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Professional Medical Malpractice: The Liability of the Psychiatrist

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ABSTRACT

Psychiatrists enjoyed a certain measure of immunity from litigation for many years. Until recently lawsuits against psychiatrists were virtually unheard of. This article deals with professional medical negligence and the legal liability of the psychiatrist. As a starting point historical aspects of medical negligence in South Africa is discussed and then focus is placed on the legal liability of the psychiatrist. The test for medical negligence, the proof of medical negligence, and the doctor-patient relationship is also discussed as well as failure to intervene with treatment. Furthermore it provides a discussion of the delictual and criminal liability of psychiatrists. In addition, aspects pertaining to the duty of care and specific issues with regard to psychiatric malpractice are discussed. It is then followed by a conclusion.

1. Introduction

"The care of human life and happiness, and not their destruction, is the first and only object of good government."[1] Not very long ago psychiatry was called the "Cinderella of medicine" because it was referred to as the stepchild of the medical family. Although that sobriquet is no longer suitable, it may explain why psychiatrists enjoyed a certain measure of immunity from litigation for many years. Until recently, lawsuits against psychiatrists were virtually unheard of.[2] The factors that influenced this reluctance to litigate are as follows: Psychiatrists treated comparatively fewer patients than other health professionals; the diagnosis of mental pathology was imprecise and it was not uncommon for reasonable psychiatrists to disagree about various disorders and definitions;[3] the variety of accepted therapeutic approaches made it difficult to establish a cognisable standard of care for evaluating the reasonableness of a psychiatrist's level of care; the stigma attached to mental disorders created considerable resistance to disclose intimate details about one's private life in court; and proof of causation was greatly impaired because the course of many disorders was unclear, making it difficult to determine if the harm was part of the natural progression of the disorder or related to the practitioner's mode of treatment.[4]

However, the traditional reluctance to litigate has crumbled, although not to its full potential in South Africa. There has globally been a steady rise in malpractice litigation against psychiatrists since the late 1960's.

The aim and scope of this article is to provide a basic, condensed, general overview of professional medical malpractice. The starting point for this discussion is to provide a historical overview of the origin and development of medical malpractice. Furthermore it provides a discussion of the delictual and criminal liability of psychiatrists. In addition, aspects pertaining to the therapist-patient relationship, the duty of care and specific issues with regard to psychiatric malpractice are discussed.

2. Historical perspectives of the origin and development of medical malpractice

2.1 GREEK AND ROMAN LAW

Both the Greeks and Romans recognised that the mentally ill were capable of causing social problems as well as harm to themselves or others. Since there were no lunatic asylums, the mentally ill became a family responsibility and the seriously impaired were restrained at home. Specific laws were passed, in which the earliest mention of madmen in Rome occurs in the Twelve Tables: "When no guardian has been appointed for an insane person, or a spendthrift, his nearest agnates, or if there are none, his other relatives, must take charge of his property."[5] This basic law remained virtually the only legal principle applied to madmen throughout the following nine centuries or more. The law of the Twelve Tables formed an important part of the foundation of all subsequent Western civil law.[6]

Furthermore, the *Corpus Iuris Civilis made provision for the insane*:

> "The insane, therefore, was to retain not only the ownership of his property for the duration of his illness, but also his position, rank and even his magistracy, if he were a magistrate at the time the illness struck him. However, the law did recognize the juridical capacity of the insane person. He was likened to a person who was absent, asleep or even dead. Consequently, he was considered unable to make a valid will according to the principle of law. Soundness of mind, not health of body, is required of a testator when he makes his will." [7]

Children, because of the innocence of their intentions, and the insane, because of the nature of their misfortune, were excused from punishment under the Lex Cornelia. In the matter of legal responsibility or culpability for wrongdoing, the Roman law followed a principle stated in one of the opinions of Paulus, namely that an insane person, like an infant, was incapable of malicious intent and the will to insult. Accordingly he was considered immune from any action for damages.[8]

The ancient Greeks enacted no legal mechanisms whereby the injured patient or relatives of one who had died while under a physician's care could seek legal redress. The treatise entitled *Law in the Hippocratic Corpus* opens with the assertion that:

Medicine is the most distinguished of all the arts, but owing to the ignorance of those who practise it and of those who rashly judge its practitioners, it is by far inferior to all the other arts. The chief cause of this mistake is that for medicine alone, in the city-states, no penalty has been defined except that of ill repute. But ill repute does not damage those who are compounded of it … Although many are physicians in name, yet very few are so in reality.[9]

Amundsen[10] quotes in support of this treatise a fragment of a comedy written by Pliny the Younger[11] as further evidence: "Only physicians and lawyers can commit murder without being put to death for it." This brings to mind the words of Pliny the Elder, perhaps the most frequently quoted expression of this prejudice: "Additionally, there is no law that would punish capital ignorance, no instance of retribution. Physicians acquire their knowledge from our dangers, making experiments at the cost of our lives. Only a physician can commit homicide with complete impunity."[12] It is interesting to note that in the lack of penalties for malpractice in Greece an important difference is noticed from the professional discipline in the present.

Pliny's writings have been used as evidence for the absence of procedures for redress under the Roman Empire but Roman law did have very specific provisions for seeking redress against the incompetent physician. The Romans had developed the distinctions between *dolus* (evil intent), *culpa* (including both negligence *(neglegentia)* and incompetence *(imperitia)*), and *casus* (accident). *Dolus* fell under intentional action, but *culpa* and *casus* generally under unintentional action. Both

negligent malpractice and incompetent malpractice were classified under the concept of *culpa*.[13] A considerable overlap existed between these areas of law and Roman jurists struggled with the intricacies of the application of these principles.[14]

According to the rule *imperitia culpae adnumeratur*, ignorance or incompetence (of for example physicians) was regarded as negligent malpractice. This rule was applied where a physician performed an operation in an unskilled manner, and also where a physician prescribed the wrong medication to a patient.[15]

Carstens[16] explains that the proof of medical negligence in Roman law was problematic as it is not mentioned in the available source literature. He submits that it can, however, be accepted that the onus of proof in cases of medical negligence was on the plaintiff who had to proof that the alleged negligence by the physician caused personal injury.

2.2 ROMAN-DUTCH LAW

Roman-Dutch jurisprudence is mainly concerned with either the emergent Roman-Dutch law, that is a synthesis of Roman law, Germanic customary law, feudal law, canon law and perhaps also certain natural law and humanistic doctrines, or the Roman law of Justinian. The *imperitia culpae adnumeratur* rule of the Roman law also found application in the Roman-Dutch law when the negligent or ignorant conduct of a physician was assessed. De Groot[17] commented as follows:

"Dat de dood door iemands schuld toegekomen, waer onder mede begrepen is verzuim ofte onwetenheid van een geneesmeester, vroedwijf, verzuim ofte onverstand van een waghanaer ofte schipper, of der zelver zwackheid in't bestieren van schip ofte paerden."

Carstens[18] explains that the Dutch concepts of *onwetenheid*, *onverstand* and *zwackheid*, in context of legal liability, were equated to the concept of fault, which implies a repetition of the position in Roman law. According to Van Leeuwen it is disputed whether a physician would be punishable for giving medicine to a patient, which has done him harm, or caused his death, through the physician's neglect and ignorance.[19] Because many amendments are made in law, a physician would probably have been punished according to the discretion of the court.

With regard to the imposition of severe penalties on physicians in instances where patients died as a result of medical negligence, Voet[20] remarked as follows:

"Dum affectare nemo debet id, in quo vel intelligit vel intelligere debet, imperitiam suam aut infirmitatem alteri periculosam futuram, consequens est ut hac quoque lege teneatur medici, pharmacopolae, obstetrics, imperite secants, perperam medicamenta venena propinantes, supponentes infundentes, pro medicamentis venena dantes."

The free translation reads as follows:

While nobody has the right to claim to do something when he understands or ought to understand that his inexperience or infirmity may be dangerous to another person, it follows that the following people will be liable in terms of this rule: physicians, pharmacists, midwives, those who without experience perform surgery, those who erroneously administer poisonous medicine or administer poison instead of medication.

The first reported case in South Africa with reference to medical malpractice is *Lee v Schönnberg*,[21] an old Cape decision. In this case the plaintiff lost both his legs in an accident and he consulted the defendant, a physician. It is not known what the nature and extent of the injuries were or what subsequent medical treatment was administered to the patient. The plaintiff alleged that the defendant was negligent in the performance of his professional duties, and claimed damages. In this decision the court confirmed that where a physician did not exercise reasonable skill and care, he is liable in damages. The court relied on the English decision of *Lamphier v Phipos*.[22] The presiding judge, De Villiers CJ, enunciated the following rule with regard to medical negligence:

There can be no doubt that a medical practitioner, like any professional man, is called upon to bring to bear a reasonable amount of skill and care in any case to which he has to attend; and that where it is shown that he has not exercised such skill and care, he will be liable in damages.[23]

In 1877, in the case of *Kovalsky v Krige*,[24] the court had the opportunity to assess professional medical negligence again. A claim based on medical negligence was instituted against the physician. The physician was summoned to treat a baby of nine months, suffering from bleeding caused by a circumcision performed at a religious ceremony. After the treatment the baby contracted gangreen to his penis resulting in permanent damage. A claim based on medical negligence was instituted against the physician. It was alleged that the physician abandoned the patient before the bleeding was stopped and that he also failed to follow up on his patient. The court ruled as follows:

"The principles there laid down have been applied in this court,[ ] and with them I entirely agree. As to capacity, Chief Justice Tindall said that every person who enters into a learned profession undertakes to bring to it the exercise of reasonable care and skill. Speaking of a surgeon, he says he does not undertake that he will perform a cure, nor does he undertake to use the highest possible degree of skill ... he undertakes to bring a fair, reasonable and competent degree of skill to his case."

The plaintiff's case, however, failed but the general principle that a physician's negligence should be assessed with reference to the yardstick of the "reasonable expert" was confirmed in this early case law, with exclusive reliance on comparable English case law.

3. The legal basis for malpractice liability[25]

3.1 PHYSICIAN-PATIENT RELATIONSHIP

The creation of the physician-patient relationship is contractual in nature and therefore based on consensus. Generally, both the physician and the patient are free to enter into or decline the relationship. The basis for most interventions is consent.[26] A physician may decline to undertake the care of a patient whose medical condition is not within the physician's current competence. However, physicians who offer their services to the public may not decline to accept patients because of race, colour, religion, national origin or any other basis that would constitute illegal discrimination.[27]

According to Van Oosten,[28] it is trite law that any medical intervention undertaken without the patient's consent or the consent of a person acting on his or her behalf is in principle unlawful or wrongful unless some other ground of justification exists. Consent by a patient to medical treatment in South African law is regarded as falling under the defence of *volenti non fit iniuria*,[29] a ground of justification which excludes the unlawfulness or wrongfulness element of a crime or delict.[30] If a medical intervention is performed without the patient's lawful consent, the doctor or hospital is exposed to liability for civil or criminal assault, civil or criminal *iniuria*, breach of contract or negligence.[31]

On the contrary, the "therapeutic privilege", in terms of which the harm caused by the disclosure of information will be greater than the harm caused by non-disclosure of information, can denote a professional privilege on the side of the doctor to withhold certain information from a patient, or it can signify a legal defence in terms of which the doctor can justifiably withhold certain information from the patient.[32] Hence, disclosure of potentially harmful information is withheld for therapeutic reasons.[33]

According to English legal principles, failure by a medical practitioner to obtain his or her patient's lawful consent to medical interventions may result in the practitioner incurring civil and/or criminal liability. Such practitioner may be convicted of criminal assault and battery, and the non-consenting and uninformed patient also has two private law remedies at his or her disposal. These remedies include an action for damages based on assault and battery, as well as an action for damages based on negligence.[34]

In *Chatterton v Gerson*,[35] Bristow stated the following: "In my judgment what the court has to do in each case is to look at all the circumstances and say, 'Was there real consent?' Equally, to avoid a claim of negligence, the information disclosed to patients, when obtaining consent, about risks must be 'reasonable' in the eyes of the court. Leaving aside breaches of professional duty so obvious that they 'speak for themselves' has traditionally been determined by the *Bolam* test." The *Bolam* test applies where expert witnesses, nearly always from within the medical profession, are asked to confirm the appropriateness of a particular aspect of medical care. The care is regarded as appropriate if the experts convince the court that a relevant, reasonable body of professional opinion would endorse the course of action that was actually taken. In the case of consent, the issue would be the amount and accuracy of information disclosed by a doctor and contested by a patient. The appropriateness of this will be irrespective of:

- The degree that claimants believe that they were morally entitled to specific information they were not given;
- the degree of harm they suffered as a result; and
- the extent to which the patient's claim for a financial remedy may be supported by the public's opinion.[36]

Therefore, consent assessed as appropriate by the *Bolam* test is judged by a "professional standard", which may be inappropriate outside the profession if it disregards the patient and is based solely on the views of clinicians.[37]

3.2 PROFESSIONAL MEDICAL NEGLIGENCE

3.2.1 Test for medical negligence

Negligence means that the defendant or the accused failed to foresee the possibility of harm in the form of bodily injury, mental injury or death occurring to another in circumstances where the reasonable person (*diligens paterfamilias*) in the defendant's or accused's position would have foreseen the possibility of harm occurring to another and would have taken steps to avoid or prevent it. The generic test for negligence is therefore one of foreseeability and preventability. Although the test for negligence is fundamentally objective, it does contain subjective elements when the negligence of an expert is assessed. Where the defendant or accused is an expert, the standard of negligence is upgraded from the reasonable layperson to the reasonable expert. Where the expert is a medical practitioner, the standard is that of the reasonable medical practitioner in the same circumstances.[38]

The test for medical negligence was formulated in *Van Wyk v Lewis*[39] in 1924:
"… A medical practitioner is not 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 in deciding what is reasonable the court will have regard to the general level of skill and diligence possessed and exercised at the time by the members of the branch of the profession to which the practitioner belongs."

In the English case *Hunter v Hanley*[40] the court stated: "The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care."

What is required from a medical practitioner, however, is not the highest possible degree of professional care and skill, but reasonable knowledge, ability, experience, care, skill and diligence. Van Oosten[41] states that the standard that is required is not based on what can be expected of the exceptionally able doctor,

but on what can be expected of the ordinary or average doctor in view of the general level of knowledge, ability, experience, skill and diligence possessed and exercised by the profession, bearing in mind that a doctor is a human being and not a machine and that no human being is infallible.[42]

In *R v Van der Merwe*,[43] the accused was a medical practitioner charged with culpable homicide. The charge arose from his treatment of the deceased with dicumarol. Evidence showed that the deceased had died of dicumarol poisoning as the result of an overdose.

Roper J stated that the definition of negligence applies to all forms of negligence and that this definition has a special application in the case of a member of a skilled profession such as a doctor, because such a person holds himself out as possessing the necessary skill and he undertakes to perform the services required of him with reasonable skill and ability. He is therefore expected to possess a degree of skill which corresponds to the ordinary level of skill in the profession to which he belongs. In deciding whether such a person is negligent or not the question is whether, applying the definition of negligence, he has exercised the degree of care and skill which a reasonable man, who is also skilled in the profession, would employ. He said that in deciding what is reasonable, regard must be had to the general level of skill and diligence possessed and exercised by members of the branch of the profession to which the practitioner belongs. The standard is the reasonable care and skill which is ordinarily exercised in the profession generally. He further said that this means that a practitioner cannot hide behind the defence that he did not know enough or was not sufficiently skilled. He said that before a medical practitioner uses a dangerous drug with which he is unfamiliar he must satisfy himself as to the properties of the drug and he cannot defend himself if he is called to account afterwards, by saying that he did not know because it is his duty to know. The court observed that in South African law the test for negligence is exactly the same in civil as in criminal cases and that it makes no difference whether a medical practitioner is sued in the civil courts for damages or is prosecuted in the criminal courts by the state. He also stated that in South African law a man is liable criminally for negligence whether his negligence is gross or slight. The jury returned a verdict of guilty.

In the English case of *Hatcher v Black*,[44] Lord Justice Denning explained the law on the subject of negligence against doctors and hospitals in the following words:
"Before I consider the individual facts, I ought to explain to you the law on this matter of negligence against doctors and hospitals. Mr. Marvan Evertt sought to liken the case against a hospital to a motor car accident or to an accident in a factory. That is the wrong approach. In the case of accident on the road, there ought not to be any accident if everyone used proper care; and the same applies in a factory; but in a hospital when a person who is ill goes in for treatment, there is always some risk, no matter what care is used. Every surgical operation involves risks. It would be wrong, and indeed bad law, to say that simply because a misadventure or mishap occurred, the hospital and the doctors are thereby liable. It would be disastrous to the community if it were so. It would mean that a doctor examining a patient or a surgeon operating at a table instead of getting on with his work, would be for ever looking over shoulder to see if someone was coming up with a dagger; *for an action for negligence against a doctor is for him unto a dagger. His professional reputation is as dear to him as his body, perhaps more so, and an action for negligence can wound his reputation as severely as a dagger can his body. You must not, therefore, find him negligent simply because something happens to go wrong*; if, for instance, one of the risks inherent in an operation actually takes place or some complication ensues which lessens or takes away the benefits that were hoped for, or if in a matter of opinion he makes an error of judgment.[45] You should only find him guilty of negligence when he falls short of the standard of a reasonably skilful medical man." (Own emphasis.)

With reference to psychiatric negligence (specialists), the test for negligence was formulated as follows in the *Bolam* case:[46] "The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent. It is a well established law that it is sufficient if he exercises the ordinary skill of an ordinary man exercising that particular art."

It is important to note that that the general test for medical negligence in terms of the liability of mental heath care practitioners and mental health care establishments, resonates in terms of section 6(1) of the Mental Health Care Act, which reads as follows:

Health establishments must -

a. provide any person requiring mental health care, treatment and rehabilitation services with the appropriate level of mental health care, treatment and rehabilitation services within its professional scope of practice; or
b. refer such person, according to established referral and admission routes, to a health establishment that provides the appropriate level of mental care, treatment and rehabilitation services.

3.2.2 Proof of medical negligence[47]

Of significance in context of the proof of medical negligence, is the case of *Van Wyk v Lewis*.[48] In this case,[49] the respondent, a physician and surgeon practising at Queenstown, received a telegram from Dr Louw of Sterkstroom asking him to meet the appellant, who was arriving by train. The respondent arranged for her admission to the Frontier Hospital where he examined her the same afternoon. Her condition was so critical that an immediate operation was necessary. He performed the operation the same evening. The anaesthetic was administered by Dr Thomas and a qualified nurse on the hospital staff acted as the theatre sister. The matron and another nurse De Wet were also in attendance. The patient's inflamed and adherent appendix was removed. The gall bladder was also in a state of acute inflammation, much distended with

necrosis on the surface and he decided to drain it. Having paced the field of the operation with swabs handed to him by the sister he made an incision and inserted a tube. This was attended with difficulty. There was a rush of highly septic matter to be dealt with and owing to the friability of the gall bladder, it was impossible to suture the opening so as to draw it around the tube. He inserted more packing to prevent the spread of sepsis. At that stage, he was warned by the anaesthetist that the patient should be taken off the operating table as soon as possible. He concluded the operation, removed all the swabs he saw or felt and being satisfied that they had all been accounted for to the satisfaction of the sister, he stitched the patient. The appellant, a young woman of 26 made a rapid recovery and was discharged from hospital on 19 February, by which time the wound had healed over. Between that date and January of the following year, the respondent saw the patient on several occasions. Some time after the operation the wound opened slightly, there was an oozing of pus and she informed the respondent that several gall stones had come through the opening. She complained of discomfort but not of pain. The last occasion on which the appellant consulted the respondent was in January 1923 when he found on examination, a slight swelling and tenderness in the region of the gall bladder which pointed, he thought, to a recurrence of the old trouble. Subsequently, on 15 February, the appellant claimed that she evacuated a piece of muslin the shape and dimensions of a small, packing swab with tape attachment. Under those circumstances she refused to pay the respondent's account which had just been rendered but commenced an action for damages. Judgment for the defendant was given by the court *a quo* and the plaintiff appealed.

Innes CJ, with regard to the question of onus of proof, stated that the general rule is that he who asserts must prove. Consequently, a plaintiff who relies on negligence must establish it. If, at the conclusion of the case, the evidence is evenly balanced, he cannot claim a verdict for he will not have discharged the onus resting upon him. Innes CJ noted that it was argued that the mere fact that a swab was sewn up inside the appellant's body is *prima facie* evidence of negligence which shifts the onus so as to throw upon the respondent the burden of rebutting the presumption raised. The maxim *res ipsa loquitur* was invoked in support of this argument. The court said that the maxim means simply what it says - that in certain circumstances the occurrence speaks for itself. It noted that the maxim was frequently employed in English cases where there was no direct evidence of negligence and that the question then arises whether the nature of the occurrence is such that the jury or the court would be justified in inferring negligence from the mere fact that the accident happened. The court said that it is really a question of inference. Innes CJ stated that it was no doubt sometimes said that in cases where the maxim applies the happening of the occurrence is in itself *prima facie* evidence of negligence and that if by this is meant that the burden of proof is automatically shifted from the plaintiff to the defendant, then he doubted the accuracy of the statement. He stated that in the present case there was no shifting of onus. In his opinion, said Innes CJ, the onus of establishing negligence rested throughout upon the plaintiff.

In a minority judgment Kotzé JA differed from the views of Innes CJ with regard to the question of *res ipsa loquitur*, saying that the placing of a foreign substance in the patient's body and leaving it there when sewing up the wound, unless satisfactorily explained, establishes a case of negligence.

He quoted from *Hillyer v The Governors of St Bartholomew's Hospital* where Kennedy LJ observed:
"It appears to me that, subject always to the reservation that I have stated in respect of the nature of the defendant's legal liability for the negligent acts or omissions of their professional staff, there was apart from the statements which two of the surgeons made subsequently to the plaintiff, and which were admitted in evidence without objection on the part of the defendant's counsel, a *prima facie* case on the issue of negligence on the facts which I have briefly set forth. I think that so far the plaintiff might, in the circumstances invoke the application of the maxim *res ipsa loquitur*.[50]"

Van den Heever[51] submits that there are reasonable grounds for advancing a persuasive argument that the judgment in *Van Wyk v Lewis* should be overruled. He states that although support for applying the doctrine to medical negligence actions can also be found with reference to constitutional and other considerations. Van den Heever further argues that in terms of section 9 of the Constitution everyone is equal before the law and has the right to equal protection and benefit of the law. In this regard, he says it could be argued that the victim of a medical accident is at a procedural disadvantage because of the fact that patients are usually anaesthetised or under the influence of an anaesthetic agent when the accident occurs as a result of which they are completely in the dark as to what actually happened. He says that to permit the plaintiff to rely on res ipsa loquitur in these circumstances would level the playing fields between the plaintiff and the defendant to a certain extent by promoting procedural equality. He also argues that section 34 of the Constitution also recognises the right to fairness in civil litigation which provides further constitutional motivation for the application of the doctrine to medical negligence actions.

3.2.3 *Imperitia culpae adnumeratur*

A physician will be blamed for being negligent where he performs an operation or embarks on the treatment of a patient well knowing that he does not have the necessary knowledge or experience and the patient is prejudiced thereby. This is in accordance with the principle imperitia culpae adnumeratur, which means "lack of skill is reckoned as fault".[52]

In Dale v Hamilton,[53] the plaintiff claimed damages for an X-ray burn received by him in the course of an X-ray examination by the defendant. He alleged that the burn was caused by the lack of skill and neglect in treatment of the defendant in conducting the X-ray examination. The defendant admitted that the plaintiff was burned in

the course of the X-ray examination he conducted but denied negligence. The defendant had only limited training and experience in radiography and the X-ray equipment at the hospital had been old when he first started to work there. Subsequently new X-ray equipment was purchased but some of the parts of the old apparatus were retained in an attempt to save costs. The defendant had some training on the new equipment which was installed at least partly by the representative of the company from which the X-ray equipment was purchased. It was argued for the plaintiff that the fact that the defendant's burn was caused in diagnostic work and that it was severe was sufficient to establish a prima facie case of negligence and to shift the onus onto the defendant of proving that there was no negligence. The expert evidence supported this position. Feetham J stated that if a doctor undertakes to do radiographic work, he must exercise in that work which he undertakes as a medical man, reasonable skill and care. But, he said, he was not sure that it made any difference whether he was a doctor or not. Anybody who undertakes radiographic work is obliged to exercise a reasonable degree of skill and care in doing that work.

The court found the defendant guilty of negligence in that he either did not exercise the care which he should have exercised being a trained man and having undertaken to use reasonable skill and care or he lacked the training necessary to enable him to use the tube which he was using. The court awarded damages for loss of earnings and also the effect of the injury on the plaintiff's future earning capacity since he could no longer return to his previous job of shaft timberman. The court further awarded damages for pain and suffering and loss of general health.[54]

3.2.4 Is there a professional duty upon a physician to heal or cure a patient?

In *Buls v Tsatsarolakis*,[55] Nicholas J raised the following question:

"Generally speaking every man has a right that others shall not injure him in his person and that involves a duty to exercise proper care. Every man has a legal right not to be harmed; but is there apart from a contract, a legal right to be healed? It is no doubt the professional duty of a medical practitioner to treat his patient with due care and skill, but does he, merely by undertaking a case, become subject to a legal duty, a breach of which founds an action for damages, to take due and proper steps to heal the patient? It is an interesting question, but because it was not argued and because it was not necessary for the purposes of the present decision to answer it, I shall not discuss it further."

Strauss[56] is of the opinion that where a patient consults with a medical practitioner, no more is required of the practitioner than to treat the patient with the reasonable care, skill and experience legally required, unless the practitioner explicitly guarantees the patient that he or she will be healed or cured - an undertaking that no prudent practitioner will subscribe to. Carstens[57] further submits that the Constitution does not impose any professional duty on physicians to heal or cure their patients, other than to act with reasonable skill, care, experience and diligence. Every medical intervention is fraught with potential risks, including bodily or mental injuries or even death. To interpret any right in the Constitution to impose a duty on medical practitioners to heal or cure their patients, would imply that medical practitioners are now responsible for man's mortality, which stance will never be sustained by any constitutional justification or limitation.[58]

3.2.5 Liability for failure to intervene

According to Strauss,[59] a doctor in private practice is an independent contractor who may, except in emergency situations, accept or refuse clients at his or her discretion. Failing to perform an operation agreed upon, which results in breach of contract, which failure caused financial loss for the client can result in a malpractice claim. Where a psychiatrist has agreed on a certain intervention and fails to honour such agreement, it might constitute malpractice.[60]

In *Edouard v Administrator Natal*,[61] the respondent's wife was admitted to a provincial hospital for a Caesarian section in order to give birth to their third child. The respondent and his wife requested that a tubal ligation be performed on the wife at the same time as they could not afford to have any more children and the wife wished to be sterilised. The tubal ligation was not in fact performed and one year later the wife gave birth to a fourth child. The respondent sued for damages on the basis of breach of contract including the cost of supporting and maintaining the child born as result of the failure to perform the sterilisation operation, and general damages for the discomfort, pain and suffering and loss of amenities of life suffered by his wife.

The two issues submitted to the court for adjudication were whether the administration was in law obliged, because of its breach of contract, to pay: (1) a sum representing the cost to the respondent and his wife of maintaining and supporting Nicole; and (2) general damages for the non-patrimonial loss suffered by the respondent's wife. It was agreed that, should the court find for the respondent on the first issue, an amount of R22 500 was to be awarded, and that an affirmative finding on the second issue would carry an award of R2 500. The court recognised an action in our law based on wrongful conception or pregnancy and found that in respect of the maintenance and support of the born child, the appellant was obliged, in contract, to pay the claimed amount to the respondents. However, the court observed with regard to damages that in South African law intangible loss is in principle awarded only in delict and then, apart from infringements of rights of personality, only in the case of a bodily injury.

In assessing liability in suicide cases, whether it involves inpatient or outpatient psychiatric or psychological treatment, the threshold issues are as follows:

- Did the defendant have or should he or she have had notice of the patient's dangerous propensities? In other words, was the patient's behaviour foreseeable?

- If such notice was known or should have been known, did the defendant act reasonably in light of that information?[62]

Accordingly, the duty of care owed to a patient by a psychiatrist or hospital is directly related to the patient's dangerous propensities that are known or discoverable by the exercise of reasonable skill and diligence. Therefore, when a hospital, psychiatrist knows or reasonably should have known of the patient's suicidal tendencies, the hospital, psychiatrist must exercise reasonable care to protect the patient from himself or herself.[63]

According to Goldstein,[64] on the issue of "dangerousness", the psychiatrist enter where angels fear to tread. The psychiatrist - being a physician in a doctor-patient relationship and an agent of social control at the same time - is expected to remedy the ills of the mentally disordered individual as well as those of the world in which that individual exist, with potentially brutal consequences. Changes in the social climate and scientific progress questioned and curtailed the power of the psychiatrist, and it was redefined by the courts as society demands civil liberties and then seeks protections. A common thread emerges from the shifting trends in civil commitment, deinstitutionalisation, medicalisation, legislation, and liability. Dichotomous thinking, though comforting in its classification of phenomena as mind or body, sick or evil, has failed to provide solutions to the problem of the "dangerous patient".

In *McMorrow v Colonial Government*,[65] the plaintiff, an employee at Valkenburg mental hospital, was assaulted by a patient. His action for damages instituted against the defendant was based on the averment that the defendant had failed to warn him about the levels or potential levels of dangerousness of the patient. The court, however, rejected the claim on account of the absence of any evidence that the particular patient was indeed dangerous. The court did not answer the question as to whether there was a duty on the defendant to warn or to protect the plaintiff, given the particular circumstances. The court ruled that members of the hospital staff were in a better position to judge whether a patient was dangerous or not and that the plaintiff, as an employee, should have known that one would be exposed to sudden attacks of this nature.

Courts have so far been reluctant to hold statutory authorities liable for the consequences of the actions of persons under their care, supervision or control.[66] Imposing liability on a psychiatrist in an outpatient, short-term setting for the actions of a patient that was, at most, based on risk factors and not foreseeability would have adverse effects on psychiatric care. It would encourage psychiatrists and other mental health providers to return to paternalistic practices, such as involuntary commitment, to protect themselves against possible medical malpractice liability. Despite public perceptions to the contrary, psychiatrists submit that the vast majority of the mentally ill are not violent, or no more violent than the general population. If a liability was imposed each time the prediction of future courses of mental illness was wrong, few releases would ever be made and the hope of recovery and rehabilitation of a vast number of patients would be impeded and frustrated.[67]

In *Seema v Executive member of Gauteng*,[68] the plaintiff, the father and guardian of L, a minor, sued the defendant for damages suffered by them when L was kidnapped from the family home and raped by B. B was at the time a patient of a nearby mental hospital managed by the defendant. B was admitted in the mental hospital in terms of a detention order issued under the provisions of chapter 3 of the Mental Health Act 18 of 1973.[69] It was alleged that B suffered (according to psychiatric expert evidence), at the time of the incident from a serious mental disorder, namely psychosis. B was transferred on the day of the rape from a security ward to an open ward. There was no proper fencing of any kind around the perimeter of the hospital premises and no real effort was otherwise made to guard the premises. Potentially dangerous patients were able to enter the adjacent residential area (where the plaintiff's home was located). The court was called upon to decide, *inter alia*, whether there was a legal duty on the defendant and his personnel at the hospital to take proper precautions to ensure that patients did not cause harm to the general public and, if so, whether they had breached that duty and whether their omission had been the direct or at least an important cause of the plaintiff's loss.

The court ruled that there was a legal duty on the defendant to protect the general public against the wrongful and unlawful conduct by one or more of the patients that were being held in the hospital, and that the defendant had negligently breached this duty by failing to take proper precautions to ensure that patients were prevented from leaving the hospital premises, with the result that B was able to kidnap and rape L. B thereby caused damages to the plaintiff which the defendant was obliged to recover. In coming to its judgment, the court relied on the expert evidence of psychiatrists who testified during the trial.

Carstens[70] and the author submit that the judgment is correct. It is also in step with current constitutional jurisprudence as found in the decision of *Carmichele v Minister of Safety and Security*[71] where the Constitutional Court ruled that there is a positive duty imposed on the state (in context of the protection of life) in terms of a constitutional obligation to protect its citizens from life-threatening attacks, and, in addition that there is a duty upon the courts to develop the common law in harmony with the objects and spirit of the Bill of Rights.

In the matter between the Dr Mariana Taljaard and the Health Professions Council of South Africa[72], 2021 the Applicant was charged with unprofessional conduct, it being alleged that on or about 7 May 2020 and in respect of her psychiatric patient, Ms E[...] G[...], she acted in a manner which was not in accordance with the norms and standards of her profession in that she negligently failed to attend to her in an emergency

situation. Her patient subsequently demised through suicide [the deceased].

3.2.6 Negligent administration of medication

The use of medication has become essential to the practice of modern psychiatry. But despite the enormous benefits associated with the administration of psychotropic drugs, these drugs also carry the risk of significant adverse reactions.[73]

Examples of a basis for a malpractice claim with regard to the administering of improper psychiatric medication include:[74]

- Administering dosages of psychiatric medication for the wrong reason or time period;
- negligent misdiagnosis resulting in the wrong prescription of psychiatric medication;
- failure to monitor the patient's condition;
- failure to appropriately reduce or discontinue psychiatric medication;
- the administering of dangerous combinations of multiple psychiatric drugs;
- failure to seek expert consultation;
- failure to take notice of a patient's medical history;
- failure to take risk factors into account; and
- failure to obtain informed consent prior to administering psychiatric medication.[75]

Strauss[76] opines that there have been several cases in South Africa in which a doctor was held legally liable for drug damage but these cases invariably involved over-prescribing or over-administration, on account of ignorance or carelessness on the part of the doctor, of drugs that are quite safe when used in accordance with the manufacturer's directions. He states that in a case of a drug which was properly designed, developed, tested, registered and distributed and which was prescribed in conformity with the statutory standards, and which is now alleged to be potentially hazardous to patients, proof of negligence on the part of a doctor may be well-nigh impossible. Without a doubt there is a duty upon the doctor to keep himself adequately informed on developments in the pharmaceutical field in so far as his profession is affected. Strauss points out that, for example, if a doctor were to prescribe or administer a drug despite the fact that its newly discovered risks have been fully described in a medical journal circulating in his area of practice, an inference of negligence can clearly be drawn. This will also be the case when a manufacturer has withdrawn a drug, the safety of which has become suspect and has given wide notice of its decision.

3.2.7 The liability of expert witnesses

An increasing number of general psychiatrists are acting as expert witnesses in the legal system. A growing number of clinicians are augmenting their practices by spending some of their time doing forensic work.[77] Traditionally, expert witnesses have been granted legal immunity for their forensic work; for example, they could not be sued and have charges of negligence or defamation brought against them.[78] The argument has been that expert witnesses are an important part of the legal system and, in the interest of justice, they need to be protected from liability. This is changing for all expert witnesses, including psychiatrists. Psychiatric expert witnesses are beginning to be held accountable for their testimony – they are subjected to sanctions by both professional associations and state medical boards, and delictual liability actions.

One of the factors leading to the desire to increase the accountability of experts is the fact that the use of experts in the legal system has proliferated over the past 30 years. Many commercial services offer experts for hire to assist with litigation, and some of these services have thousands of experts on file. There is also concern that the safeguards cited by courts to ensure honest expert witness testimony, for example potential prosecution for perjury and cross-examination, are not effective. The second primary safeguard, cross-examination, is also not an effective means of monitoring expert witness testimony. The field of expert witness ethics, unfortunately, is still undeveloped, and many professional societies do not have specific codes related to forensic work besides the general principles of honesty and avoidance of conflicts of interest. The concept of legal immunity for psychiatrists who work as expert witnesses is however eroding.[79]

Occasionally mistakes are made in, for example, cases concerning children where abuse is incorrectly diagnosed. This leads to tragic consequences for the child, family and other caregivers. Children may be taken into foster care and parents may suffer psychological trauma and psychiatric illness. Parents or caregivers may even be wrongly accused of such abuse, and consequently tried and convicted on the basis of expert medical evidence. The question arises whether those wrongly accused of such abuse, may institute a claim for damages and other relief. Although this issue has never been reported in South African law, it is particularly in the common law jurisdictions that this question has recently surfaced in context of the question whether a physician or hospital owes a duty of care to the wrongly accused parent.[80]

In the English case of *JD v East Berkshire Community Health NHS Trust*,[81] JD, the first appellant and a registered nurse, was the mother of a child, M, who suffered from multiple allergic reactions. These allergic reactions, amongst other things, led a consultant paediatrician expert in allergic reactions to suggest that the child might be suffering as a result of *Munchausen by Proxy* (a syndrome whereby an infant or a child is presented to physicians, often repeatedly, with a disability or illness fabricated by an adult, for the benefit of the adult). It was therefore suggested that JD was fabricating M's condition and harming him. At some stage JD had the opportunity to read the medical notes and discovered that *Munchausen by Proxy* was considered to be a possibility. She subsequently arranged to see a psychiatrist who found nothing wrong with her. She later claimed that she has suffered psychiatric injury as a result of the misdiagnosis of her and M's condition. She had not returned to nursing since this negligent misdiagnosis was made. She subsequently issued summons claiming damages for negligence, but her claim was dismissed on the ground that public policy

considerations militated strongly against the existence of any duty on the facts of the case.

The third appellants were RK and his wife AK. They are the parents of a young girl, M. When M was two months old and in the care of her grandmother, she started to scream when the grandmother lifted her from a settee. Her parents and grandmother took her to the hospital. On admission to the hospital the medical staff failed to take an accurate history from them and the grandmother. The attending consultant paediatrician diagnosed M as having an "inflicted injury" - a spiral fracture of the femur. The police and social services were informed. The attending physician did not investigate further the possibility of a diagnosis of *osteogenesis imperfecta* ('brittle bones'). The Oldham Borough Council applied for an interim care order to the effect that when M was discharged from hospital, she was placed in the care of her aunt with supervised access for the parents. Later the court decided that her injuries were non-accidental and care was given to the aunt. M, however, sustained further fractures while in the care of her aunt. Further tests were carried out and the revised medical opinion was that the history and injuries were consistent with brittle bone disease and not indicative of any abuse. Nearly nine months after being admitted to hospital, M was returned to the care of her parents. It was now accepted that the initial diagnosis of non-accidental injury was wrong. The fact remained that M's mother was separated from her child for a period of eight months. The parents claimed damages in negligence from the Oldham NHS Trust and from the attending paediatrician for psychiatric injury resulting from their separation from M. The trial court ruled, however, that neither defendant owed a duty of care to the parents and consequently dismissed the action.

3.2 CONCLUSION

It is clear from the above discussion that psychiatrists were (and still are in South Africa) relatively immune to lawsuits. A number of reasons have been cited for this perception and what little relevant data exists appears to give it credence.[82] However, cases in psychiatry have burgeoned over the past two decades and have been a great concern to practicing psychiatrists. Patients have become more litigious in all specialties of medicine. Plaintiff's lawyers have become more increasingly creative in finding reasons to blame physicians and psychiatrists for unexpected outcomes or unforeseen events that affect patients and other individuals.[83] This article sought to explain situations where physicians were held accountable for their negligent actions or omissions with specific reference to psychiatry where applicable.

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[1] Jefferson T as quoted in Community health nursing: Caring for the public's health ((eds) Lundy KS & Janes S) (2019) 187.

[2] Robertson JD *Psychiatric malpractice: Liability of mental health professionals* (2002) 3-4.

[3] Fink VN "Medical malpractice: The liability of psychiatrists" 1973 48 *Notre Dame Law Review* 693, 699-701.

[4] In addition, therapeutic transference prevented patients from perceiving therapists in anything but a benevolent light, thereby shrouding any thought of filing legal charges; therapists were experienced at defusing a patient's anger, disappointment or retaliatory feelings; and experts usually needed to help establish medical negligence, were frequently reluctant to testify against their fellow colleagues. See Hogan DB *Regulation of psychotherapists* (1978) 401.

[5] Table V Law V11. See Scott SP *The Civil Law, including the Twelve Tables, the Institutes Of Gaius, the rules Of Ulpian, the opinions Of Paulus, the enactments of Justinian, and the constitutions of Leo* (1932) Vol 1 67. See also Smith W *A dictionary of Greek and Roman Antiquities* (1875) 688-690.

[6] The Twelve Tables were written by the Decemviri Consulari Imperio Legibus Scribundis (the 10 Consuls) who were given unprecedented powers to draft the laws of the young Republic. Originally ten laws were drafted. Two later statutes were added prohibiting marriage between the classes and affirming the binding nature of customary law. The new code promoted the organisation of public prosecution of crimes and instituted a system whereby injured parties could seek just compensation in civil disputes. The plebeians were protected from the legal abuses of the ruling patricians, especially in the enforcement of debts. Serious punishments were levied for theft and the law gave male heads of families enormous social power (patria potestas).The important basic principle of a written legal code for Roman law was established and justice was no longer based solely on the interpretation of judges (priests). For a discussion of Roman law see Smith W A dictionary of Greek and Roman Antiquities (1878) 334ff; Gibbon E The history of the decline and fall of the Roman Empire (1881) viff; Cubberley EP Readings in the history of education: A collection of sources and readings to illustrate the development of educational practice, theory, and organization (1920) 23ff; Baynes NH "On teaching the history of the Roman Republic" 1932 1 *Greece & Rome* 2: 87ff; Lucilius Remains of old Latin: Lucilius: The Twelve Tables ((trans) Warmington EH) (1938) 424-515; Greenidge AHJ "The Authenticity of the Twelve Tables" 1905 20 *English Hist Rev* 77: 1-21; Steinberg M "The Twelve Tables and their origins: An eighteenth century debate" 1982 43 *J Hist Ideas* 3: 379-396; Coleman-Norton PR "Cicero's contribution to the text of the Twelve Tables" 1950 46 *Classical J* 3: 127-134.

[7] Platt A & Diamond BL "The origins of the right and wrong test of criminal responsibility and its subsequent development in the United States: An historical survey" 1966 54 *Cal LR* 3: 1227 at 1230.

[8] Diamond BL & Quen JM *The psychiatrist in the courtroom: Selected papers of Bernard L Diamond* (2004) 39ff.

[9] *Law in the Hippocratic Corpus* as quoted in and translated by Amundsen DW "The liability of the physician in Classical Greek legal theory and practice" 1977 XXXII *J Hist Med & Allied Sci* 2: 172. According to Amundsen both the author and date of this work are unknown. The only ancient author to mention its existence is Erotian (100 AD), a grammarian and physician who lived under the reign of Nero. Jones WHS, the translator of *Hippocrates* for the *Loeb Classical Library*, finds a Stoic influence in the work but often no suggestion as to its date: The piece is too short for this historian to base any argument upon general style or subject matter. See further Barnes J *Early Greek philosophy* (2001) 217ff.

[10] Amundsen 1977 *J Hist Med & Allied Sci* 172 at 173.

[11] Gaius Plinius Caecilius Secundus (Pliny the younger, adopted by his uncle, Pliny the Elder) (AD 61 – c 113) was a Roman author and administrator who left a collection of private letters of great literary charm, intimately illustrating public and private life in the heyday of the Roman Empire. He practiced law from the age of 18. His reputation in the civil-law courts placed him in demand in the political court that tried provincial officials for extortion. Amundsen 1977 *J Hist Med & Allied Sci* 172 at 173. See also Pliny *Select letters of Pliny the younger (with notes): Illustrative of the manners, customs, and laws of the ancient Romans* (1835) 9-88.

[12] Gaius Plinius Secundus (Pliny the Elder), (23 – 79 AD), was an ancient author, natural philosopher and a naval and military commander and also the author of *Naturalis Historia*. He believed that: "True glory consists of doing what deserves to be written, and writing what deserves to be read." Amundsen 1977 *J Hist Med & Allied Sci* 172 at 173. See also Merrill ET "On the eight-book tradition of Pliny's letters in Verona" 1910 5 *Classical Philology* 2: 175ff.

[13] Buckland AW *A textbook of Roman law from Augustus to Justinian* (1950) 556ff.

[14] Amundsen 1977 *J Hist Med & Allied Sci* 172 at 174.

[15] *Digest: Ad Legem Aquiliam 50 17 32 "(Gaius 7 ad edictuum provinciale): Imperitia culpae adnumeratur" ; Inst Just 4 3 7: "Imperitia culpae adnumeratur, veluti si medicus ideo servum tuum occiderit, quod eum male secuerit aut perperam ei medicamentum dederit."; D 9 2 7 8 "(Ulpianus 18 ad edictum) Proculus ait, si medicus servum iperite secuerit vel ex locato vel exlege Aquilia competere actionem."; D 9 2 7 8 "(Gaius 7 ad edictum provinciale): Idem iuris est si medicamento perperam usus fuerit."*

[16] Carstens PA & Pearmain DL *Foundational Principles of South African Medical Law* (2007) 614.

[17] (1583-1645.) Grotius H *Inleidinge tot die hollandsche rechts-geleerdheid* (1767) 3, 5, 33. Carstens also discusses the application of this rule. See Carstens & Pearmain 616. See also Scott TJ "Die reël Imperitia culpae adnumeratur as grondslag vir die nalatigheidstoets vir deskundiges in die deliktereg" in *Petere Fontes LC Steyn Gedenkbundel: 'n Gedenkbundel uitgegee deur die Vereniging Hugo de Groot ter ere van wyle Hoofregter LC Steyn* ((ed) Joubert DJ) (1980) 124-134.

[18] Carstens & Pearmain 616.

[19] Van Leeuwen S & Isaakszoon C *Commentaries on the Roman-Dutch law* (1820) 494.

[20] Johannes Voet (1647-1713). Berkhouwer C & Vorstman LD *De aansprakelijkheid van de medicus voor beroepsfouten*

door hem en zijn helpers gemaakt (1950) 23; Carstens & Pearmain 617; Scott in *Petere Fontes LC Steyn Gedenkbundel* 136 fn 91. See further s 134 of the *Constitutio Criminalis Carolina of 1532*.

[21] *Lee v Schönnberg* (1877) 7 Buch 136.

[22] *Lamphier v Phipos* (1838) 8 C & P 475.

[23] See *Lee v Schönnberg* 136.

[24] *Kovalsky v Krige* (1910) 20 CTR 822.

[25] See Oyebode "Clinical errors and medical negligence" 2018 *Advances in Psychiatric Treatment* 18; Weller "The importance of legal accountability in negligence and mental health care" 2024 *UNSW Law Journal* 490-518; Justin "Psychiatrist and negligence" 2025 *Australian and New Zealand Journal of Psychiatry* 17.

[26] Steyn CR *The law of malpractice liability in clinical psychiatry: Methodology, foundations and applications* (unpublished LLM dissertation, Unisa, 2002) 73. See also Van Oosten FFW "Some reflections on emergencies as justification for medical intervention" 673-684 in *Festschrift für Erwin Deutsch zum 70. Geburtstag* ((eds) Ahrens HJ *et al*) (1999) 673. Van Oosten states that it is trite law in societies subscribing to a human-rights culture that every person has the right to self-determination, which includes the freedom to choose to undergo or forego medical treatment, irrespective of its medical necessity.

[27] Simon RI *Clinical psychiatry and the law* (1992) 6.

[28] Van Oosten FFW "Castell v De Greef and the doctrine of informed consent: Medical paternalism ousted in favour of patient autonomy" 1995 28 *De Jure* 1:164 at 166.

[29] See *Lampert v Hefer* 1955 (2) SA 507 (A) 508 E-F, where it was said that generally speaking, all the numerous authorities without exception, indicate that, to establish the defence of *volenti non fit iniuria*, the plaintiff must be shown not only to have perceived the danger, for this alone would not be sufficient, but also that he fully appreciated it and consented to incur it. Schreiner JA stated: "It is usual to include in the defence *volenti non fit iniuria,* or, as I call it for convenience, consent, cases of voluntary acceptance of risk as well as cases of permission to inflict intentional assaults upon oneself, as in the case of surgical operations."

[30] *Castell v De Greef* 1994 (4) SA 408 (K) 420H, 423B-D.

[31] See *Stoffberg v Elliot* 1923 CPD 148; *Lampert v Hefer supra* 508 E-F; *Esterhuizen v Administrator Transvaal* 1957(3) SA 710(T) 718; *Richter v Estate Hammann* 1976 (3) SA 226 (C) 232 F-G; *S v Kiti* 1994 (1) SACR 14 (E) 18.

[32] Coetzee LC *Medical therapeutic privilege* (unpublished LLM dissertation, Unisa, 2001) 5.

[33] Steyn CR *The law of malpractice liability in clinical psychiatry: Methodology, foundations and applications* (unpublished LLM dissertation, Unisa, 2022) 93ff. For an indepth discussion of grounds of justification for medical interventions and other defences in medical law, see Carstens & Pearmain 871.

[34] Van Oosten FFW *The doctrine of informed consent in medical law* (unpublished LLD thesis, Unisa, 1989) 70-71.

[35] *Chatterton v Gerson* [1981] 1 All ER 257 (QB).

[36] *Bolam v Friern Hospital Management Committee* [1957] 2 ALL ER 118 (QB).

[37] For a discussion of the judicial position of the doctrine of informed consent, and the doctor's duty to disclose in the English law see Van Oosten (1989) 70-189 and the cases discussed therein.

[38] Carstens & Pearmain 621; Strauss SA *Doctor, patient and the law: A selection of practical issues* (1991) 243.

[39] *Van Wyk v Lewis* (1924) AD 438. See also *Mitchell v Dixon* 1914 AD 519, where Innes ACJ observed: "A medical practitioner is not expected to bring to bear upon the case entrusted to him the highest possible degree of professional skill and care, he is bound to employ reasonable skill and care; and he is liable for the consequences if he does not."

[40] *Hunter v Hanley* (1955) SC 200,206. This test was confirmed in *Bolam v Friern Hospital Management Committee*.

[41] Van Oosten FFW "Medical Law – South Africa" in *International encyclopaedia of laws* ((ed) Blanpain R) (1996) par [155]. See also *R v Van Schoor*.

[42] *Van Wyk v Lewis; Mitchell v Dixon*.

[43] *R v Van der Merwe*.

[44] Lord Denning in *Hatcher v Black* [1954] CLY 2289.

[45] Whether error of clinical judgment will constitute negligence depends on the particular circumstances of a particular instance. The facts in *Whitehouse v Jordan and Another*, illustrate this point: The plaintiff was born with serious brain damage allegedly caused by the negligence of the defendant, a senior registrar in control of confinements in the hospital concerned. The pregnancy of the plaintiff's mother had been problematic. She had been in labour for a considerable time before the defendant took over control of the confinement. He decided on a forceps delivery (a delicate procedure executed with the aim to determine whether a delivery *per vaginam* instead of by caesarean section will be possible) and attempted six times to pull out the baby with the forceps. When no movement was obtained during the fifth and sixth pull he decided to abandon the process in favour of a caesarean section. Shortly after birth it was determined that the plaintiff had suffered serious brain damage which the trial judge found to be caused by the attempted forceps delivery. The judge reasoned that the decision to employ the forceps method rather than immediately start a caesarean section, was reasonable under the circumstances. The defendant was, however, negligent in the he pulled for too long and too hard with the forceps which caused the plaintiff's head to get stuck and suffocation to set in. The English Court of Appeal upheld the defendant's appeal on two grounds: First, the trial court's finding that the defendant had pulled too hard and for too long with the forceps was set aside. Second, even if the defendant had acted as was alleged, this only constituted an error of clinical judgment and not negligence. In his finding in favour of the defendant Lord Justice Denning made the following statement: "… we must say, and say firmly, that, in a professional man, an error of judgment is not negligent." It is to be noted that the House of Lords held this to be an inaccurate statement of the law. At 281a Lord Fraser of Tullybelton expressed the view that: "I think Lord Denning MR must have meant to say that an error of judgment 'is not necessarily negligent.'" See *Whitehouse v Jordan and Another* [1980] I All ER 650; *Whitehouse v Jordan and Another* [1981] 1 All ER 267; Claassen NJB & Verschoor TJ *Medical negligence in South Africa* (1992) 19, 35.

[46] *Bolam v Friern Hospital Management Committee*.

[47] Appelbaum Malpractice claims in psychiatry: approaches to reducing risks 2021 *World Psychiatry* 24.

[48] *Van Wyk v Lewis*.

[49] The facts are discussed as it appears from the judgment of Innes CJ.

[50] The facts in this case were that a patient, whilst lying on the operating table in St Bartholomew's Hospital in an insensible state through the administration of the necessary anaesthetics had his left arm burned by contact with a heating apparatus under the table and his right arm was also bruised during the operation. The action was brought against the governors of the hospital, the plaintiff's case being that they were responsible in law for the negligence of the surgeons employed at the hospital. The Court of Appeal held that under the circumstances no liability attached to the governors of the hospital for negligence or unskillfulness of the surgeons in attendance at the operation. Kotzé JA said that the actual decision in *Hillyer* had no direct application to the present case but that the quoted observations of Kennedy LJ supported the view that where a plaintiff has proved certain facts from which, if not satisfactorily rebutted or explained, the conclusion may reasonably be drawn that there has been an absence of the necessary care or skill on the part of the medical man, a case of negligence against the defendant has been established, rendering him liable in damages. He noted that it is no doubt true that negligence may be manifested in many and various ways and in complicated instances the difficulties are usually in respect of the *onus probandi*. For an indepth discussion of *Van Wyk v Lewis* in context of the legal basis of the doctor-patient relationship, the test of medical negligence, the proof of medical negligence (specifically with reference to the maxim *res ipsa loquitur*), the locality rule in medical practice and the issue of joint liability of surgical staff as a team, see Carstens & Pearmain 796-801.

[51] Van den Heever P *The application of the doctrine of res ipsa loquitur to medical negligence cases: A comparative survey* (unpublished LLD thesis, UP, 2002) 320. See also Carstens PA "Die toepassing van *res ipsa loquitur* in gevalle van mediese nalatigheid" 1999 32 *De Jure* 1: 19-28; *Madyosi v SA Eagle Insurance Co Ltd* 1990 (3) SA 442 (A) in which the Appellate Division stated that: "In our law the maxim *res ipsa loquitur* has no bearing on the incidence of proof on the pleadings, and it is invoked where the only known facts, relating to negligence, are those of the occurrence itself." See further *Sardi v Standard and General Insurance Co Ltd* 1977 (3) SA 776 (A) 780 D-E G-H, where the court stated that: "At the end of the case the court has to decide whether, on all of the evidence and the probabilities and the inferences, the plaintiff has discharged the onus of proof on the pleadings on a preponderance of probabilities, just as the court would do in any other case concerning negligence. In this final analysis, the court does not adopt the piecemeal approach of (a) first drawing the inference of negligence from the occurrence itself, and regarding this as a *prima facie* case; and then (b) deciding whether this has been rebutted by the defendant's explanation."

[52] Claassen & Verschoor 16. Claassen and Verschoor state in connection with this case that according to Giesen and Fahrenhorst, a physician cannot defend himself by averring that he tried his best in accordance with his abilities and professional knowledge. If he is incompetent to treat a patient's specific illness he is obliged to refer the patient back to a specialist. A general practitioner will not, however be blamed for his lack of knowledge, training or experience if he undertakes specialist work in an emergency. See also *R v Van der Merwe supra*; *Coppen v Impey*. See also *S v Mkwetshana* 1965 (2) SA 493 (N).

[53] *Dale v Hamilton* 1924 WLD 184.

[54] See also *McDonald v Wroe* [2006] 3 All SA (C). This case is thoroughly discussed in Carstens & Pearmain 636.

[55] *Buls v Tsatsarolakis* 1976 (2) SA 891 at 893 (T). See further the following English cases: *Greaves & Co (Contractors) Ltd v Baynham Mickle & Partners* [1975] 3 All ER 99 (CA); *Eyre v Measday* [1986] 1 All ER 488 (CA); *Thake and Another v Maurice* [1986] 1 All ER 497 (CA).

[56] Strauss *Doctor, patient and the law* 40. In the cases of *Kovalsky v Krige supra*, *Coppen v Impey* 1916 CPD 309, and *Van Wyk v Lewis supra*, the court reiterated that the reasonable care, skill and experience, which are legally required of medical practitioners do not imply that a medical practitioner, in any sense, grants a guarantee to any patient that the patient would indeed be healed or cured. See also *Behrmann v Klugman* 1988 WLD unreported. In this case the plaintiffs (Mr and Mrs B) claimed damages in the amount of R299 609 from the defendant, a specialist surgeon, on account of the birth of a healthy but unwanted child born after an unsuccessful vasectomy was performed on B. The plaintiffs' claim was based on breach of contract and negligence. The plaintiffs alleged that the surgeon gave an undertaking to perform the vasectomy with the necessary skill and care and that the procedure would render B to be permanently sterile. The defendant denied any contractual or delictual liability. The court ruled on the evidence that the plaintiffs did not prove on a preponderance of probabilities that there was an explicit or tacit agreement between them and the defendant to the effect that he gave such an undertaking or guarantee. The claim was dismissed. Mr Justice Melamet held that even if the doctor used the phrase "end of the road" or "you will not father a child", it was not intended in the context as "irreversible" other than to describe the nature of the operation. Strauss submits that the refusal of the courts to regard "therapeutic reassurance" as constituting a guarantee that the patient will be cured, is sensible. The author agrees with Strauss in this regard. See Strauss *Doctor, patient and the law* 41, 176.

[57] Carstens & Pearmain 643.

[58] See Eng "Psychiatric malpractice and the standard of care" 2024 *Journal of the Psychiatric Academy and Law* 8.

[59] Strauss *Doctor, patient and the law* 189, 243.

[60] Steyn *LLM dissertation* 134. See also *Edouard v Administrator Natal / Administrator of Natal v Edouard* 1989 (2) SA 368 (A); *Minister van Polisie v Ewels* 1975 (3) SA 590 (A).

[61] *Edouard v Administrator Natal*.

[62] Simon RI *Psychiatric malpractice: Cases and comments for clinicians* (1992) 138.

[63] Steyn *LLM dissertation* 135ff.

[64] Goldstein MS "Psychiatry and the law: A history of our duty to protect" 1996 2 *McGill J Med* 1:51-54.

[65] *McMorrow v Colonial Government* 1906 CPD 626.

[66] See, for example, *Clunis v Camden & Islington Health Authority* (1998) (QB) 978.

[67] Scott R "Liability of psychiatrists and mental health services for failing to admit or detain patients with mental illness" 2006 14 *Aust Psychiatry* 3:256.

[68] *Seema v Executive member of Gauteng* 2002 (1) SA 771 (T).

[69] This Act has been repealed by the Mental Health Care Act 17 of 2002.
[70] Carstens & Pearmain 750.
[71] *Carmichele v Minister of Safety and Security* 2001 (4) SA 938 (CC).
[72] Case No. 007920/2022.
[73] Mills MJ "Legal liability with psychotropic drug use: Extrapyramidal syndromes and tardive dyskinesia" 1987 48 *J Clinical Psychiatry* 28. See the discussion of *R v Van der Merwe*.
[74] Frierson Malpractice law and psychiatry: an overview 2022 *American Psychiatric Publications* 5.
[75] Steyn *LLM dissertation* 147-148.
[76] Strauss *Doctor, patient and the law* 294 and further.
[77] Appelbaum PS "Liability for forensic evaluations: A word of caution" 2021 52 *Psychiatric Services* 885-886.
[78] The witness immunity doctrine originated hundreds of years ago in English common law for broad public policy reasons. The intent of witness immunity has been to encourage open and honest testimony without fear of a subsequent lawsuit related to the testimony. In 1585, one of the courts in England opined that without immunity, "those who have just cause for a complaint would not dare to complain for fear of infinite vexation". Also, in 1859, another court in England held that immunity was important to ensure that witnesses would speak freely when giving testimony. See Binder RL "Liability for the psychiatrist expert witness" 2022 159 *Am J Psychiatry* 1819-1825.
[79] See *Cutler v Dixon* 76 Eng Rep 886 (QB 1585); *Henderson v Broomhead* 157 Eng Rep 964, 967-968 (Ex 1859); Moore MV *et al* "Liability in litigation support and court testimony: Is it time to rethink the risks?" 1999 9 *J Legal Economics* 53-63.
[80] Carstens & Pearmain 664.
[81] *JD v East Berkshire Community Health NHS Trust* [2005] UKHL 23. See also Carstens & Pearmain 664, where Carstens discusses the facts and judgments. The facts in the case are indicative of three separate appeals. MAK, the second appellant, instituted a claim for damages in negligence for psychiatric injury and financial loss resulting from a clinical misdiagnosis against the Dewsbury Healthcare Trust on behalf of himself and his daughter, R. At the relevant time R was nine years old. She suffered form *Schamberg's disease* which produces discoloured patches on the skin. She hurt herself in the genital area while riding her bicycle which resulted in bruising marks on her legs. R was taken to hospital by her father. A Consultant Paediatrician at the hospital thought that the marks on her legs were suggestive of sexual abuse. The Consultant informed the social services. R was admitted to hospital at once and examined further. The attending doctor concluded that R had been sexually abused. Her mother was also informed. At that stage the diagnosis of *Schamberg's disease* was not known. MAK and his son, R's elder brother, were told that they could not sleep at home when R was released from hospital. In the hospital, in front of other patients and visitors to the ward, MAK was told he was not allowed to see R and that he could not visit her. Later the correct diagnosis of *Schamberg's disease* was made. The social services took no further steps, and it was accepted that there was no question of abuse. The trial court dismissed MAK's claim against the defendants, but the court ruled that R had an arguable claim for clinical negligence against the defendants.
[82] Frierson Malpractice law and psychiatry: an overview 2022 *American Psychiatric Publications* 1.
[83] Simon xvii.