REPUBLIC OF SOUTH AFRICA
IN THE HIGH COURT OF SOUTH AFRICA
GAUTENG DIVISION, PRETORIA

CASE NO:A398/2018
REPORTABLE:NO
OF INTEREST TO OTHER JUDGES:NO
DATE:9/3/2021

In the matter between:

N C First Appellant

J B Second Appellant

and

DR P. M. E Respondent

Delivered. This judgment was handed down electronically by circulation to the parties' representatives by email. The date and time for hand down is deemed to be 10h00 on 09 March 2021.

JUDGMENT

RANCHOD, J

Introduction

[1] This is an appeal against the whole of the judgment and order granted by the trial court (per Tlhapi J) on 14 August 2018. (The written judgment was handed down on 20 August 2018.) Leave to appeal was granted by the court *a quo* to the Full Court of this Division on 3 October 2018. The appellants

thereafter filed an amended notice of appeal as there was no objection by the respondent to the notice of intention to do so.

[2] The parties agreed with this court's view that the appeal may be disposed of without the need for oral hearing in terms of section 19(a) of the Superior Courts Act 10 of 2013. They were, however, afforded the opportunity – in lieu of the oral hearing – to file supplementary heads of argument which they did.

[3] The appellants seek condonation for the late filing of the record. There is no objection by the respondent and this court accepts the reason for the late filing. Condonation is accordingly granted.

The issues

[4] The appellants are the biological parents of […] ('[…]'), who was born on […]. She was diagnosed as having Down's Syndrome. The appellants instituted action against the respondent on a claim for wrongful birth. In other words, the appellants sued for the damages incurred in having to raise, maintain and care for Chelsea who is permanently disabled as a consequence of the Down's Syndrome. They pleaded both a contractual and a delictual claim against the respondent. The former is based on a partly written, partly oral agreement. The written part of the agreement is annexures "A" and "B" to the particulars of claim being a document titled 'Consent to the fees being charged by this practice' and the other titled 'General terms and conditions applicable to persons joining this practice as patients.' The terms of the

agreement are extensively pleaded but the 'catch all' term is that the respondent would provide obstetric services with the skill, care and diligence as could reasonably be expected of a specialist obstetrician. It is further pleaded that at the conclusion of the agreement a document titled 'Sonars/Screening Tests' (annexure "C" to the particulars of claim) was furnished to the first appellant [by an employee] on behalf of the defendant.

[5] The primary issue in this appeal is whether Dr E[...](the respondent) was negligent in the provision of ante-natal care to Ms […].

Factual background

[6] On 30 March 2011 the first appellant (Ms […]) consulted her general practitioner advising him that she suspected that she was pregnant. A blood test was performed which confirmed that she was indeed pregnant.

[7] Ms C[...]consulted the respondent on 1 April 2011 with a view to him providing antenatal obstetric care to her during the course of her pregnancy. He agreed to be the treating specialist gynaecologist and obstetrician and provided Ms C[...]with antenatal care. The antenatal obstetric care included screening tests to ascertain the chance that Ms […]'s unborn baby had Down's Syndrome.[1] He delivered […] by caesarean section on [….] when it was discovered that she had Down's Syndrome.

[1] Down's Syndrome is a chromosomal disorder, which is present in the foetus from the moment of conception. It is irreversible but can be detected in the foetus by certain tests during the antenatal period.

[8] The appellants contend that had the Down's Syndrome been timeously diagnosed by the respondent during the course of the pregnancy, Ms C[...]would have sought a termination of the pregnancy in terms of the Choice on Termination of Pregnancy Act 92 of 1996 (the Act). Because section 2(1) of the Act provides that a pregnancy may only be terminated up to and including the 20th week of pregnancy, only the first 20 weeks of gestation are relevant here[2]. The fact that the respondent did not diagnose the Down's Syndrome thereafter, is moot.

[9] The methods of picking up whether an unborn baby may be suffering from Down's Syndrome are fairly complex. The initial methods used to pick up whether an unborn baby may be suffering from Down's Syndrome are screening tests, as opposed to diagnostic tests. A screening test involves the provision of an odds ratio of the unborn baby having Down's Syndrome, but is not an assurance or guarantee that it does not have it. Generally, only if a screening test indicates the possibility that an unborn baby may have Down's

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[2] Section 2(1) of the Act provides:
(1) A pregnancy may be terminated –
(a) upon request of a woman during the first 12 weeks of the gestation period of her pregnancy;
(b) from the 13th up to and including the 20th week of the gestation period if a medical practitioner, after consultation with the pregnant woman, is of the opinion that –
(i) the continued pregnancy would pose a risk of injury to the woman's physical or mental health; or
(ii) there exists a substantial risk that the fetus would suffer from a severe physical or mental abnormality; or
(iii) the pregnancy resulted from rape or incest; or
(iv) the continued pregnancy would significantly affect the social or economic circumstances of the woman; or
(c) after the 20h week of the gestation period if a medical practitioner, after consultation with another medical practitioner or a registered midwife, is of the opinion that the continued pregnancy –
(i) would endanger the woman's life;
(ii) would result in a severe malformation of the fetus; or
(iii) would pose a risk of injury to the fetus.

Syndrome is a diagnostic test recommended. This is because the diagnostic test (in this case an amniocentesis)[3] has a risk (albeit small) of causing the spontaneous abortion of the unborn baby, when it may be healthy and not suffering from Down's Syndrome. The appellants' claim is one which is characterised as a wrongful birth claim[4] for the loss which they say they have suffered for having to raise Chelsea. It is not a claim by, or on behalf of, the child.

Screening and diagnostic tests during pre-natal management

[10] In the court *a quo* the experts, through counsel for both parties, caused to be prepared notes for a better understanding of the complex subject on pre-natal management.

10.1 There is always a possibility of a woman giving birth to a child with an irreversible congenital or genetic disorder and, in certain cases the risk of that happening increases as the woman grows older. Screening and diagnostic tests have been developed to assist in identifying these disorders in women who carry or are at risk of giving birth to a child with abnormalities. Therefore, antenatal management is important in that it entails the care by a general or specialist obstetrician of the health of the mother-to-be and the foetus during pregnancy. Pre-natal and post-natal

[3] Amniocentesis is a diagnostic, invasive test involving the collection of amniotic fluid by inserting a needle through the mother's abdominal wall into the uterus under ultrasonographic guidance. The amniotic fluid contains foetal cells that are examined for chromosomal disorders. There is a 1% risk of miscarriage with the performance of this test.

[4] See generally: *Stewart and Another v Botha and Another* 2008 (6) SA 310 (SCA) at para 9 footnote 12.

screening and diagnostic tests are available; pre-natal through screening and diagnostic tests and, post-natal by the identification of physical features combined with blood tests.

10.2 It has now become common practice to make pre-natal tests available to pregnant women in the early stages of pregnancy ('the first trimester') and in the middle of pregnancy ('second trimester'). Down's Syndrome can be identified as a probability, by using the risk calculations done through screening tests and can thereafter be confirmed by diagnostic tests. The patient is informed about the diagnostic tests available for her.

10.3 The screening tests are non-invasive in that they are done by ultrasound scan and tests on blood taken from the pregnant woman in the first trimester, between 11 to 14 weeks and 3 days and in the second trimester between 15 to 20 weeks, in order to determine whether there is high risk of chromosomal disorder in the foetus. In the first trimester the ultrasound scan shows images of the foetus to evaluate the nuchal translucency[5] (NT) and the presence or absence of the nasal bone. These are said to be some of the physical soft markers to determine the presence of Down's Syndrome. The ultrasound scan is also used to check the progress of foetal development throughout pregnancy. The blood samples are used to screen for certain

[5] The excess skin or fluids at the back of the foetal neck (nuchal translucency or NT) of those suffering from Down's Syndrome. It can be visualized by ultrasonography in the third month of intra-uterine life. The wider the NT, the higher the chance of an abnormality in the foetus.

blood markers that indicate increased foetal risks for certain genetic disorders including Down's Syndrome.

10.4 The ultrasound scan measuring the nuchal translucency, combined with blood tests for biochemical screening to assess the PAPP-A (pregnancy associated plasma protein A) and free BHCG (free beta-human chorionic gonadotrophin), also referred to as the Triple Test and assessment of the nasal bone, increases detection of Down's Syndrome to 95%.

10.5 If screening in the first trimester has been missed a further blood test for biochemical screening to assess free BHCG Estradiol Alpha-feto protein, can be done between 15 to 20 weeks of the pregnancy (second trimester test). The test is said to be a very poor screening test if used alone and can miss diagnosis of Down's Syndrome up to 40%. It is recommended to combine this test with the more accurate biochemical tests conducted in the first trimester for reliable results.

10.6 Diagnostic tests are offered to a pregnant woman when the screening tests have identified a high risk of the unborn child being born with Down's Syndrome. Counselling is offered to her to enable her to make a choice whether to retain the pregnancy or to terminate it.

[11] The appellants' case as set out in the original heads of argument of the appellants was that the primary issue of negligence on the part of the respondent involves a determination of the subsidiary issues of whether Ms

C[...]was provided with the results of certain screening tests, and whether she was made aware that there was a difference between screening and diagnostic tests for Down's Syndrome. In broad summary, it is the appellants' case that the respondent:

11.1.1 failed to counsel the first appellant in respect of the nature and efficacy of the various screening and diagnostic tests to enable her to make informed choices;

11.1.2 failed to inform the first appellant of his own shortcomings in the ability to perform first trimester screening (referred to as the 'failure rate')[6];

11.1.3 failed to perform a proper estimation of the gestational age of the foetus, rendering the second trimester screening test void; and

11.1.4 failed to diagnose the Down's Syndrome in the foetus during the first appellant's pregnancy, particularly in the first twenty weeks of the appellants' pregnancy.

11.2 Had the respondent counselled the first appellant appropriately, and performed the tests without negligence, she would have been able to make informed choices on the testing and diagnosis of Down's Syndrome.

11.3 In regard to the second trimester screening test, it is the appellants' case that there is so much doubt on the validity of this test (also called the triple test or 16 week test in the record) that it has been rendered nugatory. In the result, the respondent

[6] Discussed later herein.

> did no effective test for foetal abnormalities during the first appellant's pregnancy. Had the respondent performed the second trimester screen test properly by informing the laboratory of an appropriately accurate gestation period, alternatively asking the laboratory to provide two reports on the gestation of 16 weeks and 4 days as well as the gestation of 17 weeks and 5 days, the second trimester screen test is likely to have shown a high risk, which would have led to a diagnosis of Down's Syndrome in the foetus. The first appellant would then have terminated the pregnancy and she and the second appellant would not have to incur the cost, for the remainder of their lives, of raising and caring for a disabled child into adulthood.

[12] The respondent denied that he was negligent in the provision of the antenatal care.

[13] Prior to the hearing of the appeal, this court invited the parties to make submissions on whether the court *a quo* had misdirected itself on the facts, and if so, to indicate where the misdirection occurred. Both parties filed supplementary heads of argument. The appellants filed theirs dated 1 September 2020 and also filed an amended notice of appeal (dated 16 September 2020).

[14] In the extensive supplementary heads of argument it is now submitted that the appellants rely primarily on three aspects (based on common-cause facts). The argument is that:

14.1 The respondent failed to refer Ms C[…] for a level 111 foetal anomaly ultrasound scan;

14.2 The respondent failed to establish a reliable gestational age, which in turn rendered the only test that he did for Down's Syndrome, nugatory; and

14.3 The respondent failed to counsel, or adequately counsel Ms C[…] on the nature and interpretation of the screening and diagnostic tests.

[15] On the back of these new arguments which are now advanced, the appellants suggest that the trial court misdirected itself on a number of factual findings which it made.

The joint minute of Drs Pistorius and Lombaard

[16] It would be apposite to refer to a minute of the meeting between Dr Pistorius and Professor Lombaard[7]. The minute sets out the following parameters:

16.1 Paragraph 2 deals with the counselling that should be given in respect of first trimester screening. This includes advising the patient that the screening test is a combination of the measurement of the nuchal fold and a blood test; can be performed by an obstetrician; can be performed in a particular window period; is the preferred screening test; is only a

[7] Vol 4, p 363 – 365.

screening test, and that even in the best hands some cases of Down's Syndrome are missed.

16.2 What is important about the counselling of first trimester screening is that '*technical detail*' of the test is not provided to the patient, and odds ratios, or detection ratios, and risk ratios are not provided to the patient.

16.3 Paragraph 3 records that during the initial counselling sessions termination of pregnancy is not dealt with.

16.4 In paragraph 4 it is noted that counselling for first trimester screening should take place before the screening is done, and that this can happen at the start of the consultation during which the first trimester screening is done, or at the previous visit. There is no need for counselling to take place long in advance of first trimester screening.

16.5 Paragraph 5 deals with counselling in regard to diagnostic testing. It is agreed that "*more detailed … counselling is not warranted so as to overload the patient with non-essential information.*". This is a theme which runs through all counselling – namely, that patients should not be overloaded with non-essential information. Counselling on diagnostic testing includes that the patient should be advised that it is the only definitive way to make a diagnosis and that there is a risk of miscarriage associated with invasive testing. It was agreed that: "*The option of invasive testing is available to a high risk woman or a patient who prefers to have a definitive test and not screening.*".

16.6 Paragraph 7 deals with the options available to a patient where first trimester screening is impossible. The first option available to such a patient is second trimester screening. Significantly, diagnostic testing is not the preferred option.

16.7 Paragraph 8 deals with second trimester counselling. This arises where first trimester screening was not possible. Counselling for second trimester screening includes: advising the patient that a blood test can be performed as an alternative method of screening; second trimester screening "*might have a lower detection rate … but performs better than second trimester ultrasound or a nuchal translucency that was measured incorrectly.*", and that the test is not a diagnostic test.

16.8 Paragraph 10 deals with Ms C[…], and records that it was agreed that where a second trimester screening test produces a result of 1:2420, as was the case with Ms C[…], it would be categorised as a low risk "*and would not prompt referral to another specialist … for further screening or diagnostic tests.*".

16.9 Paragraph 10 is linked to paragraph 13. In paragraph 13 it is agreed that Dr E[...]acted reasonably in his management of Ms C[...] if he counselled her properly. In other words, the experts agree that the only question is a factual one which relates to counselling. There is no other issue that arises from Dr Engelbrecht's treatment of Ms C[...].

First trimester screening test

[17] It is common cause that the first trimester screening test (the 12 week test) is more sensitive, or is a better test, than second trimester screening (16 week test or triple test).

[18] It is also common cause that the respondent attempted to measure the NT of the foetus on two occasions in the first trimester but was unable to do so as the foetus would not co-operate. (By non-co-operation is meant that the foetus was not in the correct mid-sagittal position to enable the measurement to be taken.) The appellants aver that the non-provision of the first trimester screening, which is the best available screening, amounts to a breach of the Act and therefore the respondent is liable.

[19] However, the respondent contended that first trimester screening is dependent on the foetus co-operating with the obstetrician. If the foetus does not present in the correct mid-sagittal position, the first trimester screening cannot be undertaken.

[20] The respective experts of the parties who testified on this point were Professor (Dr) H. Lombaard (for the plaintiffs) and Professor Snyman (for the defendant). Dr Lombaard is a specialist obstetrician and gynaecologist and is a Principal Specialist and Head: Maternal and Foetal Medicine Unit Steve Biko Academic Hospital, Department of Obstetrics and Gynaecology at the University of Pretoria. Professor (Dr) Snyman is, likewise, a specialist obstetrician and gynaecologist. He is Principal Specialist and Adjunct Professor at Kalafong Hospital and the University of Pretoria.

[21] Both Doctors Lombaard and Snyman agreed that even in the best hands it was sometimes not possible to perform first trimester screening because the foetus would not co-operate. Based on the available images from the time that the respondent attempted to perform the first trimester screening, it was agreed that those images did not depict a foetus which was in a mid-sagittal position that would have permitted first trimester screening to be carried out. They also agreed that when an obstetrician declines to perform first trimester screening because the foetus is not in a mid-sagittal position, that refusal is a reasonable standard of conduct by that obstetrician.

[22] In my view, where it is impossible to perform first trimester screening, there can be no breach of the Act. What have to be provided are reasonable services, and depending on the circumstances, the reasonable service may be second trimester screening because the first trimester screening was not possible. I will deal with the second trimester screening presently.

The statistics issue (or, the 'failure rate') of the respondent

[23] The first trimester screening test was attempted by the respondent on two occasions. The appellants say that on his own version, the respondent was not sufficiently skilled in performing the first trimester screening test. His evidence was that (in 2011) he had a 45% chance of failing in his attempts, whereas with practice and continuing education, he now (in 2015) only failed 2 to 3% of the time. Accordingly, so it is argued, Ms C[...] was not afforded the benefit of the most sensitive screening test.

[24] As I said, according to the evidence it is clear that measuring the NT during the first trimester screening depends on foetal co-operation. In Ms C[...]'s case the foetus did not 'co-operate', i.e. it could not be coaxed into a mid-sagittal position to enable the respondent to measure the NT. Therefore, the ability to perform the first trimester screening is not a measure of the obstetrician's skill but rather a measure of foetal co-operation. Hence, to speak of a 'failure rate' seems to me to be misplaced. The 'failure rate' is in fact the rate of foetal non co-operation. The respondent was cross-examined on this issue:[8]

24.1 'Doctor, in terms of … [indistinct] translucency measurement, for purposes of first trimester screening, are you able to tell her Ladyship in how many instances, seeing that you do keep statistics and you do not manage to measure the nuchal translucency for purposes of first trimester screening? --- In 2011 it was about 45% … 35% that I could not measure, My Lady, 45%, My Lady, that I could not measure.'

24.2 In further cross-examination it is put to the respondent:[9]

'Can her Ladyship accept that you were aware in 2011 of this failure rate, seeing that you are collecting the statistics? --- Failure rate is not the right word, My Lady, I think … [intervene]. Well, use the right word … [indistinct]. --- The inability to measure a specific … inability to measure a specific nuchal fold to the extent that it could be used in the detection or in the calculation of the risk in the first trimester.'

24.3 Further on during the cross-examination the respondent says:[10]

'I think it is to a certain extent unfair to compare my figures with those of the foetal maternal specialists. There are only 40 of them in South Africa and I think it is also just fair to mention what the figures of the

[8] Vol 13 p1299 lines 4 – 10.
[9] Vol 13 p1300 lines 10 – 16.
[10] Vol 13 p1313 lines 7 – 15.

> general gynaecologists, as far as the first and second trimester screening is concerned, My Lady.
> I am not too sure, what you are referring to, Doctor? --- How many first trimester screenings and how many second trimester screenings are done by the average gynaecologists, the other 600 private gynaecologists.'

[25] The appellants contend that the respondent should have told Ms C[...] of his failure rate. Counsel for the respondent makes the point that the statistics were not available in May 2011 when the respondent saw Ms C[...] because they had only been prepared on 5 April 2012. It was therefore impossible for the respondent to tell her what his 'failure rate' was when he saw her a year earlier. The question arises whether, it would have made a difference if the respondent had prepared the statistics of his 'failure rate' earlier and had told Ms C[...] about it and if she had gone to another obstetrician. There is no evidence of what could have occurred had she gone to another obstetrician, and there is accordingly no evidence that the outcome would have been different. The first trimester screening is dependent on foetal co-operation and no amount of evidence would have been able to predict what the foetus would have done if Ms C[...] had gone to another obstetrician.

[26] The only evidence in this case of the respondent's skill in measuring a nuchal fold is his conduct in respect of Ms C[...]. Both parties' experts agreed that based on the presentation of the foetus, as it appears on the available images, the respondent was correct in not performing first trimester screening. If it is accepted, for the purpose of the argument, that the respondent's 'failure

rate' is 45%, then his 'lack of skill' goes nowhere in the case of Ms C[...] because her foetus refused to co-operate. Even if the respondent had been the world's foremost obstetrician, he would still not have been able to perform the first trimester screening on Ms C[...].

[27] The evidence of Professor Snyman, who was the only expert who gave evidence on the statistics issue because of the late stage at which the appellants introduced this into their case, said that it was not expected of a reasonable obstetrician to keep a 'score card' or to keep track of the statistics of his 'failure rate'. He testified that the reasonable standard of practice for obstetricians does not require them to advise their patients of their 'success rate' or 'failure rate'. It is unhelpful to employ a general measure of success in the context of Ms C[...] or to assess an obstetrician's 'success rate' for the purpose of assessing his proficiency. All of the experts accepted that even in the best hands it is not always possible to measure the nuchal fold, and no one can say which unborn baby's nuchal fold can, or cannot, be measured. It is therefore highly speculative to suggest, as the appellants seem to do, that another doctor would have been able to measure the nuchal fold of Ms C[...]'s unborn baby.

[28] Professor Snyman further testified that an obstetrician's election not to measure a nuchal fold because he could obtain the necessary mid-sagittal view demonstrates an acceptable level of confidence and skill. He said, given the importance of the measurement of the nuchal fold, it is unreasonable to measure it when the correct mid-sagittal view cannot be obtained. In the

context of Ms C[...], the only useful enquiry is to ask whether the respondent failed to measure the nuchal fold when he could have done so. All of the experts agreed that based on the DVD recordings of the attempts to measure the nuchal fold there was no acceptable mid-sagittal view in order to measure it. In these circumstances it seems to me that it was reasonable for the respondent not to measure the nuchal fold, and this is entirely divorced from his general level of skill in measuring nuchal folds.

[29] The respondent said: "*The average gynaecologist in South Africa presenting their screens to Lancet, have been consistent over the past five, six years, at 55%, My Lady. I just want to bring it to the courts attention that to compare me to a foetal maternal specialist is fine, but I would like to also be compared to the average gynaecologist.*" The cross examiner (Mr De Waal SC) then asked the respondent whether he had that evidence, and he said he did. He was then asked if he was going to provide the letter containing the figures from Lancet Laboratories.

[30] Having asked for the letter containing the Lancet figures the appellants should have led evidence to rebut the Lancet figures which they introduced into evidence through the respondent. Instead, Mr De Waal attempted to distinguish the Lancet figures from the respondent's failure rate but that was unsuccessful because he missed the point that the respondent was making. The point that the respondent made was that the percentage of second trimester screening tests performed by Lancet Laboratories, on a national basis, compares to his ability to measure the nuchal fold in the first trimester.

In other words a patient who goes to the respondent (when he is unable to measure 45% of nuchal folds) is in the same position as the average patient throughout South Africa, where 45% of patients do not have first trimester screening, but instead have second trimester screening. Accordingly, Ms C[...] found herself in the same position as the average obstetric patient in South Africa.

The second trimester screening test

[31] The appellants contend that the second trimester screening test is a 'weak' test and that the respondent should not have relied on it. They refer to the evidence of Professor Snyman on the *positive predictive value* and the *negative predictive value* of the second trimester screening test.[11] They contend that the evidence of the respondent's own expert, Professor Snyman was that the negative predictive value (in other words the predictive value of a test that shows a negative result) is 99.98% accurate. The positive predictive value (the predictive value of a test that is positive) is not very good, and if used alone can miss a diagnosis of Down's Syndrome up to 40%. The reasons that the negative predictive test shows an accuracy of 99.98% is because of the low prevalence of Down's Syndrome which occurs in only 1 in 1000 pregnancies. Thus most pregnant women will test negative, and that

[11] 'Positive and negative predictive values' is a concept introduced into this matter by the respondent's expert Professor Snyman. In essence these values are intended to show how strong a negative result is, or how strong a positive result is. Thus one can consider what the chances are that the test is truly false or truly positive. A false positive test result is one which shows a higher risk of an abnormality, but, in fact, there is no abnormality. A false negative test result is one which shows a low risk of abnormality, whereas there is in fact an abnormality. These results only occur in screening tests.

negative test is likely to be correct because of the low prevalence of Down's Syndrome. Thus the positive predictive value of a test can only be acceptable, if the pregnant mother is aware of its limitations and she accepts that risk.

[32] Professor Snyman's evidence of first trimester screening versus second trimester screening was that:

32.1 first trimester screening had a 99.98% chance of indicating that a baby does not have Down's Syndrome; and

32.2 second trimester screening has a 99.96% chance of indicating that a baby does not have Down's Syndrome.

[33] The appellants' reliance on a figure of only 40% for second trimester screening appears to be based on a misunderstanding of Professor Snyman's evidence and an incorrect reference to the sensitivity of second trimester screening. HIs evidence was presented graphically[12] to illustrate the respective positive and negative predictive values depending on a background prevalence of a particular condition. He testified on the importance of the positive and negative predictive value of a screening test. The appellants have simply focussed on the somewhat blunt measure of sensitivity of a test.

[34] Professor Snyman testified that even though the first and second trimester screening tests have a very high negative predictive value, the possibility remains that some babies who have Down's Syndrome will not be detected. As abnormalities in some babies will not be detected by either the

[12] Exhibit E.

first or second trimester screening test, one cannot say that a test is ‘weak’ or ‘unacceptable’ simply because a baby is born with Down’s Syndrome when the tests indicated that it probably would not have Down’s Syndrome. It seems that this is unfortunately what has happened to Ms C[...]. She is one of the 4 out of 10,000 mothers who would undergo second trimester screening testing where the presence of Down’s Syndrome would not be detected.

[35] The respondent testified about the prevalence of second trimester screening. He said that second trimester screening accounted for 55% of screening tests performed by Lancet Laboratories.[13] Two points emerge from this:

35.1 Firstly, it shows that in the majority of pregnancies (55%) the screening test that is relied on is second trimester screening. It is difficult to imagine that the majority of pregnant women would be subjected to second trimester screening if it is a weak test; and

35.2 Secondly, if second trimester screening is only used once first trimester screening has proved not to be possible, then it shows that in 45% of cases obstetricians are unable to obtain a reliable measurement of the nuchal fold.

The Level III anatomy scan

[13] Exhibit L.

[36] In their supplementary heads of argument the appellants suggest that the respondent ought to have referred Ms C[...] for a Level III anatomy scan[14]. This argument seems to be built on the premise that second trimester screening is a 'weak' test. Once it is accepted that second trimester screening is not a 'weak' test then the appellants' argument for a referral for a Level lll scan cannot be sustained.

[37] A further difficulty which the appellants face in arguing for a Level III scan is that: Professor Lombaard, the appellants' expert, agreed that the results produced by the second trimester screening test indicated a low risk of Down's Syndrome, and he agreed that those results did not indicate the need for any further tests or investigations, including a Level III anatomy scan, to be performed.[15]

[38] A further point that Professor Lombaard made about referral for a Level III scan was that although it is a theoretical possibility, it is not an option that is available in practice simply because there are not enough Level III qualified sonographers in the country.[16]

[39] In my view there is no basis to suggest that the respondent ought to have referred Ms C[...] for a Level III scan.

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[14] A Level III scan is an ultrasound scan which is aimed at looking for the so-called soft markers, or signs of abnormality. This scan is usually done by an obstetrician/gynaecologist who is also a foetal-maternal specialist. It can be done at twenty weeks or earlier if there is a suspicion of an abnormality.
[15] Expert's Minute, Professor Lombaard, p364 line 25-28; Professor Lombaard, p1052 line 7-10; p1063 line 4-5; and p1067 line 4-12.
[16] Professor Lombaard, p1067 line 18-25.

The gestational age issue

[40] The appellants, in both their main and supplementary heads of argument submit that the respondent incorrectly assessed the gestational age. The accuracy of the gestational age impacts on the accuracy of the *second trimester screening* test. The appellants contend that the gestational age was incorrect by 7 to 8 days and therefore the second trimester screening test was invalid.

[41] Professor Snyman testified that the gestational age of the foetus is measured by ultrasound (in the case, as here, where a pregnant woman does not know the date of her last menstrual period) by measuring the crown rump length[17] of the foetus on three or four successive visits early in the pregnancy. Correlation of the measurements is key.

[42] The respondent evaluated the foetal gestational age at 6 weeks on the first visit (1 April 2011) of Ms C[...]. Two weeks later (on 15 April 2011) he estimated it at 7 weeks and accordingly changed his first visit evaluation to 5 weeks. The respondent wanted to arrange a third visit at about 10 weeks as he had doubt about the accuracy of the gestational age but as he was going to be away, arranged it for about 12 weeks (based on her second visit). At the

[17] Crown Rump Length (CRL) and gestation: This is the measurement of the foetus from the crown of the head to the rump (buttocks). When the crown rump length is measured, the software of the computer will calculate the gestation. In the image below, the crown rump length is 4.25 cm and the gestation has been calculated by the software at 11 weeks and 1 day. In order to get a reliable gestation by use of this method, the crown rump length should be measured three times per visit, on three successive visits. The earlier in pregnancy that these measurements are taken, the more reliable they are. The image below is an example and is not Chelsea.

following visit on 20 May 2011, and on his own version (with the experts in agreement), his crown rump length assessment was not accurate and could not be used. At the next visit a few days later (on 24 May 2011) he did not do the measurement.

[43] At the next visit on 17 June 2011 the respondent again did not perform the measurement. His computer was ticking over the dates and showed a gestational age of 16 weeks and 4 days, based on the 15 April 2011 assessment. He, however, did do a bi-parietal diameter measurement[18] which showed a gestational age of 17 weeks and 5 days (an 8 days discrepancy). He then sent the appellant for a blood test. The laboratory was informed that the gestational age was 16 weeks and 4 days.

[44] The appellants contend that the respondent should not have relied on a single, uncorrelated gestational age and ignored the age elicited by the bi-parietal diameter measurement. He could have asked the laboratory for two reports; one based on 17 weeks and 5 days and another based on 16 weeks and 4 days but did not do so. Also, say appellants, he did not mention his doubt about the gestational age to Ms C[...] and the import of that fact. The doubt about the validity of the second trimester screen rendered it nugatory. Hence, it is argued, no valid test for foetal abnormalities was performed at all.

[18] Bi-parietal diameter (BPD): This is the measurement of the foetal skull from the parietal bone on the one side of the skull, to the parietal bone on the other side of the skull. This can also give a gestation period, but usually at about 16 weeks or so.

[45] For the second trimester screening test to be valid, the gestational age and other information supplied to the laboratory must be correct. The respondent testified:

> 'I think in modern medicine, if you see a patient early enough in the pregnancy, you should not be out by more than three days either way.'

[46] However, an incorrect gestational age is not the appellants' case says the respondent. Counsel for the respondent submitted that in their supplementary heads of argument the appellants seek to bolster their argument on gestational age by impermissibly referring to documents that did not serve before the trial court, were not introduced into evidence, were not testified to by any witnesses and did not form the subject matter of any cross-examination or consideration by an expert. Therefore, these documents, and any submission which refers to these documents must be disregarded. I agree.

[47] None of the appellants' experts had questioned the gestational age in their reports or in their evidence. Where they referred to the gestational age in their reports, they did so without criticism. Both Professor Lombaard and Professor Langenegger referred to the gestational age in their respective supplementary reports when referring to the images without any criticism.

[48] It seems to me that it is necessary to consider the context in which the gestational age issue arose. It was introduced in an application dated 9 June 2016 to re-open the appellants' case and allow, *inter alia,* for the first time an

amendment to the claim. This amendment inserted paragraphs 8.14.4 to 8.14.10 and 8.18 in the particulars of claim.

[49] The stage of the proceedings at which the amendment was introduced is relevant. The cross-examination of the respondent had started on 23 April 2015. The proceedings were adjourned on 25 April 2015 in the middle of the cross-examination. The trial resumed on 6 June 2016 and continued on 7 June 2016 and the amendment was delivered on 8 June 2016. The application by the plaintiffs to reopen their case was thereafter delivered on 9 June 2016.

[50] In the application to reopen their case the applicants stated the limitations that should be placed on the further evidence that would be led. They said they were to be limited to evidence that the respondent "*doubted the gestational age assessment ("the GA") made by him on ultrasound at the 7 week visit on 15 April 2011, and that such GA was used or relied on by the defendant [respondent] throughout the plaintiff's pregnancy and particularly for the purposes of the second trimester screening*" and "*He did not inform the first plaintiff of his doubt in this regard.*"[19]

[51] It is clear that what underpinned the appellants' application to reopen their case was that the respondent doubted the gestational age. But there is no allegation that the gestational age was, as a fact, incorrect.

[19] Vol 5, p445 line 15 to p446 line 5.

[52] The absence of a suggestion that the gestational age was incorrect appears to be consistent with what the appellants' then senior counsel (Mr De Waal) explained their case to be when confusion arose and the trial court questioned what the appellants' case was. Mr De Waal said:

> 'My Lady, can I just, to clarify at this point, seeing that there seems to be this misunderstanding of what the plaintiffs' case is? My Lady, whether or not he got it wrong, he may very well have got it wrong, but he may have got it right by chance. The point of the plaintiffs' case is that, if Dr E[...]thought that he got it wrong, he ought to have conveyed that to the first plaintiff and that could, or would, or would not have influenced the decision. That is going to be the question. It is the risk factors introduced by his uncertainty about things that need to be accurate and so forth, that causes the whole cascade of what happened after that. That is the same [*sic*] of what the plaintiff is saying, or the plaintiffs are saying in this case. So whether or not it was actually right, or wrong, we will argue in the end, is, to some extent immaterial. It is the fact that he thought he got it wrong, the doubt that he had that he did not convey, because we knew – we know today, he got it wrong in terms of the fact that the baby was born with Downs Syndrome. Just to clarify what our position is, my Lady.'[20] (My underlining)

[53] Having clarified what the appellants' case was, and having allowed the respondent to proceed with the case on that basis, the appellants cannot now, at the appeal stage, seek to positively allege that the gestational age was incorrect. The prohibition on this course of action was clearly set out in the *Knox D'Arcy* case[21] where the trial court had clarified what the plaintiffs' case was[22] and where on appeal the plaintiffs sought to argue a different case.[23]

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[20] Vol 15 p1579 lines 2 to 16.

[21] *Knox D'Arcy AG and Another v Land and Agricultural Development Bank of South Africa* [2013] 3 All SA 404 SCA.

[22] '[30] …"But Mr Burman, the defendant's case is that the parties never identified such a debt. You operate on the premises that such debt was identified, all what was thought agreed upon was the criteria … they say that even the identification never took place let alone criteria, so you people are not with each other …"

[54] As I said earlier, the appellants' experts in any event did not question the gestational age.

[55] Ms C[...] testified when the appellants' case was reopened. Her evidence started when she was referred to gestational age and the measurement of the crown rump length. But her evidence then becomes rather confused because Mr De Waal referred to the measurement of the crown rump length as a screening test when he should have referred to the measurement of the nuchal fold. Her evidence then returns to gestational age and then again erroneously slips into the measurement of the nuchal fold. She then once again returned to gestational age. She then said, when dealing with the nuchal fold:

'I would have definitely asked for a diagnostic test, to make sure. 100% sure.'[24]

[56] The reference to diagnostic tests shows that Ms C[...] appreciated the difference between screening tests and diagnostic tests. Her evidence on the issue of the gestational age is that in 2011, and specifically on 15 April 2011 she would have asked for a diagnostic test. However, she testified that she

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To this summation, the appellants Counsel responded "Yes, yes, you are entirely correct, M'Lord". The case then proceeded on that basis.

[23] '[35] It is trite that litigants must plead material facts relied upon as a basis for the relief sought and define the issues in their pleadings to enable the parties to the action to know what case they have to meet. And a party may not plead one issue and then at the trial, and in this case on appeal, attempt to canvas another which was not put in issue and fully investigated. …'

[24] Vol. 15 p1570 lines 21 - 22

only learnt what a diagnostic test is in January 2015.[25] This is what the appellants have argued before this court in paragraph 77 of their main heads of argument. There is therefore a fundamental difficulty with Ms C[...]'s evidence regarding the gestational age.

[57] Her evidence on the issue of the gestational age was taken up in cross-examination by Mr Green SC. She was asked why she says that the respondent got the dates wrong. It was at this point that the trial court raised the issue of what the appellants' case was. After Mr De Waal explained what it was the cross-examination by Mr Green continued and the following exchange took place:

> "Let us have a look at a few things you can comment on. Do you know that, when pregnancy, or gestational age is measured, it is measured from the first day of the mother's last menstrual period? --- No, I did not know.
>
> Ok, well it is and let us assume a perfect menstrual cycle of 28 days, ovulation then takes place on the 14th day. Did you know that? --- I did.
>
> Yes and it is only upon ovulation that one can have fertilization of the egg, correct? --- That is correct.
>
> And the indication to the mother that she is pregnant, is that, she would miss her next period at the 28th day. Would you agree with that? --- That is correct.
>
> Yes. When you went to see your general practitioner, you saw him at the end of March 2011, correct? --- I could not give the perfect date, but yes.
>
> It was 30 March 2011. --- Ok.

[25] Vol. 5 p492 lines 16-19.

It is in your general practitioner's records, if we need to go there --- That is fine.

Are you happy to accept that? --- I will accept that.

Thank you. Yes and you went to your general practitioner because you had missed a period, correct? --- That is correct.

Yes and this was a planned pregnancy, correct? --- That is correct.

Yes. So, let us just use the numbers I have given you now. On the perfect menstrual cycle, when you saw your general practitioner, you would have been between 4 and 5 weeks pregnant, do you agree? --- I agree.

Yes and then when you went to see Dr E[...]on 1 April he [assessed] your pregnancy, the gestational age of your pregnancy as being ± 5 weeks, correct? --- Correct.

Yes and two weeks later he assessed it as being ± 7 weeks, correct? --- Correct.

You see, Ms C[...], your evidence which you have just given, shows that Dr Engelbrecht's assessment of the gestational age, at an order of weeks, is correct. Do you want to comment on that? --- No."

[58] This evidence shows that the assessment of gestational age by the respondent as being 7 weeks is correct. It is not open to the appellants to now, on appeal, seek to argue an entirely different case when this issue was not canvassed with Ms C[...], nor is it open to the appellants to seek to introduce the general practitioner's records on appeal when Ms C[...] expressly disavowed requiring them to be produced.

[59] But the point about gestational age was not left there and was again taken up with Ms C[...] as follows:

> "Yes. Ms C[...], let us take the 7 week gestational age. That is the one we have used. [If] Dr E[...]had said to you: "I have some doubt about whether you were 7 weeks pregnant." Would you have said to him: "Hang on, doctor, this is a planned pregnancy? I watched when I missed my period. This is how things happened. 7 weeks is correct. Do not worry" --- I would not know the relevance.
>
> Yes. --- If he did not explain to me the relevance of doubting the age.
>
> Ms C[...], the question has got nothing to do with what follows from the age. It has only to do with the doubt about the age and what you would have done."

[60] The appellants contend that the respondent had doubted his own gestational age assessment. Reference is made in the heads of argument to the then counsel for the appellants' cross-examination of the respondent on this point:

> "MR DE WAAL: Dr E[…], you are not answering my question. In this jumping around between doubting and not doubting, at least twice you said that you doubted the 7 week determination of gestational age. At least twice. My question is: Why did you say that? – My Lady, I doubted the 7 week test. I am saying now that I doubted it and yes … Okay, I doubted it. That is why I did the 10 week scan.
>
> Or wanted … you did not do a 10 week screen, Doctor. You wanted to do a 10 week screen? – correct My Lady."[26]

[61] The gestational age issue started with the respondent being cross-examined about why he had initially wanted to see Ms C[...] when she was 10

[26] Vol. 14 p1052 line 17-24

weeks pregnant, and he said that one of the reasons was to attempt to get a better, more accurate, duration of pregnancy before he attempts the first trimester screen. There was some debate about the respondent getting his patients into a routine and seeing them every four or five weeks so that he could see them at about 12 weeks. In this context he explained that he wanted to see patients before the 12 week visit "*so that I can be certain that, when I see her at the 12 week visit, that I am correct as far as my gestation age is concerned.*" The respondent was then asked why he had to verify the gestational age that he had determined at seven weeks and he answered "*I did not say that, My Lady. I said that, between 7 and 10 weeks, but at 10 weeks you have the added advantage of having a morphological picture of the baby. So I wanted to make sure that my dating at seven weeks was correct, My Lady.*"

[62] Mr De Waal then asked the respondent if he thought that there was something wrong with his 7 week dating. He responded that he wanted to confirm that the date was correct. At this point the cross-examiner said "*did you doubt your estimation of the gestational age based on the ultrasound you did at 7 weeks*", and Dr E[...]said "*it could have been improved … I did not doubt it, but it could have been improved. It could have been rectified by a day or two forwards or backwards …*" The cross-examiner then wrongly asked "*So the answer is yes?"* In response, the respondent said "*I did not doubt It … I wanted to confirm that it was correct…*" The cross-examiner then asked a further incorrect question: "*What does it mean if you say it could've been corrected?*" – the question was incorrect because the respondent had not said

the date could be 'corrected.' He responded by saying "*My Lady, correct, I doubt it.*". Mr De Waal then pressed the point and asked "*So you doubted the gestational age estimation which you obtained at the 7 week visit, correct Dr E[…]?*" and the respondent said "*I wanted to confirm that it is correct, my lady*". The point was persisted with, and the cross-examiner asked "*Am I correct that you said you doubted the estimation … Gestational estimation at the 7 week visit doctor?*" The respondent said "*I did not doubt it, my lady. I was quite certain that it was … I wanted to rectified by a day or two. Yes I doubted for day, or two, but not as a principle that she was seven weeks pregnant. It could have been out by a day, or two, my lady.*". The respondent was then asked to make a choice, did he doubt the gestational age or not, and he said "*I did not doubt it.*". The respondent was then badgered by the cross-examiner and he said "*I am saying that I doubted and yes … Okay, I doubted it*", but then returned to his consistent line that "*It could have been out by a day, or two … that is on every single computer the fact that there is always a two, three day window period.*" (My underlining.)

[63] Mr Green submits – correctly in my view, a fair and correct assessment of the respondent's evidence is that he did not doubt the correctness of the gestational age any more than every other obstetrician who is compelled to deal with ultrasound machines that provide the gestational age in a range and not as an absolute date. The suggestion that there was any doubt in the respondent's mind that there was an error in the gestational age cannot be sustained.

[64] It is also significant that none of the appellants' experts questioned the gestational age that the respondent had used. The appellants' experts had looked at the ultrasound DVD and the still pictures – all of which illustrate the calculation of the gestational age by the ultrasound machine – and if there had been something wrong with the gestational age used by the respondent they would have seen the problem – but they saw nothing wrong, and gave no evidence on this issue.

[65] The only expert who testified on the gestational age issues was Professor Snyman, and this came about because the appellants introduced the gestational age issue after their experts had testified.

[66] In his evidence on the gestational age issue Professor Snyman explained what is set out in his supplementary expert summary. He said an obstetrician generally has two methods to calculate gestational age. Firstly, the last menstrual period date. A calculation based on the last menstrual period date can be out by several days because not all women have a typical 28 day cycle. The second method to calculate the date is by the ultrasound machine using the crown rump length. The crown rump length is used by the computer program to calculate the gestational age and it is easy to measure it. Because the computer uses the 50th percentile of crown rump lengths, the gestational age may be out by several days and one can add or subtract 5 days from the calculated gestational age.

[67] Professor Snyman further said that it is helpful to compare calendar days with gestational age calculated by the computer to see if they correlate because this confirms the reasonableness of the calculated gestational age.

[68] The other evidence that was led dealing with the gestational age, in my view puts the point beyond doubt:

68.1 Ms C[...] said she fell pregnant in March 2011 and it was a planned pregnancy.

68.2 Ms C[...]'s general practitioner assessed her as being pregnant and shortly thereafter the respondent assessed her as being about five weeks pregnant. His assessment of gestational age as five weeks is consistent with a woman who is planning a pregnancy, misses her menstrual period and then goes to see a doctor and the pregnancy is assessed at five weeks. This point was taken up with Ms C[...] and the numerical calculations were put to her to demonstrate that there was no basis for a suggestion that the gestational age was incorrect.

68.3 When Ms C[...] was told by the respondent that she was about five weeks pregnant at the first consultation she did not raise an objection to that estimation. Because this was a planned pregnancy Ms C[...] would have had an idea of when she conceived and she did not object to the estimate of five weeks. If there was an error it would be an error of an entire menstrual cycle, so that Ms C[...] should have said that the estimation is out by about 4 weeks. But she did not do this.

68.4 Two weeks later the respondent, using his ultrasound machine and the crown rump length measurement assessed Ms C[...] as being seven weeks pregnant. The gestational age is determined by the computer algorithm embedded in the ultrasound machine. According to the evidence the respondent does not "*determine*" the gestational age. It is determined by the ultrasound machine. So if the appellants suggest that there was an error in the respondent's assessment of the gestational age what they should be saying is that he incorrectly measured the crown rump length. They do not say so and none of the appellants' experts suggested that the respondent incorrectly measured the crown rump length.

68.5 Ms C[...]'s next consultation with the respondent was on 20 May 2011. The ultrasound machine calculated the gestational age as twelve weeks. The increase in gestational age coincided with the passing of calendar time.

68.6 At the 17 June 2011 consultation the ultrasound machine assessed the gestational age of the unborn baby at sixteen weeks. Again the increase in gestational age coincided with the increase in calendar time.

68.7 If the respondent had made a mistake in assessing gestational age at seven weeks he would have now, for the third time, made exactly the same mistake – if the mistake had been different the gestational age would not have coincided with calendar time. Professor Snyman testified that there was a correlation between

calculated gestational age and calendar dates which indicated that the gestational age was correct.

68.8 The crown rump length was also measured at 12 weeks and it too, correlated with a 12 week gestational age.

[69] The appellants, in their supplementary heads of argument, now argue that there was an error of seven to eight days in the gestational age. However, as I said earlier, the appellants' then senior counsel said that their case was not that there is an error in the gestational age. He said the case related only to doubt, and the need for the respondent to inform Ms C[...] of his doubt. The appellants therefore cannot argue for an error in the gestational age. But even if there is a variance of about seven or eight days in the gestational age, according to Professor Snyman that is generally within the accepted range of error for measurements taken during the first trimester.

[70] The appellants took issue with the bi-parietal diameter measurement[27] taken by the respondent at an estimated 16 weeks of gestational age which indicated a calculated gestational age of 17 weeks. The respondent's evidence, which was supported by Professor Snyman, was that "*… once the gestational age is determined between 7 and 10 weeks, that is it, you do not change it. You leave it there. You cannot adjust it, because that is the most accurate one that you get. If you adjust it, you will, you will ignore babies that*

[27] Bi-parietal diameter measurement is the measurement of the foetal skull from the parietal bone on the one side of the skull, to the parietal bone on the other side. This can also give a gestation age but usually at about 16 weeks.

grow too fast and babies that grow too slow. So you must have a fixed dated by 10 or 11 weeks so that you know how far this baby is."

[71] According to Professor Snyman the variance of one week is well within the expected error range of two weeks for measurements taken during the second trimester.

[72] In my view, there is simply no factual basis for the appellants to suggest that the gestational age was incorrectly calculated, or not calculated according to the standard required of a reasonable obstetrician. There is no evidence that if the gestational age was incorrectly assessed, what effect that would have had on the assessment of the likelihood of the foetus having Down's Syndrome.

The counselling issue

[73] The appellants seem to argue that the respondent provided no, or very little counselling, particularly during the consultations on 17 June 2011 (at 16 weeks) and 15 July 2011 (at 20 weeks) when the screening tests were performed. Evidence was led by the appellants of witnesses who were present at the consultations and the respondent also testified on this issue. It is the appellants' case that had they known that the second trimester screening test was not a diagnostic test Ms C[...] would have opted for one. I deal first with the second trimester screening test.

The 17 June 2011 (16 weeks) consultation

[74] Ms C[...] testified that her mother (Ms H[…]) accompanied her to the 17 June 2011 consultation with the respondent. She said the respondent gave her 'the Lancet forms' to have blood drawn. She said she did not have any discussion about these blood tests with the respondent at any stage.

[75] Under cross-examination Ms C[...] agreed that when the form was given to her she knew that it was an important test and that it was to have blood drawn for testing for Down's Syndrome in her unborn baby. She was asked whether the court could accept that the second trimester screening test "*was an important test for [Ms C[...]]*", and she answered by saying "*well I would say yes because the doctor made it sound that this would be our result, this would sort us out, so yes.*"[28] This, to my mind, clearly indicates that the respondent had discussed the second trimester screening test with her.

[76] She also agreed that she would have been anxious to know what the results of the test were, and answered affirmatively when asked whether "*the results of this test on your version is going to tell you whether you have to terminate the pregnancy or not, is that not correct? - Correct*".[29] This is contrary to her evidence that the respondent did not tell her about the results of the second trimester screening test nor did she ask him. This, in my view, is wholly improbable and must be rejected.

[28] Vol. 6 p595 line 23-24.
[29] Vol. 6 p596 line 12-14.

[77] Mr B[…] did not attend the consultation on 17 June 2011.[30] However, he was present at some of the earlier consultations and accepted that the respondent had told him and Ms C[...] that there was a 16 week blood test that he would carry out. Further, that the 16 week blood test would assess the chance of the unborn baby having Down's Syndrome, and he understood that to be the purpose of the test. Mr B[…] then adjusted his evidence to say that what the respondent said was that there was a test (referring to the second trimester screening test) "*to determine if she was Down syndrome, not if there was a chance of her having Down syndrome, as far as I can recall.*"[31] Asked whether he was changing his evidence, and whether he persisted in saying that he understood the second screening trimester test to provide a definitive answer in respect of Down's Syndrome, he confirmed that he was changing his evidence to that effect.[32] He also confirmed that he knew that the 16 week consultation was important because a definitive test to establish whether the unborn baby had Down's Syndrome would be performed. He testified that he was told by Ms C[...] that the second trimester screening test had been carried out.

[78] Ms H[…], who attended the consultation on 17 June 2011 had testified that after the consultation Ms C[...] went for a blood test. However, she said, nothing was discussed by the respondent about the blood test at the consultation.

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[30] Vol. 7 p650 line 18-19
[31] Vol. 7 p692 line 21-22.
[32] Vol. 7 p693 line 2-3.

[79] Mr Roux was not present at this consultation.

[80] The respondent testified that at the 17 June 2011 consultation he had completed the Lancet Laboratory form and ticked the block indicating that the Down's Syndrome test was to be performed. When dealing with what was said to Ms C[...] on that day he said:

> "I would have said to her that I am now sending her for a blood test to do the so-called second trimester triple test down *[sic]* screen. My lady I said it, although it is not as accurate as the first trimester test it is still an acceptable test and that the results will also be reported as either negative or positive. Negative meaning low risk and positive meaning high risk. I told them again that low risk does not exclude the possibility of a down syndrome or other chromosomal defect baby. I also again reiterated that if they want to have 100% confirmation we need to do a diagnostic test and that is an amniocentesis with as you know a risk of 1% for miscarriage."

[81] The appellants seem to take issue with this evidence on the basis that the respondent did not testify about exactly what he told Ms C[...]. The respondent did say that he could not recall the precise words used in consultation with his patients. But he would tell them all about the need for the blood test and the implications of the results. It therefore makes sense that he started off by saying *'I would have…'*. He was accepted as a credible witness by the trial court.

The 15 July 2011 (20 weeks) consultation

[82] Ms C[...] testified that at the 15 July 2011 consultation she was accompanied by Mr B[…], his mother (Mrs B[…]), Ms H[…] and Mr Roux. She said the only thing that the respondent said was that he could see on the scan and that he was doing measurements. She denied there was any discussion about the results of the 17 June 2011 blood tests and said nor were they

discussed at any time before the baby was born. She said the respondent did not inform her that the baby had a low risk of Down's Syndrome nor did he tell her that an amniocentesis was not required. In short, she testified that the blood tests were not discussed at all.

[83] Mr B[…] said the consultation on 15 July 2011 was an important one therefore, on his version, a definitive test for Down's Syndrome was going to be done that day. But as I mentioned earlier he then changed his evidence about whether the test will show a chance of Down's Syndrome or whether the test would be a definitive one. He said there was no discussion about the second trimester screening test and he also did not hear the respondent convey any information regarding it to Ms C[...].

[84] Ms H[…] flatly denied that any counselling took place at the July consultation nor, she said, did any discussions take place regarding the result or the implications of the blood tests. There was no discussion about testing for Down's Syndrome, she said.

[85] But when it was suggested to Ms H[…] that her memory may be failing her she said:

> "…, I went with her for the sonar and the whole purpose of this what is happening now was about the Down Syndrome which was not discussed at any point with myself, or it will not be discussed with me but with N[…]. That is why I am here, not to remember if she had a blood test or her blood pressure taken, that is what I am assuming she had, blood pressure or whatever they do in the little cubicle. … What is important is her Down Syndrome, the fact

> that the child had Down Syndrome and nobody picked it up, and it was not discussed. No options were discussed at any stage." (My underlining.)

[86] When it was put to her that she was only at court to offer evidence which exclusively suits the appellants' case, she said:

> "I was not in a discussion with somebody else, I was there for a reason, not to talk about nonsense. If I did talk to somebody else, I would not be able to remember it, but it is unfair to say that doctor said, by the way, N[…], the tests were negative, we are all missing it, just N[…] and the doctor knows, not sharing it with us. N[…] would not keep quiet about it, because immediately she would have said listen you know, what now, please tell me what is the next step. The tests are negative, we would all hear it, OK doctor let us talk about it now, what must we do now. Nothing was said, absolutely nothing was said."

[87] Mr Roux's evidence about the 15 July 2011 consultation contradicted Ms H[…]'s evidence. In evidence-in-chief he said no blood test was discussed in his presence.

[88] Under cross-examination however, Mr Roux accepted that he was aware that Ms C[...] had undergone blood tests at the 16 week scan, even though he had not accompanied her to the 17 June 2011 consultation. The following exchange then took place under cross-examination:

> "I understand your evidence to be that you did not hear Dr E[...]saying to Nadia that the blood test results were negative is that correct? – M'Lady I saw the doctor with the – I think it was Lancet if I can remember the logo well, because again I was a distance from him, and I could see that you know he was looking at this paper but I cannot recall that he said anything about the blood test." (My underlining)

[89] Mr Roux was then shown the laboratory form and confirmed that the logo he had seen on 15 July 2011 is what appears on the Lancet Laboratory form containing the results of the second trimester screening test. He was then asked:

> "Mr Roux I want to put it to you that we know, on your evidence, that Dr E[...]has a Lancet Laboratory piece of paper before him but what could have happened is that Dr E[...]said to N[…] the blood test results are negative, but you did not hear that because your attention was diverted. Either to the screen or you were engaged in a little bit of hushed chatter with somebody else is that a fair comment?"

Mr Roux answered:

> "M'Lady I have to speak the truth, that is possible yes but I have, afterwards I asked [Ms H[…]] what was the outcome of the blood test, which she then said to me that Nadia told her that it was low risk, did not use the word negative, I cannot exactly say but I know that the blood test did not have an indication that there is a problem with that child so we were all relaxed and we thought that everything was fine with this baby ,'Lady.". (My underlining.)

[90] Mr Roux explained that the discussion he had with Ms H[…] took place in the car on the way home from the 15 July consultation and he recounted the discussion as follows:

> "M'Lady no, it was in the vehicle when we were driving home after the discussion and I asked her what the result of the blood test, then she said no, that it was – you know I cannot recall if it was low risk or negative …".

[91] The appellants argue that Mr Roux's evidence about the discussion he overheard between Ms C[...] and Ms H[…] is hearsay and ambiguous and the trial court erred in relying on that evidence. However, Mr Roux testified about what Ms H[…] had told him afterward as well in answer to a question from himself. In any event, Mr Roux was called as a witness by the appellants. It

was he who gave this information in cross-examination. Different considerations may apply where a party calls a witness to give hearsay evidence in support of their own case. In any case, there is no absolute bar or prohibition on the acceptance of hearsay evidence.[33]

[92] The respondent's evidence about the 15 July 2011 consultation was that he explained the results of the second trimester screening test to the appellants and pointed out to them that the test indicated that there was a low risk of the unborn baby having Down's Syndrome.

[93] In my view, the probabilities on an assessment of all of the evidence in relation to the 15 July 2011 consultation are that the results of the second trimester screening test were explained to Ms C[...] and she told her mother about them. Ms C[...] must have told her mother about the explanation provided to her during the consultation, or shortly thereafter, because Mr Roux's evidence is that it was during the car journey on the way home from the consultation that he overheard Ms C[...] telling her mother that the test results showed a low risk of Down's Syndrome.

[94] Dr E[...]and Mr Roux's evidence is further supported by the probabilities. Appellants said they were concerned about whether the unborn baby suffered from Down's Syndrome. They were aware that the first trimester screening test had not been carried out, and that on 17 June 2011 blood had been drawn to perform the second trimester screening test. If the appellants

[33] Section 3 of the Law of Evidence Amendment Act 45 of 1988.

were concerned about the Down's Syndrome status of the unborn baby the probabilities are strongly in favour of the appellants having asked Dr E[...]about the results of the blood test at the 15 July 2011 consultation if he had not already volunteered those results. It is highly improbable that the appellants, with their concern about Down's Syndrome, would have allowed the 15 July 2011 consultation to pass without the results of the second trimester screening test being discussed with the respondent.

The Sonar Form and the consultations prior to 17 June 2011

[95] Whilst at the respondent's rooms at the very first consultation a Nurse Swanepoel handed the 'Sonar Form' to Ms C[...] and had her sign the patient card to indicate that she had received it. The respondent testified that during the first consultation he would tell his patients they must make sure that they read through it and understood it's content. He would tell them that it has to do with the ultrasound and the screenings *'could and might and would be done'* during that pregnancy. In the Sonar Form it is stated, *inter alia,* that ultra sounds are widely used and are regarded as a very safe form of investigation to pick up abnormalities of foetal growth and development. He performs an ultrasound investigation at each visit but only charges for the first and twenty-week scan and *'if there is a medical indication for a scan, such as threatening miscarriage or amniocentesis*….It is however important to remember that all reports will always be qualified as **"IT APPEARS NORMAL/ABNORMAL"** or **"IT SEEMS TO BE NORMAL/ABNORMAL"** and it is never indicated to **BE NORMAL OR ABNORMAL.**."

[96] It is clear from the evidence that Ms C[…] accepted that the Sonar Form was an important document, more so because she was asked to sign for it. She agreed that she would have picked up words in capitals on the Sonar Form. The words that are in capitals, and in bold indicate that the sonar scan tests are simply screening tests and are not diagnostic tests. It is also stated in the form that if he is not sure of either a normal or abnormal finding he will refer the patient for a second opinion or Level III scan. Further, that regardless of this all patients have a right to request a Level III scan. It is then stated in the form that:

> *'**RECOMMENDED** investigations regarding chromosomal defects like Down's Syndrome will be discussed at length. In short there are quite a few tests or screens available of which this practice will first try to do the twelve- week test. If this is technically impossible the so-called triple test will be done at sixteen weeks. These tests try to determine the risk of yur baby to have a chromosomal defect and will be reported as either negative (meaning low risk) or positive (high risk). In the cse of a test being negative it does not mean that the baby is normal but only that the risk is so low that an amniocentesis is not indicated. With a positive test an amniocentesis is indicated to confirm the diagnosis.'*

[97] The sonar form is a clear and concise summary of first trimester and second trimester screening and makes it clear that the results of these tests are not definitive, and that what is being reported on is the relative risk of a baby having Down's Syndrome. It also draws a clear distinction between screening tests and diagnostic tests. It uses the word amniocentesis and

makes the point that this is a test to confirm whether an unborn baby has Down's Syndrome. The form is unequivocal and clearly states that screening tests are not diagnostic and refers to high and low risks. The use of the words '*appears*' and '*seems*' makes it clear that the tests that will be carried out are not diagnostic tests. There is also a reference to Down's Syndrome being discussed at length.

[98] Ms C[...]'s evidence about the Sonar Form is that "*she scanned it*" and that in doing so she recognised words "*here and there*". When asked why she had not read the Sonar Form she replied, "*It M'Lady was my first appointment and as I said Jason and I were very exciting (sic) about confirming my pregnancy and my last concern was reading pieces of paper given to me on the first day.*" She agreed that the Sonar Form was an important piece of paper, and when asked why she did not read the Sonar Form in the evening she said that she was still excited about the fact that she was pregnant. When asked why she had not read the form a week later she replied that "*by then it was at the back of my mind, I have (sic) forgotten about this form*". Ms C[...] agreed that there was nothing to stop her from reading the Sonar Form. When the obvious negative consequence of not reading the Sonar Form was put to her she retreated from her position of not having read the Sonar Form and said that she had not read it "*properly*".

[99] The expert witnesses agreed that the use of a form to convey information to a patient is a useful aid.[34] Where a written form is used to convey information to a patient the doctor will adjust his counselling to allow for the fact that the written form has been provided. It would be a total waste of time if the Sonar Form was provided and the doctor still continued as if no form had been provided.

[100] If recommended investigations regarding chromosomal defects like Down's Syndrome are not discussed later, a patient will be able to raise the issue with the respondent. It is common cause that the appellants did not do so. Ms C[…] conceded that if she had read the sonar form and did not understand something she should have asked the respondent questions. The respondent was therefore entitled to accept that the appellants had read the form and understood its contents.

[101] Ms C[...] accepted that she was made aware that there were screening tests and that she knew that the first trimester test was not a definitive test. She knew it was an important test and that it had to be done within a certain window period. When the second trimester screening failed she was not concerned because the respondent "*… reassured [me] that I can come back for a 16 week blood test.*" She also knew this was a test for Down's Syndrome. She agreed that the 16 week test provided "*an indication*" of Down's Syndrome and when she was confronted with the fact that she knew it

[34] Lombaard Vol. 10 p1065 line 4-10. Langenegger Vol. 8 p812 line 10-13; p814 line 10-16; p815 line 19-22.

was not a definitive test she recanted and said that the respondent had "*made us feel like this is what the result is going to be*", but she could not say when he had done this. When pressed she said that he had said "*moenie worry nie, julle kan terug kom vir die 16 weke bloedtoets*" *('don't worry, you can come back for the 16 week blood test.*') What emerges is that Ms C[...] knew the difference between screening tests and diagnostic tests.

Factual findings of the trial court

[102] The appellants contend that the trial court made a number of erroneous factual findings. I do not deem it necessary to traverse them in any detail as I am of the view that the record demonstrates that the trial court's factual findings are in general correct. I agree with Mr Green that the appellants are simply 'snipping' at the minutia of what the trial court said in respect of some of the evidence and does not get close to showing a misdirection. They are required to show something fundamental that goes to the ultimate finding of the trial court. This the appellants have failed to do. In *Rex v Dhlumayo and Another*[35] it was held that a court of appeal is very reluctant to upset the findings of the trial court, as the trial judge has the advantage of seeing and hearing the witnesses and observing their personalities and demeanour. The trial court is in a better position than the appeal court to even draw inferences. The trial judge has an advantage to determine what is probable and what is improbable having observed the witnesses in the course of the trial. The court cautioned[36] that:

[35] 1948 (2) SA 677 (A) at 705.
[36] At 594.

> 'An appellate court should not seek anxiously to discover reasons adverse to the conclusions of the trial Judge. No judgment can ever be perfect and all-embracing, and it does not necessarily follow that, because something has not been mentioned, therefore it has not been considered.'

[103] In my view there was no misdirection on the part of the court *a quo* in the factual findings and the conclusions it reached that are such as warrant this court to interfere.

[104] In the result I propose an order that the appeal is dismissed with costs including the costs of senior counsel.

_____

RANCHOD, J
JUDGE OF THE HIGH COURT

I agree

_____

HUGHES, J
JUDGE OF THE HIGH COURT

I agree

_____

VAN DER WESTHUIZEN, J

JUDGE OF THE HIGH COURT

Appearances:

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