

SOUTH AFRICA / JUDGMENT

T.S and Another v Life Healthcare Group (Pty) Ltd and Another (10227/2014) [2017] ZAKZDHC 12; 2017 (4) SA 580 (KZD) (20 March 2017) [2017] ZAKZDHC 12

COURT

Kwazulu-Natal High Court, Durban

BEFORE

Ploos van Amstel

CASE / FILE NUMBER

10227/2014

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IN THE HIGH COURT OF

SOUTH AFRICA

KWAZULU-NATAL, LOCAL

DIVISION, DURBAN

REPORTABLE

CASE

NO: 10227/2014

In

the matter between: T.
S.
First
Plaintiff
M.
S. Second
Plaintiff
and
LIFE
HEALTHCARE GROUP (PTY) LTD
First
Defendant
DR
ABDOOL SAMAD
SULIMAN Second
Defendant

Order: The first defendant's claim against the second defendant
is dismissed with costs, including the costs of senior counsel.

JUDGMENT

Delivered on: 20 March 2017

PLOOS VAN AMSTEL J

- [1] The plaintiffs in this matter are the parents of a child who was born on 12 July 2008 in the Crompton Hospital in Pinetown, owned by Life Healthcare Group, which is the first defendant. The second defendant, Dr Suliman, is the specialist obstetrician and gynaecologist who attended to his birth. I shall refer to them as the hospital and Dr Suliman respectively where it is convenient to do so. The child suffered birth asphyxia while his mother was in labour, as a result of which he developed cerebral palsy. This led to a claim for damages by his parents in their personal capacities and on his behalf, against the defendants jointly and severally. In addition the first defendant issued a notice in terms of rule 13 of the Uniform Rules, in which it sought a contribution from the second defendant in terms of the provisions of the Apportionment of Damages Act 34 of 1956 (the Act). The issues relating to liability and the quantum of damages have been settled as between the plaintiffs and the defendants. The settlement agreement, in the form of correspondence between the parties' respective attorneys, forms part of the second defendant's trial bundle and records that the issue of liability (negligence and causation) was settled on the basis that the defendants undertook, jointly and severally, to pay to the plaintiffs a sum of R20 million. It also records that the offer was made without admission of negligence, breach of contract or liability on the part of the defendants. The plaintiffs played no part in the proceedings before me, which concerned the apportionment of liability as between the defendants pursuant to the third party notice.

- [2] The hospital accepts that there was negligence on the part of its nursing staff. Dr Suliman denies that he was negligent and says he settled the issues relating to liability and the quantum of damages without any admission that he had been negligent. He contends that the hospital is not entitled to a contribution from him and, in the alternative, contends for an apportionment in his favour.
- [3] I deal firstly with the facts, which were mostly undisputed. Mrs S. was 29 years old when she fell pregnant for the first time in 2007. She went into labour at about 10 pm on 11 July 2008 and went to the Kwadabeka Community Health Centre, where an early latent phase of the first stage of labour was diagnosed. The following morning she requested a transfer to the Crompton Hospital. She was admitted there at 10 am. On examination the foetal head was found to be 5/5[1], which was very high, and the cervix 2 cm dilated. Her obstetrician-gynaecologist, Dr Maise, was not available, but had arranged with Dr Suliman to cover for him. The hospital had obviously been informed of this arrangement as the nursing staff informed Dr

Suliman telephonically, at about 10.30 am, of Mrs S.'s admission and her condition. In the course of this conversation Dr

Suliman instructed Sister Savage, a midwife, to allow the labour to proceed and to sedate the patient if necessary. He prescribed

Pethidine[2] and Aterax[3] for this purpose.

- [4] At about 2.30 pm the patient was 4 cm dilated and requested pain relief. She was given the medication which Dr Suliman had prescribed

telephonically. The foetal heart rate was monitored by means of cardiotocography (CTG), which records the beats per minute as well as the contractions. At about 6.35 pm Sister Savage telephoned Dr Suliman, who had by then not seen or met the patient. She reported to him that the patient was 4 cm dilated with the head 3/5 above the pelvic brim. She also reported a deceleration of the foetal heart rate, as recorded by the CTG, at the height of a contraction, which she said recovered quickly. He ordered that the patient be transferred to the labour room, that her membranes be ruptured, that arrangements be made for an epidural[4] and that a further report be made to him at 8 pm. A second deceleration at about 6.40 pm, when the heart rate went down to 90 beats per minute, was overlooked by the nursing staff and not reported to him, although it was recorded by the CTG. At about 7.30 pm the cervix was 7-8 cm dilated and well effaced. The contractions were strong at 3 per minute, and Dr Suliman was informed. A further deceleration at about 7.40 pm was not reported to him. At about 9 pm he was informed that the patient was fully dilated. He arrived at the hospital at about 9.20 pm and did a vaginal examination. This was the first time for him to see the patient. The cervix was fully dilated but the foetal head was still 2/5 above the pelvic brim. When he looked at the CTG graphs he realised that the baby had been in distress for some time and had to be delivered as a matter of urgency. He asked for the vacuum, which is an instrument that is applied to the baby's head in order to assist in getting it out. The nurse, who was Sister Kuzwayo, could at first not find it. When she

eventually produced the vacuum it became apparent that she did not know how to use it. Dr Suliman could not

apply it on his own as two people were required to do so. He asked for a forceps and again the nurse could at first not find it. Dr Suliman said this delayed the birth of the baby by another twenty or twenty five minutes. At about 10.10 pm he performed an episiotomy[5] and the baby was born.

- [5] The baby was in a very poor condition and later developed cerebral palsy. An MRI[6] of the brain was performed on 30 October 2009 and revealed the after effects of perinatal hypoxic[7] ischaemic encephalopathy of a full term infant. The significance of the reference to a full term infant is that the insult to the brain occurred when the foetus was full term, in other words during labour.
- [6] It was common cause that the foetus was distressed while the mother was in labour. The cause of the distress is not known, although Dr Van Helsdingen thought the rapid rate of dilatation and the powerful contractions over a period of two and a half hours could have been the cause. The hospital accepts that there were warning signs on the CTG which should have been recognised by its nursing staff and that the deprivation of oxygen could have been prevented by delivering the baby by way of an emergency caesarean section.
- [7] The basis on which the hospital seeks a contribution from Dr Suliman is that he and the hospital are jointly and severally liable in delict to the plaintiffs and that they are joint wrongdoers as contemplated in the Act. In terms of section 2(12) read with section 2(6) (a) it seeks to recover from him a contribution in respect of his responsibility for such damage of such an amount as the court may deem just and equitable having regard to the degree in which he was at fault in relation to the damage suffered by the plaintiffs and to the damages awarded.
- [8] The relationship between a doctor and his patient is usually contractual. The doctor undertakes to treat the patient with the

required degree of skill and care, and the patient undertakes to pay his fees. These terms are probably seldom, if ever, agreed expressly, but those are the obligations that flow out of this kind of contract. In addition to the contractual duty to exercise the required degree of care and skill, the law also imposes such a duty on the doctor, with the result that if he fails in that duty he can be sued either in contract or in delict. In other words, he has a contractual obligation not to be negligent, and he also has a legal duty, independent of the contract, not to be negligent.[8] By way of example, where the patient was at all times unconscious and unable to conclude a contract, the doctor will nevertheless be under a legal duty not to be negligent where he has accepted responsibility for treating the patient. It is in the delictual context that the hospital contends that Dr Suliman owed the patient a legal duty and was negligent, and is liable for a contribution in terms of the Act.

- [9] I turn to consider the position of the doctor. The main submission on his behalf was that he owed the patient no legal duty until he arrived at the hospital as until then there was no doctor-patient relationship between them. He contends that Dr Maise was the patient's obstetrician and that he was merely covering for him in the event of an emergency or imminent delivery. He also denies that he was negligent, and in the event that it is found that he was, he denies that any negligence on his part was causally related to the injury to the baby.
- [10] In the light of the covering arrangement to which I have referred there was much debate before me as to when Dr Suliman's legal duty to the patient arose and what this duty required of him. The context of this is the requirement of wrongfulness in our law of delict.
- [11] Before I consider the issue relating to wrongfulness, or a legal duty as it is sometimes referred to, a brief reference to the pleadings is required. In the annexure to the third party notice, in which the hospital sought a contribution from the doctor, it was averred that Dr Suliman was the obstetrician whose duty it was to deliver the baby and that he accordingly owed the plaintiffs and their unborn child a duty to exercise such care and skill as could reasonably be expected of a competent and experienced obstetrician and without negligence.
- [12] He denied these averments in his plea to the third party notice and pleaded that the mother was not his patient, but that of Dr Maise, for whom he had agreed to cover for a few hours. He averred that he attended to the delivery of the baby and accepted that in doing so he was required to exercise the required degree of skill and care, but denied that he had been negligent. He also denied that he was under any obligation to attend to the mother in the hospital earlier than he did, which was when the delivery was imminent.
- [13] In argument before me, and in his heads of argument, counsel for the doctor submitted that no doctor/patient relationship existed between the doctor and the mother until he arrived at the hospital to attend to the delivery of her baby. He also contended, with reference to a number of American cases, that in the absence of a contractual doctor/patient relationship, there is no legal duty on a doctor which can give rise to liability on his part for harm suffered by a person. It is not clear to me that the American cases go that far. In *Holland St John MD v Pope and Pope*[9], a decision of the Supreme Court of Texas, a physician who was on call was telephoned at home by a doctor in the emergency room at a hospital. Having listened to the information provided to him telephonically the physician recommended that the patient be transferred to a different hospital as he did not have the required skill in neurology or neurosurgery. It later transpired that the patient had meningitis and he sued the physician who had declined to see him. The claim was dismissed on the basis that there had been no doctor/patient relationship. The court said it agreed with a number of cases where it was held that the duty to treat the patient with proper professional skill flows from the consensual relationship between the patient and physician, and only when that relationship exists can there be a breach of a duty resulting in medical malpractice. It also said that the creation of the physician/patient

relationship does not require the formalities of a contract, and the fact that a physician does not deal directly with a patient does not necessarily preclude the existence of a physician/patient relationship. In *Wheeler and Others v Yettie Kersting Memorial Hospital, Sergio Rodriguez and Others*,^[10] a decision of the Court of Appeals of Texas, Houston (1st Dist.), the court said the question was whether Dr Rodriguez actually rendered services to Mrs Wheeler, 'thus establishing a physician/patient relationship'. It will be surprising to find anywhere that a doctor who renders medical services to a person who arrives at the hospital in a state of unconsciousness, and therefore cannot conclude a contract, is not under a legal duty to exercise the required degree of care and skill.

^[14] Be that as it may, the test for wrongfulness in our law is different. It is trite and has been stated in many reported decisions. The general norm to be employed in determining whether a particular infringement of interests is unlawful is the legal convictions of the community: the *boni mores*. It is an objective test based on the criterion of reasonableness. The question is whether the community regards a particular act or form of conduct as delictually wrongful.^[11] The legal convictions of the community must be seen as the legal convictions of the legal policy makers of the community, such as the legislature and judges.^[12] In the case of an omission which causes harm to someone the omission will only be wrongful if in the particular circumstances a legal duty rested on the defendant to act positively to prevent harm from occurring and he failed to comply with that duty. The question of whether such a duty existed is answered with reference to the flexible criterion of the legal convictions of the community and legal policy.^[13] In *Le Roux v Dey*^[14] the Constitutional Court said that in the context of the law of delict the criterion of wrongfulness ultimately depends on a judicial

determination of whether – assuming all the other elements of delictual liability to be present – it would be reasonable to impose liability on a defendant for the damages flowing from specific conduct; and that the judicial determination of that reasonableness

would in turn depend on considerations of public and legal policy in accordance with constitutional norms. The Court added that what is meant by reasonableness in the context of wrongfulness has nothing to do with the reasonableness of the defendant's

conduct, but it concerns the reasonableness of imposing liability on the defendant for the harm resulting from that conduct.^[15] In *Telematrix (Pty) Ltd t/a Matrix Vehicle Tracking v Advertising Standards Authority SA*^[16] Harms JA said conduct is wrongful if public policy considerations demand that in the circumstances the plaintiff has to be compensated for the loss caused by the negligent act or omission of the defendant.

^[15] The test is no different in the case of a doctor, or so-called medical negligence. It is generally accepted in our law that a doctor who manages, treats or performs a procedure on a patient is under an obligation to do so with the degree of care and skill that can reasonably be expected of a doctor in his position. This is so whether or not there is a contract between them. In *Correia v Berwind*^[17] the court quoted the following with approval:^[18] 'In the

great majority of cases the duty owed by a medical man or a medical institution towards the patient is the same whether there exists a contract between them or not. Where there is no such contract, a duty arises by reason of the assumption of responsibility for the care of the patient; where there is such a contract, this duty in tort exists side by side with a similar duty arising out of the contract. But the implied contractual duty is normally the same as that which exists apart from contract'.[19]

[16] The question is therefore not whether there was a doctor/patient relationship between Dr Suliman and the patient. The question is whether public policy considerations, as explained in the authorities to which I have referred, require that Dr Suliman owed the patient and her unborn baby a legal duty and whether he should be held liable to compensate them for the damage caused by negligence on his part. Any omission by him at a time when he owed the patient no legal duty would not have been wrongful and he cannot be held liable for its consequences.

[17] Dr Suliman accepts that he owed the patient a legal duty once he arrived at the hospital to deal with the delivery. It is necessary

however to determine whether the legal duty existed earlier, at a time when it is contended that he failed to act as was required of a reasonable obstetrician.

[18] The question when the legal duty arose must be decided in the context of the relevant facts. The mother was not Dr Suliman's patient. Her obstetrician was Dr Maise, who had asked Dr Suliman to cover for him. Dr Suliman testified that it is common practice for an obstetrician to ask a colleague to cover for him while he is not available. This is obviously a sensible precaution and one readily understands that obstetricians are sometimes not available for personal or professional reasons. Dr Van Helsdingen, an experienced gynaecologist and obstetrician, and academic, who testified on behalf of the hospital, referred to it as 'a very familiar situation'.

[19] When Dr Suliman was asked to describe how the arrangement worked he said a colleague would phone and say that he was going to be unavailable for a while and ask whether he was available to cover him in the event 'of any emergency or any delivery or anything...'. On this particular occasion Dr Maise telephoned him and made the request some time between 9am and 10am.

[20] The patient was admitted to Crompton Hospital at about 10 am. She had gone into labour the previous day. A nursing sister telephoned Dr Suliman at about 10.30 am and informed him of the patient's admission. He knew that she was not his patient and that the hospital had phoned him because he was covering for Dr Maise. He instructed the nurse to allow the labour to proceed and to sedate the patient if necessary. He prescribed the medication required for this. It was common cause before me that at no stage during that day was there any indication to Dr Suliman that Dr Maise had become available again. The nurse phoned again at about 6.35 pm and reported to him on the progress of the labour. Again he gave telephonic instructions regarding the management of the patient. This happened again at

about 8pm.

- [21] Dr Van Helsdingen testified that in his view and in his experience, where an obstetrician covers for a colleague in respect of a pregnant patient, it is the responsibility of the covering doctor to look after the patient as if she is his own patient. He is, as Dr Van Helsdingen put it, '100 percent responsible for the care of the patient'. I think it is no exaggeration to say that Dr Van Helsdingen was horrified by the suggestion that the covering doctor's duty to take care of the patient only arises when he arrives at the hospital.
- [22] It is of course for the court to decide whether a legal duty existed at the relevant time, although the opinion of medical experts, such as Dr Van Helsdingen, as to what is regarded as proper and reasonable in the medical profession may be helpful in this regard.
- [23] This is not a case of a doctor who declined to treat a patient. It seems plain to me that by giving the nurse the telephonic instruction at 10.30 am Dr Suliman accepted the mother as his patient for as long as this was required, and a legal duty arose to manage her, the labour process, the unborn child and the delivery for as long as he covered for Dr Maise. I do not agree with the submission that Dr Suliman was doing no more than monitoring the situation in order to determine whether an emergency had developed. The process of labour is inherently dangerous and calls for expert monitoring and management of both mother and foetus. The implication of the case sought to be made by Dr Suliman is that during the process of labour there was no obstetrician who had the responsibility of managing the patient and her unborn child. Dr Maise was not available and Dr Suliman was not obliged or willing to do anything until an emergency developed or the delivery was imminent. I am satisfied that in those circumstances considerations of reasonableness and public policy require that the doctor should be held liable for the consequences of any negligent omissions on his part. He in other words had a legal duty to exercise the required degree of care and skill, and that duty arose at the latest at 10.30 am when he was informed of the patient's admission and gave telephonic instructions to the nursing staff with regard to her care.
- [24] This brings me to the question of negligence. With regard to what is reasonably expected of an obstetrician who has been informed that a patient who is in labour has been admitted to hospital, Dr Van Helsdingen said even in the case of a low risk patient he has to see her at least twice during the active phase of labour, and is required to verify that everything is well. One assumes that he also has to assess whether the patient is in fact a low risk patient. He said no reasonable obstetrician will leave the patient entirely in the hands of the nursing staff until the baby is about to be born. Dr Suliman confirmed that he would normally go and see his own patient within three or four hours after admission. His explanation as to why he did not see the first plaintiff in the hospital while she was in labour was unacceptable. He said he did not want to interfere with the personal relationship that existed between the patient and her own obstetrician as this could cause anxiety on her part, and he did not want there to be a discrepancy between his management of the patient and that of Dr Maise. The alternative of no obstetrician examining and managing her while

she was in labour was unreasonable and not in her interest or that of her unborn baby.

[25] An instrument known as a cardiotocograph was used by the nursing staff to monitor the regularity and duration of the patient's

contractions, and the foetal heart rate. Dr Van Helsdingen explained that one does not only look at the rate of the foetal heart, but also the baseline variability, which reduces when the foetus is not getting enough oxygen. One also has to look for decelerations in the heart rate and their relationship with the mother's contractions. He said it is common knowledge that the interpretation

of CTG graphs is fraught with interpersonal and intrapersonal variability because the valuation is not always easy. They are controversial and 60 % of positive CTG's are false positives. An average obstetrician is expected to have a reasonably good insight as to what is a normal or abnormal CTG. It is also expected of a nursing sister to know when a CTG is abnormal, but they are not expected to be able to diagnose what the cause of the abnormality is.

[26] Dr Van Helsdingen said if non-reassuring decelerations are detected the reasonable obstetrician would stay with the patient for the next couple of hours and see what sort of pattern develops. His main criticism of Dr Suliman was that by the time the nurse phoned him at about 6.30 pm the patient had been in the hospital for about eight and a half hours and had not been seen by a doctor. It was her first pregnancy and he would have expected Dr Suliman to go the hospital within an hour or so after this call and verify for himself that everything was in order. This was also Dr Harris' view. An important point made by Dr Van Helsdingen is that CTG tracings should not be looked at in isolation. They must be considered in the context of the progress of the labour. He said Dr Suliman should have gone to see the patient within an hour or so to satisfy himself that the information given to him by the nursing staff was correct and to verify for himself that everything was in order. He said an early visit to see the patient would have alerted Dr Suliman to the high head, which made her a high risk patient which required a frequent and vigilant observation. This underlines why an obstetrician who has not seen a patient who was admitted eight and a half hours earlier, cannot sit at home and judge the situation simply on what the nursing staff reports telephonically about the CTG readings. Dr Suliman accepted in his evidence that a reasonable obstetrician will not rely exclusively on the midwife. He said if the patient had been his he would have gone to check for himself. The reason he did not go was that he regarded her as Dr Maise's patient.

[27] This was a serious lapse which fell short of the degree of care and expertise that was expected of him as a specialist obstetrician. He was accordingly negligent.

[28] To summarise thus far, in my view Dr Suliman owed the patient a legal duty as a specialist obstetrician from the time that he was notified of her admission and started to manage her treatment, and he was negligent in not examining her earlier and verifying for himself that everything was in order. It remains to consider the question of causation.

- [29] Dr Suliman was criticised by the expert witnesses for not having gone to the hospital earlier to see the patient. She was admitted at about 10.30 am and it was said that he should have gone to see her within a few hours after this. The main purpose is to reassure her and see that everything is in order. Dr Suliman agreed with this in principle and said he normally does so in the case of his own patients. It however seems clear that had he gone to see Mrs S. within a few hours of her admission he would have found nothing untoward.
- [30] During the phone call from Sister Savage at about 6.35 pm he was told that there had been a deceleration in the foetal heart rate at the height of a contraction but that it had recovered quickly. The experts agreed that this information would not have been a matter of concern. Dr Van Helsdingen and Dr Harris said Dr Suliman should nevertheless have gone to see the patient within an hour or so after this phone call, as by then he had not seen her at all.
- [31] If Dr Suliman had done so, he would have arrived at the hospital at about 7.30 pm. It may be accepted that after an examination of the patient and an inspection of the CTG graphs he would have realised that there was a problem and that an emergency caesarean section had to be done. It seems from the evidence that at best this would have taken 30 minutes, and probably a bit more.
- [32] The question is whether this would have avoided the harm that caused the cerebral palsy. Dr Van Helsdingen's evidence was that he could not say that the baby would have been saved if it were delivered by caesarean section at some time between 7.30 and 8 pm. He also said, in response to a question about causation: 'I cannot even begin to answer the question whether that would have salvaged the baby and I don't think anybody can tell you that, M'Lord'. It was pointed out to Dr Van Helsdingen by counsel for the hospital that he and Dr Cronje had stated in a joint minute that it was likely that the brain damage had occurred after 8 pm or perhaps after 9 pm. When he was asked whether there was a specific reason for that opinion his answer was: 'No, I don't think there is, it is almost impossible to estimate how long it takes it depends on the degree of hypoxia. I think it was estimated on the basis of what the CTG picture showed after 20:00'.
- [33] It is trite that a court cannot simply accept the say so of an expert who expresses an opinion on a matter within his field of expertise. The court must consider whether it can safely accept the opinion and it will have regard to whether the opinion appears to be reasonable and logical and what the reasons for it are. The opinion expressed in the joint minute that the damage probably occurred after 8 pm and perhaps 9 pm was not supported by reasons and appears to have been no more than an estimate based on the CTG graphs after 8 pm. What in those graphs supported the estimate was not explained. And when Dr Van Helsdingen was asked whether there was a specific reason for the opinion he said he did not think so. He was very clear in saying that he could not say when the brain damage occurred or whether the baby would have been saved by a caesarean section at about 8 pm. He said it was possible that by then the Rubicon had been crossed. It is true that Dr Suliman did not contend that a caesarean section at 8 pm would have been too late, but I think it is clear that he simply did not know.

- [34] The onus to prove a causal link between Dr Suliman's negligence and the cerebral palsy suffered by the baby was on the hospital. This had to be established on a balance of probabilities. In this case it had to be shown that if Dr Suliman had gone to the hospital an hour after the 6.35 pm phone call, as the experts said a reasonable obstetrician would have done, the baby would not have suffered cerebral palsy. In the light of the evidence of Dr Van Helsdingen I agree with counsel for the doctor that this was not established on a balance of probabilities.
- [35] I find therefore that Dr Suliman was negligent and in breach of his legal duty to the patient by not exercising the required degree of care, but I am unable to find that had he acted as it is said he should have, the tragic outcome would have been avoided.
- [36] The first defendant's claim against the second defendant is dismissed with costs, including the costs of senior counsel.

Ploos van Amstel J

Appearances:

For the First Defendant : B A Acker SC

Instructed by

: Norton Rose Fulbright South Africa Inc.

Durban

For the Second Respondents : O A Moosa SC

Instructed by : Pather & Pather Attorneys Inc.

Date Judgment Reserved : 13

February 2017

Date of Judgment

: 20 March 2017

[1] This is a reference to how many fingers the head was above the pelvic brim.

[2] A painkiller and sedative.

[3] For nausea.

[4] A form of anaesthesia, administered by an anaesthetist.

[5] Cutting the outlet of the vagina so as to facilitate the birth of the child.

[6] Magnetic resonance imaging.

- [7] The deprivation of oxygen before it was born.
- [8] *Correira v Berwind* 1986 (4) SA 60 (ZHC)
- [9] 901 S.W.2d 420 (1995)
- [10] 866 S.W.2d 32 (1993)
- [11] Neethling, Potgieter, Visser, *Law of Delict*, 6th ed, p36-41 and the cases cited there.
- [12] *Ibid.* p42
- [13] *Ibid.* p57
- [14] *Le Roux and Others v Dey* (Freedom of Expression Institute and Restorative Justice Centre As Amici Curiae) 2011
- (3) SA 274 (CC) para [122].
- [15] Also see *Gouda Boerdery BK v Transnet* 2005
- (5) SA 490 (SCA) par [12] and [13].
- [16] *Telematrix (Pty) Ltd t/a Matrix Vehicle Tracking v Advertising Standards Authority* SA 2006 (1) SA 461 (SCA) para 13.
- [17] *Correira v Berwind* 1986 (4) SA 60 (ZHC) at 63H.
- [18] Lord Nathan, *Medical Negligence*, p15.
- [19] Also see *The Law of South Africa*, 2nd ed, Volume 17 Part 2, par 30.
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