CLINICAL NEGLIGENCE IN SOUTH AFRICA

INTRODUCTION

Medicine is a noble profession. Yet South Africa is currently in the midst of a serious crisis flowing from medical negligence, causing untold harm to multiple victims. The whole of the medical profession, and not only those who are directly involved in negligence lawsuits, suffer reputational harm and loss of emotional wellbeing. In addition to indemnity insurance premiums of hundreds of thousands of rand per annum, surgeons suffer wasted time, loss of earnings, and diminished attention to other patients, reputational harm and emotional trauma. In addition to financial harm running into millions of rand per individual, patients suffer pain, emotional trauma and losses of amenities, dignity and the capacity to work. In addition to wasteful expenditure running into billions of rand per province, the diversion of funds intended for equipment, medication, salaries etc. towards the payment of court awarded damages, results in increased risk of adverse outcomes and negligence claims due to depletion of resources. The so-called “bleeding of the public purse”, runs into many billions of rand causing the national economy to suffer a reduction of the productive workforce, with increased fear and loss of confidence.

This problem will be addressed in 5 sections, namely what it is, who is responsible, how the law responds to it, why it occurs and potential solutions.

1. WHAT IS CLINICAL NEGLIGENCE?

Medical negligence and malpractice are legal concepts, amounting to wrongful actions as found by courts of law. For purposes of this article, negligence and malpractice will be treated as the same concept, referring to wrongful conduct of omission, commission or both.

Negligence refers to a **wrongful act or failure to act**, which causes **foreseeable harm** in circumstances where it would have been reasonable to prevent such harm[1].

Medical treatment, or failure to treat appropriately, is judged by South African courts to amount to negligence when it falls **below the standard** of a **reasonable practitioner** in **that discipline** under the **prevailing circumstances**. Each one of these 6 highlighted criteria is taken into account by the courts.

When is a treatment, or a mistake, negligent?

Medical complications may occur for any of 3 types of reasons, namely: -

Group 1 – Unavoidable, naturally occurring complications. These are not mistakes nor do they constitute negligence.

Group 2 - Mistakes that are judged to be reasonable under the

[1] The classic test for negligence has been set out in *Kruger v Coetzee* 1966 (2) SA 428 (A) at 430 E.

circumstances. These do not constitute negligence.

Group 3 – Mistakes that are judged to be below the reasonable standard, and therefore negligent.

Medical practitioners differ in levels of individual professional skill and ethical behaviour. Their differing standards of practice can be grouped into 5 identifiable standards, namely: -

Level 1 – The best standard.

Level 2 – A good standard.

Level 3 – An average standard.

Level 4 – A reasonable standard that is below average.

Level 5 – Negligent standard, i.e. below the reasonable standard

Doctors who practice in the top 3 levels are mostly immune to law suits. However, unfortunately even they may slip or fail on occasion, usually under adverse circumstances.

2. WHO IS RESPONSIBLE FOR NEGLIGENT HARM?

Each doctor who negligently harms a patient is personally responsible. However, each individual case of negligent harm caused to a patient, detrimentally affects the public perception of the medical profession as a whole. All medical professionals become collectively responsible if nothing is done to reduce the occurrence of medical negligence.

Our training institutions, licensing authorities and health facilities bear an equal measure of responsibility for harm caused by any medical professionals who are inadequately educated and trained, and for those who are employed in adverse circumstances.

As much as fingers may be pointed at claimants, attorneys, expert witnesses, advocates, presiding judicial officers and providers of indemnity insurance, and as much as certain of them may be dishonest, unethical and/or unfair, these so-called “enemies of doctors” are not responsible for medical negligence. They only come into the picture after negligent harm has occurred. Their involvement is “downstream” whereas the real causes of medical negligence occur “upstream”.

How is it possible that such harm occurs at the hands of a noble profession?

Is it that noble doctors care some of the time but stop caring when the going gets tough?

Is it that we, as a society and a profession, allow ignoble individuals to get a scientific education, take the Hippocratic oath with fingers crossed, and then allow them to proceed to masquerade as real doctors?

Who is to blame when a patient suffers negligent harm?

Inadequate resources compromise many medical practitioners, at all levels of professional competence. Certain doctors who practice at a negligent standard may be ethical in their hearts, but compromised by

inadequate education, training and/or facilities. In such cases blameworthiness would lie with the training institutions, educators, licensing authorities, politicians, government officials and administrators.

The appointment of inadequately trained and experienced tutors at training hospitals would naturally lead to increased medical negligence claims by patients treated at such hospitals. Just as passengers in a commercial aircraft rely 100% on the skill and training of the pilot for their safety, so do patients rely implicitly for their safety on the competence of medical practitioners. It is an unfortunate reality that many of the medical claims emanating from state hospitals, and giving rise to the present crisis, can be traced back to inadequate training.

The rest of the medical practitioners, who despite adequate education, training and resources practice at the negligent standard, as well as those who normally practice at higher levels, but who are occasionally responsible for negligent mistakes, are personally blameworthy for their failure to maintain reasonable norms and standards.

3. HOW DOES THE LAW RESPOND TO CLINICAL NEGLIGENCE?

In general, and according to the proper application of the law, South African Courts are fair to doctors. This is contrary to popular medical belief.

It is trite to say that the onus to prove the existence of negligence, on a balance of probabilities, rests with the claimant. There is no onus on a medical practitioner being sued to disprove the existence of negligence. Thus, if the claimant fails to discharge the onus of proof, or if the probabilities are evenly balanced, a court cannot find the medical practitioner negligent.

Adverse outcomes associated with treatment by doctors who practice at below average levels, but which are judged to be reasonable under the prevailing circumstances, are accepted and not punished. It should be remembered that the standard required is not that of the exceptionally skilled, gifted or diligent surgeon, but only the ordinary surgeon acting reasonably in the prevailing circumstances[2]

The occasional mistake of a doctor who normally practices at a high level, but who has slipped or failed in a way that is judged to be reasonable under the circumstances, is likewise accepted and not punished.

It is only when treatment is proven to have been below the standard of a reasonable practitioner in that particular discipline under the prevailing circumstances, that South African Courts make a finding of negligence.

Despite the fairness in most instances, once a finding of negligence is made, the gloves come off and the doctor is ordered to pay the full

[2] See "*The Practitioner's Guide to Medical Malpractice in South African Law"* by Ian Dutton at page 89.

amount of proven damages. These awards often amount to many millions of rand in individual cases.

4. WHAT ARE TYPICAL EXAMPLES OF CLINICAL NEGLIGENCE?

In addition to repeat offenders, who are known to practitioners in the field of negligence litigation, there are also repeat offences that keep on cropping up as acts and/or omissions that end up in expensive and drawn out litigation, costing the individuals, the state and tax payer dearly.

By way of example, a review of negligence claims in spinal surgery, reveals the following repeat offences. (Experts in other fields will be able to provide similar examples in their fields.)

Pre-operative – Private practice: Recurring negligent errors in private practice include unnecessary surgery; unnecessarily complex and expensive surgery; lack of obtaining prior informed consent from the patient and failure to record and safely retain adequate medical notes.

Pre-operative – State practice: Recurring negligent errors in spinal surgery performed in state practice are caused inter alia by insufficient resources; undue delay in performing urgent surgery; failure to perform necessary surgery; lack of informed consent and failure to record and safely retain adequate notes.

Intra-operative: Recurring intra-operative negligent errors in spinal

surgery include operating at the wrong level[3]; failure to decompress spinal cord or nerve roots; injury to spinal cord or nerve roots; malposition of instrumentation; injecting into the spinal cord instead of a joint and failure to record and retain adequate notes.

Post-operative: Recurring post-operative negligent errors in spinal surgery include failure to order, perform and record regular neurological observations; failure to respond appropriately to complaints that may herald a serious complication; delay in surgical evacuation of post-operative haematomata and failure to record and retain adequate notes.

Doctor/patient interaction: Recurring general errors include failure to communicate adequately with patients[4]; failure to demonstrate respect for patient concerns and dignity; failure to act in accordance

3 See "InSpine" Volume 8, Issue 3, page 12.

4 See "InSpine" Volume 8, Issue 3, page 13 where the following is stated: "More often than not, claims of professional negligence and medical malpractice are founded by emotionally driven complaints stemming from strained physician-patient relationships and communication breakdowns rather than actual professional negligence. In fact, a survey of 1884 randomly chosen Massachusetts physicians investigating the impact of electronic Health Records (EHR) found there was no evidence of negligence in 83% of the claims filed against these physicians. Some of them most recurring complaints from patients we'll have filed negligence claims against their physicians include not being listened to, impoliteness by medical staff, a lack of understanding of diagnosis and treatments, and being addressed in an undignified manner."

with standard ethical rules and guidelines; failure to apologize when an apology is appropriate and failure to record and retain adequate notes.

5. POTENTIAL SOLUTIONS

Myths - failed attempts that have not worked and will not work

The problems that flow from medical negligence cannot be solved by blaming others; by calling for help from others; or by debating popular and counterproductive views on “defensive medicine” practices. Such incorrect views include for example “what would the lawyer expect me to do?” or “let me do a scan for the sake of the lawyers”.

It is madness to keep repeating the same behaviour and hoping for a different outcome.

Who is going to fix the problem?

As much as surgeons may wish and even demand that attorneys, expert witnesses, advocates, judges and providers of indemnity insurance must fix it, they cannot do so as they are not the cause of the problem.

If medical practitioners really want the problem of being sued to go away, then, in the first instance, doctors individually, and the medical profession collectively, must search their consciences, identify and stop the primary and direct contribution of doctors to the crisis.

In the second instance, politicians, government, educators, the HPCSA and administrators responsible for education, training, licensing and resources, must search their consciences and remedy

their considerable background contribution to the crisis.

Effective solutions

It is logical to consider solutions to the crisis in three clearly separate groups: -

Upstream interventions: These are directed at the prevention of medical negligence from the outset. They fall squarely on the shoulders of the medical profession. The solutions recommended in this article focus on upstream medical interventions.

Downstream interventions: These are directed at containment of the costs and other harm after the horse has bolted. These fall primarily on the shoulders of the legal profession, but also on those of expert witnesses and the medical profession as a whole. In the Declaration of the National Department of Health, produced pursuant to the Ministerial Health Summit held in March 2015, provision is made inter alia for 2 important processes, namely peer review and mediation.

Background interventions: These are directed at the adequacy of education, training, licensing and resources. As referred to above, these fall on the shoulders of politicians, government officials, universities, the HPCSA and hospital staff. It is beyond the scope of this article to discuss the responsibilities of these entities.

It is the responsibility of every doctor to employ reasonable upstream interventions to prevent negligent harm. The more the medical profession occupies the moral high ground, by demonstrating high professional and ethical standards, the louder and more persuasive will be their calls to those responsible for downstream- and

background interventions.

6. UPSTREAM INTERVENTIONS

ETHICAL PRACTICE BY INDIVIDUAL DOCTORS

In circumstances that a patient has suffered harm, but in which one can show that the mistake occurred despite the doctor's adherence to ethical standards, South African Courts are **most unlikely** to find the doctor liable for damages.

To keep lawyers out of your life, don't ask yourself "what would the lawyer expect me to do?" Instead ask yourself, "What would a good doctor do?" The best method of defensive practice is the same as the best method of good practice. What is best for the patient is also best for the doctor.

MEDICAL ETHICS is the key to protecting medical practitioners from legal claims.

How can doctors be taught or influenced to be ethical?

This question is deliberately provocative. More accurately, the question should be rephrased in two parts as:

"How can the minority of unethical doctors be taught and/or influenced to be ethical?" And

"How can the majority of doctors who are usually ethical, or fairly ethical, be taught and/or influenced to enhance their levels of ethical practice and to be ethical all the time?"

The authors have come to realize that a doctor will only be ethical if he or she wants to be ethical. This poses a deeper question, i.e.

> "How can doctors be taught or influenced to want to be ethical?"

Shock and dismay at the magnitude of harm, that has flowed from medical negligence to so many over the years, makes it imperative to find practical and effective answers to these questions .

How to ensure that one maintains ethical standards

To ensure the maintenance of ethical standards it is useful to regularly subject oneself to the following personal introspection, being honest with oneself at all times : -

Consider whether you are adequately trained to select, plan and perform the required operation or treatment safely[5].

If the answer is, no, refer the patient to a better-educated and

[5] An honest self-appraisal will also include considering your age related competency. See "InSpine", Volume 7, Issue 4, pages 11 – 15.

trained colleague.

If an honest answer produces uncertainty, consult a mentor or get a second opinion. A recorded second opinion is of immense value to self-protection.

If an honest answer indicates that you are adequately educated and trained, take sensible and practical steps to reduce the risks of mistakes and complications.

Ask yourself if you really want to be ethical or not?

If your honest answer is no, seriously consider finding a different occupation.

If the answer is, yes, make a habit of taking regular and purposeful steps to enhance the ethical nature of your practice.

Interrogate your own ego, hubris and conscience.

Consider whether it is in your own best interests to succumb to the dictates of your ego or hubris (e.g. bragging to colleagues or presenting a paper on your own achievements).

Consider whether it is better and safer to hearken to the voice of your conscience (e.g. when consulting with a patient,

deciding whether or not to offer a treatment or operation[6], planning a treatment or operation and obtaining informed consent).

Find and regularly consult a mentor.

If you believe that you know so much that you no longer need, or cannot find, a mentor in your own discipline, find one in the fields of law or philosophy.

Ethical rules and guidelines of the HPCSA

Read, understand and apply the ethical rules and guidelines of the HPCSA. These are readily available in the form of 16 separate booklets:[7]

Booklet 1 - General Ethical Guidelines for Good Practice.

Booklet 2 - Ethical and Professional Rules of the Health

6 Consider possible conflicts of interest between the patient's welfare and your commercial ties to hospital or suppliers of medical equipment. See Roberto Chapa MD at www.aospine.org.

7 See http://www.hpcsa.co.za/Conduct/Ethics

Professions Council of South Africa as Promulgated in Government Gazette R717/2006.

Booklet 3 - Patients' Rights Charter.

Booklet 4 - CPD Guidelines.

Booklet 5 - Perverse Incentives.

Booklet 6 - Generic Ethical Guidelines for Researchers.

Booklet 7 - Medical Biotechnology Research.

Booklet 8 - Biological Warfare.

Booklet 9 - Informed Consent.

Booklet10 - Confidentiality Protecting and Providing Information.

Booklet 11 - Good practice with regard to HIV.

Booklet 12 - Withholding and Withdrawing Treatment.

Booklet 13 - Reproductive Health.

Booklet 14 - Keeping of Patient Records.

Booklet 15 - Health Care Waste Management

Booklet 16 - Undesirable Business Practice.

In order to comply properly with the requirements of the HPCSA, and to protect oneself from disciplinary action by the HPCSA, it is advisable to adhere to the contents of each of these booklets that are applicable to your particular practice.

It is also advisable to study and comply with discipline specific guidelines published by specialist associations and other authoritative peer-reviewed groups.

Renew your commitment to comply with each rule and guideline on a regular basis. Surgeons who are naturally ethical in their hearts,

i.e. those who genuinely care about and respect the humanity, dignity and rights of their patients, should have no difficulty complying with ethical rules and guidelines.

Compliance with essential ethical rules for the purpose of remaining immune to claims for negligence

In order to keep yourself safe from being sued for medical negligence, it is necessary to adhere to the 13 core values set out on pages 2 and 3 of Booklet 1 (general ethical guidelines), namely:

> *"2.3 The core ethical values and standards required of health care practitioners include the following:*
>
> *2.3.1 Respect for persons: Health care practitioners should respect patients as persons, and acknowledge their intrinsic worth, dignity, and sense of value.*
>
> *2.3.2 Best interests or well-being: Non-maleficence: Health care practitioners should not harm or act against the best interests of patients, even when the interests of the latter conflict with their own self-interest.*
>
> *2.3.3 Best interest or well-being: Beneficence: Health care practitioners should act in the best interests of patients even when the interests of the latter conflict with their own personal self-interest.*
>
> *2.3.4 Human rights: Health care practitioners should recognise the human rights of all individuals.*
>
> *2.3.5 Autonomy: Health care practitioners should honour the right of patients to self-determination or to make their own informed choices, and to live their lives by their own beliefs, values and*

preferences.

2.3.6 Integrity: Health care practitioners should incorporate these core ethical values and standards as the foundation for their character and practice as responsible health care professionals.

2.3.7 Truthfulness: Health care practitioners should regard the truth and truthfulness as the basis of trust in their professional relationships with patients.

2.3.8 Confidentiality: Health care practitioners should treat personal or private information as confidential in professional relationships with patients - unless overriding reasons confer a moral or legal right to disclosure.

2.3.9 Compassion: Health care practitioners should be sensitive to, and empathise with, the individual and social needs of their patients and seek to create mechanisms for providing comfort and support where appropriate and possible.

2.3.10 Tolerance: Health care practitioners should respect the rights of people to have different ethical beliefs as these may arise from deeply held personal, religious or cultural convictions.

2.3.11 Justice: Health care practitioners should treat all individuals and groups in an impartial, fair and just manner.

2.3.12 Professional competence and self-improvement: Health care practitioners should continually endeavour to attain the highest level of knowledge and skills required within their area of practice.

2.3.13 Community: Health care practitioners should strive to contribute to the betterment of society in accordance with their professional abilities and standing in the community."

Further specific recommendations

Just as there are common repeat offences that invariably lead to trouble, there are particular skills and habits that are effective in keeping patients safe and in keeping both doctor and patient happy. These include: -

Patient oriented bedside manner. Show that you care, both in your verbal and non-verbal communication. Remind yourself that about 80% of your communication is non-verbal and only 20% is verbal.

Authentic communication with active listening. Explain in non-medical terminology your recommendations, available alternative treatment options, expected results, risks and potential complications to your patient. Use language and speak in a context that your patient can understand, and confirm that you have been understood. Listen actively to the concerns and questions of your patient and answer them to satisfaction. Spending time to ensure proper and adequate communication with the patient at this initial stage of the process, will curtail later recriminations, accusations and misunderstandings that could lead to unwanted or unnecessary litigation.

Thorough and appropriate preparation. Review an appropriate reference book or article on avoidance of complications with the intended procedure. Make use of

appropriate checklists[8]. Communicate your intentions as well as plans to avoid complications to your anaesthetist and scrub sister.

Review of and adherence to discipline specific guidelines. These extremely valuable guidelines, which relate to particular pathological conditions and procedures, are typically published as peer reviewed consensus documents by specialist associations or interest groups.

Mindfulness during surgery. Apply all your skill and maintain your full attention and concentration throughout the operation. Keep patient safety at the forefront of your mind.

Attentive post-operative management. In addition to writing down post-operative instructions for nursing staff (see below), ensure that the responsible staff understands the procedure, the instructions and the potential complications. Also ensure that they understand the importance of observing the patient

[8] See “InSpine” Volume 7, Issue 1, page 10.

regularly, recording patient responses to the surgery and alerting you timeously as and when necessary.

In addition, it is the responsibility of the surgeon to examine the patient post operatively. The intervals of examination that are required vary according to the pathology, the procedure and other circumstances that the surgeon needs to determine.

At the time of any complication or unexpected event, or any reported symptom that may represent a post-operative complication or unexpected event, or at any stage that the patient is unhappy, the surgeon should take the appropriate steps that are required at any first consultation or emergency consultation. These include enquiry, examination, investigation, analysis, diagnosis, a plan of action and, depending on the seriousness of the situation, consultation with a mentor or colleague as to the appropriate steps to be implemented.

Recording and preservation of adequate notes. Cursory notes in shorthand at routine follow-up consultations when everything is going well, especially when your patient is happy, will normally suffice. You should also record the crucial fact that the patient appears happy and content!

At times of **high risk,** you are best protected by **comprehensive and genuine notes** that set out: -

The relevant facts, i.e. reported symptoms, examination findings – and investigation findings.

Your diagnosis or reasoned conclusions based on those facts.

Your recommendations for further investigation, conservative treatment or operative intervention.

The level of urgency or otherwise, of any investigation or intervention.

The reasons for your conclusions and recommendations.

Notes that comply with the above will prove to a court that you adhered to ethical guidelines at the time of your consultation, i.e. that you conducted yourself as a reasonable surgeon. Under these circumstances, even if your conclusions and recommendations were mistaken, a court would be far less inclined to find that any mistake was negligent.

If, on the other hand, you write lengthy notes that are intended to mislead or cover up, you must know that lawyers and judges are very good at piercing this veil – and are likely to find that you were negligent on the basis of being dishonest.

What constitutes times of high risk that require comprehensive and genuine notes?

First consultations.

Any consultation at which you recommend an operation or any other treatment that carries a risk of significant complications.

Operation notes (e.g. surgical approach – findings – actions – closure – complications).

Post-operative nursing instructions (e.g. transfer to ICU/HCU/general ward - observations and frequency – identity of doctor in charge of post-operative care – when to alert the doctor – medication – other nursing interventions).

First meaningful post-operative consultation, which should be as early as is practically possible.

At the time of any post-operative complication or unexpected event.

At the time of any reported symptom that may represent a post-operative complication or unexpected event.

At any stage when your patient appears to be unhappy.

Further effective methods to enhance the ethical practice of yourself and your colleagues.

Spend time in solitude to contemplate, read and think about ethical practice.

Join SAMLA (South African Medico Legal Association) and participate actively in its meetings, seminars and training sessions.

Learn about the nature and benefits of mediation. Undergo mediation training (e.g. UCT-MiM, Conflict Dynamics).

Teach and inspire your colleagues. Present lectures and

participate in discussions about ethical practice.

Why should you bother – what are the personal benefits to you – pleasure vs pain?

Weigh up the personal pain associated with unethical practice and the personal pleasure associated with ethical practice.

Ethical practice is the most effective form of protection against lawyers.

Each mistake or complication you avoid through ethical practice enhances the quality of your life and the adoration in which you are held.

7. DOWNSTREAM INTERVENTIONS

In the Declaration of the National Department of Health, produced pursuant to the Ministerial Health Summit held in March 2015, provision is made inter alia for 2 important processes, namely peer review and mediation.

LEGALLY PRIVILEGED PEER REVIEW MEETINGS

Legally privileged peer review meetings should be convened as soon as practical after a summons has been issued. The attorney who is to represent the doctor convenes a legally privileged meeting with his or her client, i.e. the doctor, to which the attorney invites a peer, i.e. a doctor of equivalent or higher status and experience. This meeting holds the potential for great legal-, educational- and motivational benefits, in cases with merit as well as in those

without merit.

MEDIATION

Mediation, as opposed to litigation, is a powerful, healing and transformative process for dealing with the harm that flows from clinical negligence. This is by virtue of the capacity of mediation to save costs and time, as well as its capacity to achieve restorative justice, and to restore the mutual trust, relationships and emotional wellbeing of both patient and doctor.

8. SAMA AND OTHER PROFESSIONAL ASSOCIATIONS, HPCSA, UNIVERSITIES AND STATE HEALTH INSTITUTIONS

For all the good things that are being done by our institutions and associations, the clinical negligence crisis continues to grow. This means that the existing good things are not effective or not enough. Logically therefore, we need to do the existing good things better, and we need to find new interventions to turn the tide.

The following interventions are most likely to be effective : -

A co-ordinated drive towards widespread and regular CPD training in Applied Medical Ethics (practical examples of ethical decision-making) as opposed to the History or Philosophy of Ethics.

Integrated undergraduate education in Medical Ethics from first to final year medical studies, to include Applied Medical Ethics as well as the History and Philosophy of Ethics.

Promote strong and ethical clinical governance in hospitals.

Promote and teach the practice of regular morbidity and mortality meetings for cases with adverse outcomes.

Promote and teach the practice of legally privileged peer review meetings whenever a summons claiming damages for negligence has been received.

Promote the inclusion of a pre-mediation meeting clause into patient registration documents, and take active steps to promote resolution of disputes through mediation rather than litigation.

Identify and deal with repeat offenders that drive up the insurance premiums of ethical surgeons. This may be achieved for example by exclusion of repeat offenders from insurance pools or by suspension of their registration by the HPCSA.

9. CONCLUSION

Psychologists tell us that any behaviour that is rewarded is perpetuated. Thus, the occurrence of repetitive bad behaviour proves the existence of some or other reward. To what extent are we rewarding bad practice by the clouds of secrecy and protectionism that surround colleagues against whom claims are lodged?

Each negligent error we avoid through ethical practice saves us anguish, as well as a tremendous waste of time and money. Each colleague we teach or inspire to practice ethically will reduce our own future insurance premiums. If we join forces to entrench ethical practice we can eradicate this scourge. Let us take back our power and fix the crisis together.

Recognising the 5 identifiable standards of practice into which surgeons can be grouped, what should we strive for?

Ethical – This majority should maintain and improve their standard, participate in CPD training of colleagues, and ensure that their practice remains ETHICAL.

Sub-ethical but reasonable – This unfortunate minority should take urgent steps to improve their standard and ensure that their practice is ETHICAL.

Negligent (i.e. below reasonable) – This dangerous minority should suspend their practice, return to the drawing board and only re-enter practice once they have achieved an ETHICAL standard. Alternatively, they should find a different calling.

ANNEXURES : -

1. Downstream Consequences - Medical Negligence-Claassen-Edeling
2. DoH-Constantia-HoganLovells-MalpracticeWorkshop-Panel1-Recommendations-FINAL
3. HJ Edeling CV 2018-July
4. HJ Edeling Biopic 2018-July
5. HJ Edeling-Photo-3-Feb2017