THE SUPREME COURT OF APPEAL OF SOUTH AFRICA

JUDGMENT

Reportable

Case No: 311/2013

In the matter between:

Mrs N[…] S[…] S[…] NO **Appellant**

and

Dr D P Maitin **Respondent**

Neutral Citation: *S[…] NO v Maitin (*311/13) [2014] ZASCA 156 1 October 2014

Coram: Lewis, Ponnan and Pillay JJA and Dambuza and Mathopo AJJA

Heard: 27 August 2014

Delivered: 1 October 2014

Summary: Delict: medical negligence; plaintiff did not discharge the onus of proving negligence on the part of the doctor: informed consent not an issue once negligence is not established.

ORDER

On appeal from: KwaZulu-Natal High Court, Durban (Penzhorn AJ sitting as court of first instance)

The appeal is dismissed with costs.

JUDGMENT

Lewis JA (Ponnan and Pillay JJA and Dambuza and Mathopo AJJA concurring)

[1] Giving birth is an inherently risky process. Yet prospective parents take the risks because, usually, the anticipated reward of having a child far outweighs the risks. But what if a woman does not know of a particular, although remote, risk of natural childbirth because the doctor to whom she has entrusted her and her baby's care does not warn her of the possibility of harm ensuing, and permanent injury being caused to the baby, so that she can elect to undergo a less risky procedure in delivering the baby? Does the doctor have a duty to disclose information about remote risks? What test should be used to determine whether the duty has been discharged? And if the doctor is not negligent in failing to disclose the remote risk on what basis can liability be founded? These are the questions that Mrs N S S[…], the appellant, asks this court to determine.

[2] She asks that we develop the common law so as to recognize that the test to determine whether a doctor has discharged his duty to ensure that the consent to the

procedure is properly informed is whether the reasonable patient in the position of the plaintiff would regard the risk as significant and elect not to undergo the procedure or follow a different mode of treatment. This test would recognize the patient's right to autonomy and bodily integrity.

[3] Mrs S[…], a teacher by profession, sued Dr Maitin, an obstetrician and gynaecologist, as the first defendant, and St Augustine's Hospital (the hospital) as the second defendant, for damages in the KwaZulu-Natal High Court (Durban), but withdrew the action against the hospital. The high court (per Penzhorn AJ) dismissed the action against Dr Maitin, but granted leave to appeal to this court.

[4] Before dealing with the submissions of the appellant on appeal, I shall set out the facts that gave rise to the institution of action and the nature of the cause of action pleaded. Mrs S[…] brought the Aquilian action for damages suffered by her daughter, Y[…], as a result of the negligent conduct of the respondent, Dr D P Maitin, in delivering Y[…]. The negligent conduct alleged had resulted in injury to Y[…]'s brachial plexus, which had in turn resulted in Erb's palsy – defined in the Oxford Concise Medical Dictionary as 'weakness or paralysis of the shoulder and arm caused by injury to the upper routes of a baby's brachial plexus during birth'. The brachial plexus is a network of nerve fibres that run from the spine through the shoulder and down the arm to the hand.

[5] The injury to the brachial plexus was considered to be a result of the baby being very large – macrosomic – and shoulder dystocia having occurred. Dystocia is, simply put, a difficult childbirth. Shoulder dystocia occurs when the anterior shoulder cannot pass below the pubic symphysis (the cartilaginous joint uniting the pubic bones) and requires manipulation to release the shoulder and allow the baby to pass through the mother's pelvis. Y[…] was indeed very large at birth – she weighed 4.68kg – and her size was, on the probabilities, the cause of the shoulder dystocia. Dr Maitin did in fact perform a manoeuvre, to which I shall return, to release the shoulder and Mrs S[…] argued that a combination of his failure accurately to estimate the weight of the baby, to perform a Caesarean section (a C-section) instead of proceeding with a trial of labour, and the incorrect use of the procedure amounted to negligent conduct that caused the injury to the brachial plexus and the resultant Erb's palsy.

The facts that are common cause

[6] The facts are largely not in dispute. I shall elaborate on those of significance in due course. Mrs S[…] had been Dr Maitin's patient since the birth of her first child. He had delivered her baby boy in January 2001. The delivery was normal, although Mrs S[…] had had hypertension during that pregnancy. The baby weighed 2.9kg. In 2005 Mrs S[…] miscarried a foetus at six weeks. Dr Maitin attended to her then too. When Mrs S[…] became pregnant for the third time, in 2006, she consulted Dr Maitin again for regular check-ups. He estimated that the date of expected delivery of the baby was 1 July 2006. She was booked into the hospital on that date.

[7] When Mrs S[…] saw Dr Maitin just over a week after the expected delivery date, on 9 July, she was very uncomfortable. He estimated the weight of the baby at that stage to be 4kg – a big baby by any standard. It was agreed that she be admitted to the hospital that evening and that labour be induced.

[8] The progress and management of Mrs S[…]'s labour is put in issue by her, and so some detail is required. Most of it is recorded in a parthogram (otherwise called a partograph) which charted various factors from the moment of admission to birth. Mrs S[…] was admitted to the hospital at 16h17 and her vital signs were checked; she was assessed at 17h55 and Prandin Gel was inserted vaginally to induce labour. Dr Maitin advised on the further use of Prandin Gel at 4h00. He also prescribed a painkiller as Mrs S[…] was complaining of pain. At 22h30 Pethidine was administered at his instance. The heartbeat of the foetus was measured by means of a cardiograph (referred to in the hospital notes as a 'CTG') from 2h00. At 4h00 a pelvic examination was done on Mrs S[…], at which stage her cervix was only two cm dilated.

[9] Because Mrs S[…] was in great pain an anaesthetist was called at 6h10 and he administered an epidural anaesthetic at 6h20. By 7h00 mild to moderate decelerations (a deceleration is a slowing down of the foetal heartbeat) were noted on the CTG. Dr Maitin was advised of this and he directed the hospital staff to administer Pitocin to her at 8h25. Pitocin is a drug that causes the uterine muscles to contract: it is contractions that propel the baby down the birth canal. At 8h30 Mrs

S[…]'s cervix was five cm dilated. More Pitocin was not administered at that stage as there were still signs of decelerations, noted at 9h00.

[10] Dr Maitin saw Mrs S[…] at 9h25 and he ordered a further dose of Pitocin to be given to her. At 10h00 the midwife, Sister Khan, administered oxygen. Dr Maitin visited her again at 11h00 at which stage the cervix was eight cm dilated and no decelerations were reflected on the CTG. He asked for a further assessment to be done two hours later.

[11] By 11h30 Sister Khan noted blood in the fluid in the uterus (the liquor) and then at 12h30 she did a pelvic examination and noted that Mrs S[…]'s cervix was fully dilated and that there was blood in her urine – something that could have been attributable to various factors. She advised Dr Maitin of this, and of the fact that the head of the baby was three-fifths above the pelvic rim. He said that he would come to the hospital immediately, and he arrived at 13h00.

[12] Dr Maitin first instructed that Mrs S[…]'s legs be put on lithotomy poles to assist delivery. The epidural anaesthetic would have made it difficult for her to move her legs as required. By the time Dr Maitin examined Mrs S[…] at 13h00 the head of the baby was four-fifths above the pelvic rim. This too is significant and I shall return to it.

[13] At 13h18 Dr Maitin used a vacuum to extract the baby's head and performed an episiotomy – a surgical incision on the posterior vaginal wall – which enables the passage of the baby through the vagina. However, it appeared to Dr Maitin and Sister Khan that the anterior shoulder of the baby was stuck and would not pass through the pelvis without assistance. Dr Maitin pulled Mrs S[…] further down on the bed to ensure that he had as much access as possible to the baby and manoeuvred her through the pelvis using a technique described conventionally as the 'McRoberts' manoeuvre but with a modification in that Mrs S[…]'s legs were attached to the lithotomy poles instead of being pushed over her abdomen with the assistance of a third person. Again, as this was a point of criticism, I shall return to it. It should be noted at this point, however, that the McRoberts' manoeuvre is employed only in an emergency and to save the lives of the mother and baby.

[14] Y[…] was delivered after the manoeuvre, and was immediately placed in an ambubag (a medical resuscitator) as she had an Apgar score of only 4/10 (the score reflects the criteria by which a new-born baby is assessed: appearance, pulse, grimace, activity and respiration). Her condition improved rapidly but Dr Maitin noted that her right shoulder was not moving, and recorded that a paediatrician should see her. He recorded also that the delivery was difficult and that there was shoulder dystocia.

[15] Dr Maitin called in Dr Kara, a paediatrician who in turn called a Dr Balkisson, an orthopaedic surgeon. The latter saw Y[…] at 15h30 and diagnosed a right brachial plexus palsy resulting from traction.

[16] The following day, after Mrs S[…] and Y[…] had been seen by Dr Maitin, they were discharged. The consequences of the injury to the brachial plexus have been very serious indeed for both Mrs S[…] and Y[…]. At the outset of the trial the high court, at the request of the parties ordered a separation of the issues of liability and quantum of damages in terms of rule 33(4) of the Uniform Rules of Court. The extent of Y[…]'s disability is thus not relevant at this stage. Suffice it to say that her right shoulder and arm are paralysed so that she has very little control and movement, despite ongoing therapy. And the effect of the injury at the root of the damaged nerve is that her one eye is sunken, affecting her appearance.

The cause of action pleaded

[17] Initially, Mrs S[…] pleaded that Dr Maitin (and the hospital, at the outset of the proceedings) had been negligent in several respects: he failed to monitor her adequately when she was in labour; he failed to perform the clinical examination to estimate the size of the baby and failed to perform an ultrasound scan for that purpose; he failed to notice that the baby was large and that he should thus have performed a C-section on Mrs S[…]; he failed to assist her in giving birth in a manner that was safe for her and the baby; he failed to notice the presence of shoulder dystocia, which necessitated the performance of a C-section; he failed to warn her of the consequences of a vaginal delivery where the baby is large; he induced labour when it was neither safe nor necessary; he failed to perform the vacuum extraction procedure properly; and he failed to prevent the injury to the baby when, by

exercising due skill and care he could have done so. Other grounds of negligence averred have fallen away.

[18] Mrs S[…] alleged that Dr Maitin should have foreseen the risks of vaginal delivery given the size of the baby; that he was under a duty to warn Mrs S[…] prior to inducing labour of the 'material risks and complications which might flow' and of specific alternative procedures which might minimize the risks. He failed to warn her of the risk of shoulder dystocia and the complications and risks that were associated with it, and of alternative procedures that might have minimized or reduced the risks.

[19] As a result of the negligent conduct alleged, pleaded Mrs S[…], the baby suffered brachial nexus injury and was permamently paralysed in her right arm and hand, which led to further disability and the need for continued medical treatment.

[20] The particulars were subsequently amended to include an allegation that there was a contract between the parties in terms of which Dr Maitin owed Mrs S[…] a duty of care and would exercise reasonable care and skill. She did not plead that she had a right to be informed of any risk that was significant or that she would have regarded as significant. I shall revert to this too. In his plea Dr Maitin admitted some of the facts but denied that he was negligent and asserted that the risks referred to were not 'sufficiently material' for him to have been under a duty to warn her of them.

[21] The high court found, as I have said, that Dr Maitin had not been negligent in the care of Mrs S[…] and the delivery of Y[…]. Penzhorn AJ held also that there was no need to develop the common law in order to recognize a patient's autonomy and right to bodily integrity in making an informed decision as to whether to proceed with one course of action rather than the other – in this case to be advised of the risks of vaginal and C-section delivery respectively, and to make an informed decision accordingly.

[22] On appeal, Mrs S[…] relies principally on her right to have been informed of the risks of vaginal delivery given the estimated size of the baby, and her actual weight. That was not the case pleaded, however, and it seems to me that even if this were a proper case to develop the common law along the lines suggested by Mrs S[…], she would still have to establish negligence on the part of Dr Maitin to succeed in the action. I shall accordingly deal first with the primary issue, as I see it: was Dr

Maitin negligent in any respect and did his negligent and wrongful conduct cause the injury to Y[…]?

Negligent conduct

Misestimation of Y[...]'s weight

[23] Mrs S[…] argued that Dr Maitin was negligent in his estimation of the baby's weight before he induced her labour. He estimated that she weighed 4kg whereas in fact, at birth, she weighed 4,68kg. He should, it was argued, have taken into account that Mrs S[…]'s first baby had weighed 2,9kg only because she had suffered from hypertension. And again, given the estimation of the weight at 4kg, he should have considered the possibility that Mrs S[…] suffered from diabetes mellitus. The argument was supported by the evidence of an expert witness, Dr R E Mhlanga, whose opinion it was that Dr Maitin was negligent in assessing the weight at 4kg and in not excluding the possibility of diabetes. Had she had diabetes a C-section should have been performed.

[24] The latter factor can be discounted immediately. Mrs S[…] had not ever suffered from diabetes and there was nothing in her medical history to suggest that she might be diabetic. Dr Maitin had tested her urine right through her pregnancy with Y[…], and although he had done no blood tests to ascertain whether she did have diabetes, there was no indication that he should have done so.

[25] As to the misestimation of weight, Dr Maitin testified that he was surprised by the difference between his estimate and the actual weight of Y[…]. He said that a doctor could expect to be 'about 100 to 200 grams' out but not more. He considered that he had failed his own standard. But that does not amount to negligence. He also testified that once a baby is over 4kg in weight, it is difficult to be accurate. And he had done ultrasound examinations on Mrs S[…] and assessed the baby's weight by palpation.

[26] Although Dr Maitin's counsel referred to significant literature about the science of estimating a baby's weight before delivery, much of which suggests that it is an

inexact science and that it is difficult to predict exact weight, especially with large babies, it is not necessary to consider it. Dr Mhlanga himself testified that an experienced obstetrician might over or underestimate weight especially where a baby is large, and that an underestimate by 500g is not surprising.

[27] Ms D Nyasulu, a senior maternal and child care expert, the first witness for Mrs S[…], who explained the parthogram and the facts recorded earlier to the court, also accepted that an estimate could be out by 500g or more. She agreed that she could not say that the misestimate by Dr Maitin was negligent.

[28] Dr R Roos, a senior and very experienced gynaecologist and obstetrician who gave expert evidence for Dr Maitin, also testified that there is no acceptable medical standard for determining foetal weight, and that an estimation that was 600g out was not unusual. He said that the best that a doctor could do to establish foetal weight is to palpate in order to ascertain whether the baby was below average, average or above average weight. The estimate, he said, was a 'fatuous exercise' because it would not determine how one would manage the delivery of a baby. It was thus common cause that Dr Maitin's incorrect estimate was not in itself negligent.

Mismanagement of Mrs S[…]'s delivery

[29] All the allegations of negligent conduct leveled against Dr Maitin are based on the proposition that he had failed to appreciate that the baby was macrosomic (not in itself, as we have seen, negligent) and had thus failed to appreciate the risks attendant on a vaginal delivery. Dr Mhlanga testified that the risks of vaginal delivery of a macrosomic baby were shoulder dystocia; a poor rate of dilation; the slow descent of the foetus's head; blood in the urine; and blood in the fluid surrounding the foetus in utero (the liquor). All these risks had manifested themselves during Mrs S[…]'s labour, as had early decelerations in the foetal heartbeat. Moreover, the foetus, he said, was in distress, hence the administration of oxygen to Mrs S[…] by Sister Khan.

[30] Had Dr Maitin and Sister Khan appreciated the gravity of the risks, as they should have done, Dr Mhlanga said, they would have proceeded to perform a C-section on Mrs S[…] and thus have averted the injury to Y[…]. While conceding that it was too late to perform a C-section when Dr Maitin arrived at the hospital, because

the baby's head was four-fifths above the pelvic rim, Dr Mhlanga said that given all the potential risks, Dr Maitin should have been at the hospital attending to Mrs S[…] at the latest by 12h30 on the day of the birth. He would then still have been able to perform a C-section.

[31] Dr Maitin, Dr Roos and Sister Khan, on the other hand, all considered that these factors were common during labour and required nothing more than monitoring. Dr Roos said that at 11h00, when Dr Maitin had seen Mrs S[…], there was nothing to suggest that her labour was not progressing satisfactorily. Nothing on the CTG indicated that the well-being of the baby was compromised. Nothing warranted an immediate delivery by C-section. Although there were mild decelerations between 9h00 and 10h30, which had prompted Sister Khan to administer oxygen, by 11h00 there were no further decelerations. In any event, the mild decelerations had no effect since Y[…] did not experience any hypoxia: there was no obstruction to the supply of oxygen to her.

[32] As far as urine in the blood was concerned, found at 12h30, Dr Maitin explained that this could have been caused by a stretching of the cervix when a vaginal examination was done. This factor too did not warrant a change in course of action. The view of Dr Roos was that at 12h30, when Sister Khan called Dr Maitin, the baby was ready for vaginal delivery.

[33] The initial slow descent of the head, also a warning factor according to Dr Mhlanga, was not, in Dr Maitin or Dr Roos's opinions, of any significance. Medical literature in South Africa, put to Dr Mhlanga, shows that a slow initial descent of the head of a baby is common in African women.

The foreseeabilty of shoulder dystocia

[34] In a guideline issued in December 2012 by the Royal College of Obstetricians and Gynaecologists, dealing with shoulder dystocia, the College advised that while there is a relationship between foetal size and shoulder dystocia, 'it is not a good predictor. The large majority of infants with a birth weight of [more than] 4500 g do not develop shoulder dystocia and, equally importantly, 48% of incidences of shoulder dystocia occur in infants with a birth weight less than 4000 g'. The guideline

also pointed out that clinical foetal weight estimation is unreliable, and even ultrasound scans have a ten per cent margin of error.

The guideline continued:

'Elective caesarean section is not recommended for suspected fetal macrosomia (estimated fetal weight over 4.5 kg) without diabetes. Estimation of fetal weight is unreliable and the large majority of macrosomic infants do not experience shoulder dystocia. In the USA, a decision analysis model estimated that an additional 2345 caesarean deliveries would be required, at a cost of US$4.9 million, to prevent one permanent injury from shoulder dystocia.'

[35] The guideline was put to Dr Mhlanga by counsel for Dr Maitin. He did not dispute its validity, but insisted that in this matter, because the patient was African, and the studies were done in respect of Caucasian women, it was not conclusive. He testified that African women have smaller pelvises than do Caucasian women, a fact that none of the medical witnesses disputed. Dr Mhlanga accepted, however, that foetal size is not a good predictor of shoulder dystocia. It is clear, therefore, that there was no reason why Dr Maitin should have foreseen that the baby would present with shoulder dystocia.

The advisability of delivery by C-section

[36] Dr Mhlanga was adamant that a C-section should have been done by 12h30 at the latest. Doctors Maitin and Roos and Sister Khan, on the other hand, considered first that it was not warranted, and second that it was the less safe procedure. They, and the literature referred to, considered that a C-section carried inherent risks not only to a baby but also to a mother. Mrs Nyasula also testified that a vaginal delivery was always preferable. And the medical literature on the subject, put to Dr Mhlanga, was clear that unless the mother was diabetic or had a history of problems with shoulder dystocia a C-section was not advisable.

[37] Dr Maitin, asked whether he should not have advised a C-section instead of inducing labour, on the basis that on his own estimate the baby was big (4kg), testified that that in itself was not a reason for doing a C-section. If that route were to be recommended, he said, it would entail doing in the region of 2 000 C-sections to prevent one shoulder dystocia (an estimate borne out by the guideline discussed

above). And since the risks inherent in the procedure, including causing septacaemia and the death of the mother, are high, the suggestion of Dr Mhlanga, that in all such cases C-sections should be performed, could not be accepted.

[38] In any event, by the time Dr Maitin saw Mrs S[…] (at 13h00) the baby's head was four-fifths through the pelvic rim. Even Dr Mhlanga conceded that it would have been dangerous to perform a C-section at that stage.

[39] It is clear, therefore, that there was no mismanagement on the part of Dr Maitin of Mrs S[…]'s labour, and certainly no negligence. The reasonable obstetrician in Dr Maitin's position would not have foreseen the possibility of shoulder dystocia and would have proceeded on the same basis that Dr Maitin did. Mrs S[…], as the plaintiff, bore the onus of showing that an obstetrician with the reasonable skill and diligence possessed by that branch of the profession would have foreseen the possibility of shoulder dystocia and taken steps to mitigate the risk. (*Van Wyk v Lewis* 1924 AD 438 at 444.) She did not discharge that onus.

The McRoberts' manoeuvre

[40] Mrs S[…] contended, however, that even if there were no negligence in the management of labour, Dr Maitin was negligent in performing the McRoberts' manoeuvre with some modification and applied excessive force in releasing Y[…]'s shoulder. The McRoberts' manoeuvre is described as follows in the Royal College Guideline:

'[It] is 'flexion and abduction of the maternal hips, positioning the maternal thighs on her abdomen. It straightens the lumbo-sacral angle, rotates the maternal pelvis cephalad [towards the anterior part of the head – Collins English Dictionary 2003] and is associated with an increase in uterine pressure and amplitude of contractions. The McRoberts' manoeuvre is the single most effective intervention, with reported success rates as high as 90%. It has a low rate of complication and therefore should be employed first.

Suprapubic pressure can be employed together with McRoberts' manoeuvre to improve success rates. Suprapubic pressure reduces the bisacromial diameter and rotates the anterior shoulder into the oblique pelvic diameter. The shoulder is then free to slip underneath the symphysis pubis with the aid of routine traction.'

[41] The modification of the procedure by Dr Maitin was that he placed Mrs S[…]'s legs in straps on lithotomy poles instead of pushing them down towards her abdomen. He explained that he had to do this as she had had an epidural anaesthetic and was unable to control her legs herself. Dr Roos considered that the objective of the manoeuvre was achieved in this way: the shoulder was in fact released and Y[…] was delivered. Although Dr Mhlanga's view was different – he said that an assistant should have been called to push down Mrs S[…]'s legs – there was nothing to suggest that the outcome would have been any different if the conventional McRoberts' manoeuvre had been performed. And Dr Mhlanga agreed that the hyperflexion that was necessary was achieved. Accordingly nothing turns on the fact that a modified procedure was used.

[42] The injury to the brachial plexus was caused, in Dr Mhlanga's view, by the traction effected by Dr Maitin to dislodge the shoulder. He pulled too hard on the baby's head, Dr Mhlanga said. Again, that was mere speculation. Dr Maitin said that he did not appreciate that he used excessive pressure. He did not think so. But he accepted that he might have been responsible: it happened 'under his watch'.

[43] As counsel for Dr Maitin pointed out, the McRoberts' manoeuvre is a technique employed to save the baby's life: it is a procedure used in an emergency when the shoulder dystocia is preventing the delivery. If the baby is not delivered in this manner serious neurological damage can result. Dr Roos testified that once the shoulder is stuck, the obstetrician has only a few minutes to dislodge the baby before running the risk of serious brain damage or even death. He said that the obstetrician faced with shoulder dystocia had to use 'as much force as is required to deliver that baby. That is the object of the exercise.' Dr Maitin succeeded in avoiding the death of the baby. He achieved the objective of the McRoberts' manoeuvre.

[44] In the circumstances it is clear that Mrs S[...] did not discharge the onus of proving any negligence on the part of Dr Maitin. As Dr Roos testified, her labour was managed properly. The high court thus correctly found that Dr Maitin had not negligently caused the injury to Y[...].

Extension of the common law

[45] Mrs S[...] argued before this court that we ought to extend the common law so as to recognize that the test for whether a patient has given informed consent to a procedure should be whether the reasonably prudent patient, given the information about the risks of vaginal delivery, would have agreed to it or elected to have her baby delivered by C-section. It was common cause that Dr Maitin had at no time advised her about the possibility of shoulder dystocia occurring and of a resultant brachial plexus injury, leading to Erb's palsy.

[46] Our courts have in the past held that in order to determine whether a doctor is under a duty to disclose the risks of a procedure we must determine whether a reasonable doctor, in the position of the defendant, would have disclosed risks however remote. In *Richter & another v Estate Hamman* 1976 (3) SA 226 (C) Watermeyer J said (at 232G-H):

'A doctor whose advice is sought about an operation to which certain dangers are attached – and there are dangers attached to most operations – is in a dilemma. If he fails to disclose the risks he may render himself liable to an action for assault, whereas if he discloses them he might well frighten the patient into not having the operation when the doctor knows full well that it would be in the patient's interests to have it.

It may well be that in certain circumstances a doctor is negligent if he fails to warn a patient, and, if that is so, it seems to me in principle that his conduct should be tested by the standard of the reasonable doctor faced with the particular problem. In reaching a conclusion a Court should be guided by medical opinion as to what a reasonable doctor, having regard to all the circumstances of the particular case, should or should not do. The Court must, of course, make up its own mind, but it will be assisted in doing so by medical evidence.'

[47] The argument for Mrs S[...] is that this approach leaves the determination of a legal duty to the judgment of doctors appointed in their own cause. In keeping with the rights to autonomy and bodily protection, now entrenched in the Constitution, the test should rather be whether the reasonable patient, in her position, if warned of the risk, would attach significance to it.

[48] In *Castell v De Greef* 1994 (4) SA 408 (C) a full court accepted that this should be the test and Mrs S[...] relied on that as well as the authorities in foreign jurisdictions cited in that case. Ackermann J (Friedman JP and Farlam J concurring) said that South African courts should follow the approach of an Australian decision:

Rogers v Whitaker (1993) 67 ALJR 47 (a decision of the High Court of Australia). That court also took into account English and Canadian decisions that have adopted the same approach.

[49] Ackermann J said (at 426D-H) that South African courts ought to adopt the approach in *Rogers* 'suitably adapted to the needs of South African jurisprudence'. He continued:

'It is in accord with the fundamental right of individual autonomy and self-determination to which South African law is moving. This formulation also sets its face against paternalism, from many other species whereof South Africa is now turning away. It is in accord with developments in common law countries like Canada, the United States of America and Australia, as well as judicial views on the continent of Europe. . . .

I therefore conclude that, in our law, *for a patient's consent to constitute a justification that excludes the wrongfulness of medical treatment and its consequences,* the doctor is obliged to warn a patient so consenting of a material risk inherent in the proposed treatment; a risk being material if, in the circumstances of the particular case:

(a) a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it; or
(b) the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it.' (My emphasis)

[50] This passage makes it clear, however, that the question of informed consent goes to the wrongfulness element of the Aquilian action. Negligent conduct on the part of the doctor will be wrongful if the patient has not given informed consent. Negligence is still a requirement, and in *Castell* it was established. Where there is no negligence proved, however, the test for wrongfulness does not even arise.

[51] In this matter Mrs S[...] did not prove that Dr Maitin was negligent. In the circumstances there is no need for this court to determine which test should be adopted in relation to informed consent.

[52] In any event no evidence was led to show what the reasonable patient in Mrs S[...]'s position would have done had she been warned of the risk of shoulder dystocia (a risk that was lower than one per cent), and advised about the choice between a vaginal delivery or a C-section. Would she have taken the far greater

risks attendant on a C-section or the very minor risk of shoulder dystocia occurring? We do not know. And Mrs S[...] herself said, when asked if she knew about delivery by C-section, and about the risks attendant on it, that she did know of such risks, though not anything about shoulder dystocia, brachial plexus injury or Erb's palsy. It was suggested to her that both Dr Maitin and she had to weigh up the respective risks. She responded:

'I don't believe that. I placed all my trust in him in the sense that it was he who was going to make a decision as to the correct procedure to adopt.'

On the facts, therefore, it cannot be found that the conduct of Dr Maitin was wrongful. And since he was not negligent, liability cannot be established.

[53] Accordingly, the appeal is dismissed with costs.

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C H Lewis

Judge of Appeal

APPEARANCES

For Appellants:	N Singh SC and T V Norman SC
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