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Criminalising medical harm: Should medical professionals be subjected to criminal prosecution if patients are harmed during medical treatment?

Shuaib Kauchali

Student No.: 993248886

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Supervisor: Dr Suhayfa Bhamjee

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DEDICATION

To Maryam.

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I, Shuaib Kauchali, declare that:

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LIST OF ABBREVIATION

CC	Constitutional Court
GNM	Gross Negligence Manslaughter
HC	High Court
HPA	Health Professions Act
HPCSA	Health Professional Council of South Africa
NHA	National Health Act
OHSC	Office of Health Standards and Compliance
SAMA	South African Medical Association
SCA	Supreme Court of Appeal
UK	United Kingdom
US	United States (of America)

ABSTRACT

Criminal medical harm refers to instances where medical professionals engage in actions or omissions that cause significant harm to patients, potentially amounting to criminal offences under the law. This dissertation examines the legal consequences of medical harm resulting from intentional actions or negligence in South Africa. Within a complex healthcare system, medical professionals are legally obligated to adhere to standards of care to ensure patient safety and prevent harm. It is their duty of care. Medical professionals traditionally face civil, rather than criminal consequences for errors unless intentional harm is proven. For criminal liability, courts must establish that a medical professional's actions met the mental elements of a crime: intention (*dolus*) or negligence (*culpa*). While intention is required for most common-law crimes, culpable homicide necessitates only proof of negligence, indicating a failure to uphold the expected standard of care adjudicated as gross negligence. In South Africa, almost all fatal harm due to gross medical negligence is judged as culpable homicide.

To maintain a high standard of care expected from medical professionals, combining individual legal culpability with patient safety systems is vital. The dissertation argues that actions caused by non-intentional actions or omissions that appear as gross negligence should be treated as criminal negligence. This perspective challenges the notion that doctors should be exempt from criminal sanctions because they 'do not intend to cause harm'. Using case law analysis of landmark cases from South Africa, the dissertation illustrates how the courts have carefully applied the legal frameworks alongside ethical considerations, advocating for a balanced and reasonable approach. It emphasises that overlooking the criminal aspects of gross medical negligence undermines patient safety and individual accountability.

It is asserted that if medical professionals breach their duty of care through wrongful and unlawful actions—whether by providing sub-standard care, intentional harm, or other derelictions—they should take responsibility (ethical conduct), be held legally liable if their actions meet the threshold of criminal culpability (legal standards) and be accountable for their conduct (upholding public trust and societal values).

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CHAPTER ONE: *THE GREAT DEBATE*

1.1 INTRODUCTION

In this section of the introductory chapter, I provide a preamble to the 'great debate' on criminalising medical harm[1] by first explaining the rationale for using the generic approach to patient harm in the title of my dissertation. I then present the historical context, examining the legal and ethical frameworks that have shaped the medical profession in South Africa, and how these rules are currently applied through various administrative remedies to argue for a more balanced approach that ensures accountability while safeguarding patient safety. I conclude with a scoping review of the literature to identify knowledge and practice gaps. I address these gaps in the remainder of the dissertation.

1.2 RATIONALE FOR THE WORDING OF THE TITLE OF THE DISSERTATION

The dissertation title questions whether medical professionals should be subject to criminal prosecution when their conduct results in significant patient harm. It is important to note that in a complex healthcare environment, patient harm is bound to happen.[2] Not all harm is a result of intention or negligence, but it could be purely a result of the natural progression of the disease risk and various systems-related factors.[3] Medical professionals' work entails taking calculated risks,[4] and sometimes this risk-taking behaviour is necessary to advance medical knowledge and practice.[5] The field of medicine comes with the territory of knowing well that

[1] "Criminal medical harm", distinguished from a narrower concept of "criminal medical negligence", is a broad concept that refers to any harm caused by a medical professional to a patient that warrants criminal prosecution because of their (faulty) behaviour, regardless of whether the harm was caused by negligence or with intent (blameworthiness). Legally this can include two forms of culpability: negligence (*culpa*) and intentional harm (*dolus*).

[2] Christopher P Landrigan et al 'Temporal Trends in Rates of Patient Harm Resulting from Medical Care' (2010) 363 *New England Journal of Medicine* 2124–34.

[3] Alan Merry & Warren Brookbanks *Merry and McCall Smith's Errors, Medicine and the Law* (2017) at 141–82.

[4] Jasmine Panton et al 'How surgeons use risk calculators and non-clinical factors for informed consent and shared decision making: A qualitative study' (2023) 226 *The American Journal of Surgery* 660–7.

[5] Amel Alghrani, Rebecca Bennett & Suzanne Ost *Bioethics, Medicine and the Criminal Law: Volume 1, The Criminal Law and Bioethical Conflict: Walking the Tightrope* (2012) available at: https://books.google.com/books?hl=en&lr=&id=MrshAwAAQBAJ&oi=fnd&pg=PR1&dq=innovation+and+risk+in+medicine+criminal+law&ots=b5CCFTpl89&sig=9lQbTRXdbZRwLHoLn8ZX_825BE0.

our actions or behaviour have consequences, some minor and insignificant, and some major and even fatal.[6] Susan Ost[7], in her blog, elegantly states this:

> "If a doctor intends no harm and his actions, whilst *'very silly'* cause minimal, superficial harm, we might feel that we have good reason to question criminalising their behaviour. And where a doctor's serious failings significantly contribute to a patient's death, we might consider that using the criminal law to bring them to account is justified, even when there is no intention to cause harm."[8]

But when the risk-taking is done 'irresponsibly' and the patient is harmed, society views this as an 'infringement' of their values.[9] Medical doctors are not above the law, and at times should be held accountable for their actions or behaviour.[10] Susan Ost aptly continues:

> "I draw attention to *public* wrongs as being those that the criminal law should be concerned about. Public wrongs infringe important societal values and are wrongs that should concern all in society." [11]

Let us look at an example from the medical practice. The potential for the common law crime of assault may seem remote, yet it is a significant legal concern. Assault is defined as the intentional and unlawful application of force to another person or causing them to believe that such force is imminent.[12] Contrary to what one might assume, this concept readily applies to medical practice. For instance, a medical professional who performs a procedure without the patient's informed consent—whether due to oversight or paternalism—could be guilty of assault.

Consider a situation where a surgeon proceeds with an additional procedure during surgery without discussing it with the patient beforehand. Even if the surgeon believes it is in the patient's best interest, the lack of informed consent renders the action unlawful.[13] This breach of the patient's autonomy, a cornerstone of ethical medical practice, transforms a well-

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[6] Linda Kohn, Janet Corrigan & Molla Donaldson *To Err Is Human: Building a Safer Health System* (2000) vol 6.
[7] Mike King 'When Should a Doctor's Behaviour Be Criminal?', *Journal of Medical Ethics blog*, available at: https://blogs.bmj.com/medical-ethics/2018/12/23/when-should-a-doctors-behaviour-be-criminal/.
[8] Ibid.
[9] Ibid.
[10] WT Oosthuizen & Pieter Carstens *Medical Malpractice: The Extent, Consequences and Causes of the Problem* (2015), available at: https://papers.ssrn.com/abstract=2693960 [last accessed 16 July 2023].
[11] King, supra n 7.
[12] Jonathan M Burchell *Principles of Criminal Law* Fifth edition. (2016) at 667.
[13] MS Khan 'Failure to obtain informed consent-is it a criminal offence?' (2023) 113 *SAMJ: South African Medical Journal* 1362–3.

intended act into a legal transgression.[14] Moreover, assault does not always require physical harm.[15] A doctor threatening a non-compliant patient with an unwanted procedure or coercing them into treatment could also be liable for assault, as the law protects individuals from not only actual physical force but also the fear or anticipation of such force. Therefore, understanding and upholding the principles of informed consent and patient autonomy is crucial for medical professionals to avoid unintentionally crossing the boundary into criminal liability. This is where the intersection of medical practice and criminal finds is notoriety. Ost, relays this elegantly:

> "Besides committing private wrongs against his patients by violating their dignity and autonomy, [the doctor's] actions were so contrary to a doctor's fundamental obligations that there is a public interest in criminalising them. He committed a public wrong because his behaviour threatens trust in the medical profession and brings the profession into disrepute."

The corollary regarding assault and informed consent in South African legal system is also true. The legal provisions for obtaining bodily samples, such as blood or conducting HIV tests, from accused persons without their consent. Specifically, the Criminal Procedure Act[16] allows medical practitioners to take samples to identify bodily features or conditions for criminal proceedings, while the Sexual Offences Amendment Act[17] mandates compulsory HIV testing for individuals accused of sexual assault. These laws highlight the tension between legal requirements and the principle of informed consent in medical practice.

When the law gets involved as a remedy, the law distinguishes between ordinary medical errors and those constituting gross negligence or intentional actions to cause harm, which meet the threshold for criminal liability under South African law.[18] The focus is on actions or omissions reflecting a reckless disregard for patient safety, elevating the issue from civil negligence to criminal culpability.[19] The title stresses the necessity of holding healthcare providers criminally liable in cases where their breach of duty is so egregious as to justify penal sanctions, as evidenced in *S v Kramer*.[20] The title is deliberately framed to provoke the debate

[14] *C v Minister of Correctional Services* 1996 (4) SA 292 (T).
[15] King, supra n 7.
[16] Criminal Procedure Act No. 51 of 1977.
[17] Sexual Offences Amendment Act No. 37 of 2002.
[18] Pieter Carstens *Revisiting Criminal Medical Negligence Resulting in Death. S v Van Heerden 2010 1 SACR 529 (ECP)* (2011), available at: https://papers.ssrn.com/abstract=2103090 [last accessed 10 August 2024].
[19] *S v Van As* 1976 (2) SA 921 (A).
[20] *S v Kramer and Another* 1987 (1) SA 887 (W*).*

involving criminal law to protect patients from harm during medical care and uphold the ethical standards of medical practice in South Africa.[21]

1.3 CONTEXT AND GUIDING PRINCIPLES

The South African legal system is primarily influenced by common law, drawing from both English and Roman-Dutch legal traditions.[22] Criminal medical harm occurs when there is severe injury or death of a patient caused by a medical professional's[23] gross negligence or wilful misconduct, warranting criminal prosecution due to the significant breach of legal and ethical medical standards.[24] It is distinguished from civil negligence by the extent of carelessness or recklessness or intent involved. Where medical professionals cause harm to patients intentionally or negligently raises complex questions about the balance between holding practitioners responsible and the broader implications for the medical profession and the healthcare system.[25] This mini dissertation explores this issue by applying a risk and accountability framework to assess the legal, ethical, and professional dimensions.[26]

1.4 EXISTING LEGAL, ADMINISTRATIVE AND ETHICAL FRAMEWORK IN SOUTH AFRICA

The regulation of medical practice in South Africa is governed by a combination of constitutional provisions, statutory regulations, common law principles, and professional codes of conduct.[27] While this ethical and legal framework ensures that medical professionals are held to high standards of care, it also presents challenges in defining the boundaries of criminal liability for medical harm.[28]

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[21] David McQuoid-Mason 'What constitutes medical negligence?' (2010) 7 *SA Heart* 248–51.
[22] Shannon Vaughn Hoctor *Snyman's Criminal Law* (2020) at 5–7.
[23] Medical professionals in South Africa encompass a broad range of healthcare providers, including doctors, nurses, surgeons, anaesthetists, and other licensed individuals involved in diagnosing, treating, and caring for patients. These professionals are regulated by bodies such as the Health Professions Council of South Africa (HPCSA) and South African Nursing Council (SANC) and are bound by ethical codes, professional standards, and legal regulations to provide a high standard of care.
[24] King, supra n 7; Alexandra Mullock 'Surgical harm, consent, and English criminal law: When should 'bad-apple'surgeons be prosecuted?' (2021) 21 *Medical Law International* 343–68.
[25] Thabo Molelekwa 'Criminalisation of Medical Errors: What Are the Issues?', *Spotlight*, 12 June 2024, available at: https://www.spotlightnsp.co.za/2024/06/12/criminalisation-of-medical-errors-what-are-the-issues/ [last accessed 10 August 2024].
[26] Nancy J Wilson & Martin J Hatlie 'Advancing Patient Safety: A Framework for Accountability and Practical Action' (2001) 23 *Journal for Healthcare Quality* 30–4.
[27] Keymanthri Moodley *Medical Ethics, Law and Human Rights: A South African Perspective* Second edition (2017) at 129–33 available at: https://search.ebscohost.com/login.aspx?direct=true&scope=site&db=nlebk&db=nlabk&AN=1495514.
[28] Carstens, supra n 18.

1.4.1 Constitutional provisions

The Constitution of the Republic of South Africa serves as the foundational legal document, safeguarding human rights and guiding the principles of governance in a democratic state. Of note, Section 27(1)(a) of the South African Constitution guarantees that "everyone has the right to have access to health care services", while Section 12(2) provides that "everyone has the right to bodily and psychological integrity".[29] These provisions lay the foundation for legal accountability in the healthcare sector.

1.4.2 Statutory regulations

The National Health Act (NHA)[30] further outlines the responsibilities of healthcare providers, the systems of care and the rights of patients. The Health Professions Act (HPA)[31] establishes the Health Professions Council of South Africa (HPCSA), which regulates the ethical and disciplinary conduct of the medical profession. The two Acts work together to ensure patient safety and uphold standards by regulating healthcare practices, setting professional guidelines, and enforcing accountability among healthcare providers in South Africa.

1.4.3 Common law principles

Courts assess cases of patient harm during medical care by relying on common law principles that establish a duty of care for medical professionals, requiring them to act with reasonable skill and prevent harm.[32] Civil liability addresses medical negligence, compensating patients for substandard care.[33] For instance, in *Buthelezi v Ndaba*[34], a surgeon was held liable for post-surgery complications under the "reasonable medical practitioner" standard. Criminal liability pertains to severe breaches like gross negligence or intentional harm.[35] In *S v McGown*[36], a doctor was criminally liable for culpable homicide due to negligent anaesthesia administration. The distinction between civil and criminal liability depends on the breach's nature and proof required: civil liability seeks compensation with proof on a balance of probabilities, while

[29] Constitution of the Republic of South Africa, 1996.
[30] National Health Act 61 of 2003.
[31] Health Professions Act 56 of 1974.
[32] Kirsten Rowe & Keymanthri Moodley 'Patients as consumers of health care in South Africa: the ethical and legal implications' (2013) 14 *BMC Medical Ethics* 15.
[33] Carstens, supra n 18.
[34] *Buthelezi v Ndaba* 2013 (3) SA 275 (SCA).
[35] Shannon Hoctor 'The concept of dolus eventualis in South African law-an historical perspective' (2008) 14 *Fundamina: A Journal of Legal History* 14–23.
[36] *S v McGown* 1995 (1) SACR 591 (A).

criminal liability seeks punishment and deterrence, requiring proof beyond a reasonable doubt.[37]

1.4.4 Professional codes and regulatory bodies

Medical professionals are also held accountable through regulatory bodies like the HPCSA, ensuring they adhere to ethical standards and maintain public trust.[38] The HPCSA sets out ethical guidelines and codes of conduct for medical professionals.[39] Breaches of these codes can result in disciplinary actions, including suspension or revocation of licenses.[40]

1.4.5 How does the systems of care and accountability address redress?

The first process of redress should be led by local governance systems that identify and report these adverse outcomes.[41] In these governance meetings, the role of medical professionals' intentions, competencies and adherence to reasonable clinical standards should be evaluated.[42] Serious or fatal harm should always be scrutinised to differentiate individual blame from systems-related shortfalls. When it is uncertain where the accountability falls (individual or systems), the local governance (in the private and public sectors, should report these to the HPCSA and the Office of the Health Standards and Compliance Ombudsman.[43] The key question emanating from these standard operating procedures at the local institutional level is, 'How many of these patient safety incidents (harm) are reported and subject to further investigations by legal or professional bodies like the HPCSA?' Sadly, we only see a fraction

[37] Raheel Ahmed 'The Influence of Reasonableness in Determining Delictual or Tort Liability for Psychological or Psychiatric Harm in South African and English Law' (2023) 26 *Potchefstroom Electronic Law Journal/Potchefstroomse Elektroniese Regsblad* 1–35.
[38] Health Professions Act 56 of 1974.
[39] 'HPCSA Professional Practice: Ethics Booklets', *Ethics*, available at: https://www.hpcsa.co.za/?contentId=0&menuSubId=18&actionName=Core%20Operations [last accessed 10 August 2024].
[40] R Scherrer, DA Louw & AT Möller 'Ethical Complaints and Disciplinary Action against South African Psychologists' (2002) 32 *South African Journal of Psychology* 54–64.
[41] 'National Guideline for Patient Safety Incident Reporting and Learning in the Health Sector of South Africa - 2022 | Department of Health Knowledge Hub', available at: https://knowledgehub.health.gov.za/elibrary/national-guideline-patient-safety-incident-reporting-and-learning-health-sector-south [last accessed 10 August 2024].
[42] James Reason 'Human error: models and management' (2000) 320 *Bmj* 768–70; 'National Guideline for Patient Safety Incident Reporting and Learning in the Health Sector of South Africa - 2022 | Department of Health Knowledge Hub', supra n 41.
[43] Yahia Sabah 'ROLE OF OFFICE OF HEALTH STANDARDS COMPLIANCE', *Parliamentary Monitoring Group*, available at: https://static.pmg.org.za/190904OHSC.pdf [last accessed 10 August 2024].

of the cases that reach the courts.[44] Medical professionals should acknowledge how big this problem is so that we do not offer unreasonable defences when criminal legal action is sought.

1.3.6 Limitation of existing legal, ethical and administrative frameworks

While the current legal framework provides mechanisms for holding medical professionals accountable and seems adequate at the coalface, it also has limitations.[45] The threshold for proving negligence or intent in criminal cases is high, often resulting in civil rather than criminal remedies for victims of medical harm.[46] Additionally, there is ongoing debate about the appropriateness of criminal prosecution in medical harm cases, given the potential impact on the medical profession and patient care.[47] A significant challenge in this context is the concept of "medical protectionism".[48] While indemnity cover is essential for protecting healthcare professionals from the financial consequences of lawsuits, it can create a perception of bias in favour of doctors, especially when repeated patient harm or negligence is not adequately addressed.[49] I elucidate some of these issues in the dissertation.

1.5 HISTORICAL CONTEXT

Historically, regulating medical practice in South Africa has evolved to address the quality of care and protect patients' rights. Notable cases such as *S v Kramer*[50] have highlighted the judicial approach to medical negligence, emphasising the need for clear standards of care. I will explore these issues in detail in Chapter 4 of this dissertation.

[44] Carstens, supra n 18.
[45] Oosthuizen & Carstens, supra n 10.
[46] LC Coetzee & Pieter Carstens 'Medical malpractice and compensation in South Africa' (2011) 86 *Chi.-Kent L. Rev.* 1263.
[47] Victor Tadros 'Criminal Omissions: Culpability, Responsibility and Liberty' in Victor Tadros (ed) *Criminal Responsibility* (2007) 0 available at: https://doi.org/10.1093/acprof:oso/9780199225828.003.0008.
[48] Khuliso Managa and Senamile Madlala 'HPCSA Fails Victims of Medical Malpractice, Protects Its Own', *Daily Maverick*, 21 June 2023, available at: https://www.dailymaverick.co.za/opinionista/2023-06-21-health-professions-council-of-sa-is-failing-victims-of-medical-malpractice-protecting-their-own/ [last accessed 10 August 2024].
[49] LC Coetzee & Pieter Carstens 'Medical Malpractice and Compensation in South Africa' *Medical Malpractice and Compensation in South Africa* (2013) 397–438 at 397 available at: https://www.degruyter.com/document/doi/10.1515/9783110270235.397/pdf?licenseType=restricted.
[50] *S v Kramer and Another 1987 (1) SA 887 (W).*

1.6 NOVEL REMEDIES AND APPROACHES TO BALANCING BLAME CULTURE WITH CREATING A SAFER PATIENT CARE ENVIRONMENT

Addressing criminal medical harm requires a careful balance between ensuring accountability and fostering an environment conducive to high-quality patient care.[51] Legal actions are dealt with through civil liability when patients are harmed in medical practice, where compensation for damages is the primary remedy.[52] Increasing public demand for accountability has led to calls for criminal sanctions in cases of gross negligence or recklessness by healthcare professionals.[53] While criminalising medical harm, intentional or negligent, may deter wrongdoing, it also risks promoting defensive medicine and stifles innovations in care due to fear of criminal prosecution.[54]

Mechanisms to create a fairer system by protecting practitioners and holding them responsible for wrongdoing is vital.[55] One such recommendation has been to integrate the blame culture (individual accountability) with the safety culture (making the systems of care safer for patients).[56] The South African National Department of Health has adopted a Patient Safety Incidence Reporting System, which has been informed by established clinical governance systems at the hospital level and guided by ethical and legal scholars.[57] This system uses an integration of James Reason's Culpability Model[58] and Larry Alexander's Unified Conception of Criminal Culpability,[59] which offers a robust framework for addressing criminal medical harm. Reason's model emphasises understanding the human factors contributing to

[51] MS Pepper & MN Slabbert 'Is South Africa on the verge of a medical malpractice litigation storm?' (2011) 4 *South African Journal of Bioethics and Law* 29–35.
[52] Coetzee & Carstens, supra n 49.
[53] Canny Maphanga 'UPDATE | Dr Peter Beale Faces Fraud and Murder Charges as Case Heads to High Court in February', *News24*, available at: https://www.news24.com/news24/southafrica/news/culpable-homicide-case-off-dr-peter-beale-heads-to-the-high-court-in-february-20210120 [last accessed 19 June 2022]; Jenni Evans 'Richards Bay Surgeon Faces Shock Murder Charge after Death of Patient', *News24*, available at: https://www.news24.com/news24/southafrica/news/surgeon-faces-shock-murder-charge-after-death-of-patient-20220905 [last accessed 15 July 2023].
[54] Vera Lúcia Raposo 'Defensive Medicine and the Imposition of a More Demanding Standard of Care' (2019) 39 *Journal of Legal Medicine* 401–16.
[55] Alan Merry & Warren Brookbanks (eds) 'Beyond Blame: Responding to the Needs of the Injured' *Merry and McCall Smith's Errors, Medicine and the Law* 2 ed (2017) 263–309 available at: https://www.cambridge.org/core/books/merry-and-mccall-smiths-errors-medicine-and-the-law/beyond-blame-responding-to-the-needs-of-the-injured/4998D9468575702322B97C0F0EE5CAB9.
[56] Ibid.
[57] 'National Guideline for Patient Safety Incident Reporting and Learning in the Health Sector of South Africa - 2022 | Department of Health Knowledge Hub', supra n 41.
[58] Reason, supra n 42.
[59] Larry Alexander 'Insufficient Concern: A Unified Conception of Criminal Culpability' (2000) 88 *California Law Review* 931–54.

errors, ensuring systemic issues are not unfairly attributed to individual practitioners.[60] Alexander's model, which focuses on individual responsibility and recklessness, provides a clear basis for criminal culpability when healthcare professionals consciously disregard known risks.[61] This integrated model allows legal and regulatory systems to work together, ensuring that healthcare professionals are held to high standards while fostering an environment where they can learn from mistakes and continue to improve their practice.[62]

1.7 STATEMENT OF PURPOSE

In South Africa, medical professionals' criminal liability for patient harm due to intention or negligence is poorly defined. Many believe that medical professionals are largely immune from prosecution, even in cases of serious harm or death due to unintentional harm or sub-standard care (negligence). Outside of intentional harm, this dissertation explores whether such negligence, when egregious, should be prosecuted as a crime. It argues for a legal framework, outside of intentional harm, that holds healthcare professionals criminally liable, ensuring that gross negligence leading to significant patient harm is addressed under criminal law.[63]

1.8 RATIONALE OF THE STUDY

This dissertation explores the need to re-examine the legal response to medical errors in South Africa, particularly when severe deviation from the reasonable standard of care (gross negligence) or due to intentional harm should be treated as a crime.

1.9 RESEARCH QUESTIONS

I cover the following research questions in this dissertation:

1. How is criminal liability established for medical harm in South African law?
2. What legal distinctions exist between medical negligence and criminal culpability in healthcare?

[60] Reason, supra n 42.
[61] Alexander, supra n 59.
[62] Natasha Rafter et al 'Adverse events in healthcare: learning from mistakes' (2015) 108 *QJM: An International Journal of Medicine* 273–7.
[63] In this dissertation, I assume that medical harm rarely occurs due to intentional harm and is commonly due to non-intentional conduct, namely, medical negligence which includes a duty of care obligation towards patients, providing a reasonable standard of care, and taking every step to prevent harm.

3. Under what conditions can a healthcare provider be charged with criminal medical harm for actions taken in a medical setting?
4. How does the concept of *dolus eventualis* influence the prosecution of medical professionals in cases of fatal medical errors?
5. What mechanisms are needed to clarify the legal standards for criminal medical harm in South Africa and balance this with the need to create an environment that enforces patient safety?

1.10 LITERATURE REVIEW

The debate about criminalising medical errors that arise intentionally (*dolus*) or through negligence (*culpa*) is not new. This literature review explores legal, ethical, and practical issues to identify gaps in how South African law manages patients' harm during medical care.

1.10.1 Incidence of Medical Litigation

In South Africa, medical malpractice cases, which include negligence, have experienced a significant surge over the last twenty years, mirroring a similar pattern worldwide.[64] Nevertheless, the overall number of criminal prosecutions remains relatively limited.[65] Examining the reasons behind this disparity, the literature generally agrees that the legal system operates under the assumption that medical professionals do not have malicious intent towards their patients.[66] The conventional belief outlined in the case of *Van Wyk v Lewis*[67] has played a role in debunking the perception that medical professionals are immune from criminal prosecution. Nevertheless, the departure from the reasonable standard of care justifies criminal proceedings.[68]

[64] Letitia Pienaar 'Investigating the reasons behind the increase in medical negligence claims' (2016) 19 *Potchefstroom Electronic Law Journal (PELJ)* 1–22.
[65] Carstens, supra n 18.
[66] DJ McQuoid-Mason 'Liability of doctors based on negligence for culpable homicide: No need to change the law concerning medical negligence or to establish special medical malpractice courts – use mediation and medical assessors instead' (2022) 112 *South African Medical Journal* 216–8.
[67] *Van Wyk v Lewis* 1924 AD 438.
[68] Dieneke Hubbeling 'Criminal prosecution for medical manslaughter' (2010) 103 *Journal of the Royal Society of Medicine* 216–8.

1.10.2 The legal system and medical errors

The distinction between medical negligence via the civil law and whether harms in this context find seat in the criminal law lies at the heart of the debate on criminalising medical harm.[69] While medical negligence arises from a breach of the duty of care, resulting in substandard care and subsequent patient harm,[70] criminal law focuses on legality, *actus reus*, *mens rea*, concurrence, causation, harm, and punishment.[71] *Mens rea* (guilty mind, fault element) is particularly significant, as the intention to cause harm is integral to a crime.[72] Proving *mens rea* in cases of medical negligence is challenging, as the legal system must demonstrate that the medical professional not only breached their duty of care but also acted with a guilty mind.[73]

1.10.3 The courts and medical errors

The courts have grappled with the complexities of medical errors leading to harm, striving to balance holding medical professionals accountable and acknowledging medical practice's inherent risks, challenges and uncertainties.[74] South African courts have followed the precedent set in the *Van Wyk*[75] case, which has limited the number of criminal prosecutions for medical negligence.[76] In cases where prosecution does occur, the courts often rely on the concept of gross negligence, which requires a substantial deviation from the standard of care.[77] Examples of gross negligence include the *Kramer*[78] case, where the doctor was found guilty of culpable homicide following the death of a patient due to gross medical negligence.

1.10.4 Punishment and the common law doctrine

The common law imposes penalties for criminal offences, including those perpetrated by healthcare professionals. Within the purview of the common law are crimes like culpable homicide (causing the unlawful and negligent death of another human) and assault.[79] In South

[69] Ibid.
[70] Pieter Carstens & Debbie Pearmain *Foundational Principles of South African Medical Law* (2007) at 846.
[71] Shannon Vaughn Hoctor *Criminal Law in South Africa* (2017) at 25–30.
[72] Ibid at 159.
[73] Carstens & Pearmain, supra n 70 at 854–5.
[74] Erin Rogers et al 'A Just Culture Approach to Managing Medication Errors' (2017) 52 *Hospital Pharmacy* 308–15.
[75] *Van Wyk v Lewis* 1924 AD 438.
[76] PA Carstens 'Medical negligence as a causative factor in South African criminal law : novus actus interveniens or mere misadventure?' (2006) 19 *South African Journal of Criminal Justice* 192–211.
[77] Carstens & Pearmain, supra n 70 at 847.
[78] *S v Kramer and Another* 1987 (3) All SA 264 (W).
[79] Hoctor, supra n 71 at 30.

Africa, penal sanctions are imposed for those who are found guilty of such crimes, with such sanction including imprisonment.[80] While it is not the purpose of this mini-dissertation to do comprehensive comparative analysis of the various common law jurisdictions, such as English law, or US and Canadian law, it is observed that these jurisdictions also apply hefty punitive measure like imprisonment and professional sanctions for negligent crimes. For example, in the English[81] and US laws, culpable homicide is further codified as a specific crime as gross negligence manslaughter and involuntary manslaughter that is punished by the criminal law. [82]

1.8.5 Medical professionals and immunity

Traditionally, there has been a perception that medical professionals are exempt from criminal liability for actions or failures that harm patients. Prosecutors have typically prioritised cases involving intentional or significantly egregious departures from the accepted standard of care.[83] The concept of immunity is substantiated by the empirical evidence indicating that healthcare professionals are frequently not held legally accountable for mere errors in judgment.[84] Nevertheless, the *Van der Walt*[85] case serves as an example that highlights the potential criminal law implications that may arise when medical practitioners deviate substantially from accepted care norms. The case goes one step further as it brings into awareness that medical professionals are not immune from criminal prosecution.

1.8.6 Patient safety and the legal system

Fortunately, the medical and legal systems are concerned about promoting patient safety and preventing harm. The provision of safe healthcare is a constitutional and ethical obligation of the medical profession.[86] However, the intersection is where the crux of the matter lies: who takes accountability for when harm occurs to patients in an environment where such events ought to be rare or even unobserved? The legal system of liability assignment (more correctly, culpability assignment) focuses on the individual that caused the harm, i.e., the medical

[80] Ibid at 9–18.
[81] *R v Adomako* (1994) 3 WLR 288.
[82] Victor Tadros *The Ends of Harm: The Moral Foundations of Criminal Law* (2011).
[83] Gary Burger 'Should Doctors Be Immune from Medical Malpractice Lawsuits?', *Burger Law*, 14 June 2016, available at: https://burgerlaw.com/should-doctors-be-immune-from-medical-malpractice-lawsuits/ [last accessed 16 July 2023].
[84] AM Smith 'Criminal or merely human?: the prosecution of negligent doctors' (1995) 12 *The Journal of Contemporary Health Law and Policy* 131–46.
[85] *Van der Walt v S* (2020) ZACC 19.
[86] The Constitution of the Republic of South Africa, 1996; Health Professions Act 56 of 1974.

professional.[87] In contrast, the healthcare industry is inundated with calls to create a safe health-promoting environment where systemic and professional conduct (competencies of doctors) are continuously checked, and efforts are put in place to reduce failures due to breaches or faults in the system.[88]

In end-of-life care, determining blame requires examining the doctor's intent.[89] The key is to balance the duty to provide palliative care with the risk of crossing into illegal actions, such as withholding or withdrawing life-sustaining treatment, which could lead to criminal liability if it results in death.[90] The doctrine of double effect aims to reconcile these conflicting responsibilities.[91] A precedent case, *S v. Hartmann*,[92] is one such case where the medical doctor was convicted of murder for intentionally causing the death of his father by using a lethal dose of morphine to end his suffering and, ultimately, his life.

1.8.7 Defining negligence and gross negligence in the context of South African law

1.8.7.1 Negligence

Negligence in South African law, as derived from the common law principles,[93] is the failure to exercise the care that a reasonably prudent person would exercise under similar circumstances.[94] It is based on an objective standard, evaluating whether the defendant's actions or omissions fell short of what a reasonable person would have done to prevent harm.[95] Negligence is assessed through the "reasonable person" test, which evaluates the foreseeability of harm and the reasonableness of steps taken to prevent it.[96]

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[87] Joshua Parker & Ben Davies 'No Blame No Gain? From a No Blame Culture to a Responsibility Culture in Medicine' (2020) 37 *Journal of Applied Philosophy* 646–60.
[88] Reason, supra n 42.
[89] DJ McQuoid-Mason 'Withholding or withdrawing treatment and palliative treatment hastening death: The real reason why doctors are not held legally liable for murder' (2014) 104 *SAMJ: South African Medical Journal* 102–3.
[90] Ibid.
[91] DP Sulmasy 'Commentary: double effect--intention is the solution, not the problem' (2000) 28 *The Journal of Law, Medicine & Ethics: A Journal of the American Society of Law, Medicine & Ethics* 26–9, 2.
[92] In *S v Hartmann* 1975 (3) SA 532 (C), the court acknowledged the compassionate motives behind Dr Hartmann's actions but also recognised the legal principle that taking a life, even with good intentions, constitutes murder. The court sentenced him to one year's imprisonment, suspended for one year, and concluded with the rise of the court.
[93] Johann Neethling & Johan Potgieter 'The Law of Delict' (2015) *Ann. Surv. S. African L.* 805.
[94] Burchell, supra n 12 at 416.
[95] Ibid at 416–36.
[96] Ibid at 419.

1.8.7.2 Gross Negligence

Gross negligence in South African law refers to a severe degree of negligence that demonstrates a substantial departure from the standard of care expected of a reasonable person.[97] It involves indifference to or blatant disregard for the potential consequences of one's actions, as illustrated in *S v Kramer and Another*.[98] South African law does not distinguish between ordinary and gross negligence in separate legal categories but considers gross negligence an aggravated form of negligence.[99]

1.8.7.3 South African context: Culpable homicide and criminal liability

In South Africa, the common law crime of culpable homicide is often applied to cases where medical professionals are criminally liable for the death of a patient due to gross negligence.[100] Culpable homicide involves the unlawful negligent killing of another person and is relevant when gross deviations from standard medical care led to a patient's death.[101] In *S v Kramer*,[102] the court found the doctor guilty of culpable homicide for failing to diagnose a misplaced airway and treat a patient appropriately, resulting in the patient's death. The judgment stated that the doctor's conduct was a significant departure from the reasonable standard of care expected in the medical profession (I will discuss this case in more detail in Chapter 4).

1.8.7.4 Comparison with English law

In contrast to South African law, English law distinguishes between different degrees of negligence, particularly in medical contexts, by specifically categorising offences such as "gross negligence manslaughter".[103] English law specifically identifies gross negligence as a separate criminal offence, requiring a higher threshold of proof for establishing criminal liability in medical negligence cases.[104] Burchell notes that English law includes a section on alternative fault requirements for murder, emphasising different levels of culpability and fault in negligence.[105]

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[97] *S v Van As* 1976 (2) SA 921 (A); *S v Burger* 1975 (4) SA 877 (A); *S v Meiring* 1967 (1) SA 327 (A).
[98] *S v Kramer and Another* 1987 (1) SA 887 (W).
[99] Carstens & Pearmain, supra n 70 at 847.
[100] McQuoid-Mason, 'Liability of Doctors Based on Negligence for Culpable Homicide', supra n 66.
[101] Hoctor, supra n 71 at 391.
[102] *S v Kramer and Another* 1987 (1) SA 887 (W).
[103] Carstens & Pearmain, supra n 70 at 847.
[104] *R v Adomako* (1994) 3 WLR 288; *R v Bateman* (1925) 19 Cr App R 8.
[105] Burchell, supra n 12 at 418.

1.8.7.5 Why is there no specific crime in South Africa for gross negligence?

South African law does not have distinct categories of gross negligence.[106] Instead, South African law views gross negligence as part of a spectrum under the umbrella of negligence, particularly significant in determining criminal liability.[107] The concept of gross negligence is integral to the finding of culpable homicide when a patient's death results from a medical professional's severe departure from the standard of care.[108] As will be evidenced, this distinction plays a significant role in determining criminal liability of medical professionals – 'ordinary' negligence appears not to be serious enough to warrant a criminal prosecution nor conviction, yet 'gross' negligence does.

1.8.8 Criminal medical negligence and the threshold of culpability

Whether medical negligence should be regarded as a criminal act largely hinges on appreciating the concept of 'the threshold of culpability', as discussed by Horder[109] and Moore,[110] and the applicable legal 'tests' to ascertain this threshold. According to Hoctor, a subjective test involves the evaluation of an individual practitioner's mental state during an action or omission.[111] In contrast, an objective test (sometimes referred to as a 'reasonable practitioner test') consists of the assessment of their conduct based on the standards of a reasonable and competent practitioner.[112] These examinations can assist the legal system in ascertaining whether medical professionals have exceeded the threshold of culpability, thus justifying the initiation of criminal prosecution.[113]

1.8.9 Summary and gaps in the literature

The legal standards that inform medical malpractice originate from the common law crimes that courts rely on for passing judgment in case of a serious breach of duty of care. Negligence and gross negligence are pivotal concepts in South African law, particularly medicine. While South African law does not create separate legal categories for gross negligence, it recognises

[106] Carstens & Pearmain, supra n 70 at 847.
[107] Ibid.
[108] *S v Burger* 1975 (4) SA 877 (A).
[109] Jeremy Horder *Ashworth's Principles of Criminal Law* (2016).
[110] Michael S Moore & Heidi M Hurd 'The Culpability of Negligence' in Rowan Cruft, Matthew H Kramer & Mark R Reiff (eds) *Crime, Punishment, and Responsibility: The Jurisprudence of Antony Duff* (2011) 0 available at: https://doi.org/10.1093/acprof:oso/9780199592814.003.0018.
[111] Hoctor, supra n 71 at 185.
[112] Ibid at 186.
[113] Horder, supra n 111.

gross negligence as a severe form of negligence with significant implications for criminal liability, such as in cases of culpable homicide. The concept of fault, which includes both intention and negligence, is a fundamental element in South African criminal law, influencing the classification and prosecution of common law crimes.[114] This principle is crucial in the intersection of medical care and criminal law, where intentional acts and gross negligence can lead to criminal liability for medical professionals.

There are notable gaps in South Africa's legal approach to criminal medical harm. These include unclear boundaries between civil and criminal negligence, insufficient exploration and divergent philosophical treatments of *mens rea* in healthcare cases as opposed to offences perpetrated by lay persons, and a lack of detailed legal guidelines on criminal liability for gross negligence. The connection between medical ethics and criminal law is also inadequately defined, resulting in inconsistent legal applications. Addressing these issues requires clearer legal standards and targeted research. These are some of the murky waters covered in this dissertation.

1.11 CONCEPTUAL AND THEORETICAL FRAMEWORK

This dissertation uses a multi-theoretical approach to examine medical harm to offer a balanced perspective on the legal and ethical dimensions to medical harm. It places the legal theories of criminal law at the centre of the argument, particularly the elements of *actus reus* and *mens rea*, to understand how these apply to intentionally and negligently caused harm within a medical setting.[115] Principles of medical ethics, including beneficence, non-maleficence, autonomy, and justice, are used to assess the ethical as well as legal implications, exploring the possibility of reliance on the criminal law.[116] The argument also incorporates normative ethical theories like consequentialism, deontology, and virtue ethics to evaluate the moral aspects of criminal liability.[117] Theories of justice and punishment, including utilitarianism, retributivism, and restorative justice, are summarily explored to consider their impact on justice and

[114] Burchell, supra n 12 at 341.
[115] Larry Alexander & Kimberly Kessler Ferzan *Crime and Culpability: A Theory of Criminal Law* (2009); Hoctor, supra n 22 at 30.
[116] Tom L Beauchamp & James F Childress *Principles of Biomedical Ethics* (2001); Dhai, Aimes & David Jan McQuoid-Mason *Bioethics, Human Rights and Health Law: Principles and Practice* Second edition. (2020) available at: https://search.ebscohost.com/login.aspx?direct=true&scope=site&db=nlebk&db=nlabk&AN=2756832.
[117] Julia Driver 'Normative ethics' (2005) *The Oxford handbook of contemporary philosophy* 31–62; Cheryl N Noble 'Normative ethical theories' (1979) 62 *The Monist* 496–509.

healthcare.[118] I propose and apply the systems theory to appreciate the broader healthcare context, advocating for systemic improvements and appropriate accountability in medical harm cases.[119]

1.12 RESEARCH METHODOLOGY

A qualitative desktop analysis explored criminalising medical harm caused intentionally or negligently in South Africa through definitional and foundational elements of criminal law. Using case laws to illustrate how the courts have been applying the common law when adjudicating serious medical harm, the dissertation draws its conclusions related to the applicability of the South African criminal justice system as a means to manage medical harm.

1.13 STRUCTURE OF THE DISSERTATION

This dissertation is structured into five chapters:

(1) Chapter One: The Great Debate. This introductory chapter reviews the legal and ethical framework governing medical professionals' conduct, outlines the rationale for the wording of the title of the dissertation, introduces concepts and terms used in criminal law, and reviews the literature for gaps in our understanding surrounding the debate on criminalising medical harm, and lays out the aims, objectives and research questions the rest of the chapters respond to.

(2) Chapter Two: Legal Theoretical Frameworks to Address Criminal Medical Harm. This chapter is the central argument of this dissertation and is thus dense in its coverage. It covers legal vocabulary, concepts and frameworks that guide how the law deals with medical harm, especially secondary to negligence that leads to serious harm, such as death. The focus is on the legal and ethical understanding of concepts like intention, foreseeability, and reasonableness. The chapter is written with the medical practitioner in mind.

(3) Chapter 3: Application of the Foundational Principles of the Law to Medical Harm. This chapter reviews the knowledge base from the perspective of the patient safety movement through two lenses – that of the practitioner and that of criminal law. The chapter describes the use of various terms in medical safety literature surrounding medical errors and medical

[118] Hoctor, supra n 71 at 9–18.
[119] Sheuwen Chuang & Peter Howley 'Systems thinking in healthcare: From theory to implementation' *Focus on Systems Theory Research* (2018).

harms resulting from medical interventions. It discusses their application in medical practice, ethics and law. Chapters 2 and 3 should be read in concert.

(4) Chapter 4: Analyses of Landmark Case Laws. This chapter examines two precedent case laws prosecuted for fatal harm due to criminal negligence.

(5) Chapter 5: Conclusion. This chapter summarises the key findings and suggests areas for future research on the intersection of law and medical harm.

CHAPTER TWO: *THEORETICAL FRAMEWORKS TO ADDRESS CRIMINAL MEDICAL HARM*

2.1 INTRODUCTION

Following the review of the foundational analysis of constitutional rights and health legislation in Chapter 1, this chapter further develops the legal framework by exploring the ethical guidelines, relevant common law remedies, and the criteria for establishing criminal liability in medical harm.

2.2 ADVANCING THE LEGAL FRAMEWORK FOR CRIMINAL MEDICAL HARM IN SOUTH AFRICA

The chapter examines the foundational principles of criminal liability in South African common law, focusing on *mens rea* (guilty mind or state of mind), and includes consideration of both intention and negligence in criminal law. I present these in two sections, namely, (1) Chapter 2 covers the legal terminology as a primer for medical practitioners, and (2) Chapter 3 covers the medical terminology of the standard of care, medical errors, and harm in the context of patient safety movement as a primer for legal scholars. These two chapters should be examined concurrently, like two sides of the same coin. Next, this chapter briefly differentiates between 'ordinary' medical negligence in civil law (common law of delict) and 'criminal medical negligence'.

The dissertation argues that although medical professionals do not intend to harm patients, their negligent actions are still unlawful because they deviate from the standard of care expected of a reasonable person. In situations where they should have foreseen and prevented the harm, their failure to do so is also deemed unlawful.[120] The chapter offers a clearer understanding of *mens rea*, highlighting that it encompasses both intention (*dolus*) and negligence (*culpa*). It will be clarified that in medical cases resulting in death, the establishment of *mens rea* could lead to charges of murder or culpable homicide, depending on intent or negligence, respectively. Additionally, it is accepted that crimes like assault require intention, and there is no possibility of conviction for a person who assaults another negligently, whether the law should reform to accommodate for this is a question worth exploring, particularly if non-fatal, yet harmful incidents occasioned through medical care are to fall within the purview

[120] A Dhai, DJ McQuoid-Mason & J Moodley 'The South African law and the health profession-issues in litigation' *Obstetrics and Gynaecology Forum* (2003) 22–6.

of the criminal law. To this end, the chapter introduces the 'duck test' analogy[121] to evaluate the components of medical negligence against the definitional elements of crime, such as unlawfulness, culpability from the point of intent, foreseeability, and legal liability.

2.3 FOUNDATIONAL PRINCIPLES OF THE MORAL, ETHICAL AND LEGAL FRAMEWORK

In South Africa, the moral and ethical principles informing criminal law's approach to medical harm are rooted in the African philosophy of interconnectedness and shared humanity-Ubuntu.[122] This ethos emphasises collective responsibility and the duty of care, particularly for those in positions of trust, like medical professionals. The Constitution, reflecting these values, enshrines the rights to life (Section 10), dignity (Section 11), and bodily integrity (Section 12).[123] These rights form the ethical backbone of how our law views medical harm. When healthcare providers cause injury or death, it's seen not just as a violation of an individual but as a breach of societal trust.[124] This is the basis for the common law of negligence.

Our law also recognises the concept of *dolus eventualis*, where foresight of possible harm is sufficient for criminal liability.[125] This reflects the ethical posture that medical professionals have a heightened duty to anticipate and prevent harm.[126] However, there is a moral tension between accountability and the need to maintain a functional healthcare system.[127] The law, therefore, typically intervenes only in cases of gross negligence or intentional harm, reflecting an ethical judgement that not all medical errors warrant criminal sanction.[128] The principle of Ubuntu also informs our approach to restorative justice, emphasising rehabilitation and community healing over pure retribution.[129] This is reflected in

[121] The "duck test" analogy is a common expression used to suggest that if something exhibits the characteristics of a particular thing, it is likely to be that thing. In the context of criminal law, it implies that if a person's actions, behaviour, and circumstances strongly resemble those of someone committing a crime, they might be inferred to have committed that crime, even if direct evidence is absent. However, it is not a legal standard and should not be relied upon as a definitive test for establishing guilt or innocence in a court of law.
[122] Moodley, supra n 27 at 41–50.
[123] Constitution of the Republic of South Africa, 1996.
[124] Hoctor, supra n 22 at 55; Burchell, supra n 12 at 648.
[125] Hoctor, supra n 71 at 161–8.
[126] Carstens & Pearmain, supra n 70 at 846; David Jan McQuoid-Mason, Mahomed A Dada & Mahomed A Dada *A-Z of Medical Law* (2011) at 343.
[127] William B Runciman, Alan F Merry & Fiona Tito 'Error, Blame, and the Law in Health Care—An Antipodean Perspective' (2003) 138 *Annals of Internal Medicine* 974.
[128] Carstens & Pearmain, supra n 70 at 847.
[129] Marelize Schoeman 'The African concept of Ubuntu and restorative justice' *Reconstructing restorative justice philosophy* (2016) 291–310 available at: https://www.taylorfrancis.com/chapters/edit/10.4324/9781315604053-17/african-concept-ubuntu-restorative-justice-marelize-schoeman.

how our courts handle some medical harm cases, seeking solutions that address systemic issues rather than merely punishing individuals.[130] Ultimately, South African law in this area seeks to balance the ethical imperatives of protecting patients, maintaining public trust in healthcare, and ensuring justice while recognising the challenging realities of medical practice in our resource-constrained context.[131]

2.4 BACKGROUND AND INTRODUCTION TO LEGAL LIABILITY

Medical law, traditionally the domain of specialised lawyers, has seen significant changes, especially post-1994, following the establishment of a constitutional democracy.[132] Before this, the legal framework in healthcare was predominantly based on common law from English and Roman-Dutch origins, focusing on common law criminal offences and civil negligence as means for victims of harm to secure justice.[133] Recent times have witnessed a surge in medico-legal litigations, making the subject more visible yet often sensationalised.[134]

The NHA[135] and amendments to the HPA[136] have brought a more structured approach to healthcare governance, overseen by the HPCSA. These legislations enforce standards for ethical and legal practices, including issues of informed consent, privacy, and organ donation regulations.[137] Despite these advancements, certain areas of medical practice still need clear legal guidance, such as end-of-life decisions and criminalising medical negligence, where traditional common law principles are still applied with outcomes perceived as being unjust.[138] The totality of the law aims to regulate the provision of healthcare, which has a universal understanding that medical professionals provide healthcare services to members of society and that this service has traditionally been based on trust.[139] As a result, patients or their families often seek justice or reparation in cases of perceived medical wrongdoing.[140] In rare cases, criminal law prosecutes for medical harm resulting from negligence.[141] Ian Dutton

[130] Carstens, supra n 18.
[131] Coetzee & Carstens, supra n 46.
[132] Hoctor, supra n 22 at 23.
[133] Ibid at 5–9.
[134] Gregory Whittaker Medical Malpractice in the South African Public Sector, Actuarial Society of South Africa., 2021.
[135] National Health Act 61 of 2003.
[136] Health Professions Act 56 of 1974.
[137] 'HPCSA Professional Practice: Ethics Booklets', *Ethics*, supra n 39.
[138] Carstens & Pearmain, supra n 70 at 847–55.
[139] 'HPCSA Professional Practice: Ethics Booklets', *Ethics*, supra n 39.
[140] Ian Dutton *Practitioner's Guide to Medical Malpractice in South African Law* (2015) at 6–7.
[141] Ibid.

covers criminal procedure in the South African setting.[142] However, in relation to negligence, that due to the *mens rea* requirements, the extant criminal law in South Africa can only be invoked where the harm caused results in death.[143] For simplicity, South African law is structured to give the people the right to recourse by identifying the cause of action. Aside from identifying the wrongdoer, this also helps determine the appropriate route for recourse (i.e. civil or criminal). In civil proceedings, the patient will sue the doctor (or the health institution or the provincial health department) directly for damages caused ("x v. y" type of case), and the State does not participate in the proceedings except to provide a platform where the 'battle' will be fought between the two parties. Claiming for damages results in vast monetary gain for both the victim ("monetary relief") and their families and for the payment of legal fees. The legal system applies civil law in civil proceedings. Under this law, the wrongs are dealt with through the law of contract (doctor-patient relationship, confidentiality) and law of delict (or tort in other jurisdictions). The law of delict is defined aptly by Ian Dutton[144] as:

> "…the law of delict allows a person to claim damages negligently or intentionally caused by another, irrespective of whether a contract was concluded between the parties".[145]

While this definition may be relevant to common examples like motor vehicle accidents between a driver and a pedestrian (accident caused harm to pedestrian, and no legal contract existed between them), this is not true for medical professionals: both the contractual (doctor-patient relationship) and delictual (duty to care) wrongs are the reasons why medical professionals *get into trouble with the law*.[146]

In contrast, in criminal proceedings, the State applies criminal law and brings about criminal charges against the doctor ("s v. x" type of case). Although, the criminal proceedings incur a huge cost at the expense of the taxpayer (both in time and money), there are no monetary gains to the patient when criminal proceedings are completed. It is thus not surprising to note that there are a disproportionate number of civil proceedings versus criminal proceedings in medical cases. As Ian Dutton[147] states:

[142] Ibid at 5–10.
[143] Burchell, supra n 12 at 430.
[144] Dutton, supra n 142 at 7.
[145] Ibid.
[146] Ibid.
[147] Ibid at 6.

"The criminal law is not regularly used to prosecute medical practitioners as result of malpractice, although it has on occasion occurred."[148]

It is trite to think that:

"Suffice to say that compliance with the general principles governing civil law will almost entirely protect the medical practitioner against criminal liability."[149]

I extend this discussion in section 2.7 below as it applies to medical practice and negligence.

2.5 DEFINING A CRIME IN CRIMINAL LAW: FOUNDATIONAL REVIEW FOR MEDICAL PRACTITIONERS

2.5.1 Crime, criminals, and punishment

South African legal authorities define 'crime as a wrong against the state for which the state punishes the criminal'.[150] Common law crimes in South Africa include assault, murder, culpable homicide and theft.[151] I want to highlight a few elements in the definition that are troubling for members of the medical profession.

First, the concept of wrongfulness. This is a loaded term that evokes a lot of concerns and emotions from medical professionals. It has a connotation that, on moral grounds, it implies that someone has willfully and maliciously caused harm to another.[152] In legal terms, under the common law, this concept is further entrenched as being 'unlawful' and forbidden by the law, and for which some form of penal sanction (punishment) follows on conviction.[153]

Secondly, the involvement of the state in matters related to crimes. Although the harm caused is physical against a human victim, the offences noted above are viewed as harms against the fabric of society and are of public interest. Public interest in good conduct and order is maintained through state authority in criminal courts.[154] Again, medical professionals should appreciate this definitional element and not be surprised if criminal offence charges are lodged

[148] Ibid.
[149] Ibid.
[150] McQuoid-Mason, Dada & Dada, supra n 128 at 112; Hoctor, supra n 22 at 3–5.
[151] All common law crimes, except for culpable homicide, requires intention. Only culpable homicide requires evidence of negligence.
[152] Hoctor, supra n 22 at 25–30.
[153] Ibid.
[154] Ibid at 9–18.

against them. Van Dokkum refers to this as a matter that will 'move away from the sanctity of their consulting rooms', become public, and eventually hit the media headlines.[155]

Thirdly, the word 'criminal'. This is '…a person who has been convicted of a crime by the court of law'.[156] Inherent in this definition is 'a person', the actor (*the criminal*), who has committed the criminal act. Snyman describes this aptly: 'Both the common law and statutory law define conduct regarded as criminal'.[157] Naturally, no law-abiding citizen, least of whom doctors, want to be labelled criminals in the eyes of society. It carries a huge stigma, and specifically for doctors, this could mean an 'impact on their medical career'.[158]

Finally, punishment for the crime. In this principle, the legal authorities and ethicists agree that transgressions against the public should be punished proportionately.[159] Suppose, hypothetically, medical professionals are judged in court for criminal offences (convicted) or, more rightly, for committing a crime while performing their duties as doctors; the law prescribes a proportionate punishment commensurate with the degree of severity of the crime or degree of culpability based on the level of transgression of the law (the behaviour or conduct befitting or expected of a medical professional).[160]

2.5.2 Deconstructing a crime into its component elements: focusing on mens rea.

The anatomical structure of a crime is classically constructed by combining two elements: the criminal act itself (which is already predicated by the law on being forbidden or unlawful) and the presence of the wrongdoer's state of mind (one that is motivated and wishes to see the forbidden outcome of his actions come to being) at the time of the crime was committed.[161] The act in the legal technical term is called *actus reus* (guilty act), and the state of mind of the wrongdoer is called *mens rea* (guilty mind).[162] Placing the prefix '*guilty'* before '*act'* and '*mind'* is deliberate; as stated earlier, the act and mental state of the wrongdoer are regarded as blameworthy and, therefore, wrong by societal values.[163] The word 'guilty' means the law wants to ascribe blame to the wrongdoer or wants to 'find fault' with the wrongdoer. It should

[155] Neil van Dokkum 'The Evolution of Medical Malpractice Law in South Africa' (1997) 41 *Journal of African Law* 175–91.
[156] McQuoid-Mason, Dada & Dada, supra n 128 at 115.
[157] Ibid.
[158] Ibid.
[159] Hoctor, supra n 22 at 11.
[160] Ibid.
[161] Ibid at 59–65.
[162] Ibid.
[163] Ibid at 62–5.

be noted that guilt should only be attributed after all definitional elements of a crime are proven (we will cover this later in this chapter); thus, at this stage, it's more appropriate to refer to an act as 'wrongful' rather than 'guilty'.[164]

Mens rea in criminal cases covers both intention and negligence and is broad enough to cover *unintentional* harm.[165]

> "…evil intention of wrongdoers when committing a crime, which means that they directed their will to commit the crime and knew that their conduct was unlawful".[166]

Both common law and statutory law make the presence of *mens rea* essential for all crimes requiring intention on the part of the wrongdoer.[167] In criminal law, demonstrating intention on the part of crime is necessary both for convicting the wrongdoer and to guide the courts to agree on the punishment or sentencing requirements.[168] When used colloquially, the term 'intention' means:

> "…idea that you plan (or intend) to carry out. If you mean something, it's an intention. Your goal, purpose, or aim is your intention. It's something you mean to do, whether you pull it off or not."[169]

However, under the common law, as quoted by Hoctor[170], offers a more technical definition of intention in criminal law:

> "…means that a person commits an act:
>
> a) While his will is directed towards the commission of the act or the causing of the result,
>
> b) In the knowledge of the existence of the circumstances mentioned in the definitional elements of the relevant crime and
>
> c) In the knowledge of the unlawfulness of the act."[171]

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[164] Ibid at 59–65.
[165] Burchell, supra n 12 at 341–5.
[166] McQuoid-Mason, Dada & Dada, supra n 128 at 275.
[167] Ibid at 276.
[168] Hoctor, supra n 22 at 16–7.
[169] 'Intention - Definition, Meaning & Synonyms', *Vocabulary.com*, available at: https://www.vocabulary.com/dictionary/intention [last accessed 4 September 2023].
[170] The Criminal Procedure Act 51 of 1977 does not explicitly define "intention." The Act covers various procedures related to criminal proceedings but does not provide a verbatim definition of "intention" as such. Intention is generally understood in criminal law as a mental state where a person has a purpose or foresight of the consequences of their actions. This concept is usually interpreted through common law principles and judicial decisions rather than being codified in the Act itself.
[171] Hoctor, supra n 22 at 159.

This use of 'intention' is more complicated and warrants a much deeper understanding of the concept of intention in criminal law.[172] I outline Hoctor's and McQuoid-Mason and Dada's approaches to intention in criminal law.[173] Briefly,

> "Intention in the technical sense of the term can therefore be defined as the will to commit the act or cause the result set out in the definitional elements of the crime, in the knowledge of the circumstances rendering such act or result unlawful".[174]

If only (a) is met, then the definition of intention is similar to the layperson's definition cited above. Otherwise, if using the technical definition as per the Act, then this is referred to as the 'coloured intention'.[175] Therefore, the preferred term for intention in criminal law is *dolus*.[176] Simplified for medical professionals, in common law, this translates to knowingly committing a prohibited act and requiring intention by the wrongdoer, referred to as *mens rea* in law. *Mens rea* in statutory offences occurs through the following three forms: (a) Direct intention (*dolus directus*); (b) Indirect intention (*dolus indirectus*); and (c) Eventual intention (*dolus eventualis*).[177] Accordingly, Hoctor[178] defines each of these as such:

> "Direct intention (*dolus directus*) comprises a person's directing his will towards achieving the prohibited result or towards performing the prohibited act. This result or act is his goal. He desires the act or result."[179]
>
> "In indirect intention (*dolus indirectus*) the prohibited or result is not X goal, but he realises that if he wants to achieve his goal, the prohibited act or result will of necessity materialise"[180]
>
> "The definition of *dolus eventualis* is as follows: A person acts with intention in the form of *dolus eventualis* if the commission of the unlawful act or the causing of the unlawful result is not his main aim, but:
>
> *(a)* he subjectively foresees the possibility that, in striving towards his main aim, the unlawful act may be committed or the unlawful result may be caused, and
>
> *(b)* he reconciles himself to this possibility."[181]

[172] Ibid.
[173] Hoctor, supra n 22; McQuoid-Mason, Dada & Dada, supra n 128.
[174] Hoctor, supra n 22 at 159.
[175] Ibid.
[176] McQuoid-Mason, Dada & Dada, supra n 128 at 276.
[177] Ibid.
[178] Hoctor, supra n 22 at 160–1.
[179] Ibid at 160.
[180] Ibid.
[181] Ibid at 161.

2.5.3 Application of the definitions of intention (dolus) to medical practice

Clearly, if the doctor intentionally harms somebody (the wrongful and wilful act), the courts are obligated to determine whether the doctor had *mens rea* when the crime was committed. If so satisfied, the doctor can then (provided that the other elements of criminal liability have been proved) be convicted as charged (if harm is the death of the patient, then the charge will be murder in this case – murder being defined as the unlawful and intentional causing of death of another human being). A caveat to this component of *mens rea* is critical to identify here because it has implications on how the courts see *dolus* even when the accused is a doctor:

> "Doctors must know that even if they did not intend to have direct intention when they committed the alleged crime the court may still find that they have *mens rea* because they had indirect or eventual intention."[182]

Hoctor goes in more intricate elements of each of the types of *dolus*. In *dolus directus*, the person A does not regard the commission of the unlawful act or the causing of the result just as a mere possibility. Noteworthy, is the conceptual appreciation of *dolus eventualis*, which, in the context of this dissertation, appears to be the form of *dolus* which troubles medical professionals the most.

2.5.4 Mens rea in the form of dolus eventualis and conscious negligence[183] in medical practice.

Hoctor deconstructs these concepts and explains quite elegantly:

> "X does not comply with second part of the test to determine *dolus eventualis* if he foresees the possibility of the result but decides that it will not flow from his actions. He does not accept or reconciles himself to the result. *Dolus eventualis* is excluded even if he unreasonably comes to the conclusion that the result will not follow, because the test in respect is purely subjective, as well be explained below. The question is not whether he *should* have accepted that the result would follow, but whether *in actual fact* he accepted that it would follow.
>
> If he foresaw the result but unreasonably came to the conclusion that is would not materialize, he was negligent. One may say that he *should* have realized that the result would follow from his actions, but in fact did not realise it. He was then negligent, for the test in respect of negligence is not subjective, but objective. This form of negligence is known as conscious negligence (*luxuria*), in order to distinguish it from unconscious negligence, where X is not

[182] McQuoid-Mason, Dada & Dada, supra n 128 at 276.
[183] Hoctor, supra n 22 at 167.

> even aware of the possibility of the result, although he should have been aware of it. Conscious negligence is therefore not a form of intention, but a form of negligence."[184]

To further illustrate the point about the depth of culpability in eventual intention, Hoctor offers the following example:

> "X shoots duck swimming on a lake. On the opposite side of the lake people are having a picnic. He is aware of the presence of these people and realises that if he shoots and the bullet misses the duck, it may hit one of the picnickers. Assume that, although he does not wish to kill a picnicker, his attitude towards this foreseen possibility is: "I don't care", "I can't be bothered", or "I'm going to shoot, no matter what happens". He shoots at the duck, but the bullet misses the duck and strikes and kills a picnicker. He will then have *dolus eventualis* in respect of the picnicker's death and be guilty of murder. Assume, however, that, having foreseen the possibility that the bullet may hit a picnicker, he reasons as follows with himself: "I am a crack shot. In the past I have often shot duck here. I have never missed one, and therefore a picnicker will not be struck by a bullet." If he then shoots and misses the duck and the bullet strikes a picnicker, with fatal consequences, he lacks *dolus eventualis*; he acts with conscious negligence only, provided it is clear that a reasonable person, in his position, would not reason and act likewise. In short, in the case of *dolus eventualis*, X *hopes* that the bullet will not hit a picnicker. In the case of conscious negligence, he *bona fide believes* that it will not."[185]

Another way to look at element (b), namely, "He reconciles himself to this possibility", in *dolus eventualis* above, is that X was *reckless* about whether the act may be committed, or the result may follow.[186] In this form of *mens rea*, the question is not whether he *should* have accepted that the result would follow but whether he accepted that it would follow.[187]

2.5.5 Hypothetical medical example of dolus eventualis

Let us take a hypothetical example of how eventual intention (*dolus eventualis*) would apply to the medical setting. The direct translation of the attitude towards this "foreseen possibility"[188] can be shown thus:

> A renowned doctor (neurosurgeon in this case) exclaims:

[184] Ibid.
[185] Ibid.
[186] Ibid at 161.
[187] Ibid at 167.
[188] Ibid at 161.

'I am the best surgeon in town, and I know the risks associated with this procedure, and I can overcome these risks better than anyone else. My patients know this, and I tell my patients that no one else in town can do this type of surgery better than I can.'

This type of egotistical thinking (or 'god-complex') may be pervasive among some doctors' circles. In this mindset, performing these heroic procedures comes at a cost. This faulty thought process attracts the highest blameworthiness in the court of law.

There are a couple of issues with how this surgeon 'perceives' his behaviour or conduct. First, the surgeon's thought process has the risk of crossing the threshold of culpability. If he takes the witness stand in court and utters such words (when examined by the prosecutor), he would be admitting to subjectively foreseeing the possibility of the risks and reconciling himself with the eventual harm that would potentially result. The very frame of mind places this surgeon's behaviour or conduct criminally liable. He fulfils the definition of *dolus eventualis*, and if the harm caused is the death of the patient, the courts will judge this as murder (and not culpable homicide as many medical professionals seem to perceive).

Secondly, the surgeon's behaviour is disturbingly unethical and unlawful because his conduct is against the doctrine of informed consent.[189] This involves adequately informing the patient about the procedure and the accompanying material risks, no matter how small or, in this case, how 'effectively' the surgeon can avoid this risk.[190] Further, the surgeon's utterances broach the idea of 'guaranteeing cure', which breaches the doctor's duty of care.[191] Combined, his paternalistic behaviour is not just simply negligent but grossly so.[192] He fulfils the 'duck test' analogy of a crime.

2.6 VARIOUS EXPRESSIONS OF MENS REA AND SPECTRUM OF CULPABILITY IN CRIMINAL LAW

We have seen that *mens rea* is a quintessential element of a criminal offence in all common law crimes, even when medical professionals are accused of negligence-based harms. There are various levels of *mens rea*, sometimes called degrees of culpability or spectrum of culpability.[193] Ultimately, the individual's behaviour or conduct ('the act') of a crime is judged

[189] Dhai, Aimes & McQuoid-Mason, supra n 118 at 97–9.
[190] *Castell v De Greef* 1993 (3) SA 501 (C).
[191] Carstens & Pearmain, supra n 70 at 642.
[192] Ibid at 847.
[193] Horder, supra n 111.

on the degree of blameworthiness that determines the level of criminal responsibility.[194] This nuanced approach in criminal law is an attempt to offer a just system to the accused, and it is instructive here to review as it applies to medical conduct or behaviour that leads to harm. At the very extreme and unlikely end of the spectrum is deliberately, purposefully or maliciously acting to cause harm to the patient (intentionally, as understood by *dolus directus*). The complement end of the spectrum lies negligence: failing to meet the reasonable standard of care and not foreseeing and averting the risks.[195]

Attributing or finding the element of *mens rea* in negligence has perplexed the law for decades.[196] The tricky part of the spectrum is when the medical professional's actions or omissions are deemed negligent but insufficient for them to reach criminal levels of culpability.[197] This murky terrain includes two similar yet distinctive deviations from reasonable standards as they show some culpable mindset – where is the definitive line between intention and negligence, and then where does the law draw further lines within negligence? I offer some insight into this murky terrain below.

2.6.1 Gross negligence and recklessness

Let us examine these two special types of negligence where the actor's state of mind is deemed culpable. First, gross negligence. South African courts have provided insight into this deviation from reasonable standards.[198] Though not directly evident from the case law that the courts are applying a uniform criterion for judging deviations from reasonable standards, it can be inferred from these cases that the term ‘gross’ is used to describe the degree of deviation or severity of the harm that resulted from the negligent act.[199] The courts have, however, been consistent in issuing verdicts of ‘guilty’ whenever the accused doctor is blamed for the death of the patient in the form of ‘death by gross negligence’ and judged as having committed culpable homicide.[200] Here, the degree of deviation from the recognised standard of care is all that is required to prove gross negligence by the prosecution. In the *Van der Walt* case,[201] the judge used the phrase ‘egregious’ act to describe the conduct or behaviour of the doctor.[202]

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[194] Smith, supra n 86.
[195] Carstens & Pearmain, supra n 70 at 846.
[196] HLA Hart *Law, Liberty and Morality* (1963).
[197] Carstens & Pearmain, supra n 70 at 846.
[198] *Van Wyk v Lewis* 1924 AD 438 at 444; *Van der Walt v S* (2020) ZACC 19.
[199] Carstens & Pearmain, supra n 70 at 847–9.
[200] Ibid at 643.
[201] *Van der Walt v S (2020)* ZACC 19.
[202] We will briefly discuss later how the various jurisdictions handle gross negligence.

Secondly, the concept of recklessness. It must be stated that this form of negligence is not applied in the South African courts; instead, the definitions of recklessness and *dolus eventualis* overlap.[203] However, the subtleties in law, distinguishing between recklessness in *dolus* and recklessness in negligence, are only sometimes articulated clearly. The practitioner is judged to be negligent (reckless as a result of *negligence*) if he fulfils the following:

> "S/he should reasonably have foreseen the possibility of the occurrence of harms or complications to the patient; S/he should reasonably have guarded against that possibility; and S/he failed to take the steps which s/he should reasonably have taken to guard against the harms."[204]

It is easy to see why the concepts of recklessness in negligence and recklessness in *dolus* would be confusing to appreciate, especially to medical professionals. The difference lies in how the courts apply the subjective test (recklessness in *dolus*) versus the objective test (reasonable standard, recklessness in negligence).[205] As seen from the hypothetical scenario presented earlier about the surgeon's state of mind, the distinction here is made through the extraction of the expression of *mens rea:* the surgeon is deemed guilty of crime (murder in this case) if the prosecutor can show subjectively that the surgeon intention was eventually going to lead to the death of the patient to certain degree of certainty; the surgeon has the foreseen possibility of risk in his mind, and willfully disregards this risk (reconciles with the outcome). In the case of recklessness in negligence (a degree of culpability not recognised in South Africa); the test applied by the courts would be the one cited above.[206]

To show negligence, the objective third party (external witness) is called to attest to the conduct or behaviour of the surgeon.[207] In this testament, the expert peer would be asked if 'he (the reasonable substitute) would have foreseen the possibility of harm, and would have safeguarded against it, and *would have* taken steps to have prevented the harm'. This is not the same as asking the accused surgeon if he foresaw the harm and nonetheless reconciled with the risk, proceeded with the risky procedure, took no preventive steps and failed to do the same. If the accused doctor responds affirmatively to these questions, his statement will be interpreted

[203] Hoctor, supra n 22 at 165.
[204] David McQuoid-Mason & Mahomed A Dada *Guide to Forensic Medicine and Medical Law* (1999) at 123–44.
[205] Hoctor, supra n 22 at 167.
[206] McQuoid-Mason & Dada, supra n 206 at 123–41.
[207] Carstens & Pearmain, supra n 70 at 619.

as culpable by intention, not negligence. The court would elevate the charges from culpable homicide (negligent causing the death) to murder (intentionally causing the death).[208]

It is evident that for a doctor to be judged guilty of causing the death of a patient, the courts have to be satisfied that the doctor had either acted with a guilty mind or the actions were so egregious or grossly negligent that the harm resulted from the doctors' actions or omissions were so reprehensible that the unlawful act (death of the patient) and his mindset at the time when the act occurred are judged as being criminally liable. Culpable homicide is the common law requiring negligence as the criminal offence criterion.[209] This is where medical negligence finds its notoriety in law.[210]

2.7 MEDICAL NEGLIGENCE AND THE LAW: A REAPPRAISAL TO THE BUILDING BLOCKS TOWARDS CRIMINAL LIABILITY

2.7.1 Medical negligence in civil law borrowed from the law of delict.

Within civil law, the term 'medical negligence', alternatively termed 'ordinary' negligence, denotes the scenario wherein a healthcare professional falls short of delivering the expected standard of care, unintentionally causing harm to a patient.[211] The classical elements of negligence include duty of care, breach of that duty, and a causal correlation between the breach and the patient's harm.[212] Duty of care, as previously mentioned, embodies the legal and ethical obligation of the healthcare professional to exercise a level of care, skill, and judgement that aligns with that of a reasonably competent professional in the same field under comparable circumstances.[213] A breach of this duty materialises when the professional's actions or omissions deviate from the accepted standard of care.[214] The concluding element, causation, links the breach and the harm sustained by the patient, indicating that the professional's

[208] *S v Kramer and Another* 1987 (3) All SA 264 (W); *S v Pistorius* (CC113/2013) [2016] ZAGPPHC 724.
[209] Hoctor, supra n 22 at 30.
[210] In prosecuting criminal offences, the law relies on various tests and standards of proof. One such standard is the "proof beyond a reasonable doubt", which requires the prosecution to establish the defendant's guilt to such an extent that any reasonable person would be convinced of their culpability. This high standard of proof is necessary to protect the accused's rights and uphold the presumption of innocence.
[211] Neethling & Potgieter, supra n 95 at 164–98.
[212] Ibid.
[213] Ibid.
[214] Ibid.

negligence was a direct or indirect contributor to the harm.[215] Negligence is only proved in law when all the elements are met.

2.7.2 What is the difference between the usage of the term 'medical negligence' and 'medical malpractice'?

Medical negligence is often used interchangeably with medical malpractice;[216] however, some jurisdictions distinguish between the two.[217] Medical negligence typically denotes a failure to meet the required standard of care without intent (making this 'ordinary'). In contrast, medical malpractice implies a more egregious violation, often involving intent, gross negligence, or recklessness (which involves the deliberate or conscious disregard for patient safety and wellbeing and still proceeding with the act). The latter situation is now entering the 'territory of criminality' of medical negligence theory, where the doctor's 'state of mind' (the extended definition of criminal intent or *mens rea*) is questioned.[218] In the South African setting, medical malpractice is commonly understood as a broader term that encompasses all forms of transgressions (including negligence and medical misconduct, amongst others) against the recommended standards or codes of conduct laid down by the laws and regulations governing medical practitioners.[219]

2.7.3 So, why is medical negligence wrong or unlawful?

In South Africa, medical negligence is deemed wrongful or unlawful as it infringes upon the legal duty of care that a healthcare professional owes to their patients.[220] The legal underpinning for this duty of care is etched in the common law principles of delictual liability, in conjunction with statutory regulations that oversee the practice of medicine within the

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[215] Ibid.

[216] McQuoid-Mason, 'What Constitutes Medical Negligence?', supra n 21; David McQuoid-Mason 'An introduction to aspects of health law: bioethical principles, human rights and the law' (2008) 1 *South African Journal of Bioethics and Law* 7–10; Dhai, McQuoid-Mason & Moodley, supra n 122.

[217] McQuoid-Mason distinguishes the difference between the two concepts:

> "Medical negligence needs to be distinguished from medical malpractice. Medical malpractice includes both negligent and intentional wrongful acts. Medical negligence occurs when practitioners fail to exercise the standard of skill and care expected of reasonably competent practitioners in their branch of the profession. Negligence refers to behaviour – not a state of mind – and is measured objectively. Medical practitioners may be held vicariously liable for negligent wrongful acts committed by persons employed by them while acting in the scope and course of their employment."

Simply put, negligence is a special case of medical malpractice.

[218] Nataliya Gutorova, Oleksandr Zhytnyi & Tetyana Kaganovska 'Medical negligence subject to criminal law' (2019) 72 *Wiadomosci lekarskie (Warsaw, Poland : 1960)* 2161–6.

[219] Health Professions Act 56 of 1974.

[220] McQuoid-Mason, 'What Constitutes Medical Negligence?', supra n 21.

country.[221] Delictual liability is derived from the South African common law. It governs the legal obligation of one party (the wrongdoer) to compensate another party (the victim) for harm instigated by the wrongdoer's wrongful conduct.[222] Within the framework of medical negligence, a breach of a healthcare professional's duty of care towards a patient constitutes such wrongful conduct. Crucially, to attribute fault or blame, it must be demonstrated that the unlawful conduct led to harm through 'intent' (*dolus*) or 'negligence' (*culpa*).[223]

2.7.4 What is regarded as a standard of care, and when does failing to meet this standard lead to negligence?

A principal legal source that governs medical practice in South Africa is the HPA, which mandates the HPCSA and outlines the standards for healthcare professionals within the country.[224] The HPCSA's ethical guidelines and regulations are pivotal in defining the standard of care expected of healthcare professionals.[225] South African case law has addressed medical negligence in many judgments, establishing the criteria and principles for ascertaining liability through precedence. Noteworthy cases include (1) *Van Wyk v Lewis*,[226] which established the standard for medical negligence, asserting that healthcare professionals are expected to exercise the 'skill and care that can be reasonably expected from an ordinary member of their profession'; (2) *Castell v De Greef*,[227] which underscored the significance of informed consent in medical practice, ruling that a healthcare professional must furnish sufficient information to a patient to enable them to make an informed decision about their treatment; (3*) Michael and Another v Linksfield Park Clinic (Pty) Ltd and Another*,[228] which further emphasised the importance of informed consent and the duty of a healthcare professional to provide a comprehensive explanation of the risks involved in a particular treatment or procedure.

[221] National Health Act 61 of 2003; The Health Professions Amendment Act, 2007 (Act 29 of 2007).
[222] Carstens, supra n 76.
[223] Seraphine Ngangyu Kwanje *Distinguishing between Intention and Negligence in South African Criminal Law* (PhD Thesis, North-West University (South Africa), Mafikeng Campus, 2016).
[224] Health Professions Act 56 of 1974.
[225] 'HPCSA Professional Practice: Ethics Booklets', *Ethics*, supra n 39.
[226] *Van Wyk v Lewis* 1924 AD 438.
[227] *Castell v De Greef* 1993 (3) SA 501 (C).
[228] *Michael and Another v Linksfield Park Clinic (Pty) Ltd and Another* (2001 (3) SA 1188 (SCA).

2.7.5 What is medical negligence, and how does this differ from criminal medical negligence?

The difference between medical negligence (sometimes referred to as 'ordinary negligence') and the severe form of negligence where the threshold of culpability is so 'gross' or 'reckless' that it calls for the placement of the act or omission by the medical practitioner into the criminal spectrum.[229] As mentioned earlier, this spectrum is measured by assessing the doctor's 'state of mind' at the time of the act (reckless, grossly negligent or through eventual intention).[230]

2.7.6 Criminal medical negligence and criminal prosecution of medical professionals.

Death caused due to medical negligence presents itself in South African criminal law as the common law crime of culpable homicide but does so only when the degree of negligence is deemed gross. In other jurisdictions, these sorts of incidents are prosecuted as gross negligence manslaughter or involuntary manslaughter, and a further observation is that these crimes are codified specifically.[231] However, discussion of the position and philosophies in other jurisdictions fall outside the scope of this dissertation. Common though is that the actions or omissions of the medical professional are so severe and significantly diverge from the reasonable standard (gross negligence), demonstrating a disregard for human life or a reckless indifference to an unjustifiable risk of harm,[232] necessitating a judicial response more severe than reliance on civil action (delictual or tort). As the standard is higher in criminal cases that in civil cases, the prosecution must prove beyond a reasonable doubt that the negligence reached the 'criminal threshold'. This higher threshold does pose challenges for the prosecution in securing convictions.[233]

2.7.7 Requirements for criminal liability and application of the 'duck test' to medical harm caused by negligence. [234]

Hoctor provides a concise and elegant requirement for a conduct to be criminally liable under South African law.[235] These requirements are sequenced and include (1) Legality: The conduct

[229] Carstens & Pearmain, supra n 70 at 847.
[230] Jeremy Horder 'Gross Negligence and Criminal Culpability' (1997) 47 *The University of Toronto Law Journal* 495–521.
[231] Ibid; Suzanne Ost 'When should a doctor's behaviour be criminal? - Journal of Medical Ethics blog' 2.
[232] *Van der Walt v S* (2020) ZACC 19.
[233] Carstens & Pearmain, supra n 70 at 846.
[234] 'Duck test' available at: https://en.wikipedia.org/w/index.php?title=Duck_test&oldid=1162501138.
[235] Hoctor, supra n 22 at 25–30.

in question must be legally recognised as a crime. Courts cannot convict based solely on moral judgments; (2) Conduct: There must be an act or omission on the part of the accused. This conduct must be voluntary, and mere thoughts or decisions are not punishable; (3) Compliance with definitional elements: The conduct must meet specific criteria that define it as a crime, including the manner of the act (surgery without consent), the object or person affected (the patient), and the circumstances under which the act occurs (during surgery); (4) Unlawfulness: The conduct, even if it meets the definitional elements, must also be unlawful (in this case breach of duty of care). In certain cases, there are grounds for justification (defences), such as necessity (in case of a medical emergency) or consent that can render an act lawful; (5) Capacity: The accused must have the mental abilities to appreciate the wrongfulness of the act and to act according to that appreciation; (6) Culpability (*mens rea*): There must be grounds upon which the accused may be personally blamed for the unlawful conduct. This can be either intentional or negligent behaviour.

Medical harm may constitute criminal behaviour if it satisfies the requirements of a crime, such as *actus reus* (guilty deed) and *mens rea* (guilty thought), akin to applying the 'duck test' analogy, i.e., that the act satisfies the definitional elements of negligence (*culpa*).[236] Hoctor uses the metaphor of shooting ducks (no pun intended) from across a lake while considering the shooter's mindset in various instances. These are used to demarcate the subtle differences between the types of *dolus* amongst themselves and then further the difference between intention and negligence.[237] The crime of medical negligence could be charged against a surgeon, for example, if they unintentionally leave a surgical tool inside a patient while doing surgery because it is unreasonable for a typical surgeon to have done so. The surgeon might face criminal charges if they deliberately 'brand his name on the liver during a transplant procedure'[238] or acts carelessly in disregarding the possible repercussions. However, it is important to remember that the 'duck test' is not a legal standard employed in courts; instead, it is used here as an example to provide a heuristic approach for determining which crimes society (or the State) should 'punish.'

[236] The duck test is a form of abductive reasoning, usually expressed as "If it looks like a duck, swims like a duck, and quacks like a duck, then it probably is a duck." In this case, we apply the elements of a crime, as stipulated by Snyman, above, in the form of abductive reasoning and test if the medical professional's act or behaviour is criminal in nature.
[237] Hoctor, supra n 22 at 167.
[238] Suzanne Ost 'Drs Bramhall and Bawa-Garba and the rightful domain of the criminal law' (2019) 45 *Journal of medical ethics* 151–5.

2.8 CONCLUSION

This chapter examined when medical negligence constitutes a crime, exploring the foundational elements of criminality, culpability criteria, and the extent of legal liability. The process assessed whether the act or omission was unlawful, whether there was intent or at least foreseeable harm, and whether there was legal liability. I advance this argument in Chapter 3 by introducing a 'practical heuristic' that integrates legal, ethical, and medical perspectives on unlawfulness, culpability, and legality in the context of medical errors and harm in general and apply this heuristic to filter out those errors or mishaps as mere consequences of natural medical risk, or directly due to medical negligence, then assigning criminal liability to the act.

CHAPTER THREE: *APPLICATION OF THE FOUNDATIONAL PRINCIPLES OF THE ETHICS AND LAW TO MEDICAL HARM*

3.1 INTRODUCTION

In this chapter, I expand on the ethical principles, apply the theoretical frameworks above, and introduce a 'practical heuristic' that integrates the legal, ethical, and medical concepts of unlawfulness, culpability and legality to medical error and harm that could potentially attract criminal liability.

3.2 ETHICAL LEGAL FRAMEWORK GUIDING MEDICAL HARM

Chapter 1 introduces key ethical legal frameworks, emphasising that adherence to the ethical theories of principlism, consequentialism, deontology, and virtue ethics—supported by the HPCSA and relevant case law—is crucial in preventing medical harm.

In healthcare, ethical theories play a crucial role in guiding professionals' conduct and shaping the legal consequences of medical harm. *Principlism* emphasises respect for patient autonomy, beneficence, non-maleficence, and justice.[239] When these principles are breached, especially in ways that could foreseeably cause harm, legal consequences can follow. For example, in *S v Ntsele*,[240] the failure to foresee and prevent harm led to a finding of medical negligence, illustrating the legal risks of not upholding these ethical duties. *Consequentialism*, which judges actions based on their outcomes, is also significant in legal contexts.[241] The case of *Castell v De Greeff*[242] illustrated deontological ethics, which stresses the importance of fulfilling professional obligations. The court ruled that neglecting to obtain informed consent was negligence, highlighting the legal and ethical need to respect patient rights and follow established protocols. *Virtue ethics*, which values the moral integrity of healthcare professionals, was central in *S v Burger*.[243] The surgeon's lack of ethical judgment and neglect of foreseeable risks led to a culpable homicide conviction, showing that unethical actions can lead to significant legal consequences.

[239] Beauchamp & Childress, supra n 118.
[240] *S v Ntsele* 1998 (2) SACR 178 (SCA).
[241] Moodley, supra n 27 at 20–5.
[242] *Castell v De Greeff* 1994 (4) SA 408 (C).
[243] *S v Burger* 1975 (4) SA 877 (A).

In practice, the distinction between ethical breaches and criminal acts hinges on the degree of culpability and the nature of the harm caused to the patient.[244] In contrast, criminal acts involve a higher degree of culpability and a more severe deviation from the accepted standard of care, causing significant harm to the patient.[245] For example, a healthcare professional who fails to obtain informed consent from a patient before performing a procedure may be found to have breached the principle of autonomy, resulting in an ethical violation.[246] However, this breach may not necessarily constitute a criminal act, as the harm caused may be minimal, or the practitioner may have acted with the patient's best interests in mind.[247] In contrast, a medical practitioner who intentionally administers a lethal dose of medication to a patient without their consent may be found guilty of murder, as their conduct demonstrates a clear intent to cause harm and a complete disregard for the patient's life and safety.[248] An ethical breach might not directly result in criminal liability. Still, it can lead to professional sanctions by the HPCSA, the regulating body, such as disciplinary action, loss of licensure, or other adverse outcomes for the healthcare professional.[249] As previously stated, criminal acts entail a more significant departure from the standard of care ('egregious'), causing harm to the patient and constituting an offence punishable by law.[250]

3.3 MEDICAL ERRORS AND PATIENT HARM

Like the previous chapter's analysis of the terminology, definitions, and concepts related to criminal medical negligence, which focuses on evaluating harm caused by medical professionals, we will now briefly explore the language used in the patient safety movement.[251]

[244] Ost, 'When Should a Doctor's Behaviour Be Criminal? - Journal of Medical Ethics Blog', supra n 233.
[245] Moore & Hurd, supra n 112; Horder, supra n 232.
[246] Ost, 'Drs Bramhall and Bawa-Garba and the Rightful Domain of the Criminal Law', supra n 240.
[247] Bevinahalli N Raveesh, Ragavendra B Nayak & Shivakumar F Kumbar 'Preventing medico-legal issues in clinical practice' (2016) 19 *Annals of Indian Academy of Neurology* S15–20; McQuoid-Mason, 'Withholding or Withdrawing Treatment and Palliative Treatment Hastening Death', supra n 91.
[248] *R v Shipman* (2000) EWCA Crim 2425. There is no recent South African case where a medical professional was convicted for intentionally killing a patient. *S v Hartmann* 1975 (3) SA 532 (C) was a landmark case where the doctor (son of the father who he assisted in killing with lethal dose of pain-killers) was convicted of murder, is another case.
[249] McQuoid-Mason, 'What Constitutes Medical Negligence?', supra n 21.
[250] James M DuBois et al 'Preventing Egregious Ethical Violations in Medical Practice: Evidence-Informed Recommendations from a Multidisciplinary Working Group' (2018) 104 *Journal of medical regulation* 23–31.
[251] Alan F Merry 'How does the law recognize and deal with medical errors?' (2009) 102 *Journal of the Royal Society of Medicine* 265–71.

To improve patient safety, this movement prioritises systemic changes to enhance healthcare rather than assigning blame to individuals who have contributed to patient harm. [252]

Consider, for instance, the concept of 'medical errors'. Medical errors refer to unforeseen events or incidents that may result in unfavourable outcomes during the delivery of healthcare services. These are called a near-miss when the incident does not result in harm. The 'near-misses' have the potential to cause harm; they frequently shed light on areas that require enhancement in the provision of patient care and facilitate the identification of recurring preventable incidents. Given how often medical errors occur in practice, a thorough examination of the underlying systemic factors and human errors that contributed to the harm (incidences) should be carried out when faced with a legal case related to medical errors.[253] Conversely, the term 'medical mistakes' refers to medical professionals making mistakes in their decision-making or actions ('judgement errors'), resulting in unintended outcomes.[254] In these situations, a thorough investigation of the circumstances of the harm should be meticulously carried out to differentiate if the harm resulted from 'preventable' human error.[255] This will help ascertain to what extent the medical professional should be held responsible for the 'error' (blame) versus how much systems failures contributed to the occurrence of the harm.[256] The incident review should examine to what extent the error was considered reasonable or if it was a failure to adhere to the standard of care.[257] To this end, the focus should be on determining the extent to which established protocols and best practices were followed and evaluating the error's foreseeability and preventability.[258] Following a medical accident, the investigation must include examining safety protocols and checking if the medical staff took steps to mitigate the occurrence of the accident.[259] Finally, the term 'medical violations' occurs when the medical professional intentionally departs from established protocols, guidelines, or standards. Here, the investigation should explore the practitioners 'state of mind',

[252] In the domain of clinical settings, terminologies linked to patient safety incidents are similarly developed to bring about a common understanding of the complexity within which harm occurs. These terms function as a navigational tool, providing guidance in determining the characteristics and scope of actions or omissions made by healthcare practitioners. In order to fully comprehend the ramifications of each term, it is imperative to consider the contextual factors, underlying intentions, and subsequent outcomes of each occurrence or incident. The definitions of the terms used in this section all come from a single source.
[253] Merry & Brookbanks, supra n 3 at 103–40.
[254] Ibid at 103.
[255] Ibid at 55.
[256] Kimberly M Horns & Donna Lee Loper 'Medication errors: analysis not blame' (2002) 31 *Journal of Obstetric, Gynecologic, & Neonatal Nursing* 347–54.
[257] Ibid.
[258] Helen Lester & Jonathan Q Tritter 'Medical error: a discussion of the medical construction of error and suggestions for reforms of medical education to decrease error' (2001) 35 *Medical education* 855–61.
[259] Merry & Brookbanks, supra n 3 at 209.

the degree of professional intention and the ethical implications of such a transgression. This calls explicitly for disciplinary measures, potential legal repercussions, and evaluation of the professional's ethical conduct.[260] Medical violations fulfil the legal criteria for departure from reasonable standards in the negligence law.[261]

3.4 HOW DOES A MEDICAL ERROR, MISTAKE OR MEDICAL TREATMENT THAT CAUSES HARM DIFFER FROM NEGLIGENCE?

HJ Edeling (a neurosurgeon and medico-legal expert) and CJ Claassen (an advocate and medical law expert), in their presentation at the South African Medical (SAMA) Conference in 2018, 'Rendering Quality Care in a Litigious Environment' offer a pragmatic and concise definition and approach to how courts and legal systems handle medical harm caused by negligence.[262] The authors define negligence as follows:

> "Negligence refers to a wrongful act or failure to act, which causes foreseeable harm in circumstances where it would have been reasonable to prevent such harm . Medical treatment, or failure to treat appropriately, is judged by South African courts to amount to negligence when it falls below the standard of a reasonable practitioner in that discipline under the prevailing circumstances. Each one of these 6 highlighted criteria is taken into account by the courts."[263]

The authors offer simple classification systems of medical complications associated with chosen medical decisions. Medical complications can be categorised into three groups when assessing whether a treatment or mistake is negligent. These include:

> "Group 1 – Unavoidable, naturally occurring complications. These are not mistakes nor do they constitute negligence. Group 2 - Mistakes that are judged to be reasonable under the circumstances. These do not constitute negligence. Group 3 – Mistakes that are judged to be below the reasonable standard, and therefore negligent. These standards include:
>
> Level 1 – The best standard.
>
> Level 2 – A good standard.
>
> Level 3 – An average standard.

[260] Ibid at 141.
[261] Ibid at 183.
[262] HJ Edeling & CJ Claassen 'Rendering Quality Care in a Litigious Environment', *Presentation to SAMA Conference 2018*, 2018, available at: https://medicolegal.org.za/SubmissionToThePresident/1.2.1-SAMA%20Conference-ClinicalNegligence-Ethics-Edeling-Claassen.pdf [last accessed 6 September 2023].
[263] Ibid.

> Level 4 – A reasonable standard that is below average.
>
> Level 5 – Negligent standard, i.e., below the reasonable standard".[264]

To appreciate medical errors and mistakes, the medical practitioners' levels of professional skills and ethical behaviour are also considered by the courts when deciding if the medical error or mistake was negligent.[265] These standards represent a spectrum of practice by medical doctors. These performance levels include the competencies and ethical standards of a reasonable practitioner. Fortunately, most practitioners function at Level 3 and above, and such 'are mostly immune to the law',[266] but these practitioners 'may slip or fail on occasion, usually under adverse circumstances'.[267] Unfortunately, a few 'bad apples' among the medical professionals fail to meet the Level 3 standards (operating in Levels 4 and 5).[268] Edeling and Claassen call out this group of practitioners and recommend the following remedies to maintain 'medicine as a noble profession'. I will quote their well-articulated remedies to 'ensure one maintains ethical standards'.[269]

> "To ensure the maintenance of ethical standards, it is useful to regularly subject oneself to the following personal introspection, being honest with oneself at all times:
>
> Firstly, consider whether you are adequately trained to select, plan, and perform the required operation or treatment safely. If the answer is 'no,' refer the patient to a better-educated and trained colleague. If an honest answer produces uncertainty, consult a mentor or get a second opinion. A recorded second opinion is of immense value to self-protection. If an honest answer indicates that you are adequately educated and trained, take sensible and practical steps to reduce the risks of mistakes and complications.
>
> Secondly, ask yourself if you really want to be ethical or not? If your honest answer is 'no,' seriously consider finding a different occupation. If the answer is 'yes,' make a habit of taking regular and purposeful steps to enhance the ethical nature of your practice.
>
> Thirdly, interrogate your own ego, hubris, and conscience. Consider whether it is in your own best interests to succumb to the dictates of your ego or hubris, such as bragging to colleagues or presenting a paper on your own achievements. Consider whether it is better and safer to hearken to the voice of your conscience, for example,

[264] Ibid.
[265] Ibid.
[266] Ibid.
[267] Ibid.
[268] Ibid.
[269] Ibid.

> when consulting with a patient, deciding whether or not to offer a treatment or operation, planning a treatment or operation, and obtaining informed consent.
>
> Lastly, find and regularly consult a mentor. If you believe that you know so much that you no longer need, or cannot find, a mentor in your own discipline, find one in the fields of law or philosophy."[270]

The medical fraternity should focus on raising the standard of practice, not 'settling' for a sub-standard and unethical practice. The authors conclude their presentation with this quoted text, driving the point of maintaining professional decorum and always striving for a high standard of clinical care.[271]

> "Recognising the 5 identifiable standards of practice into which surgeons can be grouped, what should we strive for?
>
> **Ethical** – This majority should maintain and improve their standard, participate in CPD training of colleagues, and ensure that their practice remains ETHICAL.
>
> **Sub-ethical but reasonable** – This unfortunate minority should take urgent steps to improve their standard and ensure that their practice is ETHICAL.
>
> **Negligent (i.e., below reasonable)** – This *dangerous minority* should suspend their practice, return to the drawing board and only re-enter practice once they have achieved an ETHICAL standard. Alternatively, they should find a different calling."[272]

Every practitioner should feel the intense discomfort in the last recommendation. It is this minority of the so-called professionals that have and are continuing to place the 'honourable' profession into disrepute and create distrust in the public's eye. They should self-select out or, if they choose to stay, be prepared to face the might of the criminal law when they harm patients due to their negligent behaviour.

3.5 UNLAWFULNESS, CULPABILITY AND LEGAL DUTY: A SIMPLE HEURISTIC [273]

In this section and the next, I will synthesise the abovementioned components used in South African law to assist with our decision-making regarding which acts of medical professionals

[270] Ibid.
[271] Ibid.
[272] Ibid.
[273] I opted to apply this approach using the themes stated in several of McQuoid-Mason's articles and class notes kept during my coursework.

ought to be judged as criminal and those simply negligent when patients are harmed during medical treatment. As defined earlier, unlawful acts violate the legal duty or infringe upon others' rights, as defined by the common law or statutory law. So, acts harming another person are seen as in the public interest. The law would seek components for wrongdoing and blameworthiness that meet these three criteria: unlawfulness, culpability, and legal duty.

3.5.1 Criminal medical negligence: Definitions and application of the law in South Africa

Crimes in South Africa do not always result from *dolus* (intention); *culpa* (negligence) can also lead to criminal liability. According to Burchell, intention and negligence are the two primary forms of culpability recognized in South African law.[274] While most common law crimes require intention (*dolus*), there are significant exceptions where negligence (culpa) suffices, such as in cases of culpable homicide.[275] For the layperson, negligence is distinguished from crimes of intention by a failure to act with the care expected under the circumstances, it does not require a harmful intent but rather a lack of foresight or consideration that a reasonable person would have had. Of note, this is particularly relevant in cases of culpable homicide where negligence is sufficient to establish liability.[276]

Using a similar argument for common law crimes against persons (minor and severe) described above, criminal medical negligence occurs when a healthcare professional's conduct falls short of the standard of care expected in their profession, resulting in harm to a patient.[277] As seen earlier, the same criteria of unlawfulness, culpability, and the existence of a legal duty define criminal medical negligence, but with nuances in each of the criteria.

In criminal medical negligence, an act or omission is deemed unlawful if it violates the healthcare professional's duty of care to their patient.[278] What a reasonable healthcare provider with the same degree of ability and knowledge would have done in identical circumstances defines the standard of care. Deviating from this criterion may render the medical professional's actions unlawful. Culpability is typically established through negligence (*culpa*) rather than intention (*dolus*).[279] To prove culpability through negligence, the prosecutor must show that

[274] Burchell, supra n 12 at 341.
[275] Ibid.
[276] Ibid.
[277] Kwanje, supra n 225; Oosthuizen & Carstens, supra n 10.
[278] Carstens & Pearmain, supra n 70 at 846.
[279] Kwanje, supra n 225.

there should have been a reasonable foreseeability of harm, reasonable precautions against such a possibility would have been taken, and that steps to avert the harm should have been taken.[280] Lastly, medical professionals have a legal duty to provide care to their patients typified in the common law, professional codes of conduct, or statutory law, such as the doctor-patient relationship cited in the HPA and NHA, and are obliged to adhere to the standard of care expected of their profession.[281]

3.5.2 Returning to the simple heuristic model to assess criminality of the negligent act.

Let us return to our heuristic model to appreciate the nuances of criminal medical negligence. To help us understand this nuanced approach to categorising negligent crime, I have developed a simplistic schema in the form of a two-by-two contingency table (Figure 1),[282] where each cell represents a combination of legal negligence (failure to exercise reasonable care) and moral blameworthiness (culpability). To use this table, consider the two-by-two table, with legal negligence as the row field and moral blameworthiness as the column field. The intersection of legal negligence and moral blameworthiness yields the following in each cell:

(1) Cell 1 (Legal negligence and moral blameworthiness present): The professional's actions deviate from the standard of care, resulting in legal liability and being morally wrong. An example is the case of Dr Harold Shipman.[283]

(2) Cell 2 (No legal negligence and moral blameworthiness present): The professional's actions do not deviate from the standard of care but are morally wrong. Examples include dishonesty, disrespect, or breach of confidentiality (although this has now been codified into the law through the Protection of Personal Information Act[284]).

(3) Cell 3 (Legal negligence present and no moral blameworthiness): The professional's actions deviate from the standard of care, resulting in legal liability, but are not morally wrong. Examples include honest mistakes or unforeseeable complications.

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[280] SF Otto 'Medical negligence' (2004) 8 *SA Journal of Radiology*.
[281] Health Professions Act 56 of 1974; National Health Act 61 of 2003.
[282] This approach was inspired by a commonly used method to resolve dichotomous response variables quickly and simplistically in the field of epidemiology, a subject matter I have been trained as an Epidemiologist. This link offers further insights into the methodology: *Principles of Epidemiology: Lesson 4, Section 2|Self-Study Course SS1978|CDC*
[283] *R v Shipman* (2000) EWCA Crim 2425.
[284] Protection of Personal Information Act 4 of 2013.

(4) Cell 4 (No legal negligence and no moral blameworthiness): The professional's actions do not deviate from the standard of care and are morally acceptable. Examples include appropriate diagnosis and treatment.

		Moral blameworthiness	
		Present	***Not Present***
Legal Negligence	***Present***	Cell 1	Cell 2
	Not Present	Cell 3	Cell 4

Figure 1: Two-by-two contingency table: legal negligence and moral blameworthiness

3.6 DIFFERENTIATING ORDINARY NEGLIGENCE FROM CRIMINAL NEGLIGENCE: DEFINITIONAL ELEMENTS BORROWED FROM THE LAW OF DELICT

Let us step back a little as it is instructive to review the distinction between ordinary negligence and criminal negligence, as superficially and to the layperson, they may seem to resemble each other, yet have very different meanings. Establishing negligence and causation is crucial to proving the healthcare professional's liability in criminal medical negligence cases. These elements in the context of criminal medical negligence include concepts of ordinary negligence, blameworthiness and causation.[285]

(1) *Ordinary Negligence:* To establish ordinary negligence in criminal medical negligence cases, the prosecution must prove that the healthcare professional's conduct fell below the standard of care expected in their profession. This standard is typically based on what a reasonable healthcare professional with the same skill and expertise would have done in similar circumstances. The following aspects must be considered:

a) Duty of care: The healthcare professional owes a legal duty to their patients, which may arise from common law, professional codes of conduct, or statutory law.

b) Breach of duty: The prosecution must demonstrate that the healthcare professional's actions or omissions deviated from the expected standard of care, resulting in a breach of duty.

[285] Neethling & Potgieter, supra n 95.

c) Foreseeability: The healthcare professional should have been able to foresee the potential harm that could arise from their actions or omissions, which a reasonable healthcare professional in their position would have foreseen.[286]

(2) Blameworthiness or "state of mind" (extension of mens rea): In addition to proving ordinary negligence and causation, establishing blameworthiness or intention is a vital element in criminal medical negligence cases.[287] The prosecution must demonstrate that the healthcare professional's actions or omissions were negligent and involved a degree of recklessness or gross negligence that warrants criminal liability.[288] This added layer of blameworthiness differentiates criminal medical negligence from ordinary negligence in civil medical malpractice cases.[289] Unlike harm caused by ordinary negligence, which focuses on the breach of duty and causation, criminal liability requires an additional element of blameworthiness or 'state of mind' (this is not equal to mens rea, but 'resembles' the thought element in defining a crime).[290] It's important to be clear here that principles differ in their application to medical law. Terms such as 'medical malpractice', 'medical misconduct', and 'medical negligence' are aesthetically, or perhaps even egotistically more palatable in the medical field over terms like 'murder', 'culpable homicide', 'assault', or 'assault with intent to do grievous bodily harm', which are viewed as incongruent with the profession's societal nobility status.[291]

Interestingly, using 'ignorance' (lack of knowledge) as a defence may not always work for medical professionals, as it is expected that a reasonable practitioner would have known of the risks and taken steps to mitigate them.[292] Hence it is sometimes called "culpable ignorance".[293]

(3) Causation: In criminal medical negligence cases, it is essential to establish a causal link between the healthcare professional's negligent actions or omissions and the harm suffered by the patient. This involves proving[294]:

[286] Ibid.
[287] Carstens & Pearmain, supra n 70 at 522–3.
[288] Ibid at 847.
[289] Ibid.
[290] Ibid at 846.
[291] Dave Archard 'Criminalizing Medical Negligence' *Bioethics, Medicine and the Criminal Law: The Criminal Law and Bioethical Conflict: Walking the Tightrope: Volume 1* (2012) at 236–50.
[292] D O'Connor 'Mistake and Ignorance in Criminal Cases' (1976) 39 *The Modern Law Review* 644–62.
[293] PJT O'Hearn 'Criminal Negligence: An Analysis in Depth-Part II: Culpable Ignorance' (1964) 7 *Crim. LQ* 407.
[294] Carstens & Pearmain, supra n 70 at 827.

a) Factual causation: The prosecution must demonstrate that the patient's harm would not have occurred but for the healthcare professional's negligent conduct (the "but-for" test).

b) Legal causation: The prosecution must also show that the healthcare professional's negligence was the proximate or legal cause of the harm, meaning that the negligence was sufficiently connected to the harm, and it is not too remote or attenuated.

c) No intervening cause: The chain of causation should not be broken by an intervening act or event that the healthcare professional (novus actus interveniens) could not have reasonably foreseen.[295]

But, despite all of this, is it even possible for doctors to harbour the intention (as understood in the criminal law) to cause harm to their patients? Or is there some kind of reprieve or amnesty due to the nature of the profession itself? Professor McQuoid-Mason, a highly regarded expert in South African medical law affiliated with the University of Kwa-Zulu Natal, South Africa offers a response below. [296]

3.7 MCQUOID MASON'S ANSWER[297]

Within the fields of medicine and law, there is a unique space about the practices commonly referred to as 'withholding or withdrawing treatment and palliative treatment hastening death.' These practices are observed not only in South Africa but also in various other jurisdictions. Upon initial examination, this concept may seem to contradict our prevailing societal comprehension of the act of 'causing the death of another human' (homicide). Furthermore, the notion that abstaining from causing the demise of another individual through the act of withholding or withdrawing medical interventions or offering palliative care appears to be in contradiction with the fundamental principle of a physician's obligation to provide care for their patients.

[295] Carstens, supra n 76.
[296] 'Professor David McQuoid-Mason - School of Law', available at: https://law.ukzn.ac.za/prof-david-mcquoid-mason/ [last accessed 16 July 2023].
[297] McQuoid-Mason, David Jan. "Withholding or withdrawing treatment and palliative treatment hastening death: the real reason why doctors are not held legally liable for murder." *SAMJ: South African Medical Journal* 104, no. 2 (2014): 102-103.

In this section, I briefly and perhaps simplistically analyse the perspectives presented by Professor McQuoid-Mason.[298]

3.7.1 Analysis of McQuoid-Mason's argument to decriminalise actions to hasten the death of a patient receiving palliative care.

McQuoid-Mason provides a rationale for factors contributing to the absence of legal liability for doctors accused of murder in the South African legal framework. Notably, although the article does not explicitly explore the circumstances in which physicians ought to be held responsible, the piece's title could have expanded to encompass this aspect.

While it is not the scope of this dissertation to argue for or against the legality of 'active' versus 'passive' euthanasia in South Africa, I use the article to show how the argument for criminality under such clinical circumstances provides the opportunity for moral, ethical, and legal exceptionalism.[299] These conditions may be viewed as the legal defences or justifications arguments made in cases of intentional crime, like murder.[300]

In this analysis, I explore the interesting parallel between the conduct of medical professionals in end-of-life situations and the legal principle of *dolus eventualis*, as illustrated in the infamous Oscar Pistorius case.[301] The concept of dolus, especially *dolus eventualis,* forms the backbone of arguments for criminal behaviour. *Dolus eventualis*, a type of *mens rea* in criminal law, is distinguished by the offender's deliberate anticipation of the potentiality of their action resulting in death and their continued engagement in said action despite the foreseeable outcomes ('reconciling with the outcome'). In the Pistorius case, the court

[298] Briefly, the article examines the legal implications surrounding the decisions of medical practitioners to withhold or withdraw treatment or administer palliative doses that may hasten a patient's death. Although these actions meet the criteria for murder in terms of intention and causation, doctors are not held legally liable due to societal and legal considerations. If patients provide consent, if the medical intervention would be futile in prolonging life, or if palliative care accelerates the dying process, these actions are not deemed illegal. The article explores the distinction between "active" and "passive" euthanasia, clarifying that discontinuing life-sustaining interventions or reducing the functionality of medical devices does not equate to murder. Legal liability for doctors in these cases primarily hinges on societal perceptions rather than a lack of intent to cause harm or death. The article further examines the necessary elements for a murder conviction, including mens rea, causation, and the absence of lawful justification. It emphasizes how the actions of medical practitioners may fulfil technical criteria but remain legal due to prevailing societal norms and legal expectations.

[299] Burger, supra n 85; DS Bhullar & J Gargi 'Medical negligence-majesty of law-doctors' (2005) 27 *Journal of Indian Academy of Forensic Medicine* 195–200.

[300] Sara Wharton 'Defences to Criminal Liability' in Charles C Jalloh, Kamari M Clarke & Vincent O Nmehielle (eds) *The African Court of Justice and Human and Peoples' Rights in Context: Development and Challenges* (2019) 866–924 available at: https://www.cambridge.org/core/books/african-court-of-justice-and-human-and-peoples-rights-in-context/defences-to-criminal-liability/5C47ACE0597B87367A9ECB2D73A5793F.

[301] *S v Pistorius* (CC113/2013) [2016] ZAGPPHC 724.

concluded that Pistorius possessed the ability to anticipate and did anticipate the possibility of the individual (his girlfriend) behind the door who, as a result, experienced fatal consequences. Consequently, Pistorius accepted the occurrence of such an event, resulting in his conviction for the crime of murder.

When considering the application of this legal principle within the medical domain, one could posit that physicians who choose to withhold or withdraw treatment or administer a potentially lethal palliative dosage of medication are cognisant of the potentiality for their actions to expedite the demise of a patient, and nevertheless proceed with said actions. The actions of doctors, while noble and well-intentioned, could potentially meet the criteria of *dolus eventualis,* as they may foreseeably hasten the death of a patient. McQuoid-Mason does not argue in defence of this concept and introduces a nuanced understanding of the *doctor's mens rea or state of mind* during these medical interventions, namely that of 'motive'.[302] He states that we must distinguish between intention and motive:

> "There is a need to distinguish intention from motive. A person's motive good or bad is irrelevant to criminal intent. The intention required for murder is the direction of one's will to kill a person (actual intention) or subjective foresight that a person may be killed (eventual intention). Motive is the reason behind the intention and in law is irrelevant except for the purpose of sentencing in criminal cases or damages in civil cases where it may be an aggravating or mitigating factor. Thus, an unlawful act can never become lawful because of a good motive, but may reduce the sentence in murder cases (e.g. active euthanasia)."[303]

He further posits that:

> "A doctor who withholds or withdraws treatment or prescribes palliative treatment that hastens death may have a good motive – not to engage in futile treatment or to lessen pain for the patient – but legally has the eventual intention to kill the patient."[304]

However, he continues to state that even though this meets the criteria (strong as it may be) of intentional killing through 'eventual intention', he adds elements to the 'calculus' of criminal liability, namely, causation and unlawfulness. He states:

[302] McQuoid-Mason, 'Withholding or Withdrawing Treatment and Palliative Treatment Hastening Death', supra n 91.
[303] Ibid.
[304] Ibid.

> ‘However, the doctor cannot be held liable for murder if any of the other elements of the crime are missing.’[305]

Nevertheless, the central focus of McQuoid-Mason's argument revolves around the notion of 'unlawfulness', which constitutes the third component of the crime of murder. He argues that the behaviours exhibited by medical professionals in such situations are not deemed 'illegal' because of prevailing societal and legal beliefs. This argument introduces the concept of 'medical exceptionalism', which refers to the belief that the medical profession is governed by a distinct set of moral, ethical, and legal principles because of the distinctive nature of its practice, particularly regarding end-of-life treatment.[306] Moreover, he continues that society considers their actions lawful. This interpretation resembles legal defences or justifications that can be invoked in instances of deliberate criminal acts, such as homicide. These defences cover necessity, informed consent, advanced directives, societal acceptance of the actions, and the absence of malicious intent. These exceptionalism arguments rely on the belief that the distinct circumstances surrounding end-of-life care warrant doctors being exempted from the typical legal definitions of intention and causation about the act of murder. The matter is characterised by its intricate nature and subtle nuances, giving rise to substantial inquiries regarding the convergence of legal principles, ethical considerations, and medical practices. The ongoing discourse surrounding this topic is beyond the scope of this dissertation. It is expected to endure as our comprehension and capacities in healthcare continue to advance.[307]

3.8 CONCLUSION

Criminal medical negligence occurs when a healthcare provider fails to provide adequate care, resulting in harm or death. The legal system determines this by assessing whether their conduct falls below the standard of a reasonable healthcare provider. Mistakes in diagnosis, treatment, or other medical decisions leading to harm were reviewed. Not every error or adverse outcome or medical harm leads to criminal liability, as the legal system acknowledges that mistakes can happen despite best efforts. It is also clear that if the medical professionals’ behaviour or actions, despite having no direct intention to harm the patient, were exceptionally egregious and reckless, or they knew or should have known their actions would cause harm, they may be

[305] Ibid.
[306] Suzanne Ost ‘The Medical Professional as Special before the Criminal Law’ *Criminality at Work* (2020) available at: https://oxford.universitypressscholarship.com/10.1093/oso/9780198836995.001.0001/oso-9780198836995-chapter-15.
[307] R Gillon ‘The principle of double effect and medical ethics.’ (1986) 292 *British Medical Journal (Clinical research ed.)* 193–4.

considered criminally negligent. To assess the reasonable standard, the courts apply an objective test by using expert witnesses to provide expert testimony about what they would have done in similar circumstances. The ensuing chapter will explore how these legal, ethical, and medical concepts are prominently highlighted through the analyses of landmark case laws.

CHAPTER FOUR: *ANALYSES OF LANDMARK CASE LAWS*

4.1 INTRODUCTION

In the previous chapters, we have reviewed the critical elements of criminal medical negligence in the law and how patient safety systems are designed to avoid preventable harm. Outside of intentional harm, we arrived at a working definition of criminal medical negligence by deconstructing the negligence and criminal components of the concept and rebuilding a model for medical and legal professionals to appreciate the nuances within this common law doctrine of negligent crime. Briefly, the definitional elements of criminal medical negligence were analysed by breaking it down into its constituent components, namely, (1) the negligent act, (2) the severity of deviation from expected reasonable standard (gross negligence), (3) the consequent harm inflicted upon the patient, and (4) not taking mitigating steps to have prevented the harm.[308] Ordinary medical negligence rises to the level of criminality when actions or omissions include (1) deliberate harm, and (2) conscious disregard for patient wellbeing and safety, and reckless behaviour that deviates from the established standards of care, i.e., there is an element of guilty state of mind that is arrived at through the negligent (*culpa*) arm of fault. Criminal intent in criminal medical negligence is arrived at by invoking an 'oblique' pathway to *mens rea*, which pertains to a person's mental state at the time of harm.[309] Within medical negligence, it can be inferred that the medical professional's actions were not simply an inadvertent or subjective lapse in judgment but rather a deliberate departure from the recognised standard of care, leading to poor outcomes for the patient.[310]

As we have also seen in the prior chapters, the distinction between civil and criminal negligence lies in the degree of negligence exhibited. In the context of civil medical negligence, it is observed that the doctor's actions show negligence, yet intentional harm is absent. The injured party, the patient, initiates a civil litigation process to seek restitution through monetary compensation. In contrast, in a criminal medical negligence case, the physician's negligence is characterised by intentional, knowing (foreseeability), or reckless behaviour (failing to honour a reasonable standard of professional duty of care). The State institutes a charge of criminal

[308] Otto, supra n 282.
[309] Horder, supra n 232.
[310] David H Sohn 'Negligence, genuine error, and litigation' (2013) 6 *International Journal of General Medicine* 49–56.

negligence to redress the harm by imposing a punishment (imprisonment, a fine, or other disciplinary sanctions) to deter future wrongful acts of negligence.

In this chapter, I selected to analyse *S v Kramer*[311] and *S v Van der Walt*[312] because they represent pivotal moments in the evolution of South African medical law, particularly in the context of criminal liability for medical professionals. Examining these two cases, separated by over three decades, reveals the enduring relevance of the legal standards set forth in *S v Kramer*[313] and highlights their continued influence on judicial reasoning today.

4.2 CASE 1: *S v KRAMER AND ANOTHER*[314]

4.2.1 Facts of the case.

The case of *S v Kramer and Another*[315] revolves around the tragic death of a 10-year-old girl, who lost her life during a routine tonsillectomy and adenoidectomy operation. The surgeon was accused No. 1, and the anaesthetist was accused No. 2, and both were present in the theatre at the time the patient died on the theatre table.

During the operation, at the time of intubating the patient, the anaesthetist relied on the theatre nurse to choose the endotracheal tube for this 10-year-old child. The anaesthetist inserted the tube but failed to detect that the tube was correctly placed in the trachea. The surgeon began the operation, assuming the tube was in the right place. Further, when the patient started showing signs of deoxygenation, as testified by the nurse, the anaesthetist failed to monitor the patient's condition during the operation adequately. The surgeon, despite observing excessive bleeding after removing the patient's right tonsil, proceeded to remove the left tonsil. When the patient's condition started to deteriorate, the surgeon ordered the anaesthetist to inject more anaesthetic agents, the result of which caused paralysis of the muscles controlling normal breathing. The anaesthetist complied, and the patient's condition worsened rapidly. Despite attempts to resuscitate her, the patient tragically died. Both the doctors were found guilty of culpable homicide in the Magistrate court. The case was then taken on appeal to the High Court (HC).

[311] *S v Kramer and Another* 1987 (1) SA 887 (W).
[312] *Van der Walt v S* [2020] ZACC 20.
[313] *S v Kramer and Another* 1987 (1) SA 887 (W).
[314] *S v Kramer and Another* 1987 (1) SA 887 (W).
[315] *S v Kramer and Another* 1987 (1) SA 887 (W).

4.2.2 Issues.

Listed below are some of the key issues I have selected for discussion:

1. Did the accused doctors have a duty of care towards the patient?
2. Did the doctors breach that duty of care?
3. Was the theatre equipment checked for adequacy and readiness for emergencies, and if not, did the doctor's decision to proceed nonetheless constitute disregarding the risks?
4. Did accused No. 1 ensure that accused No. 2 had the necessary experience undertaking anaesthesia for a tonsillectomy?
5. Did accused No. 1 (surgeon) check the correct placement of the endotracheal tube before proceeding with the operation?
6. Did accused No. 2 correctly place the endotracheal tube, and if not, why was this not detected in time?
7. Did the accused doctors take appropriate and timely resuscitative measures when the patient showed distress?
8. Did accused No. 2 adequately monitor the patient's condition during the operation?
9. Did accused No. 2 administer an excessive amount of anaesthetic to the patient, and if so, why?
10. Did the accused doctors' alleged negligence directly cause the patient's cardiac arrest and subsequent death?
11. Did the accused doctors' conduct deviate from what a reasonable doctor would have done under the same circumstances?
12. Did the accused doctors' actions or omissions constitute unlawful conduct under the laws governing medical practice?

4.2.3 Rules that are at play relevant to the case.

Several key legal and ethical rules apply within the South African context. Common law imposes a duty of care on doctors, requiring them to act with the skill and diligence expected of a reasonable practitioner in similar circumstances. Failure to meet this standard may

constitute negligence.[316] Section 11 of the South African Constitution guarantees the right to life, obligating healthcare providers to avoid unjustifiable risks to patients.[317] The HPCSA ethical guidelines also set important standards.[318] These include that practitioners must only perform procedures they are competent to handle (HPCSA, Booklet 2, Section 3.1), ensure all equipment is adequate and ready for emergencies (HPCSA, Booklet 1, Section 3), and continuously monitor patients during procedures (HPCSA, Booklet 2, Section 2.4). Statutory law, such as the NHA, further enforces standards of care and patient safety. [319]

4.2.4 Application of the rules to the selected issues listed above.

Several questions listed above illustrate how the processes of care (in this case, an elective operation under general anaesthesia) could go wrong if medical professionals do not take 'conscious care' and check that their conduct and working environment are not sources of potential harm to their patients and adequate vigilance is applied to ensure all aspects of the care processes are geared towards patient safety. If things go wrong, and they will, and harm results from the 'negligence' of the care team, the case should be investigated and even elevated to be investigated by the State if wrongdoing is suspected. This case highlights all these scenarios well. I address each of the issues hereunder:

1. *Did the accused doctors have a duty of care towards the patient?*

As mentioned under the 'rules at play' section above, doctors are bound by the legal duty they owe to patients under South African law, expressed in the relationship between the doctor and the patient,[320] which is established when a doctor agrees to treat a patient. In this case, both the accused were responsible for the patient's care.[321]

2. *Did the doctors breach that duty of care?*

To show that the doctors breached this duty of care, the court had to rely on information about whether the doctors deviated from the expected standards of surgical and anaesthetic practice

[316] *Mitchell v Dixon* 1914 AD 519.
[317] Constitution of Republic of South Africa, 1996 (s11).
[318] 'HPCSA Professional Practice: Ethics Booklets', *Ethics*, supra n 39.
[319] National Health Act 61 of 2003; Health Professions Act 56 of 1974.
[320] National Health Act 61 of 2003.
[321] M Slabbert & M Labuschaigne 'Legal reflections on the doctor-patient relationship in preparation for South Africa's National Health Insurance' (2022) 15 *South African Journal of Bioethics and Law* 31–5.

in South Africa.[322] Like in other jurisdictions,[323] the standard of care is typically defined as what a reasonable surgeon or anaesthetist in the same speciality would do under similar circumstances. The court showed that accused No. 2, the anaesthetist, failed to verify the correct placement of the endotracheal tube, did not take appropriate measures to resuscitate the patient when her condition deteriorated, and went against the reasonable practice of upping the dose of anaesthetics, instead of first identifying the cause of the reason why the patient was deteriorating.[324] This constituted a breach of this standard. In this case, expert testimony from Professor Cooper provided this external reasonable specialist as a benchmark to measure the deviations from the standard of anaesthetic intraoperative care monitoring.[325]

3. *Was the theatre equipment checked for adequacy and readiness for emergencies, and if not, did the doctor's decision to proceed nonetheless constitute disregarding the risks?*

It is standard practice to check theatre equipment and resuscitation trolleys in the theatre.[326] The onus lies on the doctors and nurses who owe the patient the duty to ensure these measures are in place before the operation. The equipment was inadequate, but the doctors proceeded with the operation. This behaviour demonstrates their 'deliberate' disregard for the potential risk that may arise during the operation. As the case illustrates, when the patient deteriorated on the operating table and needed lifesaving interventions, the lack of equipment directly caused the death of the patient; but, if was the 'gross negligence' and 'reckless disregard' on the part of the medical staff accused, that despite knowing that the theatre was ill-equipped, and choosing to nonetheless proceed with the operation, that makes this case so important concerning the fulfilling the criteria of criminal medical negligence.[327]

4. *Did accused No 1 ensure that accused No 2 had the necessary experience undertaking anaesthesia for a tonsillectomy?*

This is an interesting situation. In practice, this is hardly done, and I am not surprised that the team that constituted to run the operation in the theatre 'just assumed' that everyone is trained

[322] *S v Kramer and Another* 1987 (1) 887 (W) para 889D.
[323] Harvey Teff 'The Standard of Care in Medical Negligence—Moving on from Bolam?' (1998) 18 *Oxford Journal of Legal Studies* 473–84.

[324] *S v Kramer and Another* 1987 (1) 887 (W) para 889I.
[325] *S v Kramer* 1987 (1) SA 938 (A).
[326] Shivani Pillay, Deidre Hoffman & Pano Parris 'Audit of emergency airway drugs and equipment at a Johannesburg hospital' (2022) 12 *African Journal of Emergency Medicine* 406–9.

[327] Carstens & Pearmain, supra n 70 at 847.

in their respective specialities.[328] The case was appealed, and in the subsequent ruling, the surgeon (accused 1), initially found guilty of culpable homicide, was acquitted.[329] The Appellate Division overturned the lower court's decision, determining that the evidence did not sufficiently prove that the surgeon's actions were directly responsible for the patient's death.[330] The court held that there was no clear causal link between the surgeon's conduct and the fatal outcome, ultimately finding that the surgeon's actions, while perhaps suboptimal, did not meet the threshold for criminal liability. This case, and many after this, have generated much debate about 'who is in charge of the theatre' and 'who is the captain of the ship'.[331]

5. *Did accused No. 1 (surgeon) check the correct placement of the endotracheal tube before proceeding with the operation?*

In this case, the surgeon assumed the anaesthetist would have known better that the tube was correctly placed and proceeded with the operation. When he realised the patient was 'deteriorating', he questioned the anaesthetist about the tube placement (the course of events is unclear from the judgement to discern if the surgeon was questioning if the tube was correctly placed or if the patient was adequately anesthetised). Instead, they opted to increase the dose of anaesthesia, which accelerated the process of the patient showing signs of deterioration (oxygen levels going down). While it is accepted best practice, the tube's correct placement is crucial to commencing surgery. As noted above, the surgeon appealed and was found not guilty of this breach of duty. It was held in this appeal that neither the surgeon nor the anaesthetist was liable for the other's negligence.[332] Their relationship was described as

> *"They are not agents of one another. They are not employed and controlled by one another. Each one performs a specific specialised function as part of a team consisting of surgeon, anaesthetist and nursing staff. The one is therefore not responsible for the others conduct in their field of expertise".*[333]

6. *Did accused No. 2 correctly place the endotracheal tube, and if not, why was this not detected in time?*

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[328] Henry Lerm 'Who Is Responsible for Mishaps in the Operating Theatre at a Private Hospital?', *De Rebus*, available at: https://www.derebus.org.za/responsible-mishaps-operating-theatre-private-hospital/.

[329] *S v Kramer* 1987 (1) SA 938 (A).
[330] *Van Wyk v Lewis* 1924 AD.
[331] Lerm, supra n 330.
[332] *S v Kramer and Another* 1987 (1) 887 (W) para 895E.
[333] *S v Kramer* 1987 (1) SA 877 (W) 895. The quote used here comes from the case of *Mitchell v Dixon* 1914 AD 519 at 525.

The anaesthetist's correct placement of the endotracheal tube is a fundamental responsibility. If accused No 2 (anaesthetist) incorrectly placed or misplaced the tube, this could be seen as a breach of his duty of care. The failure to detect this error in time could be attributed to a lack of adequate monitoring or a failure to respond appropriately to signs of distress in the patient. This anaesthetist was charged with this negligence, as seen in the judgement.

7. *Did the accused doctors take appropriate and timely resuscitative measures when the patient showed distress?*

There are two issues at play here. The first was covered above under the adequacy and readiness checks before commencing the operation in a theatre. The second is about the appropriate timing of the resuscitative measures when the doctors noticed the patient was deteriorating. In the judgement, it is posited that the anaesthetist 'froze', which created a delay between knowing that the patient was deteriorating on the table and doing something about it, necessitating accused No. 1 (surgeon) to take over the resuscitation from the anaesthetist.[334] This would have required the doctors to apply a series of simple 'ABCs of what to do when a patient deteriorates under anaesthesia'[335], which would have immediately informed the doctors that the problem was a misplaced tube and not something else causing the deterioration. This simple standard was breached, and thus, there was a delay in initiating resuscitative measures. This is a serious transgression or violation of the standard practice and constitutes legally a serious failure by the doctors to meet the minimum standards during an emergency.

8. *Did accused No. 2 adequately monitor the patient's condition during the operation?*

The judgement clearly states that he failed to adequately and timely monitor the patient during surgery, which, as stated previously, is a fundamental responsibility of the anaesthetist. Again, he did not meet the standards required by a typical anaesthetist and thus violated the duty of care. It would be prudent to examine the chronological medical records in detail to show if there were any early warning signs during the operation that would have alerted the anaesthetist about the correct placement of the tube. This would have been useful to show the 'knowledge' and 'foreseeability' angle of criminal negligence. If the anaesthetist knew or picked up the early warning signs but chose to disregard them, this would be construed as being reckless or

[334] Health Professions Act 56 of 1974 (s34).
[335] ABC's refer to the clinical evaluation (assessment and management) of the Airway, Breathing and Circulation of a patient in need of emergency care.

committing gross negligence, as this is a serious departure from the standard and shows the guilty state of mind of the anaesthetist.

9. *Did accused No. 2 administer an excessive amount of anaesthetic to the patient, and if so, why?*

This relates to the rationale (knowledge and foreseeability) for why the order to increase anaesthetic agents would 'solve' the immediate problem of 'signs of distress'. If the primary problem was an incorrectly placed tube and the surgeon continued to operate (knowing very well that in this anatomical area where the airway is already going to be compromised), the administration of an excessive amount of anaesthetic agent could potentially lead to serious complications, including cardiac arrest. As seen in this case, the patient was paralysed and would not mount her respiratory efforts, and thus, be completely dependent on the anaesthetist to ensure that an airway is patent and secured by correct placement of the tube. So, giving an extra dose of anaesthetic would worsen the situation. The anaesthetist failed to apply his duty of care and follow the standards to secure an airway and provide oxygen through a correctly placed tube. The judge called out his incompetency and regarded his behaviour as grossly negligent and reckless.[336] This is not a 'misjudgement' but a substantial deviation from the standards of care for an average reasonable anaesthetist.[337]

10. *Did the accused doctors' alleged negligence directly cause the patient's cardiac arrest and subsequent death?*

Applying the rules of causation here, this case fulfils both factual (but for) and legal causation (nothing intervening between the primary cause and the harm). The anaesthetist's behaviour and reaction to the case also augment the argument that the link between the source of primary negligence on the part of the doctor (misplaced tube) and the death of the patient is causal.[338]

11. *Did the accused doctors' conduct deviate from what a reasonable doctor would have done under the same circumstances?*

This question goes to the heart of the negligence issue. As discussed above, this is a landmark case that illustrates how duty of care and deviation from this duty, especially in acute emergency settings, where correct and timely clinical decisions need to be made, and room for error is small, can lead to a disaster worthy of being labelled in a court of law as criminal.

[336] Carstens & Pearmain, supra n 70 at 847.
[337] Merry & Brookbanks, supra n 3 at 3.
[338] Carstens & Pearmain, supra n 70 at 762.

Interestingly, the lead expert witness in this case, provided the 'objective test' to substantiate what a reasonable anaesthetist would do. Accused No.2 (anaesthetist) was proven to be 'incompetent' by this standard.[339]

12. *Did the accused doctors' actions or omissions constitute unlawful conduct under the laws governing medical practice?*

Interestingly, the court applied all the elements of the heuristic I developed to assess the legal and ethical perspectives of judging a case as unlawful and blameworthy. Typically, in South African law, for a finding of culpable homicide, the accused's conduct must be unlawful. This requires that the conduct violates the patient's legal rule or right. If the accused doctors' actions or omissions violated the ethical rules governing medical practice, in this case, following the reasonable standard for managing an operating theatre and conducting equipment and readiness checks, this could also satisfy this requirement.[340]

4.2.5 Sentiments from the Court.

The court had shed light on four primary areas in which the professional negligence of the second defendant (anaesthetist), who was found guilty of culpable homicide, was displayed. The court contended that the defendant's reliance on the nurse for the selection of an appropriate endotracheal tube was deemed inappropriate due to the potential outcome of the tube being either insufficiently long or inadequately inserted into the trachea. The situation was further exacerbated by the revelation of the defendant's negligence in fulfilling a critical medical obligation, specifically the proper insertion of the tube into the trachea.

The court expressed its disdain against accused No. 2, including inadequate supervision of the patient's condition, inability to use essential monitoring instruments, such as a blood pressure cuff and an electrocardiogram (ECG) machine and his lack of competence in effectively handling the initial phases of the crisis ('froze')[341]. The court thus found the accused No. 2 responsible for the patient's death because his actions constituted a substantial breach of the reasonable professional obligation to provide appropriate and adequate care.[342] On the other hand, accused No. 1 (surgeon) was dismissed as his appeal succeed while accused No. 1 (anaesthetist) was found guilty of culpable homicide.

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[339] *S v Kramer and Another* 1987 (1) 887 (W) para 895E.
[340] Health Professions Amendment Act, 2007 (Act 29 of 2007); Inquest Act 58 of 1959.

[341] The clinician, from a fit of panic, became dysfuctional and could not continue to resuscitate the patient.
[342] *S v Kramer and Another* 1987 (1) 887 (W) para 895C.

4.2.6 Discussion and Conclusion.

The case is fundamental in South African medical law as it established a critical legal precedent for holding medical practitioners criminally liable for negligence leading to a patient's death. This ruling stressed the importance of the duty of care in medical practice, demonstrating that failures in preparation, monitoring, and ensuring proper procedures can result in serious legal consequences, including charges of culpable homicide. As a landmark case, it has shaped the legal landscape by setting a clear standard for medical accountability and reinforcing the need for strict adherence to professional and ethical obligations. The case confirmed that when medical negligence results in a patient's death, it may lead to a charge of culpable homicide under the doctrine of *culpa*.[343]

4.3 CASE 2: *S v VAN DER WALT* [344]

4.3.1 Facts of the case.[345]

Dr Danie Van der Walt, an obstetrician and gynaecologist practising in Witbank, was charged with culpable homicide after the death of his patient, Ms Pamela Noni Daweti, in 2016. Ms Daweti had undergone a caesarean section under the care of Dr Van der Walt, and it was alleged that his negligence in post-operative care led to her death. Mrs Daweti, experienced prolonged labour and had to have a caesarean section to deliver the baby. Post-operatively, Mrs Daweti was taken to the recovery room, where she experienced an unusually large volume of blood loss from the uterus (post-partum haemorrhage), which resulted in the vital signs showing signs of circulatory shock. Expert witnesses, including another obstetrician, Dr T, who was testifying in the case, confirmed that Mrs Daweti's delivery period and an intra-operative period put her at risk of post-partum haemorrhage. The Regional Court found that Dr Van der Walt had failed to monitor Ms Daweti's condition adequately, particularly in not ensuring timely medical intervention when her condition deteriorated. This failure was deemed grossly negligent and directly causative of her death, resulting in his conviction for culpable homicide and a sentence of five years imprisonment. Dr van Der Walt served 6 months of this sentence until the case

[343] Burchell, supra n 12 at 341.
[344] *S v Van der Walt* (Unreported case, Witbank Regional Court, 2016) cited as in High Court: *S v Van der Walt* (2017) ZAGPPHC 58 (GP), Supreme Court of Appeal: *Van der Walt v S* [2019] ZASCA 74; 2019 (2) SACR 297 (SCA). Constitutional Court: *Van der Walt v S* [2020] ZACC 20.
[345] Facts of the case were reconstructed from the previous judgements in the HC, SCA and CC. The Regional Court Judgement was not easily available to me at the time of writing. Additional sources were also used to reconstruct the facts, such using media coverage, commentary from legal experts in medical law.

was taken to High Court (HC), Supreme Court of Appeal (SCA) and Constitutional Court (CC) for appeal. Both the HC and SCA upheld the Regional Court judgement, while the CC set aside the *court a quo's* judgements and dismissed on the grounds of procedural irregularity and the right to a fair trial.[346]

4.3.2 Issues.

1. Did Dr Van der Walt exercise the necessary standard of care in post-operative care?
2. How should criminal liability be assigned in medical negligence resulting in death?

4.3.3 Rules to consider when assessing the facts of the case.

The standard of care expected from medical professionals is established through common law and statutory obligations (see Chapter 1). In *S v Van Wyk*,[347] the court affirmed that a professional's actions are measured against what a reasonably competent professional would have done in similar circumstances.

4.3.4 Application of the Rules to the facts of the case.

The crux of the case against Dr Van der Walt rested on whether his actions or lack thereof, met the standard of care expected of a reasonably competent obstetrician and gynaecologist. The Regional Court found that he failed to act with the necessary urgency when Ms Daweti's post-operative condition began to deteriorate, particularly in monitoring her vital signs and responding to signs of distress. This was attested to by expert witness Dr T, a reasonable obstetrician standard, The court observed that "the negligent omission by the accused to monitor and respond timeously to the patient's deteriorating condition led to her preventable death".[348] This omission was a significant deviation from the standard of care required and was found to be the direct cause of her death.

The HPCSA provides clear guidelines on the duties of medical professionals, emphasizing that practitioners must ensure "adequate monitoring of patients" and "timely intervention" when complications arise. Dr Van der Walt's failure to adhere to these guidelines

[346] Llewelyn Gray Curlewis 'Medical Negligence and Criminal Responsibility-When the Court Infringes on a Medical Practitioner's Rights to a Fair Trial', 2021, available at: https://repository.up.ac.za/handle/2263/86542 [last accessed 10 August 2024].
[347] *S v Van Wyk* 1967 (1) SA 488 (A).
[348] *S v Van der Walt* [2020] ZACC 19, para 2.

was central to the court's finding of negligence. As Curlewis highlights, "the actions of a medical professional are scrutinised against the expected standards, and a deviation from these can lead to severe legal consequences, including criminal liability".[349]

4.3.5 Discussion and Conclusion.

The case of *S v Van der Walt*[350] highlights the stringent standards medical professionals hold, particularly in life-and-death situations. The conviction of Dr Van der Walt for culpable homicide serves as a reminder that negligence in medical practice can have severe legal consequences, including criminal liability. The case reminds us about the importance of adhering to established medical protocols and guidelines to avoid tragic outcomes and the subsequent legal repercussions. The judiciary's approach, in this case, reflects a broader commitment to ensuring that medical professionals exercise the highest standards of care, reinforcing the principle that deviations from these standards will not be tolerated where they result in harm or death to patients. Additionally, as a lesson to be derived from this case, Curlewis points out that while procedural fairness is critical, it does not absolve medical professionals from being held accountable for their actions when they fail to meet the requisite standard of care.[351]

4.4 CONCLUSION

This chapter explored key cases of criminal medical negligence from South Africa. To be more specific, we applied the rules of the law, criminal law, by analysing the facts of the cases to arrive at a reasonable legal outcome as these landmark cases illustrated. Legal and medical professionals can gain more insight into the nuances of criminal medical negligence, which remains a conceptual and practical challenge. We extracted vital elements such as the nature of the negligent act, the degree of intent (*mens rea*), and the resulting harm to the patient. Such analysis clarifies the legal landscape and provides a practical guide for medical practitioners to

[349] Curlewis, supra n 348.
[350] *S v Van der Walt* supra (n 304).
[351] The Constitutional Court in *S v Van der Walt* set aside both the conviction and sentence due to significant procedural irregularities, particularly the late ruling on the admissibility of evidence and the reliance on unintroduced medical literature. These irregularities were found to have compromised the fairness of the trial, leading the Court to conclude that the trial was "vitiated in a constitutionally impermissible manner" (*Van der Walt* [2020] ZACC 19, para 30). The case was remitted to the Director of Public Prosecutions to determine whether Dr Van der Walt should be re-arraigned.

mitigate risks and uphold ethical standards; however, there is discretion in deciding whether redress should be sought through criminal or civil law.

CHAPTER FIVE: *CONCLUSION*

5.1 INTRODUCTION

This dissertation has explored whether medical professionals in South Africa should face prosecution for medical harm caused during treatment. It examined the legal, ethical, and professional perspectives and carefully analysed case laws of criminal medical harm (intentional or negligent) in South Africa. This dissertation revealed several key findings.

5.2 FINDINGS

These themes identified in this dissertation include the question of adequacy of the current legal framework and *mens rea*, judicial caution in landmark cases, the role of regulatory bodies, ethical considerations, and theoretical models for improvement. It may seem straightforward at first, but as examined in some detail, these themes typify the intricate nature of criminal medical harm in South Africa and suggest ways to enhance legal and professional accountability.

The existing legal framework in South Africa primarily addresses medical negligence through civil remedies, which proves inadequate for handling severe cases involving gross negligence or intentional harm (through *dolus eventualis*). The concept of *mens rea*, particularly appreciating this in the context of negligence (failure to provide reasonable care and take due care to prevent harm) and *dolus eventualis* (had foreseen the harm and nonetheless proceeded by reconciling with this), is central to criminal liability. Both gross negligence and *dolus eventualis* are challenging to prove beyond a reasonable doubt, deterring criminal prosecutions in medical negligence or malpractice cases.

The judicial approach in landmark cases such as *S v Kramer and Another* and *S v Van der Walt*[352] reflects significant caution in criminalising medical errors. These cases stress the difficulties in establishing criminal liability, with courts focusing on the intent (state of mind, *mens rea*) and professional standards of care. It is also clear that litigation processes prefer civil litigation over criminal prosecution for various reasons, and although not clearly elaborated in practice, they aim to balance justice for victims with the complexities inherent in medical

[352] *S v Kramer and Another* 1987 (1) SA 887 (W); *S v Van der Walt* (Unreported case, Witbank Regional Court, 2016) cited as in High Court: *S v Van der Walt* (2017) ZAGPPHC 58 (GP), Supreme Court of Appeal: *Van der Walt v S* [2019] ZASCA 74; 2019 (2) SACR 297 (SCA). Constitutional Court: *Van der Walt v S* [2020] ZACC 20.

decision-making. This cautious judicial stance highlights the need for clear guidelines and consistent application of legal principles.[353]

Ethical obligations in the medical profession demand high standards of care and accountability. Serious ethical breaches resulting in significant harm should be examined through professional and legal lenses to ensure appropriate punishment and maintain public trust. The findings suggest that integrating ethical considerations into the legal framework can enhance the prosecution of egregious conduct without undermining the integrity of the medical profession. Professional regulatory bodies such as the HPCSA play a pivotal role in upholding medical standards and addressing ethical breaches.[354] However, tension exists between their mandate to protect the public and the internal protectionism within the profession.[355] This duality often results in inconsistent enforcement and a lack of accountability for serious breaches.[356] The worst form of sanction a medical professional would receive as punishment for breaches would be removal from the registration roll.[357] Criminal charges require the National Prosecuting Authority to successfully prosecute the case in court, depending on its merits. The findings indicate a need for a more transparent and rigorous regulatory environment.

5.3 CONCLUSIONS

Despite a robust legal framework to address criminal medical negligence in South Africa, challenges are still associated with identifying the line between 'ordinary' and 'gross' negligence. Medical professionals' work involves taking risks and this framework does not differentiate between degrees of negligence (and some authorities have argued that it should be the court's prevue to decide on the nature and culpability of the act or omission). Others have argued for re-evaluating and possibly tightening legal standards.[358] However, the South African accountability system is well established (but remains to be fully tested in practice) through rigorous regulatory oversight and incorporates ethical considerations. Adopting and

[353] McQuoid-Mason, 'Liability of Doctors Based on Negligence for Culpable Homicide', supra n 66.
[354] 'HPCSA Professional Practice: Ethics Booklets', *Ethics*, supra n 39.
[355] Molelekwa, supra n 25.
[356] 'Prosecuting Healthcare Professionals for Culpable Homicide – Who Benefits?', available at: https://www.medicalprotection.org/southafrica/casebook-and-resources/news/news-article/2020/01/21/prosecuting-healthcare-professionals-for-culpable-homicide-who-benefits [last accessed 10 August 2024].
[357] Health Professions Act 56 of 1974 (s19).
[358] Ethelwynn Stellenberg & Henry Lerm 'South African Doctors Call for Law Reform, Fearing a Harsh Penalty If Patients Die', *The Conversation*, available at: http://theconversation.com/south-african-doctors-call-for-law-reform-fearing-a-harsh-penalty-if-patients-die-175185 [last accessed 13 June 2022].

integrating novel theoretical models can further enhance this framework, fostering a culture of safety and accountability in the medical profession.

5.4 RECOMMENDATIONS: POLICY, LEGISLATIVE RECOMMENDATIONS AND FUTURE RESEARCH DIRECTIONS

South African National Department of Health Policy of Patient Safety Incident Reporting[359] has made one such proposal in the right direction.[360] Through the nuanced approach to a nuanced problem of criminal medical negligence, the South African medico-legal field could test and learn how the integration of Reason's Culpability Model[361] and Alexander's comprehensive understanding of criminal culpability model[362] could potentially contribute to the development of policy and legislation in favour of patient safety and individual accountability.[363] The law could benefit from incorporating Alexander's comprehensive framework of criminal culpability, which emphasises the concept of recklessness (the mental state of the professional where he "show blatant disregard for patient safety", while also differentiating between errors that arise from systemic issues and those that arise from individual recklessness. In this regard, there has indeed been a call for legal reform from the medical fraternity and legal authorities to adopt the nuanced approach and amend the 'catch-all' crime of culpable homicide by accepting the finer delineations of negligence in the form of gross negligence and recklessness.[364] These measures could collectively reduce adverse patient incidents by informing medical professionals that criminal sanction is a potential consequence of medical mishaps, mistakes, or errors of judgement.

Furthermore, it would be beneficial for future research to investigate the feasibility and obstacles associated with the application of Reason's model and Alexander's approach within the healthcare system of South Africa. This study should investigate the perceptions and experiences of healthcare professionals regarding these models, as well as identify potential barriers to their implementation.

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[359] The student, Shuaib Kauchali, has contributed to development of the policy from its inception in 2018 while working at a Senior Technical Advisor to the National Department of Health.
[360] 'National Guideline for Patient Safety Incident Reporting and Learning in the Health Sector of South Africa - 2022 | Department of Health Knowledge Hub', supra n 41.
[361] Reason, supra n 42.
[362] Alexander, supra n 59.
[363] 'National Guideline for Patient Safety Incident Reporting and Learning in the Health Sector of South Africa - 2022 | Department of Health Knowledge Hub', supra n 41.
[364] 'Strong Warning from SAMA on Criminalisation of Medical Decisions', *Medical Brief*, available at: https://www.medicalbrief.co.za/strong-warning-from-sama-on-criminalisation-of-medical-decisions/.

5.5 PERSONAL CONCLUDING REMARKS: AN EYE-OPENER

This dissertation is neither the first of its kind nor an exhaustive study on the criminalisation of medical harm. It does not aim to thoroughly analyse the complexities previously raised, especially those related to defining criminal behaviour in medical professionals. The objective was to illustrate the potential for criminal sanction in the medical field, highlighting that doctors are not immune to criminal prosecution. Further research is needed to determine if current criminal law should be applied to medical cases or if new legislation is more suitable, considering doctors' daily systemic and practical challenges.

I have sought to simplify the discussion, showing my limitations on the issue in the process. It reflects many doctors' experiences, making the research in this thesis relatable and significant for bringing some of the relevant legal concepts within their understanding and consideration. The purpose has been to provide an understandable and tangible lexicon, bridging the gap between *legalese* and *medicalese*. This first step is key to achieving meaningful and impactful discourse rather than maintaining the status quo of discord. In the process, I have learned useful insights from numerous authorities and professionals in this field that have now influenced my perspective on this topic. Covering and comprehending the intricacies required in defining a crime under medical law was difficult, given that medical practitioners do not aim to cause harm and, hence, do not participate in criminal behaviour.

So, ‘criminalising medical harm’ is not as easy as glibly stating it. Interestingly, there are gaps in medical professionals' arguments against criminalising medical harm, owing to confusion about the full range of approaches the law uses to define and handle deviations from the 'accepted standards' against which the conduct of medical practitioners, like many other service-based professionals, is measured.[365] To be a criminal offence, a medical practitioner's conduct must fulfil society's moral and ethical standards for wrongdoing and any deviations or breaches from the legal criteria for such professions. The dialectical and conceptual leap for medical professionals and the broader community that includes non-lawyers is important to this as it affirms that the law applies to all, regardless of profession. It is submitted that given the nature of the profession, laws specific to the profession, which acknowledge certain systemic challenges, will have to be considered so that there is fairness to both members of the profession and the patients in their care. Some have argued that our existing system of holding

[365] Oliver Quick ‘Duties of Candour in Healthcare: The Truth, the Whole Truth, and Nothing but the Truth?’ (2022) 30 *Medical Law Review* 324–47.

medical professionals accountable for patient harm is adequate and should not be amended.[366] Rather, there is a call for a better implementation of the laws and regulations so that the legal system does not get strained in the long run. As a paediatrician, I am very familiar with how patient harm occurs. Sadly, we are unaware that most of the harm could have been averted by implementing existing methods to improve the quality of care and adhere to the standards of care. That aside, awareness of criminal law repercussions will go some way towards implementing systemic change through revised protocols; this awareness may well be the driver for more speedy reform and implementation of measures that will alleviate identified challenges.

We sometimes find ourselves failing the patient. Our radar lights up only when we are sued for our errors. We are surprised when the recourse and redress avenue shifts from civil to criminal liability. These rare incidents receive much media attention, but we should view these without our egos and the subjective bias that our profession is immune from criminal prosecution. We ought to filter the noise from the signal. This will allow for introspection and personal and professional development and a domino effect, inevitably leading to systemic improvement. This is a difficult admission to make. The process or journey to achieving this goal starts with a good understanding of the landscape. It will require a multidisciplinary team approach where legal and medical professionals appreciate the complex environment in which errors that lead to harm occur. We ought to be judged against a very high standard society imposes on us (nobility element). We can't always assume a stance of 'impunity' against the law because with 'great power comes great responsibility'.[367] This responsibility is expressed in the four culpability tests suggested by both Larry Alexander and James Reason[368] ('intentional harm test,' 'incapacity test,' 'foresight test,' and 'substitution test'), which have subsequently been adopted as a norm to govern clinical practice and patient safety in several countries, including the United Kingdom and South Africa, to foster accountable systems.[369]

The question of whether 'medical professionals can be subjected to criminal prosecution when their patients suffer harm during medical treatment' was answered in the

[366] McQuoid-Mason, 'Liability of Doctors Based on Negligence for Culpable Homicide', supra n 66.
[367] Henrique Napoleão Alves 'Chomsky and Spider-Man: "With Great Power There Must Also Come Great Responsibility"', *Medium*, available at: https://hnalves.medium.com/chomsky-and-spider-man-with-great-power-there-must-also-come-great-responsibility-6085bbb7939e.
[368] Reason, supra n 42; Alexander, supra n 59.
[369] Sandra Meadows, Karen Baker & Jeremy Butler 'The Incident Decision Tree: Guidelines for Action Following Patient Safety Incidents' in Kerm Henriksen et al (eds) *Advances in Patient Safety: From Research to Implementation (Volume 4: Programs, Tools, and Products)* (2005) available at: http://www.ncbi.nlm.nih.gov/books/NBK20586/.

affirmative. However, the more complex question of whether the criminal law route should be followed is much more challenging. It requires carefully appreciating the legal and ethical responsibilities relevant to medicine and healthcare. It is a specialised area of work and is still evolving. However, given the current concerns raised in recent criminal cases,[370] it may be one that will have to evolve and develop quickly.

If medical professionals breach their duty of care through wrongful and unlawful actions, whether by sub-standard care, intentional harm, or other derelictions, they should take responsibility (ethical conduct), be held legally liable if their actions meet the threshold of criminal culpability (legal standards) and must be held accountable for their conduct (upholding public trust and societal values).

[370] 'UPDATE | Dr Peter Beale Faces Fraud and Murder Charges as Case Heads to High Court in February | News24', available at: https://www.news24.com/news24/southafrica/news/culpable-homicide-case-off-dr-peter-beale-heads-to-the-high-court-in-february-20210120 [last accessed 22 December 2023].

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APPENDIX: ETHICS CLEARANCE CERTIFICATE

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

Dr Shuaib Kauchali (993248886)
School Of Law
Howard College

Dear Dr Shuaib Kauchali,

Original application number: 00017884
Project title: Criminalizing medical harm: Should medical professionals be subjected to criminal prosecution if patients are harmed during medical treatment?

Exemption from Ethics Review

In response to your application received on 23 March 2023 , your school has indicated that the protocol has been granted **EXEMPTION FROM ETHICS REVIEW.**

Any alteration/s to the exempted research protocol, e.g., Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through an amendment/modification prior to its implementation. The original exemption number must be cited.

For any changes that could result in potential risk, an ethics application including the proposed amendments must be submitted to the relevant UKZN Research Ethics Committee. The original exemption number must be cited.

In case you have further queries, please quote the above reference number.

PLEASE NOTE:
Research data should be securely stored in the discipline/department for a period of 5 years.

I take this opportunity of wishing you everything of the best with your study.

Yours sincerely,

[redacted]

Mr Matthew Blain Kimble
obo Academic Leader Research
School Of Law

UKZN Research Ethics Office
Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban 4000
Website: http://research.ukzn.ac.za/Research-Ethics/

Founding Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville

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