



**IN THE HIGH COURT OF SOUTH AFRICA
FREE STATE DIVISION BLOEMFONTEIN**

Reportable/Not Reportable

Case no.: 4268/2015

In the matter between:

THABO ISHMAEL KANUNU

Applicant

and

THE MINISTER OF HEALTH: FREE STATE PROVINCE

Respondent

Coram: Opperman J

Heard: 25 October 2024

Delivered: 24 March 2025. This judgment was handed down in court and electronically by circulation to the parties' legal representatives by email and release to SAFLII. The date and time for hand-down is deemed to be on 24 March 2025 at 15h00.

Summary: Leave to appeal – trial – merits – medical negligence

ORDER

The application for leave to appeal is dismissed with costs.

JUDGMENT

Opperman J

Introduction

[1] Meritless appeals may not be allowed. The test in an application for leave to appeal is simply whether there are any reasonable prospects of success in an appeal, not whether a litigant has an arguable case or a mere possibility of success. The Supreme Court of Appeal (SCA) has in the past criticized the regularity with which leave to appeal is granted in matters not deserving its attention. Marais AJ stated that:

‘... The inappropriate granting of leave to appeal to this court increases the litigants’ costs and results in cases involving greater difficulty and which are truly deserving of the attention of this court having to compete for a place on the court’s roll with a case which is not.’¹

[2] The right to appeal is, among others, managed by the application for leave to appeal. It may not be abused but the hurdle of an application for leave to appeal may never become an obstacle to justice in the post-constitutional era. Section 17 of the Superior Courts Act 10 of 2013 is the law.²

¹ *Shoprite Checkers (Pty) Ltd v Bumpers Schwarmas CC and Others* (231/2002) [2003] ZASCA 57; [2003] 3 All SA 123 (SCA); 2003 (5) SA 354 (SCA) (30 May 2003) para 6.

² ‘17. Leave to appeal. — (1) Leave to appeal may only be given where the judge or judges concerned are of the opinion that—

(a) (i) the appeal would have a reasonable prospect of success; or

[3] The prevailing law was clarified in *H.B (Nee D.J) v R.J.B (Leave to Appeal)*³ in that a court may not grant leave to appeal where the threshold which warrants such leave has not been cleared by the applicant. The threshold has been given legislative force and clarity.

[4] With regard to the meaning of reasonable prospects of success, it was held in *S v Smith*⁴ as follows:

‘What the test of reasonable prospects of success postulates is a dispassionate decision, based on the facts and the law, that a court of appeal could reasonably arrive at a conclusion different to that of the trial court. In order to succeed, therefore, the appellant must convince this court on proper grounds that he has prospects of success on appeal and that those prospects are not remote but have a realistic chance of succeeding. More is required to be established than that there is a mere possibility of success, that the case is arguable on appeal or that the case cannot be categorised as hopeless. There must in other words, be a sound, rational basis for the conclusion that there are prospects of success on appeal.’

[5] The decision of *Ramakatsa and Others v African National Congress and Another*⁵ did not lower the baseline. It also reminded that there might exist some other compelling reasons why the appeal should be heard.

The issues for appeal in *casu*

[6] It is the case for the applicant (Mr. Kanunu/defendant *a quo*) that:

‘3. In demonstrating the appeal would have reasonable prospects of success and that another court may reach a different conclusion based on the facts and legal principles of this case, I

(ii) there is some other compelling reason why the appeal should be heard, including conflicting judgments on the matter under consideration;

(b) the decision sought on appeal does not fall within the ambit of section 16(2)(a); and

(c) where the decision sought to be appealed does not dispose of all the issues in the case, the appeal would lead to a just and prompt resolution of the real issues between the parties.’

³ *H.B (Nee D.J) v R.J.B (Leave to Appeal)* (21480/2014) [2024] ZAGPPHC 401 (2 April 2024).

⁴ *S v Smith* [2011] ZASCA 15; 2012 (1) SACR 567 (SCA) para 7.

⁵ *Ramakatsa and Others v African National Congress and Another* (724/2019) [2021] ZASCA 31 (31 March 2021) para [10].

address the fundamental suppositions underlying them. . . . Additionally, I shall demonstrate, there are compelling reasons why leave to appeal should be granted.’⁶

[7] The compelling reasons as to why the matter must go on appeal are the alleged flaws in the accuracy and completeness of medical records. The applicant criticises the imprecise medical records and potential miscommunication between medical professionals and patients. It is their case that the potential appeal offers an opportunity to ‘rigorously assess and reinforce the standards of care required of medical professionals, particularly in the context of record keeping, patient communication, and duty to exercise thorough medical judgement.’⁷

[8] Counsel for the respondent (MEC/Defendant *a quo*) addressed the grounds for leave to appeal⁸ one by one and, as it could be determined from the notice of application for leave to appeal. They oppose the application in its totality. Careful reading directs to seven grounds and the alleged compelling reasons. The conclusions in the heads of argument for the respondent are correct. The grounds seem to be that:

- a) The court erred in finding that there is no evidence that supports the allegation that Dr. Thejane was warned of the incident with the hayfork;
- b) the court misdirected itself by not finding that the balance of probabilities favoured the plaintiff;
- c) the court erred in not accepting the plaintiff’s version as probably true;
- d) the court erred in the finding that the records was not completed ‘after the fact’;
- e) the court erred in finding that the casualty form cannot be trusted to provide an accurate account of what the plaintiff had communicated to Dr. Thejane;
- f) the court erred in finding that Dr. Thejane was a good witness; and

⁶ Applicant (plaintiff’s) heads of argument dated 21 October 2024.

⁷ Ibid para 28.

⁸ Respondent (defendant’s) heads of argument dated 22 October 2024.

g) the court erred in not finding that the plaintiff had discharged the onus on him by having had informed Dr. Thejane that he was stabbed in the foot.

The facts and finding *a quo*

[9] The manner in which this case came to court is of concern. The applicant only targeted one of the many medical practitioners that played a vital role in the treatment of Mr. Kanunu. From the evidence as will be shown hereunder, they were involved in the ultimate outcome of the tragedy. The court cannot now be blamed for the ruling in this case. In addition, Mr. Kanunu was not a good witness, and all the medical practitioners involved as well as the expert supports a finding that the claim was not proven.

[10] This is what the judgment *a quo* is:

‘[1] The plaintiff claims delictual damages from the defendant. The issues of liability and quantum were separated at the commencement of the trial. The merits on liability are to be adjudicated here.

[2] The plaintiff's left leg was amputated above the knee on 14 July 2015. This was due to sepsis that was localized to the left foot of the plaintiff. It became systemic and potentially fatal, hence the amputation.

[3] The claim is limited to alleged medical negligence of a doctor and/or nursing personnel at the Boitumelo Hospital in Kroonstad on Monday, 6 July 2015. The defendant denies all negligence and pleaded that the plaintiff himself negligently caused and/or contributed to any damages he may have suffered.⁹

[4] The plaintiff has the burden to prove every element and requirement of the alleged delict on a balance of probabilities.

[5] No reliance is placed by the plaintiff on the conduct of other medical practitioners that treated the plaintiff and undisputedly so, played a vital role in the chain of events. Their

⁹ See the heads of argument for the defendant at paragraph 1.3.

evidence was not adduced and there hangs a legally uncomfortable silence over this aspect and their non joinder.

[6] Counsel for the plaintiff is however correct that:

3. Based on the available evidence and the opinions of the medical experts, the conduct of the private practitioners admittedly did not comply with the general standard of care expected of them. But the question in this trial is whether Dr Thejane exercised the reasonable skill and care of a practitioner in his field. The answer turns on a remarkably straightforward factual question: did the plaintiff tell Dr Thejane that he was stabbed in the foot with a fork?... (Accentuation added)

[8] The case will in the main be adjudicated on the evidence that is common cause. As indicated; the only real issue is whether the plaintiff informed Dr. Thejane on the 6th of July 2015 of the incident with the hayfork. I will deal with it during the evaluation of the case.

[9] Both counsel in their heads of argument gave extensive summaries of the evidence and it cannot be faulted. I will not regurgitate it in the judgment since the adjudication of the case turns on what is common cause and a ruling on the probabilities presented by the objective proven facts.

[10] This is the undisputed evidence:

1. On Sunday, 5 July 2015 the plaintiff was accidentally “stabbed” near the back of his ankle by a co - worker with a fork.
2. This occurred in a farm dam. The co - worker was using the fork to spear fish in the dam. The plaintiff's feet were submerged in the water at the time.
3. The fork was one typically used for loading hay. It had a long handle with four thin prongs.
4. The co – worker(s) never testified to confirm the incident. It is only the version of the plaintiff that lies before court on this fact.
5. Professor J.H.R Becker whose report was conditionally admitted into evidence for the defendant is correct when he reported¹⁰ that: “The port of entry of the bacteria was never established,...”¹¹

¹⁰ Pages 213 to 216 of the bundle marked: INDEX - EXPERT NOTICES – 12/6/2023 at specifically paragraphs 9 to 11 of his report.

¹¹ See paragraph 06 of Professor Becker's report *supra*. I will deal with this statement later.

6. The plaintiff got out of the water, washed and checked where he was stabbed. There was no visible wound according to the plaintiff himself.
7. When the plaintiff woke up later that night, his left foot was swollen and, as the plaintiff put it, his foot was “no longer functional”.
8. The next day, which is Monday, 6 July 2015, the plaintiff called his foreman (as he put it) who took him to the private practice of Dr. J.N. Nel in Kroonstad. The plaintiff was consulted by a female medical practitioner whose name he could not recall.
9. It is undisputed that one Dr. Stander diagnosed the plaintiff's injury on that day as a fracture. The plaintiff was then referred to the Boitumelo Hospital in Kroonstad and he ended up at the casualty unit of the hospital. She did not mention any open wound or stabbing incident in her referral to the hospital.
10. The plaintiff was then seen by Dr. Thejane. Dr. Thejane diagnosed the plaintiff with a “left ankle fracture” and applied a “back slab” to the plaintiff's left foot; it is a form of plaster splint. It is unlike a full plaster cast, which would have encircled the plaintiff's foot and ankle. This is also used to stabilise and address pain. Dr. Thejane then referred the plaintiff for x-rays to be taken.
11. Dr. Thejane did not detect a fracture on the x-rays' and discharged the plaintiff that same evening.
12. The plaintiff was given a health education form by one of the nursing personnel which would have informed the plaintiff how he must look after the back slab and he was told to return to hospital the same Thursday; that is within three days. The plaintiff did not do this.
13. By the Wednesday, the plaintiff experienced increased pain in his injured foot. The plaintiff's foreman took him to the practice of Dr. Nel that same day.
14. It must be noted that this foreman was not called to testify to corroborate any of the evidence of the plaintiff.
15. During this visit, the plaintiff consulted with an, according to the plaintiff, unidentified male, likely a medical practitioner. This practitioner, believing that the bandages were too tight and causing discomfort, made vertical incisions in the bandages around the top of the ankle to alleviate the pressure. This was on all evidence Dr. Nel that treated the plaintiff on this day. The medical practitioner on the evidence at this instance clearly did not consider infection at all. This is again indicative of the fact that the stabbing did not come to the attention of the medical practitioners that treated the plaintiff.

16. The day after this, the plaintiff experienced intense pain, leading him to remove the entire back slab himself. The pain persisted to the extent that he could not manage his own needs. Consequently, his foreman brought him to his wife's care in Steynsrus that same day.
 17. The plaintiff's foot had become severely swollen and was giving off a foul odour. On Saturday, 11 July 2015, his wife requested an ambulance which took him to the hospital. The plaintiff was admitted to the hospital's surgical ward.
 18. The plaintiff's left leg was amputated above the knee three days later, on 14 July 2015.
- [11] Several medical practitioners were involved in the treatment of the plaintiff over several days and at different instances and does it not make sense why nobody treated the plaintiff for infection if the plaintiff alerted them to the stabbing.
- [12] The case turns on what must be an injury so small that it was beyond any doubt not visible to the naked eye. That is if there was any "breaking of the skin" or injury on the 5th or 6th of July 2015.
- [13] The open wound or injury that caused the infection was not visible on the evidence of the plaintiff himself. This was admitted to in the evidence of the plaintiff as quoted by his counsel in their heads of argument.
- '8. The plaintiff got out of the water, washed and checked where he was stabbed. There was no visible wound.'
- [14] Whether the plaintiff conveyed that he was "stabbed" was not reported anywhere on any of the reports that were handed into evidence. It is highly improbable that if the plaintiff reported the incident as he maintains; that it would not be recorded by any of the medical practitioners; not even the nurse that admitted him.
- [15] Again; there is not any corroboration for the evidence of the plaintiff that he told of the hayfork incident. The evidence supports the evidence of Dr. Thejane that the plaintiff did not report that he was stabbed with a hayfork; it is just not probable that so many medical practitioners will not heed the information and act on it. This, not even when the plaintiff presented to Dr. Nel with a severely swollen leg. He was so unsuspecting of any infection that he merely cut the plaster for relief of the swelling.

- [16] Neither the plaintiff nor Dr. L. Stander (the private practitioner that saw the plaintiff on 6 July 2015), Dr. Thejane at the hospital and the nursing personal at the hospital on 6 July 2015 were able to see any wound or “breaking of skin”.
- [17] Professor Becker describes the situation, that is undisputed, best on the sepsis that caused the amputation of the leg of the plaintiff when he stated as follows:

07

Signs of sepsis.

The classic stigmata are,

- Rubor = red.
- Tumor = swelling.
- Calor = warmth.
- Dolor = pain.
- Suppuration = pus formation, liquefaction.

The above criteria are classic in what is experienced with the development of a pimple, (ask any teenager), red, swelling, pain, local warmth, "ripen" pus that needs to be drained.

08i

A pimple is a localized small infection, abscess, that the body can isolate to one area. Depending on the degree of the infection the body can isolate the area and form an abscess that can be drained, or the body cannot isolate the sepsis then the infection will become systemic, involving the entire body.

08ii

In the case of the plaintiff the sepsis was localized to the foot and later to the leg and was on its way to become systemic and kill the patient. The latter manifested with the admission on the 11th/07/15- 14th/07/15 when he became disorientated. The amputation was done in time and saved his life, if it was delayed for a few hours, he would have been dead. (Accentuation added)

09

Delict?

Keeping in mind the discussion above vis.

A

Invasion of organisms,

There have to be a place where the organisms, bacteria, entered the tissue via broken skin, presence of a wound.

- 1) Dr L Stander did not document any wounds. 06/07/15, par 02i.clinically diagnosed a fracture.
- 2) Dr Thejane, 06/07/15, par 02i, document no breach of the skin, treat the possible fracture with a back-slab. POP (Plaster of Paris) behind the ankle to prevent movement secured with circular bandages.
- 3) The nursing notes, p2, 12/07/15, 07:38, did not record a wound.
- 4) It has now transpired according to multiple versions that he was injured with an iron/fork just behind the medial malleolus. It is clear that the environment was not clean and a mixed flora of organisms contaminated the "wound". (Either in the river, dam or on the farm while "spitting"). By "spitting" is meant tilling the ground.

10

B

The next phase is swelling.

After the organisms entered the wound, whereof there is no proof that there was an open wound, the port of entry was not established, but nobody can deny that there were bacteria present, the organisms will multiply and cause an inflammatory response, vis. pain, swelling and redness, we have proof that pain and swelling must have been present on 06/07/15.

In the absence of an open wound and the history of an injury, the diagnosis of a fracture was a possibility, Dr Stander and Dr Thejane thought so.

I would have expected that there would also have been redness with the pain and swelling, it is not recorded.

If the diagnosis of an infection was made at this time, and an aggressive antibiotic treatment regimen followed, the course of events might have been different, and the limb preserved.

Dr Stander and Dr Thejane stand to answer about the presence or absence of inflammation, Dr Stander is not part of the defense, but will have to explain what the condition of the foot was when it was examined.¹²

¹² Imperative is that Dr. Thejane did not observe any signs of redness or infection. This stands unrefuted on his evidence. It confirms the evidence that the "port of entry" of the infection was never established nor that there existed any indication of infection or potential infection during the treatment by Dr. Thejane.

C

The next phase, symptoms get worse. Vis. pain, swelling, warmth and redness.

The plaintiff reports at Dr Nel, between 06 -11/07/15, exact date not known, the diagnosis was that the bandages were too tight.

- 1) But what actually happened was that the swelling increased within a closed compartment and gave the impression that the bandages were too tight.
- 2) The pain increased with the increased swelling of the foot due to the progressive nature of the sepsis.
- 3) A thorough examination of the foot and ankle would have shown the clinician that the swelling was due to an infection. Apropos par 07 supra the foot would be red, swollen, warm and painful. The classic stigmata of an underlying infection.
- 4) With the advantage of the retro spectroscope, knowing what the ankle looked like on 11/07/15, black skin, blisters, offensive discharge, it can with a degree of certainty and accuracy, be postulated that there were clear signs of sepsis when Dr Nel saw the patient, unless he did not examine the patient.
- 5) These signs and symptoms were missed by the practice of Dr Nel, a serious delict, Dr Nel must accept responsibility.
This omission cannot be laid on the account of the staff at Boitumelo Hospital, the staff were not afforded the opportunity to examine the patient at the same time as his visit to Dr Nel.
- 6) Had the doctors at Boitumelo Hospital seen the patient at the same time as Dr Nel the course of events might have been totally different. The visit to the practice of Dr Nel is a "Novus actus Interveniens" and cannot be ignored.
 - The diagnosis of sepsis was missed.
 - The patient was sent home without antibiotics.
 - The patient was given a false sense of security by the doctor "that everything was under control" "the bandages were too tight" and reported later back at the Hospital when the foot became black, full of blisters and offensive discharge.
 - Had Mr. Kanunu been treated aggressively with antibiotics after the visit to Dr Nel as well as a surgery consultation to drain possible pus, the outcome might have been different, and the limb maybe saved.

D

Overt sepsis, presence of pus and systemic inflammatory response syndrome SIRS.

On admission on the 11th/07/15 the “horse had already bolted”. Mr Kanunu had an overt necrotizing infection with him rapidly going into SIRS. The treatment that was given from the 11th late afternoon until the 14th was a “last ditch” effort to try and salvage the limb, that turned out to be a futile exercise.

The urgent amputation saved his life.

11

In Summary.

- 1) Mr. I Kanunu was injured with a fork/iron in the river/dam or while working on the farm cultivating (spitting).
- 2) A mixed flora of micro-organisms got inoculated into the tissue, the mechanism is unknown.
- 3) The micro-organisms rapidly proliferated and caused infective response with swelling and pain.
- 4) A private practice was consulted, Dr L Stander saw him, the history was obviously not clear, and a fracture was diagnosed by Dr Stander (private GP) and the Dr Thejane at Boitumelo Hospital and treated with a back-slab by the doctor at Boitumelo Hospital. X-rays did not confirm the fracture.
- 5) The swelling increased and caused compression of the lower limb, Dr Nel was consulted, he diagnosed tight bandages, he does not pick up signs of sepsis, swelling, redness, pain, and warmth. It is postulated that he did not examine the patient. Had he, it could have made a difference in the course of events, commencement of an aggressive antibiotic regimen and a surgery consultation.
- 6) When Mr. Kanunu reported at Boitumelo Hospital, the ankle was, swollen, skin turning black with blisters and an offensive discharge.
- 7) Mr. Kanunu rapidly deteriorated, within 3 days became confused and was going into septic shock.
- 8) A life-saving emergency above knee amputation was performed.
- 9) The amputation achieved source control and it was possible to save his life.
- 10) He was very catabolic, BMI of 18, S-Albumin of 18, the surgery team need to be complemented with the result.
- 11) A typical case of life over limb was the end result.
- 12) Aggressive early intervention by the practitioners that treated him prior to admission on the 11th/07/15 might have made a difference.

- [18] The law on the incident of the 6th of July 2015 is clear. Given the facts it was proven on a balance of probabilities that there was not any presentation of infection or history that there might be infection.
- [19] That said, the defendant was under a legal duty to dispense proficient medical care to the plaintiff. The Constitutional Court in *Oppelt v Head: Health, Department of Health Provincial Administration: Western Cape* 2016 (1) SA 325 (CC) at paragraph [54] held that:
- ‘There is no doubt that the legal convictions of the community demand that hospitals and health care practitioners must provide proficient healthcare services to members of the public. These convictions also demand that those who fail to do so must incur liability.’
- [20] The question is if the service rendered on the 6th of July 2015 at the Boitumelo Hospital in Kroonstad was not proficient?
1. In *Topham v MEC for the Department of Health, Mpumalanga* (351/2012) [2013] ZASCA 65 (27 May 2013) it was held that:

[6] Professional negligence is determined by reference to the standard of conduct of the reasonably skilled and careful practitioner in the particular field and in similar circumstances. A medical practitioner diagnosing and treating a patient is expected to adhere to the general level of skill, care and diligence possessed and exercised at that time by the members of the branch of the profession to which he or she belongs. It follows that a wrong diagnosis does not per se amount to negligence on the part of the medical practitioner concerned. It will only be negligence if the practitioner’s conduct does not comply with the general standard of care to which I have referred. (Accentuation added)
 2. The test for medical negligence was aptly captured in November 2023 by Joubert¹³ when he discussed the cases of *Chapeikin and Another v Mini* (103/2015) [2016] ZASCA 105 (14 July 2016) and *Oppelt v Head: Health, Department of Health Provincial Administration: Western Cape* (CCT185/14) [2015] ZACC 33; 2016 (1) SA 325 (CC); 2015 (12) BCLR 1471 (CC) (14 October 2015). He concluded that:
 - a. The existence of negligence for the purpose of liability is that fault arises if a reasonable person in the position of the defendant would foresee the reasonable possibility of his conduct injuring another in his person or property and causing him patrimonial loss; and would take reasonable steps to guard against such occurrence; and the defendant failed to take such steps.

¹³ <https://www.millers.co.za/OurInsights/ArticleDetail.aspx?ArticleID=3121> accessed on 2 May 2024. Also see Joubert, W: *WHEN CONSTITUTIONAL GUARANTEES MEET REALITY IN HEALTH CARE*, 29 April 2016, Medical Negligence, De Rebus in 2017 (June) DR 42, <https://vzlr.co.za/2016/04/29/when-constitutional-guarantees-meet-reality-in-health-care/> accessed on 2 May 2024.

- b. There are two steps, the first is foreseeability – would a reasonable person in the position of the defendant foresee the reasonable possibility of injuring another and causing loss. The second is preventability – would that person take reasonable steps to guard against the injury happening.
- c. Negligence must be evaluated in light of all the circumstances.
- d. Because the test is defendant-specific the standards are upgraded for medical professionals. The question for them is whether a reasonable medical professional would have foreseen the damage and taken steps to avoid it.
- e. The appellate division noted that this standard does not expect the impossible of medical personnel.
- f. A medical practitioner is not expected to bring to bear upon the case entrusted to him the highest possible degree of professional skill, but he is bound to employ reasonable skill and care and he is liable for the consequences if he does not.
- g. A practitioner can only be held liable if his diagnosis is so palpably wrong as to prove negligence, that is to say, if his mistake is of such a nature as to imply absence of reasonable skill and care on his part, regard being had to the ordinary skill in the profession.
- h. The test is always whether the practitioner exercised reasonable skill and care or put differently, whether his or her conduct fell below the standard of a reasonably competent practitioner in the field.
- i. If the error is one that a reasonably competent practitioner might have made it will not constitute negligence.

[21] The final conclusion lies in the words of the expert for the plaintiff as he was quoted in the heads of argument for the plaintiff. Dr. Du Plessis concluded unequivocally that if the wound was not visible, and Dr. Thejane did not know of the circumstances of the plaintiff's injury, it would not be expected of Dr. Thejane to have been particularly vigilant about the danger of an infection in the plaintiff's foot. The wound was not visible and it was proven that there was no information that the plaintiff was at risk of infection available to Dr. Thejane.

[22] I ruled that there is not any evidence that support the allegation that Dr. Thejane was warned of the incident with the hayfork that took place. This is supported by the medical reports that served as evidence as well as the conduct and treatment of the plaintiff by the other medical practitioners.¹⁴ The plaintiff failed to make out a proper case on which the defendant may be found liable for any damages suffered by him.

[23] Finally: As Lord Denning remarked in *Roe v Ministry of Health* [1954] 2 All ER 131 (CA) at 139:¹⁵

¹⁴ Also see the heads of argument of the defendant from paragraphs 6 to 13.

¹⁵ Also see *Medi-Clinic v Vermeulen* 2015 (1) SA 241 (SCA) at [33].

‘But we should be doing a disservice to the community at large if we were to impose liability on hospitals and doctors for everything that happens to go wrong.... we must not condemn as negligence that which is merely a misadventure.’

The compelling reason

[11] The fact that counsel for the applicant wants for this matter to go on appeal because the medical practitioner kept, what they consider as imprecise medical records and circumstances prevailed that may cause potential miscommunication between medical professionals and patients, is not within the realm of the courts. Firstly, one cannot speculate about what might happen in future cases and secondly, this is to be dealt with by the professional organisation that ensures the quality and veracity of the medical profession. It is an executive function that the court must not step into. The doctrine of the separation of powers is clear.¹⁶ The doctrine of separation of powers underlies the principle of judicial independence. The idea is that only the judicial branch of government should discharge judicial functions and that it should do so free of interference from the other two branches. The judicial arm of the State should not step into the terrain of the other branches of the State unless it is constitutionally allowed to do so.

[12] When adjudicating courts should be careful not to venture into policy formulation, which is the role of the executive, or law-making, which is performed by the legislative arm. The best that can be done by counsel for the applicant is to lodge a complaint with the hospital or the professional organisation the medical practitioner affiliates with and is accountable to. The manner of keeping of records by medical practitioners is completely peripheral in this case and does not lie before the court for judgment.

¹⁶ MT Thabo and KO Odeku *Separation of powers, checks and balances and judicial exercise of self-restraint: an analysis of case law* (2021) vol 42 *Obiter* 547-560. See also I Currie and J de Waal *The Bill of Rights Handbook* 6ed (2022) at 18-20.

‘[2] A compelling reason includes an important question of law or a discreet issue of public importance that will have an effect on future disputes. But here too, the merits remain vitally important and are often decisive. Caratco must satisfy this court that it has met this threshold.’¹⁷

Conclusion

[13] The applicant did not meet any of the thresholds in law that will allow this court to send the matter on appeal. The application for leave to appeal must be denied and costs must be for the account of the unsuccessful party.

[14] Order

The following order is thus the consequence of the application as it is:

‘The application for leave to appeal is dismissed with costs.’

 
Opperman J

Appearances

For applicant:	WA VAN ASWEGEN Bloemfontein
Instructed by:	Symington & De Kok Attorneys Bloemfontein
For respondent:	GJM WRIGHT Bloemfontein
Instructed by:	State Attorney: Free State Bloemfontein

¹⁷ *Caratco (Pty) Ltd v Independent Advisory (Pty) Ltd* (982/18) [2020] ZASCA 17; 2020 (5) SA 35 (SCA) (25 March 2020).