REPUBLIC OF SOUTH AFRICA

IN THE HIGH COURT OF SOUTH AFRICA
GAUTENG DIVISION, PRETORIA

CASE NUMBER: A274/2024

(1) REPORTABLE: ~~YES~~/NO
(2) OF INTEREST TO OTHER JUDGES: ~~YES~~/NO
(3) REVISED: YES/~~NO~~

4/07/2025 [redacted]
DATE SIGNATURE

In the matters between: -

DR NORBERT WELKOVICS **APPELLANT**

And

HEALTH PROFESSIONAL COUNCIL OF SOUTH AFRICA **RESPONDENT**

The matter was heard in open court and the judgment was prepared and authored by the judge whose name is reflected herein and was handed down electronically by circulation to the parties' legal representatives by email and by uploading it to the electronic file of this matter on Caselines. The date of handing-down is deemed to be 4 July 2025

JUDGMENT

KEKANA, AJ

INTRODUCTION

[1] This is an appeal in terms of Section 20 of the Health Professions Act 56 of 1974 ("the Act") against the verdict and sanction imposed on the appellant by the respondent. The appeal is opposed.

CONDONATION

[2] The appellant brought an application for condonation for the late filing of the appeal. The condonation application is unopposed.

[3] In terms of Section 20(2) of the Act, the Notice of appeal must be given within one month from the date on which the decision was given. The appellant received the reasons for the decision on 13th June 2024 and was required to file his appeal by 13th July 2024. However, he only launched this application on the 09th September 2024.

[4] The appellant attributes the delay to the fact that his legal representative was out of the country and further that he had to source funds as his insurer had been liquidated. After his legal representative returned, he consulted, but still took some time to secure the finances required to pay his counsel.

[5] It is trite that to succeed with a condonation application the applicant has firstly to explain the delay; good cause for the delay, the period of delay; the prospect of success in the appeal and absence of prejudice to the other party are amongst the factors the court considers in determining whether to grant condonation.

[6] In Melane v Santam Insurance Co Ltd 1962 (4) SA 531 (A) at 532C-F, the Appellate Division stated:

"In deciding whether sufficient cause has been shown, the basic principle is that the Court has a discretion, to be exercised judicially upon a consideration of all the facts, and in essence it is a matter of fairness to both sides. Among the facts usually relevant are the degree of lateness, the explanation therefor, the prospects of success and the importance of the case. Ordinarily these facts are inter-related; they are not individually decisive, for that would be a piecemeal approach incompatible with a true discretion..."

[7] This principle was reaffirmed by the Constitutional Court in Grootboom v National Prosecuting Authority 2014 (2) SA 68 (CC), where the Court held that while the absence of a reasonable explanation or poor prospects of success may be decisive, courts must adopt a context-sensitive approach that balances all relevant factors and ensures that the "interests of justice" are served.

[8] In the present matter, the degree of lateness is approximately 57 days. The explanation for the delay, the need to secure funds, constitutes a valid and acceptable reason. The applicant has set out a bona fide defence. He indicated that as a private healthcare practitioner, he has a right

to accept or reject private patients unless it is an emergency, denying negligence on his part, thereby raising reasonable prospects of success. There is no suggestion of prejudice to the respondent, who has not opposed the condonation application.

[9] In the circumstances, I am satisfied that the applicant has shown good cause for the late filing of the appeal. The delay was neither wilful nor reckless. The application is brought bona fide and without undue delay. The interests of justice demands that the matter be heard on the merits.

GROUNDS FOR APPEAL

[10] The grounds of appeal were listed as follows:

'10.1. Appellant's right to decline to accept a private patient;

10.2. No doctor-patient relationship came into existence between the appellant and the patient.

10.3. The HPCSA ad hoc appeals committee erred when finding and confirming that the appellant was guilty of unprofessional conduct without making any finding that the appellant contravened any of the HPCSA ethical rules;

10.4. The HPCSA ad hoc appeals committee erred when making reference to and applied foreign law, more specifically, the ethical rules, codes and principles relating to medical professionals as they apply in the United States of America, without providing any legal justification;

10.5. The HPCSA ad hoc appeals committee erred and misdirected itself when failing to evaluate the evidence led at the PCC hearing in its totality; and

10.6 The HPCSA ad hoc appeals committee concurred with the contention that the Appellant made an alleged "indirect acknowledgement", and that this might be construed as an admission or confession when juxtaposed to all the evidence as a whole; and

10.7 The HPCSA ad hoc appeals committee erred and misdirected itself by ruling, without any legal justification and reasons, that:

10.7.1. the appeals committee erred in its imposition of the sanction on the Appellant on 11 September 2021, and orders that the sanction be varied to a fine of R40,000, for negligence; and

10.7.2 the appellant's suspension from practice to be reduced to 6 months, the operation of which is suspended for twelve (12) months, on condition that the Appellant is not found guilty of the same or similar offence within the said period."

THE LAW

[11] As previously mentioned, this appeal is brought in terms of Section 20(1) of the Health Professions Act 56 of 1974, which provides that any person who is aggrieved by any decision of the council, a professional board or a disciplinary appeal committee, may appeal to the appropriate High Court against such a decision.

[12] It is trite that an appellate court will not ordinarily interfere with the factual findings of the trial court unless they are clearly wrong or influenced by material misdirection. See S v Hadebe & Others 1997 (2) SACR 641 (SCA) at 645E–F.

[13] In Beukes v Smith 2020 (4) SA 51 (SCA) at para 22 it was held that although the powers of the appeal court to overturn the factual findings of the trial court are restricted, the appeal court is bound to reverse such findings if they are based on false premises or where the factual findings are clearly wrong.

BACKGROUND

[14] Mr Johannes Abram Le Roux Phillips, (the deceased) arrived by ambulance at Netcare Unitas Hospital Hospital on the 19th May 2020 at 18h45, after he collapsed at home. He complained of shortness of breath, general body weakness, and fatigue. These symptoms had persisted for two days. He had chronic obstructive pulmonary disease and was on home oxygen therapy and also suffered from hypertension and diabetes.

[15] Dr Notrem, a casualty doctor, employed by Gouws and Partners Incorporated, a private practice operating the hospital's casualty department, treated the deceased and diagnosed him with heart and kidney failure. He recommended admission to high care or ICU for further investigations and treatment. Dr Notrem contacted the appellant, the intensivist on call, telephonically at 21h20 regarding the admission of the deceased. The appellant declined to accept the deceased as a patient after enquiring whether his medical condition constituted an emergency.

[16] The deceased was subsequently transferred to Steve Biko Hospital, where he died the following day on the 20th May 2020. Mrs Sales, the deceased's daughter, lodged a complaint with the respondent regarding the appellant's refusal to admit the deceased at Netcare Unitas Hospital. The respondent decided to charge the appellant based on the complaint by Mrs Sales. The appellant was ultimately charged, and found guilty after a disciplinary hearing was held.

DISCIPLINARY PROCEEDINGS

Charge

[17] The disciplinary hearing was convened and held on 2nd to 3rd June, and 17th to 18th August 2021. The charge read as follows:

"You are guilty of unprofessional conduct which when regard is had to your profession regard with section 1 of the Health Professions Act 54 of 1974, as amended, is unprofessional in that on or about 19th to 20th May 2020, in relation to Mr Johannes Abraham Le Roux Phillips. (the deceased patient) you acted in a manner that is not in accordance with the norms and standards of your profession in that:

You were negligent as you failed to examine the patient prior to making a decision to refuse admission."

Evidence

Dr Notrem

[18] Dr Notrem testified that he is employed in the Emergency Department, where he receives all patients who present for treatment. He explained that his role involves conducting assessments, formulating diagnoses, and thereafter determining the appropriate course of action to be taken. Depending on the clinical findings, he either discharges the patient or refers the patient to a higher level of care, specifically to the relevant medical specialist.

[19] Dr Notrem further testified that he attended to the deceased and diagnosed him with heart and kidney failure. Upon clinical assessment, he concluded that the deceased required admission to the Intensive Care Unit (ICU) or high care for further management. In light of this, he contacted Dr Welkovics telephonically to discuss the possibility of admitting the patient. *(A recording of their telephone conversation was presented at the hearing.)* The conversation between them proceeded as follows:

"DR WELKOVICS: Hello.
DR NOTREM: Hi, Norbert,
DR WELKOVICS: Yes.
DR NOTREM: I have to try my luck and ask short private patient, I have got a gentleman here who is private. You take on private patients, hey?
DR WELKOVICS: ...[indistinct] medical emergency.
DR NOTREM: Sorry

DR WELKOVICS: A medical emergency. Is it a medical emergency?
DR NOTREM: Look, he is a, he is a chronic hypertensive

... [intervenes]

DR WELKOVICS: ...[indistinct, speaking simultaneously]
DR NOTREM: No look, in the last couple of days he is becoming
progressively short of breath, so he has got signs of heart failure
and he has got kidney failure as well, but it
has been progressive for a couple of days.
DR WELKOVICS: No, I am not seeing private patients, hey.
DR NOTREM: Okay, alright. Thanks, hey.
DR WELKOVICS: Save if it is immediately life-threatening. Okay, thanks
DR NOTREM: Okay, alright. Thanks then, sure. Bye"

[20] Dr Notrem testified that, following the appellant's refusal to admit the deceased, he contacted four other doctors at neiglibouring private hospitals. However, none of them were willing to accept the deceased as a patient. He then communicated with two different doctors at Steve Biko Academic Hospital, whereafter arrangements were made for the deceased to be transferred to that facility. Dr Notrem confirmed that at no stage did he discuss the issue of costs with the appellant. He further stated that Mrs Sales had informed him that the family was in a position to cover the costs associated with the deceased's hospitalization.

Mr and Mrs Sales

[21] Mr and Mrs Sales testified about the conversation they had with Dr Notrem regarding the fact that the deceased required admission to the ICU or high care. The costs were estimated to be between R100 000.00 and R200 000.00, which they indicated they could afford. Dr Notrem phoned the appellant regarding the deceased's admission at Netcare Unitas Hospital but the appellant refused to admit the deceased because he was self-funded. Proof was provided that they had over R5 million rands in the bank accounts.

Dr Welkovics

[22] Dr Welkovics testified that he declined to accept the deceased as a patient after satisfying himself that the case did not constitute an emergency. He stated that, had the case been an emergency, he would have proceeded to the casualty department to render assistance. He further indicated that he had worked with Dr Notrem for approximately five to six years and expressed confidence in Dr Notrem's clinical judgment.

Dr Van Dyk

[23] She testified that the appellant had the right to refuse to admit a private patient. He acted accordingly by ensuring that it was not an emergency before declining to accept the deceased as a patient.

THE FINDINGS OF THE PROFESSIONAL CONDUCT COMMITTEE

[24] The Professional Conduct Committee (PCC) had found that: (a) the appellant demonstrated a dismissive attitude when presented with the deceased's case by Dr Notrem; (b) he based his decision not to enquire further on the fact that the deceased was privately funded; and (c) by failing to ask any pertinent questions, he neglected to conduct an appropriate examination of the deceased. The PCC found that the appellant's decision was primarily motivated by financial considerations.

[25] The PCC viewed the appellant's acceptance of Prof Dhai's criticism of his failure to ask questions regarding the deceased's condition as an indirect acknowledgment of wrongdoing. Furthermore, his concession that nowhere in the applicable ethical guidelines is there any provision permitting financial considerations to influence decisions regarding the admission of patients into the hospital, strengthened the PCC's position as regards to his guilt.

[26] The appellant was found guilty on the 25th August 2021, and on the 21st September 2021, he was handed the following sanction:

"a fine of R100 000 under the following categories.

Withholding Medical Care: R10 000

Danger of Harm to Patient: R20 000

Negligence: R70 000

Suspension from practice for 12 months, the operation of which is suspended for (3) three years on condition that he is not found guilty of the same or similar offence within the said period."

APPEAL TO THE HPCSA APPEALS COMMITTEE

[27] The appellant upon his sanction being imposed proceeded to lodged an appeal to the HPCSA Appeals Committee against the verdict and the sanction. On the 27th May 2024 the HPCSA appeals committee confirmed the verdict but amended the sanction as follows: a fine of R40 000 for negligence and a six months suspension from practice, suspended for a period of 12 months.

ANALYSIS

The right to decline a private patient

[28] The appellant contends that the appeal committee focused on the wrong question—namely, whether a private *hospital* could turn away a patient who could not pay, rather than whether a private *doctor* could refuse to take on a patient.

[29] The respondent contends that this ground of appeal has no merit. It was submitted that the emergency department where Dr Noirem practices is an independent entity and therefore only practitioners at Netcare Unitas Hospital have the power to admit patients to the hospital. The

respondent argued that on the date in question, the appellant was on standby and since the medical condition of the deceased required his expertise, the decision to refuse or admit the deceased as a patient rested on the appellant. According to the respondent, the evidence is that the appellant refused to admit the deceased as a patient because he did not have a medical aid.

[30] The evidence however shows that the appellant only had to decide whether to take the patient into his care. Dr. Notrem did not ask the appellant to take over the treatment of the deceased; he merely enquired whether the appellant was accepting private patients. Once he accepted the patient, the patient would then be admitted to ICU or high care under his supervision.

[31] The appeal committee accepted that doctors in private practice can choose whether to take on private patients or not. But that right does not apply in cases of emergency or where refusal would violate any constitutional rights. The key question is whether, in this case, the appellant had a duty to examine the patient before refusing— something that cannot be answered by simply saying he had a general right to refuse. I will return to this point.

Emergency Medical Care

[32] Section 27(3) of the Constitution and section 5 of the National Health Act 61 of 2003 provide that no one may be refused emergency medical treatment. The central question here is whether the patient's condition constituted such an emergency on the day.

[33] The evidence of Dr Notrem, the casualty doctor who assessed and treated the deceased, was that while the deceased was in heart and kidney failure, his condition had stabilised by the time he contacted the appellant. When asked by the appellant whether the condition constituted an emergency, Dr Notrem responded in the negative.

[34] The evidence of Dr Notrem in this regard was as follows:

"Mr. Govender: … you gave Dr. Welkovic a brief exposition of the clinical picture of the patient. Correct?
Dr Notrem: That is correct.
Mr. Govender: And in your view, when Dr. Welkovic asked you whether it was a medical emergency or immediately life- and limb-threatening in the next six hours, your answer to that was no, correct?
Dr. Notrem: Yes, I stabilized the patient.
Mr Govender: If it was a medical emergency, and if it was something that was life or limb threatening in the next 4 to 6 hours, you would have said so; not so, Dr Notrem?
Dr Notrem: I would have said so. I mean, from past experiences, yes. If I am worried that I cannot, beyond my training, that I cannot manage a patient further and they are facing imminent death or loss of limb, I would immediately ask him to come to the hospital to manage the patient further or to come to the emergency department."

[35] The evidence shows that Dr Notrem, the casualty doctor who saw the deceased, did not consider the situation to be an emergency. As the doctor working in the emergency department, he was in the best position to judge whether urgent care was needed. He did not ask the appellant to come to the casualty unit that day, which the appellant testified he would have done if urgent care was needed.

[36] In my view, the Appeal Committee focused on the seriousness of the diagnosis, but they overlooked Dr Notrem's clear evidence that the patient was not in immediate danger. Since there was no medical emergency, the appellant still had the discretion to decide whether to take on the private patient. His decision not to do so does not amount to a breach of any legal, constitutional, or ethical duty related to emergency care.

Doctor-patient relationship and duty of care

[37] The respondent contends that a doctor-patient relationship was established when the appellant took Dr Notrem's call, discussed the patient's condition, and accepted or relied on Dr Notrem's medical opinion.

[38] The appellant, however, referred us to the case of Life Health Care Group (Pty) Ltd v Suliman 2019 (2) SA 185 (SCA), where the court found that a legal duty arose once the doctor accepted responsibility for a patient — for example, by agreeing to cover for another doctor, by responding to a nurse's call after admission, or by giving treatment instructions.

[39] The appellant argues that these facts do not apply here. The deceased was a private patient who had not been admitted under his care. He took the call but clearly refused to accept the patient and gave no instructions or medical orders to Dr Notrem.

[40] The appeal committee incorrectly concluded that a doctor-patient relationship existed simply because the appellant answered the call and discussed the case. This conclusion is flawed. In the *Suliman* case, the court emphasized that a legal duty arises when the doctor accepts responsibility, something the appellant in this case did not do. The appellant did not discuss the deceased's condition. He enquired more than once whether it was a medical emergency and declined to accept the deceased as a patient once Dr Notrem confirmed that it was not a medical emergency. The appellant neither took control of the patient's care nor gave any indication that he had accepted responsibility.

Indirect acknowledgment

[41] The appellant's acceptance of Prof Dhai's criticism that he failed to make further inquiries about the deceased's condition was interpreted by the committee as an acknowledgment of fault. According to appellant the Appeal committee erred in this regard. In my view, such acceptance of professional critique cannot be equated with a legal admission or confession. An

acknowledgment in a professional or ethical context does not meet the legal standard for an admission of guilt in disciplinary proceedings.

Unprofessional conduct-breach of ethical rules

[42] The appellant further argued that the appeal committee erred in concluding that the appellant was motivated by profit and that he failed to act in the best interest of the patient in contravention of the council's regulations and ethics of his profession. The respondent contends that the appellant's decision was based on financial grounds, which is a breach of ethical rules.

[43] The appellant explained in his testimony that he knew that if he agreed to see the patient, a doctor-patient relationship would have been established. This would mean he could not later refuse to treat the patient, even if it turned out that the patient could not afford the medical care needed. He said his concern was not about his own finances, but about whether he would be able to give the patient the proper care without later being told that there was no money to pay for the treatment required. His decision was based on the fear of being placed in a position where he would have a duty to treat, but without the means to do so effectively.

[44] While the appellant conceded that the ethical rules do not permit financial considerations to influence the decision to admit a patient, this concession must be considered in its proper context. He denied that his decision not to accept the deceased as a private patient was financially motivated. His concession cannot be taken as proof that the appellant's decision was based on financial grounds. This is mainly because the appeals committee appears to acknowledge that there are systemic flaws that might have influenced the appellant's decision. In this regard the committee remarked as follows:

"The system is such, we do understand, but it is regulated by the Council, and Dr Welkovics is bound by those regulations. Having chosen to operate within the system, he cannot invoke its flaws as a justification for failing to examine the patient."

[45] The committee's finding that the appellant cannot rely on the flaws of the healthcare system to justify his failure to examine the patient requires closer scrutiny. While practitioners are indeed bound by the rules and ethical guidelines of the Health Professions Council, those rules must be applied with due regard to the realities of the private healthcare sector. The system is one where access to care is often determined by a patient's ability to pay. This is not a justification for unethical conduct, but it is a relevant consideration in assessing the reasonableness of the appellant's actions. The committee's approach, which appears to isolate the appellant's conduct from the broader context, risks unfairly placing the entire burden of systemic failure on the appellant. Notably, Dr Notrem testified that he contacted four other doctors in the neighbouring private hospitals, all of whom also refused to accept a self-funded patient.

[46] This lends support to the view that the appellant's decision not to accept a private patient was not extraordinary or individually negligent, but reflective of a broader systemic pattern. The committee failed to give adequate weight to the evidence.

Reference to international law

[47] Regarding the reference to foreign law, in my view, the PCC was at liberty to refer to foreign law which has persuasive value and could therefore not be said to have erred in this regard.

Did the appeal committee misdirect itself?

[48] The Constitutional Court made the following instructive remarks in Bernert v Absa Bank Ltd 2011 (3) SA 92 (CC)

"The principle that appellate courts should not ordinarily interfere with factual findings of trial courts is not rigid. It acknowledges the trial court's advantage in observing and hearing witnesses, particularly regarding demeanour. However, this principle must not 'tie the hands'

of appellate courts. It should assist, not hinder, appellate courts in doing justice. Thus, where the trial court has materially misdirected itself on the facts, or where the appellate court is convinced the conclusion was clearly wrong, it is entitled to intervene and come to its own conclusion on the record. Similarly, where the appellate court is convinced that the conclusion reached by the trial court is clearly wrong, it will reverse it."

[49] It is accepted that the appellant, as a private healthcare practitioner, had the right to refuse to accept a patient, provided that such refusal was exercised ethically and in accordance with professional standards. However, the exercise of this right does not absolve a practitioner from the obligation to act reasonably and with due care, particularly where the patient's clinical presentation suggests the need for further inquiry.

[50] Returning to the question of whether the applicant ought to have examined the deceased before deciding not to accept him as a patient. The evidence shows that Dr Notrem provided the deceased with the emergency medical care required by him until he was stabilised. There is no evidence contradicting the claim that the deceased's condition had stabilised by the time that Dr Notrem contacted the appellant. Dr Notrem further testified that, due to the deceased's multiple organ failure, he sought to have the patient admitted to ICU or high care. However, he was clear that at the time of the telephone call, although the condition was serious and progressive, it did not constitute an emergency. In his call to the appellant, Dr Notrem enquired whether the appellant was taking private patients; he did not request the appellant to intervene in the deceased's treatment.

[51] Moreover, no evidence was placed before the PCC regarding the deceased's condition at the time of Dr Notrem's call. Consequently, there was no evidence that the deceased's clinical presentation required further inquiry, which required the appellant to examine the deceased.

CONCLUSION

[52] After considering all the evidence, it is clear that the appellant had no contract or clinical responsibility for the patient; he was told that the patient was stable and he did not accept the patient for treatment. The fact that the patient was a private patient, not formally admitted to the hospital, and not presented to the appellant as an emergency, all support the view that the appellant did not assume any responsibility.

[53] While the appellant's decision not to examine or admit the patient may, in hindsight, be viewed as regrettable, it does not amount to negligence or a breach of professional or ethical duty within the circumstances of this case. Dr Notrem reiterated that it was not an emergency and that if it were, he would have asked the appellant to come to his assistance, which he did not do in this case as the deceased had been stabilised.

[54] The appeal committee's conclusion does not align with the evidence and fails to properly consider the context. For these reasons, I find that the appeal committee erred in concluding that the appellant acted unprofessionally based solely on financial reasons and that such finding made by it constituted a material misdirection. Such finding cannot stand and must be set aside.

[55] In the result, I propose the following order:

1. The application for condonation is granted with costs including costs of counsel.

2. The appeal against both conviction and sanction is upheld with costs including costs of counsel.

P D KEKANA
ACTING JUDGE OF THE HIGH COURT
GAUTENG DIVISION

[redacted]

P D KEKANA
ACTING JUDGE OF THE HIGH COURT
GAUTENG DIVISION

I AGREE and it is so ORDERED.

[redacted]

C COLLIS
JUDGE OF THE HIGH COURT
GAUTENG DIVISION

DATE OF HEARING: 25 FEBRUARY 2025

DATE OF JUDGMENT: 4 July 2025

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