.
162 Arbitration Act 42 of 1965. Still mainly used in Labour and industrial disputes.
163 Theophilopus, Rowan, Van Heerden *et al Foundational Principles of Civil Procedure* 5.

proceedings. This would be more cost effective for all parties.[164] The ADR also takes place in private and media might not be allowed. Thus the reputation of a defendant doctor is protected and a plaintiff might be spared the stressful experience of cross examination. The arbitrator will have sufficient medical and legal knowledge to make fair findings. The other main advantage is that the MEWs on behalf of the various parties would be able to debate and argue their opinions and testimony without fear of aggression and confrontation, assisted by their legal teams. All parties can participate and is voluntary and have an actual say in the final outcome. However time limitation could be applied for each party to put their side as well as cap limitation on compensation.[165] The anguish of unpredictable findings of a high court which would prolong the endurance of the case will be preventable and MEWs should know and be prepared to rather appear before an arbitrator. Errors of judgment made by a MEW would be more easily retracted and excused without any embarrassment.[166]

Frivolous medical malpractice claims and "case building" could be prevented. The exact cause of the condition or the series of events that caused an adverse event and possible medical negligence are then not obscured, and all parties would be able to understand the issues.[167]

There are disadvantages and sometimes for the plaintiff it would be "harder to sell" the plaintiff's side. Doctors and MEW might be adverse to agree to mediation and arbitration, with concerns to their reputation and desire to defend their care. As doctors would have to contractually avail themselves to arbitration if the patient has a dispute, the doctors could feel that an open contract in the informed consent process would actually encourage frivolous litigation. This would also create the impression that the doctor would want to shy away from the High Courts as he has many litigation prone habits and prohibiting the patient to go through a 'normal" civil litigation process.[168] Here confidentiality clauses should allay these fears. The

164 Greer 2009 AAOS http://www.aaos.org/news/aaosnow/jul09/managing7.asp 1 (Date of use: 3 March 2014).
165 Metzloff 1996 *Wake Forest Law Review* 228.
166 Greer 2009 AAOS http://www.aaos.org/news/aaosnow/jul09/managing7.asp 2 (Date of use: 3 March 2014).
167 Kennedy and Grubb *Medical Law: Texts with Material* 467.
168 Stein http://blogs.law.harvard.edu/billof health/2013/08/29/the-incentives to arbitrate-medical-malpractice –disputes (Date of use: 3 March 2014).

settlement is then confidential and private and will not or cannot be published publicly. It must be realised by all parties the Arbitration is voluntary, in that there is agreement by all of this avenue, and binding in that the dispute is conclusively resolved with no or very limited rights to appeal.[169] However it is inevitable that facts of the case and settlement would emerge at some stage making the physician and MEW feel vulnerable. The largest disadvantage is that lessons learnt from a case would not be easily known as no reporting of the case would be allowed. Some form of reporting must be done for monitoring purposes by a professional medico-legal, maintaining confidentiality. Some compromise must be reached between the public's "right to information", the professional bodies monitoring the standard of health care and the privacy, reputation and good name of the professional person.[170]

The future internationally of ADR seems to be vibrant and MEW must be prepared for an increase of this method, because Courts themselves will be making mediation and arbitration approaches mandatory, lessening their work load and alleviating the numerous problems with the current litigation systems.[171] The South African MEW should then strive to get some form of legal training and should attend mediation and arbitration courses which would enable them to give a sensible and cost-effective service to the litigating parties. This is where special courts, mediation and arbitration could play a major role under the auspices of a highly trained and knowledgeable MEW. The ultimate aim is to establish a medical-legal system, that by using the MEW correctly, that there should be little need to resort to formal litigation.[172]

It is important, especially here in South Africa, that a MEW should adhere to a "Code of Ethics" which would mainly consist of the MEW to be uninfluenced, independent, be factual and have reasonable assumptions and be objective. The MEW must remain in his field of expertise. It should further be stated, that if the provided data was insufficient to use as a basis for establishing facts, that the

169 Metzloff 1996 *Wake Forest Law Review* 204.
170 Greer 2009 AAOS http://www.aaos.org/news/aaosnow/jul09/managing7.asp 3 (Date of use: 3 March 2014).
171 Metzloff 1996 *Wake Forest Law Review* 203. Although this article had been written in 1996, it is still most applicable in present times.
172 Carey *Medical Negligence Litigation* 143.

MEW may change his opinion, even if the other party's expert report provides additional material to be considered.[173]

The testifying physician, as some SA case studies show (*Lourens v Oldwage* 2006 (2) SA 161 (SCA), *Michael and Another v Linksfield Park Clinic Ltd and Another* 2001(3) SA 1188(SCA) and others) particularly in professional liability ADR cases should:

- Assess the merits of the case separately from and before agreeing to testify.
- Insist in reviewing all the records thoroughly. It could be argued that the patient must be examined by the MEW.[174]
- Develop a solid medical posture for each case and review the case in a balanced critical manner.
- Articulate carefully the standard of care before expressing it in the deposition.
- Stay within the role and duty as an expert witness and not as an advocate.[175]

A MEW should take advantage of the opportunity offered ADR, like being forewarned within a given situation, to generate novel and inventive outcomes.[176] This must combine self-knowledge and confidence, the role expected to be performed and the understanding of medico-legal strategies and tactics. This then implies that the medical expert witness must have some form of legal training and qualifications to perform to these criteria. From as early as possible, the designated MEW should assist the physician under litigation.[177]

6.5 The dilemma of the "Expert Paradox"

This concept of the "expert paradox" is also emerging as a dilemma MEW's. As no presiding officer could judge the contents or accuracy of expert witnesses one against the other, a ruling should be enforced that the opposing witnesses should meet and settle their opinions and differences as much as possible, the one

173 Meintjes-Van Der Walt 2003 *Child Abuse Research SA* 45.
174 Recommendation at WAML Congress in Maceio, Brazil 2012.
175 Hookman *Medical Malpractice Expert Witnessing* 405. Quoting from the article "Practical Measures to Reduce Medical Expert Witness Bias" (Journal of Forensic Science 1989 4 (5) 1259-1265).
176 *Praemonitus praemonunitus,* Latin warning applicable in medical law, meaning: "forewarned is forearmed".
177 Hookman *Medical Malpractice Expert Witnessing* 2.

arguing that his opinion is the better than the other and the other perhaps conceding on certain facts.[178] This is then often attempted by getting expert witnesses to give a joint notice or statement. However in practice this seldom works efficiently, adding to everybody's dissatisfaction. This statement would enhance and make the MEWs so much more reliable and add weight and credibility to a "united" expert opinion.[179]

If there are differences, then the reasons and arguments are set out before hand and discussed. If not, a disciplinary hearing or a court is placed in an untenable position to decide between the disagreeing experts. This is then the main problem of the "expert paradox", in that the "expertness" loses its value.[180]

Due to a lack of medical knowledge, the legal profession cannot control the experts. The legal team then enforces the MEW to "reason like a lawyer" and the MEW, wishes the legal team to "think like a doctor", the first reasoning on "true facts" and the latter on deductions, assumptions and probabilities, thus contributing to the dilemma of the "expert paradox".[181]

The aim here should be to always strive to have more than two experts agreeing. The joint conclusion of the expert witness could be given as credible proof. If there are differences it could be minimalised. The logical setting out of the opinions could shorten the trial length and enhance effectiveness and a satisfactory finding. It saves time and money. The ideal is that a settlement will be reached before trial. The danger is that a MEW could be instructed not to change his opinion, or cling to an unreasonable point. The main purpose is to lessen the difference between expert witnesses, but they need not settle while they at least can discuss and identify differences. Thus they can define reasons why there are disagreement and find ways of solving the differences. It could still be an advantage especially if the agreed upon issues are listed, the disunity showed on points and

178 This is at presently done and encouraged by the MEW's joint statement notice that is set up. Unfortunately the conditions under which this is often set up is unsatisfactory like positioning, unwillingness to compromise, discuss and concede points.
179 Gomez 2005 *The Journal of Legal Medicine* 390.
180 Hoving 2012 *Nederlands Juristenblad* 873.
181 Hoving 2012 *Nederlands Juristenblad* 873.

recommendation given for the judge to contemplate. This also takes the subjectivity out of the field of the MEW, levelling the playing field for all.[182]

The MEW can also get an opportunity to change his opinion without embarrassment. With maximal use of professional freedom, knowledge and experienced used, new insights are obtained promoting the interests of justice. If there are instructions to prevent the experts meeting, as punitive measures, the judge should disallow the transgressor party's expert evidence. The parties need not agree, but at least they can logically put their reasons to a judge why they do not accept consensus, for example the expert is testifying outside his field of expertise or is known to be inexperienced or incompetent.[183]

Although difficult to achieve in all cases of alleged professional negligence, a case must be referred to a "forum of expert witnesses" with the purpose of streamlining and promoting expert testimony. These experts, from the academia as well as private practice, should act as *diligens paterfamilias* and not so much as professional witnesses.[184] High quality of expert evidence can however only be achieved with appropriate medico-legal and additional legal training.[185]

Procedures should be changed to allow both parties to agree on the expert witnesses at the outset. The danger of a "battle" of experts could ensue and must be prevented, perhaps by a mediator. Obviously legal representatives would want to call experts who will be most helpful to their client's case, but it is unfortunately true that some experts show little impartiality or objectiveness. Highly qualified and niche experts may not be the best MEWs to give opinions on accepted practice by reasonable average practitioners. The insistence to use these types of witnesses must be counterbalanced by a warning that their witnessing could be viewed as perjury under oath. The *General Medical Council v Meadow* would be a prime *locus classicus* case.[186]

It is argued by the American Medical Association that giving medical expert testimony is actually the same as the practice of medicine and subjected to all its

182 Hoving 2012 *Nederlands Juristenblad* 873.
183 Hoving 2012 *Nederlands Juristenblad* 869.
184 Hookman *Medical Malpractice Expert Witnessing* 5.
185 Redlinghuys, Butow, Carstens 2006 *South African Dental Journal* 137.
186 *General Medical Council v Meadow* (2006) EWCA Civ 1390.

ethical and stated rules as well as norms. Thus unprofessional conduct of a MEW must be disciplined, just as unprofessional conduct of the average doctor. The MEW must be able to be held accountable, by proposed legislation, peer review boards, reporting to data banks and having some form of qualification and registration. MEWs who are untruthful, miasmatic or even have fabricated opinions "for hire" must be deterred.[187] This should be taken note of by the South African medico-legal community.

6.6 Conclusion

Although it could be concluded that the South African judicial system has few or any proper, trained, qualified and experienced MEWs, the expertise witness and testimony as well as opinions, under guidance of judicial officers, have generally been of a high standard. The MEW must be guided by the purpose of helping and aiding the court to reach a fair, equitable, reasonable and justifiable finding. Every medical professional negligent case is unique, thus the MEW must evaluate and testify in such a way that all aspects of an expert testimony, should be borne in mind. With legal background the MEW should be able to formulate a proper case, via the elements of delictual law and causality.

A great source of learning aspects of a MEW is gained from many case reports and the main points of being an effective MEW is discussed under the appropriate headings. The central binding theme still comes down to causality and whether the alleged negligent act or omission was indeed the cause of the harm or injury. Also the background evaluation of the "reasonable man" subjective definition must be applied before any blame could be put on the defending doctor. Thereafter therapeutic privilege and informed consent must be weighed into the opinion. Every step in giving an opinion or testimony must be logical and scientifically supported. The MEW must be seen to be objective, fair, reasonable, trustworthy and credible, possessing the ability to reason logically and scientifically correct. He or she must be able to communicate effectively, even under the adversarial legal system, to the court. The average South African MEW, even of high academic standard, has very limited legal insight and background and makes himself and his testimony vulnerable. To counter these problems, proper training, briefing and

187 Gomez 2005 *The Journal of Legal Medicine* 398.

advice must be given to MEW's, who preferably should have some legal background.

The MEW must know how to handle conflicting expert opinions and under guidance of the legal team, there should be a joint statement issued for the use of all parties and the court to facilitate the court case and expedite the legal process. More work should be done by all concerned to facilitate this and also to use the MEW, even as a mediator and if trained, as an arbitrator in medical litigation. By using the MEW, reforms in litigation should be introduced (like capping damage claims) and consolidating all defences of the medical profession under guidance of MEW's. "Rules" could be enforced by a body or panel of medical expert witnesses. The dilemma of the "expert paradox", where doctors are forced to reason like lawyers and where MEWs with the same qualifications would contradict one the other, could be prevented. The aim, especially in the RSA, is that the MEW should be subjected to all the ethical rules and norms of practicing good medicine. This in South Africa could only be achieved with appropriate medico-legal training.[188]

188 Redelinghuys, Butow, Carstens 2006 *South African Dental Journal* 137.

CHAPTER SEVEN

SUMMARY AND CONCLUSIONS

"*I beseech you…., think it possible you may be mistaken*" – Oliver Cromwell (1650)[1]

7.1 Summary

The malpractice litigation quagmire is not the fault of the "onerous efforts of lawyers" but rather due to MEWs, who because of opportunism and greed, exploit the judicial system.[2]

It must be remembered that society changes with time and so also its values – *O tempore, o mores*.[3] The law and its application follows suit with the values of people and society determining much of the seriousness of offences, whether an offence is *contra bono mores*, "abhorrent" or "not in favour of public opinion". In the medical litigation field a lot of antagonistic public opinion is directed against the medical and especially the surgical disciplines. It is contrite medical opinion that medical litigation in the RSA is more about winning than about justice. For this reason it is important to reach a resolution by mediation or arbitration.[4] It is presumed that if so, more medical witnesses will become available. The so-called "medical wall of silence" phenomenon, which in most cases result in litigation, would be uplifted, eventually lessening legal action and costs.[5]

A conclusion is made that a MEW and the legal team must understand this increase in medical litigation and the adverse effects it can have on the practice of medicine and medical practitioners. The legal team and the medical expert witness should strive to play such an ethical role that through medical litigation, the effect would be to improve the general standard of medical care. Many tests and rules have been defined to help comprehend the value and interpretation of the medical expert witness. The common factor in these "tests" is to determine an

1 Quoted by Adv. Emiel van Vuuren, lecture Medical Malpractice Seminar, University of Pretoria 29 September 2012, referring to it as the Cromwellian Challenge every MEW and Lawyer, in fairness and reasonableness, must ask himself during a trial.
2 Smith and Madden *The Surgical Litigation Crises* 14.
3 Latin phrase bewailing: "o the times, o the morals".
4 Herring *Medical Law and Ethics* 206.
5 Prof Dawid McQuid Mason as quoted in Bateman 1995 *SAMJ* 78.

outcome on the balance of probabilities, to avoid speculation, that statements must be based on a degree of acceptance in a specialised field and especially the Daubert rule must be accepted where the journal evidence must be relevant, reliable and be of help to a court. The MEW and legal teams should demonstrate an understanding of and the correct application of the mentioned legal tests which could be of help.[6] Causes, as times have changed with the Medico-legal "deluge" must be taken note of as many factors here could form the angle of approach in the defence or prosecution. Note should also be taken of the so-called "hired-gun" witness. In the RSA paradigm shifts have occurred, complicated by consumerism, impersonality and financial constraints. The *locus classicus* case of *Van Wyk v Lewis*, has been studied worldwide emphasising the application of the "reasonable man" test.[7]

Negligence as a main act of omission must be defined and well understood, especially by a MEW. Negligence must be verified and knowledge of concepts here would avoid fruitless and unnecessary litigation. To help, the legality principles of criminal law could apply like the *ius acceptum* principle and several others. The borders of negligence must be defined as whether abandonment could be negligent and the circumstances, like a case of a retained swab during an operation. The study of case law would help here. With negligence, causation must be proven and tests like for a factual cause need to be done in the *conditio sine qua non* test and judicially in, *i.a.* the proximate cause test also known as "the but for…" test.

Other dilemmas making a case difficult is an absence of a proper history, that no thorough clinical examination was done and the presence of unreasonable and unrealistic expectations. Medical practitioners have limited medico-legal knowledge and great pressure could be brought on a practitioner to admit and resolve an issue, compromising fairness and justice. The lack of imputed knowledge amongst lay people is a factor and must be used as a reasonable defence. The proof must also be understood as it is the key issue in any litigation. Proof is essential for any litigious resolution but is afflicted with conundrums, influenced by complex rules and objective as well as subjective tests.

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6 Cameron and Gumbel *Clinical Negligence – A Practitioner's Handbook* 149
7 *Van Wyk v Lewis* 1924 AD 438.

In regard of the requirements and expected qualities of a MEW, knowledge about medical litigation is most important. The definition of malpractice must be known, but also that of professional negligence. This involves understanding “duty of care”, an adverse outcome, failure to provide a good standard of care and direct causality. The term expert must not be mistakenly interpreted as having above average and exceptional knowledge but emphasis must be on competence, knowledge and ability to aid a court.

The concept of errors and the definition of errors of judgement must be understood. The “substitution test” must be used namely whether another person in the same circumstances would have behaved differently”. This is closely related to the “reasonable person test” which now creates the dilemma that its limitations are the failure to take actual “reasonable” situations and people into account! The legal processes must be understood and warnings are given why textbooks and journal articles as evidence could give rise to many pitfalls, due to wrong interpretations. Pending a case, the so-called Daubert rules regarding medical literature as evidence, would apply emphasizing that there must be peer review, random controlled studies, the error rate must be known and the article must be widely accepted in the particular scientific community. An expert’s testimony must be based upon a reasonable degree of acceptance.

When comparing the South African aspects with other legal systems, it is obvious that as the worldwide incidence is rising as far as medical litigation is concerned, virtually every legal system has to adapt and find new applications. The high cost of indemnity insurance is fast becoming unaffordable. In South Africa there are no distinct guidelines, in the form of books which every doctor can use and study like in Canada, Australia and the UK. Obviously a solution is that costs and claims must be limited and caps put in place, as in Ireland, the UK and Australasia. Non-patrimonial damage claims must be more realistic. Legal reforms must be done and in Australia after the collapse of an insurer in 2001, recommendations have been made. Patients must be better informed of foreseeable risks.

7.2 Suggestions and recommendations

The defences for a doctor in litigation must be consolidated in that all data must be shared and litigation monitored. Contributory negligence and the voluntary

acceptance of procedures must be mentioned if applicable. Emergency cases leading to litigation must be seen more fairly to the defendant, as likely errors of judgement will be increased under such circumstances. Patients, who have suffered harm and injury, should have adequate support. An effective system must be in place for the early identification of doctors becoming “grossly” negligent, incompetent or impaired.

There is a strong case of developing the “no-fault” system backed up by mediation and arbitration. Here the extended role of the MEW is important. The MEW must adhere to ethical principles towards all parties. The MEW must not be a victim to the pitfall of case building, based on wrong assumptions like the “*post hoc, ergo propter hoc*” weaknesses. The causation must be understood as the pivotal point, bearing in mind the factual causation versus the legal causation expressed at first with the proximate “but for” test.

It must be borne in mind by legal teams that the MEW can pay a high price amongst his peers by being exposed to continuous tension, cost-risk benefit, lost friendships and loss of respect. The MEW must also guard against false testimony with inaccuracies, misleading testimonies or being biased.

The MEW could play a major role in preventative strategies. Here the MEW could through education, promote the Bolam principle, the modified Bolam rule and the Bolitho rule. The MEW must understand the principle of *res ipsa loquitor* where the emphasis presently should be on *res ipsa neglegentia*. It is accepted that these arguments cannot be presented primarily but after argumentation could and should be presented on a secondary level as support argumentation. The MEW, if statistics are to be used, must ensure that it is well studied and clearly argued. It must be made applicable to the case *in casu* realising that it is a particular case. The MEW must understand and define negligence. The dilemma of multiple doctor involvement and complicated cases must be simplified in discussing every doctor’s individual role and every course of the incidents involved. The subconscious insidious influence of *ex post facto* knowledge (hindsight) must be guarded against. The MEW must be aware of the expert paradox where one form is where vehemently disagreeing expert witnesses are presenting their cases and

secondly, where doctors are forced to think like lawyers and lawyers think like doctors.

7.3 Conclusions regarding the points of departure, assumptions and hypotheses

The point of departure, assumptions and hypotheses is that the medico-legal need for qualified and ethical medico-legal expertise and witnesses is great. The dissertation tried demonstrate this point. It is also demonstrated and argued that the knowledge and practice of medical ethics is the corner stone for effective medical expert witnessing. The legal representatives and the so-called medical legal expert must therefore be aware of the dilemma regarding the ethics, credibility and relevance of the expert witness and the pitfalls comprising mainly of irrelevant or wrongly interpreted facts and the building of cases by “trawling”, “fishing” or becoming a case of the “hired gun”. This could lead to an unsatisfactory finding and outcome of a case. Contributing factors to this phenomenon would be and is a conflict of goals between the legal and medical fraternity as well as the adversarial court procedures.[8] Expert Witnesses must know not to usurp the function of the court or prove the law in argument.[9]

It is trusted that this dissertation will rekindle and create awareness that a MEW must be a suitable, fit and proper person, being knowledgeable about their field of specialty but also the law. The MEW should be medico-legally qualified as much as possible for the improvement of not only the legal standards but also enhancing the practice of good medicine via good medico-legal jurisprudence.

8 Hookman *Medical Malpractice Witnessing* 219.
9 Hookman *Medical Malpractice Witnessing* 286.

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LIST OF ABBREVIATIONS USED

ACLM	American College of Legal Medicine
BoR	Bill of Rights
DM	Diabetes Mellitus
e.g.	*exempli gratia*
ECHR	European Charter of Human Rights
GMC	General Medical Council (British)
HCP	Health Care Provider / Practitioner
HPCSA	Health Professions Council of South Africa
i.e.	*id est*
i.a.	*inter alia*
IC	Informed Consent
MCO	Medical Care Organization
MEW	Medical Expert Witness / Medical Expert Witnesses
MRP	Medical Review Panel
NHS	National Health Service
PTSD	Post-Traumatic Stress Disorder
RIL	*Res Ipsa Loquitor*
RSA	Republic of South Africa
TP	Therapeutic Privilege
UNCHR	United Nations Charter on Human Rights

UK United Kingdom

WAML World Association of Medicine and Law

TABLE OF STATUTES

The following Acts were read in the collective compiling of this dissertation and should be the minimum number of Acts a Medical Expert Witness should have accessed:

- The Constitution of the Republic of South Africa, 1996.

Other Acts:

- The Arbitration Act 42 of 1965.
- The Children's Act 38 of 2005.
- The Civil Procedure Evidence Act 25 of 1965.
- The Compensation for Occupational Injuries and Diseases Act 130 of 1993.
- The Consumer Protection Act 68 of 2008.
- The Criminal Procedure Act 51 of1977.
- The Health Professions Amendment Act 29 of 2007.
- The High Court Rules.
- The Medical Schemes Act 131 of 1998.
- The Medicines and Related Substances Control Amendment Act 90 of 1997
- The National Credit Act 34 of 2005.
- The National Health Act 61 of 2003.
- The New Zealand Accident, Rehabilitation and Compensation Act (1992)
- The Promotion of Access to Information Act 2 of 2000.
- The Promotion of Equality and the Prevention of Unfair Discrimination Act 4 of 2000.
- The Road Accident Fund Amendment Act 19 of 2005.

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S v Melrose 1981 (1) SA 720 (Z) para 724I

S v Mokgethi 1990 (1) SA 32 (A)

S v Nel 1987 PD

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Bell v R (1973) 44 DCR (3rd) 553

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Bolitho v City & Hackney Health Authority (1993) 13 BMLR 111 (CA)

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Chappel v Hart (1993) 195 ClR 232

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General Medical Council v Meadow (2006) EWCA Civ 1390

Hotson v East Berks Area Health Authority (1987) AC 750

Hucks v Cole (1993) 4 Med LR 393 (CA)

Hunter v Hanley (1955) SLT 213 1st Div

Jones v Kaney (2011) UKSC 13

Kenny v Lockwood (1932) OR 141

Lamphier v Phipps (!838) 8 CAR 475

LB of Islington v Al Alas and Wray (2012) EWHC 865 (Fam)

Levine v Wiss 478A 2nd 397 NJ (1984)

Mahon v Osborne (1939) 1 All ER 535

Maynard v West Midlands Regional Health Authority (1985) 1 All ER 635 (HL)

McGhee v National Coal Board (1973) 1 WLR 1

Perre v Apand Pty Ltd (1999) 198 CLR 180

Potter et al V Firestone Tire and Rubber Co (1993) 6 Cal,4th 965

Rogers v Whitaker (1992) 175 CLR 479HCC

Rosenberg v Percival (2001) HCA 18 223

Riebl v Hughes (1980) 114 Dlr 3rd 1

Riff v Morgan Pharmacy (1986) 508 A 2d1247

Schliesman v Fisher (1979) 158 Cal Rpter 527 (CA)

Seltsam Pty Ltd v McGuiness (2000) NSWCA 347

Sidaway v Governors of Bethlehem Royal Hospital (1985) AC 871

Whitehouse v Jordan (1980) 1 All ER 650

Wilsher V Essex Area Health Authority (1988) AC 1074