PHSDSBC

PUBLIC HEALTH AND SOCIAL DEVELOPMENT SECTORAL BARGAINING COUNCIL

ARBITRATION AWARD

Panellist: **Archibald Ngoako Mafa**

Case No: **PSHS689-16/17**

Date of Award: **14 April 2017**

In the matter between:

DR. K.G MUGANZA (Union / Applicant)

and

DEPARTMENT OF HEALTH – MPUMALANGA (Respondent)

DETAILS OF HEARING AND REPRESENTATION

1. This matter was set down for arbitration on 02, 03 and 23 March 2017 at Evander Hospital in Evander and at 10:00 am. Both parties attended the proceedings.
2. The applicant, Dr. K.G Muganza appeared in person, and Mr. M.R Khoza represented the respondent.
3. The proceedings were digitally recorded and detailed handwritten notes were also taken which forms part of the record.

PRELIMINARY ISSUES

4. None

ISSUE TO BE DECIDED

5. Whether the per-cautionary suspension of the applicant was fair or not.
6. Whether or not applicant is guilty of the allegations leveled against him..
7. Whether the sanction of final written warning and 3 months suspension without pay was appropriate under the circumstances or not.

BACKGROUND TO THE ISSUE

8. The applicant is employed by the respondent and deployed at Evander Hospital as a Medical Officer Grade 3 since 2011.
9. As at the date of his suspension for acts of misconduct on 8 July 2015 he was earning a monthly salary on the level of grade 3 medical officers.
10. The applicant was charged for gross negligence alternatively prejudicing the administration, discipline and/or efficiency of the department of health and in the further alternative for poor work performance.
11. The outcome of the disciplinary hearing was a finding of guilt against the applicant and the sanction was a final written warning and 3 months suspension without pay
12. The applicant referred the matter to Council having not been satisfied with the outcome which was unsuccessfully conciliated and referred for arbitration.
13. Notwithstanding the fact that the duty to begin rest with the applicant both parties agreed that in order to expedite the matter the respondent party will first lead evidence.

SURVEY OF EVIDENCE AND ARGUMENT

RESPONDENT'S CASE

14. **Nomsa Nathwala Velheminah Masondo** was the 1st witness and testifies as follows:

15. She is employed as Nursing Service Manager and her responsibility is to oversee all nursing units within the hospital and to provide oversight on all nursing activities in all nursing units with the facility and also to provide supervision.
16. She confirmed the existence of Adverse Events Management Policy within the department which has been in place since 2013 and signed by the CEO and communicated to all employees in their meetings especially nurses.
17. According to her an adverse event that has to be reported is anything that give rise to or has the potential to lead to unintended, unwanted or unexpected loss or damage to individual and when it occurs the committee will convene to discuss it as it happened.
18. She is aware of an incident of a 19 years old girl who was admitted at the hospital on 15 June 2016 with a condition and who was unconscious.
19. According to her in her entire professional career since 1988 she has never witness an emergency operation performed in a labour ward, more so of a pregnant woman without her consent, and an operation that was performed by Dr. Arimo assisted by Dr. Muganza was abnormal.
20. Her understanding is that should such operation be executed without consent, post the operation the Clinical Manger has to be immediately informed of the process and outcome and if he/she can give consent under extreme emergency post operatively.
21. In her view the operation that was carried out by Dr. Arimo assisted by applicant falls within the category of adverse events that had to be reported.
22. She does not recall any adverse incident meeting regarding such incident that was reported but recall it being reported by a sister from the theatre. In other words it was reported from the nursing side but not from the medical side according to her.
23. She described a document in the bundle as part of maternity case record that is used for the client/patient attending antenatal care at he clinic which is also used during labour when a woman gives birth.
24. She confirmed the name of the patient appearing on the document as Sesi Malaza and according to her the duty of the two doctors and nurses that were involved were suppose to give the Clinical Manager to complete the consent form.
25. After the event was reported to her by the nursing sister she immediately reported the incident to the Clinical Manager and asked sister Sinqathi telephonically as she was also involved during the operation as a professional but did not report and was never disciplined at any stage.

26. During cross examination she confirmed reporting the incident to Dr. Pule, the Clinical Manager because a s a member of the adverse incident committee she had to advise stakeholders and to make the chairperson aware of the incident.
27. She confirmed that the purpose of informing Dr. Pule was so at to inform the stakeholders of what happened.
28. She denied that Dr. Pule failed in his duties by not convening the committee meeting in that his responsibility is to communicate the information to stakeholders as to what should be happening.
29. Although she confirmed that the file went with the patient when she was transferred, she insisted that consent had to be obtained immediately after the operation.
30. She confirmed that the Clinical Manger would have signed the consent form if he was informed by the doctor who performs the operation.
31. She contended that in her entire professional career it was wrong to perform an operation in a labour ward as the area is not conducive and an adverse event.
32. She however confirmed that there are conducive areas where an operation can be performed outside labour ward and referred to ICU even if it is not a theatre.
33. She conceded that in her knowledge and from the midwifery books she read there is exhaustive list of areas where an operation could be performed outside a theatre but insisted that a labour ward is not one of the identified areas.
34. Her understanding of cardiac arrest was that once identified it should be managed in line with the guidelines and that in her view emergency hysterectomy on cardiac arrest falls within both an adverse event and application of what the guide lines provides.
35. She confirmed that within the facility she is not aware if the sister who did not report the incident if she was disciplined.
36. Under re-examination she confirmed that had the report given to the Clinical Manager it would have been signed.

37. **Ronald Edgar Mhlanga** was the second witness and testified as follows:
38. He qualified as a doctor in 1977 and his area of specialization is obstetrics and gynecology, maternal and child health and has both Diplomas and Masters in maternal and child health.
39. He is a provincial specialist in obstetrics and gynecology and a coordinator of the district clinical specialist team.
40. He testified that within the province there are fellow colleagues who attained same qualifications but in terms of experience he is senior.

41. According to him the responsibility of a doctor who receives a patient under a condition of the patient in question with eclampsia (fits with high blood) is to assess and call for help and make sure that a patient is breathing and it is a team effort.
42. To make sure that a patient has a drip to in order to prevent further fits and to control blood pressure.
43. To restore the circulation of blood (homeostasis), to deliver the patient and to monitor the condition of the patient and rehabilitate the patient.
44. His involvement in the matter was to investigate circumstances surrounding the case. He went to Evander Hospital to retrieve the notes and took statements of people who were involved in the process.
45. He made findings and from the medical side he found that the patient was not treated as an emergency.
46. According to him the doctor who attended the patient did not adhere to the principles as stated above by calling for help and preventing further fits, and blood pressure was never controlled and as such resuscitation was not properly done.
47. In his view what was done was to deliver a child in a labour ward which was not an appropriate place to deliver a child through operation. The necessary precautions were not adhered to for infection control because labour ward is not a sterile place and does not have equipment for sustaining life and necessary skilled people.
48. He found that there was ample time before the operation was done to control blood pressure and prevent further fits and as such the appropriate place to perform the operation under the circumstance was the operating theatre.
49. It was his evidence that the symptoms presented itself from the patient during her admission required urgent attention as emergency. He confirmed that it does happen that a patient is operated without consent but verbal consent has to be obtained from the clinical manager and the following day it has to be taken to the person responsible to sign.
50. He found that there was no consent obtained as the clinical manager only became aware of the incident after even though he was within the institution.
51. It was his evidence that when a patient is transferred all documents should take with including the consent documents and the fact that the doctor who performed the operation did not obtain consent is a serious omission in that it is equivalent to an assault.
52. He classified the event as an adverse event which had to be reported and in his view it was the responsibility of both Dr. Akimo and applicant to report the incident as medical officers.
53. It was his finding that there was no intention on the part of the medical officers but an omission.

54. It was his evidence that in his experience he never came across an incident where a caesarian section operation performed in the labour ward but in a theatre. At some stage while the patient was still present he was busy treating other patients which he views as substandard care attention as he was suppose to give his full attention to that patient.
55. Furthermore, a working of the nervous system of the patient was never looked at, pupil and reflexes.EMS had to come and incubate the patient while they had senior doctors which he found disturbing.
56. Accordingly his conclusion was that the patient was not managed as eclumsia.
57. He confirmed his report in the bundle which he could have probably compiled in a day as adverse events reports are to be in writing submitted within 72 hours.
58. He could not confirm that his report was made in haste and contended that the HPSA process is not the same as the one he undertook.
59. He confirmed that the motivation for the suspension of applicant was his preliminary findings that he operated a patient in a hazardous environment, failure to report an adverse event of that nature and operating a patient without consent and his findings are generic and not pointing at anyone.
60. He insisted that his report was not only dependent on maternity care records. His findings of consent were also based on what he was told during the interviews.
61. It was his contention that applicant is implicated on the control of blood pressure in that they were the only two senior medical officers managing the patient and operated the patient.
62. He contended further that the fact that applicant's name does not appear on any of the documents cannot be the reason why he cannot be implicated as he performed the caesarian section with Dr. Arimo.
63. He insisted that there is no rule as to who should obtain consent but whoever was involved has the responsibility.
64. When it was put to him that the patient was classified as complicated eclampsia his response was that the patient was lying on her back , the incubation was wrong and was left with one nurse.

APPLICANT'S CASE

65. **Patience Phikela Sinqadi** was the first witness and testified as follows:
66. She is employed by the respondent since 1997 and with Evander Hospital as Midwife Sister since 2009.

67. She was on duty on the 15 June 2015 working at the labour ward and a senior to the staff in the ward on that day. She recalls attending a patient by the name Sesi Malaza who was brought by paramedics and she was having fits and was accompanied by an elderly lady who claimed to be her neighbour.
68. The neighbor reported that she found the lay fitting and she wanted to see the patient's maternity record but could not find it. The paramedics then took the patient to the labour ward and she instructed nurse Mthebula to do vital science on the patient.
69. As the blood pressure was high she inserted an IV line with sodium 200ml and also injected 4mg of magnesium sulphate in the drip. She injected 5ml of magnesium sulphate in each buttock and the n inserted a chtheter to monitor urine output.
70. PET bloods were taken by Sister T.P Mkhatshwa and sent urgently to laboratory. She then sent sister Mkhatshwa to call Dr. Arimo who was at the sonar room attending high risk patients.
71. On arrival Dr. Arimo inserted an airway and the patient vomited a thick brownish staff. Suctioning was done and Dr. Arimo order a second IV line which was inserted by sister M.C Mpilo and a epanutin was given IV and still the patient was not responding positive to the treatment as she was still fitting.
72. Dr. Arimo then ordered a dormircum which he sent Sister T.P Mkhatshwa to collect at casualty as they do not keep stock in the maternity ward. The dormircum was injected to the patient by Dr. Arimo and in the process Dr. Mokoena came and found Dr. Arimo still struggling with the incubation of the patient.
73. On arrival Dr. Mokoena successfully incubated the patient and left. The patient was however still fitting and a second dormircum was ordered and it was injected to the patient and the patient was then stable following the second dormircum.
74. She then left the labour ward to attend other patients leaving the patient with Dr. Arimo, sister Mkhatshwa and sister Mashinini.
75. After a while she heard a voice of Dr. Muganza screaming asking her whereabouts and met him at the door where the patient was kept. Dr. Muganza and Dr. Arimo then went out of the labour ward to the nursing station and when they come back Dr. Arimo reported to Dr. Muganza that he could not find a bed at Witbank and Rob Ferreira Hospital but at Cosmos Hospital in Witbank.
76. She then instructed sister Mkhatshwa to call ICU ambulance and when she came back she reported that only a helicopter was available. While waiting for the helicopter to arrive she continued with her other duties at the patient was no longer fitting and calm.
77. Afterwards 4 paramedics came with big bags and she directed them to where the patient was. They did vital science as the patient was fitting for the second time. The paramedics then requested a dormircum and she advised them that it was already give to the patient and they insisted on another dosage and the patient was given a dose from the back.

78. While they were busy she went back to the labour ward and found Dr. Arimo closing the abdomen of the patient and sister Mashaba was helping with instruments.
79. She then went back to where Dr. Muganza and the paramedics were busy resuscitating the patient and the patient was stable. They then cleaned the patient preparing her for the flight and she accompanied the patient and the paramedics to the helicopter.
80. When the patient left the hospital she had no other injuries but for the caesarian wound. In her view the patient had high blood pressure and in a severe condition and gasping.
81. The helicopter took long to arrive at the hospital and she could not write a report on that day because it was busy but she wrote it later and it got lost.
82. In her view applicant was not negligent as he was not there when the patient arrive.
83. Under cross-examination she confirmed that in her entire professional career she never witnessed a patient being operated in a ward.
84. She conceded that when the patient was prepared for operation and when Dr. Muganza assisted Dr. Arimo with the operation she was not there.
85. She concede further that consent has to be obtained when operation is performed and in this case she has no knowledge if such was obtained and cannot also attest to Dr. Muganza's negligence as she was not there when the operation was performed nor attest on whether the environment was conducive to perform the operation.

86. **Mudzunga Cynthia Mpilo** was the second witness and she testified as follows:
87. On the day of the incident she was on duty working in the maternity ward in neo-natal department.
88. She was asked to help at the maternity ward by bringing scholine to the paramedics and on her way back she met Dr. Muganza.
89. After meeting Dr. Muganza she was asked to bring the caesarian pack. She called sister Mashaba from the theatre and went back to where she was working to call Dr. Ishmail wherein Dr. Ismail and Dr. Muganza resuscitated the baby in neo-natal ward.
90. When Dr. Ishmail sked for the file he was told that the file left with the patient and opened another file. When she went back to the ward she found that the baby did not make it and Dr. Muganza asked her to write a report.
91. Under cross examination she confirmed that she never witnessed an operation performed in a labour or maternity ward.
92. She could also not attested attest to the issue of consent and also did not witness the operation and therefore she could not testify on the role played by Dr. Muganza.

93. **Kazinguvu Ghislain Muganza (applicant)** was the third witness and testified as follows:
94. He is employed as a Medical Officer grade 3 since 27 June 2011. His duties include all that a medical doctor would perform. He spent some years in the maternity ward in that in from June 2011 until 2012 he was allocated the outpatient department.
95. From 2012 until the date of the incident he was based in the maternity ward and also allocated clinical leading role of inward patients.
96. As at the date of the incident he had practiced as a doctor for 15 years in all levels. He went through training in all aspects of general medicine including emergency medicine.
97. He has a Diploma in Obstetrics from the College of Obstetricians and Gynecologists of South Africa which he obtained in 2013.
98. On 15 June 2015 he was on duty and Dr. Arimo was in charge of emergency including labour ward, anti-natal ward, post-natal ward and high risk patients and he was in charge of the gynecology ward and outpatients.
99. Around 11:00am on that day he made a turn at the maternity ward and where he found Dr. Arimo and Dr. Mokoena in the labour ward at the bedside of a patient.
100. Dr. Arimo reported to him the condition of the patient at the time describing her to be having persistent fit convulsion on admission, high blood pressure, 9 months pregnant and that she was admitted semi- conscious
101. He was told by Dr. Arimo that he diagnosed the patient with severe eclamsia and gave treatment for such to patient and that he was struggling to stop the convulsions. He also told him that PET blood were taken and send for laboratory investigations, that IV lines are in place and running and that the urinary catheter is in place.
102. According to him he was further informed that the matter was discussed with Dr. Manana from Witbank Provincial Hospital for the patient to be transferred and arranged a helicopter from Nelspruit.
103. He was further told that the patient came with the edema of the tongue and narrowed airway which necessitated to be secured which means they had to put a tube.
104. He testified that Dr. Arimo called Dr. Ekujumi. A family physician who is senior in the hospital who told him he was busy with files and with the Clinical Manager.
105. His first encounter with the patient she never witness any fits and the blood pressure was 140/62. The amount of oxygen (saturation) was above 92%. His overall assessment was that the clinical assessment of the patient at the time was controlled.
106. The patient on continued oxygen and everything was done on their side and he went back to his ward until around 2:00pm when he was told that the patient' s condition deteriorated but the chopper has landed at the time.

107. The resuscitation process was started again and the paramedics assisted with the chest compression. Dr. Arimo and one of the paramedics did the rescue breathing by inflating air in the lungs in five cycles which takes two minutes.

108. He joined the one who was doing chest compression because he was not doing it efficiently and they continued with the process and when the checked the ECG rhythm on the monitor it showed that there is no heart beating so they had to continue as the patient was still on cardiac arrest.

109. After four minutes they did the peri-mortem caesarian session. They screamed for caesarian pack but in the meantime continue with the LPR while waiting for the pack. He was on the left side of the patient and Dr,. Arimo was on the right side and paramedics continued with the airway.

110. The applicant, Dr. Arimo and sister Mashaba concentrated on the operation and got the baby delivered and gave her to Dr. Ishamail. Thereafter they cleaned the uterus, repaired and closed it and checked if there was no bleeding.

111. He then joined Dr. Ishmail to resuscitate the baby and while they were busy one of the paramedics informed them that the patient is resuscitated and was taken to the helicopter which was also confirmed by Dr. Arimo. Thereafter they wrote a report and had a debriefing.

112. The following morning it was a holoday according to him and Dr. Pule was not at work. The next day he went to check him again and found him in the matron's office as expected him to convene a meeting.

113. He testified that he had a verbal discussion with Dr. Pule about the incident and told him he will tell the details in the meeting which never took place to date nor called by the Adverse Events Committee.

114. Around 1st July 2015 the Chief Obstetrician in the province Dr. Mhlanga came to the hospital and they had a meeting in Dr. Pule's office who also reported the matter on the same day with unverified facts.

115. On 3 July 2015 he received a notice of intention to suspend letter which led to his suspension and charges. In his view during the disciplinary hearing there was no evidence to the effect that he broke any rule.

116. He insisted that Dr. Pule's evidence was not hearsay when it was put to him that it is not on record.

117. He could not dispute the requirements to obtain consent when operating an unconscious patient but contended that it was Dr. Arimo who was to obtain the consent as he was assisting him.

118. He conceded that it was his first time to assist in similar operations and insisted that for unplanned and life saving operation they can be performed in a ward without life supporting mechanism.

119. He contended that in his view reports will be written when required and any evidence that it was a requirement is an opinion.

120. He refuted the allegation that the incident was an adverse event but for the death of the child but later conceded when it was put to him that the mother's condition could also be classified as such.

121. While he demanded proof that him and Dr. Arimo did not the incident as it was an adverse event he equally could not provide proof that they did report it in cross examination.

122. He insisted that he reported it to Dr. Pule verbally and according to him in terms of the policy it can be reported both verbally and in writing.

ANALYSIS OF EVIDENCE, ARGUMENTS AND FINDINGS

123. It is common cause that the applicant was suspended following an investigation into allegations of misconduct after an incident which took place at Evander Hospital where he is employed and took part in the said incident.

124. It is common cause that he was later charged together with his colleague Dr. Arimo who resigned before the disciplinary proceedings could be finalized.

125. The outcome of the hearing was a guilty verdict against the applicant and the sanction was a final written warning coupled with 3 months suspension without pay.

126. It is so that the management of the patient Sesi Malaza was a team work consisting of the nursing and medical team.

127. From the evidence presented during these proceedings, the evidence of Dr Mhlanga on the procedure and practice to be observed when handling a patient in the state of Sesi Malaza was materially not disputed.

128. What rather became an issue were the exceptions to the standard procedure and practice under emergency and life saving situations.

129. It was not in dispute that applicant did not receive the patient herein. He however was involved in the further management of the patient.

130. Moving from the premise that the management of the patient was a team work, I cannot find any plausible explanation why a certain member of the team should take more blame than the other.

131. It is not applicant's case that there was no negligence in the process of managing the patient. The applicant's case is that he was not in the forefront of patient management but Dr. Arimo and he only assisted.

132. In my view it is for the same reason that applicant raises consistency in that he finds himself as the only culprit within the medical team.

133. The evidence regarding Dr. Mokoena which was presented by one of the applicant's witnesses, clearly vindicates him in that he came and resuscitated the patient and left. There is no evidence that he was not involved in operating the patient nor he was negligent even though he participated in management of the patient.

134. The charges leveled against applicant and Dr. Arimo relates to their participation before, during and after the operation.

135. On a balance of probabilities I cannot find applicant grossly negligent on performing a caesarian section of a patient Sesi Malaza in a hazardous environment in that it was an emergency and a life saving exercise where one cannot be expected to fully comply with procedures in place. I am however in my view attribute some degree of negligence on his part in that given the time space available at the time he could have advise that the patient to be moved to a more hygienic environment as there is no evidence that it was not possible to more the patient to a theatre.

136. Furthermore, post the operation I am of the view that applicant equally had an obligation as part of the team to make sure that consent is obtained and the incident is reported as such. I this regard I find that applicant's conduct to have been prejudicial to the administration and/or efficiency of the department.

137. The issue regarding inconsistency does not arise in my view in that Dr, Arimo was equally charged with the applicant but decided to resign in the process and therefore employer/employee relationship does not exist anymore . As to the nursing staff notwithstanding the fact that the evidence was not clear on what actually happened in their case, I am hesitant to compare them with the medical team when dealing with issues of discipline as the duty and responsibility to perform operation is that of the medical stuff complement.

138. Accordingly, I am unable to interfere with the verdict and sanction imposed by the disciplinary hearing chairperson in that I find it to be one that a reasonable decision maker would have arrive at under the circumstance

139. Accordingly, I therefore proceed to render the following award:

AWARD

140. The Applicant's failed to make out a case for unfair labour practice against the Respondent.

141. The Applicant's case is hereby dismissed.

142. I make no order as to costs.

Signature: _____

Commissioner: *Archibald Ngoako Mafa*

Sector: *Public Health & Social Development*