Medical guidelines in South African courts: Exploring their role in medical negligence matters[1]

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Abstract

This chapter analyses South African courts' approach to clinical guidelines in medical negligence case law. It is widely accepted that guidelines 'do not have the status of law' and this was recently confirmed by the Western Cape High Court. However, this statement conveys very little about the subject and there is a need to explore this issue because various healthcare providers have been found negligent for failing to comply with medical guidelines and this suggests that guidelines hold *some value* in law. In this chapter I offer an overview of what the case law has to say on the subject and I explore the role of guidelines in the context of proving reasonable foreseeability and preventability of harm. Further, I tease out some underlying issues that might impact decision making such as conflicting expert medical opinions, conflicting positions between healthcare professionals and medical guidelines, the role of limited resources, and the acceptability of foreign medical guidelines within the South African context. The chapter also analyses indications that South African courts are, in some instances, swayed by the privileged position of doctors in society or by the influential nature of medical knowledge (a form of authoritative knowledge). To this end, courts are found to 'bend over backwards' to avoid a finding of negligence where guidelines have been ignored and the chapter explores this issue in detail.

Keywords: Medical negligence; medical guidelines; authoritative knowledge; judicial deference; foreseeability and preventability of harm; South Africa

1. Introduction

To date, there is no precedent regarding how South African courts should approach medical guidelines and superior courts are yet to establish meaningful guidance regarding the evidential weight to be afforded to different types of medical guidelines. There is no literature exploring this subject either. At first glance, there appears to be much uncertainty in this area. Few courts have made pronouncements regarding the legal significance of medical guidelines. *Oldwage v Louwrens* is the first case of note; Yekiso J remarks:

[1] I am grateful to Dr Emile Zitzke from the Witwatersrand Law School for his helpful and supportive comments on an earlier draft of this chapter.

> [T]he Health Profession's Council of South Africa, a statutory body regulating the medical profession, has issued various guidelines regulating good practice, ethical rules and professional self-development, which the medical profession is expected to adhere to. *There is no certainty as to the legal status of these guidelines except to say they constitute general practice accepted in the medical profession*.[2]

Nearly ten years after *Oldwage*, the Western Cape High Court in *Pandie v Isaacs*, stated unequivocally, that the Health Profession Council's guidelines 'do not have the status of law and are merely part of the evidential material to be weighed in determining the standards reasonably to be observed by doctors.'[3] Guidelines are not laws for obvious reasons, but the court did not divulge how to determine the evidential weight of guidelines and it seemed to adopt a rather dismissive approach to guidelines which suggests that they hold very little weight.[4] Not too long after *Pandie* was decided, the Western Cape Division took a different position. In *Daniels v Minister of Defence*, Allie J stated that the National Health Act 16 of 2003 and the Health Profession Council's guidelines on informed consent 'form part of the *legal framework* for the standard of care and prescribed procedures that all healthcare practitioners must comply with.'[5]

The court's approach in *Daniels* suggests that guidelines mean something more than that suggested in *Pandie* and that they cannot be too easily brushed aside. However, it would be a mistake to conclude that *all* professional guidelines form part of the legal framework for professionals' standard of care. In *Daniels*, as in *Pandie*, the relevant clinical guidelines reflected the position of the South African law on informed consent. The court recognised that the guidelines had incorporated the informed consent provisions of the National Health Act and together they 'constitute a yardstick against which standards of professional conduct can be measured.'[6]

These three positions on guidelines paint a rather confusing picture and it seems that there will always be a measure of uncertainty while there is no precedent providing direction regarding how to include and weigh guidelines in a medical negligence matter. Nevertheless, a coherent picture begins to emerge when one systematically unpacks the relevant case law. A scratch below the surface reveals that guidelines are regularly received as evidence of the standard of care that can be expected from healthcare professionals and there are identifiable factors that can influence the weight afforded to guidelines. In this context there is a rich landscape of case law to draw

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[2] *Oldwage v Louwrens* 2004 JDR 0023 (C) [73]-[74]. Emphasis added.
[3] *Pandie v Isaacs* [2013] ZAWCHC 123 [37].
[4] This case has faced some criticism and it will be the subject of further analysis later in this chapter.
[5] *Daniels v Minister of Defence* 2016 (6) SA 561 (WCC) [185]. Emphasis added.
[6] ibid [124].

from to paint a more informed picture regarding the value of guidelines in the mechanics of medical negligence law.

This chapter is the first of its kind to explore the landscape regarding medical guidelines in South African courts, and for this reason I adopt a very inclusive approach when sourcing relevant case law to include in my analysis. I consider all medical negligence case law (reported and unreported) originating from all South African courts that include within their scope the consideration of medical guidelines.[7] This broad approach helps to map some notable trends in relation to how courts might approach and incorporate medical guidelines during decision making.

Ultimately, this chapter attempts to establish a clearer picture of the South African context. First, it traces the gradual inclusion of guidelines into medical negligence litigation and it explores the role that guidelines play by working through a selection of case law. I consider case law that demonstrates the role of guidelines in establishing the standard of care expected of healthcare professionals and then I tease out those factors that can affect the weight that a court might afford medical guidelines in negligence matters. This process highlights four themes: contradictions between professional opinions and medical guidelines, clashing professional opinions more generally, limited resources, and acceptability of foreign guidelines. Finally, I unearth those factors that might render medical guidelines particularly fragile in courts of law. In this regard I interrogate the court's approach to medical guidelines in *Pandie* and I explore the possible impact of the privileged position of some healthcare professionals and the consequences of the authoritative position of medical knowledge in courts.

[7] In this regard, I used the search strings 'negligence' and 'guidelines' to identify the case law relevant to my analysis. This approach provided the following judgments: *Oldwage* (n 2); *Ntungele v MEC, Department of Health, Eastern Cape* 2015 JDR 0104 (ECM); *Nkayiya v Member of the Executive Council for Health, Eastern Cape* 2015 JDR 2421 (ECM); *Mucavele v Member of the Executive Council for Health* 2015 JDR 1942 (GP); *Molefe v Member of the Executive Council for Health* 2015 JDR 0449 (GP); *Neveling v MEC for Health and Social Development, Gauteng Province* 2016 JDR 1219 (GJ); *Daniels* (n 5); *Chapeikin v Mini* 2016 JDR 1324 (SCA); *Mampoza v The Member of the Executive Council for Health, Eastern Cape Province* 2017 JDR 1699 (ECM); *Magqeya v Member of the Executive Council for Health, Eastern Cape* 2017 JDR 0598 (ECM); *Khoza v MEC Health and Social Development* 2017 JDR 1912 (GJ); *Nontangane v Member of the Executive Council for Health, EC* 2018 JDR 0467 (ECM); *Ngobese v MEC for Health, KZN* 2018 JDR 0488 (KZD); *Ndwandwa v Member of the Executive Council for Health Eastern Cape Province* 2018 JDR 0050 (ECB); *NAM v Member of the Executive Council for the Department of Health* 2018 JDR 1695 (NWM*)*; *Myende v The Member of the Executive Council for Health KwaZulu-Natal* 2018 JDR 1680 (KZD); *Mokoena-Moalusi v MEC for Health and Social Development, Gauteng Province* 2018 JDR 2207 (GJ); *Magqeya v Member of the Executive Council for Health, Eastern Cape* 2018 JDR 1667 (SCA); *NN v The Member of the Executive Council for Health and Social Development of the Gauteng Provincial Government* 2019 JDR 0179 (GJ); *Davies v MEC for Health for the Province of KwaZulu-Natal* 2019 JDR 0500 (KZP); *AN v MEC for Health, Eastern Cape* (585/2018) [2019] ZASCA 102. It was not necessary to discuss every judgment in this chapter.

2. Guidelines in the medical negligence case law

Contrary to the UK position, negligence is not a delict in and of itself; it is one of the five elements of delict which include an act, wrongfulness, fault, causation, and harm. Within the context of fault, guidelines feature frequently as evidence used to establish reasonable foreseeability and preventability of harm. However, their emergence as evidence of the required standard of care is a recent development.

Historically, evidence regarding what would be reasonable to expect from healthcare professionals could be established through evidence of expert witnesses. *Mitchell v Dixon*[8] is the first case of note to consider reasonable professional skill. The then Appellate Division found that 'a medical professional 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.'[9] In this case the court did not explicitly explain how to establish what might be considered reasonable but it did rely on expert evidence to establish that the defendant healthcare professional acted with reasonable skill. The Appellate Division expanded on its position 10 years after *Mitchell*.

In *Van Wyk v Lewis* it explained:[10]

> [I]n deciding what is reasonable the Court will have regard to the general level of skill and diligence possessed and exercised at the time by the members of the branch of the profession to which the practitioner belongs. The evidence of qualified surgeons or physicians is of the greatest assistance in estimating that general level.

The testimony of experienced members of the profession was deemed to be the 'greatest value'[11] to the question of reasonableness and their evidence brings to light what should be regarded as 'usual practice'.[12] In relation to establishing usual practice, the court cited and relied on the approach taken in the United States: 'In America it has been decided that a physician is entitled to have his treatment of his patient tested by the rules and principles of the school of medicine to which he belongs'.[13] Nevertheless, the court cautioned that while it will give due regard to the views of the profession it is not bound to adopt them[14] and that it cannot 'lay down for the profession a rule of practice' from the evidence it receives from expert witnesses.[15]

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[8] 1014 AD 519, 525.
[9] Ibid.
[10] *Van Wyk v Lewis* 1924 AD 438, 444.
[11] *Van Wyk* (n 10) 447.
[12] *Van Wyk* (n 10) 457.
[13] *Van Wyk* (n 10) 458, citing *Force v Gregory* 38 Am St Rep 371 and *Pattin v Wiggins* 81 Am Dec 593.
[14] *Van Wyk* (n 10) 447.
[15] *Van Wyk* (n 10) 457.

While in 1924, the evidence of qualified surgeons or physicians was deemed of great import, guidelines have proven to be just as important to more recent negligence related decision-making. For instance, in *Mucavele*[16] the court emphasised that *medical guidelines* 'set out prudent practices with regard to the general level of skill and diligence exercised by the relevant profession' and, in essence, this approach expands the position taken in *Van Wyk*. Instead of focusing on the individual say-so of experienced healthcare professionals, the courts will include a consideration of other, authoritative sources that influence professional practice. The emergence of guidelines into the case law reveals a judicial alignment with the growth of the broader regulation of the healthcare profession.[17] To this end, an analysis of the available case law reveals what can be reasonably expected from healthcare professionals in South Africa and I consider five themes next: guidelines in the context of reasonable foreseeability and preventability; contradictions between professional experience and medical guidelines; guidelines in the context of clashing professional opinion, the acceptability of foreign guidelines in South Africa, and noncompliance with guidelines in the context of limited resources.

2.1 Establishing reasonable foreseeability and preventability

Obstetric-related negligence case law reveals the sad state of public healthcare facilities in South Africa and it lays bare the devastating consequences thereof. It provides a rich source of data regarding the role of medical guidelines in establishing foreseeability and preventability legs of medical negligence and I will examine these here.

Mucavele[18] concerns a claim for negligent maternal and foetal monitoring during labour and response to indications of foetal distress. Mrs Mucavele gave birth to Baby Bennett at the Tambo Memorial Hospital, a state healthcare facility. She experienced several issues in relation to the standard of care she received and Baby Bennett who now lives with cerebral palsy. Mrs Mucavele argued that the defendant's employee midwives and obstetricians negligently breached their standard of care and the Guidelines for Maternity Care in South Africa[19] played a central role in the makeup of her case against the state.

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[16] (n 7) [79].
[17] G Weisz et al, 'The Emergence of Clinical Practice Guidelines' (2007) 85(4) Milbank Q 691.
[18] (n 7).
[19] The judgment does not cite the year or edition of the relevant guidelines, but I assume that the parities relied on the 3rd edition of the 'Guidelines for Maternity Care in South Africa' given the time frame when the facts of the case materialised. See Department of Health, 'Guidelines for Maternity Care in South Africa' (3rd ed, 2007) <www.kznhealth.gov.za/family/Maternity_care_guidelines_2007.pdf> accessed 26 July 2019.

Mrs Mucavele's litigation team relied on the guidelines to establish the standard care in the context of foetal monitoring during labour which required regular monitoring of the foetal heart rate. Mrs Mucavele's medical records reveal that foetal heart rate monitoring did not meet the standards established in the guidelines, and it appeared that there were times during her labour that there was no monitoring at all.[20] Had there been adequate monitoring, Mrs Mucavele's medical team would have been alerted to the fact that Baby Bennett was becoming distressed, and this would have triggered prescribed procedures to manage this complication. The court found that it was 'satisfied that the conduct of the defendant's employees did not adhere to the skill and diligence prevailing in the medical profession standardly required by the Guidelines'.[21]

Additionally, Mrs Mucavele's litigation team relied on the guidelines to establish the case that the healthcare professional's management of foetal distress was below the accepted standard of care. Critically important to her case is the fact that the guidelines list the required steps for intrapartum resuscitation and require emergency caesarean sections to be performed within one hour of making the decision to operate.[22] Mrs Mucavele's medical records reveal that not all the intrapartum resuscitation steps were performed and her caesarean section operation did not take place within the prescribed time.[23] The court accepted that this was substandard care and that it constituted a further compromise to Baby Bennett's condition: 'The plaintiff has proven on a preponderance of probabilities that the conduct just before and during the [caesarean] section of the employees of the defendant was not within the standard expected of them, they were accordingly negligent.'[24] Here guidelines played a defining and unchallenged role in demonstrating the foreseeability of harm (this is why they exist to start with) and in establishing the reasonable steps that should have been taken by healthcare professionals in the circumstances.[25]

The successful integration of medical guidelines into this case appears to be a rather uncontentious move. The court seemed to draw very easily from the guidelines to establish healthcare professionals' standard of care and the state did not challenge the legitimacy and reasonableness of the standard of care established by the guidelines.

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[20] *Mucavele* (n 7) [75].
[21] *Mucavele* (n 7) [79].
[22] Department of Health (n 19) 54.
[23] *Mucavele* (n 7) [71] and [103].
[24] *Mucavele* (n 7) [107].
[25] The court found that negligence was established in respect of other aspects of Mrs Mucavele's treatment, but these are not considered here because medical guidelines were not relevant to those issues.

There are several reasons that could explain the court's readiness to draw from and accept the guidelines. The reasons advanced here are speculative because the court did not evaluate the veracity of the guidelines. First, none of the parties disputed the legitimacy of the guidelines. Having said that, it would have been surprising if the state had disputed their legitimacy given that state led the development of these guidelines.[26] Second, the guidelines were developed from 'the best available evidence from published research, modified where necessary to suit local conditions'[27] and its 'contents are the result of broad and intensive discussions, feedback and debate.'[28] In addition to drawing from the local pool of knowledge, the National Maternity Guidelines Committee drew from international sources (such as the World Health Organization) and as a result thereof, the guidelines are supported by the authoritative might of influential international organisations.[29] Third, the Guidelines for Maternity Care in South Africa are extensively and regularly updated, taking into account important local and international developments.[30] Finally, evidence tendered by expert witnesses were aligned with the guidelines, leaving little room to question their authoritative veracity on the subject.

The court's approach to guidelines in the *Mucavele* suggests that their evidential sway in relation to reasonable foreseeability and preventability will be relative to the authoritative position of the institution developing such guidelines (and whether that institution is a party to the dispute), the basis from which the guidelines are developed, their alignment with broader international trends, and local professional support for the position taken in the guidelines.

2.2 The court's approach to a contradiction between professional experience and medical guidelines

Mampoza[31] concerns another case of the South African government's employees' failure to adequately respond to a serious case of foetal distress. Ms Mampoza attended Siphethu Hospital, a public healthcare facility, to give birth to her son, Baby Siyolise. It soon became clear to the attending healthcare professionals that Baby Siyolise was distressed, and they needed to expedite his birth and the discussion that follows is concerned with the decision to not support Ms Mampoza with a forceps delivery.

[26] Department of Health (n 19) 7.
[27] Department of Health (n 19) 10.
[28] Department of Health (n 19) 3.
[29] Department of Health (n 19) 8; 133.
[30] Department of Health (n 19) 3.
[31] (n 7).

Sr Mpisane, the qualified midwife who attended to Ms Mampoza during labour and childbirth, testified that expedited birth with the assistance of forceps was not an option in this case for two reasons. First, Ms Mampoza was uncooperative due her inability to cope with the pain of labour and hospital policy prevents her from using forceps when a patient is uncooperative.[32] Second, while she recognised that managing the pain would render Ms Mampoza more cooperative, Sr Mpisane testified that 'her experience as a midwife taught her' that she could not 'give [Ms Mamposa] anything for pain because [Ms Mamposa was] in [the] active phase of labour, painkillers affect the foetus, that is the policy.'[33] There is no evidence tendered regarding the policy that Sr Mpisane refers to but she has significant professional experience to draw from to support her position. She had been practising as a midwifery since 2003, she had cared for over 1800 women during their uncomplicated childbirths, and supported women through 30 complicated childbirths.[34] She was trained in advanced midwifery which included an extensive study dedicated to complications during childbirth.[35] This background reveals that Sr Mpisane is well placed to develop a professional opinion and according to her, if she 'were to administer pethidine the baby would not be able to assist the mother, when [Ms Mamposa] delivers'[36] and that administering pain relief medication during this phase of labour 'can kill the child'.[37]

Sr Mpisane's stance was challenged because her position on the provision of pain relief medication stands in stark contrast to the guidelines which support the use of pain relief medication at any stage during labour.[38] According to the Guidelines for Maternity Care in South Africa '[p]ain relief should be offered to all women in labour' and it specifically indicates that 'Pethidine 100 mg IM with promethazine 25 mg IM 4 hourly is acceptable in both the latent and active phases, even up to full dilatation of the cervix'.[39] Expert testimony by Dr Shweni, a fellow witness for the State, testified that pain relief medication could be administered at any point during the childbirth process thus confirming the directions offered in the guidelines.[40] Dr Shweni stands in a position of authority within the maternity care context; he is a specialist obstetrician and gynaecologist who leads the Eastern Cape Provincial Head of Districts Special Teams and he is noted for being actively involved in efforts to improve the standards of maternal health, particularly in relation to maternal deaths.[41]

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[32] *Mampoza* (n 7) [89]. The court notes that this position is supported by the Midwifery handbook, P Sellers, *Midwifery: A Textbook and Reference Book for Midwives in Southern Africa* (Juta 1993).
[33] Ibid.
[34] *Mampoza* (n 7) [83].
[35] Ibid.
[36] *Mampoza* (n 7) [98].
[37] Ibid.
[38] Ibid.
[39] Department of Health (n 19) 37.
[40] *Mampoza* (n 7) [142].
[41] *Mampoza* (n 7) [60].

The court rejected Sr Mpisane's position but it did so without clarifying the exact reason, except for emphasising that '*[e]ven* Dr Shweni said painkillers can be given to patients in that state.'[42] The 'even' is important to note. Dr Shweni and Sr Mpisane formed part of the same team of expert witnesses for the state and it demonstrates that her professional view is perceived to be so far removed from the accepted position that her own team members cannot support it. The court appears to rely on Dr Shweni's lack of support as an indication that Sr Mpisane's position is an unreasonable one to hold.

As with *Bolam*,[43] in South Africa the 'governing test for professional negligence is the standard of conduct of the reasonable practitioner in the particular professional field' but this test is not always helpful when a court is presented with conflicting professional positions.[44] In these contexts the Supreme Court of Appeal[45] has confirmed that courts should apply *Bolitho*[46] and evaluate the evidence to establish whether and to what extent the different expert opinions are founded on logical reasoning and that the expert has reached a defensible conclusion.[47] If an expert opinion cannot withstand logical analysis, it will not be reasonable even if it has the support of a body of professional opinion sanctioning that particular opinion.[48] This approach to conflicting expert opinions was confirmed by the Constitutional Court[49] and it is essential that expert opinions are supported by broader evidence that the court can use to evaluate the reasonableness and logical basis of the professional opinion.

Despite her extensive training and experience, Sr Mpisane clearly did not offer the court enough evidence to demonstrate that her deviation from the guidelines was reasonable and that this decision was derived from a logical basis. The courts approach suggests that drawing from personal professional experience on its own will not be enough to support a decision to deviate from established guidelines. Further, it suggests that establishing the reasonableness of deviating from medical guidelines might be frustrated in those cases where senior and specialist healthcare professionals' positions offer professional opinions that are aligned with those guidelines. While the place of *Bolitho* within the South African legal landscape has not been the subject of critical interrogation,[50] it worth noting that there are some concerning anomalies in the court's approach to this issue.

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[42] *Mampoza* (n 7) [142]. Emphasis added.
[43] *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.
[44] *Michael v Linksfield Park Clinic* 2001 (3) SA 1188 (SCA) [35].
[45] *Michael* (n 44) [36]-[40].
[46] *Bolitho v City and Hackney Authority* [1998] AC 232.
[47] *Michael* (n 44) [37].
[48] *Michael* (n 44) [39].
[49] See *Oppelt v Department of Health, Western Cape* 2016 (1) SA 325 (CC) [36].
[50] For a descriptive account of South Africa's incorporation of *Bolam* (n 43) and *Bolitho* (n 46), see Moffat Maitele Ndou, 'Assessment of Contested Expert Medical Evidence in Medical Negligence Cases:

The court's analysis of the reasonableness and logical basis of the conflicting positions presented by Dr Shweni and Sr Mpisane is wanting. The reasonableness of Sr Mpisane's conduct in deviating from the guidelines must be considered in the light of her 'particular professional field' being midwifery and not according to obstetrics and gynaecology. Further, the court accepts Dr Shweni's opinion without him demonstrating the basis for this opinion. There is no evidence noted in the judgment that directly challenges or refutes the acceptability of Sr Mpisane's professional opinion which is allegedly supported by hospital policy. Case law makes it clear that '[j]udges must be careful not to accept readily isolated statements by experts … their evidence must be weighed as a whole'.[51] Without the necessary evidence to evaluate, it can be argued that the court accepts Dr Shweni's opinion only because he holds a more senior position within the maternity care context in comparison to Sr Mpisane. It is arguable that the court is unduly influenced by the hierarchy of specialisms that devalues midwifery as subordinate to specialist areas of obstetrics and gynaecology,[52] and this is complicated in the South African context where midwifery is shaped by South Africa's racist past and persistent gender inequalities more generally.[53] I revisit this issue later, where I highlight the differences in how South African courts have approached evidence tendered by Sr Mpisane in this case and evidence tendered by specialist doctors in another case, *Pandie*.[54]

2.3 The court's approach to guidelines in context of clashing professional opinions and the acceptability of foreign guidelines

Neveling[55] is another example of a case where guidelines played a defining role in establishing reasonable foreseeability and preventability but the focus here is on how the court will approach a clash in professional approach. The plaintiff's and defendant's expert witness relied on different guidelines to establish what is

A Comparative Analysis of the Court's Approach to the *Bolam*/*Bolitho* Test in England, South Africa and Singapore' (2019) 33(1) Speculum Juris 54. This is in stark contrast to the plethora of analysis available in the UK and it appears that some of the issues raised in the UK have not filtered through to South Africa.

[51] *Life Healthcare Group v Suliman* 2019 (2) SA 185 (SCA) [15].

[52] Barbara Ehrenreich and Deirdre English, *Witches, Midwives and Nurses: A History of Women Healers* (2nd edn, Feminist Press 2010); Brigitte Jordan, 'Authoritative Knowledge and its Construction' in Robbie Davis-Floyd and Carolyn Sargent (eds), *Childbirth and Authoritative Knowledge: Cross Cultural Perspectives* (University of California Press 1997) 55; Anthea Symonds and Sheila Hunt, *Midwife and Society: Perspectives, Policies and Practice* (MacMillan 1996). This is an especially pressing issue among midwives practicing in African and Latin American countries, see World Health Organization, 'Midwives' Voices, Midwives Realties: Findings from a Global Consultation on Providing Quality Midwifery Care' (2016) at <https://apps.who.int/iris/bitstream/handle/10665/250376/9789241510547-eng.pdf?sequence=1> accessed 24 June 2020.

[53] Hoosen Coovadia et al, 'The Health and Health System of South Africa: Historical Roots of Current Public Health Challenges' (2009) 374(9692) The Lancet 817; R Jewkes et al, 'Why do Nurses Abuse Patients? Reflections from South African Obstetric Services' (1998) 47(11) Soc Sci Med 1781.

[54] See para 3 below.

[55] (n 7).

reasonably foreseeable and preventable, the National Guideline: Prevention of Blindness in South Africa[56] and guidelines issued by Royal College of Ophthalmologists in the United Kingdom,[57] respectively. The *Neveling* judgment provides insight on two issues related to medical guidelines. First, how South African courts might approach a conflict between healthcare professionals who draw from different guidelines that include diverging recommendations. Second, how persuasive foreign guidelines might be when presented as evidence before South African courts to prove the standard of care that can be reasonably expected of healthcare professionals working in South Africa.

Baby Ishaan was born at 32 weeks' gestation, weighing 1810g at Leratong Hospital, a state healthcare facility. Baby Ishaan struggled to breathe soon after birth and his attending healthcare providers administered unblended oxygen via nasal prongs for four days.[58] During this time, the oxygen saturation levels varied from 94 per cent to 99 per cent.[59] He was discharged nine days after his birth without being referred to an ophthalmologist for screening despite it being recorded that he was premature and hyperoxemic.[60] Baby Ishaan was later found to have developed Retinopathy of Prematurity (ROP) which caused blindness in one eye and partial blindness in the other.[61] His mother, Mrs Lorna Neveling, claimed damages on behalf of herself and Baby Ishaan.

Mrs Neveling's litigation team used the National Guidelines: Prevention of Blindness in South Africa[62] as the standard to establish the reasonable foreseeability of the risk of Baby Ishaan's blindness and to demonstrate the reasonable steps necessary to prevent the materialisation of that harm. The national guidelines recognise that ROP is a leading cause of blindness in children and that it is an entirely preventable disability. The guidelines recommend that oxygen saturation levels must be maintained between 86 per cent and 92 per cent in premature babies.[63] Further, it

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[56] Department of Health, 'National Guideline: Prevention of Blindness in South Africa' (2002) <www.westerncape.gov.za/text/2003/blindness.pdf> accessed 8 August 2019.
[57] *Neveling* (n 7) [86]. These guidelines were not referenced in the judgment but Professor Mayet most likely relied on an earlier version of the current guidelines, Royal College of Ophthalmologists et al, 'Guideline for the Screening and Treatment of Retinopathy of Prematurity' (2008) <www.rcophth.ac.uk/wp-content/uploads/2014/12/2008-SCI-021-Guidelines-Retinopathy-of-Prematurity.pdf> accessed 7 August 2019. According to the current guidelines, these supersede earlier guidelines established in AR Fielder and others (on behalf of the Royal Colleges of Ophthalmologists and Paediatrics and Child Health and the British Association of Perinatal Medicine), 'Retinopathy of Prematurity in the UK II: Audit of National Guidelines for Screening and Treatment' (2002) 16(3) Eye 285.
[58] *Neveling* (n 7) [11].
[59] *Neveling* (n 7) [12].
[60] Ibid.
[61] *Neveling* (n 7) [17].
[62] Department of Health (n 56).
[63] Department of Health (n 56) 7.

recommends that *all* babies who are less than or equal to 33 weeks' post-conceptual age or who weigh less than 1250g at birth should be screened by an ophthalmologist, and this should take place between five and seven weeks' after birth.[64] The application of these guidelines to Baby Ishaan's case meant that he was at risk of developing ROP, that this was foreseeable and it was preventable, provided the guidelines were adequately followed.

The defendant, on the other hand, relied on the guidelines issued by Royal College of Ophthalmologists in the United Kingdom.[65] In this regard, Professor Mayet, who was the clinical head of St John's Eye Hospital, testified that Baby Ishaan's attending hospital followed these guidelines. The Royal College of Ophthalmologist's guidelines differ from South African guidelines in that they recommend that all babies with a birth weight of less than 1501g and/or a gestational age of less than 32 weeks are to be referred for screening.[66] The application of these guidelines to Baby Ishaan's case meant that he was not deemed to be at risk of developing ROP and there was no need to take steps to prevent the development of the condition.

The court seemed unpersuaded by the guidelines issued by the Royal College of Ophthalmologists primarily because the evidence tendered by Mrs Neveling's litigation team revealed these to be improper for the South African context. To this end, the plaintiff's expert witnesses gave testimony regarding their general practice in the South African healthcare industry relevant to this issue; the general practice being contrary to the recommendations given by the Royal College of Ophthalmologists. The expert witness also referred the court to important published research that focused on developing world contexts more generally.[67] Using this research, they made the case that 'it is widely known that bigger and more mature babies present with severe ROP in developing countries (low- and middle income countries) and this has been known for more than two decades.'[68] The published findings demonstrate that the position taken in the Royal College of Ophthalmologist's guidelines were not appropriate for

[64] Department of Health (n 56) 8. The birth weight was increased in 2013 guidelines from 1250g to 1500g.
[65] Fielder and others (n 57).
[66] Ibid.
[67] Several articles were cited, see *Neveling* (n 7) [7]; [122]. These include, S Reisneret al, 'Retinopathy of Prematurity: Incidence and Treatment' (1985) 60(8) Arch Dis Child 698; Y Ng et al, 'Epidemiology of Retinopathy of Prematurity' (1988) 332(8622) Lancet 1235; M Al-Essa, N Rashwan, and M Al-Ajmi, 'Retinopathy of Prematurity in Infants with Birth Weight above 1500 Grams' (2000) 77(10) East Afr Med J 562; C Gilbert et al, 'Characteristics of Infants with Severe Retinopathy of Prematurity in Countries with Low, Moderate, and High Levels of Development: Implications for Screening Programs' (2005) 115(5) Pediatrics e518; L Visser et al, 'Guideline for the Prevention, Screening and Treatment of Retinopathy of Prematurity (ROP)' (2013) 103(2) SAMJ 116; PK Shah, V Narendran, and N Kalpana, 'Aggressive Posterior Retinopathy of Prematurity in Large Preterm Babies in South India' (2012) 97(5) Arch Dis Child (Fetal and Neonatal Edition) F371.
[68] *Neveling* (n 7) [122].

the South African context.[69] Finally, the national guidelines in place were aligned with the positions taken by South African healthcare professionals and the published peer-reviewed literature. Collectively, these three considerations rendered it unreasonable to rely on the Royal College of Ophthalmologist's guidelines as evidence of the reasonable standard of care to be expected.

The national guidelines were particularly persuasive in this matter, and the Mrs Nevling's litigation team successfully established that Baby Ishaan's blindness was reasonably foreseeable and preventable through the application of 'well-established protocols' indicated in the guidelines.[70] Drawing from the hospital records, the guidelines and expert testimony which relied on the dictates of the guidelines, the court found that: 'The defendant's staff ought to have been aware of the dangers of hyperoxemia and at the very least, they ought to have known of the 2002 National Guidelines … and to have complied with its established protocols.'[71]

Some important points can be highlighted from the court's approach in this case. First, guidelines developed by institutions in other jurisdictions will not automatically hold authoritative sway before South African courts. However, these guidelines might prove helpful in establishing the expected standard of care in cases where South Africa has not established guidelines of its own. For instance, in *Myende* both the plaintiff and defendant relied on guidelines issued by the Royal College of Obstetricians and Gynaecologists[72] in their evidence on how to identify the risk of shoulder dystocia and manage it if it should manifest during childbirth.[73] There are no guidelines relevant to shoulder dystocia in South Africa and in this case the court readily accepted the United Kingdom's guidelines as evidence of the reasonable foreseeability and preventability of the occurrence of this issue.[74]

Second, *Neveling* suggests that the particularities of local context are important when assessing the significance of guidelines tendered as evidence of the standard of care to be expected of healthcare professionals. In *Neveling*, the published research on ROP established that heavier and more mature premature babies born in developing countries are at risk of developing ROP, and it would have been inappropriate to consider guidelines that do not take into account these local conditions when establishing what is reasonably foreseeable and preventable. Having said that, it is

[69] Ibid.
[70] *Neveling* (n 7) [7]; [8]. The birth weight was increased in 2013 guidelines from 1250g to 1500g, see para 9.
[71] *Neveling* (n 7) [190]-[191].
[72] Royal College of Obstetricians and Gynaecologists, 'Shoulder Dystocia (Green-top Guideline No 42)' (2ed edn, 2012).
[73] (n 7) [20]-[22]; [29].
[74] *Myende* (n 7) [33]; [36].

not entirely clear what evidence the court took into account in *Myende*. Elective caesarean section procedures are listed as one of the methods to be employed to prevent the occurrence of shoulder dystocia in high risk women.[75] The state's expert witness argued that the South African public healthcare sector does not have the resources to meet that demand, but the court rejected this position and opined:

> I cannot understand that when a more difficult delivery is foreseeable, why a woman, cannot have an elective caesarean section. Women have a right to dignity and right to make an informed decision when facing peril. … The costs of a caesarean section in the cases where disability is foreseeable cannot be compared to the lifelong costs of living with disability, the stigma and the socio-economic conditions that attach to disability.[76]

I will return to the theme of limited resources in the next part below. For now, it is worth noting that once a court accepts that guidelines issued by foreign institutions holds enough authoritative sway regarding the expected standard of care, local conditions may need to be sufficiently compelling in order to support a deviation therefrom.

2.4 The court's approaches to noncompliance with guidelines within the context of limited resources

Mokoena-Moalusi[77] also concerns ineffective monitoring of labour during facility-based childbirth and inadequate responses to a diagnosis of severe foetal distress. Ms Mokoena-Moalusi attended the Rahima Moosa Mother and Child Hospital, a state healthcare facility, to give birth to Baby Tshireletso. During the early hours of the morning her attending healthcare professionals noted severe foetal distress after failing to monitor her labour progression for several hours. Ms Mokoena-Moalusi's condition triggered referral for an emergency caesarean-section procedure. The record notes that the theatre was in use at the time and she was attended to two hours and five minutes after the referral for emergency care.[78] Baby Tshireletso now lives with cerebral palsy.

According to the Guidelines for Maternity Care in South Africa '[a]ll hospitals should be able to perform an emergency caesarean section within 1 hour of the decision to operate.'[79] The state accepted that this was the correct approach but it advanced a defence for non-compliance: It argued that the hospital was unable to perform the caesarean-section procedure because of 'an unavoidable lack of resources available to it.'[80] In this regard, the state explained that the hospital has one theatre and there was only one specialist available and this specialist was performing another

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[75] Royal College of Obstetricians and Gynaecologists (n 72).
[76] *Myende* (n 7) [38].
[77] (n 7)
[78] *Mokoena-Moalusi* (n 7) [8].
[79] Department of Health, 'Guidelines for Maternity Care in South Africa' (4th edn, 2015) <file:///C:/Users/camil/Downloads/maternalcareguidelines2015%20(1).pdf> accessed 21 August 2019, 37
[80] *Mokoena-Moalusi* (n 7) [20].

caesarean-section procedure in that theatre.[81] The court rejected this explanation; it found:

> Even if there was only one operating theatre available and one doctor who could perform the operation, there is nothing … to explain why the theatre in question only became available after two hours. There is certainly no evidence to suggest that Dr Kgomo had more than one other caesarean to attend to, let alone the emergency status of the surgery he was performing. There is also no evidence as to why the caesarean section which was in progress at 01h05 took so long if indeed that was the reason why the plaintiff could not be attended to earlier.

Functioning within the context of extremely limited resources is a lived reality for South Africans. The judiciary is alive to this[82] and the Constitution of the Republic of South Africa has made it clear: access to healthcare (including reproductive healthcare) is a basic human right that is subject to progressive realisation and the availability of resources.[83] The court's approach depicted in the above quote makes it clear that the defence was not rejected because this defence was bad in law, but because the state failed to develop a proper evidentiary foundation to support its justification for non-compliance with guidelines.[84] South African courts have reiterated that bald assertions of resource constraints will do little to render reasonable the state's conduct: 'Details of the precise character of the resource constraints, whether human or financial, in the context of the overall resourcing of the organ of state will need to be provided.'[85]

Collectively, this suggests that healthcare professionals might be able to justify their non-compliance with guidelines because their *particular* facility lacks the necessary resources. Carstens and Pearmain refer to this as the 'rule of "special circumstance"' which requires courts to consider the objective circumstances of the locality where doctors practice when confronted with negligence claims.[86] This perspective recognises that South Africa is a developing country shaped by broader social inequalities that impact the provision of care, and that healthcare professionals cannot be expected to perform miracles. The South African approach can be contrast to the UK position where limited resources cannot serve as a defence to a negligence claim.[87] Christian Witting notes several issues with the UK's approach and stresses that the courts are failing to recognise that '[d]ecision-making in healthcare is

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[81] *Mokoena-Moalusi* (n 7) [20].
[82] For instance, see *Soobramoney v Minister of Health (Kwazulu-Natal)* 1998 (1) SA 765 (CC); *Oppelt* (n 49).
[83] Section 27 of the Constitution of the Republic of South Africa, 1996.
[84] *Mokoena-Moalusi* (n 7) [20].
[85] *Rail Commuters Action Group v Transnet Ltd t/a Metrorail* 2005 (2) SA 359 (CC) [88].
[86] Pieter Carstens and Debbie Pearmain, *Foundational Principles of South African Medical Law* (Lexis Nexis 2008) 638.
[87] See *Wilsher v Essex AHA* [1986] QB 730; *Bull v Devo AHA* [1993] 4 Med LR 117; *Garcia v St Mary's NHS Trust* [2006] EWHC 2314 (QB). Further, Emily Jackson, *Medical Law: Text, Cases, and Materials* (5th edn, Oxford University Press 2019) 136; Shaun Pattinson*, Medical Law and Ethics* (5th edn, Sweet and Maxwell 2017) 37; Christian Witting, 'National Health Service Rationing: Implications for the Standard of Care in Negligence' (2001) 21(3) *OJLS* 443.

polycentric and the failures of the most immediate parties might be the least significant in the causal chain.'[88] In order for this defence to hold meaningful sway within the South African context, healthcare professionals are required to extensively canvass the evidentiary material in support of such contention before the court.

In *Mokoena-Moalusi*, the court directs us to *Soobramoney*[89] to give an indication of what would constitute a suitable evidentiary foundation where limited resources becomes an issue.[90] In the case before the Constitutional Court, the Minster of Health tendered extensive evidence revealing the limited local budget available to provide lifesaving treatment (this case was concerned with the provision of renal dialysis to those with living with chronic renal failure), the extent of the budget deficits at local and national levels which affect the provision of healthcare in general, and the measures in place used to mitigate the harmful impact of working within this resource-deficient context. *Soobramoney* very helpfully offers an example of the extent of the evidence that a healthcare professional should be prepared to offer in cases where they deviate from established guidelines based on a lack of resources. That is, healthcare professionals should provide details of the extent and precise nature of the resource constraints that prevented compliance with guidance and place their circumstances within the broader context of the overall resourcing for that service. Healthcare professionals will also be required to tender evidence to show that there are measures in place to alleviate the detrimental impact of having to work in a resource deficient context. In *Soobramoney*, the hospital had a referral policy in place that ensured that resources that were available were used in an efficient manner.[91] All these details are lacking in *Mokoena-Moalusi*.

The case law discussed here demonstrates that guidelines certainly do have a role to play and that South African courts tend to be willing to receive them. They have proven to be particularly valuable when it comes to establishing the standard of care that we can expect from healthcare professionals. Together with other supporting evidence regarding general practice, guidelines help to establish foreseeability of harm and they map out the steps that should be taken by reasonable healthcare professionals to avoid the materialisation of risk of that harm. It would be fair to conclude that there is a developing trend in relation to their inclusion as part of litigation strategies. Further, if it is successfully established that guidelines are relevant to an issue, it is likely that the court will include those within its considerations and, once corroborated by boarder expert evidence, guidelines can be particularly persuasive regarding the standard of care. Despite the development of a somewhat cohesive landscape presented here, *Pandie*[92] diverges therefrom and this case deserves special attention. It highlights that

[88] Witting (n 87) 459.
[89] (n 82).
[90] *Mokoena-Moalusi* (n 7) [21].
[91] These were specially developed to help decision-making about who got access to dialysis machines and who did not, see *Soobramoney* (n 82) [24]-[25].
[92] (n 3).

medical guidelines can be easily ignored when brought before South African courts, and I consider this next.

3. The Western Cape High Court's curious approach to medical guidelines

In this section I explore the courts' approach to guidelines in the context of Mrs Isaacs's unauthorised sterilisation. The trial court[93] comprehensively embraced medical guidelines while the appeal court[94] rejected the relevant guidelines, outright. I regard the appeal court's approach 'curious' because it contradicts the trend revealed above and by doing so it highlights several factors that might influence the weight assigned to guidelines in court. Before unpacking the appeal court's findings, I consider the trial court's position to set the scene.

Dr Pandie is a qualified obstetrician who supported Mrs Isaacs during her fourth pregnancy and childbirth. Her care plan included a caesarean section procedure and Dr Pandie sterilised her immediately after he performed the caesarean section.[95] The sterilisation procedure was performed even though Mrs Isaacs had explicitly refused to give consent for sterilisation upon admission into hospital on the day of the procedure. Her signed consent form collected and held by the hospital corroborates this fact.[96]

Dr Pandie testified that he was under the impression that she had consented because Mrs Isaacs allegedly gave her consent in his consultation rooms the day before she was admitted into hospital to give birth to her child.[97] He therefore included 'tubal ligation' in her hospital admission documents. Mrs Isaacs alleged that she repeatedly stated to Dr Pandie during her antenatal consultations with him that she was not interested in being sterilised.[98] In line with this, she refused to sign the consent forms when she saw tubal ligation was included therein and demanded that the consent form be amended before she signed it.[99] The nurses amended the consent form, she signed it, and she was taken to theatre.

Dr Pandie did not consult with Mrs Isaacs before she was taken to theatre, he did not inspect her file or consent form before commencing with the procedures, and he never spoke to her during the procedure.[100] Thus, he was not aware that she had not given

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[93] *Isaacs* (n 7).
[94] *Pandie* (n 3).
[95] *Isaacs* (n 7) [10].
[96] *Isaacs* (n 7) [70].
[97] *Isaacs* (n 7) [34].
[98] *Isaacs* (n 7) [7].
[99] Ibid.
[100] *Isaacs* (n 7) [36[; [37].

her consent for the procedure. Dr Pandie testified that before he commenced with the sterilisation, he asked an assisting theatre nurse whether they were continuing with the sterilisation, and she confirmed that they should proceed.[101] In addition to this verbal confirmation, the table with all the relevant surgical equipment was prepared for the performance of the sterilisation.[102] Dr Pandie testified that 'he does not take written consent from a patient in hospital. He was not aware whether his colleagues did so. He does not check whether the consent form is signed by the patient or not, and [he] was not aware whether his colleagues were doing likewise.'[103] According to Dr Pandie, it was the responsibility of the theatre nurses to inform him of the 'change'[104] and he considered it inappropriate to ask Mrs Isaacs if she wanted to proceed with the sterilisation after the conclusion of the caesarean section procedure because she 'would not have been in a position to give him a proper answer given the euphoria of her baby being born.'[105]

I pause here to emphasise that Dr Pandie's position is a reflection of medical paternalism and harmful gender stereotypes about women in childbirth, similar to those found in recent Namibian case law[106] and older English case law.[107] These present women as needing others to act in their best interests because women are perceived as being incapable of making a valid decisions during childbirth due of the pain and emotional stress associated with labour.[108] Medical paternalism and gender stereotyping are pervasive in present-day maternity care,[109] but South African courts rejected this approach in 1994 as South Africa transitioned towards a constitutional democracy. In *Castell v De Greef* the court declared that medical paternalism is based on outdated patriarchal attitudes and it recognised that the fundamental right to individual autonomy and self-determination demand a patient-orientated approach to establish standards of disclosure.[110] Thus, it is for the patient to determine whether to

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[101] Ibid.
[102] *Pandie* (n 3) [90].
[103] *Isaacs* (n 7) [36].
[104] Ibid.
[105] *Isaacs* (n 7) [37].
[106] *Government of the Republic of Namibia v LM* [2014] NASC 19.
[107] *Norfolk and Norwich Healthcare (NHS) Trust v W* (1996) 34 BMLR 16; *Rochdale Healthcare (NHS) Trust v C* [1997] 1 FCR 274. For a detailed analysis of this case law see Samantha Halliday, *Autonomy and Pregnancy: A Comparative Analysis of Compelled Obstetric Intervention* (Routledge 2016).
[108] For more on this issue, see Camilla Pickles, 'Sounding the Alarm: Government of the Republic of Namibia v LM and Women's Rights during Childbirth in South Africa' (2018) 21(1) PER 1, 12-18; Rebecca Cook and Simone Cusack, *Gender Stereotyping: Transnational Legal Perspectives* (University of Pennsylvania Press Philadelphia 2010), Rebecca Cook et al, 'Unethical Female Stereotyping in Reproductive Health' (2010) 109(3) Int J Gynaecol Obstet 255; Simone Cusack and Rebecca Cook 'Stereotyping Women in the Health Sector: Lessons from CEDAW' (2009) 16(1) JCRSJ 47.
[109] Christina Zampas, 'Human Rights and Gender Stereotypes in Childbirth' in Camilla Pickles and Jonathan Herring (eds), *Women's Birthing Bodies and the Law: Unauthorised Intimate Examinations, Power and Vulnerability* (Hart 2020) 79.
[110] *Castell v De Greef* 1994 (4) SA 408 (C) 422. It is noteworthy that this case was decided decades before *Montgomery v Lanarkshire Health Board* [2015] UKSA 11 and it was here where *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] AC 871 was

undergo any proposed treatment and the right to self-determination also protects a patient's right to refuse treatment, even if 'the patient's attitude is grossly unreasonable in the eyes of the medical profession'.[111] The court's position is supported by the Constitution of the Republic of South Africa[112] and it is reflected in the National Health Act,[113] Further, the Guidelines for Good Practice in Health Care Professionals Seeking Informed Consent issued by the Health Professions Council of South Africa[114] reflect this position too and these guidelines formed a key part of Mrs Isaacs' case against Dr Pandie.

The Guidelines for Good Practice in Health Care Professionals Seeking Informed Consent establish that:

> A health care practitioner providing treatment or undertaking an investigation, has the responsibility to discuss it with the patient and obtain consent … Where this is not practicable, health care practitioners may delegate these tasks …
>
> A health care practitioner will remain responsible for ensuring that, before he or she starts any treatment, the patient has been given sufficient time and information to make an informed decision, and has given consent to the investigation or procedure.[115]

This guidance reveals that while it might be acceptable for hospital staff to ensure signed consent is obtained (which is usual practice within the South African context), it remains the responsibility of the healthcare professional who performs the procedure to ensure that they have the relevant consent before beginning with any procedure. Mrs Isaacs' expert witness tendered evidence that supported the position taken in the guidelines.[116] Interestingly, even Dr Pandie's expert witness, Dr van Helsdingen, inadvertently supported the approach adopted in the guidelines too. He had written a chapter in *Basic Principles of Gynaecological and Obstetric Surgery,* a booklet used for teaching purposes in the Department of Obstetrics and Gynaecology at the

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rejected by Ackermann J as being 'out of harmony with medical malpractice jurisprudence in other common law countries.' In relation to its approach to disclosure requirements, the court aligned itself with Canada, Australia and the United States which all support the patient's right to informed consent. This is the first and last time *Sidaway* was referenced in a South African court. For further analysis see F Van Oosten, '*Castell v De Greef* and the Doctrine of Informed Consent: Medical Paternalism Ousted in Favour of Patient Autonomy' (1995) 28(1) De Jure 164; Rhiannon Thomas, 'Where to from *Castell v De Greef*? Lessons from Recent Developments in South Africa and Abroad Regarding Consent to Treatment and the Standard of Disclosure' (2007) 124(1) SALJ 188.

[111] *Castell* (n 110) 421-422.

[112] Sections 10 (right to dignity) and 12(2) (right to bodily and psychological integrity).

[113] 61 of 2003, ss 6 and 7.

[114] Health Professions Council of South Africa, 'Guidelines for Good Practice in the Health Care Professions Seeking Patients' Informed Consent: The Ethical Considerations' (Booklet 9, 2008)' <www.hpcsa.co.za/Uploads/editor/UserFiles/downloads/conduct_ethics/rules/generic_ethical_rules/booklet_9_informed_consent.pdf> accessed 28 August 2019.

[115] ibid.

[116] *Isaacs* (n 7) [31].

University of Cape Town.[117] It was developed for gynaecologists in training and postgraduates, and Dr van Helsdingen's chapter focused on the doctor's role in the consent process.[118] Therein he directs the reader to always 'check the consent form'.[119] When pressed on this statement, Dr van Helsdingen 'changed his stance and failed to explain what he meant by this'[120] and the court saw this as 'covering for the Defendant as he could not come out boldly and tell the court that the Defendant was wrong.'[121] Dr van Helsdingen testified that he adopts a similar approach to Dr Pandie and that 'he did not know of any surgeons who themselves checked the written consent form.'[122]

The trial court considered Dr Pandie's conduct within the broader context of the laws regulating general access to healthcare and the provision of contraceptive sterilisations, expert evidence and the Health Professions Council of South Africa's guideline and it found:

> By not checking the consent form before commencing the sterilisation procedure on the Plaintiff, I am of the view that the Defendant did not act like a diligens pater familias (reasonable person). Knowing the seriousness of the operation he was about to commence namely, reversible or irreversible in certain circumstances, the Defendant should have satisfied himself by checking the consent form. … The failure to check the consent form in my view was gross negligence.[123]

The trial court's approach to the guidelines falls in line with the general trend depicted in the discussion above. In this regard, the outcome of this case seems expectable. However, Dr Pandie appealed, and the appeal court took a very different approach towards the Health Professions Council of South Africa's guidelines.

While it appears that courts, in general, are aware that guidelines are not legally binding, guidelines appear to be particularly persuasive in relation evidencing the standard of care to be expected from healthcare professionals in South Africa. Despite this, the appeal court plays down this feature: 'guidelines do not have the status of law and are *merely* part of the evidential material to be weighed in determining the standards reasonably to be observed by doctors.'[124] The court's interrogation of the guidelines stops there and it did not evaluate the expected professional standard developed by the guidelines. Further, it did not take on board the fact that the Health

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[117] *Isaacs* (n 7) [84].
[118] ibid.
[119] *Isaacs* (n 7) [51].
[120] ibid.
[121] *Isaacs* (n 7) [84].
[122] *Pandie* (n 3) [76].
[123] *Isaacs* (n 7) [78.2]-[79].
[124] *Pandie* (n 3) [37]. Emphasis added.

Professions Council is tasked with the responsibility to develop standards of competence, care and conduct,[125] and that healthcare professionals are required to adhere to these more generally.[126] The appeal court's statement lays the foundation for the court to disregard the content of the guidelines. Their non-binding character, in addition to the complete lack of guidance from precedent-setting case law regarding the role of medical guidelines in law, allows the appeal court to regard these medical guidelines as entirely insignificant in this matter.

Its rejection of the guidelines clears the space for the court to explore other evidence that would demonstrate what might be reasonable in the circumstances. In this regard, and rather controversially, it went on to evaluate and re-establish the credibility of some of the witnesses who testified before the trial court.[127]

The appeal court found that Dr Pandie and Dr van Helsdingen were credible witnesses and that their testimonies were thus more persuasive, and their versions were probably closer to the truth. It was Dr Pandie's version that Mrs Isaacs had consented to the sterilisation during her last antenatal visit, and it was their version that it was not the general practice to inspect consent forms before procedures and that this would be the responsibility of the hospital staff.[128] This placed the responsibility squarely on the shoulders of the hospital staff and nurses who assisted in theatre on the day of the procedures.[129] The court held that 'given the expert evidence … I am not satisfied that the defendant's conduct, which appears to be in accordance with the standards of his profession, was in law negligent.'[130] Instead, '[i]t is clear that the hospital staff were negligent in not communicating to the defendant that the plaintiff no longer wanted the sterilisation and [that she] had refused to sign the required consent for sterilisation.'[131]

Furthermore, the appeal court found that Dr Rosemann, Mrs Isaacs's expert witness, had mistakenly relied on the Health Professions Council's guidelines.[132] This is because these guidelines are concerned with general informed consent and not consent for purposes of sterilisation procedures and for cases where patients have given consent but later changed their minds.[133] This approach overlooks the fact that all consent forms must be checked before healthcare professionals commence with

[125] Section 3 of the Health Professions Act 56 of 1976.
[126] *Oldwage* (n 2) [74]. Art 1 of the Guidelines for Good Practice in the Health Care Professions Seeking Patients' Informed Consent (n 115).
[127] *Pandie* (n 3) [49].
[128] *Pandie* (n 3) [73]; [84].
[129] *Pandie* (n 3) [79].
[130] *Pandie* (n 3) [90].
[131] *Pandie* (n 3) [91].
[132] *Pandie* (n 3) [88].
[133] ibid.

treatments or procedures, irrespective of the type of procedure. In fact, one would expect this to ensure that attending healthcare professionals are alerted to a patient's change of mind.

Pandie highlights four factors that seem to work together to reduce their value in court: First, guidelines are not legally binding and there is no case law offering direction on how to include them and when to draw from them. These circumstances leave courts with wide discretionary powers regarding the weight to be afforded to medical guidelines and whether they will be considered or not. Second, *Pandie* reveals that demonstrable collective non-compliance with the medical guidelines can render guidelines rather useless in the context of establishing evidence of a general practice and what can be reasonably expected of healthcare professionals in South Africa. This is concerning because the court's approach might hamper progressive improvement of healthcare services and it could frustrate efforts to offer services that protect and promote patients' rights more generally. Alarmingly, it did not seem to take much by way of expert evidence to convince the appeal court that there was a general practice in place that was contrary to that established by the guidelines. Third, the guidelines need to be very clear regarding the conduct the regulatory body aims to guide and the contexts in which the guidelines would be relevant.

Finally, another reason why the court may have so easily dismissed the guidelines could lie in the fact that these guidelines were concerned with ethical considerations rather than guidelines based on objective, scientific evidence regarding the best course of clinical action. Leahy explains that judicial consideration of medical guidelines on standard of care issues depends on the reliability and integrity with which those standards are derived.[134] While no South African court has offered any direction on this, one might expect courts to approach different types of guidelines differently with evidence-based guidelines holding more weight than guidelines informed by ethical considerations. However, it is difficult to overlook the fact that the guidelines in the *Pandie* matter reflect the position in South African law on informed consent[135] and thus support the broader values of patient autonomy and human dignity.[136] In 2016, the same guidelines were brought before the Western Cape Division and it reiterated: 'The guidelines [Seeking Patient's Informed Consent: The Ethical Considerations] incorporate the provisions of the National Health Act, which, together with the guidelines constitute a yardstick against which standards of professional conduct can be measured.'[137]

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[134] RE Leahy, 'Rational Health Policy and the Legal Standard of Care: A Call for Judicial Deference to Medical Practice Guidelines' (1989) 77 Calif L Rev 1483, 1515.
[135] Castell (n 110) and s 7 of the National Health Act.
[136] Human dignity is a protected human right and a founding constitutional value in the South African Constitution.
[137] *Daniels* (n 5) [124].

The South African position can be contrast to the position in the United Kingdom where it appears that guidelines drive the development of the law in relation to patient autonomy. Fovargue and Miola[138] emphasise that, historically, the standard of disclosure required by the General Medical Council was set higher than that demanded by the common law as set out in *Sidaway*.[139] The Supreme Court recognised this very issue in *Montgomery*,[140] and this suggests that courts are required to play 'catch up' and develop the law through the process of endorsing guidelines or relying heavily on guidelines as an indication of an acceptable route to take. *Montgomery* is evidence of this. While the Supreme Court's approach in *Montgomery* advanced patient autonomy, uncritical endorsement of guidelines may amount to judicial deference to medical authority and this approach would do little to promote autonomy and patients' bests interests beyond medical interests.[141]

It would not be unreasonable to expect the court in *Pandie* to be sensitive to South Africa's legal and broader regulatory context and engage these considerations, but instead it appears that the appeal court contorts itself into a position that protects Dr Pandie. According to Badul, the appeal court appears to bend over backwards to defend Dr Pandie's conduct.[142]

Badul suggests that this is because there was no evidence that Dr Pandie had an intention to harm Mrs Isaacs or to gain financially from performing the sterilisation procedure.[143] I agree with Badul to a certain extent; there is an uneasy sense that the court goes to great lengths to preserve the integrity of Dr Pandie and his expert witness, Dr Helsdingen. The appeal court rather controversially reassessed the credibility of expert witnesses who never testified before it. It found that Dr Pandie and Dr Helsdingen were credible despite the concerning facts that Dr Pandie was noted for probably doctoring his clinical notes[144] and Dr van Helsdingen contradicted himself in relation to what he teaches and what he practices.[145] While there were several inconsistencies in some of the testimonies the court offers no compelling explanation that would justify preferring one version over the other. In addition to this, the appeal

[138] Sara Fovargue and José Miola, 'One Step Forward, Two Steps Back? The GMC, the Common Law and 'Informed Consent' (2010) 36 J Med Ethics 494.
[139] (n 110).
[140] (n 110) [77]-[81].
[141] Foster considers this issue in Charles Foster, 'The Rebirth of Medical Paternalism: An NHS Trust v Y' (2019) J Med Ethics 3.
[142] CJ Badul, *The Coerced and Forced Sterilisation of Women Living with HIV in South Africa: A Critical Review of Existing Legal Remedies* (PhD thesis, University of KwaZulu Natal 2018) 61.
[143] ibid.
[144] *Isaacs* (n 7) [44].
[145] *Isaacs* (n 7) [86].

court filled in some of the gaps found in Dr van Helsdingen's testimony regarding what he meant by 'check the consent form':

> Given the summarised style of the six steps listed on the relevant page [in the chapter on consent], it would not be right to place too much weight on it as evidence of appropriate professional standards. Although the book is directed at gynaecological and obstetrical surgeons, step six *could perhaps mean that somebody must check the consent form, not necessarily the surgeon*.[146]

I suggest that the reason why the appeal court bends over backwards for Dr Pandie goes far beyond the specifics of Dr Pandie's intentions and lack of financial gain. The appeal court's approach appears to represent judicial deference to the medical profession and its authoritative knowledge.[147] To this end, I argue that this case demonstrates that the authoritative position of medical knowledge is a broader factor that might have a bearing on the application of medical guidelines in a given case, particularly in those cases where interests of a senior male healthcare professional are at risk. I unpack this next.

Jordan explains that despite there being multiple kinds of legitimate knowledge (or ways of knowing) some knowledge is deemed more powerful and authoritative than others, and thus carry more weight within a particular setting.[148] The authoritative nature of certain types of knowledge originates from the perception that these types of knowledge are able to explain things better and/or because they are associated with a stronger power base (formalised education, for instance).[149] The generation of authoritative knowledge is a social process; it builds from and reflects power relationships within a community of practice which creates a hierarchy of knowledge structures that cause the devaluation or outright dismissal of other forms of knowledge.[150] Authoritative knowledge is authoritative not because it is correct; it is authoritative because it is the knowledge that participants to a community agree that it counts.[151] To this end, they see it as consequential in that it serves as the basis to make certain decisions and it can be used to legitimise and justify particular conduct.[152]

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[146] *Pandie* (n 3) [86].
[147] For more on this trend, see Foster (n 137); Louise Austin, 'Grimstone v Epsom and St Helier University Hospitals NHS Trust:(It's Not) Hip to Be Square' (2018) 26(4) MLR 665; J Miola, 'The Impact of the Loss of Deference Towards the Medical Profession' in A Alghrani, R Bennett, and S Ost (eds), *Bioethics, Medicine and the Criminal Law: The Criminal Law and Biolethical Conflict: Walking the Tightrope,* vol 1 (Cambridge University Press, 2013) 223; S Sheldon, '"A Responsible Body of Medical Men Skilled in that Particular Art …": Rethinking Bolam Test' in S Sheldon and M Thomson (eds), *Feminist Perspectives in Health Care Law* (Cavendish 1998) 25.
[148] Jordan (n 52) 56.
[149] Ibid.
[150] ibid.
[151] Jordan (n 52) 58.
[152] ibid.

Professional medical knowledge is very well-established as the dominant form of knowledge in the context of health care.[153] Through the acquisition of authoritative knowledge, doctors themselves come to be in charge of the facts and they are vested with the authority to define the circumstances and practice boundaries; they define what counts as an illness, what constitutes best interests, competency, and so on.[154] Consequently, healthcare providers' level of education and technical biomedical knowledge confer superior social status on them in relation to their patients and this power imbalance influences how healthcare providers behave and how they are perceived more broadly.[155]

Authoritative knowledge places healthcare professionals in a particularly privileged position that comes with useful benefits, especially in the context of the law. In this regard, there is a long and very clear history of judicial deference towards the medical profession. For instance, judges are noted for identifying more with doctors and are more willing to question the decision of patients.[156] The goodwill and altruistic nature of healthcare professionals are regularly assumed and sometimes explicitly stressed by judges but the same approach is not afforded to claimants in medical law disputes.[157] Irwin and Jordan have explored the impact of the medical professions' authoritative knowledge in the context of the court-ordered caesarean-section procedures.[158] Their analysis reveals that courts have ordered caesarean sections without considering the reasons why women refused surgery and the orders were provided even though the law clearly did not support this approach.[159] They noted that women's voices were silenced in these cases and the law lost its authority; Irwin and Jordan argue that this is a consequence of authoritative knowledge:

> In spite of the fact that medical opinions change over time and that doctors often disagree with one another, assertions made by medical professionals are consistently respected by the members of this society, including the legal establishment.[160]

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[153] S Irwin and B Jordan, 'Knowledge, Practice, and Power: Court-Ordered Cesarean Sections' (1987) 1(3) Med Anthropol Q 319, 320.
[154] Jordan (n 52) 57, citing Paul Starr, *The Social Transformation of American Medicine* (Basic Books 1982).
[155] A Solnes Miltenburg et al, 'Disrespect and Abuse in Maternity Care: Individual Consequences of Structural Violence' (2018) 26(53) RHM 88, 102.
[156] Miola (n 147) 223; Sheldon (n 147) 25.
[157] ibid.
[158] Irwin and Jordan (n 153) 330. See also, AB Wolf, 'Metaphysical Violence and Medicalized Childbirth' (2013) 27(1) Int J Appl Philos 101.
[159] Irwin and Jordan (n 153) 330.
[160] ibid.

At times the privileged position afforded to the medical profession can manifest as form of 'legal protectionism'; Carstens explores this issue in the context of criminal medical negligence.[161]

The consequences of medical professional's authoritative position impacts jurisdictions around the world and this demonstrates that deference to medical knowledge can emerge as an embedded feature of the relationship shared between the judiciary and the medical profession. Erdman explains that legal rules are routinely 'read through and subordinated to a system of medical authority.'[162] Medical authority is well-positioned to 'foster a culture of impunity' where patient harms do not only go unremedied, but they eventually become unnoticed and morph into 'normal' clinical practice.[163]

When confronted with professional regulatory tools that are as legally porous as medical guidelines, the injection of medical authority might outshine the regulatory content of some guidelines. Clearly this is not always the case as the case law discussed earlier reveals that guidelines can be particularly persuasive. However, this then suggests that there are features of the *Pandie* matter that distinguish it from the case law considered earlier in this chapter. I will discuss three here, and I argue that these features render the matter fertile for authoritative medical knowledge and its privileged social standing to be particularly influential when it comes to deciding whether to incorporate medical guidelines in cases where these would help to establish liability.

First, it is noteworthy that *Pandie* concerns liability of an individual doctor acting in his own capacity. The judgments that have received and accepted medical guidelines as evidence of a reasonable standard of care all implicate the state which is vicariously liable for negligent conduct of the health care professionals it employs. Consequently, a finding of negligence in these instances casts a shadow over the state and it tarnishes the state's integrity rather than that of individual healthcare professionals. At most, the medical profession and its registered professionals are indirectly affected. The negligent staff are mere witnesses and their names are not recorded in the title of the judgment either. Thus, vicarious liability might serve to shield the integrity of

[161] P Carstens, 'Judicial Recognition of Substandard Medical Treatment in South African Public Hospitals: The Slippery Slope of Policy Considerations and Implications for Liability in the Context of Criminal Medical Negligence' (2008) 23(1) SA Public Law 168, 176; PA Carstens, 'Medical Negligence as a Causative Factor in South African Criminal Law: Novus Actus Interveniens or Mere Misadventure?' (2006) 19(2) SACJ 192, 209-210.
[162] JN Erdmann, 'Bioethics, Human Rights, and Childbirth' (2015) 17 HHR 43, 47.
[163] Erdmann (n 162) 48.

medical profession to a certain extent and it poses less of a threat to privileged position of medical professionals' authoritative knowledge.

Second, *Pandie* concerned the behaviour of a *specialist* medical professional (an obstetrician) while the other case law that incorporates guidelines into their assessment of negligence primarily involves nurses or midwives.[164] There is a long history of nurses being subordinate to doctors within the South African context[165] and the privileges attached to authoritative medical knowledge might not necessarily reach those professions that are typically perceived to be below specialist doctors. It is within this context that I want to return to *Mampoza* because *Mampoza* and *Pandie* share some similarities. Both concern non-compliance with established guidelines and one of the reasons for non-compliance rests on an existing hospital practice or policy. Sr Mpisane testified that her experience taught her to not administer pain relief medication during the last stage of labour because it has an 'effect' on the foetus and her decision was in line with hospital policy.[166] While the Guidelines for Maternity Care in South Africa do not support Sr Mpisane's position,[167] her evidence points to a contravening practice or hospital policy. Further, it seems that her concern for foetal well-being was corroborated by a separate expert witness for the state, Dr Shweni.[168] Finally, it is very well known that pain relief medication is a scarce resource in South African public healthcare facilities which suggests that there might be a policy/practice in place to establish who gets access to pain relief and when.[169]

In *Pandie*, the court seemed all too ready to reject the guidelines and part of the reason for this was because there was a contrary practice in place. *One* expert witness testified to this practice and his evidence was not particularly strong. In *Mampoza*, the Eastern Cape Local Division was very critical of Sr Mpisane's position on the administration of pain relief medication.[170] There was no interrogation of the hospital policy and the court seemed to overlook the fact that a portion of Dr Shweni's testimony reveals that there are concerns about foetal wellbeing in the case of administration of pain relief later in the birth process. I support the outcome in the *Mampoza* case, however, when compared to *Pandie*, it seems that Sr Mpisane was required to tender

[164] *Mucavele* (n 7) concerned both and midwives, but the doctors in this case were still completing their training programme. The case law (that incorporates medical guidelines) rarely concerns a specialist acting on their own.
[165] For instance, see Jewkes and others (n 53) 1783.
[166] *Mampoza* (n 7) [98].
[167] Department of Health (n 19) 37.
[168] *Mampoza* (n 7), at para [65], the Court appears to accept Dr Shewni's evidence that 'the effect of [pain] medication could make the baby suffer when given close to the time of delivery.'
[169] For instance, see SJ Oosthuizen et al, 'It Does Matter Where You Come From: Mothers' Experiences of Childbirth in Midwife Obstetric Units, Tshwane, South Africa' (2017) 14(1) Reprod Health 151. *Soobramoney* (n 82) demonstrates that courts are alive to these social complexities but they need to be argued specifically.
[170] *Mampoza* (n 7) [98].

far more evidence to persuade the court of the presence of collective non-compliance with the medical guidelines to justify non-compliance therewith.

Third, Dr Pandie got very bad press after the trial court found in favour of Mrs Isaacs. The local press went with the headline, '"Lying" doctor must pay up for surgery' and it reported that Dr Pandie's conduct 'constituted assault' and '[i]nconsistencies exposed during Pandie's cross-examination led to the conclusion that he was an outright liar.'[171] There is a very strong sense of sensationalism and a marked effort to villainise Dr Pandie. The trial court did find that Dr Pandie 'assaulted' Mrs Isaacs in terms of the civil law,[172] but the media failed to emphasise the tort/non-criminal dimension of this term. The trial court found that Dr Pandie was 'economic with the truth, and consequently failed to impress me as an honest and credible witness';[173] and the press used this to conjure the image of a 'lying doctor' which is a particularly jarring and stigmatic. These circumstances very clearly challenge the privileged position of the medical profession within South African society and the appeal court was especially disturbed by these narratives; it dedicated portions of its judgment to undo some of this damage.

The appeal court rejected the use of 'assault' in the South African civil law context where we do not recognise a separate collection of torts.[174] It found that 'assault' incorrectly misleads others into perceiving the conduct as intentional which comes with criminal condemnation.[175] Further, in relation to framing Dr Pandie as a liar:

> It would not be fair to conclude this matter without reverting to the trial judge's very critical remarks about the defendant, in which inter alia he branded the defendant an 'outright liar'. … To describe him as an 'outright liar' is obviously not in keeping with the findings in this court's judgment. I venture to suggest that in civil matters, where factual disputes often have to be resolved with reference to inherent probabilities, caution should be shown in expressing credibility findings in such strong terms. The fact that on balance one factual version is preferred over another does not normally justify leaving the losing party with the stigma of having been labelled by a court as an outright liar.[176]

The appeal court was very clearly influenced by the framing adopted by the press because the trial court did not use the 'liar' narrative. Such 'damage control' is rarely, if ever, used in medical negligence cases that implicate the state. The state regularly

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[171] A Hartley, '"Lying" Doctor Must Pay Up for Surgery' (Pretoria News, 21 May 2012) <www.iol.co.za/pretoria-news/lying-doctor-must-pay-up-for-surgery-1301327> accessed 13 August 2019.
[172] *Isaacs* (n 7) [66].
[173] *Isaacs* (n 7) [80.14].
[174] *Pandie* (n 3) [34].
[175] ibid.
[176] *Pandie* (n 3) [94].

receives bad press regarding the its poor performance in relation to the concerningly high rates of maternal mortality and morbidity but the Courts seldom attempt to undo the damage in their judgments, in fact they usually take to the state to task.[177]

Authoritative medical knowledge and the privileges it brings with it within the context of the law and the application of its rules could influence the way a court might receive evidence, including medical guidelines. I suggest that this issue needs further attention and the findings from further investigations could support the development of a more concrete framework to guide courts in these contexts and offer more transparency in relation to decision-making.

4. Conclusion

The relationship between medical guidelines and law is a neglected subject with little to no meaningful engagement emerging from South African medical law literature. Even the judiciary has remained relatively quiet on the subject, but for some conflicting statements every so often. While there is no precedent to draw from it is noteworthy that guidelines are beginning to play an increasing role in medical negligence litigation and the time is ripe to reflect on their value in law given this recent development.

The non-binding nature of medical guidelines is a given, but this says very little about their role more generally. This chapter reveals that medical guidelines play a particularly important role in establishing negligence. Their contribution in this respect is surprisingly complex and textured. There is no one-size-fits-all approach and various factors influence their acceptability and evidential weight. Guidelines developed from a strong evidence-base by an authoritative institution, that are subject to continuous revision, and that are sensitive to local context appear to be particularly weighty. Further, those guidelines that reflect law supported by human rights and constitutional values are also considered to be significant, so much so that in some instances they are deemed to be part of the 'legal framework'. The true effect of limited resources as a legitimate justification for non-compliance with guidelines in medical negligence matters is yet to be properly established given that litigation strategies appear to be rather weak. Nevertheless, more informed strategies might begin to emerge as debates and further insights are developed on the subject.

It is clear that courts are afforded a significant measure of discretion when it comes to including and weighing medical guidelines. Discretion creates the necessary space to effectively respond to and shape a judgment to the unique contours of individual matters. This chapter shows that discretion is especially important when a court is confronted with resource-related issues, contradicting expert opinions, and practices that are not aligned with established guidelines. However, *Pandie* is very concerning and the court's unjustified treatment of guidelines highlights some worrying facets of broad discretionary powers. There might be too much room for broader influences,

[177] A good example of this can be found in *Madida v MEC for Health for the Province of KwaZulu-Natal* JDR 0477 (KZP)

such as underlying bias towards medical professionals, and *Pandie* demonstrates that South African courts need a guiding framework in relation to their reception and weighing of medical guidelines in medical law matters.

WORD COUNT: 13192 (excl. abstract and keywords)