ETHICO-LEGAL ISSUES IN THE CRIMINAL PROSECUTION OF NEGLIGENT MEDICAL DOCTORS IN SOUTH AFRICA

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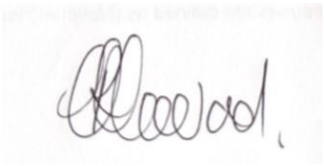
Signature:  Date: 2024-07-25

DEDICATION

To my father, Goolam R Moorad (1943-2021)

When I go

don't learn to live without me

just learn to look for me in the moments

I will be there

(Donna Ashworth)

ACKNOWLEDGEMENTS

To my children, Havana and Sean: Thank you for your friendship, love, and support. You have been and always will be my reason for living.

To Emmanuel and Winona, thank you for the messages of encouragement and support.

To Solly and Jesse... This is for you.

To Skaii and Coco, my constant companions who reminded me that all work and no play is boring.

A special acknowledgement to my supervisor, Mr. Khan. His guidance, advice, and impressive knowledge made this easier.

Last but not least, I would like to thank me. For believing in me, for doing all this hard work, for having no days off, and for never quitting.

ABSTRACT

Iatrogenic deaths are deaths that arise in the course of medical treatment and are regarded as unnatural deaths in South Africa. Several statutes regulate the medicolegal investigation of unnatural deaths. Should there be evidence of negligence, then a doctor may be criminally charged with culpable homicide. Only a handful of doctors in South Africa have been criminally prosecuted and fewer still have been found guilty or imprisoned. Despite the low conviction rate the use of criminal law in response to iatrogenic deaths has been criticised by doctors. The South African Medical Association argue that criminalisation negatively affects patient safety and have called for a review of the law of culpable homicide. They have also called for the introduction of special legislation to address criminal medical negligence. To address these arguments the report evaluates the current legal framework of the criminal justice system. The report addresses the ethical issues around patient safety when doctors are prosecuted for criminal medical negligence. The study is normative and reviews the existing literature, current legal framework and ethical principles to defend a thesis as to why it is justifiable to hold medical doctors criminally liable for the deaths of patients under their care. This research report concludes that when the law is used judiciously and sparingly it is helpful for progressing and improving patient safety.

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Keywords:

Iatrogenic, Unnatural, Criminal Law, Culpable homicide, Patient Safety, Utilitarianism, Retributivism, Restorative Justice, Ethical

ACRONYMS

CJS	Criminal Justice System
DPP	Directorate of Public Prosecutions
FPS	Forensic Pathology Services
HPAA	Health Professions Amendment Act
HPCSA	Health Professions Council of South Africa
IOM	Institute of Medicine
MPS	Medical Protection Society
NPA	National Prosecuting Authority
RJ	Restorative Justice
SALRC	South African Law Reform Commission
SAMA	South African Medical Association
SAMRC	South African Medical Research Council
SAPS	South African Police Services

CHAPTER 1

Overview of the Research

1.1. Background Literature

In 400 BC, Hippocrates wrote ‘Of the Epidemics’. In the book, he advised doctors to ‘…know the present, and foretell the future…and have two special objects in view with regard to disease, namely, to do good or to do no harm’ (Hippocrates, 400 B.C). Ethical principles of non-maleficence and the maxim of ‘first do no harm’ derive from this and have been a cornerstone of ethical teaching in medical schools. The death of a patient due to negligence therefore concerns society at large, the medical and legal professions and regulatory medical boards.

Regulatory medical boards, the government, and society serve punishment on negligent doctors in three ways. Doctors may be sued under civil law for monetary compensation for damages sustained by a patient. The Health Professions Council of South Africa (HPCSA) may initiate disciplinary proceedings against doctors as an additional measure. Lastly, should the death of a patient occur, then the death will be subject to a medicolegal investigation. The outcome may result in a negligent doctor being prosecuted for culpable homicide.

The approach of the criminal justice system in prosecuting doctors for criminal negligence has become a source of growing consternation amongst doctors. Recent widely publicized arrests and prosecutions of medical doctors in South Africa for criminal negligence have raised the ire of the medical profession. The trend in South Africa mimics an increase in criminal prosecutions of negligent medical doctors in other countries as well. Over a 17-year period in New Zealand six medical doctors were prosecuted for criminal negligence; four were convicted of ‘medical manslaughter’ (Paterson, 2013). In the United Kingdom, Ferner and McDowell (2006) identified a dramatic increase in the number of doctors charged with criminal negligence. Similar increases in prosecutions were noted in the United States and Canada (McDonald, 2008).

1.2 The South African Context

In 2016, Dr. Danie van der Walt became the first South African doctor to be imprisoned for culpable homicide following the death of a patient. Dr. van der Walt’s clinical management of a

patient was found to be negligent by the Mpumalanga Regional Court. After sentencing, Dr. van der Walt made a series of unsuccessful appeals to the High Court of South Africa and the Supreme Court of Appeal, which were dismissed. However, in 2020, the matter was brought before the Constitutional Court. The Court ruled against the conviction based on evidentiary irregularities committed by the lower court that infringed the doctor's constitutional right to a fair trial. It must be noted that the Court's decision was not based on the merits of the case but on the accused's right to adduce and challenge evidence protected under Section 35(3)(i) of the Constitution. The possibility remains that Dr. van der Walt may still face a criminal conviction and possibly imprisonment (Kennedy, Campos and Ishmael, 2020). In 2019, paediatric surgeon Professor Beale was charged with culpable homicide following the death of a 10-year-old boy who was undergoing a routine surgical procedure. In January 2021, the National Prosecuting Authority (NPA) amended the charges against Professor Beale from culpable homicide to murder (Mosalankwe, 2021). Most recently, a surgeon, Dr Dayanand, was charged with murder following the death of a patient under his care in 2019 (Singh, 2022).

In response to the charges against these doctors, nine medical associations in South Africa raised objections against the criminal prosecution of doctors for negligence. They called for the establishment of specialised medical courts and a review of the laws governing culpable homicide. The South African Medical Association stated that '…processes and guidelines should be introduced to ensure that investigators, coroners and prosecutors are guided by independent medical experts to determine whether further investigation or prosecution is warranted' (jutamedicalbrief.co.za, 2021). Howarth (2020) described the criminal prosecution of doctors for negligence as harsh, stating that only intention to harm should be criminalised. The Medical Protection Society (MPS) argued for the introduction of degrees of negligence, such as gross or reckless negligence to determine culpability (Howarth, 2020). The MPS stated that '…the number of culpable homicide cases being brought against doctors in South Africa is striking…' and that they were currently providing legal support to five doctors charged with culpable homicide (Howarth and Behrman, 2020). McQuoid-Mason (2022), however, argues that there are relatively few cases in which doctors are 'charged criminally with culpable homicide'. He asserts that charges are only brought against those doctors whose behaviour was either intentional, or a drastic departure from the recognised and accepted medical standard of a reasonable medical profession in that field of practice. The perceived increase in prosecutions may reflect a shift in society's attitude towards the medical profession, with factors such as an increasingly litigious and less deferential culture playing a role (Holbrook, 2003). Increased public awareness about patient

rights as well as the recent proliferation of civil malpractice claims against doctors may contribute to the growing intolerance of patients to medical mistakes (Oosthuizen and Carstens, 2015).

The medicolegal investigation of unnatural deaths in South Africa is regulated by the Inquests Act 58 of 1959. The medicolegal investigation of iatrogenic deaths is regulated by the Health Professions Amendment Act 29 of 2007. Section 48 of the Act stipulates that the death of a patient '…undergoing, or as a result of, a procedure of a therapeutic, diagnostic or palliative nature, or of which any aspect of such a procedure has been a contributory cause, shall not be deemed to be a death from natural causes'. Therefore, all cases of death associated with or due to anaesthesia or where a medical or therapeutic procedure has been a contributing factor must be referred for a medicolegal autopsy. Based on the outcome of the medicolegal report, the National Prosecuting Authority (NPA) may institute criminal charges against the medical practitioner. Another line of inquiry that may be pursued is an Inquest which investigates whether '…death was brought about by any act or omission involving or amounting to an offence' on the part of the medical practitioner. The matter may then be referred to the Directorate of Public Prosecutions (DPP) for possible institution of criminal charges. Criminal charges that may be instituted are culpable homicide or murder. Most often doctors are charged with culpable homicide, which requires fault in the form of negligence (du Preez, 2016). However, a murder charge may also be brought against the doctor should fault in the form of intention be present.

1.3 Ethical and Legal Arguments Against the Criminal Prosecution of Doctors for Negligence

The South African Medical Association has argued that the criminal prosecution of doctors for negligence has a negative impact on patient safety (Molelekwa, 2024). The Medical Protection Society has contended that '... the fear of criminal charges also has a negative knock-on effect on patient care.' (Medical Protection Society, 2021). Samanta and Samanta (2019) contend that the criminal prosecution of doctors for negligence '…is fraught with ethical tensions at levels of individual blameworthiness, systemic failures, professionalism, patient safety…'. It is argued that criminalisation affects patient safety because it discourages doctors from practicing high-risk specialties such as obstetrics and anaesthesia . Furthermore, the fear of criminal prosecution may cause doctors to leave the country causing more strain on the South African health system. Lastly, it is argued that the prosecution of individual doctors does address the system errors that may

affect patient care and safety. Given that doctors work in multidisciplinary teams the justification of holding individual doctors accountable for negligence has been questoined. Criminalisation fails to protect patients because it promotes a culture of blame, discourages disclosure of error and prevents doctors from learning from their mistakes (Govender, 2021). Samanta and Samanta (2019) additionally question whether is it is ethically justifiable to set unintended medical error … within a model of criminal culpability' (Samanta and Samanta, 2019). It is felt that justice and patient safety would be better served by placing the negligent act in the context of teamwork, the relationship between individuals and the role of human cognition in clinical decision-making (Samanta and Samanta, 2019). The criminal prosecution of '…a well-intentioned person who makes a single, although lethal, causal error and particularly where others are partially to blame' is ethically unjustified (Merry and Brookbanks, 2017).

The primary goal of any healthcare system is to 'protect, maintain and promote the safety of care delivered to the public' (Kangasniemi *et al*, 2013). This goal is shared by the criminal justice system which aims to protect the public. Patient safety is impacted by both legislative obligations and ethical imperatives. The legislative perspective determines that negligent actions that affect patient safety may be punished. The ethical perspective relates to issues around professional ethics. Although ethical obligations are not legally enforceable and are voluntary in nature, there is a responsibility on doctors to adhere to professional codes of conduct. The ethical values underlying patient safety relate to concepts of justice, non-maleficence, responsibility, accountability and trustworthiness.

The discourse surrounding the criminal prosecution of negligent doctors raises several legal and ethical questions:

a. What are the current laws in South Africa regarding deaths associated with medical interventions?
b. Should the legal threshold for negligence be raised from 'ordinary' negligence to reckless negligence?
c. What are the ethical justifications for holding doctors criminally liable for negligence resulting in the death of a patient?
d. If found guilty of culpable homicide, how should doctors be punished for their crime?
e. Do the criminal prosecutions of negligent medical doctors adversely affect patient safety?

This research report will critically examine these questions and critically evaluate the current laws and literature to address the research question.

1.3. Research Question

Should doctors be held criminally liable for negligence resulting in the deaths of patients under their care?

1.4. Rationale for the Study

There is limited research in South Africa addressing the ethicolegal issues related to the criminal prosecution of negligent doctors. Cases of negligence against doctors in the criminal setting have gained publicity and this report seeks to provide insight into the value of the criminal justice system in upholding standards in medicine and thereby improving patient safety.

1.5. Thesis Statement

I argue that it is justifiable to hold medical doctors criminally liable for the deaths of patients under their care as it is legally required and will improve patient safety.

1.6. Research Aim

This report aims to make out a case that criminal sanctions are appropriate where the negligence of doctors has caused the death of a patient and may contribute positively to patient safety

1.7. Research Objectives

I aim to articulate and defend the thesis statement by achieving the following objectives:

- To provide a thematic overview of the literature regarding the ethical and legal issues addressing criminal medical negligence.
- To argue that the criminal justice system is an appropriate system to hold negligent medical doctors accountable for the deaths of patients under their care.
- To argue that the criminal justice system protects the welfare of patients by prosecuting negligent doctors whose standard of practice falls below that of that of a reasonable doctor.
- To respond to and counter objections raised against my arguments.

1.8. Research Design

This report will be a normative study using ethico-legal research methodology. The relevant applicable laws and case law related to unnatural deaths will be evaluated. The sources of literature used in this report will include books, South African legislation and case law, and journal articles from leading databases.

1.9. Research Methods

An ethical and legal analysis of findings from the literature will be discussed with interpretation and critical analysis of the most important texts, case law and relevant legislation to answer the research question. Sources of literature include, but not limited to, research articles, books, Google Scholar, PubMed, Government legislation and other academic search engines for gathering the research data. I consider and interpret key literature and theoretical frameworks and define and apply ethical and legal concepts. There is no empirical component. No new data will be collected or analysed.

The analytical process will include the following: i) the definition and explanation of key legal concepts, ii) the identification and critique of possible counter arguments, iii) the analysis, evaluation and application of selected theoretical frameworks.

1.10. Research Outcomes

This report will provide an analysis of the ethical and legal issues in the criminal prosecution of negligent medical doctors to address the current discourse. By providing an in-depth analysis of the legal and ethical frameworks relating to the criminal prosecution of negligent doctors, the report clarifies some of the areas of concern reported by the medical profession. By evaluating the existing legal framework in South Africa the report shows that amendments to the existing law is not necessary. Regarding the ethical issues of whether the criminal prosecution of negligent doctors negatively impacts patient safety, the report provides insights into how the medical profession may incorporate criminal law judgments as a tool to improve patient safety.

1.11. Ethical Approval

No ethical approval for this research report is required, as the study is purely normative and does not involve research subjects.

1.12. Limitations

The primary limitation is the lack of existing literature and limited number of reported judgments related to the criminal prosecution of negligent medical doctors in South Africa. The research report focuses only on the South African context and is not generalisable to other jurisdictions.

1.13. Argumentative Strategy

In this research report I will argue that doctors should be held criminally liable for the death of patients under their care.

Firstly I will provide a discussion of the Criminal Justice System in South Africa. The relevant role-players and the values of the CJS will be evaluated. I will argue that the values of the CJS make it an appropriate forum to hold negligent doctors accountable for the deaths of patients under their care.

Secondly, I will discuss the existing legislative framework that regulates unnatural deaths. I will show that the existing legislation sufficiently addresses procedure-related deaths and makes it mandatory to report such deaths. I will also highlight the shortcomings in the medicolegal investigation of procedure-related deaths in the current framework.

Thirdly, I discuss negligence and the common law crime of culpable homicide with application to criminal medical negligence. I will demonstrate that there is no need to review the requirement to prove negligence in culpable homicide using selected case law to demonstrate the point. There have been suggestions by medical organisations that there are ‘deficiencies in the current legal framework’ (Juta Medical Brief, 2021) and that the courts do not have the necessary medical training or expertise to deal with complex medical matters. I will therefore discuss the role of medical assessors and expert medical witnesses and show that the standard of care of negligent doctors is effectively determined by the medical profession.

Fourthly, I will critically evaluate the ethical considerations in the criminal prosecution of negligent medical doctors. I will present counter-arguments to the current criticisms by arguing that

prosecution and punishment of negligent medical doctors is ethically justifiable and in the interest of patient safety. The recent criminal charges against doctors have reawakened the debate on the role of the criminal justice system in medical matters and whether doctors should be prosecuted for negligence (Robson *et al*, 2020). Since the criminal justice system is based on principles of accountability, transparency, and collective welfare it functions to enforce laws and to prosecute and punish those who break the law (Burchell and Milton, 2005). In Chapter 5, I discuss the ethical issues related to the criminal prosecution of negligent doctors. Using both backward and forward looking ethical justifications I will show that holding negligent doctors accountable is ethically justified. I argue that the criminal justice system, by the punishment of negligent doctors, sets an example of 'what not to do' to the medical community and sends a strong message to other doctors to refrain from similar negligent acts.

Medical professionals have also voiced concern that the threat of criminal prosecution for negligence will adversely affect patient safety. This is addressed in Chapter 5 where ethical theories will be applied to the criminal justice system to provide justification as to why it is justified punished doctors found guilty of criminal medical negligence. Criminal law criminalises conduct to protect society and uphold standards. Where the conduct of a doctor falls below the standard of a reasonable doctor and results in the death of a patient, then a charge of culpable homicide may be brought against the doctor. Patient safety reporting systems aim to examine medical errors leading to prevention and reduction of such errors. Criminal investigations may help to understand the decision-making process in healthcare and analysis and publication of the information may serve to understand the causes of failure, look for solutions, and prevent similar errors from occurring in the future. Both case law and inquest findings may be used to improve patient safety in hospitals (Pudney et al. 2016).

I will conclude that doctors should be held criminally liable for negligence, resulting in the deaths of patients under their care. Punishment of criminally negligent doctors should be proportional, limited, and inflicted to improve patient safety.

Chapter 2

The Criminal Justice System and its Role in Criminal Medical Negligence in South Africa

2.1. Introduction

There has been renewed academic and public interest in the relationship between law, medicine, and bioethics over the past thirty years (Brazier and Ost, 2013). Although physicians have been subjected to professional regulation and censure through civil law, questions of criminal medical negligence are increasingly coming before the criminal courts. In some circumstances, the role of criminal law in medicine is self-evident, such as in the case of murder. It is also a criminal law issue when the conduct of a negligent doctor results in the death of a patient. Criminal law exemplifies the wrongs that society considers especially grievous. Such wrongs may include the violation of values such as the sanctity of life and the protection of the vulnerable. Those who support the involvement of criminal law in medicine see it as a forum to make amends for what is seen as a 'conspiracy of professions' whereby the law showed marked deference towards the authority of doctors (Miola, 2013). Even those who oppose the use of criminal law in medicine observe that 'Not even the staunchest sympathiser of the medical profession would call for a blanket ban on criminalisation. Some events will always be beyond the pale and warrant a criminal response' (Quick, 2017). The overriding concern of the medical professionals who oppose criminalisation is whether a medical 'error' is a wrong that concerns the criminal justice system (Brazier and Ost, 2013).

This chapter aims to answer the question of why the Criminal Justice System should be involved when the actions of a negligent medical doctor has caused the death of a patient. The objectives, aims, and values of the criminal justice system (CJS) will be explored to show that it is an appropriate forum to regulate standards in medicine, protect patients and hold negligent doctors accountable.

2.2. The Criminal Justice System

2.2.1 Introduction

The primary purpose of the criminal justice system is to maintain social order and stability (Snyman, 2008). It does so by protecting and benefiting society by preventing and reducing crime

(Daly, 2011). It also aims to '…redress imbalances caused by those people who take illegal advantage of another or diminish their human dignity' (Daly, 2011). The criminal justice system, a 'collection of interdependent agencies', enforces criminal law by responding to crime through prevention, deterrence, and punishment (Daly, 2011). As a system, the CJS functions to 'protect society and punish wrongs that society considers grievous' (Alghrani, Bennet and Ost, 2013). The CJS carries out this mandate by coercing members of society '…through threat of pain and suffering or other sanction to abstain from conduct that is harmful to various interests of society' (Burchell and Milton, 2005). The CJS recognises wrongdoing and, in so doing, communicates formal censure and condemnation of the conduct. As a method of censure, the CJS 'speaks with a powerful moral voice, authoritatively condemning wrongdoing, and wrongdoers on behalf of the community as a whole' (Simester and Von Hirsch, 2011).

Since criminal sanction and the imposition of punishment are the most intrusive forms of social control, the invocation of criminal law should, as far as possible, be kept to a minimum (Persak, 2010). In condemning wrongs and vindicating the rights of the public, the CJS fulfils a variety of functions. It deters and prevents crime, imposes punishment on those who are deserving of it, incapacitates those who pose a danger to society, and attempts to reform their character (Chaio, 2016). Arguably, the most important function is that it 'stabilises a public sense of justice by providing assurance of general cooperation with legal rules' (Chaio, 2016).

2.2.2. Components of the CJS

In South Africa, the CJS consists of six justice agencies responsible for managing crime and perpetrators of crime. There are investigative, adjudicative, and correctional arms whose common objective is to create a safer society, enforce rules fairly, and comply with legal and constitutional requirements (Walker et al., 2018). What follows is a brief introduction to the various agencies and their role within the system.

The South African Police Service is mandated by Section 205(3) of the Constitution to '…prevent, combat and investigate crime, maintain public order and... support and enforce the law'. The police are the primary point of entry into the criminal justice system, as crimes are reported to them. The NPA is mandated both by Section 179 of the Constitution and by the National Prosecuting Authority Act 32 of 1998 to act on behalf of the state to decide whether criminal charges against an accused will be pursued or withdrawn. In this regard, the NPA represents the interests of the

community and assists the court in reaching a verdict.

The adjudicative authority of the CJS is vested in the system of courts and presiding officers. Section 165(2) of the Constitution establishes that the judiciary must be independent, impartial, and subject only to the Constitution and the law (Cohen, Roberts & Stander, 2019). Presiding officers are tasked with ensuring that the law is followed and that both parties are allowed to present their case, reach a verdict, and determine sentencing.

The Correctional Services system is overseen by the Department of Correctional Services and is responsible for containing, rehabilitating, and releasing convicted criminals. The service is constitutionally mandated to ensure that the rights of convicted persons are upheld. Legislative mandates in terms of the Correctional Services Act 111 of 1998 and the Criminal Procedure Act 51 of 1977 regulate the service. Probation officers and social services are also involved in the reintegration of convicted persons into society. Overall responsibility for the above-mentioned elements that constitute the criminal justice system falls under the Department of Justice and Constitutional Development.

Criminal law is the backbone of the criminal justice system. It informs the operations of the police, judiciary, prosecuting authority, the public, and victims (Clarkson, Keating, Kyd, Elliot & Walters, 2017). Criminal law defines '…certain forms of human conduct as crimes and provides for the punishment of those persons with criminal capacity who unlawfully and with a guilty mind commit a crime' (Burchell & Milton, 2005). It is important in 'any society that utilises the criminal law to reflect its basic values (Alghrani, Bennet and Ost, 2013). The main objective of criminal law is '…to prohibit behaviour that represents a serious wrong against an individual or... social value or institution' (Ashworth and Horder, 2013).

2.2.3 Shortcomings in the CJS in South Africa in relation to Criminal Medical Negligence

Legislation (Inquests Act) compels 'any person' who has knowledge of an unnatural death to report such a death to the SAPS. With regard to procedure-related deaths, the onus to comply with the law (HPAA) lies with the medical practitioner. Due to lack of undergraduate and postgraduate training most doctors are not familiar with the laws governing medical practice, especially those relating to deaths of patients (Moodley, 2019). Doctors are not fully conversant with their legal obligations regarding the death of a patient resulting in delays in autopsy examinations and

incorrectly completed death certificates leading to inaccurate mortality data. Additionally, the lack of clear and concise guidelines, training and access to knowledgeable colleagues results in either unnecessary referrals to the FPS or lack of appropriate referrals to the FPS. Provisions for access to a forensic pathologist are included in the Regulations Regarding Rendering of Forensic Pathology Services (NHA), thus providing an avenue for doctors to access specialist medicolegal advice.

The high number of unnatural deaths in South Africa also pose practical challenges for the holding of inquests. Statistics provided by an inquest magistrate in Johannesburg show that there are on average 238 outstanding inquest matters outstanding per month, with an intake of 112 new dockets per month. 34 dockets per month are referred to the SAPS as incomplete and it takes an average of 2-3 years for these dockets to be returned. Only 18 informal inquests are completed per month. Only 1 formal inquest was held in 2014 in the jurisdiction being referred to (Theophilopoulos and Tuson, 2016). The delays are due to the difficulty in obtaining medical records and expert medical opinions to assist the Inquest magistrate in making a finding (Theophilopoulos and Tuson, 2016).

2.2.4 Criminal Law and the Values Underpinning the CJS

Criminal laws regulate human conduct by prescribing the activities people can and cannot do within society. Criminal law may also be viewed as a guide to what society expects from fellow citizens and what the values and morals of a society are. In contrast to other branches of law, the distinctive feature of criminal law is the imposition of punishment. The criminal law ‘exists in order to punish people for their culpable misconduct’ (Simester and von Hirsch, 2011). Prevention of harm to others is the foremost justification for criminalisation of conduct, articulated by John Stuart Mill (1859) as ‘…the only purpose for which power can rightfully be exercised over any member of a civilised community against his will is to prevent harm to others’. The use of criminal law is further justified based on two fundamental principles: individual responsibility and collective welfare (Ashworth and Horder, 2013).

The pursuit of individual responsibility and individual autonomy is the ‘most significant guiding light’ of criminal law (Burchell & Milton, 2005). Criminal law holds human beings as morally autonomous agents. Downie and Calman (1987) define an autonomous person as ‘having the ability to choose, formulate and carry out her plans along with her ability to govern personal conduct by rules and

values’. Criminal law assumes that, as rational beings, we can distinguish right from wrong and can appreciate and adhere to social norms and standards (Hoctor, 2004). It further assumes that, as autonomous, rational agents, '... they may be properly held responsible for their conduct and matters within their control' (Ashworth and Horder, 2013). The principle of individual responsibility is based on factual and normative elements (Ashworth and Horder, 2013). The factual component relates to an individual's capacity and free will to make rational choices. The normative element of individual responsibility relates to treating individuals as moral agents by respecting their autonomy. In recognising individual autonomy, criminal law acknowledges individual rights, such as the right to dignity, life, freedom and security. An autonomous person who infringes on the rights of others should therefore be held accountable. In justification for the use of criminal law, Raz (1986) stated, ‘...one may not pursue any goal which infringe people’s autonomy unless action is justified by the need to protect or promote the autonomy …of others’.

The principle of collective welfare, as described by Ashworth and Horder (2013), is the recognition of the ‘…social context in which the law must operate and gives weight to collective goals.’ It advocates for preserving and protecting the collective interests of the community. Criminal law denounces and punishes behaviour that threatens the collective welfare of society. Duff (2007) states that for behaviour to be criminalised, there must be sufficient public interest in the wrongdoing, and the consequences of the conduct must be high. Intervention of criminal law is warranted when there is a need to protect the public interest. Carstens and Pearmain (2007) describe public interest as a ‘flexible concept that changes with changing conditions and circumstances’. Sentiment within society regarding the standards of public and private healthcare has changed over the past thirty years. The changing conditions in South Africa are reflected in the increased awareness of patients’ rights (South African Law Review Commission, 2021) and the diminishing trust in healthcare (Sweeney, 2018). In South Africa, interest in the standard of healthcare has been widely publicised, necessitating responses from both the government and the public. The perceived breach of patient rights and lack of trust in healthcare reflect the current values of society and account for the increasing intervention of criminal law. The standard of care provided by doctors is of public interest, as substandard care may result in harm or death. Criminalisation of conduct that causes direct harm to others is justified because it infringes on the rights of another person.

2.3 Conclusion

The various stakeholders of the CJS collaborate to The CJS's intervention in medical negligence is therefore not only appropriate but also required. Holding doctors accountable for criminal negligence resulting in the death of a patient sends out a clear message to the public and other medical professionals that they will be held responsible. Such censure provides the medical fraternity with the opportunity for reflection, to consider the wrongfulness of the behaviour, and to use it as an opportunity to prevent similar occurrences. Failing to deal with negligent physicians through the CJS and using other 'neutral systems of disincentives that convey no disapproval' would fail to respect people as agents capable of moral understanding (Simester and von Hirsch, 2011).

Chapter 3

Overview of Legislation Concerning Deaths Associated with Medical Procedures in South Africa

3.1. Introduction

Iatrogenic deaths are a concern for patients, doctors, and public health. The Institute of Medicine Report 'To Err is Human' (1999) reported that 98 000 deaths due to preventable medical error occurred annually in the United States. The report recommended that mandatory reporting systems be implemented to monitor and investigate these types of deaths. In South Africa, iatrogenic deaths are classified as being due to unnatural causes which thus requires medicolegal investigation. The legal authority to investigate deaths associated with diagnostic/therapeutic procedures is vested in several statutes.

The investigation of unnatural deaths is important for criminal justice and public health. Death investigations provide evidence to convict the guilty and protect the innocent (Hanzlick, 2003). They are critical in the sphere of public health concerning the quality of health care (Hanzlick, 2003). Deaths due to unnatural causes are defined as (National Health Act 61 of 2003):

a. any death due to the application of force, direct or indirect, and its complications
b. any death due to the effects of any chemical or toxic substance, or drug, or any death due to an electrical effect;
c. any death where another person, by negligent act or omission can be held responsible for the death;
d. Any procedure related (including anaesthesia-related) death as contemplated in section 48 of the Health Professions Amendment Act 29 of 2007
e. where the death is sudden and unexpected or unexplained.

The medicolegal investigation of iatrogenic deaths may result in criminal charges being brought against a doctor for negligence. It is argued by medical organisations that there are '…deficiencies (in) the current legal framework' regarding medical cases and that '…magistrates (are) adjudicating exceedingly complex clinical interventions, without possessing the necessary training or medical expertise' (SAMA, 2021). In this chapter, I discuss the current legal framework and argue that the existing legislative framework in South Africa is well-suited to the investigation into deaths associated with medical procedures. Built into this framework is the ability for courts to obtain

medical opinions on technical and scientific medical matters. Medical experts are therefore able to guide the court on acceptable and reasonable medical practice.

Before discussing specific legislation pertaining to the investigation of unnatural and iatrogenic deaths, a broad overview of the South African legal system is necessary. History often determines the character of a legal system, and the South African legal system is a hybrid of Roman-Dutch, English, and indigenous law (Joubert, 2016).

3.2. Inquests Act 58 of 1959

The purpose of the Inquests Act is to provide for the holding of inquests in cases of deaths from '…other than natural causes'. An inquest is a medicolegal investigation of a death and takes the form of a non-adversarial inquiry. In 44 BC, Julius Caesar mentioned a process similar to that of an inquest where '…suspicion about a death, they hold an inquiry (*a quaestio*)…' (Aamodt, 2021). The earliest statutes included the Inquests (Death) Act of 1875 and the Fire Inquests Act of the Cape of Good Hope (1884), which were derived from Roman-Dutch law. Inquests were presided over by magistrates, who at the time were not required to have any legal training (Kitchin, 1914). The medicolegal investigation of death was formalised in 1919 with the promulgation of the Inquests Act 12 of 1919. This Act was later repealed and replaced by the Inquests Act 58 of 1959 (Saayman, 2020). Later amendments to the Act were made in 1992 (Inquest Amendment Act 145 of 1992).

The Act places a duty on any person to report a death from 'other than natural causes' to the police, who must 'investigate or cause to be investigated the circumstances of the death…' (Section 3(1)). The investigation includes the medical examination of the deceased with the aim of '…ascertaining with greater certainty the cause of death' (Section 3(2)). A postmortem report is issued after the medical examination has been completed and forms part of the police docket. In deaths related to medical procedures, the completed docket contains clinical, surgical, and anaesthetic notes and statements from all health personnel involved in the matter. Should the prosecutor decline to institute criminal charges, then the matter is referred to the inquest magistrate for the holding of an inquest (Inquests Act 58 of 1959, Section 5(1)).

An inquest is defined as a judicial inquiry to ascertain the facts relating to an incident (Oxford English Dictionary, 2022). An inquest is not a criminal trial and is an inquisitorial and non-adversarial process of investigation. In *Marais NO v Tiley* 1990 2 SA 899 (A), Smalberger JA held that the purpose of an inquest is:

> …to promote public confidence and satisfaction; to reassure the public that all deaths from unnatural causes will receive proper attention and investigation so that, where necessary, appropriate measures can be taken to prevent similar occurrences, and so that persons responsible for such deaths may, as far as possible, be brought to justice.

The main findings that the judicial officer holding the inquest is required to ascertain are the (i) identity of the deceased, (ii) the cause or likely cause of death, (iii) the date of death, and (iv) whether the death was '…brought about by an act or omission involving or amounting to an offence on the part of any person' (Inquests Act, Section 16(2)). The importance of an inquest in the context of criminal negligence cannot be underestimated. Based on the findings of an inquest, the medical practitioner may face criminal charges.

The role of the medical profession in both inquests and during a criminal trial cannot be underestimated. Medical professionals may act as assessors to assist the court and to present expert medical evidence on behalf of the prosecution and the defence. Complex technical medical matters will usually be beyond the grasp of the reasonable average presiding officer and may require the appointment of suitably qualified assessors to advise the magistrate on technical matters (Lerm, 2012). Section 9 (1-4) of the Inquest Act provides for this. Matters of law are, however, decided solely by the magistrate. The final outcome of the inquest is made by both the magistrate and assessors (Theophilopoulos and Tuson, 2016).

The need for expert witnesses to testify in medical negligence matters has its origins in English common law in the case of *Slater v Baker & Stapleton* 95 Eng. 860 2 Wils. KB 359 1767 (Bal, 2009). In this judgment, the court held that the generally accepted standard of medical treatment was to be judged by the rules of the profession as testified to by medical practitioners themselves (Bal, 2009). In *Van Wyk v Lewis* (1924) Innes J stated that the '…evidence of qualified surgeons or physicians is of the greatest assistance in estimating that general level'.

Doctors accused of criminal negligence are usually represented in court by excellent and well-prepared legal teams provided by medical defence unions such as the Medical Protection Society. These legal teams have access to specialists across the many fields of medicine who are well-remunerated to provide expert evidence on behalf of the defence (van der Heyde, 2008). The state prosecutor rarely has access to similar resources, and medical doctors are either reluctant to testify against colleagues or unwilling to assist the court due to a lack of adequate remuneration (van der Heyde, 2008). The lack of balanced and objective testimony affects the outcome of the inquests and criminal cases. Medical experts thus play an important role in presenting and interpreting scientific evidence. Considered expert medical evidence provides an opportunity for the courts to objectively assess the standard of treatment against that of other reasonable doctors.

3.3. The National Health Act

The National Health Act 61 of 2003 regulates the provision and coordination of Forensic Pathology Services in South Africa, including the provision of medico-legal mortuaries and medico-legal services (Section 25(2)). The Forensic Pathology Service (FPS) is mandated to provide medicolegal investigations of unnatural deaths, defined as the investigation into the circumstances, manner, and possible causes of death. Unnatural deaths are defined in the Regulations Regarding Rendering of Forensic Pathology Services (NHA 61 of 2003). The Regulations provide the FPS with a wide scope of practice, which, regarding procedure-related deaths, includes obtaining relevant medical history and clinical notes. The expanded role of the FPS as well as the ability to remove, retain, and examine any substance or content of the body (Inquests Act 58 of 1959, Section 3(3)) provides for a comprehensive and scientific medicolegal examination of procedure-related deaths.

3.4. The Health Professions Act

The mandatory reporting of deaths due to anaesthesia has been in place in South Africa since the Medical, Dental and Pharmacy Act 13 of 1928. Clause 86 stipulated that ‘The death of a person whilst under the influence of a general anaesthetic or local anaesthetic or to which the administration of the anaesthetic has been a contributory cause, shall not be deemed to be a death from natural causes within the meaning of the Inquest Act’. The Act was repealed in 1974 and replaced by the Health Professions Act 56 of 1974 (HPA); the reference to anaesthetic deaths was

retained under Section 56. The Health Professions Amendment Act 29 of 2007 (HPAA) repealed Section 56 of the HPA with Section 48. Section 48 of the HPAA created an expanded definition of a reportable unnatural death, 'undergoing, or as a result of, a procedure of a therapeutic, diagnostic or palliative nature, or of which any aspect of such a procedure has been a contributory cause, shall not be deemed to be a death from natural causes'.

The singling out of deaths due to anaesthesia was based on various commissions of inquiry regarding the perceived increase in deaths due to anaesthesia, safety of procedures, and the drugs used. The Minister of the Interior instructed a ministerial committee to '… investigate the causes of the high death rate from … anaesthetics and generally to make recommendations more especially with a view to the possibility of measures being introduced which may have some practical effect in lessening the mortality' (Harrison, 1968). The mandatory reporting of anaesthetic deaths has, over time, led to improvements in administration of anaesthesia, reduction in mortality, and increased patient safety. The expanded requirement to report all deaths due to medical, therapeutic, or diagnostic causes will have a similar effect.

The HPA provides for the establishment and powers of the Health Professions Council of South Africa (HPCSA), which is the *custos morum* or guardian of the morals of health professionals. Section 41(1) of the Act confers power on the Professional Boards of the HPCSA to 'institute an inquiry into any complaint, charge or allegation of unprofessional conduct against any person registered under the Act'. The Act defines unprofessional conduct as '…improper or disgraceful or dishonourable or unworthy conduct'. Importantly, the HPCSA is tasked with maintaining professional ethical standards and protecting both the public and the profession.

Where a doctor has been criminally charged, this charge may initiate disciplinary proceedings by the HPCSA as provided in Section 45 of the HPA. The HPCSA is not obliged to wait for the final outcome of the criminal case and must investigate any unethical and unprofessional conduct. Section 45(2) of the HPA also requires that where legal action is taken against a practitioner in any court in South Africa and there is *prima facie* proof of unprofessional conduct, the court must forward a copy of the court record to the relevant professional board of the HPCSA. The Act, however, places no reciprocal duty on the HPCSA to refer a matter suggestive of criminal negligence to the relevant law enforcement authorities.

3.5 Conclusion

Several laws are in place to regulate medicolegal investigations of unnatural or ‘other than natural’ deaths. There is specific legislation relating to unnatural deaths and the investigation of deaths associated with medical procedures. Presiding officers rely on the medical profession to assist the court in the interpretation of medical findings, both as assessors and as expert witnesses. In determining reasonable conduct, the court takes the prevailing level of skill and diligence demonstrated by professionals within the relevant branch of the profession at the time into consideration (Carstens and Pearmain, 2007). Legal judgments are therefore informed by medical expertise and opinion. There is an ethical duty on medical doctors who provide expert evidence in criminal negligence cases to provide a thorough, fair, objective, and impartial review of medical facts (Ronquillo et al., 2023). In this way, the medical profession can ensure that negligent colleagues are held accountable by the criminal justice system for negligent conduct.

Chapter 4

Review of Criminal Medical Negligence in South Africa

4.1. Introduction

The term criminal medical negligence is used when negligence has resulted in death and the doctor is charged with culpable homicide. This distinguishes the criminal charge from a civil claim which is commonly referred to as medical malpractice. Medical malpractice, however, is a broad term that encompasses all forms of unprofessional medical conduct e.g. breaches of confidentiality or lack of consent.

The increasing use of criminal law to hold doctors accountable for negligence resulting in the death of a patient has garnered much media attention and caused disquiet among doctors in South Africa. There is a perception amongst doctors that the NPA '…appears to be more eager to proceed with such cases' (Stellenberg and Lerm, 2022). The MPS of South Africa affirmed that they were currently supporting five doctors charged with culpable homicide and were aware of 'many other cases' across the country (Howarth and Behrman, 2020). The South African Medical Association (SAMA) has called for the introduction of specialised medical courts that use expert medical witnesses and trained prosecutors to 'review decisions made by doctors' (Sonjica, 2021). Nine medical associations have also called on the Minister of Justice to review the requirements for culpable homicide and its application in medicine, arguing that the threshold for criminal culpability for culpable homicide was too low (Howarth and Behrman, 2020). The MPS states that 'Lessons can be learned from other jurisdictions, where charges are only brought against doctors if an act is proved to be intentional, reckless or grossly careless' (Howarth and Behrman, 2020).

This chapter examines criminal medical negligence in the South African context and how criminal law is applied to negligent acts of doctors during their professional practice. Discussion of negligence with particular reference to the challenges raised by medical organisations regarding degrees of negligence are addressed.

The professional obligation placed on doctors to practice medicine with reasonable skill and care dates to the laws of ancient Rome and England (Bal, 2009). The Code of Hammurabi, an ancient legal document, imposed a responsibility on doctors and imposed penalties on negligent medical practitioners. The first known ethical code for doctors was written by Hippocrates (460-360 BC). The code can be considered a guide for physicians on what they ought to do. Doctors who

practiced with a lack of skill and care were held to be at fault and were considered negligent (Papavramidou and Voultsos, 2019). During the Roman period, doctors could be charged with intentional, negligent, or ignorant malpractice (Carstens and Pearmain, 2007). The term *culpa* was used during this time to denote malpractice due to negligence or ignorance. English common law developed in the 12th century, and with it came the requirement of '…expert testimony from a member of the profession in medical negligence claims, to establish the standard of care' (Bal, 2009). The development of the concept of negligence in medicine reflects society's values over time and the role of the law in regulating medical practice and protecting patient rights.

4.2. Criminal Liability

Persons can only be held criminally liable if the state proves beyond reasonable doubt that the conduct was unlawful and was accompanied by capacity and fault at the time of the act or omission (Burchell & Milton, 2005). These principles are required for liability in all crimes. To be accused of a crime, it must be shown that the accused has done something (an act) or failed to do something (omission) where a legal duty to do something exists (Burchell & Milton, 2005). Omissions imply a failure to take positive steps to prevent damage from occurring. Several examples may be found in criminal negligence case law, e.g., *S v Van Heerden* and *S v Van der Walt*, where the gynaecologists in both cases failed to provide adequate post-operative care to their patients.

Murder and culpable homicide are consequence or 'result' crimes (Burchell & Milton, 2005) and a causal link between the initiating event and death must, therefore, be proven. The accused's act or omission must be both the factual and legal cause of death (Snyman, 2008). In criminal cases, factual causation must be proved by the state beyond a reasonable doubt. To determine causation, South African courts have developed a two-phase approach to assessing factual and legal causation. The test used by the courts to determine factual condition is the *conditio sine qua non* test, which examines whether negligent conduct was the necessary condition for the death (Carstens and Pearmain, 2017). Causation in medicine may be difficult to prove because the negligent treatment resulting in death must be distinguished from any pre-existing illnesses or conditions that the patient may have had (Politis, 2018).

Conduct that fulfils the definitional elements of the crime and which is unlawful alone is not sufficient to render one criminally liable (Snyman, 2008). Fault in the form of either intention (*dolus*) or negligence (*culpa*) is required (Kwanje, 2016). The focus of this research report is on negligence. When a person is accused of negligence '…he is blamed for an attitude or conduct of carelessness, thoughtlessness or imprudence, because, by giving insufficient attention to his actions he failed to adhere to the standard of care legally required of him' (Neethling and Potgieter, 2020).

4.3. Culpable Homicide

The common law crime of culpable homicide derived from the Roman-Dutch law of *homicidium culposum* and encompassed the negligent killing of another. It encompassed all forms of killing that were not intentional to distinguish it from murder or *homicidium dolosum (*Milton and Hunt, 1996). Although South African law was influenced by English common law, the last written record of the term 'manslaughter' in South Africa was in 1862 (Milton & Hunt, 1996). Thereafter, the early Cape records indicate that only the terms homicide and culpable homicide were used. In English law, negligent homicide is referred to as gross negligence manslaughter ~~involuntary manslaughter are gross negligence or recklessness. Today, in England and Wales, the crime of gross negligence manslaughter remains in place;~~ the requirement for conviction is 'death which has occurred as a result of a grossly negligent act or omission' (Hendry, 2018). Gross negligence manslaughter does not exist in Scotland which has its own legal system (Hendry, 2018). The equivalent crime in Scotland is that of culpable homicide, which requires intent, recklessness, or 'public interest in the prosecution' (Hendry, 2018). Howarth and Behrman (2020) argue for a similar qualification to be made to South African common law, asserting that the requirement for recklessness will raise the legal threshold for conviction. Culpable homicide was defined in *S v Ntuli* 1975 (1) SA 429 (A) as the 'unlawful negligent causing of the death of another human being'. From this definition, the elements of the crime are conduct that is unlawful and negligent and that causes the death of another human being.

The concept of negligence is found in both civil and criminal law. In common law, the only crimes requiring negligence are culpable homicide and a form of contempt of court. Negligence may be defined as conduct that fails to live up to a prescribed standard of being a reasonable person (Burchell and Milton, 2005). Despite the similarity in the concept of negligence in both civil and criminal matters, there are some fundamental differences (*R v Meiring* 1927 AD 41). In civil claims,

the interests of individuals in their private capacity are protected, whereas in criminal matters, the interests of the public are upheld (Neethling and Potgieter, 2020). There are also differences in the remedies; in civil matters, the remedy is compensatory in nature. Conversely, in criminal cases, the main objective is to punish the offender with either a fine or imprisonment for 'transgression against the public interest' (Neethling and Potgieter, 2020). In civil matters, the burden of proof required is that of a balance of probabilities, whereas in criminal cases, the state must prove guilt beyond all reasonable doubt (Snyman, 2008).

The standard of 'beyond a reasonable doubt' is the standard used in criminal trials and is the highest standard of proof imposed upon a party at trial (Justia, 2023). To prove guilt, the state must show that, from the facts presented, the only logical explanation is that the accused committed the alleged crime and that there is no other logical explanation that can be deduced from the evidence. In *S v T* 2005 (2) SACR 318 (E), it was held that:

> This high standard of proof-universally required in civilized systems of criminal justice–is a core component of the fundamental right that every person enjoys under the Constitution, and under the common law prior to 1994, to a fair trial. It is not part of a charter for criminals, and neither is it a mere technicality.

Proof beyond reasonable doubt does not mean proof with absolute certainty, however, the proof must carry a high degree of probability. In *S v Glegg* 1973 (1) SA 34 (A), it was held that:

> The concept 'reasonable doubt' cannot be precisely defined, but this can be said: That it is a doubt which exists because of probabilities or possibilities which are considered reasonable on the grounds of general human experience and knowledge. Proof beyond a reasonable doubt is not equated with proof beyond the slightest doubt, because the onus to render proof at so a higher standard would frustrate the administration of the criminal law.

4.3.1 Negligence

Negligence is tested objectively using the reasonable person test. The test is a ‘statement of principle’ (Milton and Hunt, 1996) and is applicable to every person with no exceptions. The fictitious reasonable man is derived from Roman law and classically refers to the *bonus paterfamilias* or *diligens paterfamilias*. Translated, this means the ‘good father of the family’ and was the standard accepted as the conduct of a reasonable man. In *R v Meiring* 1927 AD 41, Innes CJ held that the reasonable person test for negligence was equally applicable in both civil and criminal matters. The only difference between negligence in civil and criminal cases was that in criminal proceedings, the state ‘…intervenes to punish the offender’.

The accepted test for negligence (*culpa*) was best articulated by Holmes JA in *Kruger v Coetzee* 1966 (2) SA 428 (A) as arising if:

> A *diligens paterfamilias* in the position of the defendant –
>
> i. would foresee the reasonable possibility of his conduct injuring another in his person or property and causing him patrimonial loss; and
> ii. would take reasonable steps to guard against such an occurrence; and
> iii. the defendant failed to take such steps

Four important concepts regarding negligence can be extracted from *Kruger v Coetzee* (Mukheibir et al., 2018). Firstly, the standard of the reasonable person must be considered in light of similar circumstances as those of the accused. Secondly, the foreseeability of harm occurring must be evaluated in the context of the circumstances and situation that the accused was in. The third concept is the steps taken by the accused to prevent harm and the choices available to the accused at the time of the incident. Finally, the course of action of the accused is judged against the course of action that a reasonable person would have taken. Mukheibir *et al*. (2018) point out, therefore, that the objective test of negligence is a flexible one that is dependent on the circumstances of each case and the judicial evaluation of the risks taken. Although a higher standard of care is expected of professionals, the requirement of reasonableness is exactly that: reasonableness. It is not expected that professionals provide exceptional skill and care; however, reckless thoughtlessness is also not expected (Mukheibir *et al*., 2018).

In criminal medical negligence cases, the courts use an objective test to compare the conduct of the allegedly negligence doctor with that of a 'reasonable doctor' under similar circumstances (Carstens and Pearmain, 2007). If the conduct falls below the expected benchmark of a reasonable doctor, then the accused doctor should be held liable for negligence. The reasonable person test is adapted in the case of medical professionals to that of a reasonable expert. The challenge faced by the courts is that of interpreting and applying the 'reasonable expert' test to medical doctors.

4.3.2 Evolution of the test for negligence

The first recorded application of the test for medical negligence can be found in *Lee v Schonnberg* 1877 7 Buch 136. The case involved the alleged negligence of a doctor, which necessitated the amputation of the plaintiff's legs. De Villiers CJ referred to the English case of *Lanphier v Phipos* and stated that '… a medical practitioner, like any professional man, is called upon to bear a reasonable amount of skill and care…'. In *Kovalsky v Krige* 1910 20 CTR 822, a nine-month-old baby was circumcised but later developed penis gangrene. A claim was instituted against the surgeon for medical negligence. The doctor was held not liable, and the court held that doctors are only expected to '…bring a fair, reasonable and competent degree of skill to his case'. In *Mitchell v Dixon* 1914 AD 519, the court held that:

> a medical practitioner is not expected to bring to bear upon the case entrusted to him the highest possible degree of professional skill, but he is bound to employ reasonable skill and care; and he is liable for the consequences if he does not.

In *van Wyk v Lewis* 1924 AD 438 a swab was left in the abdomen following a laparotomy, van der Riet J, held that the standard of care expected of doctors is that of '... the general level of skill and diligence possessed and exercised at the time by members of the branch of the profession…'. It was further held that 'To expect of him an impossible standard of perfection would be against public policy'.

In *R v Van Schoor* 1948 (4) SA 349 (C) the doctor was charged with culpable homicide for causing the death of two patients following administration of a lethal arsenic-containing compound. The

doctor submitted as a defence that his knowledge of the drug was limited. Steyn J, however, found the accused doctor guilty, stating that he failed to demonstrate the necessary level of reasonable skill and care when administrating a dangerous drug. In 1953, Dr van der Merwe was charged with culpable homicide for the administration of dicumarol, resulting in the death of the patient. In addressing the question of negligence on the part of the doctor, Roper J, relying on earlier case law, reaffirmed the standard of a reasonable expert. He added '…that a practitioner in a skilled profession cannot shelter himself behind a defence that he did know enough about it or was not sufficiently skilled'. It is interesting to note that the law makes a clear distinction between medical mistakes and negligence. In *Buthelezi v Ndaba* [2014] JOL 31524 (SCA) the court referred to the English case of *Hucks v Cole* [1986] 118 New LJ, wherein it was held that 'With the best will in the world things sometimes went amiss in surgical operations or medical treatment. A doctor was not to be held negligent simply because something went wrong'.

Various factors are taken into consideration when the courts determine whether the conduct of a doctor was reasonable. The level of skill and experience of the doctor, specialisation, and the location of the medical practice are considered. A greater level of skill and care is expected of a medical specialist than a general practitioner (*R v Van der Merwe,* 1953). Medical specialists are those doctors, who, through extra training and qualification are registered with the HPCSA as medical specialists in a specialty or sub-specialty. If a general medical practitioner knowingly performs procedures that would normally be carried out by a specialist, then the practitioner will be judged against the standard of a specialist. In *McDonald v Wroe* 2006 (3) All SA 656, the court found a dentist liable for damages due to negligence. The court held that a general dentist who carried out the work of a maxillofacial surgeon, is to be judged against the standard of a maxillofacial surgeon. Doctors should therefore practice within their field of specialisation and not undertake to perform procedures that they are not sufficiently trained or experience in. This creates a dilemma for doctors who work in rural and peri-urban areas of South Africa. These areas do not usually have access to specialists, and general medical doctors may have to perform procedures that would normally fall under the ambit of a specialist. In law, however, the maxim *imperitia culpae adnumeratur* applies which means that ignorance or lack of skill in law equates to negligence (*S v Mkwetshana,* 1965). The rule has been applied in criminal medical negligence cases including *R v Van Schoor* and *R v Van Der Merwe*.

The question of area or locality of practice becomes relevant when one considers whether a higher standard of care is expected from a doctor who practices in an urban area. In *van Wyk v Lewis,*

Innes CJ and Wessels JA differed in opinion about the relevance of the locality in which a doctor practices. Innes CJ opined that locality should make no difference to the degree of skill and care of an ordinary medical practitioner, whereas Wessels JA held that locality of practice is '…an element in judging whether or not reasonable skill, care, and judgment have been exercised'. As a doctor's negligence is legally assessed with reference to the yardstick of the reasonable doctor in the same circumstances, then the locality plays an important role in determining whether a doctor is negligent or not (Carstens and Pearmain, 2007).

Locality may also be applied in instances where a medical practitioner works in the private or public health sector. The reality of the inequalities that exist in South African healthcare is considered by the courts when applying the reasonable expert standard. This was highlighted in *S v Tembani* 1999 1 SACR 192 (W) in which a patient sustained 'readily treatable' gunshot wounds to her leg and chest. The patient succumbed to her injuries and died two weeks later. An autopsy confirmed the cause of death as 'Septicemia as a consequence of a Gunshot Wound to the Chest'. The accused appealed his conviction, arguing that his actions were not the factual and legal cause of death as the patient received 'inadequate and negligent' medical care at Tembisa Hospital. The SCA held that 'Improper medical treatment was neither abnormal nor extraordinary…' in the context of public health care where resources are poor and scarce'.

For purposes of establishing liability, there are no degrees of negligence in South Africa. One is either negligent or not and the slightest deviation from the norm is sufficient for negligence. This legal precedent was set in *R v van Schoor* and *R v Meiring.* Medical organisations have argued that the threshold for blameworthiness be raised to that of gross or reckless negligence. This is in keeping with the law in England, New Zealand and Scotland. In South Africa, the concept of 'recklessness' is incorporated in the definition of *dolus eventualis.* In *S v Malinga* 1963 (1) SA 692 (A)*, the locus classicus* for *dolus eventualis* the concept was defined as 'intention to kill, the test is whether the [accused] foresaw the possibility that the act in question ... would have fatal consequences, and was reckless whether death resulted or not'. English law a distinction is made between negligence and gross negligence. The requirement for negligence is 'carelessness'; for gross negligence, '…a high degree of negligence…' is required (Oxford Dictionary of Law, 2022). Howarth (2022) argues that:

> The degree of fault in most of these countries is gross negligence manslaughter, a far higher threshold than in South Africa. In Scotland, which shares the terminology of culpable

homicide with South Africa, the threshold is even higher. There the threshold is recklessness. The threshold in Scotland for culpable homicide is not dissimilar to *dolus eventualis* in South African law, which in South Africa is used for murder charges.

Law reform in New Zealand requires that negligence requires a ‘major departure’ from the accepted reasonable standard of care. In England, the crime of gross negligence manslaughter requires conduct that is ‘…so reprehensible and fell so far below the standards to be expected of a person in the defendant's position with his qualifications, experience and responsibilities that it amounted to a crime’ (*R v Adomako* 1995 [1] AC 171, 2019). Arguments against the use of gross negligence manslaughter include criticisms that it ‘…is challengeable on the basis that its requirements are ill-defined, too broad in scope and, as a consequence, inconsistently applied’ (Lodge, 2017). This is supported by Dyer (2018) who states that it requires a jury to subjectively decide on ‘truly exceptionally bad behaviour’, which is ill-defined in law. In *R v Adomako*, Lord Mackay held that gross negligence manslaughter is assessed based on ‘…the seriousness of the breach of duty committed by the defendant in all the circumstances in which the defendant was placed when it occurred’. In this way, the law of gross negligence manslaughter ‘is merely an application of the ordinary principles of the law of negligence’ (Alison, 2018).

4.4 Conclusion

The calls for the introduction of special legislation regarding the criminal prosecution of doctors for culpable homicide charging of doctors for culpable homicide is, in my opinion, not warranted. The existing legal framework is adequate for dealing with criminal negligence matters. The courts do not hold doctors criminally liable for ‘mere errors of judgement’ and assess the standard of practice against the standards held by the medical profession itself.

Chapter 5

The Application of Ethical Theories to the Criminal Justice System

5.1. Introduction

It was established in Chapter 2 that the criminal justice system (CJS) enables investigations, prosecutions, convictions and punishments of those whose conduct is unlawful. Criminal law is the most potent tool a state possesses to enforce accountability for actions that are deemed harmful to public interest. Since criminal liability and the associated infliction of punishment are the strongest 'form of censure' society can inflict the punishment of negligent doctors should be justifiable (Ashworth and Horder, 2013). Culpable homicide is a crime in South Africa; subjecting allegedly negligent doctors to the criminal justice system would be futile if society stands to achieve nothing from the inflicted punishment. The benefits of punishment therefore need to be considered if one is to ascertain whether the criminal law should be invoked in these cases.

5.2 Punishment

Before engaging with the justifications for the infliction of punishment, it is worthwhile to consider that punishment means. There are five conditions that must be satisfied for an act to be considered as an instance of 'punishment'. These are (i) it must involve pain or other unpleasant consequences; (ii) it must be for an offence against legal rules; (iii) it must be for an actual or supposed offender for his offence; (iv) it must be intentionally administered by human beings other than the offender; (v) it must be imposed and administered by an authority constituted by a legal system against which the offence is committed' (Hart and Gardner, 2009). Joel Feinberg (1965) provided an enhanced version of this definition, adding that punishment should encompass 'judgments of disapproval and reprobation'.

Legal punishment is defined as the '…principled infliction by a state-constituted institution of unpleasant consequences upon individuals who have breached the law' (Lacey, 2012). Although the deliberate infliction of harm on others is considered to be generally morally wrong when done under certain circumstances the harm is not only acceptable but can be morally justified. There are several reasons why offenders should be punished. These include the prevention of further crimes, to protect and offer reassurance to society, to allow offenders to make amends for harms causes,

and, finally, simply because they deserve it. Theories that set the goal of punishment as the prevention and deterrence of future crime are referred to as utilitarian because they are derived from utilitarian philosophy. Backward-oriented theories which focus on the past actions of the offender, are referred to as retributivist, because they seek retribution from offenders for their crimes. Retributivism considers the aim of punishment as assigning moral blame to offenders for the crimes and that their future conduct is not a proper concern for imposing punishment (Hudson, 2003). These two contrasting philosophies have spawned concepts of deterrence, retribution, just deserts, and restorative justice. This chapter considers the ethical theories underlying the justification for imposing punishment on criminally negligent medical doctors.

5.3. Forward-looking theories - Consequentialism and Utilitarianism

Consequentialism may be defined ‘as the belief that ’the rightness or wrongness’ of an agent’s action depends solely on the value of the consequences of this action, compared to the value of the consequences of any other actions that the agent could have undertaken’ (Hiller, Ilea and Kahn, 2013). Actions are right if the ‘end justifies the means’ (Dhai and McQuoid-Mason, 2011). In determining the right action, an agent is instructed to consider all possible actions and to choose one that has the best outcome.

The different consequentialist ethical theories justify how one decides which consequences are good or bad based on the value of the consequence, e.g., happiness, pleasure, or welfare. Consequences can furthermore be evaluated in two ways: act-consequentialism and rule-consequentialism (Savulescu and Wilkinson, 2019). Act-consequentialism focuses on evaluating the moral properties of individual actions based on their consequences. According to act-consequentialism, an action is morally wrong if it results in less good than some alternative that is possible and available. In contrast, rule-consequentialism assesses moral properties based on the consequences of rules rather than individual actions (Mosdell, 2011). For rule-consequentialists, an action is deemed wrong if it violates a rule that is justified by its consequences. The goal of rule-consequentialism is to establish principles of action that, when followed, lead to the best overall consequences. Rule-consequentialism underpins various aspects of our social structure, including social norms, professional codes of conduct, civil and criminal laws (Mosdell, 2011). The distinction between act- and rule-consequentialism can, however, sometimes be unclear. An action may have no adverse consequences but still be prohibited by a rule. A notable example is the case of Dr. Simon Bramhall, who in 2017 branded his initials onto the livers of two transplant patients using an

argon laser. While no harm was caused to the patients, doctors are prohibited from taking advantage of anaesthetized patients, illustrating the connection between rules and consequentialist ethics (Savulescu and Wilkinson, 2019).

Should doctors who are found guilty of criminal negligence for the death of their patient be punished? In considering the answer utilitarians would ask what the consequences of punishment would be and evaluate what would bring about the best outcome for the greatest number of people. Consequentialism is an important ethical theory which determines that the rightness or wrongness of an action is based purely on the consequences. The fundamentals of utilitarianism were first articulated by Chinese philosopher Mozi, who questioned whether certain traditions, such as the killing of a first-born son, should be continued as they brought about more harm than good (De Lazari-Radek and Singer, 2017). Similar utilitarian ideology was demonstrated by Gautama in India, Epicurus in Greece, and Cumberland and Lord Shaftesbury in England. The classical utilitarian (consequentialist) theorists were Jeremy Bentham (1748-1832) and John Stuart Mill (1806-1873). Bentham is considered to be the originator of the doctrine of consequentialism and his successor Mill, is said to have refined the theory. Bentham and Milll were concerned with law reform at the time in England using utilitarian approaches. They attempted to formulate an objective principle that would determine whether a particular action was ethically right or wrong; this became known as the principle of utility. Mill defined utility as '…happiness is intended pleasure, and the absence of pain; by unhappiness, pain, and the privation of pleasure' (De Lazari-Radek and Singer, 2017). In justifying happiness as an ultimate aim, Mill stated that '…each person's happiness is a good to that person, and the general happiness, therefore, a good to the aggregate of all persons' (Schefczyk, 2023). An action is considered 'right' if it produces the greatest happiness for the greatest number of people affected. In considering which option to choose actions or inactions that bring benefits to a greater number of people while causing harm to fewer individuals will typically be regarded as morally right (Abumere, 2019). Bentham and Mill believed that pain results in a social and moral 'cost', whereas pleasure is a social benefit. The utilitarian doctrine holds that '…pleasure and freedom from pain are the only things that are desirable as ends' (Mill, 1863).

Utilitarian justifications for punishment find their origins in the works of Beccaria and Bentham. Beccaria produced one of the first books on utilitarian theory of punishment which influenced Bentham (Easton and Piper, 2012). Beccaria regarded the aim of punishment as preventing new crime and deterring others from committing offences. Bentham considered punishment a 'mischief'

that can only be justified if the harm that it prevents is greater than the harm inflicted on the offender (Hudson, 2003). He stated that:

> all punishment is mischief: all punishment in itself is evil. Upon the principle of utility, if it ought at all to be admitted, it ought only to be admitted in as far as it promises to exclude some greater evil (Bentham, 1823).

5.3.1. Deterrence

According to the utilitarian theory, punishment is justified because 'the evil of punishment reduces the evil of crime' (Wolf, 2002). The utility of punishment lies, therefore, in its ability to prevent and deter future crimes. Regarding the benefit of punishment, Bentham (1830) stated:

> …when we consider that an unpunished crime leaves the path of crime open, not only to the same delinquent but also to those who may have the same motives and opportunities for entering upon it, we perceive that punishment inflicted on the individual becomes a source of security to all.

The basis of the doctor-patient relationship is trust. Doctors are required to commit to '…sound professional and ethical practice and an overriding dedication to the interests and wellbeing of one's fellow human beings and society' (HPCSA, 2021). This relationship is adversely affected when the negligence of a doctor leads to the death of a patient. Intervention through criminal law demonstrates to the public that the state is committed to protecting society when medical standards are breached. Failure to intervene may lead to two problems (Lacey, 2012). Firstly, there may be a tendency to exact revenge or vengeance privately. This may be demonstrated by the alleged assassination of Dr. Munshi, an anaesthetist that was involved in the death of a 10-year-old boy. Dr. Munshi had been charged with culpable homicide together with the paediatric surgeon Professor Beale (Shange, 2020). Secondly, persistent failures by the state to enforce laws will erode public trust in the legal system as a whole. Since one of the functions of the CJS is to protect the collective welfare of society, the commitment of the state to punish negligent doctors reinforces this function. It may therefore be argued that, through punishment, the criminal justice system may 'increase a sense of social solidarity or cohesion, and a sense of public security'

(Lacey, 2012).

The utilitarian approach to punishment is that it is only justifiable if it brings about maximum overall utility. Punishment may be justified if the gain outweighs the pain and cost of punishment in societal happiness through the crime reduction. Bentham (1830) stated that:

> That punishment which, considered in itself, appeared base and repugnant to all generous sentiments, is elevated to the first rank of benefits, when it is regarded not as an act of wrath or of vengeance against a guilty or unfortunate individual who has given way to mischievous inclinations, but as an indispensable sacrifice to the common safety.

Against the background of utilitarian moral principles of maximisation of net happiness, enhancing pleasure, and the avoidance of pain, the threat of punishment has a deterrent effect on potential offenders (Lacey, 2012). Deterrence is achieved when people choose to refrain from committing offences because they fear punishment. Beccaria (1767) stated that the purpose of punishment '…can only be to prevent the criminal from inflicting new injuries … and to deter others from similar acts'. Deterrence plays a crucial role in preventing future criminal activities by highlighting the consequences faced by convicted offenders. The importance of deterrence is that it can affect and influence not only the offender but all of society from committing crimes. Two primary types of deterrence exist: individual deterrence and general deterrence (Lacey, 2012). Individual deterrence targets the offender who faces punishment for his committed crimes, aiming to prevent him from repeating their criminal conduct. This approach operates on the principle that experiencing punishment will deter future criminal acts by the offender. Individual deterrence serves three preventive functions regarding the offender: incapacitation through incarceration or capital punishment, rehabilitation by removing the desire to offend, and intimidation or fear to prevent re-offending (du Preez and Muthaphuli, 2019). Doctors are not repeat offenders–individual deterrence is therefore of lesser importance when applied to the medical profession. General deterrence uses the offender as a 'means to an end' as the offender is 'sacrificed' for the greater good of society (Lacey, 2012). Since an important justification for punishment is that it promotes safety and security in society, general deterrence is often thought to be the principal mechanism by which this may be accomplished (Beccaria, 1767). Beccaria and Bentham argued that criminal acts inherently cause harm and diminish overall happiness within society. Consequently, by effectively deterring crime, punishments serve to mitigate harm and thereby enhance societal happiness.

Evaluating the effect of deterrence on deterring criminal medical negligence has not been established. The effects of the effectiveness of deterrence in civil law has however been studied and the findings are inconclusive. In Scandanavian countries and the United Kingdom the threat of imprisonment for driving under the influence of alcohol has reduced the incidence of the offence (Hudson, 2003). Mello *et al* (2020) found that the threat of civil liability claims produced no improvement in patient care outcomes. However, Zabinksi and Black (2022) found that an increased risk of liability for harm induced a greater level of care amongst doctors and increased patient safety. Du Preez and Muthapuli (2019) concluded that '…appropriate level of punishment coupled with a high likelihood of arrest is likely to deter some potential criminals'. South African courts have given significant recognition to the role of deterrence by acknowledging that certain and severe punishment can dissuade both current offenders and potential ones from engaging in criminal activities (du Preez and Muthapuli, 2019). Research on the deterrence value of punishment indicates that individuals with conventional values or strong social ties, such as medical professionals, are more easily deterred from committing offenses (Shepherd, 2001).

5.3.2. Rehabilitation

Consequentialists recognise rehabilitation as an alternative form of punishment and hold that we are obligated to rehabilitate criminals for the greater good of all. Specifically the goal is to help the offender transition from being a law-breaker to a law-abiding citizen. For rehabilitation to succeed the offender must voluntarily reject the crime, show remorse and express a desire to change. Rehabilitation acknowledges the hardship one can face when being removed from 'normal life' while incarcerated. The objective of rehabilitation is thus to reintegrate the offender into society after a period of punishment and aims to change the offender for the better (Bennet, 2010). The use of rehabilitation has been employed in New Zealand, where reform of the Crimes Act and the introduction of new system of regulation of doctors came into effect in 1996. These changes shifted the focus from accountability and prosecution to rehabilitation, allowing the medical regulatory board to institute 'competency reviews' instead of disciplinary proceedings. The result was that since the reforms, no medical doctor has been convicted of 'medical manslaughter' since 1996. However, the number of disciplinary hearings also declined; less than three disciplinary proceedings were conducted in 1996 (Paterson, 2013). The net outcome of this rehabilitative approach was that 'that careless practitioners are rarely prosecuted or punished, and seldom 'held to account' in any meaningful way for mistakes that harm patients (Paterson, 2013).

5.4. Backward-looking Theory – Non-consequentialist Retributivism

Retributivist theory holds that punishment is justified because it is deserved. Retribution means 'deserved punishment' (Chambers 21st Century Dictionary, 2024) and two elements of retribution are that punishment should be in return for past crimes; and that the punishment should be suitable for the crime. Retribution puts forth the concept of 'desert' as a justification for punishment. 'Desert' is defined as 'an action or quality that deserves its appropriate recompense' (Oxford English Dictionary, 2024). Retributivists feel that punishment is good in and of itself and is independent of the consequences. Under this theory, the infliction of punishment on offenders is justified as giving the offender their 'just deserts' as a result of their negligent conduct. Retributive theories of punishment are backward-looking since it is only the crime itself that is the object of interest for retributivists. Immanuel Kant was a proponent of retributivism and held that, uphold moral order, the guilty must be punished and should suffer. The underlying principle of retribution is that punishment is justified insofar as it is a morally appropriate response to the violation of another person's rights. The rationale for retributivism is justice, which is satisfied when the guilty are punished according to desert and in proportion to the gravity of the offence (Easton and Piper, 2016). Retributivist theory is more protective of individuals' rights than the utilitarian approaches – punishment which is excessive or inappropriate, or which fails to respect the dignity of the offender may be considered unjust. Furthermore, punishment which is imposed for external reasons is considered unjust.

Retributivist philosophy relies on the Kantian model of the individual. Kant recognised an individual as a rational agent who recognises their duties and obligations in terms of the law (Kant 1796-7). Furthermore, Kant acknowledged the inherent autonomy of individuals such that even offenders should have their dignity and autonomy respected. Another justification for punishment held by retributivists is that punishment 'cancels out' the crime or the righting of a wrong. This justification holds that there is a connection between the wrongful conduct that warrants punishment and the punishment itself (Wood, 2010). The commission of a crime disturbs the pre-existing moral balance between the offender and society. By imposing fair and proportionate punishment on the offender the balance is restored.

5.5. Alternate Dispute Resolution - Restorative Justice

As a form of alternate dispute resolution (ADR), restorative justice (RJ) has over the years become the dominant form of justice outside the traditional criminal justice system and is increasingly making an impression as an alternative option of dealing with crime. There are more than 80 countries that use restorative interventions to deal with crime (van Ness, 2005). Despite the wide adoption and interest in restorative justice, a unifying description of what restorative justice is, remains elusive. Braithwaite (2013) describes it as 'restoring victims, a more victim-centred criminal justice system, as well as restoring offenders and restoring community'. The South African Department of Justice (2011) defines restorative justice as:

> an approach to justice that aims to involve the parties to a dispute and others affected by the harm (victims, offenders, families concerned and community members) in collectively identifying harms, needs and obligations through accepting responsibilities, making restitution, and taking measures to prevent a recurrence of the incident and promoting reconciliation.

Three principles are important to understanding restorative justice. The first principle is that crimes impact victims, offenders and the community and therefore justice should focus on repairing the harm suffered by all. Crime not only affects the offender but affects relationships between the offender, the victim and the community. This is especially relevant in healthcare where the doctor-patient relationship is based on trust and duty of care. Secondly, the affected parties should participate in formulating a response to the crime. Lastly, the relative roles and responsibilities of the government and community in responding to crime should be transformed (van Ness and Strong, 2010).

The role of restorative justice in criminal medical negligence is promising. Many medical organisations such as the South African Medical Association and the Medical Protection Society have called for a more just culture approach in response to criminal medical negligence. This approach ties in with patient safety movement goals and allows for integration of 'systems, procedures and processes surrounding the criminal law and medical regulation being applied' (GMC, 2019). The restorative justice approach has several benefits over traditional criminal justice

system approaches. It is argued that it provides more support for negligent doctors and bereaved families, allows for greater transparency, re-establishes trust between doctors and patients and promotes are better system of professional learning to prevent a reoccurrence of the events that led to the death of patients (Farrell, Alghrani, Kazarian, 2020). Furthermore, it may be argued that RJ is appropriate in cases of criminal medical negligence because these cases arise in the context of fatal errors devoid of deliberate intent and arise in multidisciplinary teams where systemic failures in healthcare environments play a role. The primary concern of RJ should continue to be that the state is responsible for ensuring that criminals face consequences for their actions, deciding the appropriate punishment to fit the crime, while considering factors like fairness and the well-being of society at large.

5.6. Conclusion

Punishment is an inevitable consequence of being criminally prosecuted and convicted. This chapter has provided an overview of the ethical theories underlying punishment to provide answers as to why doctors convicted of negligence for the death of their patient ought to be punished and how.

CHAPTER 6

The Criminal Justice System and Patient Safety

6.1. Introduction

The principle of ‘First, do no harm’ holds a revered position within healthcare. However, recent data indicates a marked escalation in the occurrence of preventable medical errors, which has led to a concomitant rise in both civil medicolegal claims and criminal prosecutions against allegedly negligent medical practitioners. This phenomenon has garnered the attention of medical organisations both in developed and developing nations. Safeguarding patients from iatrogenic harm has become a critical priority for the World Health Organisation (WHO, 2021). The consequences of patient harm extend beyond the individual, as it encompasses ethical, financial, and legal implications for healthcare systems and medical practitioners alike.

Medical organisations hold the view that the criminal prosecution of negligent doctors adversely affects patient safety (Ferner and McDowell, 2006; Quick, 2005). To support this stance, they have advanced several arguments. First, it is argued that the prosecution of individual doctors for negligence overlooks multifactorial system failures that may have contributed to patient fatalities. It is also asserted that the fear of criminal prosecution deters doctors from disclosing medical errors, thereby cultivating an environment that encourages the concealment of medical errors (Hilfiker, 1984; Brazier and Allen, 2007). Another argument put forth is that doctors, fearing prosecution for errors, shy away from high-risk specialties, ultimately negatively impacting patient care (Bateman, 2022). Arguments such as these have dominated patient safety research by presenting a largely one-sided argument against the criminalisation of negligent doctors.

Identifying and fully investigating incidents of medical negligence, including those attributable to individual errors, may contribute to improvements in patient safety and to higher standards of medical practice. In 2021, the World Health Organisation estimated that 2.6 million deaths annually were attributable to adverse medical events (World Health Organisation, 2019). Data from the Patient Safety Incident Reporting System in 2022 showed a 27% incidence of ‘serious medical harm or death’ from adverse medical events. Little research has been conducted on the relationship between patient safety and criminal law, or on the impact of criminal prosecutions on the medical profession and patient safety (Quick, 2017). This is particularly so in South Africa,

where information regarding the number prosecutions is limited and the small number of reported cases presents a challenge to engage with criminal law in this area. I argue that the criminal justice system, through criminalisation of negligent conduct by doctors, offers an opportunity to improve patient safety. Criminal law, I argue, performs a regulatory function by forbidding behaviours that harm public health and safety. This chapter delves into the historical development of the patient safety movement, the significance of patient safety, and the value of the criminal justice system in improving patient safety in South Africa.

6.2. History of Patient Safety

Patient safety is defined as 'the absence of preventable harm to a patient and reduction of risk of unnecessary harm associated with health care to an acceptable minimum' (WHO, 2023). Although there has been a recent interest in harm associated with medical treatment, recognition of patient safety dates to the 1800s and the dictum of 'first do no harm' (Hajar, 2017). In the late nineteenth century, Thomas Percival and Florence Nightingale formally documented and analysed patient files to improve medical management and patient safety (Quick, 2017). In 1911, surgeon Ernest Codman found that medical errors occurred in 123 of 337 patients. The errors were due to lack of skill, equipment, diagnostic accuracy, and poor surgical judgment (Neuhauser, 2002). Codman identified additional errors that he classified as '…calamities of surgery or those accidents and complications over which we have no known control. These should be acknowledged to ourselves and to the public and study directed to their prevention' (Neuhauser, 2002). To study the actual incidence of iatrogenic harm, the California Medical Association funded a Medical Insurance Feasibility Study, which reported injuries in 4.65 of every 100 hospitalised patients (Mills, 1978). This study was followed by the Colorado, Utah, and Harvard Medical Practice Studies, which likened the number of iatrogenic deaths to '…three jumbo jet crashes every two to three days' (Leape, 1994). The landmark Institute of Medicine Report, To Err is Human (1999), revealed that 98 000 patient deaths annually in the United States were caused by preventable medical errors. A similar study conducted in Australia showed a 16.6% incidence of adverse events; 51% were deemed 'highly preventable' (Wilson et al., 1995). It is estimated that, in middle- and low-income countries, adverse medical events account for 2.6 million deaths annually (WHO, 2021). In developing and low-income countries, deaths from healthcare pose a significant threat to public health and have implications for resource allocation and healthcare planning (Wilson et al. 1995).

In response to these studies, governments and health organisations have formed patient safety agencies to determine the scope of the problem worldwide and to implement safety protocols to minimise patient harm. One of the strategic objectives of the National Department of Health is to contribute towards human dignity by improving the quality of care. Accordingly, in 2016, a Patient Safety Incident (PSI) reporting system was implemented in South Africa. The 2022 PSI report showed a 27% incidence of 'serious harm or death' due to medical error. The report pointed out that 'Professional errors…and reckless misconduct or negligent behaviour contribute to patient safety incidents' (NDOH, 2022).

6.3. Evolving perspectives in patient safety

A considerable discourse has emerged in the patient safety movement. The earliest phase of the patient safety movement emphasised errors in health systems rather than placing blame on individual doctors (Aveling et al., 2015). This 'no-blame' system, although welcomed by doctors, did little to reduce patient deaths due to iatrogenic injury (Schiff and Shojania, 2021). However, with no reduction in the rate of medical errors and an increase in both civil malpractice claims and criminal prosecutions, Leape and Fromson (2006) called for a more aggressive approach to 'problem doctors'. They argued that '…ensuring high standards of professional conduct is arguably the greatest responsibility of a professional and on that the public, lacking an alternative mechanism for oversight, has a right to expect'. Wachter and Pronovost (2009) felt the '…reason to find the right balance between 'no blame' and individual accountability is that doing so will save lives'. The perspective in the patient safety movement has thus moved from system failures to individual accountability.

6.4. Regulation of Professional Medical Standards in South Africa

The term 'regulation', defined broadly, encompasses 'any form of influence on behaviour' (Quick, 2017). Both public health and patient safety goals have been supported and promoted by the evolving legal framework in South Africa. This framework includes statutes and regulations that affect the responsibilities of healthcare practitioners to improve patient safety. The Health Professions Act 89 of 1997 (HPA) established the Health Professions Council of South Africa as the primary regulatory authority. The ultimate objective of the Act is to '…ensure quality health standards…to protect the public and to guide the medical profession' (Carstens and Pearmain,

2021). Other regulatory bodies involved in healthcare standard settings are the Office of the Health Ombudsman, Office of Health Standards Compliance, and Patient Safety Committees. The HPCSA, which is responsible for oversight of doctors, has been plagued by maladministration, resulting in a 'lack of effectiveness in conducting professional conduct inquiries' (siu.org.za; 2023). The SIU report specifically cited a lack of effectiveness in administration of professional conduct enquiries and that the legal department delayed investigations, prejudicing practitioners and members of the public (hsf.org.za, 2021). Lacking effective alternative avenues for redress there is scope for the criminal justice to regulate the standards of medical practice by influencing behaviour through deterrence, prevention and punishment. Since serious adverse events are 'largely preventable', there is potential for the criminal justice system to provide an avenue for learning (Hegarty et al., 2021).

The Medical Protection Society of South Africa has stated that there is an increase in the numbers of doctors being prosecuted for culpable homicide following the death of a patient under their care. Explanations for this increase may not be overzealousness on the part of the NPA to prosecute, but rather reflects an emphasis on individual accountability (Wachter and Pronovost, 2009). In South Africa, the mandatory reporting of iatrogenic deaths as unnatural (HPAA) has reduced the non-disclosure of iatrogenic deaths. This is supported by data from the Medical Research Council's Injury Mortality Surveys, which showed an increase in the number of deaths attributed to medical and surgical complications (SAMRC, 2023). As a result of the increase in reporting of iatrogenic deaths, the increased frequency of criminal prosecutions may reflect an actual increase in substandard care.

6.5. Case Law: Criminal Medical Negligence

The dearth of case law in South Africa is a testament to the relatively small number of criminal prosecutions of doctors for negligence related to deaths in healthcare settings. To engage fully with the reported case law and to show its potential value in improving patient safety, I discuss a small cohort of reported cases in South Africa.

In *R v Van Schoor* 1948 4 All SA 224 (C), Dr. van Schoor was found guilty of culpable homicide when he incorrectly administered a lethal dose of Neo-Halarsine, an arsenic-containing medicine.

In a detailed judgment, Steyn J, sitting with assessors, determined that the doctor failed to exercise the degree of care expected of a reasonable man when administering a dangerous drug intravenously. The required degree of care included checking the label on the box, reading the instructions, and consulting with a senior doctor. The court did not accept that a junior doctor did not have sufficient knowledge of the drug he was administering. Similarly, in *R v Van der Merwe* 1953 2 PH H 124 (W), a medical practitioner was found guilty of culpable homicide for sub-standard monitoring of a patient after administration of a drug, dicumarol. Roper J held that negligence has a special application in the case of doctors or other skilled professions because a person professing to be a professional undertakes to perform with reasonable skill. In *S v Mkwetshane* 1965 2 All SA 457 (N), an intern incorrectly administered an excessive dose of paraldehyde to a patient, resulting in her death. Referring to previous decisions, the court concluded that the doctor admitted a lack of knowledge about using paraldehyde and, regardless, chose to use it. The court further held that there were sufficient resources for Dr. Mkwetshane to have consulted before using a drug. The death of a 6-year-old patient due to an alleged overdose of urograffin resulted in the conviction of a radiologist in *S v Bezuidenhout* 1989*.* In 1987, a general practitioner, Dr. Nel, was convicted of culpable homicide for the death of his patient during the removal of the placenta (*S v Nel* 1987). The court held that the practitioner lacked the necessary skills and experience to perform the procedure and should have referred the patient to a specialist obstetrician for management. In *S v Kramer and Another* 1987 (1) SA 887 (W), a surgeon and anaesthetist were both charged with culpable homicide for the death of a 10-year-old patient undergoing a tonsillectomy and adenoidectomy. The surgeon was acquitted, but the anaesthetist was convicted of culpable homicide for negligent intraoperative care of a patient. An Ear, Nose and Throat Specialist (*Akhoury v S* [1999] JOL 5428 (Ck)) was convicted of culpable homicide for incorrect technique whilst performing a right mastoidectomy. The doctor's conviction was set aside on appeal on the grounds that the state failed to show beyond a reasonable doubt that Dr. Akhoury's conduct fell short of the standard expected of a reasonable expert as determined by expert medical evidence. In the case of S *v Van Heerden* 2010 (1) SACR 529 ECP, a gynaecologist was convicted of culpable homicide for poor post-operative management of a patient. The conviction and sentence were set aside on appeal for failure to prove negligence. The most publicised case in recent times is that of *S v Van Der Walt*, a gynaecologist convicted of culpable homicide for inadequate management of a patient after she gave birth. The conviction was set aside on appeal, not on the merits of the case but on the accused's right to challenge evidence.

6.6. Improving Patient Safety

Case law and inquest findings may offer valuable insights into medical and therapeutic-related deaths and contain information most likely not offered by other types of reporting systems, such as Patient Safety Incident Reporting. Engagement with the available reported judgments involving doctors shows that there is a clear ability on behalf of the criminal justice system to distinguish between culpable and non-culpable cases of iatrogenic death. Rather than being seen as a hindrance to patient safety, criminal law should be regarded as another method to improve patient safety.

Information emanating from the criminal justice system is currently being used to improve patient safety in countries with coronial systems. For example, coroners in the United Kingdom are required to issue an annual Prevention of Future Death (PFD) report. The objective of a PFD report is to make recommendations to prevent similar deaths. The PFDs are issued annually by coroners to describe deaths that are concerning to the coroner and that require intervention. A recent PFD report related to the death of a child who died of bronchopneumonia while in the hospital. The coroner identified ‘missed opportunities’ due to a lack of compliance with clinical standards which may have prevented the death (www.judiciary.uk; 2023). No finding of negligence was made by the coroner; the concern, rather, was to prevent similar deaths. Research into patient safety has recently begun to utilise these reports to identify areas in which patient safety can be improved. Pudney (2016) performed a retrospective analysis of inquest data in Australia to assess the potential for improving patient safety in hospitals at a system level. His study showed a recurrence of eleven themes over the 20 years under review, including post-surgical complications, inadequate supervision of junior doctors, and medication errors. Bremnar et al (2023) conducted a narrative literature review of studies using PFD data and identified 17 studies that used inquest data to highlight areas of concern in healthcare. In South Africa, iatrogenic deaths, regulated by the HPAA, are regarded as unnatural and referred for medicolegal investigation. Most of these deaths are submitted to the inquest court, which plays a vital role in the investigation. In addition to having a potential impact on future criminal prosecution, an inquest may be useful in identifying and monitoring patterns of deaths (Theophilopoulos and Tuson, 2016). In the context of patient safety, health departments and health professionals may use the findings as a means of improving patient care.

The overwhelming majority of literature paints the involvement of the criminal justice system as having a detrimental effect on patient safety. The view that criminal law simply seeks to mete out revenge and blame is dominant in current patient safety literature (Ferner and McDowell, 2006). Conviction rates have been relatively low (Quick, 2011), and sentencing doctors to imprisonment in South Africa is exceedingly rare. The use of the criminal justice system in the context of patient safety is two-fold: individual accountability and deterrence. It is the latter that has a positive role in patient safety, especially when errors leading to death are due to negligent conduct. The criminal justice system should thus be viewed as an adjunct to other reporting mechanisms to improve the standard of care patients receive.

Chapter 7

Conclusion

This research report aims to critically evaluate the ethical, and legal issues related to criminal medical negligence. The first objective was to provide an overview of the existing literature relating to the subject. My second objective was to argue that the criminal justice system is an appropriate system to hold negligent medical doctors accountable for the deaths of patients under their care. The third objective was to argue that the criminal justice system protects the welfare of patients by prosecuting negligent doctors whose standard of practice falls below that of a reasonable doctor. The last objective was to offer a response to the main objection to criminalising medical error pertaining to patient safety. I approached the report by structuring my argument in a way that would provide clarity on the purpose, values, and aims of the criminal justice system. As my argument progressed, it showed that most of the objections to the prosecution of doctors for criminal negligence were based on a lack of engagement with the law. A careful analysis of the practical application of the law in criminal medical negligence cases shows that there is no need to introduce special legislation to address criminal medical negligence. By presenting the few reported judgments in South Africa, I addressed the appropriate use of criminal law in prosecuting doctors for criminal negligence. The cases presented confirm that legal principles are applied uniformly and consistently. Presenting the evidence in this way speaks to the low rate of engagement of the criminal justice system in criminal medical negligence matters. It also highlights the capacity of the NPA to distinguish between culpable and non-culpable harm. Despite calls for law reform through comparison with other international jurisdictions such as England and New Zealand, my report has shown that the charge of culpable homicide in response to iatrogenic death in South Africa has been infrequent and judicious.

Chapter 1 provides an overview of the literature relating to criminal medical negligence. The subject of the ‘criminalisation of medical error’ is dominated by literature that rejects the use of criminal law on two main grounds: that it is an inappropriate forum to hold doctors accountable, and that it is detrimental to patient safety. I provided the arguments against the invocation of criminal law in iatrogenic deaths. My argumentative strategy in favour of the criminal justice system was presented.

Chapter 2 discussed the aims, objectives, functions, and values of the criminal justice system. The chapter focused on two specific values: collective welfare and individual responsibility. Based on these values, I argued that the underlying values of the CJS promote accountability of negligent doctors and ensure that the public, especially patients, are protected. The values of the criminal justice system are very much in keeping with the bioethical principles of autonomy, beneficence, and non-maleficence.

Chapter 3 discussed the existing legal framework in South Africa for the investigation of unnatural deaths. I defined an unnatural death and discussed the pertinent legislation relating to medicolegal investigations of unnatural deaths. I provided the history and purpose of an inquest and the importance of an inquest in the investigation of iatrogenic deaths. The role of medical doctors, both as assessors and as expert witnesses, was presented. While assessors assist the court in interpreting complex technical medical issues, the need for expert witnesses to assist the prosecution was addressed. This continued 'conspiracy of silence' amongst doctors when presenting evidence against a colleague is problematic for the correct administration of justice.

Chapter 4 critically evaluates the concept of negligence in South African criminal law. The history of negligence pertaining to medical practice was presented. A detailed analysis of the concept of negligence and a discussion of its application in medical negligence cases were provided. The evolution of the common law crime of culpable homicide was discussed. The various factors that the courts take into consideration, such as level of skill and area of practice, were discussed with support from relevant case law. By taking all the circumstances into consideration, the courts can engage with the standards of medical practice as expressed by the profession itself. By assessing the standard of care of an accused doctor against her colleagues, the test for negligence reflects the standards of medicine rather than imposing subjective standards. I addressed the arguments presented by doctors for the introduction of a higher degree of blameworthiness. These arguments compare South African law to that of England, Scotland, and New Zealand. These countries qualify the degree of negligence into 'gross' or 'reckless' by introducing a subjective element. I address these arguments and conclude that the current test for negligence has been correctly applied in cases of criminal medical negligence in South Africa. There is no need, therefore, to introduce special legislation.

Chapter 5 provides the ethical justifications for punishment. One of the research questions this report aimed to answer was whether doctors should be punished if convicted of culpable homicide.

Using both forward and backward-looking ethical theories I argued that punishment of negligent doctors is justified. I also addressed the use of restorative justice in cases of criminal medical negligence as an alternative to incarceration and incapacitation.

Chapter 6 presented counterarguments to the principal objection presented against the use of the criminal justice system in iatrogenic deaths. The history of the patient safety movement was presented to provide background information on the scale of medical negligence. Several reported judgments involving criminal medical negligence were discussed to show how the courts have applied the law. Literature to support the use of inquest data to improve patient safety and medical standards was presented. I presented evidence to show that the criticism that criminal prosecution is detrimental to patient safety is unfounded. The fact that the patient safety movement, medicine, and criminal law share similar values of accountability, welfare, and prevention of harm should indicate that they serve a common purpose.

My report has, with the benefit of historical, theoretical, and legal material, dispelled some of the prevalent perceptions around criminal negligence relating to iatrogenic deaths. My discussion of relevant aspects of criminal law and moral theory relating to iatrogenic deaths presents a comprehensive account of the application of criminal law to this category of death. The research creates the potential for a new conversation about the role of criminal law in these matters. The conversation should revolve around what the medical profession may take away as valuable from the criminal justice system in enhancing standards of care.

The first recommendation emanating from the report is the provision of expert medical witness evidence. Doctors are hesitant to give testimony against each other, and those who do may experience exclusion from the medical community. Providing assistance to the court should be considered a necessary service in determining standards of care and negligent conduct (Letzler, 2012). This is especially so in an adversarial legal system where equality of representation is critical (Ryan, 2003). In response to this problem, medical associations in the United States have issued professional guidelines for medical expert witnesses in specific fields of medicine, e.g., paediatrics or anaesthesia. These recommendations limit the monetary remuneration of expert witnesses and recommend peer review of expert testimony. Another suggestion is to hold medical experts accountable if the evidence they provide is considered biased. In some jurisdictions, expert witnesses are required to read and sign a ‘witness code of conduct’. This code compels the expert

witness to act independently, comply with orders, and work cooperatively with other expert witnesses (rch.org.au, 2022). An additional recommendation would be for a panel of expert witnesses to be made available and that the selection of the witnesses be agreed upon by both the defence and prosecution. Two major reviews into gross negligence manslaughter in the United Kingdom recommended that a central register of medical experts be created to improve the quality of expertise (medicalprotection.org.uk, 2022). They also suggested that medicolegal work be included as a core part of a doctor's role (medicalprotection.org.uk, 2023). A final suggestion, based on a report by the British Medical Association, recommends that it be mandatory for expert witnesses to have formal medicolegal training (British Medical Association, 2022). There are currently no guidelines from the HPCSA regarding the provision of such evidence in court. Some guidance has been provided in *Schneider NO and Others v AA and Another* 2010 (5) SA 203 (WCC), where Davis J held that 'An expert is not a hired gun who dispenses his or her expertise for the purposes of a particular case' (Lerm, 2015).

This report has discussed the Inquests Act and the procedures to be followed in the investigation of unnatural deaths. Where the findings of the inquest do not show any evidence that the death was brought about by an '…act or omission', then the finding is documented. It is proposed that South Africa adopt a system of reporting similar to that found in other Commonwealth countries where the coroner issues reports on the prevention of future deaths. These reports are made available to the relevant health department, which is legally required to respond within 56 days. Reports such as these will prove critical to understanding why fatal medical errors occur so that healthcare professionals can respond. The utility of these reports, however, is dependent on the fulfilment of my first recommendation. Medical professionals should focus on collaborating with the criminal justice system, rather than criticising its involvement, to enhance patient safety.

The final recommendation is to apply a restorative justice approach to doctors found guilty of criminal medical negligence. This approach will address many of the arguments raised against criminalisation of medical error, while still holding negligent doctors accountable for the error. Firstly, a restorative justice approach is more holistic and can incorporate retributive concepts such as the righting of wrong. This approach restores trust in the ever important doctor-patient relationship by promoting open and '…undominated dialogue about the consequences of an injustice and what is to be done to put them right…' (Braithwaite, 2002). A restorative justice approach may also be preferable in cases of culpable homicide which involves no deliberate intent.

It may also alleviate the current problems facing the complexity in the investigation and prosecution of negligent doctors and the lack of unbiased expert evidence.

The aims of the criminal justice system and healthcare are similar. The primary goal of the CJS is to protect the public by upholding values and standards. According to the HPCSA, a ‘lifelong commitment to sound professional and ethical practice, as well as an overriding dedication to the interests and wellbeing of one's fellow human beings and society’, is essential to being a good doctor (HPCSA, 2021). The tensions between the criminal justice system and healthcare will not easily be resolved. Perhaps they should not be easy to resolve because any interaction between the two, in the context of criminal medical negligence, should be regarded as an opportunity to promote the well-being of society.

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Appendix A

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30 January 2024
Person No: 1630710
PAG

Dr RGR Moorad
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South Africa

Dear Dr Ruweida Moorad

Master of Science in Medicine: Approval of Title

We have pleasure in advising that your proposal entitled *Ethicolegal issues in the criminal prosecution of negligent medical doctors in South Africa* has been approved. Please note that any amendments to this title have to be endorsed by the Faculty's higher degrees committee and formally approved.

Yours sincerely

Mrs Sandra Benn
Faculty Registrar
Faculty of Health Sciences

Appendix B