Law, Ethics and Medicine in Zimbabwe

Second Edition

2023

by

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The first edition of this book was written by G.Feltoe and the late TJ. Nyapadi

Preface

This book is the second edition of a medico-legal text written some twenty years ago by Prof. Feltoe and the late Mr Nyapadi. This new edition incorporates the many changes that have been made to the legislation relating to medical practice in Zimbabwe and more recent rulings by our courts relating to matters such as consent and medical negligence.

It is hoped that this new edition will provide guidance to medical practitioners on a variety of legal and ethical issues and to legal practitioners on the law relating to medical practice.

In a number of medical matters, the Zimbabwean law is not well developed. Here reference will be made to South African and English law. The law from those counties is not binding in Zimbabwe but is of persuasive value only.

This book is intended as a guide to medical practitioners and nurses on certain aspects of the Zimbabwean law affecting the practice of medicine in this country. The topics covered are the ones which, in the opinion of the authors, are of most interest and concern to those engaging in medical practice. The selected topics are not covered exhaustively. Some of these topics involve highly complex considerations and the law has to be applied to numerous different fact situations. This book sets out to provide a simple non-legalistic overview of some of the important points of law and how the law will be applied in certain specific situations.

About the author

Geoff Feltoe is a former Professor of Law at the University of Zimbabwe. His main specialist subjects are Criminal Law and the Law of Delict (civil wrongs). Feltoe has for a number of years lectured to doctors, nurses and student doctors on medico-legal problems such as medical negligence and confidentiality of patient information. He holds the degrees of BA (Rhodes), LLB (Lond), M. Phil (Kent). He is a registered legal practitioner.

The late Timothy Joseph Nyapadi was a Lecturer in Law at the University of Zimbabwe. His main specialist subjects are Company Law, Insurance Law and Advocacy. Before qualifying and practising as a lawyer in Britain, Nyapadi qualified and practised as a nurse. He was therefore in a good position to understand well the legal problems which arise out of the practice of medicine. He also lectured on the subject of Law and the Nurse to students studying for the Diploma in Nursing Education at the Godfrey Huggins School of Medicine and serves as an internal examiner in this unit of the course. He had degrees of BA (Law), LLM (Lond) and was an SRN. He was also a Fellow Member of the Institute of Taxation (UK) and a barrister- at-law/legal practitioner.

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The First Edition of this publication was endorsed and recommended by Dr T. Gwata MBChB (East Africa), MMed. (Medicine) (Makerere) Consultant Physician and Dr R. J. Ndlovu GN., BSc., MSc., Nursing Education PhD. (Education) (Syracuse University), Chairperson and Senior Lecturer, Department of Nursing Science, University of Zimbabwe.

Susan Feltoe checked and meticulously edited the text of the second edition and Professor Julie Stewart made a series of very useful suggestions for improvement of this work.

Dr T. Zimunhu kindly provided helpful input from a medical perspective.

Foreword by Dr T Zimunyu MBChB, MMED(Surgery) FCS(Paeds) ECSA

Its nearly 35years since the first edition of *Law, Ethics and Medicine in Zimbabwe* was written by Prof. G. Feltoe and Mr T.J Nyapadi. We need no reminder of the major advances that have since happened in the social and physical world around us and the impact of those changes to the law and ethics of medical practice in Zimbabwe. It seems right that those major changes be reflected, in general, in the revision of the first edition of the publication, bringing in this second edition which incorporates many changes that have been made to the legislation relating to medical practice in Zimbabwe.

As someone who has spent time in the training of nurses and doctors at various levels, I can clearly appreciate the important place of this book in their curricula. This volume should be of value to the trainee as much as it should be to the seasoned senior consultant in healthcare. While not exhaustive, the authors have included topics which are of interest in today's world. There is no doubt the impact of artificial intelligence, stem cell research, and gene editing has already been felt in medicine. Dealing with such major advances in our environment requires a perspective that includes ethics and the law.

I therefore urge all in health-care to familiarise themselves with the contents of this 2nd edition and to appreciate the critical interface of the law, ethics and medicine in our Zimbabwean environment.

Taurai Zimunhu

Reference will be made to various textbooks on law and medicine. Two recent texts in particular will be frequently cited. These are—

Brazier, M. and Cave, A., *Medicine, Patients and the Law* (Manchester University Press) 2016

Mason, J. K. and McCall Smith, D. J., *Law and Medical Ethics* (Oxford) Eleventh edition 2018) by Laurie, Harmon and Porter

To avoid having to refer each time to the full citations for these texts, they will simply be cited as

Brazier and Cave

Mason and Mc Call Smith

GENERAL INTRODUCTION

Public and private health care

Presently there is a vast difference between the quality of public and private health services. Only a small elite can afford the high standard of health care offered by the private sector and most people are dependent upon public health care. Regrettably, the standard of public health care is now generally very poor due to neglect and underfunding and even the main public hospitals often lack even basic equipment and medicines public medical care. Yet, the legal and ethical standards set out in this book are supposed to be the same immaterial of whether the treatment has been rendered by doctors and nurses operating in the private and public sectors. However, as will be seen later, various problems can arise in applying a common standard. For instance, when we are considering whether a public sector doctor has been negligent should we take into account that that the doctor was having to work unreasonably long hours because the hospital was badly underfunded and the underfunding also meant that the doctor did not have access to basic medicines and equipment?

The medical profession

When we refer to a "profession" what do we mean? The word “professional” may simply describe one who performs a certain function for their livelihood rather than as a hobby (e.g. a professional and not an amateur boxer). It can also mean that tasks are performed with skill (e.g. the traditional midwife).

It is, however, clear that the professionalism involved in the practice of medicine in the modern era involves—

- skill based upon specialised knowledge;
- training supplemented by examinations to establish competence, and ongoing education;
- adherence to a code of conduct based upon a concern for the maintenance of the highest standards of integrity and the protection of the reputation of the profession and the protection of the interests of patients, such code enforced by a disciplinary mechanism.

The Health Professions Act [*Chapter 27:19*] governs all branches of medical practice and allied health practice. It governs—

- medical practitioners in general practice and those who are specialists in particular areas, such as
- surgery,
- paediatrics, gynaecology and obstetrics;
- dental practitioners;
- general nurses, psychiatric nurses, midwives and maternity nurses;
- various other health care professionals such as physiotherapists, psychologists, opticians,
- occupational
- therapists, pharmaceutical chemists and opticians.

The full list of the professions dealt with in the Act can be found in the First Schedule to the Act. This Schedule is reproduced at the end of this book in Annexure 6.

The medical profession is a caring profession. The aim is to provide medical care to those who are sick or injured. The primary aim of medical intervention is to try to save and preserve the lives of patients whose lives are in danger due to illness or injury. It is also to try to cure curable medical conditions. It provides palliative care to those with terminal illnesses.

Registration of medical practitioners and nurses

All doctors and nurses (and other members of the Health Professions Act [*Chapter 27:19*] as specified in the Third Schedule to the Act) are entitled to apply to the Council to be registered after successfully completing the training specified by the Health Professions Council at a recognised institution.

Section 85 of the Act provides that a council may from time to time prescribe the qualifications which, when held singly or jointly with any other qualification, will—

- qualify the holders for registration in a register established in terms of this Act; or
- subject to this Part, entitle holders to registration if they have, before or in connection with or after the acquisition of the qualification, complied with such conditions or requirements as may be prescribed.

However, under s 86 the council may refuse to register the applicant if, notwithstanding the fact that applicant is otherwise qualified, the council is of the opinion that the person is not a fit person to be registered because of—

- their physical or mental health; or
- the fact that they are not of good character or reputation; or
- the fact that they do not have an adequate knowledge of the English language; or
- any conduct on their part which, if they had been registered, would have constituted improper or disgraceful conduct or conduct which, having regard to the profession or calling for which they have applied to be registered, is improper or disgraceful.

Before refusing registration on any of these grounds a council must refer the matter to its disciplinary committee for a ruling in this regard.

Before a doctor or nurse or other health worker can practice, they must obtain a practicing certificate. The body responsible for issuing and withdrawing such certificates is the Practice Control Committee. To obtain the practice certificate the prescribed fee must be paid. However, the Committee can refuse to grant this certificate if it considers that the applicant is not competent or proficient to practice. It can also grant the certificate subject to certain conditions.

A private practice certificate for medical practitioners will be granted only if the practitioner has served at least five years in a designated health institution, although exemptions from this requirement may be granted in certain cases by the Committee. Note that the practice certificate, in terms of the Medical and Allied Professions Act, is now required to be renewed annually and not to do so will be an offence.

Legislation on medical practice

Laws may be loosely described as the body of rules of conduct or action prescribed or formally recognised as binding upon the people in a country. These rules can be written down in legislation or they can be unwritten rules developed over time by judges based upon precedent. The body of unwritten laws is referred to as the common law. Written criminal laws lay down which forms of conduct are prohibited, the violation of which will attract criminal penalties. Other written laws regulate how activities are to be conducted. For instance, there are various Acts that regulate medical practice such as the Health Professions Act, the Medical Services Act and the Public Health Act.

On the other hand, civil laws are there to provide a framework within which civil disputes can be decided. Civil rules are used in relation to contractual disputes or to decide whether a person is liable to pay damages for harm done. For example, if a doctor negligently causes harm to a patient, the patient can sue the doctor under delict

(tort) for damages. If a nurse negligently causes the death of a patient, they may be prosecuted for culpable homicide under the criminal law.

The most important law is the Constitution of Zimbabwe. This is the Supreme Law of the country and all laws must be consistent with the provisions of the Constitution. As regards health matters, the most relevant provisions are those setting out the nation's founding values and objectives, its national objectives and the various fundamental rights provisions. The Constitution addresses key health rights to which people are entitled and sets out the mechanisms for the realization of these rights. Section 29 requires the State to "take all practical measures to ensure the provision of basic, accessible and adequate health services throughout Zimbabwe"

The right of everyone to health care is entrenched in s 76. This provides that—

- All citizens and permanent residents of Zimbabwe have the right to access basis care services, including reproductive health care services;
- Every person living with chronic illness has the right to basic health services for the illness;
- Every person living with a chronic illness has the right to have access to basic health-care services for the illness;
- No person may be refused emergency medical treatment in any health-care institution.

The State is obligated by s 76 to take reasonable legislative and other measures, within the limits of the resources available to it, to achieve the progressive realisation of the rights.

There are various fundamental rights provisions which affect the way in which medical practitioners perform their work. Section 48 guarantees the right of a person to life. The only time that a person's life can be ended is when that person has been convicted of murder in aggravating circumstances. The sanctity of life is obviously also a prime consideration in medical practice. The medical practitioner will normally be expected to apply medical procedures to save the lives of their patients.

Section 48 also provides that "An Act of Parliament must protect the lives of unborn children, and that Act must provide that pregnancy may be terminated only in accordance with that law." The current law on termination of pregnancy is the Termination of Pregnancy Act [*Chapter 15:10*]

Section 51 provides that every person has inherent human dignity and the right to have that dignity respected and protected. In the medical sphere this translates into the requirement that medical practitioners must treat their patients with respect and take heed of their wishes and concerns, respect their privacy and keep patient information confidential.

Section 53 entrenches the right not to be subjected to cruel, inhuman or degrading punishment or treatment and s 57 guarantees the right to privacy.

There are limitations to these rights though. In terms of s 86 (1) of the Constitution it is provided that "the fundamental rights and freedoms set out in the Bill of Rights must be exercised reasonably and with due regards for the rights and freedoms of the other person". Further, s 87 of the Constitution provides that rights may be limited in public emergencies and this therefore means that the rights are not absolute. In the medical area it will be seen that there are situations where the right of patients to expect their medical details to be kept confidential is overridden by such things as protection of public health.

Role of law in the medical field

There are those who maintain that the law's interference in the field of medicine has wrought havoc on the efficient practice of medicine and that doctors and nurses should be left to perform their duties without legal intrusion. Others would not go so far, but still complain that many of the restrictions imposed by the law upon the practice of medicine are unrealistic and unreasonable.

What we seek to establish in this short text is that present legal controls in the medical field are both necessary and desirable and, properly applied, the restrictions imposed are not unreasonable. The general approach of the law is that a medical procedure is lawful if it is in conformity with the accepted ethical standards of the medical profession. It should be appreciated that law and medicine have the common goal of protecting the welfare of patients and that legal controls applied by the law are there to protect patients against members of medical and allied professions who are unscrupulous, unethical, careless or incompetent. On the other hand, doctors and nurses who perform their duties conscientiously and competently and with due regard to the rights of their patients have nothing to fear from the law. Indeed, the various controls and safeguards applied by the law are the product of consultation with the medical profession and reflect what the profession itself considers necessary and appropriate safeguards. They reflect the agreed medical ethical standards. They are not, as some people seem to think, inventions of lawyers who know nothing about medicine and have not sought expert guidance from medical practitioners.

Moreover, when a matter such as medical negligence come before the court, the court will rely very heavily upon expert medical testimony in deciding such a case. Judges are not doctors and therefore need to be guided on what may be complex medical matters. It is vitally important for a judge dealing with such a case to hear evidence as to whether other competent medical practitioners consider that the doctor in question failed to behave in a reasonably competent fashion.

The medical profession has a disciplinary process to deal with doctors and nurses who are accused of negligence and other forms of professional misconduct. Under this process the cases are decided by fellow medical professionals. This will be dealt with in detail later.

Medical ethics

Mason and McCall Smith[1] say this—

> It should not be thought that ethics is necessarily about discovering what is right. Rather, ethics is a system of principles or values that assist in decision-making. Ethics allows us to justify a particular course of action by reference to wider, socially acceptable norms or values. Bioethics [or medical ethics], then is the branch of moral philosophy concerned with the ethical issues that arise out of medical practice, life sciences, and a range of other interventions involving humans and animals. Ethics comes into play when we are faced with a dilemma: that is, when we can see two or more possible and justifiable paths to take over any difficult decision. Arguing by reference to ethical principles or concepts helps us to decide which path is the better one; note, however, this also means there we may legitimately disagree over which path to take. In, this sense, then, there may be more than one 'right' answer. A 'wrong" answer would be to take a path when we cannot justify doing so- it would be unethical to do so.

[1] Mason and McCall Smith p. 2.

Medical ethics is a set of moral principles, beliefs and values that guide medical practitioners in making choices about medical care. Some medical decisions are ethically straightforward but there are many decisions which raise sensitive and complex ethical issues.

The primary goal of medical treatment is to benefit patients, by restoring or maintaining their health as far as possible, thereby maximising benefit and minimising harm. Any medical intervention must be in the best health interests of the patient.

Sanctity of life is a primary consideration. A medical procedure that saves the life of a patient is usually in the interests of and for the benefit of the patient, as is a procedure that seeks to prolong the life of the patient.

It is because health professionals are duty bound to protect and preserve human life, we are profoundly shocked when mentally deranged doctors and nurses, such as Harold Shipman and Charles Cullen, are found to have abused their positions to deliberately murder multiple helpless adult and infant patients.

But is a medical practitioner obliged to prolong life in all circumstances and at all costs? What if the treatment or continued treatment is now futile or has ceased to give a net benefit to the patient but instead is unduly burdensome to them? What of an elderly, terminally ill patient who wishes to die with dignity rather than lingering on in what the patient considers to be a miserable condition. This patient can refuse medical treatment if they are conscious even though the lack of treatment will hasten their death. But what of a situation where that patient is not conscious? Are the doctors obliged to do everything possible to keep alive a baby who is born with severe deformities and who is unlikely to live into adulthood whatever treatment is rendered? If this is the wish of the parents should the doctor allow nature to take its course by refraining from taking aggressive medical steps to prolong the baby's life? Are doctors entitled to make judgments about the minimum standard of the quality of life of their patients? Can there be situations where it is so poor that medical intervention is not justified and the patient should be given only palliative care?

Decisions relating to treatment of those reaching the end of their lives often pose difficult ethical issues. The General Medical Council points out—

> Providing treatment and care towards the end of life will often involve decisions that are clinically complex and emotionally distressing; and some decisions may involve ethical dilemmas and uncertainties about the law that further complicate the decision-making process.[2]

Medical practitioners must not harm their patients. Although a surgical incision is harmful to the patient, the surgery is done in order to remedy a malady within the patient's body. Making an incision into a patient with appendicitis technically causes harm but it was made in order to remove the inflamed appendix and thereby eliminate the risk of progression to rupture, peritonitis and death.

Patients must be treated with respect and competent adult patients have the right to self-determination and must have the freedom to choose freely whether to undergo medical procedures, even if the failure to have the procedures will result in the death of or harm to the patients. Their autonomy must be respected and the consent of the patient to the treatment must always be obtained. It is unacceptable to adopt a paternalistic medical approach where others decide what is best for the patient and the patient's consent is not necessary.

[2] General Medical Council Treatment and care towards the end of life. https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/treatment-and-care-towards-the-end-of-life/guidance

Where a patient is mentally disordered and lacks capacity to make decisions about what medical treatment they will receive, some other person or a court will have to make the decision on behalf of that patient, provided that the decision is in the best interests of the patient. Children, particularly very young children, do not have the capacity to make decisions about their medical treatment and decisions about this will have to be made by others such as the parents, provided that those decisions are in the best health interests of the patients.

Medical practitioners must be competent to perform their professional work because incompetence will result in harm being caused to their patients. They are thus expected to perform their work with reasonable skill and competence. They must seek to prevent death where death is preventable; they must seek to cure where cure is possible and where it is not, to provide palliative care.

At the core of health care ethics is a sense of right and wrong and our beliefs about rights we possess and duties we owe others.

The ethical responsibilities in a given situation depend in part on the nature of the decision and in part on the roles played. For example, a patient and their family play different roles and owe different ethical obligations to each other than a patient and their physician.

Rights and responsibilities of patients

Mentally competent patients are expected to co-operate with health care providers at a health institution. In order for medical treatment to be a collaborative effort between the doctor and the patient, the patient must provide the doctor with accurate information about their health status. Once the patient agrees to a certain form of treatment, they are expected to comply with the doctor's instructions before, during and after the treatment.

In terms of the amendments to the Health Service Act [*Chapter 15:13*]—

8J Duties of patients

A patient must—

(a) adhere to the rules of a health institution when receiving treatment or health services at the institution; and

(b) subject to section 8H, provide a health care provider with accurate information pertaining to his or her health status and-co-operate with health care providers at a health institution; and

(c) treat health care providers with dignity and respect; and

(d) sign a discharge certificate or release from liability if he or she refuses to accept recommended treatment.

CONSENT

Introduction

Usually, medical treatment, even of a minor nature, should not be carried out unless the doctor has first obtained the patient's consent to such treatment. This rule, which is enforced by the law, applies in most cases.

Mentally competent adults have the right to decide what medical treatment they will undergo, if any. In order to make an informed decision, they need medical information about the nature, benefits and risks attaching to the proposed medical treatment and of any alternative treatments. It is the duty of their medical practitioner to supply the information in a form that the patients will understand and to satisfy themselves that the patients do understand that information. In particular, the medical practitioners have a duty to explain the risks attaching to the proposed medical treatment.

With mentally incompetent patients and with patients who are minors (i.e. unmarried persons under the age of 18) the law provides that certain persons other than the patients themselves may give consent to the performance of medical treatment. This is also the case with sane adult patients who are unconscious and in dire need of emergency medical treatment. Again, certain persons are legally permitted to give consent on behalf of such patients, if intervention is required immediately and the patient would die if time was spent trying to obtain the consent of persons authorised to give consent for the patient.

Adult patients of sound mind

All persons over eighteen years of age who are of sound mind have the legal right to determine and control what is done to their bodies. They have the right to decide for themselves whether or not they will subject themselves to a certain course of medical treatment after weighing the pros and cons of having such treatment. The legal requirement of consent protects this right and upholds the vitally important values of self-determination and personal autonomy. Doctors who violate patients' rights of self-determination by rendering treatment to which their patients have not consented can be held liable in law for this violation. The law thus provides that any performance of any medical procedure upon a sane adult patient without that person's informed consent is an assault for which the medical practitioner could be sued.

Just as a patient can consent to undergoing medical treatment, so too, the patient can refuse to undergo treatment, even when the refusal will result in disability or death. Doctors may not override a patient's refusal of treatment simply because they think it is a foolish or illogical decision. And they may not disregard patients who choose not to take their advice. If the patient is not giving clear reasons for refusing the proposed treatment, it may be worth probing a little further to find out whether they are harbouring hidden fears and anxieties that could be assuaged with further information and discussion. Any such discussion, however, must be conducted sensitively and respectfully, otherwise it could be construed as coercion. Occasionally, it may be appropriate to assess the patient's decisional capacity, but the patient's refusal should never, in itself, be taken as evidence of lack of decisional capacity.

A decisional patient should be given all material information to ensure that the refusal is truly informed. Available alternatives should then be offered, with a reminder that the patient may change their mind. Patients with decisional capacity may also withdraw consent for continuing treatment. If, during a procedure, a patient indicates that they want the procedure stopped, such as where the patient is experiencing pain, it must be stopped as soon as it is safe to do so. The health consequences of not proceeding further with the treatment should then be

explained, without trying to coerce the patient into receiving the treatment. The rights of patients who lack decisional capacity should also be respected in this regard. It is important to let patients know that stopping this procedure will not compromise their general medical care.

Meaning of consent

What exactly is meant by consent? The law lays down that the consent of the patient must be free and informed. This embodies two separate ideas: First, consent must be freely and willingly given. Secondly, the patient must give their consent on an informed basis after the nature of the proposed medical procedure and its likely consequences have been properly explained to them. We will look at each of these requirements in turn.

Free and voluntary consent

A person cannot be said to have freely consented if the doctor uses coercion, intimidation, deception or undue influence to obtain consent. If such methods are used by the doctor, the apparent consent will not be real consent and an action for assault could be brought against the doctor.

Requirements of consent

A person is only able to give consent in any real sense to an intended course of action if they know what the intended action entails. Thus it is an essential aspect of consent that there be knowledge and appreciation of the procedure and consequences of the action for which consent is being sought. Not only must the nature of the procedure be explained to the patient, but any major risks attaching to the procedure must also be disclosed. This is so because the law stresses the patient's right to make their own decision whether to undergo the proposed treatment. The patient is only able to make an informed decision if they know the advantages and disadvantages of the proposed course of action. The law thus stresses the individual's right to decide for themselves what will be done to them.

Doctors tend to adopt a rather paternalist attitude in this area. They may be inclined to believe that they know what is best for patients and feel that patients generally would not understand properly the technical details of treatment procedures. Thus doctors often believe that they should make medical decisions for their patients. Doctors who adopt this approach are likely to give patients a bare minimum of information about intended procedures and extract what is really token consent from them before proceeding.

Doctors, of course, are in positions of authority. Their patients are vulnerable and insecure as a result of the ailments from which they are suffering. In this type of relationship, it is easy for the highly trained and busy doctor to adopt a very cursory and dismissive approach when it comes to informing patients of medical details in obtaining consent.

However, this approach, which is said to be fairly widespread in Zimbabwe, is neither ethically nor legally acceptable. As noted in the previous chapter, failure to communicate properly with patients is likely to increase the chance of disgruntled patients bringing litigation against doctors. But more fundamentally, a doctor who makes no proper attempt to communicate with their patient destroys the whole treatment relationship between doctor and patient. The patient becomes a mere specimen upon which the doctor feels at liberty to perform whatever treatment they believe appropriate. There will obviously be no bond of trust between patient and doctor.

The law thus demands that the doctor communicate properly with their patients and provide them with sufficient

medical information to allow them to make informed decisions about what treatment they will receive. It should be clearly noted that by entering a hospital a person is not to be taken to have agreed to submit to any surgical treatment which the doctors in attendance see fit to perform. A person retains an absolute right to decide with each proposed treatment whether or not they will consent thereto. (This is made quite clear in two South African cases, namely *Ex Parte Dixie* 1950 (4) SA 748 and *Stoffberg v Elliott* 1923 CPD148.) In *Stoffberg* it was said—

> ... [A] man by entering a hospital does not submit himself to such surgical treatment as the doctors in attendance upon him may think necessary... He remains a human being and he retains his rights of control and disposal of his own body; he still has the right to say what operation he will submit to, and ... any operation performed upon him without his consent is an unlawful interference with his right of security and control of his own body, and is a wrong entitling him to damage if he suffers any.

The law requires that the doctor inform the patient in simple, non-technical language which the patient can understand what it is that the doctor believes necessary in the health interests of the patient. The doctor should explain basically how the treatment will be carried out, what consequences the procedure will have and what major risks attach to the procedure. The doctor is not obliged to elaborate on unpleasant and distressing details to the extent that the patient is discouraged from having certain treatment which they may require. The doctor must merely give enough detail to allow the patient to appreciate the basic nature of the procedure.

Informed consent

A surgeon must take all reasonable steps to obtain a competent adult patient's informed consent to a surgical procedure. Consent must be freely given without any coercion.

The patient must be given sufficient medical information to enable them to make an informed decision and must be given information about—

- the nature of the patient's medical ailment and why the surgeon thinks the operation is needed
- to treat the medical condition;
- the nature of the intended operation;
- the material risks involved in the surgical procedure; and
- any alternate treatments for the condition.

Unavoidable consequences

The doctor must disclose all consequences which they know, or should know, will inevitably result from that procedure. For example, in the case of a hysterectomy, the woman should be told that she will be unable to bear children after this operation. In the case of a colostomy, the patient must be told that they will have to be fitted with an artificial opening of the colon on the surface of the body and that natural bowel movements will be affected as a result of this operation.

Risks of harm from the medical procedure

The degree of risk and the extent of the harm which will result if the risk materializes, are both factors which are taken into account when deciding whether the risk should have been revealed to the patient by the doctor. Clearly the more serious the risk and the graver the likely harm, the more likely it is that the court will find that the doctor was wrong in failing to inform a patient about the risk. Thus there would be no doubt whatsoever that a doctor would be liable to a patient if they failed to disclose to them that a particular treatment they were about to undergo was known to carry with it a high risk, for example, of grave disfigurement or loss of limbs.

At the opposite extreme, a doctor is not obliged to inform a patient of a remote or slight risk of trivial harm occurring. See cases *Lymberry v Jeffries* 1925 AD 236; *Richter & Anor v Estate Hammann* 1976 (3) SA 227 (C) and *Lourens v Oldwage* 2006 All SA 197 (SCA).

As a general rule, the doctor is obliged to inform the patient of all material or significant risks attached to the procedure in question. The doctor must make a proper medical assessment of what significant information should be disclosed to the patient.

Non-disclosure of risks in the health interests of the patient

The question arises as to whether it is ever permissible for a doctor to withhold from the patient information about the risks attaching to a procedure if they consider that full disclosure of the risks would be detrimental to the patient.

It seems clear that a doctor is not entitled to withhold information as to material risks, simply because they believe that this would lead the patient to refuse to receive the intended form of treatment. The sane patient has a right to self-determination and the right to decide whether or not to undergo a medical procedure and the law will uphold this right.

In the case of *Richter & Anor v Estate Hamman* 1976 (3) SA 227 (C) at 232 it is stated that—

> A doctor whose advice is sought about an operation to which certain dangers are attached - and there are dangers attached to most operations - is in a dilemma. If he fails to disclose the risks, he may render himself liable to an action for assault, whereas if he discloses them he might well frighten the patient into not having the operation when the doctor knows full well that it would be in the patient's interests to have it.

Beyond this there are basically two schools of thought as to the extent of the duty of disclosure. The first of these approaches is often called the "professional standard" approach. The second is the “patient standard” approach.

Professional standard approach

Here, the doctor is required to disclose such information to the patient as would have been given by an ordinary skilled doctor acting in accordance with the practice accepted at the time as proper by a responsible body of medical opinion. The professional standard approach may permit non-disclosure of certain details to the patient provided that other reasonable doctors would have shared the belief of the doctor in question that full disclosure would have been contrary to the patient's medical interests. Thus, in respect of treatment which is beneficial for the patient, the doctor is not legally liable if they withhold information from their patient which will merely serve to distress or confuse the patient or to retard the process of recovery after the procedure has been carried out and where reasonable fellow professionals would have done likewise. A disadvantage of this approach is that it may result in paternalistic withholding of medically relevant information if the doctor believes that it is not within the patient's interests to know this information.

The court in *Lymberry v Jeffries* 1925 AD 236 said that the standard to be applied is whether a reasonable doctor faced with the particular situation would have disclosed the risk. In reaching a conclusion, a Court should be guided by medical opinion as to what a reasonable doctor, having regard to all the circumstances of the particular case, should or should not do. The Court must, of course, make up its own mind, but it will be assisted in doing so by the medical evidence.

Patient focused approach

Here the doctor is obliged to tell the patient all medically significant details about the intended procedure. The test is of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk. If the patient would, the doctor must disclose such risk to the patient.

The doctor has no right to withhold any of this information simply because they believe that it is not in the patient's interests to know these details. The "patient standard" stresses the patient's right to know what is involved and to decide what they will do on a fully informed basis.

The professional standard was previously adopted by the courts in Britain. See cases such as: *Bolan v Friern Hospital* [1957] 2 All ER 118; *Chatterton v Gerson* [1981] QB 432; and *Sidaway v Board of Governors of Bethlehem Royal Hospital* [1985] 1 AC 871; [1985]1 All ER. However, in the later case of *Montgomery v Lanarkshire Health Board* 2015 UKSC 11, the Law Lords moved in the direction of the patient standard approach. In the later cases the court decided that while the assessment of the risks was properly regarded as part of medical expertise, the decision about whether those risks, benefits and alternatives options should be discussed with the patient is not purely a matter of professional judgment. Such an approach ignored the patient's entitlement to decide on the risks to their health that they are willing to run.

In South Africa also there has been a shift from an overtly paternalistic approach in terms of which the patient was expected to make a choice based on the information (if any) that the doctor chose to reveal, to the position that the patient is an autonomous subject and therefore is entitled to be fully informed and, on the basis of that information, to make the final choice regarding treatment. See *Castell v De Greef* 1993 (3) SA 501 (C); *Castell v De Greef* 1994 (4) SA 408 (C).

The "patient standard" test has been adopted by the Canadian courts. The test adopted in the *Reibl v Hughes* (1980) 114 DLR (3d) 1 case was whether a reasonable patient with the characteristics of the patient concerned would have given their consent when confronted with full information of the risks and difficulties attaching to the procedure in question.

There is no case law in Zimbabwe establishing which of these two approaches is to be followed in our legislature. It might be argued that the test to be applied should take account the current poor state of the health delivery system in Zimbabwe where there is an acute shortage of medical practitioners due to many practitioners taking up posts in other countries. This means that the remaining health professionals are overstretched. Thus it might be argued that the adoption of the "patient standard" in the prevailing situation presently might result in—

- the burdening of busy and overworked Zimbabwean doctors with the onerous duty of explaining in detail the intricacies of various procedures. This would often be very time-consuming and would interfere with the performance of other pressing duties;
- the unjustified expansion of legal liability of doctors; and
- the prejudicing of patients' health interests in certain situations.

On the other hand, the patient standard gives the fullest possible recognition to the right of patients to autonomous and informed decision-making.

It would seem that the Zimbabwean courts would be reluctant to impose liability upon doctors who, for compelling clinical reasons, have shielded their patients from knowledge of certain risks. If the court was simply

to accept without more evidence the claimant's assertion that they would not have had the medical treatment in question had they known in advance of the risks involved, it would be only too easy for this assertion to be made even when it was not true.

There is no reported case in Zimbabwe in which a doctor was made to pay damages for failure to obtain consent to a procedure or failure to inform a patient as to the risks attaching to a procedure. In other countries, the action arising out of failure to obtain consent or informed consent has tended to be the action which is brought as a last resort when no other more obvious medical negligence is evident.

In the future, however, as patients become more aware of their rights it is quite possible that doctors will be sued if they disregard patients' rights to self-determination, to be supplied with adequate information and to decide for themselves on the basis of this information whether they will permit a particular treatment or not. If this happens, our courts will clearly have to develop proper principles and policies to deal carefully with such actions.

To sum up, the details contained in the consent form must be reasonably specific and comprehensive. Consent to submit to an unspecified operation or treatment at the doctor's discretion would be ruled invalid by our courts and would not protect the doctor against legal liability. The fact that a patient, under pressure from their doctor, had signed a consent form which stated that the nature and effects of a procedure had been explained to the patient would not protect the doctor if it emerged that the doctor had in fact given no such explanation to the patient.

Where it is likely, given the nature of the condition, that more extensive surgery than that which was initially planned may be necessary to treat the condition, then this must be put to the patient and their consent for certain additional procedures should they become necessary should be obtained. The consent form should also specify any conditions to treatment which the patient has imposed, such as that they are not willing to receive any form of treatment which will result in infertility or impotence. Finally, it is useful to include a clause to the effect that the patient agrees to incidental procedures such as premedication, anaesthesia and exploratory surgery.

Impact of access to medical information on the Internet

Many patients who have access to the Internet will peruse sites that provide medical information about the nature of their ailments, possible treatments for their ailments and risks attaching to various types of treatment, both surgical and medicinal.

When such patients consult medical practitioners, it is inevitable that they will go to the Internet to find out medical information.

When dealing with a sick patient who has already extracted a lot of medical information from the Internet, the general practitioner will need to make sure that the patient has not misunderstood or misconstrued the information they have read. When explaining the risks attaching to a surgical procedure or a drug regime, the medical practitioner should address the patient’s concerns about the risks as a result of reading online information. For instance, the patient may have failed to understand that a certain risk was a very remote one and, even if it occurred, the possible adverse consequences would be minor.

Underprivileged members of the society who do not have access to the Internet will be reliant upon the medical information they need to give informed consent to the recommended medical treatment.

Informing others of patient's refusal to consent

Where a person of sound mind who is over 18 refuses to consent to much needed medical treatment, on religious grounds for example, the doctor would be entitled to communicate the patient's decision to persons such as the spouse, parents and relatives. These persons might be able to persuade the patient to be sensible and consent to treatment. But if the patient continues to refuse to consent, the spouse or relatives have a right to know about the patient's condition as, for instance, the patient may be the breadwinner and if they die due to their refusal to receive treatment, these persons may be left without any means of support.

Taking surgical steps other than those authorised

When operating on a patient, the surgeon may discover some unanticipated condition requiring treatment other than the one for which the patient has consented to have surgical treatment. The question is whether the doctor will incur legal liability if they go ahead and treat this further condition without having obtained the patient's consent to do so. Clearly, if some serious complication occurred during surgery which required some immediate action, such as a tracheostomy in order to save a patient from choking to death, the defence of necessity would protect the doctor against legal liability.

When the unauthorised extra procedure is not necessary as a measure to save the patient's life, but the surgeon nonetheless feels that it is clearly in the patient's health interests that the extra procedure be carried out immediately rather than later in a separate operation to which the patient has given their consent, the question of liability is more complex.

Can the doctor go ahead with the extra procedure or must the patient’s consent first be obtained? In such cases our courts are likely to follow the same approach adopted in a number of cases from other jurisdictions. (See the end of this Chapter for these foreign cases.) Essentially this approach is that there would be no liability for performing an additional surgical procedure if—

- the further procedure is immediately required to protect the patient's health;
- it would jeopardize these health interests to postpone the procedure until a later time; and
- a reasonable doctor would not have postponed the further procedure until the patient's consent could be obtained.

If, on the other hand, it is not necessary to perform the additional procedure immediately but it is merely convenient to do so, then the doctor should not carry out the additional procedure until they have secured the patient's consent. This latter rule applies particularly where the additional procedure is of a drastic nature and has important implications for the patient in the future. Thus there are a number of cases at the end of this Chapter in which the doctors were held liable to pay damages to patients when, after performing authorised operations, they went on to perform unauthorised sterilization operations on their patients because they thought that it was in the long-term health interests of the patients that they should not become pregnant again. A woman clearly has the right to decide for herself whether she wishes to have an operation which will result in her losing her ability to reproduce.

Consent between married persons

As regards medical treatment of married persons, generally, any married person, in their own right, is entitled to give or withhold consent to any form of treatment which the doctor advises them to take. The spouse of that person does not have any right to interfere with that person's treatment decision. However, it is generally

accepted practice that if the treatment will cause or is likely to result in sterility, the consent of the patient's spouse will be sought, not so much because this is a definite legal requirement, but because of the social and emotional consequences which may result from failure to obtain the consent of the spouse. The special difficulties involved in this situation are dealt with in detail later.

Parental consent to medical procedure upon a child

In Zimbabwe, there is no legislation that specifies the age limit below which parental consent is required to receive medical treatment. Children (those under the age of 18) are minors. Under the common law, the general rule is the parents or guardian of a child have to give consent for a medical procedure to be performed on their child; the child's consent alone is not sufficient for the medical practitioners to perform the procedure. This is applied even to children who are close to the age of 18. (A guardian is a person who by law has the custody and control of the minor.)

However, as will be seen below, it is arguable that the children who are 16 and 17 should be able to receive medical treatment without parental consent, and mature children who are between 13 and 15 should be able consent to medical treatment and parental consent should not be required.

If parental consent is required and there are two parents, it would seem that the consent of one of the parents would suffice, although if both parents are available, it may be advisable to obtain the consent of both parents. This is the legal position in England. In the United Kingdom by law, healthcare professionals need only one person with parental responsibility to give consent for them to provide treatment.

Where the parents unreasonably refuse to consent to a medical procedure which is the health interests of the child, the doctor can apply to a magistrate in terms s 76 of the Children's Act [*Chapter 5:06*] and if the magistrate decides that it is in the best interests of the child for the child to have the procedure, the magistrate can authorise the doctor to go ahead with it despite the objections of the parents.

A problem arises where one parent gives consent and the other parent is adamantly opposed to the medical procedure on the child and refuses to give consent. Here the health care providers may have to obtain a ruling by the magistrate to allow the doctor to go ahead. If it is an emergency, the doctor would be justified in going ahead on the basis of the consent of one parent despite the objections of the second parent.

The doctor is lawfully entitled to carry out an emergency procedure on an unconscious child where immediate medical intervention is required to save life or to prevent serious harm from occurring and there is no time to contact the parents or guardian to obtain their consent.

Evolving capacity of children to decide upon medical treatment

Parents are responsible for the upbringing of their children. They have the responsibility to provide for the needs and welfare of their children, and their best interests. They are required to obtain health care for them where this is needed.

Previously, it was thought that only the child's parents or guardian could decide whether or not their child should undergo the medical treatment recommended by medical practitioner; this was so because a child was considered to lack capacity to make an informed decision about whether or not to receive the treatment. There were, however, provisions allowing a parents' unreasonable refusal to consent to be overridden.

When a person reaches the age of 18, they are now an adult and, unless that person is incompetent such as where

that person is mentally disordered, that person alone can decide whether or not to consent to an operation or other medical procedure.

In contemporary human rights jurisprudence, it has been recognised that as the child moves through childhood, the particular child has “evolving capacities” and parental rights of supervision of the child must be consistent with the evolving capacities of that child. See s 14(1) the Children’s Rights Convention. Article 12 of the Convention requires States Parties to assure to the child who is capable of forming their own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child. Thus the child’s right to self-determination and autonomy should not be ignored when it comes to decisions about medical treatment.

At the time of writing this new edition, there is no legislation dealing with this situation and there have also not been any case law decisions setting out what our courts consider to be the correct position. When deciding this matter, the court will give consideration to the position adopted in other jurisdictions and will also have to factor in the constitutional provisions on the rights of children and the various international and regional human rights instruments to which we are state parties.

Legal position in other jurisdictions

Other jurisdictions, such as South Africa by legislation and the United Kingdom by case law decisions, have changed the common law position and now allow “mature” children to decide for themselves whether or not they will undergo the medical procedure.

Legal position in the United Kingdom

The general approach to whether a child alone can consent to their medical treatment is set out in *Gillick v Norfolk & Wisbech AHA* [1985] 3 All ER 402 (HL) was in the context of doctors providing contraceptives to girls under the age of 16 without parental consent. However, the court also set out how the law should deal with consent to medical treatment generally of persons under 16. (In the UK, children who are 16 or older can give their consent to medical procedures without the need for parental consent.) It is the general approach in that case which is addressed here. The specific matter of supplying contraceptives to persons under the age of 16 will be addressed later.

In the *Gillick* case, the court ruled that persons under the age of 16 can consent to treatment if they demonstrate competence to do so. A child has sufficient competence if deemed to have the maturity, understanding and intelligence to be capable of making decisions about their own health and medical treatment. The doctor must consider the level of maturity of each child seeking treatment. This test allows for an individualistic assessment of a particular child's level of maturity and intellectual ability. This test has been referred to as the *Gillick* competence test. This can be overruled only in exceptional circumstances. If a child over 16 refuses treatment, which may lead to their death or a severe permanent injury, their decision can be overruled by the Court of Protection which is the legal body that oversees the operation of the Mental Capacity Act. If the child has such competence, it is legally permissible for the doctor to proceed with a medical procedure on the basis of the consent of a child alone.

Lord Scarman put it like this in the judgement: "…the parental right yields to the child's right to make his [sic] own decisions when he reaches a sufficient understanding and intelligence to be capable of making up his own mind on the matter requiring decision." Lord Scarman explicitly found that parental authority was not absolute. He held that parental rights (including the right to decide on medical treatment on behalf of a child) “exist only for as long

as they are needed to protect the child. When the child acquires the capacity to make his or her own decisions, parental rights come to an end … and yield to the child's right to make his/her own decisions".

See also in *R (on the application of Sue Axon) v The Secretary of State for Health & Anor* [2006] EWHC 37 (Admin), [2006] 1 FCR 175.

The General Medical Council in the United Kingdom has given these guidelines to doctors for applying the *Gillick* competence test—

- The capacity to consent depends on the young person's ability and maturity to understand and weigh up the options, not on their age.
- The young person must be provided with all the relevant information and it must be discussed with them thoroughly. They decide whether they can understand and retain what they have been told about the nature, purpose and possible consequences of any proposed treatment, and whether they can weigh up the information to make a decision.
- It is important to assess maturity and understanding on a case-by-case basis. A young person who has the ability and maturity to understand and consent to straightforward, relatively risk-free treatment may still lack the competence for more complex treatment with high-risk outcomes.
- A young person's capacity to consent may be affected by their physical and emotional development, as well as changes in their health and treatment.

Legal position in South Africa

In South Africa the position is now governed by legislation. Under the Children's Act No. 38 of 2005, a distinction is drawn between children below 12 and those who are 12 or older. McQuoid Mason[3] summarises the current position in South Africa as follows—

> Children who are 12 or older may consent to medical treatment upon themselves if they are of sufficient maturity and with the mental capacity to understand the benefits, risks, and social and other implications of such treatment to give informed consent. However, for surgical operations, if they sufficiently mature and mentally capable they may consent to surgical operations with the assistance of their parent or guardian. If the child cannot give such consent, the doctor must rely on the consent of the parent or guardian or other legally competent person to satisfy the legal requirement of consent.

As regards a child under 12, or over the age of 12 years but insufficiently mature or unable to understand the benefits, risks and social implications of the medical treatment or surgical operation, the following may consent to medical treatment or surgical operations—

- the parent or guardian;
- in emergencies, the superintendent of a hospital (or the person in charge of the hospital in the absence of superintendent);
- if the parent or guardian unreasonably refuses to give consent or assist, is incapable of doing so, cannot be readily traced or is deceased, the Minister of Social Development; and

[3] Mc Quoid Mason, D. J.: "Provisions for consent by children to medical treatment and surgical operations, and duties to report child and aged persons abuse: 1 April 2010" in *South African Medical Journal.* The specific section numbers in the Children's Act are cited in the article. http://www.scielo.org.za/scielo.php?script=sci_arttext&pid=S0256-95742010001000012#:~:text=The%20Children's%20Act%20states%20that,other%20implications%20of%20such%20treatment

- in all instances where another person who may give consent refuses or is unable to give such consent, a High Court or a children's court.

Legal position in Zimbabwe

It would be possible by legislation or by development of the common law by the courts to allow for situations in which a "mature" child could consent to a medical procedure without the knowledge and consent of the parents. We could adopt the approach that a 13, 14, 15, 16 and 17-year-old child should be presumed to have the capacity to consent unless the doctor decides that the particular child did not have such capacity. We could, however, include a proviso that the parents would have to consent to a major operation to be performed upon the child. Parental consent would be required for a medical procedure on a child who is 12 or below.

By way of comparison it should be pointed out that under the present Criminal Law Code, a child under seven is deemed to lack criminal capacity and there is a rebuttable presumption that a child of 7 or over but under 14 lacks criminal capacity. The Child Justice Bill H.B. 11, 2021 will, when passed, change the age of consent to the age of 12. A child who is 14 but under 18 has criminal capacity unless a lack of criminal capacity can be proven. For the purposes of sexual offences such as rape, a girl who is 12 or below cannot consent to the sexual conduct.

It is submitted that we should follow this approach in Zimbabwe which if consistent with international jurisprudence.

Provision of contraceptives to girls under 18

If the parents have been told by the girl about her past or intended sexual activities and they give their consent to the doctor either to fit a contraceptive device or to supply contraceptives to their daughter and the doctor complies with the request made by the girl with the consent of the parents after explaining the dangers of sexual activity at such a tender age, it is clear that the doctor does not expose themself to any legal action (even though, as we will see below, the male who has sexual relations with the girl is committing a criminal offence).

But what is the doctor's legal position if they supply the contraceptives to the girl after having failed to persuade her to discuss this matter with her parents first so that they are acting without parental consent? The question here is whether the doctor is criminally liable on the basis that they have facilitated the commission of a sexual offence upon the girl? If a girl's parents later discover what the doctor has done, can they sue the doctor for damages?

In Zimbabwe, as in many other countries, many teenagers become pregnant. The law must do all in its power to deter illegal sexual intercourse with girls and to protect girls against sexual exploitation which often leads to pregnancy.

The foremost approach must be to provide sexual education in terms of which girls and boys are strongly advised against engaging in sexual intercourse before they are old enough to comprehend the health risk that early sexuality carries.

However, it is clear that sex education has not stopped teenage sexual behaviour. The question arises as to whether it is better to make contraceptives freely available to the teenagers so that girls can avoid pregnancy. We know that because contraceptives are not freely available, many pregnant children who cannot obtain lawful abortions resort to the untender "mercies" of back street abortionists or try to perform acts to end their pregnancies. These illegal abortions carry a significant risk of death from bleeding, infection, shock and damage

to the cervix and womb when untrained people attempt to perform surgical abortions on themselves or others, often with inappropriate instruments. Material left in the womb, which could cause pain and increase the risk of problems such as infection, is a further risk.

If there are restrictions on supplying contraceptives (which include the so-called day after pill) girls may not access the means to avoid pregnancy. If the girls do not want their parents to know that they are having sexual relations and want access to contraceptives, and the doctor, nurse or pharmacists will not supply contraceptives unless the parents give their consent, the girls may still go ahead, have unprotected sex and may become pregnant. There has, therefore, been pressure to provide contraceptives if various conditions are satisfied.

No one doubts that it is highly desirable for parents to become involved in discussion about the sexual problems of their children. Parents have custody and control over their under-age children and it is expected of parents that they offer advice and guidance to their children on matters such as their sexual behaviour. Doctors are thus expected to do their utmost to persuade under-age patients to communicate with their parents about sexual matters.

It would seem socially undesirable for a doctor to be obliged always to inform the girl's parents and obtain their consent before supplying contraceptives to a girl under 16. In Zimbabwe, illegal abortions and baby killing are a considerable problem. To avoid these drastic and unacceptable phenomena, contraception should be encouraged as much as possible. If girls know that doctors are obliged to disclose these matters to their parents, they may well refrain from approaching doctors and family planning units to obtain contraceptive protection. The end result of this may often be that these girls have unwanted pregnancies which they attempt to deal with either by dangerous illegal abortions or by dumping or killing their babies. Societal interests would be better served by allowing unimpeded access to contraceptives.

What is the situation, then, when young females obstinately refuse to involve their parents on the grounds that their parents will not understand? What happens if, after explaining to such girls the dangers of sexual activity at an early age, the doctor decides to supply contraceptives without parental consent in order to protect the girl against an unwanted pregnancy with all the attendant dangers for persons so young? Would the doctor be criminally or civilly liable to the parents?

In regard to the issue of possible criminal liability, it is first necessary to set out briefly the relevant criminal laws in Zimbabwe contained in the Criminal Law Code. A male who has sexual intercourse with a girl and impregnates her has committed serious criminal offences. He would be guilty of rape if the girl is 12 or below because the law provides that a girl of this age cannot consent to the sexual intercourse. Sexual intercourse with a girl over 12 but under 16 is statutory rape if the girl was a willing participant. This age must now be raised to 18 in the light of the judgment of the constitutional court in the case of *Kawenda v Minister of Justice, Legal and Parliamentary Affairs & Ors* CCZ-3-22. Statutory rape is essentially paternalistic in its nature as it seeks to protect young girls from sexual exploitation and from their own folly due to their immaturity. A person who intentionally facilitates the commission of these crimes or assists another to commit these crimes can be held criminally liable on the basis of accomplice liability: that by supplying contraceptives to an under-age girl they have facilitated commission of the crime of statutory rape upon her by her sexual partner or partners.

There has been no decision in the Zimbabwean courts on this issue but in the United Kingdom the highest court, the House of Lords, had occasion to deal with the legal aspects of this situation in the case of *Gillick v West Norfolk*

Health Authority [1985] 3 All ER 402 (HL).

Approach to contraceptives in the United Kingdom

In the leading case of *Gillick v Norfolk & Wisbech AHA* [1985] 3 All ER 402 (HL) it was decided that in certain circumstances a doctor should be able lawfully to supply contraceptives to a "mature" girl without notifying and involving the parents.

The case stemmed from a circular issued by the DHSS (then the Department of Health and Social Security) aimed at improving contraceptive services for young people. The advice for doctors was that, in exceptional circumstances, girls under 16 could be provided with contraception without informing the parents. It specified that doctors should always seek to persuade these patients to involve their parents but, if they refused to do so, then the doctors would have to decide whether, in the health interests of their patients, to avoid the severe risk of physical and psychological harm associated with unwanted pregnancy at an early age, by supplying contraceptives without the parents being informed. (This might apply particularly where the parents were, for example, unconcerned, entirely unresponsive or grossly disturbed.)

Mrs Victoria Gillick wanted assurances that her daughters would not be provided with contraceptives or abortion advice, without her prior knowledge and consent, until they were 16. When that was refused, Mrs Gillick took her case to court. Her counsel challenged the assumption that, under common law, young people under 16 could be treated without the agreement of a parent. They wanted the DHSS advice to be declared unlawful.

The case went to three courts. At first, Mrs Gillick was unsuccessful, so she took her case to the Court of Appeal, which found in her favour. The DHSS then appealed to the House of Lords where, by a majority, it was held that the original advice circulated by DHSS was not unlawful. Under certain circumstances, a mature child under 16 can give valid consent to medical treatment, including contraception or abortion, without parental knowledge or authority.

In his judgement, Lord Fraser listed the aspects a doctor should consider before giving contraceptive advice to a young person under 16 without parental agreement if—

- she understands the advice and implications of treatment;
- she cannot be persuaded to involve her parents;
- she is likely to have sex with or without treatment;
- she is likely to suffer physically or mentally unless they receive the treatment;
- it is in her best interests to receive advice and treatment without parental consent.

It was held that a doctor who supplies contraceptives after following these steps to an under-age girl would not generally render themselves liable to criminal prosecution on the grounds that they had become an accomplice to the illegal act of statutory rape. The doctor would not face any criminal liability as they had not incited another to commit sexual offences against the girl and nor are they an accomplice to such offences. The doctor was justified in taking the action on the basis of the health interests of the child. So too, the doctor would not be civilly liable to the parents if they had followed these steps.

Should Zimbabwe follow the Gillick case?

There is no Zimbabwean case in which this matter has been dealt with by our courts. It submitted that if such a case were to come before our courts, the court will be likely to follow the approach in the *Gillick* case. As stated

earlier, the court should first adopt the general approach that a girl under 18 should be allowed to decide for herself what medical treatment she will receive providing she has the ability and maturity to understand the nature of the procedure, its purpose and possible adverse consequences of the treatment. (*Gillick* competence).

A doctor should be lawfully permitted to supply contraceptives to a girl who has *Gillick* competence and who does not want her parents involved provided that—

- she understands the advice and implications of treatment;
- she is likely to have sex with or without treatment;
- she is likely to suffer physically or mentally unless they receive the treatment;
- it is in her best interests to receive advice and treatment without parental consent.

Contraception and criminal liability

It is clear that the doctor should not open themself to such liability. Their intention is to act in the best health interests of the girl by protecting her against an unwanted pregnancy. It is obvious that they have neither incited the male to commit the offence nor have they been an accomplice to the male.

The doctor has not incited the crime of statutory rape as they will not have communicated with the male partner of an under-age girl. In addition, they will not have had any intention to assist in the commission of the crime, which intention is a necessary pre-requisite for liability as an accomplice. The doctor's intention is to protect the health interests of the girl and not to encourage her boyfriend to have sexual relations with an under-age girl. Of course, a doctor may know that if they supply contraceptives to an under-age girl who has not yet had sexual relations but who is intending to do so, her boyfriend, who might have been restraining himself for fear of making her pregnant, might then proceed since the girl is now protected against pregnancy. However, there is no evidence that he would not ultimately have had sexual relations with the girl even if she had not been so protected. Thus the doctor has not necessarily caused the illegal act to happen and clearly had no intention to assist the male to commit this illegal act.

Perhaps the only situation in which a doctor might be found liable as an accomplice is if a man aged, for example, 30 came to him and disclosed that he was intending to have sexual intercourse with, for example, a 13-year-old girl and told the doctor that the only way in which he could persuade her to agree to have sexual relations with him was to give her contraceptives to take first. If then the doctor gave contraceptives to the man to allow him to persuade the girl to agree to sexual relations, they could be considered to be an accomplice to the crime committed by the man.

Contraception and civil liability

There is no civil wrong of interference in parental authority. The supply of contraceptives does not constitute a surgical procedure and thus there can be no question of an action for assault arising out of treatment of a minor without consent from the parents. Even if such an action were applicable, the doctor has acted in the best interest of their patient and it is difficult to see on what basis the court could award damages against them. The same absence of a basis for awarding damages applies to the fitting of an intra-uterine contraceptive device without the consent of the parents, even though this is a form of surgical treatment and at face value requires parental consent to prevent it from amounting to an assault.

One last point needs attention and this is the performance of sterilization operations upon minors. Such operations are drastic procedures and should obviously never be carried out upon a minor, even if the minor is

very close to the age of majority and is mature enough to understand the full consequences of the operation, without the parents or guardian of the minor giving their consent on an informed basis after discussion with the doctor. Requests by minors not to involve their parents should not be complied with.

One further provision should be mentioned in this regard. This is s 8(2) of the Children's Act [*Chapter 5:06*]. In terms of this provision it is a crime for anyone to cause or conduce "the seduction, abduction or prostitution of a child or the commission by a child of immoral acts."

It is submitted that a doctor who supplies contraceptives to a girl under the age of 16 would not expose themself to prosecution for this offence as this offence is a crime requiring proof of intention. Clearly the doctor's intention is to protect their patient from the adverse consequences arising out of an unwanted pregnancy and not to cause or conduce her to commit immoral acts. The mischief which this provision seeks to punish is clearly not such protective action by a doctor.

Treatment of child for sexually transmitted infection

The *Gillick* case ruled that a doctor could treat a child for such infection where the child does not want their parents to be involved. It is recommended that this approach be used in Zimbabwe provided the conditions have been satisfied.

Termination of pregnancy of child

In England, the *Gillick* case suggests that provided that the girl is mature enough to understand what abortion entails physically and emotionally, the doctor may go ahead on the basis of her consent alone, and the doctor is not obliged to inform her parents. In the case of *In Re P (A Minor)* (1981) 80 LGR 301, a 15-year-old who already had one child became pregnant again while in local authority care. She wanted to have an abortion. The doctors believed that the birth of a second child would damage her mental health. The girl's father objected on religious grounds. The local authority applied to be made a ward of court and sought authorisation from the court to go ahead with the abortion. Although the court took into account the feelings of the father, it found that it was in the best interests of the girl that her pregnancy be ended.

The present law in Zimbabwe has not recognised that a mature child can decide for herself what medical procedure to undergo without the consent of her parents. If the test of the mature child is accepted by the courts, then the mature child would have the capacity to consent to an abortion on any of the grounds set out in the Termination of Pregnancy Act. As this test has not yet been accepted, it would seem that the consent of the parents would be required for the abortion even for the mature child. However, situations could arise as in the English case of Re P, where the court may decide that an abortion is in the best interest of the child despite parental objection to the abortion.

Under the Termination of Pregnancy Act medical practitioners can lawfully terminate a pregnancy of a girl who has been raped provided a magistrate has certified that there is a reasonable possibility that the pregnancy was the result of rape. With the consent of the girl and her parents, the medical practitioners can carry out the termination. But what if the girl, who is sufficiently mature to have competence, decides that she wants a termination but the parents, for religious reasons, refuse to consent. Here the medical practitioner can apply to a magistrate for authorisation to allow the medical practitioner to proceed without the parents' consent where this is in the best interests of the child.

Parent or guardian unreasonably refusing consent to medical treatment

Where the parent or guardian unreasonably refuses to consent to necessary medical treatment of a child, such as a blood transfusion or operation, s 76 of The Children's Act [*Chapter 5:06*] provides that, on application, a magistrate may authorise medical treatment after due inquiry, including hearing from parent or guardian where reasonably practicable. If the magistrate is satisfied that the treatment is necessary in health interests of a minor, they may order the treatment to take place. If it is an emergency where a procedure is immediately necessary to save the life of the child or avert serious harm to the child, the doctor would be legally justified in proceeding despite the objections of the parents on the basis of necessity.

In terms of s 9(13) the Children's Act it is a criminal offence for a parent or guardian, without reasonable cause, to deny medical treatment or access to medical treatment to a child. The penalty for this offence is a fine or imprisonment for up to 6 months or both these penalties.

The Medical Services Act [*Chapter 15:13*] has been amended to align it with the Constitution by providing in a new section 8D for the rights of children to access health services. "It shall be unlawful for any parent or guardian of a child to prevent a child from receiving any health service which is in the best interests of the child concerned, or to withhold consent for any health service in contravention of section 60(3) of the Constitution". Anyone contravening this provision can be fined or jailed for up to a year or given both if Parliament approves the Bill.

Section 60(3) of the Constitution provides that parents and guardians of minor children have the right to raise their children in accordance with their moral and religious beliefs. However, they may not do this in a way that prejudices the fundamental rights of children to health, safety and welfare. Thus Jehovah's Witness parents may not refuse to allow their child to receive a blood transfusion that is necessary to save the child's life.

In South Africa in terms of the Children's Act No. 38 of 2005, a parent or guardian of a child may not—

(i) refuse to assist a child who consents to a surgical procedure, or

(ii) withhold consent for medical treatment or a surgical operation solely on the grounds of religious or other beliefs — unless such parent or guardian can show that there is a medically accepted alternative to the medical treatment or surgical operation concerned.

Consent to clinical trials of medicines upon children

Under s 20(1)(b) of the Medicines and Allied Substances Control Act [*Chapter 15:03*], even if the authority has granted written authorisation for the conduct of a clinical trial, the trial may not take place upon minors or persons under legal disability until the parents or guardians have voluntarily and freely given written consent thereto.

If agreement about a particular treatment or what is in the child's best interests cannot be reached, the courts can make a decision.

Duties and responsibilities in relation to abused and neglected children

The Children's Amendment Bill H.B. 12, 2021 compels medical practitioners and other health care providers to report abused or neglected children to a designated child protection organisation, the provincial department of social development or a police official. Health care providers include dentists, homeopaths, medical practitioners, midwives, ministers of religion, nurses, occupational therapists, physiotherapists, psychologists, speech therapists, traditional health practitioners, and members of staff or volunteer workers at partial care facilities, drop-in centres or child and youth care centres who on reasonable grounds conclude that a child has been

physically injured, sexually abused or deliberately neglected.

If the report of abuse is substantiated on the prescribed form, made in good faith, and reported to the relevant designated child protection organisation, the provincial department of social development or a police official, the person making it cannot be held legally liable.

Children and abusive relationships

If what the young person tells in confidence leads the medical practitioner to believe they may be involved in abusive or seriously harmful sexual activity, they must share this information with appropriate people or agencies (e.g. the police or social services).

Factors suggesting an abusive relationship—

- the young person is too immature to understand or consent;
- there is a big difference in age, maturity or power between sexual partners;
- the young person's sexual partner is in a position of trust;
- there is force or threat of force, emotional or psychological pressure, bribery or payment to engage in
- sexual activity, or to keep it secret;
- drugs or alcohol are used to influence the young person to engage in sexual activity;
- the sexual partner is known to the police or child protection as having abusive relationships with children.

Discretionary authority to report children in need of care and protection

Any person, including a medical practitioner, who on reasonable grounds believes that a child is in need of care and protection may report that belief to the provincial designated child protection organisation or a police official. The reporting person has a degree of discretion about whether or not to make a report. The report must be substantiated in the prescribed manner and, if made in good faith, the person making it is not liable to a civil action. The provision applies to anyone – not only the above listed persons who are legally obliged to report child abuse or neglect.

Mentally incompetent persons and medical consent

Mentally incompetent persons are usually unable to comprehend the nature of any medical treatment that they may require, thus they are normally unable to give their consent thereto. Thus the law allows for substitutionary consent to be given on behalf of such persons. This matter is dealt with later in more detail.

Compulsory treatment of infectious diseases

It is obviously socially imperative that highly infectious and dangerous illnesses be prevented from spreading. Thus any society is entitled to take urgent and decisive measures to ensure that such diseases do not proliferate. These measures must include the power to quarantine and treat persons suffering from such diseases, if necessary, on a compulsory basis if such persons refuse to submit themselves voluntarily to such treatment. In Zimbabwe the public health authorities have such powers in terms of the Public Health Act [*Chapter 15:17*]. Some of the important provisions contained in this Act are—

- s 17 which lists the infectious diseases for which persons can be placed in isolation and treated on a
- compulsory basis;
- s 24 and s 26 which detail the various measures which can be taken by the medical officer of health and
- local authorities in respect of persons suffering from infectious diseases.

With respect to venereal diseases as defined in s 47 of the Public Health Act, in terms of s 53, where venereal

disease is believed by the Chief Health Officer to be prevalent in a certain locality, examination of residents of the area may be ordered and residents who refuse to submit themselves to such examination will be guilty of an offence. (It should be noted that under s 54 females are entitled to refuse to be examined by male doctors if female medical practitioners are available.)

Defence of necessity and medical practice

As we will see, there are a number of medical situations in which, if a doctor or nurse takes a certain action which could lead to them being held civilly or criminally liable, the defence of necessity may be raised. Mason and McCall Smith[4] describe this defence as follows—

> It is widely recognized in both criminal and civil law that there are certain circumstances in which acting out of necessity legitimates an otherwise wrongful act. The basis of this doctrine is that acting unlawfully is justified if the resulting good effect materially outweighs the consequences of not adhering strictly to the law.

In the context of consent, if, in committing the wrongful act of performing the treatment without the normally required consent, a doctor was protecting a far more important value, such as saving a patient's life, then their action would be justified and they would not be criminally or civilly liable.

An example of such a situation is when medical intervention is required immediately if the patient is to survive and it would take time to contact relatives to obtain substitutionary consent. In this case, a doctor who proceeded with a life-saving procedure without first obtaining substitutionary consent because there was no time to do so would be protected against legal liability on the basis of necessity. It must be emphasised, however, that this only applies to dire emergencies. Where there is time to allow a patient to recover from a temporary incapacity and there is no need to render treatment immediately, the patient should be allowed to recover their faculties and consent to the proposed treatment before it is carried out. This rule applies particularly to drastic procedures with long range consequences for the patient.

The same principle applies in other emergency situations, for example, where immediate action is required and the patient is unable to give consent because they are suffering from a short-term mental incapacity such as that caused by heavy intoxication from consumption of alcohol or other drugs; from heavy loss of blood as a result of a serious motor accident; or from prior administration of a general anaesthetic. In these cases, treatment without consent would be justified on the basis of necessity if substitutionary consent is not timeously available.

Must the patient's consent be in writing?

At law, oral consent is perfectly valid. The problem with oral consent is that, as there is no evidence in writing, disputes may arise later as to exactly what the patient was told by the doctor and what the patient consented to. It should also be noted that consent may be expressed or implied. Consent is implied when a patient presents themself to the doctor for examination and then acquiesces in the suggested routine. The problem with implied consent, as with oral consent, is that there is no material evidence of an agreement between doctor and patient.

From a legal point of view, therefore, it is always safer for doctors to obtain written consent to any intended medical procedure. In other words, after explaining properly to the patient in simple language the proposed medical procedure and its probable or special attendant risks, the main details of the procedure and its main risks

[4] Mason and McCall Smith p. 13.

should be put in writing and the patient should then be asked to sign this document to indicate that they have consented to this treatment with its listed attendant risks. This is particularly important in respect of surgical operations or where the treatment is very drastic or unusual. In these cases, signed written consent in which the nature of the treatment is described in detail should be obtained. For example, in Zimbabwe Government hospitals patients are required to sign the "Consent to Operate" form (see below).

62326-8

Consent to Operate

Hospital ..... Date .....20.....

I, the undersigned, hereby consent to the administration of anaesthetics and the performance of any operation upon ..... (Patient's full name), for ..... (Nature of operation), the nature of which operation or operations has been explained to me. I further agree to the performance of any additional or alternative measure that may be considered necessary by the surgeon during the course of the operation

Witness ..... *Signature*.....

N.B. This consent form should be completed by anyone over the age of 21 years to whom an anaesthetic (other than a minor local anaesthetic) is to be administered or who is to have an operation. In the case of a person under the age of 21 years, the signature of the father, mother or guardian must be obtained or, failing that,, the consent of a magistrate in terms of the Children's Protection and Adoption Act [*Chapter 33*]. When the form is signed by a person other than the patient, the capacity in which he signs should also be indicated, i.e. Parent, guardian, curator, etc, of the patient.

Having the patient sign this consent form also serves as a valuable reminder to the medical practitioner of the need to explain to the patient about the treatment, risks and alternatives, and obtain their consent.

However, the wording of the current consent form presents several problems. The first is simply a technical matter, namely that the age of 21 should be altered to 18 in the light of the fixing of the age of majority at 18 in the Legal Age of Majority Act and in the Constitution of Zimbabwe.

Another problem is, as stated earlier, that the law requires informed consent from the patient. As we now know, this requires that the doctor explain to the patient not only the nature of the intended operation, but also the risks involved and the possible consequences of the operation. Only then can the patient make an informed decision as to whether to give consent. Therefore, additional words similar to those in the American form of consent shown in the Annexure 2 should be added to indicate explicitly that the nature of the risks of the intended operation have also been adequately explained to the patient.

Finally, and even more fundamentally, there are considerable legal difficulties with the sentence in the consent form that reads "I further agree to the performance of any additional or alternative measure that may be considered necessary by the surgeon during the course of the operation."

The objective of this provision is to allow the surgeon to deal with the condition that necessitated the operation by carrying out additional measures indicated by discoveries made during surgery. Thus if somewhat more extensive surgery than was originally anticipated is required to cure the condition, it would be unreasonable to have to sew the patient up and seek further consent to more extensive surgery after they have recovered from the first operation. In the health interests of the patient it should be permissible for the more extensive surgery

to take place without further consent being sought from the patient, hence the requirement for this provision in the consent form.

The problem with this provision as it stands is in the general nature of its wording. It could be read as allowing the surgeon to perform whatever additional or alternative surgical measures they saw fit. The question then arises as to whether a doctor who has obtained consent from a patient to perform a minor surgical operation may go ahead with a major operation on the patient if they concluded that this was necessary, even though this major surgery involved much greater risks for the patient or would have far greater consequences for the patient in the future? Surely the answer is no. A patient who has consented to a minor operation on themself has not consented to amputation of the leg, and a surgeon should obviously not be permitted to amputate without the patient's consent. Thus the provision does not provide doctors with protection from legal action based upon lack of consent if a drastic and completely different "additional or alternative" operation from the one which had been explained to the patient and for which the patient's consent had been obtained was performed.

See Annexure 2 for some sample forms from other countries which are much more comprehensive in content.

The patient should, of course, be advised that they should read the details on the consent form carefully and that they should not sign it if there is anything contained therein which they disagree with or do not understand. If the patient is illiterate, the contents of the consent form should be read to them before they are required to place their mark thereon.

This approach would have the effect of assuring the patient that the doctor is making an effort to ensure that the patient is fully conversant with the proposed action and accepts that it is in their interest.

When deciding whether to consent to a proposed course of treatment or not, a patient is entitled to ask and receive information in response to questions such as—

- Why do I need this treatment or operation and are there any alternative courses of action?
- How often have you performed this type of procedure in the past?
- Exactly what will be done?
- Are there any risks attaching to it?
- Will there be any side effects from the drugs?
- How long will it take to recover?
- What will happen if I don't have the treatment?

The doctor who is to carry out the treatment or to perform the operation is the most suitable person to explain the nature of the operation or treatment and its risks to the patient. It follows that, wherever possible, the doctor should do this and obtain the patient's consent after answering any questions the patient may have. However, after the doctor has properly explained the intended procedure and its risks, should a patient ask for time to consider whether they should have the treatment or not then a nurse may obtain the patient's signature on the consent form which sets out the details of the doctor's explanation.

When an operation is necessary it is very important that at least one of the nurses attending to the patient be present when the doctor tells the patient about the operation. Frequently, it may take time for the patient to digest what the doctor has told them and it may only be after the doctor has left that questions occur to the patient. Also the patient may become apprehensive after hearing stories about the operation from other patients. They may then seek more information or clarification from nurses if they cannot speak to the doctor again.

If the nurse was present when the doctor explained the operation to the patient the nurse will be in a good position to answer the patient's queries. If the nurse was not present, they will be uncertain of what information the patient was given and this may make them reluctant to speak to the patient for fear of contradicting the doctor's information.

If a doctor decides to delegate the responsibility of explaining the operation and of obtaining the patient's consent to a nurse, they must provide the nurse with full particulars of the planned operation so that the nurse is in turn able to provide the patient with all the necessary information and to answer the patient's questions properly. Unfortunately, at present nurses are often assigned the task of informing patients about their operations and obtaining their consent without adequate information from the doctor.

Consequently, nurses may not be able to provide their patients with adequate information. When asked questions, they may be unable to answer. This in turn may cause patients to withhold consent to much needed operations.

If a patient refuses to sign the consent form, the nurse should inform the doctor who should then interview the patient to ascertain why they are refusing to sign. Similarly, if a patient expresses reservations or lays down any conditions upon signing, the surgeon should be informed before the operation takes place so that the surgeon can decide whether to go ahead or to interview the patient again before proceeding.

Patient's legal remedy against doctor or nurse

As we have seen in this chapter, there are two types of cases which can lead to patients harbouring grievances against doctors. The first and most drastic case is where a doctor has performed a medical procedure upon a patient without obtaining the patient's consent for that procedure. The second is where a doctor has obtained the patient's permission to carry out a certain medical procedure, but has failed to inform the patient about the material risks attaching to that procedure and so it cannot be said that the patient has given informed consent to the treatment. We will deal with each of these situations in turn and examine the legal basis for the action for damages.

Proceeding without consent

If a doctor carries out a therapeutic operation upon a patient who has given consent thereto, the doctor's action is lawful (unless, of course, they performed the operation in a negligent fashion). But if they carry out that operation without the patient's consent, their action will amount to an unlawful assault upon the patient for which they can either be criminally prosecuted or sued in a civil action. (In both criminal and civil law an assault is an intentional aggression upon the body of another.)

In a civil action for assault, the person claiming against a doctor can recover compensation for pain and suffering and for any financial loss stemming from the uninvited intrusion upon their body (e.g. if the unauthorised treatment worsened the patient's condition and further medical treatment was required for which the patient had to pay, or the patient lost wages as a result of being away from work due to the unauthorised treatment). This would also apply where a doctor gave treatment different from or in excess of the treatment agreed to. Even if the unauthorised treatment was carried out in order to prevent greater harm to the patient (e.g. if, without seeking the patient's consent, a doctor amputated a gangrenous limb in order to prevent the patient from dying), the patient is still entitled to claim damages against the doctor for violating their right to decide for themself whether to receive a particular form of treatment or not. (Here the claim would be under the *actio injuriarum* for

infringement upon the patient's personal rights of dignity and privacy.)

Proceeding with consent but without disclosing material risks

If the doctor obtains consent, but does so without disclosing the material risks involved, it would seem that the appropriate action in terms of which damages could be claimed is not the action for assault but instead the Aquilian action. In order to succeed under the Aquilian action the person claiming damages would have to prove that—

- the doctor was negligent in failing to inform the patient of the risks involved in the medical procedure (i.e.
- that a reasonable doctor would have done so); and
- the patient suffered injury as a result of the procedure, which injury they would not have suffered had
- they been informed of the risks involved in the procedure since had they been so informed, they would
- have declined to have the medical treatment in question.

However, if the court were simply to accept without more evidence the claimant's assertion that they would not have had the medical treatment in question had they known in advance of the risks involved this would be unacceptable as it would be only too easy for this assertion to be made, even when it was not true.

Thus it would be safer for our courts to adopt a more objective approach and deal with this issue by asking whether a reasonable patient with the characteristics of the patient concerned would have given consent when confronted with full information of the risks and difficulties attaching to the procedure in question. (This was the test adopted in the Canadian case of *Reibl v Hughes* (1980) 114 DLR (3d) 1.)

It should be pointed out that there is no reported case in Zimbabwe in which a doctor was made to pay damages for failure to obtain consent to a procedure or failure to inform a patient as to the risks attaching to a procedure. In other countries, the action arising out of failure to obtain consent or informed consent has tended to be the action which is brought as a last resort when no other more obvious medical negligence is evident.

In the future, however, as patients become more aware of their rights it is quite possible that doctors will be sued if they disregard patients' rights to self-determination; to be supplied with adequate information; and to decide for themselves on the basis of this information whether they will permit a particular treatment or not. If this happens, our courts will have to develop proper principles and policies to deal carefully with such actions.

Although there are no reported cases of doctors or nurses being sued for damages under the *actio injurarium***,** aggrieved patients may well bring such actions against indiscreet doctors or nurses in the future.

Finally, in terms of the Medical Practitioners (Professional Conduct) Regulations it is provided in s 22 that—

No practitioner shall divulge, either orally or in writing, any confidential information concerning his patient which ought not to be divulged, except

a) where so required by law; or
b) with the consent of that patient; or
c) where the patient—

(i) is a minor, with the consent of the parent or guardian of the patient, or
(ii) has died, with the consent, in writing, of the executor or next of kin of that patient.

Any breach of this provision will amount to improper or disgraceful conduct in terms of s 3 of these regulations. See also s 6 of the Nurses and Midwives (Professional Conduct) Regulations Statutory Instrument 340 of 1982.

Cases on treatment without consent

Case 1

No consent to deep X-ray treatment (South Africa)

In *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T), at the age of 10 the plaintiff was found to have a disease which involved the spreading of malignant tumours from the extremities inwards throughout the body. This disease would ultimately prove fatal unless checked. On two occasions the patient had received superficial X-ray treatment with the parents' consent and for a while the patient appeared to be cured. Four years later, further tumours were discovered at the extremities and the mother took the child into hospital for treatment. (The father had died by this time.) She assumed that the child would receive the same type of superficial X-ray treatment as before and no-one told her otherwise. In fact, the young patient was given deep X-ray treatment, in consequence of which the patient was severely disfigured: her legs and right hand had to be amputated and the left hand would also probably have to be amputated.

The court found that the doctor was liable to pay large amounts of damages. It held that where such an extreme technique was to be employed, the doctor should have explained the situation and the resultant dangers fully and should have obtained consent to the technique before proceeding.

Case 2

Whether patient told of risk of stroke during surgery (Canada)

In *Reibl v Hughes* [1980] 2 S.C.R. 880, while or immediately after undergoing serious but competently performed surgery to reduce the chances of suffering a stroke, the patient suffered a massive stroke causing paralysis on the right side of the body and impotence. Stroke paralysis, or even death, were among the risks attending both this surgery or its aftermath and the patient's refusal to undergo the operation. In answering the patient's query about the possibility of stroke, the surgeon did not inform him of his chance of being paralyzed during or shortly after the operation but stressed that the chances of paralysis were greater if the patient did not undergo surgery. The patient testified that he would have foregone this elective surgery until a lifetime retirement pension had vested in a year and a half, and would have opted for a shorter, normal life rather than a longer one as a cripple. The court said that merely because medical evidence established the reasonableness of a recommended operation did not mean that a reasonable person in the patient's position would necessarily agree to it if proper disclosure had been made of the risk attendant upon it, balanced by those against it. The patient's particular situation and the degree to which the risk of surgery or no surgery were balanced would reduce the force, on objective appraisal, of the surgeon's recommendation. In deciding what decision a reasonable person in the patient's position would have made, the patient's particular position should be considered objectively and not subjectively. Here, a reasonable person in the plaintiff's position would, on the balance of probabilities, have opted against the surgery rather than undergoing it at the particular time.

Case 3

Amputation of penis without consent (South Africa)

In *Stoffberg v Elliot* 1923 CPD 148, the patient was being treated for cancer. While the patient was under anaesthetic, the doctor found that the patient's penis was cancerous and amputated this organ on the grounds that this was necessary to prevent the cancer from spreading further and endangering the patient's life. The doctor admitted that there had been no express consent to this operation, but argued that the patient had impliedly consented to undergo whatever treatment was necessary to treat his condition.

The court found the doctor liable. It stated—

> … in the eyes of the law every person has certain absolute rights which the law protects. They are not dependent on statute or upon contract, but they are rights to be respected, and one of the rights is absolute security to the person... Any bodily interference with or restraint of a man's person which is not justified, or excused or consented to is a wrong... [A] man by entering a hospital does not submit himself to such surgical treatment as the doctors in attendance upon him may think necessary... He remains a human being and he retains his rights of control and disposal of his own body; he still has the right to say what operation he will submit to, and ... any operation performed upon him without his consent is an unlawful interference with his right of security and control of his own body, and is a wrong entitling him to damage if he suffers any.

Case 4

Removal of testicle during hernia operation (Canada)

In the course of an operation on a hernia, the doctor had discovered that his patient had a grossly diseased left testicle. He had formed the opinion that if the testicle was not removed it might become gangrenous; pus from the diseased organ might be absorbed into the blood circulation and a condition of blood poisoning might result. The patient, at the time, was under general anaesthetic and rather than wait until the patient's consent could be sought, the doctor had simply removed the diseased organ. The patient brought an action for damages against the doctor alleging unlawful interference with his right of security and control of his body. The defence of the doctor was that if the testicle had not been removed, the patient's health and life would have been jeopardized *Marshall v Curry* (1933) 3 DLR 260; (Whincup, M. 115; Skegg (1974) 90 *LQR* 512 at 516). The court stated—

> …where a great emergency which could not be anticipated arises a doctor will be justified in acting in order to save the life or preserve the health of his patient." It found that in the present case the doctor had discovered conditions which neither party had anticipated and which the defendant could not reasonably have foreseen" and that in removing the testicle the doctor had acted "in the interests of his patient and for the protection of his health and possibly his life.

As the removal of the testicle was necessary to protect the patient and as it would have been unreasonable to have postponed the removal to a later date, the doctor's action was held to have been justified.

Case 5

Forced sterilization of HIV positive pregnant women (Namibia)

In 2014 Namibia's Supreme Court upheld a High Court ruling that health workers who had sterilized three HIV-positive women without their consent had acted illegally. The health workers had sterilized the woman to prevent further pregnancies so that the women would not transmit HIV to their babies.

The court found the health workers in government hospitals had either coerced HIV-positive mothers in labour to sign sterilization consent forms or made them sign when they did not fully understand what they were signing. One woman signed a formthat used only acronyms to describe procedure, while another signed after being told she didn't have a choice. The Court said sterilization is a drastic procedure to treat HIV-positive women to prevent HIV transmission to their babies as mother-to-child transmission of HIV and AIDS can be prevented with medication. *Government of the Republic of Namibia v LM & Ors* (SA 49 of 2012) [2014] NASC 19 (03 November 2014).[5]

[5] See *https://www.bbc.com/news/world-europe-63863084* regarding forced sterilization of pregnant women in Namibia.

Since the case was filed in 2009, dozens more women have told stories of similar experiences at public hospitals to the Namibian Women's Health Network.

Case 6

Failure to warn of remote risk (United Kingdom)

In *Chatterton v Gerson* [1981] 1 QB 432, the patient suffered intense pain from a post-operative scar. As all other methods of obtaining relief had failed, she was sent to a pain clinic where the defendant doctor administered an intrathecal injection to block the sensory nerve. The pain was temporarily relieved but the patient experienced numbness in her right leg. After some months the pain returned and the doctor then administered a second spinal injection. He did not warn her of possible side effects as he considered that the second operation involved no more risk than the first operation. The second operation failed to relieve the pain, but instead her right leg became completely numb and she suffered from considerably impaired mobility.

The patient sued the doctor on the basis that the doctor had proceeded without obtaining real consent from her, as he had failed to give her adequate explanation of the nature and implications of the treatment and in particular, of the risks involved. It was argued that the doctor had committed a civil wrong by failing to explain these risks to the patient so that her consent to undergo the treatment did not constitute proper consent such as to protect him against liability.

The court found the doctor not liable on the grounds that informed consent had in fact been obtained. The woman adequately understood the general nature of a nerve block treatment. There was no real risk of misfortune involved in this procedure. Thus, as the doctor only had an obligation to inform the patient about real risks of misfortune inherent in the procedure, the doctor had not committed a wrong in this case. The judge went on to say that in what the doctor "says to his patient any good doctor has to take into account the personality of the patient, the likelihood of misfortune, and what in the way of warning is for the particular patient's welfare."

Case 7

Failure to warn of risks of electro-convulsive therapy (United Kingdom)

In *Bolam v Friern Hospital* [1957] 2 All ER118, a mentally ill patient received a fracture whilst undergoing electro-convulsive treatment. The risk of this happening had not been explained to him.

The court held that, in the light of the patient's condition, the doctor was entitled to proceed without explanation of the risk involved, especially as the risk was minimal.

Case 8

No warning of slight risk (United Kingdom)

In *Hatcher v Black* (1954) *The Times* (England), July 2/754, the plaintiff was a singer who suffered from a goitre. The surgeon discussed with her the alternatives of a thyroidectomy, which he regarded as much the wiser course, or lengthy drug treatment. He told her there was no risk to her voice in the operation, although he knew there was, inevitably, a slight risk. Because the risk was so slight and because it was vital that she should not worry about the operation, the surgeon felt this untruth was justified. The patient took the doctor's advice and consented to the operation. Unfortunately, her laryngeal nerve was damaged in the operation and her left vocal cord was paralysed.

The judge ruled in this case that the doctor was not to be blamed for his conduct. The doctor had to decide what he should tell his patient in a case like this and he had to take this decision with reference to the patient's health

interests. However, he added that if doctors were habitually evasive, they would lose the trust which was so essential to the relationship of doctor and patient.

Case 9

No warning of slight risk (Canada)

A patient went into hospital for a voluntary sterilization operation which involved a very small risk of bowel perforation. The doctor was held liable for failing to disclose this risk to the patient. He said that "it may well not be necessary to warn a patient – it may well be a disservice – of minimal risks where an operation is essential or advisable for his continued good health." However, in the present case, although the danger was not great, it was real and outside that inherent in any operation and it had not been established that, if the risk had been disclosed to the patient, she would have still agreed to undergo the operation. This case seems to suggest that the amount of information to be given to the patient may be determined to some extent by the necessity or otherwise of the operation.

Case 10

Unauthorised sterilization (United Kingdom)

Damages were awarded for loss of ability to conceive and a resultant serious neurosis for an unauthorised sterilization performed in the course of a minor womb operation because the surgeons found the womb was ruptured and believed it would rupture again in any further pregnancy.

Case 11

Unauthorised sterilization (Canada)

In the course of carrying out a Caesarian section, the doctor discovered a number of fibroid tumours in the walls of the patient's uterus. He became concerned with the hazards she would face if she had another pregnancy and, after consultation with the doctor who was assisting him, he decided to tie the patient's Fallopian tubes. The patient later brought an action for unlawful interference with her right of security and control over her body.

The judge distinguished between the situation where the operation was "necessary in the sense that it would be, in the circumstances, unreasonable to postpone the operation to a later date" and the situation where it was merely "convenient" to perform the operation without having to wait until the consent of the patient was obtained at a later date. He said that if an operation is "necessary" (as opposed to being merely convenient) for the protection of life or even for the preservation of the health of the patient a doctor is justified in proceeding without consent. In the present case, however, although probably the great majority of women would want it, it would not have been unreasonable to have postponed the sterilization procedure until the patient had given her consent thereto and thus the patient was awarded damages.

Case 12

Unauthorised sterilization (United Kingdom)

A woman was sterilized without her consent during her third Caesarian delivery because the doctor thought her life would be in danger if she became pregnant again. The woman who was a Catholic said that she would have preferred death to sterility.

The woman recovered damages from the doctor.

Case 13

Risk of scarring (Canada)

In *White v Turner* et al 1982 Can LII 1919, the patient had a breast reduction operation which had left her with large scars, the possibility of which had not been adequately explained to her. The doctor was held liable to pay damages to her.

In a lighter "vein", there is a reported American case in which a woman had successfully sued a doctor who had carried out a cosmetic operation to remove a scar on her neck. She had been assured by the doctor that he would be able to remove this scar without having to take a skin graft from another part of her body. When he was carrying out the procedure, however, he found that a skin graft was necessary to cover the scar, so he proceeded to take skin from her belly for this purpose. The woman who was a belly dancer by profession, was most unamused by the unauthorised taking of the skin from her belly and proceeded to sue the doctor for damages for proceeding with the skin graft without her consent.

Case 14

Very remote risk of burns during X-ray treatment (South Africa)

A woman who was receiving X-ray treatment for fibrositis of the uterus sustained bums as a result of this treatment.

It was alleged that the doctor was negligent in not informing the patient of the risk of burns. Because such burns were rare and only a very remote possibility, the court found that the doctor had not been negligent in failing to warn her of such a remote risk. (The court did say that if the procedure was dangerous and might end in death or it would be accompanied by great pain, then there would have been a duty to warn of such risks in general terms, although the doctor would not have been obliged here to point out in meticulous detail all the complications which could arise.)

There is no obligation on the physician to disclose details of rare, uncommon, unusual or remote adverse consequences that may result from the proposed intervention (*Lymbery v Jeffries* 1925 AD 236; *Esterhuizen v Administrator Transvaal* 1957 (3) SA 710 (T)).

The court in *Sidaway v Board of Governors of Bethlem Royal Hospital and the Maudslet J Hospital* [1985]1 All ER 643-653 referred to the scope of the privilege as follows—

> This exception enables the doctor to withhold from his patient information as to risk if it can be shown that a reasonable assessment of the patient would have indicated to the doctor that disclosure would have posed a serious threat of psychological detriment to the patient.

Case 15

Risk of complications—very remote possibility (South Africa)

In *Richter & Anor v Estate Hammann* 1976 (3) SA 227 (C), a patient approached a neuro-surgeon for treatment for severe pain which the patient was suffering in the aftermath of a fall. The neuro-surgeon administered a phenol block to the lower sacral nerves. The pain was relieved, but there were further consequences in the form of loss of control of the bladder and bowel, loss of sexual feeling and loss of power in the right leg and foot.

The doctor was sued on the basis that he had been negligent in failing to warn the patient of the risk of these other consequences occurring.

The court held that the doctor was not liable because there was only a very remote possibility of complications stemming from this procedure and thus there was no duty to warn of such a remote risk.

Case 16

Risk of having abnormal child

In *Friedman v Glicksman* 1996 (1) SA 1134 (W), a doctor wrongly advised a pregnant woman that she was not at greater risk than normal of having an abnormal or disabled child. After she gave birth to a disabled child, the woman was entitled in her personal capacity to sue doctor for damages under the *lex Aquilia* for expenses of maintaining and rearing her disabled child and future medical and hospital expenses. But she was not entitled to sue as mother and natural guardian for child's general damages and loss of earnings either in contract or delict.

Clinical trials of drugs

Under Part III of the Medicines and Allied Substances Control Act [*Chapter 15:03*] there are stringent control measures for the conducting of clinical trials of drugs and comprehensive safeguards for the safety of persons taking part in such trials. (The provisions in respect of trials using animals will not be dealt with here.)

All clinical trials of drugs require written approval from the Drugs Control Council.

It is provided in s 20 that when the Authority grants written authorisation for the conduct of a clinical trial of a medicine, no such trial may take place until—

- in the case of a medicine for the treatment of adult persons, the voluntary written consents of all such persons taking part in the clinical trial have been freely obtained; and
- in the case of a medicine for the treatment of minors or persons under legal disability, the voluntary written consents of their parents or legal guardians, as the case may be, have been freely obtained.

Before commencing such a trial, the person conducting it must inform participants of—

- the aims and objectives of the clinical trial and the way in which it will be conducted; and
- the possible risks, discomforts and other adverse effects that may result therefrom;
- insure participants against any injury or risk of injury during the trial; and
- they must sign a form indemnifying the State and the Medical Council against any liability for harm resulting from the trial.

The Council is empowered to stop the trial if, taking into account initial risk, discomforts or other adverse effects for participants, it is satisfied that it is not in the public interest to allow the trial to continue. In addition, the Council must monitor the trial throughout to ensure that the trial is being properly conducted.

MEDICAL NEGLIGENCE

Introduction

The law requires that everyone in society should exercise reasonable care when going about their various activities. Careless conduct often results in harm to others and social interaction would be almost impossible if there was no obligation to exercise reasonable care so as to avoid causing harm to others. Thus the law says that if a person fails to display due care and the failure results in harm to another, the person causing the harm can be legally responsible for that harm. The failure to exercise reasonable care referred to as "negligence", or to put it another way, a person is negligent when they fail to exercise reasonable care. A few examples of negligence conduct can be given—

- If a car driver causes an accident by carelessly failing to stop at a robot or carelessly driving at an excessive speed, they can be brought before a court of law to answer for their negligence.
- If a person carelessly starts a fire and that fire spreads and causes injury to a person or damage to property, again the negligent person can be held accountable for their negligence in court.

The duty to avoid causing harm by negligence rests on all people in our society. A person can be legally liable if they cause the death of, or harm to, another person in circumstances in which a reasonable person would have foreseen and guarded against causing the death or injury. Under this fault-based system, the injured party would have to prove that the person against whom the claim was made negligently caused the harm to the claimant.

Doctors and nurses are qualified persons who are members of the medical profession. As will be seen below, they will be found to be negligent if they have failed to measure up to the standard of the reasonably competent members of their profession. If they have not, and the negligent conduct has caused harm to the patient, they can be sued for damages by the injured party. Injured parties often face considerable problems in obtaining compensation under the fault-based system. Before addressing the drawbacks of the fault system of liability, it is first necessary to deal in detail with the way in which the courts have applied the standard of negligence to doctors and nurses.

The test for negligence in medical cases

Doctors and nurses are professional people who have received lengthy and intensive training to equip them with the necessary skills to practice their often-exacting profession proficiently and with a reasonable degree of skill and competence. After qualification, doctors acquire practical experience under supervision and if they wish to become specialists, they have to sit further examinations after acquiring specialist skills under supervision. Doctors therefore have skills that others do not have and they are required to make good use of these skills.

Patients are thus entitled to expect that they will receive reasonably competent care and treatment from qualified medical personnel. The law reflects this legitimate expectation by prescribing that qualified medical practitioners must bring to bear upon their work that degree of skill and competence which would have been displayed by any other competent doctor with a comparable amount of training and experience. See *Ashcroft v Mersey Regional Health Authority* [1983] 2 All ER 245 (QB).

The law requires doctors to behave as ordinary, reasonably skillful doctors would have behaved in the circumstances. They are not obliged to exercise the skill possessed by a doctor who has acquired the highest possible skill and expertise in their calling. They are expected to exercise a reasonable degree of care and skill.

The doctor is not expected to be a miracle worker guaranteeing that they will cure the patient and restore them to full health. Some medical conditions are incurable and some may be extremely difficult to cure. However, a doctor who misguidedly contractually binds themself to cure a patient and fails to do so would be liable for their failure.

Non-specialist doctors

Non-specialist doctors, such as general practitioners, will be held to be negligent if they cause harm to their patients by acting in a manner that no reasonably competent general practitioner would have acted. One example of negligence by a general practitioner is where the doctor carelessly prescribes the wrong drug or the wrong dosage of the right drug.

Specialist doctors

Doctors who have received additional training in order to qualify as specialists are expected to exercise a higher degree of proficiency in their chosen areas of special expertise than doctors who do not hold such specialist qualifications. The test for negligence in respect of such doctors is whether they have displayed that degree of skill which a reasonable specialist in that field would have displayed. Thus the actions of a top brain surgeon would be tested by using the standard of a reasonably competent specialist in this field.

A doctor who is not a specialist may not attempt to carry out a procedure that requires specialist skill unless it is a life-threatening emergency situation and there is no specialist available to carry out the procedure.

This test is applied to all stages of the medical care. It applies when the doctor is diagnosing the ailment; to the administration of drugs to the patients; to the performance of surgery on the patient and to post-operative care of the patient. Thus, when a case of medical negligence comes before the courts, the judge or magistrate will decide the case on the basis of this test.

As the judge or magistrate is not medically trained, there will be before the court expert medical testimony and usually the case will be decided on the basis of this expert testimony. Medical witnesses will be called to give their expert opinion on whether the doctor concerned behaved as a reasonable doctor of comparable training and experience would have behaved in the circumstances. However, medical testimony will not be required where the doctor admits that they were negligent or the alleged negligence is so blatant that little or no expert evidence is required to prove the case against the doctor.

If the medical witnesses testify that the doctor acted in accordance with accepted medical standard and did not make an unreasonable mistake, the doctor will be found not liable. In effect it is the medical profession itself which determines the applicable standards of medical proficiency.

Difficulties arise, however, when there is conflicting medical testimony with one medical expert giving an opinion that there was no medical negligence and another expert testifying that there was negligence.

The law takes account of the difficulties inherent in the practice of medicine. It recognises that despite all the advances in the field of medicine, medicine remains a somewhat inexact science because the human body is a highly complex organism and the treatment of human ailments is often a complicated business as there may be a tremendous number of variables involved in the treatment process. For instance, people may respond differently to certain types of treatment. For this reason, it would be totally unreasonable for the law to demand a standard of perfection or that the doctor must guarantee that the patient will be cured. The law, in fact, demands none of

these things. Indeed, a doctor will not be legally liable even if a patient's health does not improve or grows worse after treatment, unless they have done or failed to do something which no other reasonable doctor would have done or omitted to do in the circumstances. Doctors should, however, guard against over-confidence. Should they mislead a patient by exaggerating the anticipated results of certain forms of treatment, they could find themselves liable if these results are not forthcoming.

Nurses

Nurses also receive intensive training before they qualify. They are required to carry out all their nursing duties competently and diligently.

Excusable mistakes

Doctors are not expected to be miracle workers who will undertake always to cure their patients. Nor are they expected to be infallible. Some mistakes are excusable. As previously stated, in *S v McGown* 1995 (1) ZLR 4 (H) at 30D the court quoted with approval this statement of the law from an English case: "it is not every slip or mistake which imports negligence."

In *Castell v de Greef* 1993 (3) SA 501 (C) the court said that both in performing surgery and in their post-operative treatment, a surgeon is obliged to exercise only reasonable diligence, skill and care; no more than the general level of skill and diligence possessed and exercised by members of the branch of the profession to which they belong. The mere fact that an operation was not successful, or that the treatment they administered did not have the desired effect, does not necessarily justify the inference of lack of diligence, skill or lack of care on the surgeon's part. The test remains always whether the practitioner exercised reasonable skill and care or, in other words, whether or not their conduct fell below the standard of a reasonably competent practitioner in the field. If the 'error' is one which a reasonably competent practitioner might have made, it will not amount to negligence. If it is one which a reasonably competent practitioner would not have made, it will amount to negligence.

In *Hucks v Cole* [1968] 118 *New LJ* 469 ([1993] 4 *Med LR* 393 it was stated—

> With the best will in the world things sometimes goes amiss in surgical operations or medical treatment. A doctor was not to be held negligent simply because something went wrong.

In *Buls v Tsatsarolakis* 1976 (2) SA 891 (T), the doctor treating a person for a wrist injury failed to detect that there was a fracture of the wrist. It was only detected later by an orthopedic surgeon. The court found that the original doctor's failure to detect the fracture was not negligent. The mistake was honest and reasonable in the light of the expert evidence that such fracture was often missed and would normally only be detected by a specialist.

In *Ruth Sai v Avenues Clinic* HH-26-17 the plaintiff failed to prove that her miscarriage was due to medical negligence.

What are not excusable are blatant, indefensible mistakes that would not be made by reasonably competent doctors. It is these sorts of errors that rightly attract sanctions. See *Thebe v Mbewe t/a Checkpoint Laboratory Services* 2000 (1) ZLR 578 (S) at 585-586.

In a South African case, the test for medical negligence was stated in these terms—

> Both in performing surgery and in his post-operative treatment, a surgeon is obliged to exercise only reasonable diligence, skill and care, no more than the general level of skill and diligence possessed and exercised at the time by members of that branch of the profession to which he belongs. The mere fact that

an operation was not successful or that the treatment he administered did not have the desired effect does not necessarily justify an inference of lack of diligence, skill or care on the surgeon's part.

In the English case of *Whitehouse v Jordan* [1981] 1 All ER 267 (HL) Lord Fraser said—

> The true position is that an error of judgment may, or may not, be negligent; it depends on the nature of the error. If it is one that would not have been made by a reasonably competent professional man professing to have the standard and type of skill that the defendant holds himself out as having, and acting with ordinary care, then it is negligence. If, on the other hand, it is an error that such a man, acting with ordinary care, might have made, then it is not negligence.

Liability for harm caused by negligence

There are two types of liability that can arise. The first is civil liability for damages. The second is criminal liability.

A patient will be able to obtain civil compensation if they can prove on a balance of probabilities that the doctor and the negligence caused harm to the patient. Where a patient dies, dependents can claim damages for loss of support from a doctor if they can prove that the deceased died as a result of the doctor's negligent medical treatment of the deceased. In civil cases the patient has the onus to prove on a balance of probabilities that the doctor or nurse was negligent in the treatment rendered and that that the negligence caused the harm that was suffered by the patient.

In the civil case of *Chibage* v *Ndawana* 2009 (2) ZLR 387 (H), the court stated that the test to decide whether there has been professional negligence on part of medical practitioner is the standard average reasonable professional doctor. See also *Thebe v Mbewe t/a Checkpoint Laboratory Services* 2000 (1) ZLR 578 (S).

If a patient dies as a result of the doctor's negligence, the doctor may be prosecuted for culpable homicide. Culpable homicide is committed when a person negligently causes the death of another person. In order for the doctor to be convicted, the State must prove beyond reasonable doubt that the doctor's negligence caused the patient's death.

See "Doctors who cause the patient deaths: Case note on *S v McGown*" 1995 (1) *ZLR* 4 (H).[6]

In *S v Mkwetshana* 1965 (2) SA 493 (N), a junior doctor administered the wrong dosage of a medicine. The patient died. The doctor was found guilty of culpable homicide.

The standard of proof is the same at all stages of medical intervention, that of the reasonably competent doctor. It applies in relation to diagnosis, treatment, surgery and post-operative care.

Contract and delict

In *Chibage v Ndawana* 2009 (2) ZLR 387 (H) it was pointed out that the issue of whether to bring claims of professional negligence against medical practitioners, in delict or in contract, is not new. The line of division where negligence is alleged is not always easy to draw; for negligence underlies the field both of contract and of delict. It is not necessary for a plaintiff to plead a contractual relationship between the parties to enable them to bring an action in delict against a defendant medical practitioner. Our law acknowledges a concurrence of actions where the same set of facts can give rise to a claim for damages in delict and in contract, and permits the plaintiff in such

[6] ''Doctors who cause the patient deaths: Case note on *S v McGown*" 1995 (1) *ZLR* 4 (H). Available online on ZIMLII at https://zimlii.org/zw/journal/2018-zelj-01/%5Bnode%3Afield_jpubdate%3Acustom%3AY/doctors-who-cause-patient-deaths-case-note-s-v.

a case to choose which he wishes to pursue. Where the conduct of a defendant medical practitioner towards a plaintiff, who may not be their patient, is unlawful and causes injury to the plaintiff, the medical practitioner is liable if their conduct was negligent. The particulars of negligence alleged against a medical practitioner can only be validated by reference to the standard operating procedures of other medical practitioners in that field. This is so because, to test the negligence of a professional, one has to first establish what an average reasonable professional in the place of the defendant would have done. An average professional is not one who is so careful that they will weigh each and every risk attendant upon the task at hand and advise the client of all such risks before proceeding. They will weigh the obvious risks and advise the client of same. The reasonable professional is one who will bring their training to bear on the task at hand to assess the attendant risks and proceed with alertness. They have a certain degree of confidence in their capacity and skill that allows them to proceed without undue timidity and are, to a large extent, a practical person who wishes to achieve a specified result.

Causation

In an action for damages against a doctor not only must the claimant prove that the doctor acted negligently but also that the negligence caused or materially contributed to injury to the patient or caused their death. These ingredients must be proved on a balance of probabilities.

In a criminal case in which the doctor has been charged with culpable homicide, the State must prove beyond reasonable doubt not only that the doctor was negligent but that the negligence caused or materially contributed to the death.

One example where the problem of causation would arise is this: A patient is brought into hospital because they have been stabbed in the chest and need treatment for their wound. There is a delay in treating and the patient bleeds to death. The hospital would not be found liable if the evidence shows that had medical treatment had been rendered as soon as the patient arrived at the hospital, the doctors would still have not been able to save the life of the patient.

Where a patient is being treated for a serious medical condition and, after medical treatment, the condition gets worse, the doctor would not be liable if the medical evidence establishes that the deterioration was not attributable to the medical treatment but simply to the natural progress of the condition from which the patient was suffering.

There would be liability if the patient had to undergo a further operation to deal with first botched operation.

Usual or widely accepted practice

The courts will be guided by evidence as to whether or not there existed usual and accepted procedures for dealing with the conditions. Evidence of a widely recognised procedure to avoid unnecessary risk of injury to patients will be vitally important. During their training doctors are taught the safest and most appropriate ways of treating particular ailments. The law thus rules that a doctor should normally adopt those procedures which the medical profession considers to be the best for dealing with various problems. Therefore, if the medical profession generally accepts that there is only one safe procedure to treat a certain condition, and a doctor adopts another procedure with the result that the patient suffers harm which they would not have suffered if the standard procedure had been employed, the doctor would probably be found guilty of negligence.

Conversely, where a better and safer procedure has been found to replace the old procedure or technique, and

this new procedure or technique is widely and commonly adopted by medical practitioners, the doctor must not stubbornly insist on continuing to use an old procedure especially where it has been clearly established that the old procedure or technique involves undue risk of harm to the patient. See *Ashcroft v Mersey Regional Health Authority* [1983] 2 All ER 245 (QB).

There is often more than one procedure which is universally accepted by the medical profession and there may be various schools of thought advocating different techniques. Certainly a court would not hold a doctor to be negligent if they employed a technique supported by a responsible body of opinion within the medical profession even though there was another body of practitioners who supported the use of another technique.

On the other hand, the doctor might well be adjudged to have been negligent if they adopt some new, unproven procedure supported by a small body of doctors, when it had not been established that this new procedure was in any way superior to the standard procedure but, on the contrary, entailed unnecessary risks of injury to the patient.

Deviation from recognised procedure or failure to take recognised medical precaution

One of the ways to seek to prove negligence is to allege that the doctor who caused harm deviated from a usual and normal practice. If there is a widely recognised way of dealing with a particular condition or there is a generally accepted precaution that needs to be taken, departure from the normal practice will point to negligence and the doctor will have to justify this departure. But this will only apply where there is a commonly accepted approach. Where there are differing medical opinions as to the best way to proceed, the doctor is entitled to adopt the approach that they believe is the most appropriate. For instance, in *Clarke v McLennan & Anor* [1983] 1 All ER 416 (QB) the gynaecologist failed to comply with a recognised medical precaution.

Innovative techniques

Resort to innovative techniques may be appropriate in certain circumstances but doctors should be cautious in employing such techniques, especially where they carry greater risks than more conventional forms of treatment. In deciding whether resort to a novel technique is justified, the court takes into account such facts as the seriousness of the patient's condition; their previous response to more conventional treatment and their attitude to the use of the new procedure upon them. In *S v McGown* 1995 (1) *ZLR* 4 (H) the court stated that if a doctor departs from a general and approved practice for no good cause and damage results, they are likely to be found to have been negligent. But such deviation is not necessarily evidence of negligence. It is in the public interest that new forms of treatment should be developed and the law should not stifle such development. The procedure adopted would have to be shown to be one which no reasonable skilled medical practitioner would not have adopted.

In *Turner v Health Professions Council* 2000 (1) *ZLR* 722 (H), medical practitioner was found not guilty of improper professional conduct where he had injected a number of patients intravenously with a drug which was licensed only for external application. This was because terminally ill patients consented to this procedure; medical literature showed that the drug could have a beneficial effect on patients if applied internally and the drug in most instances had such a beneficial effect on the patients.

Medical personnel who perform their professional work carefully, competently and conscientiously have nothing to fear from the law. The law will intervene only if harm is caused to patients because medical work is carried out without due care and diligence. If there is medical negligence, either criminal prosecution or a civil action may be

brought. For example, if a patient dies due to careless medical treatment, the careless doctor or nurse could be prosecuted for culpable homicide (negligent causing of death) or they could be sued by persons who were dependent upon the dead patient for support, such as a wife or the children. If the patient is harmed by carelessness, the patient could sue the doctor or nurse for damages.

In both criminal and civil cases, the same test is used to determine whether the doctor or nurse is legally liable, namely, was the doctor or nurse negligent in the performance of their duties and did that negligence result in harm to the patient? Negligence can consist either of taking action which no reasonable doctor or nurse would have taken in those circumstances or failing to take action which any reasonable doctor or nurse would have taken in those circumstances

Overworked, overtired doctors

Hospital doctors, especially junior doctors, are often required to work very long hours, sometimes almost to the point of utter exhaustion. Overtired doctors may end up making mistakes that they would not have made if they had not been so tired. The tiredness may impair the judgment. The situation is compounded where a hospital is short staffed because it has been unable to recruit a full complement of doctors due to a shortage of qualified doctors in the country. In Zimbabwe many qualified doctors and nurses have left the country and are working in countries that offer far better financial and working conditions.

Brazier and Cave[7] note that, not infrequently, medical accidents are not so much the result of poor professional behaviour, but rather of intolerable pressure on doctors due to under-staffing. Drastically overworked doctors working under great pressure will eventually, inevitably, end up making mistakes. The situation is compounded where a shortage of specialist skills leads to junior doctors being given only minimal supervision.

However, if the reason why the doctor made an unreasonable mistake was because they were exhausted, this should not be a defence otherwise the patient who has been harmed will go without compensation. Although the court may sympathise with hard pressed doctors, the patient has the right to reasonable medical treatment and is entitled to sue for damages if harmed by an unreasonable mistake. To hold that an unreasonable mistake is excusable because the doctor claims that they would not have made the mistake if they had not been exhausted would be to deny the patient compensation for the harm suffered.

The hospital itself may be to blame for subjecting its medical staff to intolerable working hours. This is particularly the case where they could have employed extra staff but chose not to do so. Thus there is a possibility that the hospital can be sued on the basis of vicarious liability.

Brazier and Cave[8] say this—

> The patient might, though, more appropriately proceed against the doctor's employers, the hospital. He would allege that the hospital undertook to provide them with adequate care. Requiring their doctors to work to the point of utter exhaustion … is a breach of that duty. The essence of the patient's claim would become, not that the hospital was vicariously liable for an individual doctor's negligence, but that there was a breach of primary duty to ensure, and adequate and competent service.

[7] Brazier and Cave p. 213.
[8] Brazier and Cave p. 213.

Inexperienced doctors and nurses

Prior to qualifying, as part of the training process, trainee doctors and nurses may be called upon to carry out certain medical procedures under supervision from qualified persons. If they carry out these in accordance with instructions, they cannot be held liable unless they realise that the instructions were faulty and they nevertheless carried them out without querying them. The hospital would be negligent if it failed to provide proper supervision for these trainees.

Qualifications alone do not guarantee a doctor's skill and competence to perform all medical procedures. Newly-qualified doctors require further experience and instruction from experienced medical staff in order to acquire proficiency in certain procedures. They can only acquire experience over time by learning on the job. Extensive use is made in hospitals of recently qualified doctors and nurses.

In the interests of protecting patients against harm, the test that has been applied by the courts is not how would a newly qualified doctor or nurse have dealt with the situation, but instead it is how a reasonable doctor or nurse have carried out the procedure. If a reasonable doctor or nurse would not have done what that novice doctor or nurse have done and the patient has suffered harm, the doctor or nurse would be held liable.

Thus, in *S v Mkwetshana* 1965 (2) SA 493 (N) a junior doctor negligently administered the wrong dosage of a drug, thereby causing the death of the patient. The doctor was found guilty of culpable homicide. Even though the doctor was inexperienced and was dealing with an emergency, the doctor had insufficient knowledge of the drug to administer it as he did and should have checked first about correct dosage of the drug or called in a more experienced doctor. In *Wilsher v Essex Area Health Authority* 1987 QB 730, junior doctors were dealing in a neonatal unit with a premature baby. They negligently failed to monitor the oxygen being supplied to the baby and this resulted in excess oxygen being given. This, it was claimed, led to the baby suffering from a virtually blinding condition.

Thus it would be negligent for a newly-qualified doctor serving their housemanship to attempt some medical procedure which they knew, or should have known, was beyond their capacity to perform competently. The duty of the newly-qualified doctor in these circumstances is to call upon a more experienced doctor who can perform the procedure safely. They would be negligent if they took a chance in performing a procedure when they were uncertain about aspects of the treatment and in the process harmed the patient.

If the inexperienced doctor has consulted a more experienced colleague and has been given instructions on how to proceed, the inexperience doctor must follow the instructions unless the instructions were so obviously wrong that the inexperienced doctor should have queried them.

A trainee could, however, be held liable if they attempt, without being instructed to do so, to render a form of treatment which they know or should have known they are not competent to perform and which they should have called upon a qualified doctor or nurse to perform.

Moreover, the person responsible for supervising the trainee may themself be liable for negligence if, for instance, they gave the trainee wrong or inadequate instructions or they called upon the trainee to carry out a task which they should have known was beyond the trainee's capacity to perform, or if they failed to take over from the trainee when it was quite apparent that the trainee was not able to cope with the task in hand.

If the newly-qualified doctor performed a procedure to the best of their ability in emergency circumstances when

no other more experienced doctor was available, the doctor may be able to raise the defence of necessity in relation to an allegation of negligence.

The hospital in which such negligence occurs may be sued for damages as it will be vicariously liable for the negligence of the junior doctors and nurses.

The hospital could also be sued if the junior doctor or nurse makes a mistake because the hospital has left the junior doctor or nurse to deal with medical procedures without providing adequate supervision.

Emergency situations

In circumstances of dire emergency doctors are forced to act immediately and decisively if they are to save the lives of their patients or to rescue their patients from serious harm. They may not have time to use ordinary diagnostic techniques and to consider carefully various alternative treatment techniques. In deciding whether a doctor has been negligent in the treatment they have rendered in such a situation, the court takes full account of the fact that the doctor was dealing with an emergency.

In adjudging whether an action was negligent in these circumstances the question which will be asked is whether the doctor behaved as a reasonably competent doctor would have done in a similar emergency. Only if the doctor did something which no other reasonably skillful doctor would have done in such emergency circumstances, would the doctor concerned be held to have been negligent. For example, a doctor could be found liable if they panicked and rendered a treatment which was entirely inappropriate for the condition of the patient. If, however, in a genuine attempt to save the patient the doctor adopted a course of action which other reasonably skillful doctors might well have adopted in such circumstances, they would not be found guilty of negligence even if the patient's condition deteriorated as a result of the treatment.

A casualty ward at a hospital may suddenly be faced with a large increase in the number of badly injured patients with which the doctors and nurses will have to cope. For example, the hospital is close to where a bad bus accident has occurred in which many passengers suffered severe injuries. Only a limited number of the injured persons can be transferred to other distant hospitals. The doctors on duty, plus other doctors who are called in, must try to cope. They have to quickly assess the condition of the patients and will prioritise those who are most urgently in need of treatment. Under the pressure of dealing with such a large number of patients mistakes may be made. In deciding whether the mistakes made amounted to actionable negligence, the court should apply the test of whether a reasonably competent doctor faced with such a situation would have made the mistake in question. The court in applying the test for negligence will take into account that the doctor was dealing with an emergency, with inadequate facilities, and under great pressure. The court should not use the standard of the doctor working in more ideal circumstances.

Unavailability of equipment

Equipment which might be used to deal with certain medical problems in a large urban hospital as a matter of routine may be unavailable in small, rural hospitals. The law recognises this social reality. Therefore, while it may be negligent for a doctor in an urban hospital not to employ particular available equipment, it obviously does not constitute negligence for a rural doctor not to use equipment which their hospital does not possess, although where there was time to do so, the failure to transfer the patient to a hospital that has the equipment might amount to negligence.

As previously stated, currently, even large urban hospitals run by government are experiencing acute shortages of even basic medical items such as medicines, bandages, saline drips, bed linen, non-functioning diagnostic equipment and may also be faced with power cuts if they do not have adequate backup systems.

Misdiagnosis

If a patient's disease or injury is not diagnosed, no appropriate treatment will be given and the result may be that the patient dies or suffers further harm which would have been avoided had the condition been properly diagnosed and treated. So, too, a wrong diagnosis may cause harm if it leads to inadequate or totally unsuitable treatment.

In deciding whether the doctor has been negligent in this sort of case, the courts will again take cognisance of the fact that human ailments are often difficult to diagnose since the "language of the body is limited and the range of possible diseases is almost limitless."

In the process of diagnosis of ailments, doctors are required by law to use the same reasonable degree of skill and care which they are required to exercise in all their other dealings with patients. If a doctor has exercised this degree of skill and care, they will not be held to have been negligent, even if the diagnosis turns out to be wrong or mistaken. Such a mistake will be treated as non-culpable and as one of the inevitable hazards of practice.

However, if the mistake was one which would not have been made if a reasonable degree of skill and care had been observed, then the doctor will be liable. For example, if a mistaken diagnosis is made because the doctor failed to conduct tests which a reasonably competent doctor would have considered appropriate, or if a doctor has failed to diagnose a condition which would have been detected by a reasonably competent doctor, then the doctor may be held liable for negligence.

To give an example, a disease or injury may be so obvious that any reasonably competent doctor would be able to diagnose the nature of the ailment after a basic examination of the patient.

In *Wood v Thurston* (1951) *The Times* 25 May, a casualty doctor was found liable for negligence for failing to examine or X-ray a drunken patient. The doctor knew from information that the patient had been seen under a moving lorry. The patient died the next day. After his death, he was discovered to have eighteen fractured ribs and extensive damage to his lungs. It was no defence that the patient never complained of pain as the doctor should have known that alcohol would dull the patient’s reaction to pain. The doctor treating a patient must be alert to the background circumstances of the patient

If the ailment is less obvious, the question arises as to what investigative or diagnostic techniques a reasonably competent doctor would consider necessary in the circumstances.

Ordinary laboratory tests or the use of X-rays would be called for by a reasonable doctor if the symptoms are such as to suggest their use. The failure to use such tests in these circumstances may constitute negligence. However, the use of elaborate and expensive investigative procedures may not be considered necessary by a competent doctor except in relation to serious ailments which are especially complicated or puzzling.

A diagnostic procedure may not be used routinely and may be painful, risky and expensive. The failure to order such procedures may not be negligent and the patient may also decline to submit themself to such test.

Remote rural hospitals may lack the equipment to carry out even fairly basic tests. Where this is the case, patients must be referred to more sophisticated hospitals for diagnostic tests to be performed (unless of course the

condition of the patient is such that urgent and immediate medical intervention is required).

Prescription errors

When a doctor writes a prescription, they must be extremely careful to ensure that they do not prescribe—

- the incorrect medicine for the patient's medical condition;
- the incorrect dosage of the right medicine for the patient's medical condition.

The doctor must first ascertain if there are any medicines to which the patient is allergic so that they can avoid giving the patient such medication.

Prescribing the incorrect medication or a completely wrong dosage of a medicine can cause harm or even death and the doctor would then be legally liable.

Mistakes can be made because, presently, prescriptions are handwritten and the handwriting of doctors is often very difficult to decipher. If the pharmacist cannot read the prescription, they must contact the doctor in order to check exactly what is being prescribed before dispensing the medicine. This problem could be overcome by the simple expedient of requiring all prescriptions to be typed.

Even if the prescription clearly indicates the medicine and its dosage, where the pharmacist spots that the doctor has made a bad mistake by prescribing what is a massive and potentially lethal overdose, the pharmacist would face liability for negligence if they went ahead and dispensed the medicine as ordered by the doctor. The pharmacist must contact the doctor and get them to correct the mistake.

Allergic reaction to the administration of penicillin (anaphylactic shock reaction)

A particular problem arises with the use of penicillin. (It may also arise with other antibiotics and commonly used drugs.) It is well known that some patients are allergic to penicillin and that they could die or suffer grave harm if this drug is administered to them. Doctors, therefore, have a duty to take reasonable precautions to ensure that penicillin is not administered to a patient who is allergic to it. Clearly, if a doctor knows full well that a patient is allergic to penicillin and nonetheless injects the patient with this drug the doctor would be guilty of negligence. This would apply if the patient told the doctor that they had suffered allergic reactions in the past when penicillin had been given to them or they wore a Medic Alert bracelet which warned of penicillin allergy and this had been seen by the doctor or nurse prior to the patient being injected with penicillin.

What, however, of cases where the doctor enquires from the patient whether they have had any penicillin reaction in the past and the patient informs the doctor either that this drug has never been administered to them before or, that when it has, they have not suffered any allergic reaction to it?

Since a serious allergic reaction can take place even in patients who have not suffered a reaction in the past when the drug has been used, doctors are still obliged to take reasonable precautions to guard against allergic reactions. Jonsen *et al*[9] give the general advice that penicillin should only be used where specifically indicated and another antibiotic should be used instead if it will be equally effective, especially in allergic or asthmatic subjects. Further, if penicillin is indicated, a skin sensitivity test (not the scratch test) should be employed if there is any reason to suspect possible allergy.

[9] Jonsen, A.R., Siegler, M. and Winslade, W.]., *Clinical Ethics* (Macmillan) 1986.

Surgical procedures

Surgical procedures range from those which are simple and straightforward to those which are extremely intricate and complicated. The same basic rule concerning negligence applies to all surgical measures whether they be complex or simple. The rule is that surgeons are called upon to display a reasonable degree of skill and care. If a gross, glaring or entirely indefensible error is committed, there will be little doubt that there was negligence.

For example, a doctor operating on the wrong patient or on the wrong part of the body; leaving a scalpel or forceps inside the patient after an operation, or an experienced doctor failing to follow some elementary procedure in non-emergency circumstances, are all instances of negligence. The doctor will be found to have been negligent because no other reasonably competent doctor would have done what they did. Such cases do not cause any difficulty in the courts. (One blatant error which led to a court case in Britain a few years ago involved an "administrative error" which led to a young boy receiving a circumcision instead of a tonsillectomy.)

The cases which cause difficulty are usually those in which errors occur during the course of more complex surgical procedures. It should be noted that the doctor embarking upon complex procedures must have had the requisite training and experience to enable them to carry it out properly. If they do not, it would constitute negligence for the doctor to attempt such a procedure, unless it was an emergency and there was no experienced doctor available. Cases of this nature are covered in the Medical Practitioners (Professional Conduct) Regulations 41 of 2004 by a provision which reads "No practitioner shall, except in an emergency, perform any operation or other professional act for which s/he is inadequately trained or insufficiently experienced."

If an error is made and the doctor is found to have had the requisite training and experience, then the test of negligence applied is whether a reasonable doctor with comparable training and experience would have dealt with the case without causing this harm to the patient. Naturally the scope for things to go wrong is greater with difficult and complex procedures. The court would take this factor into account when adjudicating upon alleged negligence. The court may find that the harm caused to the patient resulted from an inevitable risk inherent in the procedure which not even a competent doctor would have been able to eliminate, or that the error committed was excusable and non-negligent taken in the context of such a delicate procedure. The complexity of the procedure, however, will not provide an excuse for the doctor who commits a gross mistake during the course of such a procedure.

Leaving objects inside patients after operations

The law requires that doctors adopt procedures which will minimise the possibility of foreign bodies being left inside patients. Overall responsibility to ensure that swabs and other objects such as scalpels and forceps are not left in a patient lies on the doctor and they cannot delegate the entire responsibility for preventing these from being left behind to a nurse. The doctor can, however, enlist the aid of the nurse to assist in counting exactly how many swabs and instruments have been used and in making sure that they have all been removed. The doctor in charge could be found guilty of negligence if they failed to take reasonable steps to ensure that all swabs and instruments were removed and harm was caused to the patient as a result of their non-removal.

However, it must be noted that what is reasonably required in an emergency situation may be different from what is required in a non-emergency setting. If a person has suffered grave injuries and major surgery has to be carried out immediately, it may be imperative after such an operation to close up the patient as soon as possible. In such a case, the law would accept that some of the normal precautions to check for swabs and instruments might of

necessity have to be dispensed with in the interests of the immediate health of the patient.

Post-operative treatment and care

The responsibility for treating and caring for a patient obviously does not end after a surgical procedure has been completed. The patient must be properly cared for whilst they are recovering from the operation and, if there are any complications stemming from the operation, these must be properly dealt with. Again, at the post-operative stage, the doctors and nurses attending the patient must display a reasonable degree of skill and care. The doctor must ensure that the facilities for post-operative care are reasonably sufficient to deal properly with the care required by that patient after the operation. See *S v McGown* 1995 (1) *ZLR* 4 (H).

The failure to diagnose and treat a post-operative complication timeously may amount to negligence if the patient suffers harm from this failure and a reasonable doctor would have detected and treated the condition before it caused such harm.

There are, for instance, a number of cases where a fracture reduction operation has been carried out, the limb has been encased in plaster and later the doctor treating the patient has been remiss in not detecting that ischaemia has set in, so that by the time it is realised, the limb has already been severely damaged. There would be negligence in such a case if a reasonable doctor would have diagnosed and treated this condition earlier. (See end of this section for the facts of some of these cases.)

When a patient is recovering from an ailment or an operation, they may be required to take certain precautions in their own health interests. Where this is the case, the doctor should advise the patient accordingly and failure to transmit this vital information would amount to negligence if a reasonable doctor would have done so.

General practitioners

The general practitioner must display reasonable care in dealing with patients, whether they be long standing patients whom they know well or new patients. The general practitioner's duties include the examination of patients; diagnosis of the ailments; sending patients for tests such as X-rays; the prescriptions of medicines; the performance of minor operations and referral of patients to specialists such as surgeons if major surgery is required.

Mistaken diagnosis or an error in making out a prescription can lead to liability. Also failure to refer a patient to a specialist where the matter is beyond the capability of the GP could also lead to liability

Anaethetists

As the anaethetist is a specialist doctor, they will be judged by the standard of the reasonably competent anaesthetist.

The administration of a general anaesthetic is done to render the patient unconscious during an operation so as to feel no pain. After the patient is unconscious, the anaesthetist inserts a small tube connected to a ventilator into the patient's airway. There have been a number of cases where the anaethetist inserted tube wrongly and the patient died as a result of being deprived of essential oxygen.

The anaesthetist must carry out a proper pre-operative assessment of the patient to ascertain whether the patient has a condition such as a heart problem or diabetes or an allergy to drugs. Failure to do this will result in the court finding that there was negligence if the patient dies because the anaesthetic, combined with the pre-existing condition, caused death.

The administration of anaesthetics carries various risks. The patient will have been instructed not to eat or drink for several hours before surgery. This is to ensure that they will not vomit and block their airway during the operation.

The anaesthetist controls the length of time the patient is asleep, and constantly monitors pulse, breathing and blood pressure. If necessary, the anaesthetist will give the intravenous fluids before, during and after surgery.

Once the surgery is over, the patient may have other drugs injected that will reverse the effect of the anaesthetic and any other drugs used during the operation (such as muscle relaxant). When the anaesthetist is satisfied with the breathing and blood circulation, the patient is wheeled into the recovery room where specialised staff members look after the patient.

The anaesthetist may also be found to be negligent if they—

- fail to check the equipment before the operation and as a result of equipment malfunction the patient died or was harmed;
- fail to monitor the patient's blood pressure and/or heartbeat during surgery;
- fail to anaesthetize the patient completely but the patient is paralyzed and is unable to communicate, remains awake and experiences pain throughout the surgery;
- inject the wrong drug or the wrong dosage of the drug e.g. in one English case, the anaesthetist injected cocaine instead of procaine;
- fail to apply proper resuscitation measures after an inevitable accident has occurred.

In *S v McGown* 1995 (1) *ZLR* 4 (H), an anaesthetist was found guilty of a number of counts of culpable homicide. One aspect of the judgment looked at whether he was negligent because he departed from approved practices for no good cause and death resulted.

Gynaecologists and obstetricians

A gynecologist is a doctor who specialises in female reproductive health. They diagnose and treat issues related to the female reproductive tract. This includes the uterus, fallopian tubes, and ovaries and breasts.

Gynecologists give reproductive and sexual health services that include pelvic exams, Pap tests, cancer screenings, and testing and treatment for vaginal infections.

They diagnose and treat reproductive system disorders such as endometriosis, infertility, ovarian cysts, and pelvic pain. They may also care for people with ovarian, cervical, and other reproductive cancers.

An obstetrician is a doctor who specialises in pregnancy, childbirth, and a woman's reproductive system. Although other doctors can deliver babies, many women see an obstetrician who will can take care of them throughout their pregnancy, and give follow-up care such as annual Pap tests for years to come.

Some gynecologists also practice as obstetricians, who give care during pregnancy and birth.

From time to time, male gynaecologists have been found guilty of sexual assaults on their female patients. In order to deal with the medical problems of their patients it will be necessary to carry out sensitive, intimate physical examinations upon patients who may be in a vulnerable emotional state. But if the gynaecologist acts in a manner which amounts to sexual abuse or exploitation of their patients rather than an intimate examination necessary for diagnostic purposes, they may be guilty of crimes such as rape or indecent assault. Sexual misconduct by physicians is an abuse of professional power and a violation of patient trust.

Some conduct that may indicate the gynecologist has violated medical and ethical standards, and potentially committed sexual assault are these—

- **Being alone with the patient while she is undressed.** Although it is ultimately up to the gynecologist's judgment and availability of other office staff members, most gynecologists choose not be alone in the room with an undressed patient to avoid making her feel uncomfortable. Depending on availability, a nurse or physician's assistant may be present during the types of exams discussed above, unless the patient specifically requests to speak to the doctor privately.
- **Make prolonged contact with sensitive areas or engage in sexual activity.** Unless a specific cause for concern is identified during a breast exam, Pap smear, or vaginal exam, the doctor should not make prolonged contact with the patient's breasts or vagina. Sexual activity between a gynecologist is *never* appropriate and likely violates civil and criminal law.
- **Make inappropriate sexual innuendo or flirtatious comments.** During a routine exam, a gynecologist may make remarks such as "your breast tissue seems healthy" or "no cause for concern" after your pelvic exam. Any further remarks (such as "your breasts are really perky" or "you have an amazing body") are not appropriate.
- **Taking pictures of breasts, genitals, or naked body.** Photos of patients during routine gynecological exams are almost never necessary. If any unusual symptoms are noticed, the doctor should note this in the patient's medical file and follow up with appropriate tests. Absent any serious health conditions with visible physical symptoms, a gynecologist should never photograph a patient's breasts, genitals, or naked body.

Physical examinations should be explained appropriately, undertaken only with the patient's consent, and performed with the minimum amount of physical contact required to obtain data for diagnosis and treatment. Draping should be used to minimise patients' exposure during examinations. Patients should be offered the opportunity to ask questions or raise concerns about any element of the examination.

It is recommended that a chaperone be present for all breast, genital, and rectal examinations. The need for a chaperone is irrespective of the sex or gender of the person performing the examination and applies to examinations performed in the outpatient and inpatient settings, including labour and delivery, as well as during diagnostic studies such as transvaginal ultrasonography and urodynamic testing.[10]

Psychiatrists

There are a number of instances where psychiatrists could be sued for medical negligence. In common with all other doctors, if a psychiatrist negligently prescribes or administers drugs with the result that the patient suffers harm, the psychiatrist could be held liable to pay damages. Liability could also follow where dangerous mental patients are wrongly and negligently adjudged safe enough to be released from mental institutions in which they have been compulsorily detained, and after their release cause harm to others. In one American case, *Tarasoff v Regents of University of California* 551 P2d 334 (Cal 1976), damages were awarded against a hospital in these circumstances. A patient with a history of criminal attacks on women had been involuntarily committed to a mental hospital. After several years of treatment, a committee of three psychiatrists met and decided that he was

[10] These guidelines are extracted from American College of Obstetrician and Gynecologists' Committee on Ethics: Opinion of the Committee on Ethics.
https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2020/01/sexual-misconduct

ready for discharge. At this very meeting, however, he went berserk and had to be restrained. No attempt was made to re-evaluate him and he was released on schedule. Within twenty minutes of leaving the hospital he went to a subway station and attacked two women, beating one severely and pushing the other onto the tracks. Both women claimed successfully against the hospital.

Psychiatric hospitals are obliged to take reasonable steps to prevent suicidal patients from harming themselves and dangerous patients from causing harm to their fellow patients. If they fail to fulfil this duty, they may be held legally liable. Doctors and nursing staff are not called upon to keep suicidal patients under constant supervision, but they must take appropriate preventive measures. Thus, in the American case of *Tarasoff v Regents of the University of California* 551 P 2d 334 (Cal 1976), a hospital was held liable in circumstances where the staff had been warned that a patient might try to harm himself and yet the patient had been placed in a second-floor room without any bars and had subsequently jumped out of the window.

Relationship between nurse and doctor

Nurses often complain that doctors wrongly try to say that they are responsible when mishaps occur during the course of medical treatment. However, the law allocates different responsibilities to doctors and nurses. The circumstances in which nurses might be held liable for negligence are defined by this division of responsibility.

Nurses are, of course, not doctors. It is doctors who are responsible for diagnosing illnesses; making decisions on appropriate treatments and carrying out surgical operations upon patients who require these. The nursing staff is there to provide support for doctors. They implement the treatment regime decided upon by the doctors by administering drugs which have been prescribed; by assisting in the operating theatre by way of supplying instruments to surgeons as these are required; by monitoring patients' post-operative recovery processes, and so on.

Thus in relation to doctors, nurses are in a subordinate position. They cannot, therefore, be held liable for mistakes made by doctors. For example, a nurse may cause harm as a result of doing exactly what they were instructed to do by a doctor. However, if the doctor was in error in ordering that course of treatment or if the doctor negligently ordered the administration by the nurse of the wrong drug or the wrong quantity of the right drug and this caused harm to the patient, the nurse will not be responsible for the harm that resulted unless they realised that a mistake had been made by the doctor and still proceeded to carry out the treatment ordered without attempting to have the mistake rectified.

Negligence of nurse

Nurses can be held legally liable for their own negligent mistakes or for negligent default in carrying out their duties. A nurse could thus be liable if, for example, they—

- mistakenly administered a drug other than that prescribed or a dosage other than that prescribed to the patient and this caused death or harm;
- failed to summon a doctor when it was quite apparent that the condition of the patient was such that treatment by a doctor was desperately needed;
- failed to monitor a sick patient's progress at regular intervals as required and this failure led to the patient's death or to a deterioration in their condition which could have been avoided;
- failed to attend to a patient who obviously required immediate attention, despite the fact that they were not engaged in treating other patients at that time;

- when assisting a sick patient to have a bath, carelessly allowed the patient to fall down as a result of which the patient suffered injuries;
- when diagnosing and treating patients for minor ailments, made some negligent mistake which led to harm being caused to the patient.

Poor communication leading to errors and mishaps

Poor communication is often a recipe for medical disaster and often leads to actions for damages for negligence. In one of its reports, the Medical Defence Union observed—

> In general practice poor clinical notes, failure to visit and the inadequate recording or passing of messages are common ingredients for a medical disaster with serious legal consequences.

This viewpoint was echoed by the Registrar of the Health Professions Council when he met with the authors. Quite a number of complaints made by members of the public, he said, related directly to lack of communication between doctors or nurses and patients, or between medical practitioners themselves.

The way to avoid or minimise the chances of disasters occurring because of poor communication is, of course, to improve the processes of communication.

Poor communication may take various forms. We now deal with problems arising out of poor communication in a number of specific situations.

Communication between doctor or nurse and patient

In order to diagnose and treat a patient properly, it is vitally important that all relevant information be obtained from the patient. Let us take a simple example of how harm can be caused to a patient if this is not done. If penicillin is administered without first finding out from the patient who knows they are allergic to this drug whether they are in fact allergic, the doctor will have been negligent.

Miscommunication can cause harm in many other situations. During the treatment process itself or during the post-operative stage, the patient may be required to do certain things or to refrain from doing certain things to ensure the success of the treatment or recuperation process. Where this is the case, the failure to transmit adequate, clear and understandable instructions to the patient may amount to negligence on the part of the doctor or nurse. If, on the other hand, full and clear instructions have been given but the patient fails to observe these, the doctor or nurse will normally be exempt from any liability.

On the matter of communication with patients, Brown[11] observes that many of the problems of medical malpractice can be avoided by proper, sympathetic and understanding communication with the patient. He stresses the importance of the doctor taking time to talk to patients and to become acquainted with them. He rightly observes that the chance of a malpractice action is greatly increased if the doctor is seen as remote, arrogant, snappy, uncommunicative or entirely superficial in their examination by the patient. Doctors who listen to the legitimate complaints of their patients and who show that they care about their patients are far less likely to be sued for medical negligence. Finally, if something does go wrong during treatment, for example if an unanticipated complication causes further harm to the patient, it is advisable for the doctor to inform the patient about this complication, explain its implications and state what will be done to correct the problem. If the doctor

[11] Brown, K. L., *Medical Problems and the Law* (Thomas) 1971 p.120.

does not pass on sufficient information the patient may become annoyed when they discover the problem and this may incline them to bring an action for damages against the doctor. On the other hand, if the doctor is honest with the patient and reveals the problem to them, it is far less likely that the patient will turn around and sue the doctor. This is not to say, however, that the doctor who commits a blatant and seriously damaging error will be able to avoid being sued if they simply inform the patient of the error and the steps which they are taking to rectify it; the patient will probably insist on taking legal action.

Negligence arising from communication between medical practitioners

It is vitally important that all relevant information given by the patient or gleaned from observation of the patient is properly transmitted to all other medical persons engaged in treating the patient. Failure to pass on such information may amount to negligence. To give a simple example, if a patient tells a nurse that they are allergic to a particular drug but the nurse fails to transmit this information to the doctor who is treating the patient with the result that the drug is administered and causes harm to the patient, the nurse may be held to have been negligent. A ward nurse may face legal proceedings if they fail to report certain changes in a patient's condition which should have led to an alteration in the treatment. For example, if a patient complains to the nurse of excessive and unexpected pain about which they have not complained previously, this complaint must obviously be reported to the doctor. Similarly, if a doctor treating a patient transfers the patient to another doctor for treatment, they must take steps to ensure that all salient medical information about the patient is transmitted to the second doctor.

Other instances of miscommunication between practitioners involve the identity of the patient. In a recent case in Zimbabwe, a patient received treatment intended for another as a result of incorrect identification. Such mistakes can lead to tragic results and everything must be done to ensure that they do not occur. Wherever possible, patients being admitted should be fitted with identity bracelets around their wrists. (In emergency cases there may be no time for this, but here mistakes as to identity are unlikely to occur.) The nurse must carefully check that the right patient is being taken to the operating theatre and the theatre staff should also check this. Stringent precautions should be taken to ensure that the medical records taken to the operating theatre are the records of the person being operated upon. (A helpful pamphlet containing practical advice on how to avoid such mistakes has been issued by the Medical Defence Union. It is suggested that the Health Professions Council should issue a similar pamphlet in Zimbabwe.)

As part of the communication system, good medical records should be kept. When writing up notes on a patient, the medical practitioner should do this in a clear and intelligible fashion so that other medical practitioners can read and understand these notes.

With written instructions, bad handwriting can easily lead to misunderstandings which result in harm to the patient. For example, the patient may receive the wrong drug or the wrong dosage of the drug, or an entirely inappropriate treatment may be carried out, such as the left leg being operated on instead of the right.

All drugs must be carefully and legibly labelled so that there is no chance of an error occurring when other medical practitioners use them even in an emergency situation.

Careful, accurate recording is also a safeguard against unjustified legal actions for negligence. Reference to the record may clearly establish that there was no negligence in the manner of treatment of the patient. A good record should—

- note accurately all observations, actions taken and opinions formed. The time and date should always be noted;
- wherever possible, record events immediately after making the observation or taking the action as entries made some time after the event can be inaccurate. When this is not possible and the entry has to be made later, the fact of the delay and its duration should also be recorded;
- only use abbreviations if they are commonly understood by other medical practitioners;
- record any call, by telephone or other means, to a doctor or specialist to attend to the patient. If possible, a person who can confirm the call should be present. Oral instructions must also be given in clear and understandable language. See *Maksimovich v Dominguez & Mater Dei Hospital* and *Mater Dei Hospital v Domiguez & Maksimovich* HB-94-15.

Instructions pertaining to patients should not be transmitted hastily and in a superficial way as this increases the chances of the message being misunderstood. Nevertheless, it is the duty of the medical practitioner to ensure that they receive correct, precise information. For example, a busy doctor may tell a nurse to give an enema to Mrs Moyo. Unbeknown to him there are in fact two Mrs Moyos in the ward. The nurse will be acting in a negligent fashion if they simply hazard a guess as to which Mrs Moyo the doctor was referring to and choses the wrong chosen is the patient and the treatment given to this wrong patient has serious harmful consequences. The correct thing to do in this case is for the nurse to check first with the doctor to seek clarification before proceeding.

Liability of hospitals for negligence by hospital doctors, nurses or staff

The law lays down that an employer is liable for their employee's negligent acts, provided that the employee is acting in the course of their employment. Lawyers refer to such liability as vicarious liability as one person is being held liable for the acts of another. The same rule applies within the medical field. Thus, if a doctor or nurse employed by a hospital (whether it be a private or a government hospital) negligently causes harm to a patient whom they are treating, the hospital itself can be held responsible for payment of compensation to the injured patient. This does not mean that the doctor or nurse is exempt from liability for their negligence. If the patient dies, the doctor or nurse could still be prosecuted even if the hospital has paid compensation to the dependents of the dead patient. Similarly, a patient who has been injured has the option to sue the culpable doctor or nurse together with the hospital. A decision is often made to sue only the hospital since the institution is usually in a much better financial position to pay out damages, especially substantial damages, than the individual doctor or nurse.

The case of *Mtetwa v Minister of Health* 1989 (3) SA 600 (D) deals with whether the Ministry was vicariously liable for negligence by professional doctors under its command but not subject to the dictation of others.

The hospital will not, however, be held liable when a doctor performing an operation in a hospital is not an employee of the hospital, but is instead an independent doctor who has simply been permitted to make use of the hospital facilities. (In the USA and Canada, however, there appears to be a tendency to make the hospital liable for the negligence of any doctor using its facilities, whether or not the doctor is employed by the hospital.)

A related issue is whether the hospital is liable when the hospital not only allows the independent doctor to use its facilities, but also permits its own medical staff to assist them. If one of the hospital's own medical staff negligently causes harm to the patient whilst assisting the independent doctor, is the hospital or the independent doctor liable? There is no legal decision on this point in Zimbabwe but, in the United Kingdom, it has been held

that the hospital itself can be held vicariously liable in these circumstances.

In *Majuru v Harare Central Hospital & Anor* HH-475-19 the plaintiff was in bed recovering from a labour related operation in a post-natal ward at a public hospital. Another patient, a young woman called Alice, who had previously been in a high care ward, had been placed in the same ward as the plaintiff after Alice had given birth to a stillborn child. Alice approached the plaintiff and uttered strange words calling on some unknown person's mother to accompany her to breastfeed their babies. Alice then assaulted the plaintiff with her fists. As she was being attacked, the plaintiff cried out calling the nurses in the ward to come and help her. A nurse escorted Alice back to her bed but barely ten minutes later, Alice returned to the plaintiff's bed and hit plaintiff with a clenched fist on the wound that had been operated on and dragged her victim out of the bed. The plaintiff fell onto the floor with Alice still insisting that they should go to breastfeed their babies. The plaintiff was again screaming during this attack. Alice was placed in her bed and sheets were used to tie her to the bed to restrain her.

The plaintiff sued the hospital and the clinical director of the hospital for damages for the assault. The basis of the claim was that the hospital and its medical director were negligent in placing a psychiatric patient with violent tendencies in the post-natal ward. Plaintiff sought damages for pain and suffering and emotional and psychological harm. The hospital, through its team of doctors and nurses, had a duty of care towards the plaintiff. It stemmed from the professional relationship with the plaintiff as a patient in the hospital ward. There was a professional duty not only to provide proper medical care for the plaintiff but also to protect her from reasonably foreseeable harm while she was under its care. The plaintiff had also a constitutional right to personal security and human dignity.

Although the plaintiff failed to establish that Alice was a psychiatric patient in the hospital at the time she was placed in the post-natal, understandably, she formed the impression that Alice was mentally unsound because of her behaviour. From the detailed medical evidence relating to Alice, it was abundantly clear that Alice was mentally unstable. She had suffered from fits in the past causing brain damage which was compounded by vaginal infection. When she was placed in the post-natal ward she was confused and disoriented and a reasonable doctor would have foreseen that she was like a loose cannon who could do anything. Thus, when she was placed in the post-natal ward, it was reasonably foreseeable that Alice might engage in violence. The hospital should not have exposed the patients in that ward to such risk. The staff responsible for locating patients in wards (whoever they were) should have placed Alice in a psychiatric patients' ward instead. The hospital was vicariously liable for the negligent failure by its medical staff to prevent the plaintiff suffering harm. However, the clinical director could not be held liable for the harm that befell the patient as no evidence was adduced that it the clinical director's duty to admit patients into wards at the hospital.

The plaintiff would be awarded damages for pain and suffering including under that head damages for emotional and psychological harm.

Cases on medical negligence

To illustrate how the law has dealt with particular allegations of medical negligence, we provide here summaries of a number of cases decided in Zimbabwe and in other jurisdictions. The cases, taken from other jurisdictions, were selected on the basis that Zimbabwean courts would have arrived at identical decisions had those cases

come before them.[12]

The Medical and Dental Practitioners Council of Zimbabwe[13] gives details of various disciplinary cases that have been dealt with by the Council.

Diagnosis: cases

Case 1

Failure to take X-ray (UK)

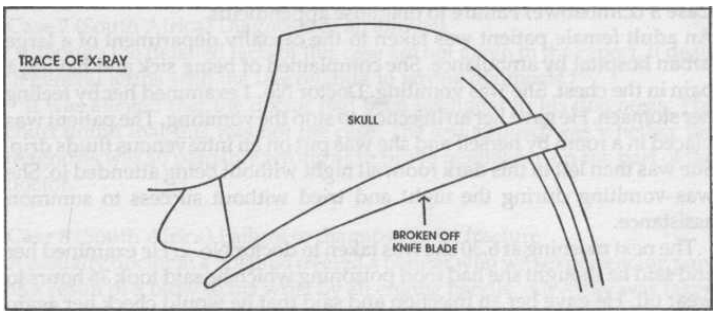
A 48-year-old woman attended a casualty department after falling down some steps at work. She was seen by a locum consultant who found that she had a painful right arm and ankle but no clinical signs of a fracture. No X-rays were taken. She received regular check-ups from the locum. Five weeks after the accident, her shoulder movement was still restricted. The locum had failed to diagnose a fracture due to his failure to have an X-ray taken. The result of this failure was that the patient suffered severe permanent disability with disfigurement and restriction of movement. In this case negligence was admitted and the claim was settled out of court.

Case 2

Failure to detect broken-off blade in skull (Zimbabwe) (Not litigated)

A middle-aged man had been stabbed in the forehead. He was treated in the casualty department of a large hospital. A one-inch knife wound was sutured and stitched. The wound was not palpated and no X-ray was taken. The patient was discharged the next day. About a week later the patient returned to the casualty department complaining of a headache and blindness in his right eye. He was given Panadol and was referred to the eye clinic. The patient subsequently went to another clinic on two occasions and was given Panadol for his headache.

More than a month after the original examination in the casualty section of the hospital, the patient was brought into the same casualty ward in an unconscious state. An X-ray was taken and disclosed that a piece of broken-off blade four inches long had been lodged in the patient's skull from the time of the stabbing. There were large abscesses around the blade. The blade was protruding from the skull to an extent that it would have been detected if the wound had been palpated. This is a trace of the X-ray:



The person who stabbed this patient was charged in the criminal courts with homicide. The question arose as to whether the person charged should be found guilty or not. It was argued that the subsequent medical treatment had been so negligent that the stabbing could not be treated at law as having caused the death. Giving evidence

[12] An invaluable source of instructive cases on medical negligence are the Journal and Annual Reports of the Medical Defence Union. These are available in the University of Zimbabwe Medical Library.

[13] The Medical and Dental Practitioners Council of Zimbabwe *Disciplinary Bulletin* Volume 1 2014: www.mdpcz.co.zw.

at the trial, the State doctor testified that there had been medical negligence. The doctor who first treated the patient also admitted that he should have palpated the wound, but that he had not done so because of pressure of work. The court found that there had been negligence on the part of the doctor.

No legal proceedings were taken against the doctor concerned in this case but it would seem that the doctor could have been sued for damages by dependent relatives of the deceased.

Case 3

Failure to diagnose malaria (UK)

A patient had returned to the UK from East Africa. Shortly thereafter he had developed symptoms of an illness. A general practitioner failed to diagnose malaria, despite this illness being suggested to him by the patient's relatives. The patient died. The doctor was found guilty of negligence.

Case 4

Failure to use diagnostic instrument (UK)

A doctor incorrectly diagnosed carcinoma of the bladder. The doctor had used diagnostic methods which were in common use at this time. He did not, however, use a cystoscope.

The doctor was found not guilty of negligence, the court holding that as the doctor did not have a cystoscope and it would have been difficult to obtain one, it was not negligent for him to use commonly accepted methods of diagnosis instead of employing a cystoscope.

Case 5

Failure to diagnose appendicitis (Zimbabwe)

Case details taken from disciplinary case before the Health Professions Council

An adult female patient was taken to the casualty department of a large urban hospital by ambulance. She complained of being sick and having a pain in the chest. She was vomiting. Doctor No. 1 examined her by feeling her stomach. He gave her an injection to stop the vomiting. The patient was placed in a room by herself and she was put on an intravenous fluids drip. She was then left in this dark room all night without being attended to. She was vomiting during the night and tried without success to summon assistance.

The next morning at 6.30 she was taken to doctor No. 2. He examined her and said he thought she had food poisoning which he said took 36 hours to wear off. He gave her an injection and said that he would check her again later. She was then left on a trolley in a busy corridor, but was later taken to the children's ward and was again put on a drip. She was left there the whole day without being attended to. At about 4 p.m. the same day she was seen by doctor No. 2. By now she was experiencing pain in the side and she suggested to him that she might have appendicitis. The doctor agreed that this might be the case. He informed her that there were no surgeons on duty at the hospital and that she should contact her own personal doctor and make arrangements with him.

The patient was taken off the drip and fortunately a friend present was able to transport her to her own private doctor. She reached his office just before he was due to close. The doctor told her that she required an immediate operation. Half an hour later she was operated upon by a surgeon at a private hospital and the surgeon later told her that had she not then been operated upon she might have died as her appendix had already ruptured.

At no stage whilst in the large hospital had blood tests been performed. (If such tests had been carried out, it would have been clearly established that the patient was suffering from appendicitis and not food poisoning.)

Comment: This was a clear case of medical negligence. The first two doctors did not employ reasonable skill and care in dealing with this patient. The patient's condition would have been properly diagnosed had the correct procedures been followed. The second doctor's action of leaving the patient to engage in self-help by way of contacting her own doctor at a stage when she was already in a critical condition was totally unacceptable conduct. Had the patient died, a charge of culpable homicide could have been brought.

Case 6

Failure to diagnose wrist fracture by casualty doctor (South Africa)

In *Buis v Tsatsarolakis* 1976 (2) SA 891 (T), a casualty doctor at a hospital treated a patient who was experiencing pain as a result of a blow to his wrist by an engine handle. An X-ray was taken but no evidence of a fracture was found. A further X-ray was taken a week later and again the radiologist found no evidence of a fracture. Finally, a week later, an orthopaedic surgeon at the hospital ordered further X-rays and these revealed a fracture of the scaphoid bone. The patient sued for damages, alleging negligence on the part of the casualty doctor for failing to diagnose this fracture in the beginning, since this failure to diagnose and treat had led him to suffer an unnecessary period of pain.

Expert evidence disclosed that this type of fracture was extremely difficult to diagnose and that it took up to 3 weeks to become apparent on X-rays. In addition, the casualty doctor had been reassured clinically when he saw the patient for the second time as by then the swelling had substantially disappeared and the pain had been reduced.

The court held that the correct standard to apply to this sort of case was not how a specialist orthopaedic surgeon would have acted in the treatment of the patient but how an ordinary general practitioner carrying on their duties as a casualty officer in a public hospital would have acted. Applying this standard, the court found that the doctor had not been negligent.

Anaesthetics: cases

Case 7

Dangerous experimentation and inadequate aftercare (Zimbabwe)

In *S v McGown* 1995 (1) *ZLR* 4 (H) the anesthetist was convicted of two counts of culpable homicide arising from the deaths of two children due to post-operative complications. It found that the deaths were reasonably foreseeable and the anaesthetist had failed to take reasonable steps to prevent these deaths.

Count 1, a two-year-old child was admitted to hospital to undergo a routine circumcision operation under general anaesthesia. After the operation the accused administered 1.25 mg of morphine caudally to the child together with adrenalin and lignocaine to control post-operative pain. After the child had been in recovery for only two minutes, he had released the child into the custody of the parents who had taken him home. The child died that night. The child's respiration had been depressed due to the morphine and the other drugs. The child had vomited and because his reflexes were also depressed, he was not able to eject the vomit from his airway. He died from asphyxia.

The court held that it was reasonably foreseeable that the child would die if complications arose as the parents would be completely unable to cope with the situation.

Count 2, the doctor administered 4 mg of morphine together with adrenalin and lignocaine to a child aged ten who had undergone appendectomy surgery under general anaesthesia. After the operation the accused

discharged the boy into a general ward. He died that night due to respiratory depression due to the combined effects of the general anaesthesia and the drugs administered epidurally to relieve post-operative pain.

The first issue in both cases was whether the accused was negligent in using morphine epidurals for the control of post-operative pain. The court found, on the basis of the medical testimony, that it was not in itself "wrong" for the accused to have administered epidural morphine even to a young child.

The court's finding that the accused was guilty of culpable homicide was on the basis that the accused failed to ensure proper post-operative care. It said that all the medical experts agreed that the risks attaching to the anaesthetic process employed on the two children made it imperative that the children be under appropriate medical surveillance in hospital for 24 hours after their operations. Either the children should have been in a high care ward which was available at the hospital or in a general ward in which the nurses had been specially trained to monitor the children and to be able to respond properly to any complications that could arise from the procedure.

In respect of the child who was circumcised, Count 1, the accused was guilty of gross negligence. After the child had been in recovery for only two minutes, he had released the child into the custody of the parents who had taken him home. It was reasonably foreseeable that the child would die if complications arose as the parents would be completely unable to cope with the situation.

In respect of the situation of the child who had had an appendectomy, Count 2, the child was admitted into a general ward in which a single nurse had to attend to ten child patients in the ward. The accused was negligent in discharging the child into this ward where proper post-operative facilities were not available whereas he could have discharged the child into the high care ward which was available at the hospital. He failed to ascertain what facilities were available and he was negligent in not checking that the facilities in the general ward were adequate. His negligence was compounded by the accused giving the nurse inadequate and misleading instructions as to how to deal with the patient which she had followed. The court did not accept that the nurse had herself been negligent in the way in which she had responded when the complications arose but, even if she had been negligent in failing to call for help immediately, it was reasonably foreseeable that she would not be able to cope and any negligence on her part did not break the causal link between the accused's negligence and the death of the child.

Case 8

Contaminated anaesthetic (UK)

In *Roe v Ministry of Health and Anor* [1954] 2 QB 66, two labourers were admitted to hospital for minor operations. After these operations, both were permanently paralysed from the waist downwards. The cause of this was that the anaesthetic injected into their spines before these operations had become contaminated with phenol, in which liquid the ampoules of anaesthetic had been stored in order to keep them sterile.

The ampoules had developed tiny cracks which were invisible to the naked eye and the sterilizing liquid had seeped through these cracks into the anaesthetic. The anaesthetist had then used the contaminated anaesthetic without knowing that it had been contaminated. Before using them, he had visually carefully inspected the ampoules for cracks and had found none.

The court found that there had been no negligence, as at that time it was not known to medical science that ampoules could develop such minute cracks and that any solution in which they were stored could seep through and contaminate the contents. This case brought to light this phenomenon and thereafter the danger was known

and written about in medical journals. Thus, if a hospital was to have continued thereafter with this unsafe method of storage, negligence would have been present.

Case 9

Faulty equipment (UK)

A hospital was held liable for a fault in anaesthetic equipment as the fault would have been detected if reasonable care had been exercised. The result of this fault was that a young teacher received nitrous oxide instead of oxygen during a routine operation and suffered severe brain damage and blindness. In terms of s 27 of the Zimbabwean Professional Conduct Regulations—

> No medical practitioner shall, in the course of his work, make use of any apparatus or treatment of any nature whatsoever which proves, upon an investigation by the council, to be incapable of fulfilling the claims made with regards to it: Provided that it shall be a good defence if the practitioner proves that he acted *bona fide* in making use of such equipment.

It should be noted that if a doctor is being sued for alleged negligence arising out of use of faulty equipment, the fact that the doctor acted *bona fide* would not be decisive. The critical issue would be whether a reasonable doctor would have detected the fault and corrected it before the patient suffered harm.

Case 10

Breathing tube placed in oesophagus instead of trachea (South Africa)

In *S v Kramer* & *Anor* 1987 (1) SA 887 (W), an anaesthetist was found guilty of culpable homicide (negligent killing). Due to his negligence he had incorrectly placed a tube in the oesophagus instead of in the trachea, as a result of which the patient died from lack of oxygen. (The patient was a girl who was undergoing a tonsils and adenoids operation.) The anaesthetist had also been negligent in failing to monitor the patient's condition properly and to detect timeously the misplacement of the tube. (On appeal, the surgeon was held not liable for culpable homicide on the basis that it was not his duty to check on the tube and the trachea prior to the operation. This duty was that of the anaesthetist.)

Treatment: cases

Case 11

Cast improperly applied (Zimbabwe)

In *Magwara v Minister of Health* 1981 ZLR 315, a patient sustained an unstable bimalleolar fracture dislocation to the right ankle. He was taken to the casualty department of a large urban hospital. A plaster cast was incorrectly applied. No X-ray was taken that day or the next day as it should have been. Only two weeks later was this done, revealing that the fracture was in an unacceptable position and thus required immediate correction. Despite this discovery, the doctors failed to take the appropriate remedial action and, as a result, the injury did not heal properly. In this case negligence was admitted by the Ministry of Health on behalf of the hospital.

Case 12

Failure to diagnose and promptly treat ischaemia (South Africa)

In *Blyth v van den Heever* 1980 (1) SA 191 (A), the patient suffered fractured bones in his right arm. The doctor performed an open reduction and an unsplit plaster cast was applied. Some days later massive sepsis together with an ischaemic condition had set in. By the time the case was referred to another doctor for treatment, the arm had already been irreparably damaged to a very grave extent.

The first doctor was found liable to pay damages because of his negligent failure to detect timeously, despite clear warning signs, that ischaemia was setting in. Had he shown the care of a reasonable doctor he would have detected the problem and taken appropriate action before the problem developed beyond control.

Case 13

Excessive force to remove small growth

In *Pringle v Administrator of Transvaal* 1990 (2) SA 379 (W), the doctor used excessive force to remove a small growth on chest and caused massive bleeding and brain damage. The doctor was held liable.

Case 14

General practice not followed (UK)

In *Clarke v MacLennan* [1983] 1 All ER 416 (QB), after the birth of her first child, the patient suffered stress incontinence. To treat this, a gynaecologist performed an operation but this made the condition worse. It is generally recognised by doctors that this operation is not to be performed until at least three months after giving birth to a child. The gynaecologist had performed the operation only one month after birth. The court found that this departure from the general practice was not justified in the circumstances and was negligent.

Case 15

Syringe needle breaking off and lodging in patient (South Africa)

In *Mitchell v Dixon* 1914 AD 519, a syringe was inserted into a patient's chest cavity. The needle broke and lodged in the patient's back. It was probable that the reason for the break was some sudden movement on the part of the patient when the needle was being inserted. Thus the doctor could not be found to have been at fault in respect of the breaking of the needle and he was found not liable to pay damages.

Case 16

Leaving of swab in patient's body (South Africa)

In *Van Wyk v Lewis* 1924 AD 438, a doctor left a swab in the patient's body after performing an urgent and difficult operation. The operation had taken place in a hospital at night. The doctor had been assisted by a qualified nurse. The swab had remained in the patient's body for 12 months. It was the usual practice at the hospital to rely upon the nurse to count and check the swabs used. The nurse had believed that all the swabs had been removed and the doctor had made as careful a search as the critical condition of the patient allowed before sewing him up.

In these circumstances the court found that the doctor had not been negligent.

The surgeon must allow sufficient time for the check to be made and before completing the operation should ascertain by direct enquiry whether all the swabs and packs have been accounted for. The nurse should inform the surgeon of any discrepancy in the routine checks.[14]

In *van Wyk v Lewis* 1924 AD 438 at 456 the judge said the following on the standard of competence of a surgeon:

> …the surgeon will perform the operation with such technical skill as the average medical practitioner in South Africa possesses and that he will apply that skill with reasonable care and judgment…(he) is not expected to bring to bear on a case entrusted to him the highest possible professional skill but is bound to employ reasonable skill and care and is liable for the consequences if he does not.

[14] The Medical Defence Union *Theatre Safeguards* p.6.

Case 17

Swab left in patient

In *Goliath v Member of the Executive Council for Health, Eastern Cape* (085/2014) [2014] ZASCA 182, a swab was left in a patient after a hysterectomy operation. On appeal. the court found that the plaintiff had discharged the onus of proving on a balance of probabilities the negligence averred against the defendant.

Case 18

Failure to monitor foetal heart of unborn child

In *MEC for Health and Social Development, Gauteng v MM on behalf of OM* (Case no 697/2020) [2021] ZASCA 128, a woman in hospital gave birth to a child with cerebral palsy. She was a high-risk patient with ruptured membranes and was HIV positive. The latter is a risk factor for hypoxia. It is common ground that both of these factors signalled the need for careful monitoring, *inter alia*, by way of a cardiotocograph (CTG) to measure foetal heart patterns. If the foetus is not supplied with sufficient oxygen, abnormal heart rates result. There are various warning signs of impending foetal hypoxic distress. Where these are present, the medical staff need to take action. The medical staff negligently failed to monitor the patient properly for these warning signs and take action. As a result of this negligent, the baby suffered cerebral palsy which condition could have been avoided. The hospital was liable.

Case 19

Error in monitoring baby's blood

In *Wilsher v Essex Area Health Authority* [1986] 3 All ER 801 EHL 24-Jul-1986, a premature baby suffered injury after mistaken treatment by a hospital doctor. He had inserted a monitor into the umbilical vein. The claimant suggested the treatment should have been by a more senior doctor. The hospital appealed.

Wilsher v Essex Area Health Authority 1987 QB 730 junior doctors made an error in monitoring baby's blood and on two occasions baby received an excess of oxygen. It was alleged that this led the baby to develop condition that left baby almost blind. It was argued that the junior doctors did their best in view of their inexperience. This was rejected law requires all doctors to meet standard of competence required, although it is recognised need to train doctors on the job.

Case 20

Incomplete surgery leading to infection and failure to monitor after operation

In *Y M v MEC Department of Health Free State & Anor* Case No 4551/2015, an emergency appendectomy was performed upon the plaintiff at a hospital. The appendix was only partially removed; the residue of the appendix became infected and this led to severe sepsis in the abdomen of the plaintiff.

The court held that the medical personnel had not acted in accordance with accepted medical and surgical standards. The plaintiff has established that the post-operative care administered to her was not the reasonable and acceptable medical care expected from specialist medical practitioners. The personal loss and damage suffered by the plaintiff resulted from the negligent conduct of the defendants and/or their employees, both in not performing the appendectomy according to accepted medical and surgical procedures as well as rendering inappropriate and unacceptable post-operative medical care to the plaintiff. They had failed to properly monitor the plaintiff's condition post-surgery and had discharged without ensuring that her condition was stable.

Case 21

Use of forceps during delivery

In *Whitehouse v Jordan* [1981] 1 All ER 267 (HL), the claimant was a baby who suffered severe brain damage after a difficult birth. The defendant, a senior hospital registrar, was supervising delivery in a high-risk pregnancy. After the mother had been in labour for 22 hours, the defendant used forceps to assist the delivery. The Lords found that the doctor's standard of care did not fall below that of a reasonable doctor in the circumstances and so the baby was awarded no compensation.

Administration of drugs: cases

Case 22

***Pharmacist mislabelling drugs* (Zimbabwe)**

In *Green v Hardcombe t/a Albert Zinn Medical Centre & Anor* HH-239-20*,* a doctor had prescribed ciprofloxacin tablets for the plaintiff and had prescribed that the plaintiff was to take one tablet a day until the tablets were finished. The pharmacist dispensing the tablets had mislabelled the sachets containing the tablets in such a way that led the plaintiff to think that all the tablets were to be taken together in one dose. The plaintiff suffered kidney failure as a result of taking all the tablets in a single dose. The plaintiff successfully sued the pharmacist and the pharmacy for damages. The court found the pharmacist was negligent.

In *Thebe v Mbewe t/a Checkpoint Laboratory Services* 2000 (1) ZLR 578, (S) P had a routine blood test for insurance purposes. The test, carried out in D's laboratory, showed positive for AIDS. P immediately went for further tests, both with her own doctor and at the instance of the insurer. The results of both these further tests were negative for AIDS. P claimed damages for shock and suffering caused by D's alleged negligence. The court held that D's laboratory as a professional institution was obliged to exercise reasonable skill and care. The laboratory had been guilty of professional negligence. It had made an error in the collecting and labelling of the blood sample in question. This error was in relation to the most fundamental aspect of blood testing. The laboratory was thus liable to P. This negligence was not an "inherent risk" of the kind that is attendant on surgical procedures, nor was it an excusable error of judgment of the kind a professional person might make.

Case 23

Wrong dosage given to patient (South Africa)

In *S v Mkwetshana* 1965 (2) SA 493 (N), a doctor was serving his twelve months' internship after qualifying at a hospital. He was the only doctor on duty when he was called by a nurse to examine a female patient who was in a distressed condition. (This patient had been under treatment for bronchial asthma.) The patient was restless, kicking her feet and waving her arms. Her lips and tongue were bluish. The doctor diagnosed acute asthma and injected the patient with a recognised drug for asthma. Some minutes later when the condition of the patient had not improved, the doctor thought that he might have overlooked the possibility that the patient could be suffering an epileptic attack and proceeded to inject 20cc of undiluted paraldehyde intravenously. This was a massive overdose and the patient died therefrom. (A safe dose was no more than 5cc diluted in saline in proportions of 1-10.)

The court found the doctor guilty of culpable homicide (negligent killing). It was held that as the doctor had insufficient knowledge and experience of this drug, he should have checked first as to the correct dosage or should have refrained from administering it and instead have sent for a more experienced doctor. In coming to this conclusion, the court took into account that the doctor was inexperienced, that he was faced with an emergency and that no other doctor was immediately available (but an experienced doctor could have been summoned speedily). Even taking into account these factors, the doctor had in the circumstances been negligent.

Case 24

Wrong dosage (UK)

Nurses who administered a wrong dosage of paraldehyde through misreading the amount ordered by the doctor, when they could easily have checked what the correct dosage was, were held liable to pay damages.

Case 25

Wrong drug (UK)

The hospital was held liable when an inexperienced doctor injected cocaine instead of procaine into a patient. *Collins v Hertfordshire County Council* [1947] KB 598.

Case 26

Wrong surgical procedure

In *Maksimovich v Dominguez & Mater Dei Hospital* and *Mater Dei Hospital v Domiguez & Maksimovich* HB-94-15, it was alleged that the doctor, an ear and nose specialist, had negligently carried out an incorrect and inappropriate reduction of the double-fractured mandible leaving the plaintiff with a variety of facial injuries problems including paralysis of the left eye. He also failed to discover pieces of glass in the plaintiff's ear.

Case 27

Doctor had inadequate training on equipment (South Africa)

In *Dale v Hamilton* 1924 WLD 184, 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 the treatment of the defendant in conducting the X-ray examination. The defendant had only limited training and experience in radiography and the X ray equipment at the hospital had been old when he first went 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 on costs. The defendant had some training on the new equipment that 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. 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 that 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. It also awarded damages for pain and suffering and loss of general health.

It is thus clear that a physician cannot defend themself by averring that they tried their best in accordance with their abilities and professional knowledge. If they are incompetent to treat a patient's specific illness, they are obliged to refer the patient back to a specialist. A general practitioner will not however, be blamed for their lack of knowledge, training or experience if they undertake specialist work in an emergency. This is a clear case of *imperitia culpae adnumeratur* i.e. where lack of skill is reckoned as a fault.

Case 28

Negligent performance of surgery

In *Correira v Berwind* 1986 (1) ZLR 192 (H), the court found that surgery had been performed negligently.

Case 29

Administration of overdose of drug (South Africa)

A doctor administered a dangerous drug with which he was unfamiliar to a patient and the patient died. He was convicted of culpable homicide. The court held that a doctor should never use a drug that is new or unfamiliar to him without first satisfying himself as to its properties or without first acquainting himself with the proper methods of using it.

Case 30

Penicillin allergy—liability (USA)

When a patient had been given penicillin on a previous occasion, he had developed a rash and his doctor had warned him against ever taking the drug again. He had given him a note to keep in his wallet indicating that he was allergic to penicillin.

The patient was subsequently involved in a road accident and was brought to the emergency room of a hospital where he gave an intern doctor the note from his wallet. The intern did not enter this information on the patient's hospital chart. When the patient was undergoing surgery, the intern remembered about the allergy and took the patient's note to the operating theatre where he gave it to a nurse. He told the nurse to inform the surgeon about the letter but she failed to do so. Penicillin was administered to the patient both during surgery and afterwards. The patient told a nurse who was about to administer penicillin to him that he was allergic to the drug but she insisted on giving it to him.

Finally, after several days the patient refused to receive the injection until he saw his surgeon. When the surgeon was told about the patient's allergy, he ordered an immediate cessation of penicillin treatment, but the patient still suffered an acute and serious cardiovascular accident due to the penicillin which had previously been administered to him. The hospital was held liable to pay damages because of the harm which had been caused by the negligence of its staff.

Case 31

Penicillin allergy—no liability (USA)

A patient was being treated for an infected finger. The doctor asked her whether she was allergic to penicillin. She said she was not and that she had had penicillin on previous occasions and there had been no adverse reactions. The doctor then proceeded to give her a penicillin injection and she dropped dead from anaphylactic shock.

The doctor was held not liable because he had used all known means to determine whether she was allergic to penicillin.

Case 32

Post-operative care (Zimbabwe)

In *S v McGown* 1995 (1) *ZLR* 4 (H), an anaesthetist was held criminally liable for causing the deaths of two patients. He had used an anaesthetic technique which required careful monitoring of the patient's condition after the operation and had failed to take reasonable steps to ensure that the facilities were available for the post-operative monitoring. In this case the court quoted a dictum from an English case as follows: "It is not every slip or mistake which imports negligence and, in applying the duty of care to the case of the surgeon, it is peculiarly necessary to have regard to the kinds of circumstance."

Poor communication leading to mistakes: cases

Case 33

Referral to own doctor (UK)

A butcher had injured his abdomen with a boning knife. He was taken to a local hospital which had no resident medical staff. A visiting doctor thought the patient had only sustained a surface wound and had it stitched and dressed. The butcher was then sent home with instructions to see his own doctor that evening. The butcher told his own doctor that he had been examined and that his wound was superficial, which his doctor accepted. The knife had in fact ruptured the butcher's peritoneum and he died two days later. It was accepted that he would have lived if there had been proper examination and surgical treatment on the day of the injury.

The court originally held the first doctor liable for negligence for failing to communicate directly with the second doctor but, on appeal, it was held that his failure to do so was not negligent since he had told the butcher to see his own doctor immediately and this meant that he had taken reasonably sufficient steps to safeguard the patient.

Case 34

Inadequate instructions to patient under treatment (UK)

A physiotherapist told a patient who was receiving diathermy treatment: "When I turn on the machine, I want you to experience a comfortable warmth and nothing more; if you do I want you to tell me."

The court held this to be an inadequate warning of the danger of excessive heat from the apparatus and of the need to call out if this happened. The physiotherapist was held liable to pay damages for causing burns to the patient.

Case 35

Inability to contact doctor when required (UK)

In *Corder v Banks The Times* 9 April 1960, a plastic surgeon who had performed a cosmetic operation on an outpatient gave her his telephone number in case of an emergency. However, when bleeding began, she was unable to contact him and so suffered permanent disfigurement. The judge ruled that the patient had been properly treated originally but that the doctor was negligent for failing to ensure that he could be contacted when it became necessary.

Case 36

No instructions on how soon patient could get up after operation (UK)

A patient got up the day after a minor operation and fainted and fractured her skull. The hospital was found to be blameworthy because the patient should have been warned to stay in bed for a sufficient period. *Chimusoro & Anor v Minister of Health* HH-254-89.

Problems with fault-based system of compensation of patients

The vast majority of people in Zimbabwe have no medical insurance as such insurance for them is unaffordable. If they require medical treatment, they will struggle to patch together even the low fees charged by government hospitals. They certainly will not be able to pay for the superior medical care provided by private medical institutions.

If during medical treatment ordinary people suffer further harm due to alleged medical malpractice, and it is denied by there was negligence, the only way they will be compensated is if they prove in court that there was medical negligence.

As has been seen, the system for compensating patients injured by medical malpractice is fault-based. Liability of a doctor or nurse is dependent on proof that the doctor or nurse was negligent and the negligent conduct caused the harm suffered by the patient. To succeed in a civil claim for compensation, the patient would have to prove on a balance of probabilities that the doctor or nurse negligently caused them harm.

Patients in Zimbabwe who allege that they have been harmed by medical negligence face a daunting battle to obtain compensation. The injured party will need the assistance of a lawyer to litigate the matter and the lawyer will need to call medical testimony to try to prove that there has been negligence on the part of the medical practitioner who is being sued. Many patients will not be able to afford to engage a lawyer and the expense of calling an expert witness. Government legal aid facilities for civil litigation is largely unavailable. In a small number of cases non-government organisations, such as Zimbabwe Lawyers for Human Rights, will litigate on behalf of such injured persons.

Even if the patient can afford to engage a lawyer in order to mount a civil action or obtains legal aid to do so, the litigation will often be protracted and compensation which is needed immediately will only be secured long after the harm was caused. Yet especially if the medical malpractice has resulted in serious harm, the patient needs compensation immediately.

There is the added difficulty in the context of Zimbabwe and that is to find a medical expert who is prepared to testify against a medical colleague. This is because in Zimbabwe the medical profession is small and closely knit and members of the profession know each other on personal levels. To some extent, testifying against a fellow professional is still frowned upon as being in itself unprofessional and thus evidence of negligence may be difficult to come by. In her article,[15] Ms Pepetua Dube points out some of the other evidentiary problems faced by litigants. She points out that medical records may not have been kept properly or may be lost or even deliberately altered or destroyed. She also points out the difficulties in pinpointing the medical professional who was the person who was at fault as different nurses and different doctors may have been caring for the patient at different stages. In the light of these difficulties, Ms Dube suggests a series of measures to try to make it easier for victims of medical negligence to sue, such as by reversing the onus of proof and requiring the medical practitioner to prove that they were not at fault.

If the doctor or nurse accused of medical negligence denies that they were negligent, they will have to spend time and money to defend the claim in court; the trial is likely to be reported and that is likely to affect their professional reputation even if the court exonerates them.

The whole process of dealing with claims for medical negligence through the court system is both costly and laborious.

A further point is that even if the patient is harmed by a mistake made by a doctor, the doctor will not be held liable if the court finds that the mistake was an excusable rather than a negligent mistake, yet the patient has still been injured by a mistake but is not able to recover damages.

Because of the shortcomings of the fault system for compensating victims of medical malpractice, a number of countries have introduced or are considering the introduction of a no-fault system.

In Zimbabwe we already have a no-fault system The National Social Insurance scheme entitles workers to claim

[15] Dube, P. "Towards Defining and Reforming the Current Law of Medical Malpractice" 1999 Vol 1 No 1 *Legal Forum* 36.

from a workers' compensation fund some compensation for injuries they have sustained in their workplaces. They do not have to establish that their injuries were caused by negligence on the part of their employers; they can claim from the fund even if their employers were not negligent. Employers are required to pay into the compensation fund.

This scheme, however, does not provide for compensation for harm caused by botched medical procedures.

New Zealand has a radical comprehensive no-fault liability system under which persons injured in accidents at work, at home and in road accidents are entitled to receive compensation from a fund financed by taxation. This scheme provides compensation for most forms of personal injury suffered by patients receiving treatment from health professionals. The essence of this system is that society should take responsibility for providing compensation to victims rather than leaving the injured parties to try to recover damages by litigation against those who caused the injury. It is a form of social insurance. Sweden has standalone legislation dealing with compensation, although fairly restricted, for injuries to patient by malpractice, on a no-fault basis.[16]

We will only deal here with the feasibility of establishing a no-fault scheme to compensate victims without the need for litigation. In considering this proposition, two key issues will arise. The first and foremost is how such a scheme would be funded and who would administer the fund. Secondly, the question will need to be answered as to whether we will no longer be holding the negligent medical professional accountable for their actions. The response to the point of accountability is that a no-fault compensation scheme still allows negligent doctors and nurses to be subjected to stern disciplinary measures by the medical professional body set up for this purpose. After patients have been compensation has been paid to injured patients, the fund could then require the culpable doctors and nurses to pay costs of the compensation pay-outs.

The biggest stumbling block to the introduction of such a scheme into Zimbabwe is the matter of costs. Although government will save considerable amounts by taking away these cases from the court system which government funds, nonetheless government will still have to establish and fund an administrative structure to operate the fund. Crucially, is the matter of where the pool of money to compensate victims will be procured. The entire public health sector is in tatters due to drastic underfunding and the exodus of doctors and nurses due to very poor salaries and unsatisfactory working conditions. Zimbabweans are already heavily overtaxed and doctors and nurses and the general cannot be looked to pay an extra tax to fund this project. Local and imported medicines are already very expensive and it would cause an outcry to impose further taxes on these medicines.

Until the economy picks up and the health sector as a whole has been rehabilitated, much as a no-fault system would be very beneficial to injured patients, a scheme along these lines would appear to be a long way off.

In the meantime, there is one possible way to alleviate the plight of patients that have been harmed rather than cured by medical treatment. That is to give additional powers to the professional disciplinary body to order doctors and nurses found guilty of medical malpractice to pay compensation to the victims in accordance with scales similar to those used for workers' compensation. This compensation will certainly not be full compensation but, as in the workers' compensation scheme, the injured patients will be entitled to claim additional compensation in court actions. In such actions, proof of negligence will be required. There will need to be a mechanism for dealing with those who do not pay the compensation ordered by the disciplinary tribunal.

[16] Brazier and Cave pp. 276-278 and Mason and McCall Smith pp. 110-117.

In many ways, the system of in-house discipline of erring health professionals by fellow health professionals is a salutary one provided that the disciplinary body ensures that proper professional standards are upheld. The public need to be assured that the disciplinary body will not be biased in favour of the doctors and nurses and will not seem to find untenable excuses to exonerate the medical professionals. Once this is assured, it makes good sense that a panel of medical professionals who are operating the same fields as the accused doctors assesses objectively whether the doctors have erred. The confrontational court system where judicial officers without any medical training are supposed to assess medical evidence is far from ideal.

Professional discipline of medical practitioners

A serious breach of professional standards by health practitioners may result not only in a doctor or nurse being sued or prosecuted in a court of law, but also in separate disciplinary proceedings within the profession itself, with the ultimate penalty being that the doctor or nurse is struck off the professional register so that they are no longer permitted to practice medicine or to nurse.

The provisions for dealing with professional misconduct are in addition to the provisions in the Health Professions Regulations 2022 which in part VIII set out the mechanisms for dealing with work related misconduct by employees in the health sector. These provisions are dealt with later in the section entitled Contracts of Doctors and Nurses.

We saw previously that a doctor who negligently causes the death of a patient can be found guilty of the criminal offence of culpable homicide. The doctor can also be found guilty of other criminal offences, such as assault if they perform surgery on a patient without the patient's consent. A gynaecologist who sexually assaults a patient whilst purporting to examine her will be guilty of a criminal offence such as rape or indecent assault.

At civil law, a doctor can be also sued for damages if they negligently treat and cause harm to the patient. A doctor who discloses confidential medical information relating to their patient to persons who are not entitled to receive that information can be sued for damages under the *actio injuriarum*.

But the liability of the doctor does not stop after they have been held at law criminally or civilly liable. The medical profession has a vested interest in ensuring that all medical practitioners adhere to reasonable professional standards and thus medical practitioners who fall below the required standards are subject to a separate disciplinary process.

If the disciplinary matter is likely to arise from criminal proceedings underway or pending against the doctor, the disciplinary proceedings can be postponed until the criminal case has been concluded [s 112(2)(b)]. After conviction by the criminal court, the disciplinary committee can request a copy of the criminal record and, without hearing further evidence, it may decide that the criminal offence constitutes—

(*a*) improper or disgraceful conduct; or

(*b*) conduct which, when regard is had to the profession or calling of that person, is improper or disgraceful.

In this instance the medical practitioner is entitled to address the committee on the matter of extenuation (s 111). Thus, in the case of Dr McGown who was convicted of three counts of culpable homicide, the disciplinary committee dealing with his case decided that he was guilty of improper or disgraceful conduct and he was struck off the register of medical practitioners.

Subjecting the medical practitioner to both criminal and disciplinary proceedings does not violate the

constitutional provisions disallowing double jeopardy as this provision only prohibits a person from being tried twice and punished twice by the criminal courts for the same criminal offence. The medical profession is thus not stopped from taking separate disciplinary proceedings against the offending medical practitioner to uphold professional medical standards.

Health Practitioners of the Health Professions

The details of the disciplinary process relating to medical practitioners are contained in Part XIX Discipline of Health Practitioners of the Health Professions Act [*Chapter 27:19*].

That Act establishes the Health Professions Authority which is the body in charge of all health professionals. The Act makes provisions for various councils to covers the different branches of the Health Professions in Zimbabwe. Each council has a disciplinary committee to deal with discipline of members of that branch of the profession. These are the professional councils—

- Allied Health Practitioners Council;
- Environmental Health Practitioners Council;
- Medical and Dental Practitioners Council;
- Medical Laboratory and Clinical Scientists Council;
- Medical Rehabilitation Practitioners Council;
- Natural Therapists Council;
- Nurses Council;
- Pharmacists Council.

Any member of the public is entitled to make a complaint to the Health Professions Authority about alleged medical misconduct and these complaints will be investigated.

Medical and Dental Practitioners Council of Zimbabwe: composition, process and functions

The Medical and Dental Practitioners Council of Zimbabwe[17] points out that in terms of s 112 of the Health Professions Act [*Chapter 27:19*] any allegations which might be a subject of an inquiry by the Disciplinary Committee of Council will be first investigated by the Executive Committee (Excom) through the Preliminary Inquiries Committee (PIC). The PIC is a Committee, whose majority of members are senior members of the profession who are not members of the Council, from both the medical and dental professions. Only after exhaustive investigations which include interviews will a case be referred to the Excom. Excom is comprised of Chairpersons of Committees of Council who will review recommendations and may refer the cases back to PIC for further investigation if not satisfied with the evidence and findings of the PIC. After these investigations are concluded, if Excom decides that the health practitioner should be brought before a disciplinary committee, it will refer the matter for a disciplinary inquiry.

If the complaint is found to have substance but it is not a sufficiently serious matter to warrant referral to the Disciplinary Committee, it can be dealt with by means of an informal warning or admonition from the Excom Committee which is entered in the record of the medical practitioner or nurse. In more serious cases the matter is referred to the Disciplinary Committee so that a formal enquiry can take place.

[17] Medical and Dental Practitioners Council of Zimbabwe Disciplinary Bulletin No 1 July 2014. Available on website of the Health Professions Authority https://www.hpa.co.zw/

The Bulletin publishes some of the cases that appeared before the Disciplinary Committee of the Medical and Dental Practitioners Council (MDPCZ). The names of the practitioners have been removed but they are based on real cases.

The key points of disciplinary inquiry process are set out below.

Composition of disciplinary committee

Each council has a disciplinary committee consisting of—

- the chairman of the council, who will be chairman of the committee (if the chairman considers that he should not be chairperson in a particular case he will appoint another member of the council in his place)
- not less than two and not more than four other persons who must be—
- specially appointed to the committee for the particular inquiry by the chairman of the council in consultation with the council's Excom; and
- either members of the council concerned or registered on the same register as the person in respect of whom the inquiry is to be held.

At least one of the persons appointed must be registered on the same register as the person in respect of whom the inquiry is to be held.

All the members of the committee will thus be senior health practitioners.

Function of disciplinary committee

The committee must inquire into allegations that registered persons whom the council represents—

- have been guilty of improper conduct or disgraceful conduct or conduct which, when regard is had to their professions or callings, is improper or disgraceful; or
- are grossly incompetent or have performed any act pertaining to their professions or callings in a grossly incompetent manner.

Improper or disgraceful conduct (what we may call professional misconduct in short) is not limited to misconduct in a doctor or nurse's professional activities such as medical negligence. Any behaviour may be regarded as misconduct if, in the opinion of the Health Professions Council, it tends to make a doctor or nurse unfit to discharge their duties of medical or nursing practice. Situations may arise where a doctor or nurse or any other person registered with the Health Professions Council is charged and convicted in a court of law with an offence which may properly be regarded as improper or disgraceful to the health profession. For example, a doctor or nurse convicted of knowingly being the landlord of a brothel or living on immoral earnings, although not directly affecting the professional capacity of that doctor or nurse, will constitute professional misconduct and empower the Council to strike him or her off the register. It is not possible to list all offences which may lead to further disciplinary proceedings but most certainly prostitution, pimping, serious assaults, murder, robbery, rape, drug trafficking and all other similar serious offences will be considered improper or disgraceful to the health profession.

The Disciplinary Committee's enquiry into a medical practitioner's improper or disgraceful conduct does not stop an employer, for example, the Ministry of Health, from enquiring into the case independently. Where necessary the employer may terminate the contract of employment (following the procedure laid down in the Labour Act without waiting for a final decision from the Disciplinary Committee or the Council.) An independent enquiry of this nature was carried out in 1987 when a 17-year-old girl who had given birth for the first time alleged that she delivered her baby unattended in a toilet at Mpilo Central Hospital. She publicly complained that the nurse who was supposed to attend to her was guilty of gross negligence and improper and disgraceful conduct. The employer (the Ministry of Health) immediately carried out its own investigations. In this case the allegations were unfounded and as a result no action was taken by the employer. The matter was apparently not reported to the Council. An inquest was subsequently held regarding this matter. The magistrate held that the nursing staff had been at fault in failing to attend properly to the mother.

Disciplinary powers of disciplinary committee

If after due inquiry a disciplinary committee decides that a health practitioner—

- has been guilty of improper or disgraceful conduct or conduct which, when regard is had to his profession or calling, is improper or disgraceful and that such conduct warrants the cancellation of his registration; or
- is grossly incompetent or has performed any act pertaining to his profession or calling in a grossly
- incompetent manner;

the disciplinary committee must refer the matter to the council for the removal of the health practitioner's name from the register and may suspend him from practice pending a final decision by the council.

If after due inquiry a disciplinary committee decides that a health practitioner has been guilty of improper or disgraceful conduct or conduct which, when regard is had to his profession or calling, is improper or disgraceful but that such conduct does not warrant the cancellation of his registration, the disciplinary committee must do one or more of the following—

- order his suspension for a specified period from practising or performing acts specially pertaining to his profession or calling;
- impose such conditions as it considers fit subject to which he shall be entitled to carry on his profession or calling;
- order him to pay a penalty not exceeding an amount equivalent to a fine of level six, which penalty shall be payable to the council;
- order him to pay any cost or expenses of and incidental to the inquiry;
- censure him;
- caution him and postpone, for a period not exceeding three years, any further action against him on one or more conditions as to his future conduct, including the conduct or nature of his practice during that period (Provision is made for what is to happen if during the period of postponement there is non-compliance with the conditions imposed.)

A council may, in regulations made in terms of s 145, define what, in the case of any class of health practitioners whom the council represents, will constitute improper or disgraceful conduct.

If any health practitioner has counselled or knowingly been a party to the performance of any act in respect of which an unregistered person has been convicted of an offence under Part XX, the conduct of that health practitioner shall, for the purposes of this Part, constitute improper or disgraceful conduct provided that this subsection shall not be construed as exempting such a health practitioner from prosecution in a court for any offence which his conduct may constitute.

Procedures of committee

A legal practitioner will be present to advise the committee on matters of procedure and evidence.

The health practitioner must be given reasonable notice of the disciplinary proceedings against them and a reasonable opportunity of being heard either by himself or, if he so wishes, through a legal practitioner. Thus the health practitioner has a right to be represented by their legal practitioner if they so wish.

At any meeting of a disciplinary committee, the chairman and two other members shall form a quorum. All acts, matters or things authorised or required to be done by a disciplinary committee shall be decided by a majority vote at a meeting of the disciplinary committee at which a quorum is present. At all meetings of a disciplinary committee, each member present will have one vote on any question before the disciplinary committee and, in the event of an equality of votes, the chairman shall have a casting vote in addition to a deliberative vote.

Except as otherwise expressly provided in Part XIX, a disciplinary committee may regulate its procedure in such manner as it thinks fit.

Taking of evidence

A disciplinary committee may take evidence and may summon witnesses and require the production of any book, record, document, or thing; and through its chairperson, may administer an oath to any person and may examine any book, record, document or thing which a witness has been required to produce.

Expert witnesses, who are senior members of the same profession, may be called to give evidence on how a reasonable practitioner of the same experience, status and education would have conducted themselves given the same circumstances (reasonable person's test). It is important to note that a practitioner is judged by their own peers (concept of self-regulation). Thus practitioners are judged by members of the same profession and standing as themselves who make the determination on disciplinary cases. Council only enforces that determination made by the Disciplinary Committee.

A summons for attendance before a disciplinary committee or for the production to it of any book, record, document or thing shall be as nearly as practicable in the form prescribed by the council concerned and signed by the chairperson of the committee or the registrar of the council concerned. The summons should be served either by registered letter sent through the post or in the same manner as it would be served if it were a subpoena issued by a magistrate's court in criminal proceedings.

Any person who has been summoned who, without sufficient cause fails or refuses to attend and give evidence relevant to the inquiry at the time and place specified in the summons or refuses to be sworn or affirmed when the chairperson of the disciplinary committee wishes to administer an oath to him or fails or refuses to produce any book, record, document or thing which he has been required by that summons to produce or being a witness, refuses to answer or to answer fully and satisfactorily to the best of his knowledge and belief any question lawfully put to him shall be guilty of an offence and liable to a fine not exceeding level five or to imprisonment for a period not exceeding six months or to both such fine and such imprisonment.

Any person who gives false evidence on oath at an inquiry held in terms of this Part, knowing such evidence to be false or not having reasonable grounds for believing it to be true, will be guilty of an offence and liable to a fine not exceeding level seven or to imprisonment for a period not exceeding two years or to both such fine and such imprisonment.

Record of disciplinary inquiry

A disciplinary committee must keep a record of the proceedings, evidence heard and the decision and the reasons for the decision. shall, in any inquiry held by it in terms of this Part, record the proceedings and any evidence heard, and the decision made by it and the reasons therefor.

Minister to be informed

The Minister must be informed about all disciplinary cases and actions taken by the committee against health professionals.

Appeals

Under s 22 of the Health Professions Act [*Chapter 27:*19] practitioners have a right to appeal. The first appeal is to the Health Professions Authority which appeal must be lodged within 30 days. If not satisfied with the determination of the Authority, there is a further right of appeal to the Administrative Court, High Court and the Supreme Court. The Court will deal with such appeals in terms of s 128 of the Health Professions Act [*Chapter 27:19*]. The Courts will determine appeals based on expert evidence.

Publication of result of disciplinary proceedings

A registrar must, if so directed by the council or disciplinary committee concerned, cause to be published in the *Gazette* the name of any person—

- whose registration has been cancelled; or
- who has been suspended from practice.

No liability of Council, executive committee and disciplinary committee

Except as is provided in the Act, no legal proceedings, whether civil or criminal, will lie against a council, executive committee or disciplinary committee or any member or officer thereof in respect of any act or duty performed in accordance with provisions of the Act.

A council will not be responsible for any loss of earnings by a person as a result of action taken under this Part, whether by its disciplinary committee or executive committee or by the council and whether or not the finding or penalty is subsequently varied or cancelled.

Recovery of costs or penalty by council

A council may, by action in a competent court, recover any costs or penalty ordered in terms of this Part to be paid by a registered person.

Zimbabwe: Doctors Under Probe

At least 48 cases of incompetence and unethical conduct against doctors are investigated annually in Zimbabwe, the Medical and Dental Practitioners Council of Zimbabwe has said.[18]

This follows several complaints by patients who have reported that doctors are making errors in carrying out medical procedures or in diagnosis resulting in wrong prescriptions that pose dangers to health.

It emerged that in 2016, the Council received 93 complaints against doctors which led to cases. Seventy-three cases went through the preliminary enquiries committee while the remaining 20 were dismissed due to lack of evidence. From the 73 cases handled by the committee, 40 were referred to the disciplinary committee and 38 were found guilty.

Mrs Mwakutuya highlighted that whenever a complaint is received by the council, a committee of doctors carries out a preliminary evaluation of the facts. If there is any possibility that there is any substance to the complaint, then the matter is referred to a disciplinary committee. She added that practitioners who were dissatisfied with the findings of disciplinary committee could appeal, first to the Health Professions Authority of Zimbabwe, and then to the High Court and Supreme Court.

[18] *The Herald* 31 October 2016.

CONFIDENTIALITY

Confidentiality is one of the core duties of all medical practitioners and all nurses. It requires health care providers to keep a patient's personal health information private unless the patient has consented to the release of the information. Unauthorised disclosure of patient information is not only unethical but it may also lead to legal actions for damages against the offending doctors or nurses. In some countries like South Africa it is also a criminal offence. We will see later that this duty is not absolute and there are some situations is which disclosure is justified.

Medical Services Act

The Medical Services Act [*Chapter 15:13*] has added this section—

8G Confidentiality

(1) All information concerning a patient, including information relating to his or her health status, treatment or stay in a health institution is confidential.

(2) Subject to subsection (3), no person may disclose any information referred to in subsection (1) unless—

(a) the patient consents to that disclosure in writing;

(b) a court order or any law requires the disclosure; or

(c) non-disclosure of the information represents a serious threat to public health.

(3) A health care provider that has access to the health records of a patient may disclose such information to any other health care provider as is necessary for any legitimate purpose within the ordinary course and scope of his or her duties where such access or disclosure is in the interests of the patient.

(4) A health care provider may examine a patient's health records for the purposes of—

(a) treatment with the consent of the patient; and

(b) study, teaching or research subject to the consent or authority granted in terms of section 8G.

(5) If the study, teaching or research referred to in subsection (4) (b) discloses no information as to the identity of the patient concerned, it shall not be necessary to obtain the consent or authorisation referred to in that subsection.

In Zimbabwe, s 23 of the Medical Practitioners (Professional Conduct) Regulations 41 of 2004 provides that no medical practitioner may divulge confidential patient information which ought not to be divulged but it provides for exceptions such as where the disclosure is required by law. Breach of this regulation would amount to unprofessional conduct leading to disciplinary proceedings against the doctor concerned.

In *NM & Ors v Smith & Ors (Freedom of Expression Institute as Amicus Curiae)* 2007 (5) SA 250 (CC) the court held that the publication in a book of applicants' HIV status without requisite consent from them constituted wrongful publication of a private fact, in breach of applicants' rights to privacy and dignity. The court awarded damages.

There must be a relationship of trust as patients are only likely to confide in doctors if they know their doctors will not disclose patient information without their authorisation.

Obviously, a General Practitioner can pass on necessary patient information to a specialist treating the patient.

But it is totally unprofessional, for instance, to disclose to others at a party, medical details about a patient that those persons have no right to disclose.

Under the common law of delict (tort) the unlawful disclosure of confidential patient information constitutes what is known as an *injuria* for which the patient is entitled to sue for damages. In *Jansen van Vuuren & Another NNO v Kruger* 1993 (4) SA 842 (A), P's GP disclosed that P had AIDS to another GP and dentist from same town as P, who was known to latter two persons. P had specifically requested D not to disclose that he had AIDS and D had

agreed not to do so. D had no duty to disclose such information and the other general practitioner and dentist had had no right to receive it. The D's disclosure unreasonable and therefore unjustified and wrongful.

Disclosure is criminal offence in South Africa

In South Africa, they have these provisions in the National Health Act (No.61 of 2003):

> **Confidentiality**
> 14. (1)…
> (2) Subject to section 15, no person may disclose any information contemplated in health status, treatment or stay in a health establishment, is confidential. subsection 1) unless-
> (a) the user consents to that disclosure in writing;
> (b) a court order or any law requires that disclosure; or
> (c) non-disclosure of the information represents a serious threat to public health.
> **Access to health records**
> 15. (1) A health worker or any health care provider that has access to the health records of a user may disclose such personal information to any other person, health care provider or health establishment as is necessary for any legitimate purpose within the ordinary course and scope of his or her duties where such access or disclosure is in the interests of the user.
> "information" as defined in section 1 of the Promotion of Access to Information Act, 2000 (Act No. 2 of 2000).
> (2) For the purpose of this section, "personal information" means personal information as defined in section 1 of Access to Information Act, 2000 (Act No. 2 of 2000).

Justifiable breach of confidentiality

There are some situations where conflict arises between a doctor's duty to their patient and the duty they have to protect others from harm. In these circumstances the doctor's normal duty not to reveal confidential information gleaned from the patient may be set aside in the interests of protection of the public or a particular member of the public. In other words, the latter duty has the effect of overriding the former duty.

In some cases, doctors are placed under an obligation to reveal certain medical details about patients by statute. Thus in terms of the Public Health Act [*Chapter 15:17*], a doctor who discovers that their patient is suffering from one or more of certain types of dangerous infectious diseases is obliged to notify the public health authorities of this fact, even if the patient specifically requests that no-one be told about the disease. This must be done so that the patient can be quarantined in order to protect other members of the public.

Confidentiality of medical information relating to children

Children have a right to expect that their medical information will be kept confidential. Generally, parental consent is required for medical treatment upon their children which means that the parents must be notified and give their consent before doctors can perform medical procedures upon their children, although in an emergency the doctors can proceed without parental consent and a court can override the unreasonable withholding of consent by parents.

If we adopt in Zimbabwe the approach that a mature child who is competent to make decisions (*Gillick* competence) about what medical treatment they will receive, the position will change. For medical treatment generally, a mature competent child will be able to decide to have a medical procedure or decline to have a recommended procedure even though their parents disagree with that decision. Thus a mature, competent girl would be entitled to seek contraceptive treatment from a doctor without involving her parents. The doctor would

be permitted to supply the contraceptives without informing the girl's parents provided that they had encouraged her to inform her parents and made sure the girl was aware of the consequences of early sexuality.

In these circumstances, it would constitute a breach of the girl's right to have her medical information kept confidential if the doctor informs the girl's parents that she has approached about contraceptive advice contrary to the wishes of the girl.

Duty to protect others

There are some other cases where, although there is no statutory duty to disclose the information, the law may nonetheless expect a doctor to breach confidentiality. A few examples of these situations are given below.

A doctor discovers that a patient who is a bus driver suffers from epilepsy. The doctor warns the patient that, in spite of medication. they could suffer epileptic fits without warning and that it is therefore highly dangerous to continue to drive buses. They tell the patient to inform their employer of this condition immediately. The patient points out that doing so would result in immediate dismissal from their job and that this would be disastrous as they have a large family to support. They plead with the doctor to refrain from informing their employer of this medical condition. If all the doctor's attempts to persuade the bus driver to notify their company and to refrain from driving passenger buses fail, the doctor would have a clear duty to report this patient's condition to the employer. Not to do so, when the patient might pass out whilst driving and thereby injure or kill passengers, would be a clear dereliction of duty on the part of the doctor.

Whilst under outpatient treatment by a psychiatrist, a patient discloses to the doctor that he is planning to kill his girlfriend. Knowing the mental state of this patient, the psychiatrist believes that the patient seriously intends to carry out this threat. The psychiatrist tries unsuccessfully to dissuade the patient from carrying out his plan and the patient refuses to commit himself to a mental institution for treatment.

The clear duty of the doctor is to report this matter to the police and also to initiate proceedings to have this patient committed to a mental institution on a compulsory basis. If the doctor failed to do anything and his patient killed or injured his girlfriend, the doctor would have failed in their duty to afford protection to a person whom they knew was in grave danger.

Whilst under outpatient treatment by a psychiatrist, a seriously disturbed patient admits to his doctor that he has raped a number of women or has sexually molested a number of young girls including his own daughter. The doctor believes that the patient has actually performed these acts and that he may repeat them before he is successfully treated. The doctor tries to persuade the patient either to commit himself to a mental institution for treatment or to hand himself in to the police. The patient refuses to do either of these things.

As the doctor knows that their patient has committed serious crimes and that they are likely to continue to commit these crimes, the paramount duty of the doctor is to protect members of the public from the patient and they must take steps which will ensure this.

A 30-year-old man is diagnosed as suffering from Huntington's chorea. He commands his doctor not to inform his wife, whom the doctor knows (because she is also their patient) is keen to have children. The doctor warns the man of the genetic risks of having children and pleads with the man either to adopt contraceptive measures or to inform his wife of his condition. The man refuses to do these things, saying that he is quite determined to have children.

On the basis of a well-founded risk of harm to future children by way of genetic disease, it would seem that in this instance the doctor should inform the woman of her husband's condition and this would seem also to be the case even if she was not their patient.

A 24-year-old man is seen at a clinic with enlarged lymph nodes and medical investigations establish that these are due to HIV (Aids). The doctor is aware that this patient is about to be married. The doctor informs the patient that he has Aids and asks him whether he has already had sexual intercourse with his fiancée. The patient says that he has not. The doctor then informs the patient that if he has sexual intercourse with his fiancée, he will transmit this potentially fatal disease to her. The patient informs the doctor that he has no intention of changing his plans to marry and he orders the doctor not to tell his fiancée of his condition. He also tells the doctor that after marriage he will have normal sexual relations with his wife and that he intends to have children.

Should the doctor inform the fiancée after efforts to persuade the patient to tell his fiancée himself have failed? The answer must be yes. Not only is the woman in grave danger, but also if she becomes pregnant the disease could be transmitted to the child. Clearly there is an overriding duty towards the woman and to any future children and the patient's wishes about keeping this information confidential should not be respected.

A doctor has started to treat a 40-year-old man for gonorrhea which he contracted on a business trip outside the country. The man returned from this trip ten days ago. The patient insists that his wife should not be told about his condition as his marriage could be destroyed if she found out. The doctor urges the patient to refrain from having sex with his wife until the disease has been successfully treated as there is a serious risk that the disease could be transmitted to her. The patient says that he cannot do this as his wife would become suspicious if he did so.

Should the doctor notify the wife about the husband's disease? Normally the doctor has no right or duty to interfere in the relationship between husband and wife. In this case, however, they know that the wife is facing a very likely risk of being caused serious harm and it could be argued that the doctor has a duty to breach confidentiality.

A 50-year-old patient is in imminent danger of myocardial infarction. The patient requests his doctor not to tell his wife about this as it will merely cause her severe distress and anxiety. The doctor knows his patient does not drive a car and that therefore the man's condition does not pose any imminent danger to his wife.

Unlike the previous cases, there is no valid reason why the doctor should not respect the patient's wishes. However, if the patient did drive and the doctor knew that the man was about to take his wife on an extensive driving trip around the country, they might have cause to inform the wife of her husband's condition.

All of these situations create difficult ethical dilemmas for doctors as well as nurses. Apart from the patients themselves, doctors may be the only persons who know about the dangers connected with their patient's illnesses and who can thus take action to prevent harm from occurring. It should be stressed, however, that in most cases where confidentiality should be breached in the interests of protection of third parties, litigation against the doctor concerned is most unlikely. There have certainly been no such cases in Zimbabwe to date. Theoretically, however, injured third parties might seek to sue doctors or nurses for neglecting a possible legal duty to safeguard the interests of third parties from their patients.

It is only in the litigation-prone USA that a case was taken to court in circumstances similar to example 2. The

Californian court awarded damages to the parents of a girl who had been killed by a psychiatric patient against the doctors who knew of the patient's intentions as a result of the patient disclosing them during treatment. The doctors did not inform the police, the girl or her parents, and did not have the patient committed. (It should be noted that the doctor treating the patient had wanted to have the patient committed, but his superior had ordered that confidentiality should be respected and no such action should be taken.)

Notification of infectious diseases and sexually transmitted diseases

The Public Health Act [*Chapter 15:17*] requires that medical practitioners notify the authorities when they discover that patients have contracted certain infectious diseases or have a sexually transmitted disease. (STD). In order to fulfil this duty, the medical practitioner will have to disclose medical information to others which otherwise should have been kept confidential. The reason why they must do so it to allow the medical authorities to take steps to contain epidemics of such diseases. The measures they can take include isolation, addressing the sources of the epidemics, contract tracing and vaccination.

Every medical practitioner who attends or advises any patient in respect of any STD or infection from which the patient is suffering must direct the attention of the patient to the infectious nature of the disease; counsel the patient to notify their sexual partner and refer them for treatment; and

- warn the patient against engaging in sexual activities unless and until they have been cured of such disease or are free from such disease in a communicable form; and
- give to the patient such information relating to the prevention and treatment of STD and to the duties and responsibilities of persons infected therewith as may be supplied to the medical practitioner by the Ministry; and
- refer the person to any other person or authority able to provide services to treat the condition, including counselling services.

Every medical practitioner who knows or has reason to believe that any person is infected with a STD in a communicable form that is notifiable in terms of s 46 and is not under treatment by a medical practitioner or is not attending for medical treatment regularly and as prescribed by such medical practitioner, must report the matter in writing to the Director health services or to the Government health officer. Failure to report is a criminal offence.

If a patient suffering, to the knowledge of the medical practitioner attending them, from an infectious disease dies therefrom, such medical practitioner must immediately furnish to the local authority of the district and District medical officer a written certificate containing the appropriate particulars relating to the patient’s illness and cause of death. It is a criminal offence that a medical practitioner has failed to furnish a certificate of notification.

Obligatory disclosure as a result of legal proceedings

In both Zimbabwe and the United Kingdom, no privilege attaches to communications between patient and doctor, and a doctor can therefore be ordered by court to disclose information obtained from their patient for treatment purposes. (Privilege in this context means a right recognised by law not to have to disclose information in court.)

The British Medical Association has given this instruction to doctors in the United Kingdom—

> When asked by a Court to disclose information without the patient's consent, the doctor should refuse on the ground of professional confidence and say why he feels that disclosure should not be enforced. The court would be expected to take the doctor's statement into consideration but in spite of this he still may be

directed to answer the questions and to disclose the information. The doctor would then have to decide upon what he considers to be the proper course of action, but knowing that his non-disclosure will be treated by the court as being illegal and punishable.

Some special problems of confidentiality arising out of treatment of minors

General

The chapter on consent indicated that before a doctor may perform a surgical procedure of any nature upon a minor (i.e. an unmarried person under the age of eighteen), they must first obtain the consent of at least one of the parents of the minor or the minor's guardian (unless it is an emergency situation). In order to obtain this consent, the doctor is obliged to inform the parent or guardian of the condition from which the minor is suffering and the treatment they wish to employ to deal with that condition. Nowadays minors often commence sexual activity at a young age. Doctors are therefore often confronted with requests by minors for contraceptives or for treatment for venereal diseases. Minors often implore their doctors to comply with their requests without involving their parents.

What is the position of the doctor? Can they comply with such requests without first notifying the patient's parents and obtaining their consent? Are they obliged to respect the wishes of the minor and keep the patient's information private from all persons not involved in the treatment, including the minor's parents?

Treatment of venereal disease

Let us take the case of a doctor being approached by a 14-year-old boy who is not accompanied by his parents. The doctor examines the boy and finds that he is suffering from a STD. The boy tells the doctor that his parents do not know that he has been sexually active and implores the doctor not to tell his parents that he has this disease as they are staunch Catholics and they would be horrified by his conduct.

It would seem quite clear that if in this instance the doctor gave the boy a course of injections to cure the venereal disease without referring to the boy's parents, the parents could not successfully take legal action against the doctor. The minor obviously had to have treatment and, even if the parents had been involved before the treatment was carried out, although they would have been upset by the conduct of their child, they almost certainly would have authorised the necessary treatment. Indeed, if the parents were to refuse consent to treatment in this sort of case, a court would have no hesitation in overriding their refusal.

SURROGACY

Many couples want to have children but are unable to do so. In our brave new world couples who can't have children naturally can now have children by surrogacy provided that they have the financial means to do so. The medical procedures for surrogacy are extremely expensive and are only available to the affluent.

A woman and her husband or partner want to have a child but they cannot do so because the woman—

- is infertile;
- is unable to bear a child because she has had a hysterectomy;
- suffers from a condition that would make it dangerous for her to go through pregnancy;
- there are genetic reasons against natural childbirth because she may carry a dominant deleterious gene or both partners are known to carry adverse recessive characteristics.

A single woman who is unable to have a child may also want to have a child.

Surrogacy is a method of assisted reproduction where intended parents work with a gestational surrogate who will carry and give birth to the baby. An egg is harvested from the biological (intended) mother or a donor; it is fertilized using sperm from the intended father or donor via in vitro fertilization (IVF), in a laboratory, and then transferred to the gestational surrogate during a minor medical procedure of artificial insemination. IVF now makes it possible to gather eggs from the mother (or an egg donor), fertilize them with sperm from the father (or a sperm donor), and place the embryo into the uterus of a gestational surrogate.

The surrogate then carries the baby until birth. They don't have any genetic ties to the child because it wasn't their egg that was used.

Surrogacy is an arrangement, supported by a legal agreement, whereby a woman agrees to carry the child until birth for the persons who will become the child's parents after birth. In surrogacy arrangements, monetary compensation may or may not be involved. Receiving money for the arrangement is known as commercial surrogacy. In South Africa, the surrogate mother may not receive payment whereas in the United Kingdom the surrogate may receive payment but blatant commercialization of childbearing profit-making agencies is prohibited.

In Zimbabwe there are presently no statutory provisions regulating surrogacy arrangements but there are no laws prohibiting entering into such arrangements. There is a need to formulate a law to regulate such arrangements, particularly relating to the parentage of children born from surrogacy. This law can draw from legislation in other countries. The legislation must recognize the enforceability of proper legal documentation setting out the arrangement. The most acute problem would be where the surrogate refuses to allow the commissioning parents to take the baby after it is born.

In South Africa surrogacy is regulated by the Children's Act, Act 38 of 2005. For the commissioning parties to make use of a surrogate they need to comply with the requirements of the Act. The parties need to have a written agreement with the surrogate mother. This agreement needs to be made an order of the High Court. Once the child has been conceived through artificial fertilisation, the agreement may not be terminated. The surrogate mother and the commissioning parents need to be domiciled within South Africa. If the surrogate mother is married or in a relationship, her husband and/or partner should agree to her becoming a surrogate.

One of the crucial elements of surrogacy law is that psychological evaluations must be done regarding the

surrogate mother and the commissioning parents. In terms of surrogacy laws and regulations enforced in South Africa, ovaries may not be taken from a woman younger than 18 years of age for the purpose of artificial insemination. The preferred age for female donors is set between 21 and 34 years of age.

A child and/or children born from a surrogate mother is by law the child of the commissioning parents. The surrogate mother and her partner have no parental rights towards the child. A surrogate mother is not allowed to receive payment for being a surrogate, other than expenses that she incurred, i.e. medical expenses or loss of income due to her not working.

In United Kingdom, surrogacy is governed by the Surrogacy Arrangements Act of 1985. However, many problems have arisen from the legislation and it needs to be improved. See Mason and McCall Smith at 279-289.

CONTRACEPTION

Avoidance of pregnancy is far preferable to abortion, even legal abortion.

Post-coital contraceptive

The antiprogestin mifepristone (also known as RU-486) is a low-dose or mid-dose emergency contraceptive tablet, effective up to 120 hours after intercourse.

However, mifepristone is also a medication that can be used with misoprostol to bring about an abortion. This combination is more than 95% effective during the first 50 days of pregnancy. It is also effective in the second trimester of pregnancy. Thus a distinction needs to be drawn between when mifepristone is being used to try to avoid pregnancy and when it is being used to terminate pregnancy.

A woman needs to attend an approved clinic to take mifepristone which blocks the hormones to maintain pregnancy. She must return two days later to receive misoprostol which causes the uterus to contract. The practice of many clinics is to allow the woman to take misoprostol and return home to miscarry in privacy. This usually occurs four to six hours later.

Sterilization

Generally, sterilization operations for therapeutic purposes are legal provided that they are carried out with the consent of the patients. Non-therapeutic sterilizations are now being sought by couples who do not wish to have any more children. If it would be medically dangerous for a woman to become pregnant, the doctor may carry out a sterilization operation with her consent in order to protect the woman against this danger and the operation is performed in the health interests of the patient.

Even where the operation is being performed solely as a contraceptive measure, there can be no doubt that the doctor who performs this operation with the consent of a patient who is capable at law of consenting (a man or a woman who is a major and who is not mentally defective) is acting legally.

The patient can only seek to sue the doctor if they carried out the operation without her consent or negligently fails to sterilize a woman and she has an unwanted pregnancy.

In various countries, there have been revelations about highly repressible programmes of force sterilization.

Thousands of women in Greenland, including some as young as 12, had a contraceptive device implanted in their womb, often without consent, as part of a Danish campaign to control Greenland's growing Inuit population in the 60s and 70s.[19]

In Canada youths, minorities, and women were sterilized in disproportionately high numbers. Minors, because of their legal dependency on adults, were almost always assigned as "mental defectives", thus bypassing the parental consent requirement. Albertan Aboriginal people and Métis, regardless of age, were also targeted. Aboriginal people represented only 2.3% of the general population in Alberta, but made up 6% of the institutionalized population. Towards the end of Alberta's sterilization program, Aboriginal people and Métis made up 25% of the sterilizations performed. Furthermore, those of Aboriginal ancestry were disproportionately assigned the "mentally deficient" rating, which denied them their legal rights and made them eligible for sterilization without

[19] ''Doctors fitted a contraceptive coil without my consent'' BBC report 8 December 2022. Available at https://www.bbc.com/news/world-europe-63863088

consent. Women, particularly women who were young, poor, and unmarried, were also disproportionately represented; they were thought to be at high risk for prostitution or at the very least promiscuity, activities suspected of breeding further immorality. While it was conceded that sterilization would not change the behavior of these women, sterilization was intended to prevent them from bearing similarly defective progeny.[20]

Forced sterilization or sterilization without consent are generally a violation of s 52 of the Constitution which provides that every person has the right to bodily and psychological integrity which includes, subject to any other provisions of this Constitution, the right to make decisions concerning reproduction.

This means that no mentally competent adult woman can be forced to be sterilized against her will.

Certain categories of patients, however, create special difficulties in regard to this operation. These classes of patients are discussed below.

Minors

Presently in Zimbabwe, it would seem that even if the minor is close to the age of 18 and appears to understand fully the nature of the operation and its consequences, a doctor may lawfully proceed with a sterilization operation only if the consent of the parents or guardian is forthcoming. However, the position will change if our courts decide that the mature competence test applies along the lines of the *Gillick* case.

Married women

Marriage of persons below the age of 18 is impermissible under Zimbabwean law. A woman who is 18 or over has majority status and has full legal capacity to make her own decisions as to what medical treatment she will undergo and consent to. Such decisions are hers alone and her husband has no capacity to veto or override her decisions in this regard.

Nonetheless there is one area where doctors are understandably reluctant to proceed without a husband's knowledge and consent, that is, the sterilization of a married woman. The question which arises is whether a husband has grounds in law for suing a doctor who sterilizes his wife without his knowledge and consent?

A medico-legal text from the United Kingdom states—

> The doctor may rightly refuse to sterilize in the absence of consent to spousal consultation but he would, it is thought, be acting correctly both in law and in ethics were he to do so; adults have a right to privacy and it could be left to the Divorce Court... to decide whether such unilateral action rendered marriage intolerable.

On the other hand, the leading medico-legal text in South Africa which, like Zimbabwe, practices Roman-Dutch law, argues that as it is recognised grounds for divorce if one spouse refuses to have children—

> … it would ... be only a small step from there for a court to hold that a third party, a doctor, has violated the husband's right to procreation" if a doctor sterilizes a married woman without her husband's consent or if a doctor prescribes contraceptives or inserts an IUD without the husband's knowledge.

The authors of this text argues that a violation of this right could lead to liability under the *actio injuriarum* and could constitute an *injuria,* entitling the husband to at least nominal damages.

As there has not been a court decision on this issue in Zimbabwe, it is a moot point whether the view that the husband may have such a right to sue is correct. However, even if ultimately our courts were to decide that a

[20] Taken from: https://en.wikipedia.org/wiki/Compulsory_sterilization_in_Canada

husband has no right of action against a doctor in these circumstances, this would not entirely solve the problem for doctors. A doctor would still hesitate to perform this operation without spousal consent since, upon discovery of what has been done, they would probably be faced with angry and emotional responses from husbands. Also, as this operation directly affects more than one aspect of the marriage, it is desirable for both spouses to agree to it. If a wife has been sterilized for contraceptive purposes and not health reasons without her husband's knowledge or consent, the husband may succeed in divorcing her on the basis that her unilateral act has caused an irremediable break-down of the marriage.

What has been said so far concerns the sterilization of a married woman solely for reasons of contraception. Where the sterilization operation is required for medical reasons, such as when another pregnancy might endanger a woman's life, there is no doubt whatsoever that the operation may be carried out on the basis of the woman's consent alone and without her husband giving his consent. In this instance, the husband would not be able to sue the doctor as the doctor has acted in order to protect the woman from harm.

Mentally defective persons

Are there ever any circumstances in which a doctor may lawfully perform a sterilization operation on a person who is so mentally defective or disordered that they are incapable of understanding and giving consent to the operation? Would such an operation be lawful if the mentally incompetent's parents or guardian or curator or the person in charge of the institution where they are housed give consent for the performance of the operation? Should the operation only take place if the High Court has authorised the operation after an application has been made to it?

With respect to a mentally defective girl or woman, it may be feared if she is sexually active that she will become pregnant and give birth to a child which, in her mental condition, she may be unable to care for and raise. In such cases, sterilization may be the only realistic method of birth control.

However, the right to reproduction should only be taken away if there are compelling reasons for doing so. The decision to sterilize the girl or woman is so onerous that it should not be taken by the doctor alone, even though they act on the recommendation of the person responsible for the mentally defective person. This matter should be referred to the High Court for a ruling as to whether the operation should take place.

There have been a number of cases in other countries which make it advisable for the doctor to obtain a direction from the court before proceeding.

For instance, in the1976 case in the United Kingdom of *R v D* (1986) 1 All ER 326, the court prohibited a doctor, who was intending to sterilize an 11-year-old mentally handicapped girl on the request of the girl's mother, from carrying out this operation. The court did this because, on the basis of medical evidence, the girl's condition had improved over time. Future prospects were as yet unpredictable but there was the likelihood that, in later years, she would have sufficient mental capacity to make her own choice in the matter, at which time it could have a devastating effect upon her to find out that she had previously been sterilized without her consent.

In April 1987 in the case of *Re B* 1987 (2) All ER 206 (HL) the House of Lords unanimously ruled that a sterilization on a 17-year-old mentally retarded girl who had a mental age of 5 or 6 could be undertaken as it was in her best interests that this operation should take place in order to stop her from becoming pregnant. The original application for permission to have the girl sterilized had been made by the Borough Council which had the girl in their care. This application was supported by the mother. After the lower court had granted the application, there

had been a series of court appeals until finally the matter came before the House of Lords. The House of Lords stated that only a court of law was empowered to authorise such a drastic step as sterilization after a full and informed investigation into the case.

In this particular case there was only a 40% chance of establishing an acceptable oral contraceptive regime and this regime would carry serious side effects. The evidence was overwhelming that it was in the long-term interests of the girl that she be sterilized as pregnancy would have been an unmitigated disaster. Any child she carried would probably have required delivery by Caesarian section but, because of her high pain threshold, she would have been likely to pick at the wound and tear it open. She was unlikely to develop any maternal instincts, did not desire children and, if she bore a child, would be incapable of caring for it. To restrict her liberty to prevent her becoming pregnant would be gravely detrimental to the quality of her life.

In R DD (Sterilization) 2015 EWCOP 4, the court decided that sterilization was in the best interests of a 36-year-old woman with autistic spectrum disorder who lacked capacity. She already had six children who were all being cared for by others. The medical evidence was that a future pregnancy was highly likely to lead to her death, especially if she concealed the pregnancy.

If a Zimbabwean doctor were to be requested by the mother of a mentally defective female to carry out a sterilization operation on the mentally incompetent person, the doctor would need to first obtain authorisation to proceed with this operation from the High Court. This would apply even where the doctor finds that the female in question is seriously and permanently mentally handicapped.

Vasectomy

A vasectomy is a sterilization operation on a man. Where married couples are concerned, sterilization of the woman may be harmful to her physical or mental health. It may, for example, cause her physical pain or emotional trauma. In such circumstances doctors may advise that the husband should have a vasectomy. Although it would seem that a doctor may lawfully carry out this operation with the consent of the husband alone, again it is preferable that the consent of both the husband and wife be obtained. If the operation has been sought by the husband without the wife being consulted, this unilateral act is likely to affect the marriage when the wife finds out what the husband has done if she was hoping to have more children. She may be able to divorce him on the basis that his unilateral act has led to an irretrievable breakdown of the marriage.

The question arises whether a doctor can be sued if a vasectomy operation does not prevent further pregnancies. If the failure of the operation to prevent contraception was attributable to negligent performance of the operation, then the doctor could be sued successfully. However, sometimes the tissues rejoin naturally even after the operation has been performed impeccably and conception once again becomes possible. Doctors are not responsible for this act of nature but they should warn their patients that there is a risk of a natural reversal of the vasectomy.

In the English case of *Thake v Mourice* [1984] 2 All ER 513, Mr Thake decided to have a vasectomy as he already had five children and very little income. His wife agreed that he should have this operation. Some years after the operation was performed on him, Mrs Thake became pregnant again. The couple sued the surgeon who had done the operation. The court found the surgeon liable to pay damages, not because he had performed the operation negligently but on the basis that he had failed to warn Mr Thake of the small but real risk that nature could reverse the effects of the surgery. Consequently, the court found, this failure to warn of the possibility of natural reversal

meant that the doctor had guaranteed to make his patient sterile. The doctor was therefore liable to pay damages for the financial loss to the family occasioned by the unplanned birth of the child. The surgeon could have avoided this liability by warning of the risk of reversal.

Doctor's liability for failure to sterilize leading to unwanted pregnancy

There are no decided cases on this issue in Zimbabwe but it is likely that we will follow the approach adopted by the South African courts.

In respect of wrongful birth (unwanted pregnancy) where a doctor has negligently failed to perform a sterilization operation or to carry out the operation properly, it is clear that a doctor can be held liable to the parents to pay compensation in the form of maintenance for the upkeep of the child until the child reaches the age of 18.

In *Administrator, Natal v Edouard* 1990 (3) SA 581(A), a woman entered into a contract, assisted by her husband. Under this contract, a medical practitioner would sterilize the woman by performing a tubal ligation on her. The woman was pregnant and the tubal ligation was to be carried out during her caesarian section. To the knowledge of the hospital, the couple decided to have the sterilization because they could not afford to support and maintain any more children as they already had three. In breach of the contract, the sterilisation was not performed.

A year later the respondent's wife gave birth to another child, their fourth, and the husband instituted an action for damages based on the breach of contract. He claimed damages for the cost of maintaining the child until she turned 18 years old.

With regard to the wrongful conception claims based on a breach of contract, it was held that it did not matter whether the breach consists of a complete failure to perform the sterilisation or whether the sterilisation was not performed correctly and was therefore ineffective The judge stated that neither the terms 'wrongful birth', 'wrongful conception' nor 'wrongful pregnancy' are appropriate names for the claim being brought and chose rather to refer to claims for the expense of raising a child as a "pregnancy claim".

The court noted that it was not the unplanned birth of the child that constitutes the 'wrong', but rather the breach of contract which subsequently led to the birth of the child and the resultant financial burden. The hospital submitted that public policy does not allow for a wrongful conception claim because to saddle the appellant with the obligation of maintaining the child interferes with the "sanctity accorded by law to the relationship between parent and child". The court rejected thisargument and stated that on the contrary, allowing the claim enabled the parents of the child to fulfil their obligation to support and maintain the child.

In *Mukheiber v Raath* 1999 (3) SA 1065 (SCA), a husband and wife instituted action against the medical practitioner. They alleged that the medical practitioner had negligently misrepresented that he had performed a sterilisation on the wife when in fact this was not the case. As a result of the misrepresentation, the couple stopped taking contraceptive measures which led to the birth of another child. Therefore, they sought to claim compensation from the appellant for expenses they would incur in bringing up the child,

The court considered the decision in *Edouard* and stated that with regard to wrongfulness, whether the claim is based in delict or a breach of contract is irrelevant. Even in the absence of a contract, a medical practitioner owes his patient a legal duty of care.

The court saw no reason to limit liability for wrongful conception to only those instances where the request for sterilisation was made for socio-economic reasons, as had been done in *Edouard*. It was found that holding the

medical practitioner liable for the damages claimed in these circumstances is not contrary to public policy and the appeal was accordingly dismissed.

It would be possible for the claim to include not only the prospective expenses for raising the child but also the costs incurred during pregnancy.

The question will be dealt with later under termination of pregnancy as to whether a doctor can be held liable for damages where the doctor negligently failed to detect and inform the parents that the child was likely to be born with severe disabilities and thereafter the child was born with these disabilities.

TERMINATION OF PREGNANCY (ABORTION)

Introduction

All around the world there has been heated debate about the extent to which a female should be legally entitled to terminate an unwanted pregnancy. This longstanding controversy raises moral, legal, medical, and religious aspects of induced abortion. Religion plays an important role in Zimbabwe which is a largely Christian nation.

Pro-choice advocates emphasize a woman's right to bodily autonomy and her right to health. These can only be properly accommodated by allowing abortion on broad grounds. Restrictive abortion laws that criminalise abortion except on narrow grounds entrench inequalities and drives vulnerable groups, including people living in poverty or in rural areas and adolescents, to resort to clandestine, unsafe abortions. In Zimbabwe over 70,000 unsafe illegal abortions are performed each year and complications from clandestine abortion are a leading cause of maternal mortality from hemorrhage, infection or shock. At the heart of the agitation for reform of the law is the issue of teenagers who become pregnant and who are not entitled at law to have abortions and therefore resort to unsafe illegal abortions. "Illegal abortions in Zimbabwe have increased from 60,000 to 80,000 per annum,"[21] Ruth Labode, chairwoman of parliament's Portfolio Committee on Health and Child Care has told lawmakers.

These illegal abortions carry a significant risk of death from bleeding, infection, shock, damage to the cervix and womb when untrained people attempt to perform surgical abortions on themselves or others, often with inappropriate instruments. Material may be left in the womb, which could cause pain and increase the risk of problems such as infection. The risk of complications is much higher than for a safe, legal abortion performed by a doctor.

Those who are pro-life insist that the unborn child is a human deserving of legal protection, separate from the will of the mother. They would therefore want the law to allow abortion on very limited grounds such as to save the life of the mother. They would argue that abortion represents a failure to recognize the sanctity of human life and promotes a culture in which human life in its most vulnerable moment is perceived as disposable. Abortion is killing of human life and the law should never legalise such killing.

Both the pro-lifer and the pro-choice camps would see prevention of pregnancy through contraception preferable to abortion after pregnancy and therefore would encourage use of contraceptives, although there would still be debate about whether teenagers should be able to obtain contraception from doctors without their parents being informed.

Constitutional provision on unborn child

A new provision was inserted in the 2013 Constitution that was not in the pre-2013 Constitution. Under the right to life guarantee (s 4(2)] "An Act of Parliament must protect the lives of unborn children, and that Act must provide that pregnancy may be terminated only in accordance with that law." The current Act, the Termination of Pregnancy Act, dates back to 1977. This law is a conservative law that only allows termination of pregnancy on limited grounds and there has been increasing pressure to broaden the grounds for lawful abortion. When making proposals for changes to the this Act, the constitutional provision requiring protection of the unborn child would

[21] *World Africa* ''Illegal abortion industry thriving in Zimbabwe'' https://www.aa.com.tr/en/africa/illegal-abortion-industry-thriving-in-zimbabwe/2354711

have to be taken into account but that provision must be balanced against the rights of pregnant women. These include the right to life (s 48), the right to bodily and psychological integrity which includes the right, subject to this Constitution to make decisions concerning reproduction (s 52) and the right of women not to be discriminated against on the grounds of sex, gender or pregnancy (s 56).

There has thus mounting been calls to amend the 1977 abortion law amid growing awareness of the large number of teenage girls dying from backstreet abortions.

Termination of Pregnancy Act [*Chapter 15:10*]

Under the Termination of Pregnancy Act [*Chapter 15:10*], law an illegally induced abortion is a serious crime. The medically unqualified "back-street" abortionist can be punished severely, especially if their action results in the death of the woman on whom the illegal abortion was committed.

An abortion may only be carried out lawfully on the limited grounds set out in the Act. Those grounds do not include socio-economic grounds and, even during the early stages of pregnancy, the pregnancy may not be terminated simply because the pregnancy was not wanted and the female wants it ended. An abortion not within the provisions of the Termination of Pregnancy Act is illegal and any doctor who carries it out and any nurse who knowingly assists them to do so commits an offence which can attract a maximum penalty of five years' imprisonment.

This Act lays down on what grounds an abortion may lawfully be performed by a doctor and lays down the procedures which must be followed before the doctor may perform an abortion on such grounds.

Grounds for lawful abortion

The grounds on which a pregnancy may lawfully be terminated are laid down in s 4 of the Act. They are—

- where the continuation of the pregnancy will endanger the life of the mother;
- where the continuation of the pregnancy will cause a serious threat of permanent impairment of her physical health (note that serious threat to mental health is not included);
- where there is a serious risk that the child will be permanently and seriously physically or mentally handicapped;
- where there is a reasonable possibility that the foetus was conceived as a result of rape or incest (note that, although it is a criminal offence known as statutory rape for a male to have sexual intercourse with a girl under the age of 16 even though she consented, this Act does not allow a doctor to terminate the pregnancy if she becomes pregnant in such circumstances. Note also that statutory rape will soon be amended to protect girls under the age of 18).

Section 4 of the Act read with the definition s 2, permits termination of pregnancy of a female who has been raped but does not permit termination if the pregnancy results from marital rape or unlawful consensual sexual intercourse with a girl under the age of 16 in contravention of s 70 of the Criminal Law Code (so-called statutory rape).

In the Act "unlawful intercourse" is defined to permit a lawful abortion where the pregnancy has resulted from rape except marital rape. Also excluded are sexual intercourse within a prohibited degree of relationship, other than sexual intercourse between the person and their first or second cousin; or any person and an ascendant or descendant of their spouse or former spouse.

Regarding statutory rape, this crime is committed if a man has consensual sexual intercourse with a girl under the age of 16 but, if the girl is 12 or under, it will be rape because a girl who is 12 or under is deemed to be incapable of giving consent. The purpose of the offence of statutory rape is to protect young girls against sexual exploitation and against the harmful health effects of early sexuality such as pregnancy at an age where such pregnancy can carry health risks to the girls. Thus if a young girl has been sexually exploited and becomes pregnant despite the attempts by law to avoid this, it would seem appropriate to deal with the consequence of pregnancy to allow the girl, with parental approval, to have a lawful abortion. This is also in line with the impending law which will criminalise child marriage.

The present Act does not have specific provisions dealing with the rape of mentally incompetent females but sexual intercourse with a mentally incompetent female would constitute rape as such a female would have no capacity to consent to the sexual act. Thus, if the sexual intercourse resulted in pregnancy, the question which arises is whether the relatives of the female or the person in charge a mental institution in which the female is being held could apply to a magistrate for the termination of the pregnancy.

Even where the lawful grounds are present, there are stringent requirements and safeguards which must be complied with. Thus, save in an emergency, a pregnancy may be terminated only by a registered medical practitioner in a designated institution (a state hospital or such other institution as may be declared to be a designated institution for the purposes of this Act) with the permission in writing of the Superintendent.

Furthermore, this permission cannot be given unless the doctor intending to perform the abortion and one other independent doctor or two other independent doctors have certified that one of the grounds provided for in the Act exists. Additionally, if the ground is that of pregnancy resulting from rape or incest, a magistrate must certify that they are satisfied that there is a reasonable probability that the pregnancy resulted from rape or incest.

In an emergency situation where the life of the mother is under threat, a registered medical practitioner is permitted to terminate the pregnancy at a place other than a designated institution and without a second medical opinion if the urgency of the situation demanded this. However, within 48 hours of doing this they must submit a report to the Secretary of Health regarding their action.

It must be emphasized that abortions by doctors will be legal under the Act only if—

- proper checks have been carried out to establish that one of the specified grounds is present; and
- the required rules and procedures have been followed.

The doctors certifying that, for example, there was a serious risk of physical injury to the mother must obviously have carried out a detailed check on the patient before reaching their conclusion. In a case in the United Kingdom, a doctor was found guilty of abortion as he had carried out the procedure on a woman without carrying out any examination on her. He was found guilty because he had carried out the abortion in disregard of the statutory provisions.

Conscientious objection to performance of abortions by doctors and nurses

In terms of s 10 of the Termination of Pregnancy Act, provision is made for doctors and nurses who object to abortions on religious or other grounds. This makes it clear that such doctors or nurses shall not be obliged to participate or assist in termination of pregnancy.

If the mother's life was threatened in a remote rural area and the only doctor available was one who strongly

objected to abortion, it would seem that they would be obliged to carry out the abortion nonetheless. Where nurses object to abortion, then it is sensible for them to request not to be assigned to theatres where such operations are carried out.

What should the nurse do if they have good reason to believe that the requirements of the Termination of Pregnancy Act for the lawful performance of an abortion have not been complied with in respect of an abortion operation which is about to take place? In this situation the nurse should discuss the matter with the matron in charge or with the Superintendent of the hospital.

Married women

Can a husband stop his wife from having an abortion?

This point arose for decision in an English case decided in 1978, namely the case of *Paton v B.P.A.J.T.* [1978] J2 All ER 987. The facts were that a wife had conceived a child by her husband. Being concerned about her pregnancy, without informing her husband that she was going to do so, she consulted two doctors. These doctors formed the genuine opinion that the continuation of this pregnancy would involve a risk of injury to her physical or mental health and issued the necessary certificate as required by statute so that the pregnancy could be lawfully terminated. When the husband found out what had happened, he applied to court for an order to restrain his wife from having the abortion performed without his consent, arguing that he had a right to have a say in the destiny of the unborn child.

Delivering judgement, the Judge pointed out that with abortion "controversy can rage over the moral rights, duties, interests, standards and religious view of the parties." However, he was solely concerned with the legal issues in this case. As the foetus has no rights until it is born and as the wife required the abortion for health reasons, the husband had no right to prevent the wife from having a lawful abortion. (It would have been different if the intended abortion had been illegal or the doctors had not come to their conclusion that the abortion was necessary on reasonable grounds.)

In Zimbabwe, if doctors come to the genuine conclusion that a continuation of the pregnancy would pose a threat to the mother's life or a serious threat to her physical health, it is submitted that the doctors could, provided they followed the procedures required by the Termination of Pregnancy Act, lawfully terminate the pregnancy even though the husband had not given his consent or even if the husband directed that the abortion should not to take place. However, although this is the technical legal position, it is obviously wise policy for doctors, wherever possible, to encourage the husband to participate with his wife in making this decision because the pregnancy is the product of the marital union and unilateral action by the wife without her husband's knowledge and approval may have negative consequences for the marital relationship in the future. Of course, if after consultation, the husband unreasonably declines to consent to the abortion where it is necessary in the health interest of the mother, then the doctors are still entitled to proceed with the abortion on the basis of the consent given by the woman as her health needs require this action.

Children

In Zimbabwe, unless our courts follow the approach in the *Gillick* case, even a 17-year-old girl would require the consent of her parents to have an abortion on one of the lawful grounds. In the *Gillick* case on the other hand, it is suggested that as long as the girl below the age of 16 is mature enough to understand what abortion entails physically and emotionally, the doctor can go ahead on the basis of her consent alone. The doctor is not under a

legal obligation to inform the parents.

There is no problem where the girl and her parents agree that a termination should take place. But especially in rape cases the consent of a girl who is at least over 12 and is mature, the consent of the girl alone should suffice. Where the parents withhold consent unreasonably, a court order to override the parents' refusal should be sought. This would also apply in cases such as where termination is required to save her life or prevent serious physical harm.

Clearly if the pregnancy is life-threatening, and the girl wants a termination, the parents should have no right to refuse their consent.

Possible amendments to the Termination of Pregnancy Act [*Chapter 15:10*]

Far-reaching reform

The Termination of Pregnancy Act could be re-formulated to allow a female to have her pregnancy terminated on socio-economic grounds or, even more radically, allow a female to have an unwanted pregnancy terminated simply on the grounds that she does not want to give birth to the child. This would give full recognition to the woman's right to autonomy.

Harm to psychological health

The Act could be amended to allow a lawful abortion where the continued pregnancy will create a serious risk of grave harm to the female's mental health.

Pregnancy from statutory rape

If the girl is 12 or under. the male who has sexual intercourse with her will be guilty of rape because a girl who is 12 or under is deemed to be incapable of giving consent. Thus, even if she had willingly participated in the sexual intercourse, the male is guilty of rape and her pregnancy can be lawfully terminated on the grounds of rape.

If a male has sexual intercourse with a girl over 12 but under 18 years, he is guilty of the lesser offence of statutory rape. The purpose of the offence of statutory rape is to protect young girls against sexual exploitation and against the harmful health effects of early sexuality such as pregnancy at an age where such pregnancy can carry health risks to the girls. Thus if a young girl has been sexually exploited and becomes pregnant despite the attempts by law to avoid this, it would seem appropriate to deal with the consequence of pregnancy to allow the girl, with parental approval, to have a lawful abortion. This is also in line with the impending law which will criminalise child marriage. Here again, if man commits a crime by marrying an underage girl, but he has impregnated her before he is arrested, there is a strong argument for allowing the girl to have a lawful termination.

It is strongly arguable that the termination of pregnancy legislation should be changed so as to allow termination of pregnancy where a female over 12 but under 18 years becomes pregnant after having consensual sexual intercourse with a male.

Marital rape

Regarding marital rape, a man can be charged with rape of his spouse as the marital rape exemption has been abolished (s 68(a) of the Criminal Law Code.) Thus, a wife who has been impregnated as a result of being raped by her husband should have the right to terminate the pregnancy if she so wishes. She should also have this right where the spouses are separated but not divorced and the husband breaks into the house where his wife is living, rapes her and impregnates her with a child she did not want. This should also apply where the wife has been medically advised that she should not have more children, but she is raped and impregnated by her husband.

Mentally incompetent females

Further, the present Act does not have specific provisions dealing with the rape of mentally incompetent females. Sexual intercourse with a mentally incompetent female would constitute rape as such a female would have no capacity to consent to the sexual act. If the sexual intercourse resulted in pregnancy, the question which arises is whether the relatives of the female or the person in charge of a mental institution in which the female is being held could apply to a magistrate for the termination of the pregnancy.

Explicit provisions on post-coital contraceptives

The Act should specifically have a provision that the use of the drug mifepristone to prevent pregnancy is legal and does not constitute illegal termination of pregnancy.

Explicit provision on termination of pregnancy by abortion pill

There should be a specific provision stating that an abortion pill may only be used to terminate a pregnancy where the abortion falls within the conditions for lawful abortions set out in the Termination of Pregnancy Act. Mifepristone (RU-486) and misoprostol (prostaglandin) drugs can be administered within first nine weeks of pregnancy and will, in most women, induce complete miscarriage.

Procedure for termination on grounds of rape

After Mildred Mapingure was raped, she immediately lodged a report with the police and requested that she be taken to a doctor to be given medication to prevent pregnancy. Due to the negligent bungling by the police and the doctor, she failed to obtain the contraception in time and she became pregnant. She then sought to obtain a lawful termination of her pregnancy but the required magisterial certificate authorizing the termination was received only when it was too late to obtain a safe termination. Part of the reason for this failure was that she was wrongly told by the prosecutor who had consulted with a magistrate that she could obtain the magisterial certificate only after the trial of her rapists had been concluded. However, the court decided that under the Act it is the responsibility of the victim of the alleged rape to institute proceedings for the issuance of a magisterial certificate, which she had failed to do in time. The court decided that under the Act it was not the function of the prosecutor and magistrate to give legal advice on the procedural steps required to terminate a pregnancy, *Mapingure v Minister of Home Affairs & Ors* 2014 (1) ZLR 369(S).

Arising from the *Mildred Mapingure* case, there is a need to amend the Termination of Pregnancy Act to place the duty squarely upon the police and other authorities dealing with rape to guide and assist rape victims through the processes necessary to obtain contraception to avoid pregnancy or, where the victims wish this, to obtain termination of pregnancy. The judgement creates the obligation to act.

Two possible legislative formulations of how to deal with this matter are set out Annexure 4 below. The first requires the involvement of a magistrate whereas the second would not. The second has the advantage of not needing to obtain a magisterial certificate which, if required, might delay the termination until it is no longer medically safe to perform it. However, it is likely that the authorities will insist that a magistrate be involved in the process.

Consent for females under the age of eighteen

The issue of post-coital contraception and termination of the pregnancy of females under the age of 18 years will need to be addressed.

"Emergency contraception" means a contraceptive administered to prevent pregnancy but does not include use of medicines to induce an abortion after pregnancy has ensued.

9. Emergency contraception after unlawful sexual intercourse

(1) Where a medical practitioner or nurse is satisfied that unlawful sexual intercourse may have taken place upon a female and there is a risk that the female may become pregnant as a result, the medical practitioner may, with the consent of the female or, if she is incapable of giving consent, with the consent of her parents or guardians, administer such contraceptive medication as may be approved by the Ministry of Health for this purpose.

(2) Where a female person or her parents or guardians have laid a complaint with the police that unlawful sexual intercourse has taken place, the police must immediately arrange for the female to be examined by a medical practitioner or nurse to determine whether it is still possible to avoid pregnancy by administration of emergency contraception and, if it is, such contraception may be administered by the doctor or nurse.

(3) If it is too late to avoid the pregnancy by such emergency post-coital contraception and the female person is already pregnant, the medical practitioner must advise the persons stated below that the pregnancy may be lawfully terminated on the grounds for termination set out in this Act—

(a) a female over the age of 18;

(b) a female under the age of 18 and her parents or guardian.

When making proposals for changes to the Act, the constitutional provision requiring protection of the unborn child must be taken into account but that provision must be balanced against the rights of pregnant women; these include the right to life (s 48), the right to bodily and psychological integrity which includes the right, subject to this Constitution, to make decisions concerning reproduction (s 52) and the right of women not to be discriminated against on the grounds of sex, gender or pregnancy (s 56).

See Annexure 5 for a possible draft for new legislation on termination of pregnancy.

BIOTECHNOLOGY

Control of biotechnology

In recent years, there have been many advances in the field of biotechnology. The unravelling of the genetic code has allowed for DNA profiling in criminal and civil cases. Human stem cells now offer great promise in medical treatments for cell and tissue regeneration. New artificial insemination techniques have been developed, such as in vitro fertilization, to allow couples to have children when they themselves cannot reproduce naturally.

These advances raise numerous legal and ethical issues and there is a need for legislative controls and to have a statutory body that will supervise and set appropriate standards for the use of these biotechnologies.

National Biotechnology Authority

In Zimbabwe in 2006 the National Biotechnology Authority was established in terms of the National Biotechnology Act [*Chapter 14:31*].

One of the functions of this autonomous Authority is to conduct research into medical and pharmaceutical biotechnology. It will carry out research on the development and application of biotechnology in Zimbabwe and will monitor the use of biotechnology by institutions to which permits have been granted. It will set the requirements for the laboratory development of biotechnology. It will also set the standards to which facilities developing, producing and applying biotechnology must conform.

This Act provides the following definitions—

"gene therapy"
means any technique for delivering functional genes to replace aberrant ones into living cells by means of a genetically modified vector or by physical means in order to genetically alter the living cell;

"genetically modified organism"
means an organism the genes or genetic material of which have been modified in a way that does not occur naturally through mating or natural recombination or both, and "genetic modification" shall have a corresponding meaning;

"organism" means any biological entity, whether microscopic or not, capable of replication;

"permit" means a permit granted in terms of s 25;

"potentially harmful research or undertaking"
means any activity involving the processes or techniques declared to be potentially harmful research or a potentially harmful undertaking;

"product of biotechnology"
means any organism or part of any organism resulting from the application of any biotechnology technique, and includes a genetically modified organism;

"recombinant DNA"
means genetic material produced by the combining of DNA molecules from different organisms.

The National Biotechnology Authority has established a Genomics Centre, the initial focus of which is to advance scientific and technological competencies in the design, development and application of genomics technologies including:

- Genome and gene sequencing;
- Gene annotation, editing and expression;

- Forensics and diagnostics; and
- Bioinformatics.

Screening for defects in pre-natal babies

Medical science has developed an array of tests to determine whether the unborn baby is suffering from such a serious “defect”.

Various tests during pregnancy can be done before birth to screen for genetic disorders to detect congenital malformations and genetic disorders.

Genetic testing before pregnancy

If a person has a gene for a disorder but does not have the condition themselves, that person is a carrier. It now is possible for genetic carrier screening to take place to ascertain whether a woman and her partner have these genes.

If it is found that the parties have such genes, they may decide not to have their own child because of the high risk that the child will be born with a serious genetic disorder and, if so, the chances they will pass them on to their children should they decide to have children. If so, they could instead have a child by IVF.

Testing during pregnancy

Most prenatal genetic screenings start by using the pregnant person’s blood. If the screening test results indicate a high risk for an abnormality, more invasive tests may be used to diagnose specific conditions. Invasive diagnostic tests include amniocentesis and chorionic villis sampling (CVS).

Genetic disorders are caused by changes in a person’s genes or chromosomes. Aneuploidy is a condition in which there are missing or extra chromosomes. In a trisomy, there is an extra chromosome. In a monosomy, a chromosome is missing. Inherited disorders are caused by changes in genes. Prenatal genetic testing gives parents-to-be information about whether their foetus has certain genetic disorders called mutations. Inherited disorders include sickle cell disease, cystic fibrosis, Tay-Sachs disease, and many others. Cell-free DNA is the small amount of DNA that is released from the placenta into a pregnant woman’s bloodstream. The cell-free DNA in a sample of a woman’s blood can be screened for Down’s syndrome.

A Down’s syndrome child has various physical impairments such as a small head and flattened face. They tend to have a lower range IQ, are slower to speak than other children and will have learning problems. They may also have heart defects and problems with vision and hearing. The severity of these problems varies from child to child. Down’s syndrome is one of the most common genetic birth defects.

Tests can be one done cells from the foetus or placenta obtained through amniocentesis or CVS. Amniocentesis involves removing and testing a small sample of cells from the amniotic fluid surrounding the baby in the womb or from the placenta. Genetic screening tests measure risk only. They do not establish with certainty whether the foetus has a genetic condition. A positive result means the foetus is at a higher risk for that disorder than the general population. A negative result means the foetus is at a lower risk of having that disorder than the general population. Amniocentesis carries a small risk of infection, bleeding or miscarriage.

There are also congenital disorders which are structural or functional anomalies that occur during intrauterine life such as spina bifida. Spina bifida is the result of incomplete development in the womb of the baby's spine and spinal cord, causing a gap in the spine. Spina bifida is a type of neural tube defect. The neural tube is the structure

that eventually develops into the baby's brain and spinal cord. The neural tube starts to form in early pregnancy and closes about four weeks after conception. In spina bifida, part of the neural tube does not develop or close properly, leading to defects in the spinal cord and bones of the spine. It is also possible to identify a major congenital brain defect by prenatal screening using cranial ultrasound or CVS when the mother is between 10 to 12 weeks' pregnant.

With any type of testing, there is a possibility of false-positive results and false-negative results. A screening test result that shows there is a problem when one does not exist is called a false-positive result. A screening test result that shows there is not a problem when one does exist is called a false-negative.

Diagnostic testing with CVS or amniocentesis gives a more definite result. A health care professional or genetic counsellor will discuss test results and help the persons affected in deciding the way forward.

Preimplantation genetic testing (PGT) for embryos

Genetic testing of embryos is a powerful technology available only to those who are doing IVF. To perform these tests, a small number of cells (usually about five or fewer) are taken from an embryo in a process called a biopsy; the genetic makeup of these cells is then evaluated in a genetics lab. Typically, after testing, only genetically normal and healthy embryos are chosen to be transferred into the uterus for a potential pregnancy.

Fertility specialists conduct these tests for two important reasons. One is to determine if embryos have genetic abnormalities that often cause failed implantation and miscarriage, resulting in unsuccessful IVF. The second is to identify embryos with genetic defects that can result in a child with a genetic disorder that could cause death or such inheritable conditions as muscular dystrophy.

Embryos found to have such flaws are excluded from being transferred to the mother's womb for a pregnancy. Research has shown that genetic errors in embryos are a major cause of failed pregnancy and live birth. A fertility specialist can consult with couples interested in PGT testing to discuss available procedures.

Termination of pregnancy due to genetic and congenital defects

Section 4 of the Termination of Pregnancy Act lays down that one of the circumstances in which pregnancy may be lawfully terminated is "where there is a serious risk that the child to be born will suffer from a physical or mental defect of such a nature that s/he will permanently be seriously handicapped".

Section 5 further provides that the superintendent of the institution may grant permission for the termination on this ground only if they are satisfied that either the medical practitioner at the designated institution and one other medical practitioner, or two medical practitioners who are not members of the same medical partnership or otherwise involved in the same medical practice, have certified in the prescribed form that in their opinion under these circumstances there is a serious risk that the child to be born will suffer from a physical or mental defect and any prescribed investigation, scientific or otherwise, has been carried out.

A lawful termination of pregnancy may take place only at the request of the mother and two medical practitioners who certify that, as a result of tests carried out on the pregnant woman, that there is a serious risk that the child to be born will suffer from a physical or mental defect of such a nature that they will be permanently seriously handicapped.

The pregnant mother will have made her decision to terminate on the basis that the tests carried out show that these requirements have been satisfied.

With major congenital defects, it is possible using ultrasound to determine that an unborn baby has malformations that will permanently seriously handicap them. Genetic testing will indicate whether there is a high risk that the baby will be born with a genetic disorder that will permanently handicap them.

The decision whether or not the unborn child should be aborted lies with the mother. She is not obliged to have a termination. It is possible that, even though the child is likely to have defects that will permanently seriously handicap them, she wishes nonetheless to have the child and is prepared to love and support the child. If it is clear that the woman would have wanted the child aborted, the issue arises if the doctor negligently failed to detect likely major defects during monitoring or the pregnancy.

Liability of doctors for wrongful birth and wrongful life in respect of disabled children

A woman gives birth to a child who is permanently seriously handicapped child. Her doctor was tasked with detecting any genetic disposition to give birth to a seriously handicapped child or to detect during pregnancy the likelihood of the baby having such disabilities. The doctor negligently fails to detect and inform the woman that her baby is likely to be severely handicapped. If the woman had been alerted about the likelihood, she would have had her pregnancy lawfully terminated or would have chosen not to conceive at all.

The question arises as to whether the negligent doctor is liable to pay damages in this situation for failing to prevent the birth of a severely handicapped child and, if they are liable, to whom they are liable. As will be seen below, in many jurisdictions the courts allow claims for wrongful birth but deny claims for wrongful life. A wrongful birth claim is brought by the child's parents or mother for the expenses they will incur in maintaining and rearing a severely handicapped child. This action could also include a claim for the mother's own pregnancy medical bills and, possibly, the cost of psychiatric treatment for both parents' emotional distress resulting from the realization that their child is disabled.

On the other hand, a wrongful life action is brought by the handicapped child or by the parents or guardian on behalf of the child. This alleges that the child would not have been born if not for the negligent failure to detect the severe disabilities from which they would suffer from birth. Such a claim could include damages for prospective financial expense that will be incurred after the parents are no longer legally liable for the handicapped person's maintenance.

In *Friedman v Glicksman* 1996 (1) SA 1134 (W), a South African case, a doctor wrongly advised a pregnant woman that she was not at greater risk than normal of having an abnormal or disabled child. She gave birth to a severely disabled child. The court allowed her claim based on wrongful birth but rejected her claim based on so-called wrongful life.

As regards the wrongful birth action, the court held that after she gave birth to a disabled child, the woman was entitled in her personal capacity to sue the doctor for damages under the *lex Aquilia* for expenses of maintaining and rearing her disabled child and future medical and hospital expenses.

However, it rejected the claim on behalf of the child for wrongful life. In the *Friedman* case, the judge decided that allowing such a claim would be *contra bonos mores* and against public policy because it called on the courts to hold that non-existence is preferable to life in a disabled state. This would also mean that the measure of damages would be the difference between existence in a disabled state and non-existence, which he held to be contrary to what is allowed for in delict. The plaintiff submitted that the calculation of damages awarded for wrongful life claims does not require a comparison between existence and non-existence. Instead, what should be measured is the "amount

necessary to compensate the child for having to live in a disabled state". This submission was, however, not accepted. The judge further rejected the claim on the basis that it would open the door for disabled children to sue their parents for not having terminated the pregnancy whilst knowing that the child would be born disabled in some way. Additionally, the court held that in such cases the medical practitioner would not be held liable for a child's disabilities which he did not cause and is not responsible for causing.

It could be argued that where the parents of the child have successfully instituted a wrongful birth action and have received compensation for maintenance of a handicapped child, it is unnecessary for the child to claim compensation for themselves. But what if the parents have died without instituting action or their claim has prescribed? Even if the parents' claim has prescribed, under s 17 of the Prescription Act [*Chapter 8:11*], the claim by a minor prescription will be completed only one year after the child attains majority, thus giving minors an advantage in the form of an extended time frame within which they can institute action against the medical practitioner.

Thus, it can be argued that if the parents have failed to bring an unlawful birth action, the child should be entitled to sue for compensation under an unlawful life action. It could also be argued that if the compensation claimed by the parents is inadequate to cover the needs of the handicapped child, the child should be entitled to sue for compensation for expenses for specialist care.

A number of States in the USA allow the action for wrongful life but confine damages to objectively provable economic damages, which excludes general damages like subjective "pain and suffering"—that is, monetary compensation for the experience of having a disabled life versus having a healthy mind and/or body. Claims can be made for compensation for such things as medical expenses for treating the birth injury; future medical bills associated with special care that the child needs; specialized non-medical care that the child will need, like wheelchairs and special education, and home modifications to accommodate the child's disabilities and physical injuries.

If compensation for wrongful life is restricted to financial compensation for medical expenses and for specialist care, the court would not be faced with the vexed issue of how to decide what amount it is appropriate to award for a person who is forced to live in a disabled condition for the rest of their life, often accompanied by pain and suffering.

Courts in England, Canada and Australia have also refused to allow wrongful life actions. However, in 2005, the Dutch Supreme Court fully upheld a wrongful life claim in the Netherlands' first ever wrongful life case.

There is little authoritative court decision in Zimbabwe in which a doctor has been sued either for wrongful birth [22]or wrongful life or both. It is likely that our courts would follow the approach in South Africa and many other countries of allowing a wrongful birth action by the parents but disallowing a wrongful life action by the handicapped child. But if the Zimbabwean courts were to allow a wrongful life action, they would probably limit the damages claimable to economic damages.

The only Zimbabwe case which is of relevance is that of *Mapingure v Minister of Home Affairs* 2014(1) ZLR 369(S) A month after the rape, the appellant's pregnancy was formally confirmed, she then informed the investigating police officer of her pregnancy who referred her to a public prosecutor. She was told by the prosecutor that she

had to wait until the rape trial had been completed to have her pregnancy terminated. At the direction of the police, she returned to the prosecutor's office four months later and was advised that she required a pregnancy termination order. The prosecutor requested that a magistrate certify the termination. The magistrate said he could not assist because the rape trial had not been completed. She eventually obtained the necessary magisterial certificate nearly six months after the rape, the hospital felt that it was no longer safe to carry out the termination procedure. The appellant carried to full term and gave birth to a child. The applicant brought an action against the Ministers of Home Affairs, Health and Justice for damages for the physical and mental pain, anguish and stress she suffered and care for the child until the child turned 18. The basis of the claim was that the employees of the three Ministries concerned were negligent in their failure to prevent the pregnancy or to expedite its termination. The particulars of negligence were itemized. Her claim was dismissed. The questions for determination on appeal were (i) whether or not the respondents' employees were negligent in responding to the appellant, (ii) if they were, whether the appellant suffered any actionable harm as a result of such negligence and, (iii) if so, whether the respondents were liable for damages for pain, suffering, and the care of her child. The Supreme Court held, on appeal, that the State was liable for failing to provide the appellant with emergency contraception to prevent the pregnancy and ordered it to pay damages. However, the court dismissed the claim that the State was liable for failing to ensure a timely termination of the pregnancy and in turn that they were liable to pay for the care of the child. The case was referred back to the High Court for a determination of the amount of damages.

MEDICAL TREATMENT OF THE MENTALLY ILL

Mental Health Act

The legislation dealing with the treatment of mentally disordered persons is the Mental Health Act [*Chapter 15:12*]. This legislation provides that when persons are mentally disordered or defective and require psychiatric care and treatment, such persons can either receive voluntary treatment or, subject to stringent safeguards, where necessary, they can receive treatment on an involuntary basis.

Voluntary treatment

In terms of s 42 of this Act any person over 16 can submit themself on a voluntary basis for treatment in a medical institution. A person under the age of 16 requires the parent or guardian to apply for admission to the institution on their behalf.

If the doctors believe that medical procedures are necessary to treat the patient institutionalized in this way, in respect of treatment of persons under 18, the consent of the parent or guardian must be obtained before proceeding. With respect to persons over 18, who have sufficient mental capacity to comprehend properly the nature of the intended procedure and its risks and to make an informed decision on whether to receive the treatment, it is legally permissible for the doctor to rely upon that consent alone. However, if there is any doubt whatsoever about the patient's capacity to give proper consent, the consent of the parents or spouse of the patient should be sought.

Involuntary treatment

The law guards jealously the freedom of the individual and thus the procedures for having a person committed for mental treatment on an involuntary basis are exacting to ensure that persons will only be committed for involuntary treatment when this is absolutely necessary, either in the patient's own interests or in order to safeguard the public against a dangerously deranged person. This legislation is very complex. Fundamentally, however, in terms of s 26 a magistrate, upon application from the spouse or near relative of the patient or a police officer, after enquiry, and after considering the reports on the patient which they are obliged to obtain from two medical practitioners, may order the detention of the patient in a medical institution for up to six weeks "if he is satisfied that the patient concerned is mentally disordered or defective and—

- is not under safe and proper care, treatment or control; or
- is neglected or cruelly treated by any person having the care or charge of him; or
- is of suicidal tendency or in any way dangerous to himself or to others; or
- has committed or attempted to commit any crime or offence or has acted in a manner offensive to public decency; or
- is an inebriate, that is to say, a person who habitually drinks to excess or who uses any drug to excess; or
- is in receipt of relief or assistance from public or charitable funds at the time of giving birth to an illegitimate child or when pregnant with such child; or
- the person having the care, treatment or control of the patient consents; or
- in the case of a psychopathic disorder, is required to be detained.

There are also provisions for admission of mentally disordered or defective persons to institutions on an urgent basis when this is necessary in the public interest or in the interests of the person admitted. Thus a relative could apply to a hospital for admission of the person on an urgent basis, but the relative must produce a medical

certificate from a doctor who has examined the patient within the last 48 hours. If force is necessary to remove the patient to the place of treatment, then application may be made to a magistrate for an order of apprehension of this person and removal to the place of treatment.

Under s 12 where the police apprehend a person who is apparently mentally disordered or defective and is dangerous to themself or others or is wandering at large and unable to take care of themself and it is necessary for public safety or the patient's welfare, they may be taken immediately to a hospital or prison for examination. Within 24 hours of reception at the hospital (except where a Sunday or public holiday intervenes) a magistrate must be notified of the detention of the patient and may issue an order for the further detention of the patient for a period up to 14 days. All reception orders must be examined by a judge who can, amongst other things, order further detention of the patient for an indefinite period, or definite period or direct that the patient be immediately released.

The Act also provides in sections 52-59 for temporary treatment in hospitals or other institutions, without reception orders, of mentally disordered or defective persons, and for the treatment of persons suffering from mental retardation.

Criminally insane

There are provisions in the Mental Health Act to deal with persons facing criminal charges who are found on medical examination to be mentally defective or disordered.

If, either before or during a trial of a person for a criminal offence, it appears that they are mentally disordered or defective, a medical examination may be carried out to ascertain whether the person is fit to stand trial. If the medical examination discloses that the person would not be able to understand the nature of the criminal proceedings or to conduct their defence properly, then the procedures to be followed are those set out in sections 26 and 27 of the Mental Health Act. If the judge before whom the person is being tried decides that they are unfit to stand trial, the judge can order the detention of this person in a mental institution for a definite or indefinite period.

A person standing trial for a criminal offence can raise the defence that they were "mentally disordered or defective so as not to be responsible according to law for their action at the time when the act was done or the omission made." Where this defence is raised, the court will base their decision on the evidence of the psychiatrist or psychiatrists who have examined the accused.

If the court concludes that the accused person was indeed mentally disordered or defective at the time they committed the crime, it will return what is known as a "special" verdict. The result of this is detention of the accused for treatment in a special institution for the mentally ill who have committed crimes. This committal will be for an indefinite period.

It should be noted that this special verdict will be rendered even where the mental disorder, defect or disability was only of a temporary nature, provided that the disorder was present at the time the accused committed the crime. If it was present when the accused committed the crime it would mean that they were not responsible for their actions. The cause of disability may be organic, functional or physical in its origin. Thus, even if the mental disability stemmed from concussion due to a blow to the head, the special verdict would still be returned.

Once a person has been placed in a mental institution for an indefinite period, the Mental Health Act stipulates

that the superintendent of the institution should make periodic reports about the patient. Only the President may order the release of a mental patient who has been detained in a mental institution as a result of a special verdict being returned. Before ordering the release, however, the President is required to call for a report from a special board.

There are special provisions to deal with mentally disordered or defective patients who are dangerous to others which allow the detention of such persons in a special institution which has facilities to cope with such persons.

CHILD ABUSE

Pending legislation on duty to report child abuse

Under pending amendments to the Children' Act, a new s 9A will impose a duty on persons such as medical practitioners, nurses, teachers, lawyers and ministers of religion to report child abuse to the police or a child protection officer when in a professional or vocational capacity they become aware of, or reasonably suspect that child abuse is taking place or is likely to take place. Even if a Code of Conduct governing a profession does not make this a disciplinary offence, it will be taken as if such a clause was in the Code.

The sanction for such failure is not criminal liability as in South Africa but instead disciplinary action by the professional or vocational body to which the defaulter belongs.

Section 9A may be difficult to apply. Take the situation of a medical practitioner who when treating a young female child for malaria discovers clear evidence that the child has been raped.

By failing to report this matter, the person who has knowledge of these facts is allowing the continued perpetration of criminal abuse of the child. If it will be left to professional and other bodies to bring disciplinary action against the defaulters, the question arises as to how these matters will be brought to the attention of such bodies. Will it emerge during the course of the criminal investigations or as a result of a report made to the disciplinary body by a third party such as a fellow professional? Or could it be a complaint in later life by the abused child that the professional did nothing after the abuse was reported to that person?

The purpose of imposing a legal duty upon professionals who are likely in the course of their duties to learn of child abuse is to send a clear duty that such persons must act by alerting the authorities that child abuse is occurring or may be occurring so that criminal investigations can be conducted. Child abuse is often concealed and is difficult to root out. If the legal obligation is to have any real impact it is better to back it up with a criminal sanction, rather than with the remote sanction of some sort of disciplinary sanction, even if that could even be termination of employment.

In South Africa s 54 of the Sexual Offences Act of 2007 provides that any person who has knowledge that a sexual offence has been committed against a child must immediately report this to a police official. The report must be made to the police immediately upon the person becoming aware of the commission of a sexual offence against the child. Failure to report is a criminal offence and a person convicted in terms of this section is liable on conviction to a fine or imprisonment for a period not exceeding five years or to both such fine and imprisonment.

Treatment of children whose health needs are not being properly cared for by their parents

The Children's Act [*Chapter 5:06*] contains provisions which seek to protect children against neglect and ill treatment by their parents.

Where parents have neglected the health needs of their child, they can be directed to have their child medically examined. If that examination discloses that the child requires medical treatment, the parents can be directed to have the treatment carried out on the child. If the parents refuse to comply with the direction, the matter can be referred to a magistrate. If, after enquiry (where the parents will be afforded a reasonable opportunity to be heard, except where their whereabouts is unknown or where, in the circumstances, to afford them a chance to be heard is not reasonably practicable), the magistrate decides that medical treatment of the child is "necessary or desirable in the interest of the health of the child", they can give written authority for the removal of the child

to a hospital or other suitable institution for treatment.

If a doctor who is treating a child finds clear evidence of physical maltreatment or sexual molestation of the child, they should take action.

Parents have the right to inflict moderate corporal punishment on their children for disciplinary purposes but they have no right to inflict serious injuries upon them. Parental child battering is an offence in terms of s 7 of the Children's Act. It can also be charged as assault. If a father sexually molests his daughter, he will be committing the crime of rape or aggravated indecent assault. Doctors have one or two options in such cases. When a doctor discovers that a child patient has been criminally maltreated, they can report the matter to the Social Welfare Department or they can report the matter directly to the police. It is ethically unacceptable for a doctor to maintain silence in such a case when they know that the physical and mental well-being of a child is being severely jeopardized by mistreatment by parents or others such as teachers.

MEDICAL EVIDENCE IN RESPECT OF CRIMES

Sexual crimes

When a doctor compiles a medical report on a female or male who may have been sexually assaulted, the doctor should be aware of the specific crime of which the person has been accused.

The most serious sexual crimes that can be committed against adults and children are rape and aggravated indecent assault. These crimes are particularly detestable when committed against young children.

Rape

Rape is committed when a male has vaginal or anal sexual intercourse without the consent of the female. The law lays down that a child who is 12 or below that age cannot consent to sexual intercourse and therefore a male who has sexual intercourse with a child is guilty of rape and the issue of consent does not arise.

There must be penetration of the vagina or the anus of a female by the penis of the male. It is important for doctors compiling medical examinations upon complainants in such cases that this crime is committed if there is the slightest penetration of the female genitals or the anus. Should genitalia of a female include the clitoris and the vulva? Can touching of the clitoris with the penis amount to penetration? Does penetration include both penetration of the external as well as the internal genitalia.

It is not necessary that there should be full penetration. The medical definition of what constitutes penetration does not accord with the legal requirement for the crime of rape, although the slightest penetration suffices: there must be evidence of penetration otherwise X cannot be convicted of rape.

Aggravated indecent assault

Aggravated indecent assault is committed when a male or a female, without the consent of the complainant and with indecent intent, commits any indecent act upon the complainant, other than rape, that involves non-consensual penetration with indecent intent of any part of the body of the complainant.

This offence can be committed when these non-consensual acts are performed—

- A female has non-consensual sexual intercourse with a male;
- A male has non-consensual anal sexual intercourse with another male. If the males are adults and the anal sexual intercourse is consensual, both males are guilty of the separate offence of sodomy;
- A male inserts an object other than penis into a female's vagina;
- A male inserts his penis into a female's mouth;
- A female sucks the penis of a male;
- A female inserts her finger or an object into the vagina of a female.

Other crimes involving physical harm

Murder (intentional causing of death)
Culpable homicide (negligent causing of death of a person)
Physical assault (such as upon a child or during domestic violence).

Counselling of survivors of sexual assaults

The Adult Rape Clinic[23] was established with support from the Ministry of Health and Child Care at Parirenyatwa Hospital in Harare as a response to the dire lack of appropriate facilities for a holistic and sensitive response for rape survivors in government hospitals in Zimbabwe. It provides comprehensive management including medical management, counselling, training and support services which includes formal partnerships with organisations providing complementary services. The clinic offers medical care, ongoing psycho-social support services, awareness raising and advocacy surrounding gender-based violence issues.

The Adult Rape Clinic offers these post-rape services for survivors:

- Psychological support/counselling;
- Voluntary HIV Counselling and Testing (VCT);
- Administering of Post Exposure Prophylaxis (PEP);
- Prophylaxis and treatment for Sexually Transmitted Infections (STIs);
- Pregnancy Testing;
- Administering of Emergency Contraceptive Pill (ECP);
- Medical examination and collection of forensic evidence;
- Follow up care;
- Referral to other services.

Taking of bodily samples

The Criminal Procedure and Evidence Act [*Chapter 9:07*] (CPEA) has various provisions on the taking of bodily samples in connection with criminal investigations.

A bodily sample means an intimate or buccal sample. A buccal sample means a sample of the cellular material taken from inside a person's mouth for the purposes of conducting a forensic DNA analysis of that sample.

The Act provides that only an authorised person may take an intimate or buccal sample. An authorised person is a health practitioner, medical officer or other person who has successfully undergone the relevant training to enable them to take a bodily sample.

Section 41B provides that an authorised person may take a bodily sample of a person or group of persons, or supervise the taking of a bodily sample from any person or group of persons, if the person or persons concerned consent to such sample being taken at the verbal or written request of a peace officer who is satisfied that there are reasonable grounds—

- to suspect that the person, or any one or more persons in a group of persons, has committed an offence; or
- for believing that the bodily sample and the resulting forensic DNA analysis thereof will be of value in the investigation of an offence by excluding or including one or more persons as possible perpetrators of the offence.

If a person does not consent to the taking of a bodily sample, a warrant may be issued by a judge or magistrate upon written request by a police officer who is of or above the rank of inspector, if it appears from written information given by the police officer under oath that there are reasonable grounds—

[23] Adult Rape Clinic – Post rape services in Zimbabwe http://www.adultrapeclinic.org.zw/

- to suspect that the person named in the information, or any one or more persons in a group of persons so named, has committed an offence; or
- for believing that the bodily sample and the resulting forensic DNA analysis thereof will be of value in the investigation of an offence by excluding or including one or more named persons as possible perpetrators of the offence.

In terms of s 32 (3) of CPEA, a bodily sample must be taken—

- by an authorised person or by a person under the supervision and in the presence of the authorised person; and
- with strict regard for decency and decorum: Provided that no intimate or buccal sample may be taken from the person who has been arrested except—
  - in case of a buccal sample, by an authorised person at the request and in the presence of the peace officer; or
  - in the case of an intimate sample, in private by—
    - ✓ a medical officer at the written request of a police officer of or above the rank of superintendent; or
    - ✓ the medical officer of any prison at which the arrested person is detained; or
    - ✓ by an authorised person of the same sex as the person from whom the intimate sample is to be taken; in order to ascertain some fact which is material to the investigation of the charge upon which such person has been arrested.

If, in any criminal proceedings the results of a forensic DNA analysis of a bodily sample are embodied in an affidavit sworn to by an authorised person in which that person deposes to the following facts—

- that they are an authorised person who is qualified to undertake forensic DNA analysis of bodily samples; and
- that the bodily sample was obtained by that person or by another named authorised person under the supervision of the first named person under conditions which safeguard as much as is reasonably possible against the possibility of the contamination of that sample;

such affidavit will, upon its mere production, be admissible as *prima facie* proof of the facts deposed therein (5).

Any bodily sample taken from a person and the records of any steps taken from—

- an accused person, be destroyed if they have been found not guilty at their trial, or their conviction is set aside by a superior court, or the charge against them is withdrawn, unless the person consents in writing to the preservation of the bodily sample;
- a person other than an accused person, be retained until the criminal proceedings to which they are relevant have been finally concluded, whereupon they shall be destroyed, unless the person consents in writing to the preservation of the bodily sample.

Taking blood samples in drunk driving cases

Drunken driving is a serious offence. In terms of s 45 of CPEA it is an offence for a driver to use their vehicle on the road with a concentration of alcohol of more than 80 milligrams per 100 millilitres of blood and in terms of s 46 it is an even more serious offence [than that in s 45] for a person to be drunk to such an extent that they are incapable of properly controlling their vehicle. With this latter offence it is presumed that the driver was incapable of controlling their vehicle if the concentration of alcohol in the blood is more than 150 milligrams per 100

millilitres.

Drunken driving can be proved from information obtained using a breath analysis machine, but as these machines are in short supply in Zimbabwe, more frequently the method used to establish this offence is by taking a blood sample for analysis.

Thus, in terms of CPEA s 68, where the police are dealing with accidents they are empowered to require the driver to permit a specimen of blood to be taken from them by a medical practitioner or a member of a class of persons designated for this purpose by the Secretary of Health, which may include a qualified nurse.

The medical practitioner should request the police officer requiring the taking of this specimen to place their request in writing. There are two situations specified where the medical practitioner may decline to extract the blood sample. These are—

- where they consider that taking of this blood would be prejudicial to the health or proper care or treatment of the patient. This would be the case, for example, where the driver is badly injured as a result of the accident and is unconscious or requires a blood transfusion;
- where the patient refuses to permit the taking of the specimen. In this latter instance, where the person has hindered the taking of blood or refused to allow the taking of blood without reasonable excuse, they will be guilty of a separate offence which will attract severe penalties.

Where a driver has refused to allow blood to be taken, a doctor should still carefully examine the patient for signs of intoxication and record their observation as they may later be called upon to testify against the driver if a prosecution is brought against the driver for culpable homicide or for contravening s 46 of the Act, which offences do not necessarily require proof from a blood sample.

If an examiner, in considering an application for a driver's licence, has any doubt whether or not the applicant is suffering from any disease or other disability which would render them incapable of effectively driving and controlling a motor vehicle of the class concerned without endangering the public safety, the examiner may require the applicant to undergo such examination or test as may be prescribed to assist the examiner in determining whether or not the applicant is so suffering; or
(b) to produce to the examiner a medical or optical certificate on the prescribed form;
or to undergo such examination or test and to produce such medical or optical certificate.

THE BEGINNING AND THE END OF LIFE

The Criminal Law (Codification and Reform) Act (Criminal Law Code) (*Chapter 9:23*] sets out in s 51 when, under the criminal law, life begins and when it ends.

The 2013 Constitution in s 48 underscores the sanctity of life by providing that everyone has a right to life and s 44 provides that it is the duty of every person to respect and protect this right., as well as other rights.

Beginning of life

For the purposes of the law of homicide, life is "deemed to have commenced when a newly-born child has breathed, whether or not it has an independent circulation at that time and whether or not it is entirely separated from the body of its mother."

The Births and Deaths Registration Act [*Chapter 5:02*] obliges the medical practitioner or midwife who was in attendance at the birth of a still-born child to sign a certificate stating that the child was still-born and to deliver that certificate to a responsible person at the household or the hospital. This provision specifies who such a responsible person would be.

The Constitution provides in s 48 which guarantees the right to life, that an Act of Parliament must protect the lives of unborn children, and that Act must provide that pregnancy may be terminated only in accordance with that law. The Termination of Pregnancy Act sets out the grounds upon which a pregnancy can be terminated. Any abortion that is not carried out in accordance with that Act is illegal. (See earlier discussion on this issue).

After the baby is born it is protected under the law of murder, culpable homicide and infanticide.

Death

In Zimbabwe, s 51 of the Criminal Law Code provides that for the purposes of the law on homicide, death is taken to have occurred when a person has suffered an irreversible cessation of heart-lung functions. However, when a person has been installed on a heart-lung or ventilator machine or other life-support system, death is taken to occur when ''a competent medical practitioner, after carrying out appropriate tests, diagnoses and confirms that brain death has occurred."

In the United Kingdom the test that is used to decide whether there has been brain death is the irreversible loss of the brain stem functions.

Brazier and Cave[24] point out that defining the exact point when death occurred is difficult because, biologically, death is a process and not an event. They further explain that previously determining when a person had died was once not a difficulty; death was taken to have occurred when there was an irreversible cessation of heart lung functions. However, advances in medicine started to demonstrate that this was not a valid test for all purposes. Desperately ill or injured patients can be installed on mechanical ventilators or respirators to provide artificial life support whilst receiving treatment. But it is pointless to keep the patients on the machines if brain death has occurred already. They cite various English cases in which the brain death test was used.

In Re A [1992] 3 Med LR 303 a 2-year-old boy suffered a serious head injury. The doctors struggled to save his life and he was put on a ventilator. His condition deteriorated and tests established that he was, undoubtedly, brain stem dead. His parents vehemently opposed the decision to switch off the ventilator. The hospital obtained a

[24] Brazier and Cave pp. 507-509.

declaration that doctors would not be acting unlawfully in switching off the machine. The court held that the child was for all purposes legally dead as there was irreversible brain stem death.

See also Mason and McCall Smith[25] for the problems associated with brain stem death and the concerns that mistakes may be made is diagnosing whether brain stem death has actually occurred.

Births and Deaths Registration Act [Chapter 5:02]

The medical practitioner or midwife who was in attendance at the birth of a still-born child must sign a certificate stating that the child was still-born and deliver that certificate to a responsible person at the household or the hospital.

A medical practitioner who examined the body of the dead person, or, if no such examination occurred, a medical practitioner who attended the person during their last illness must, unless they believe the death was not the result of natural causes, sign a certificate stating the cause of the death to the best of their knowledge and belief. They must then deliver this certificate to a responsible person personally or by registered post.

In terms of s 23 the Registrar of Births and Deaths can, after notification of a death in respect of which there is to be no inquest or criminal proceedings, institute such enquiry into the cause of death as they think necessary and if they are satisfied that the death was due to unnatural causes, they must report the matter.

Coroner's Office Act [Chapter 7:21]

This Act, which replaces the repealed Inquests Act, establishes the Coroner's Office to conduct independent and impartial investigations into all unnatural deaths in order to determine the circumstances of such deaths. It also sets out the appointment, functions, and powers of the Coroner-General, Deputy Coroner-General and coroners in relation to postmortems, inquests and their findings.

The primary function of the Office is to investigate deaths which appear to come about in a sudden, suspicious or violent manner; deaths occurring within 24 hours of a patient arriving at a health institution and death occurring during treatment or care.

In this Act—

"body" in relation to the body of a deceased person, includes any part or remains of such body, but does not include any part of the body of a deceased person removed from their body during their lifetime;

"still-born child" means any child which has issued forth from its mother after the twenty-eighth week of pregnancy and which did not, after being completely expelled from its mother, breathe or show any signs of life;

"natural death" means a death that is primarily attributed to an illness or an internal malfunction of the body not directly influenced by external forces;

"unnatural death" means any death which is not a natural death and in particular one that comes or appears to come about in a sudden, suspicious or violent manner.

A medical practitioner who examined the body of the deceased person or, if no such examination occurred, a medical practitioner who attended to the person during their last illness, must, unless they believe the death was not as the result of natural causes, sign a certificate stating the cause of death to the best of their knowledge and belief. The certificate must be delivered to a responsible person.

[25] Mason and McCall Smith pp. 576-579.

The functions of the Office are to provide independent and impartial investigations into the circumstances surrounding any unnatural deaths,

- arising from homicides, infanticides, drownings, suicides and accidents; or
- occurring within twenty-four hours of admission into a health institution; or during a surgical operation;
- occurring when a person is being escorted to a police cell, prison, health institution or other place of custody.

It will also provide expert forensic pathology evidence in any judicial proceedings concerning or involving unnatural deaths.

Where a person dies, while in any health institution for medical treatment or care, the records officer must preserve all medical records, health-care records and any other documents pertaining to the medical treatment or care. It is a criminal offence to willfully or recklessly destroy or fail to preserve these records.

Where a person has died in custody, the medical records pertaining to the period in which that person must be preserved by the custodial officer and it is a criminal offence to willfully or recklessly destroy or fail to preserve these records. The Coroner-General may make special arrangements with health institutions; Zimbabwe Prisons and Correctional Services; the Zimbabwe Republic Police or any other institution for the efficient notification of unnatural deaths by persons employed in those institutions.

The Act lists persons within the community who have a legal duty to notify the authorities about an unnatural death. Members of the deceased's immediate family who have attained the age of 18 years and who were present at the death, or who became aware of the death have the primary duty to report but then the Act lists other persons who have the responsibility to report unnatural deaths where such family members are not available. These include adult relatives or adults living in the area or Headmen who become aware of such deaths. The notification must be made as soon as possible but, in any case, within 48 hours of the death.

Unnatural death

After receiving notification of an unnatural death a coroner may do all or any of the following—

- review the person's medical history and the circumstances of the death;
- require medical records pertaining to the matter and the custodian of those records may not invoke medical practitioner-patient confidentiality privilege and the person supplying the records is not liable to an action based on the sharing of such records under this Act;
- direct a medical practitioner to conduct a post-mortem examination of the body of a person who has died in any of the circumstances in relation to which the coroner has jurisdiction. A coroner may issue a written summons to any medical practitioner who in their opinion has the competency to conduct a post-mortem and such medical practitioner must be paid an allowance and their expenses for doing so, according to the prescribed tariff. It is an offence for the medical practitioner to refuse to conduct the post-mortem.

A coroner may dispense with a post-mortem examination if they, after considering the information given to them relating to the death, is satisfied that the manner and cause of death are sufficiently revealed in the certificate of the medical practitioners.

A coroner will not order an inquest into a death in a health institution or in custody if they are satisfied that the death was due to natural causes.

A coroner may, after a post-mortem examination, decide not to hold an inquest into a death if the coroner is satisfied that the manner and cause of death are sufficiently disclosed and an inquest is unnecessary.

Inquest

An inquest will be held if the coroner is of the opinion that it is necessary—

- to ascertain the identity of the deceased and determine how, when, where and by what means they died; or
- to inform the public of the circumstances surrounding a death and bring dangerous practices or conditions to light; or
- to facilitate the making of recommendations to avoid preventable deaths; or
- where the death occurred in a place or circumstances where any law requires an inquest.

A coroner may summon witnesses for the purpose of holding an inquest and may cause the oath to be administered to them and call for the production of documents or objects.

Any person summoned as a witness who, without reasonable excuse as proved by affidavit, does not attend pursuant to such summons, or who fails to produce any document or object as required by the coroner, shall be guilty of an offence. A coroner who intends to hold an inquest may authorise—

- the burial of the body before the inquest is held by completion of a medical certificate of death by a registered medical practitioner; or
- the exhumation and subsequent reburial of a body.
- An inquest will be held in public unless the coroner or the Minister believes that there are compelling matters of national security at stake that require it to be done in camera.
- An inquest will be presided over by a coroner assisted by two assessors, in an advisory capacity—
  one assessor will be appointed by the Law Society of Zimbabwe and one appointed by the Medical and Dental Practitioners Council of Zimbabwe and who has any skill or experience in any matter which may have to be considered in the inquest.
- Where two or more deaths appear to have occurred from the same event or from a common cause, the Coroner-General or Deputy Coroner-General may direct that a single inquest be held in relation to all the deaths.
- Where a person has been charged with an offence arising out of a death, an inquest into the death may be held only on the direction of the Coroner-General or Deputy Coroner-General.

Rules of evidence applicable in a court of law will not be applicable in inquest proceedings but the proceedings must be conducted fairly and thoroughly so that all the relevant facts relating to the death are established.

At an inquest the coroner will hear any person who wishes to give evidence and such a person may—

- be represented by a legal practitioner; and
- call, examine and cross-examine witnesses; and
- obtain from the coroner a summons to require the attendance of any witness the person wishes to be called; and
- present arguments and submissions and address the coroner at the conclusion of the evidence.

An inquest may be suspended or delayed or closed if—

- a person is charged with an offence arising out of a death for which an inquest is underway; or

- where for any reason a coroner cannot continue to hold the inquest.

An inquest suspended or delayed may at the instance of the coroner be resumed on the date on which—

- the person charged was convicted or acquitted; or
- an appeal from any conviction or sentence has been finally dismissed or abandoned or the time for lodging an appeal has expired.

At the conclusion of an inquest, the coroner must make a report that includes their findings as to—

- who the deceased person was; and
- how the person died; and
- when the person died; and
- where the person died, in particular whether the person died in Zimbabwe; and
- what caused the person to die, and any other observations related to the findings.

There must also be a record of all evidence and copies of all documents received at the inquest.

A coroner must, at the conclusion of an inquest and on request, release documents and objects put in evidence at the inquest to the lawful owner or person entitled to them.

The coroner must give a written copy of the part of the report consisting of findings and observations to—

- a member of the immediate family deceased person; and
- any person with a sufficient and legitimate interest in the inquest, who appeared at the inquest; and
- if the coroner is not the Coroner-General, the Coroner-General; and
- in case of a death in a place of custody, the appropriate authority of the place of custody.

The coroner must not include in their findings any statement that a person is, or may be guilty of a criminal offence or may be civilly liable.

A coroner may, whenever appropriate, make observations in their report on anything connected with a death investigated at an inquest that relates to—

- public health or safety; or
- the administration of justice; or
- ways to prevent unnatural deaths from happening in similar circumstances in the future.

A person who is given a report such a report must respond to the report giving a statement of the action (if any) that has been, or is being, taken in relation to any aspect of the findings contained in the report.

The coroner must give a written copy of the part of the report consisting of findings and observations to—

- a member of the immediate family deceased person; and
- any person with a sufficient and legitimate interest in the inquest, who appeared at the inquest; and
- if the coroner is not the Coroner-General, the Coroner-General; and
- in case of a death in a place of custody, the appropriate authority of the place of custody.

In case of a death in a place of custody, the appropriate authority of the place of custody must not later than two months after the date of receipt of the report, give to the Minister responsible for the place of custody a written response to the findings contained in the report. This response must include a statement of the action (if any) that has been, or is being, taken in relation to any aspect of the findings contained in the report.

Any person may within the prescribed time apply to the High Court for an order that some or all of the findings determined by the coroner be set aside. The High Court will grant an application if it is satisfied that the coroner misdirected themselves or did not have or take into consideration relevant facts and circumstances and in doing so the High Court may order the coroner to conduct a new investigation into the death to determine whether another inquest should be held.

Where an inquest if held, the coroner holds an inquest, the coroner must within three months publish the following on the Coroner-General's official formal electronic communication platform and the formal official electronic communication platform of the Ministries responsible for Justice, Health and Home Affairs unless the Coroner-General orders otherwise—

- the coroner's findings; and
- any other part of the coroner's report.

If a coroner investigated a death but did not hold an inquest the coroner may direct that the coroner's findings be published on the Coroner-General's bulletin only if—

- the coroner considers the publication is in the public interest; and
- to the extent practicable, the coroner has consulted with and taken into account the views of the immediate family of the deceased person.

Anatomical Donations and Post-Mortem Examinations Act* [*Chapter 15:01]

The restrictions upon and procedures for the use of human tissues and organs of dead persons are set out in the Anatomical Donations and Post-Mortem Examinations Act [*Chapter 15:01*].

This Act provides for the donation of human bodies and human tissue for scientific or therapeutic purposes. Human tissue includes any flesh, organ, bone, body fluid or tissue or derivative thereof. Therapeutic purposes include organ transplants and use of other human tissue in the body of another person.

A competent person can donate their body after death for scientific or therapeutic purposes in their will or in a written document attested to by two competent witnesses or orally in the presence of two witnesses.

If the deceased has made no such prior donation, a relative of the deceased may donate the body for scientific or therapeutic purposes provided that the relative has no reason to believe that the deceased did not want this to happen. A Government medical officer may also in certain circumstances authorize the use of tissue from a deceased.

The Act requires that before removing tissue from the body of a deceased, authority must be sought from a magistrate or the person in charge of the hospital in which the deceased died.[26] Authority will not be given where a post-mortem examination is required, for instance, to determine the cause of the death.

The Act further provides that no person, other than an authorized institution, may receive any fee, profit or remuneration for providing any other person for scientific purposes or therapeutic purposes with any tissue, other than blood or a blood product, removed from the body of any deceased or living person, and any payment which has been received for such provision of tissue shall be refundable to the person who made it. Any person, other than an authorized institution, who in consideration for any fee, profit or remuneration procures for any other

[26] In

person for scientific purposes or therapeutic purposes any tissue, other than blood or a blood product, from the body of any deceased or living person shall be guilty of an offence.[27]

This Act should be carefully studied by those who may be involved in medical procedures which make use of human tissues and organs.

Crimes for causing death

These offences are set out in the Criminal Law (Codification and Reform) Act.

Section 47 provides that a person who deliberately and intentionally ends the life of another person commits the crime of murder. Murder can be perpetrated by a positive act such as by stabbing a person to death or by omission, such as where a father deliberately starves his infant child to death. Murder may be committed by a direct, positive act such as shooting a person in the head or by a failure to act where there is a duty to act, such as where a parent deliberately starves their young child to death by failing to feed them.

If X deliberately and intentionally ends the life of Y, it is no defence to a charge of murder that X did so at the request of Y who was terminally ill and whose quality of life was now extremely poor. Thus, so-called mercy killing (euthanasia) is murder. For example, if a husband ends the life of his terminally ill wife who was suffering excruciating pain and she had pleaded with him to end her suffering by killing her, the husband would still be convicted of murder. However, the compassionate motive of the husband would affect the sentence which the court would impose.

Thus a doctor may be found guilty of murder if they deliberately and intentionally end a patient's life such as where, knowing that this will kill the patient, they inject a lethal dose of a medicine. It is no defence to this charge that the elderly patient was on the verge of death, was suffering excruciating pain, their quality of life was very poor and they had pleaded with the doctor to end their life.

Section 49 provides that a person is guilty of culpable homicide if that person negligently causes the death of another person.

Doctors have a legal duty to take reasonable steps to treat sick patients. Failure to treat a patient or negligent treatment can lead to liability for culpable homicide if the patient dies as a result, but a competent adult patient may refuse to undergo a recommended treatment.

Section 52 provides that for the purposes of homicide charges, a person is deemed "to have caused the death of another if they accelerate a death that would not have occurred as a result of independent causes". Thus even if a patient has a terminal disease and is on the verge of death, any person who hastens the death is taken to have caused that death.

Section 50 makes it a criminal offence to incite, aid, counsel, procure or provide the means for a person to commit suicide where the inciter knows that the other person intends to commit suicide. A person who attempts unsuccessfully to commit suicide commits no crime, though the person hospitalized after failed suicide will be medically treated to save their life or help them to recover. They may be required to undergo mandatory

[27] Any authorisation for an organ transplant in addition to the consent of the donor would obviously have to be obtained quickly after death before the organ deteriorates. This also applies after the termination of life support.

psychiatric evaluation and treatment.

Section 54 (1) provides that it is no defence to a charge of murder or inciting or assisting suicide that–

(*a*) the person charged with the crime acted or omitted to act, as the case may be, in order to relieve suffering; or

(b) the deceased person requested that their life should be ended;

but a court may take any such factor into account in deciding upon an appropriate sentence.

It is therefore illegal for a doctor to provide a lethal dose of medicine for the terminally ill patient to take in order that the patient can end their life. If the patient dies, the doctor may be charged either with murder or with assisting suicide and it is no defence that the doctor acted on the request of a suffering patient who was near death. In some countries, Physician Assisted Suicide is lawful but not in Zimbabwe.

In *Vacco v Quill* 117 S. Ct. 2293 (U.S. 1997) the United States Supreme Court held that there was no constitutional right to die with the help of a physician, and hence that prohibitions on assisted suicide were constitutionally valid.

The distinction between causing death by a positive act and assisting a patient to end their life by providing the patient with the medicine that they can take to end their own life is somewhat tenuous. An elderly patient may be paralysed and unable to take the medicine themselves or may not be able to swallow all the medicine required to end their life. It could be argued that it more humane to allow the doctor to end the patient's life as a last resort in order that this can be done as painlessly as possible.

Suicide itself is not a crime. A mentally competent adult patient is entitled to refuse medical treatment or further medical treatment. They may do so even though they have been told by the doctor that without the treatment or further treatment, they will die. The doctor has to abide by the patient's decision and the end result is that the patient dies.

Doctors and nurses are duty bound to take all reasonable steps to save and preserve the lives of their patients. They will seek to cure curable ailments and where the ailment is not curable, they will try to relieve the suffering of the patients.

Doctors are supposed to be healers not killers. It therefore causes profound shock when we read of cases in other countries where rogue doctors and nurses have turned killers. For instance, in the United Kingdom, Harold Shipman was convicted in 2000 of killing 15 elderly patients under his care with lethal injections of morphine. A later public inquiry into his crimes found that he killed at least 250 patients between 1971 and 1998. In America, a nurse called Charles Cullen was responsible for murdering a large number of patients in his care.

Euthanasia (mercy killing)

Voluntary euthanasia

Where a person is suffering from a painful terminal illness, that person may wish to die in order to end their suffering. If that person is physically unable to take their own life, they will often plead with their doctor to kill them with a lethal injection or assist them to die by providing them with a lethal concoction of drugs they can take themselves.

As will be seen in more detail later, in Zimbabwe, a person who kills another by a positive act or assists a person to die commits the crime of murder or assisting another to commit suicide. The fact that they took the action at the request of the other person who was suffering is no defence to these charges. This applies equally to a doctor

and a nurse.

In some other countries, by legislation and subject to stringent conditions to avoid abuse, doctors may lawfully assist a person who wishes to end their life because their life has become unbearable by providing them with medicines to terminate their life (assisted suicide).

There is no legislation in Zimbabwe that would allow a doctor to assist a person to commit suicide.

The main arguments against any legalisation of "voluntary euthanasia" have been put as follows—

> The damage to the medical profession if doctors became to be seen as potential executioners, the advantage to the unscrupulous; the burden on the scrupulous, weighed down with guilt after bereavement; the impossibility of framing any legislation which would not open the door to terrible abuse; the inevitable exploitation of the vulnerable, weak and elderly; the loss to society if the sense of sanctity of life should be further weakened. What the advocates of euthanasia offer is a false freedom based on pessimism about the human condition.

Right to life but no right to die with dignity

The 2013 Constitution in s 48 provides that everyone has a right to life and s 44 provides that it is the duty of every person to respect and protect this right. There is no provision in the Constitution giving the right to a person to die with dignity. Thus the constitution upholds the sanctity of human life.

These laws apply equally to doctors and nurses. Medical practitioners enjoy no special privileges when these laws are applied. In a case of murder, it is not a defence that the person ending the other's life did so out of motives of pity and compassion or that the victim gave their consent to the termination of their life. Mercy killing is treated as murder in Zimbabwe, although the reasons for the murder will be taken into account when it comes to the matter of sentence. A doctor commits murder if they intentionally and deliberately inject a lethal medicine into a patient thereby causing their death. It makes no difference that the doctor ended the life of an elderly terminally ill patient who is mentally competent and who has pleaded with the doctor to end his intolerable, pain ridden life. It makes no difference that the doctor ended the life of a newly born child who is severely handicapped and the child is likely to have a short and painful life.

In *S v Hartmann* 1975 (3) SA 332 (C), a medical practitioner inserted a lethal dose of pentothal into an intravenous drip in his father's arm. His father was 87 years of age, bedridden, dying of cancer and in a critical state of health and great pain. The son's motive in doing this was entirely in what he conceived to be his father's best interests. He was nonetheless convicted of murder, but sentenced to a year's imprisonment of which all but the period until the rising of the court was suspended for one year.

In *Stransham-Ford v Minister of Justice and Correctional Services & Ors* 2015 (4) SA 50 (GP); [2015] 3 All SA 109 (GP), the court authorised a terminally ill person to end his own life with assistance from a medical practitioner either by the administration of a lethal agent or by providing the applicant with the necessary lethal agent to administer himself. However, this decision was later overturned on 6 December 2016 by a decision of the Supreme Court of Appeal: *Minister of Justice and Correctional Services & Ors v Estate Late James Stransham-Ford & Ors* [2017] 1 All SA 354 (SCA); 2017 (3) BCLR 364 (SCA); 2017 (3) SA 152 (SCA). The appeal court said that any decision to change the common law was a matter that should be decided upon by Parliament. It referred to laws in other countries which had legalized euthanasia. Laws in Belgium, the Netherlands, Colombia and Luxemburg allow mercy deaths for adults, which usually means a doctor administering lethal doses of barbiturates. In Switzerland,

Germany, Japan and Canada, doctor-assisted suicide, where people take the final action themselves, is legal. Only Parliament should decide whether to change the law to allow a medical practitioner to end a patient's life at the request of a terminally ill patient by the medical practitioner administering lethal medication or assisting such a patient to end their life by providing the patient with lethal medication for the patient to take.

The position in Zimbabwe is the same as in South Africa. The common law disallows euthanasia. This position is reflected in the case of *S v Hove* 2009 (1) ZLR 68 (H). Here a young unmarried mother killed her 5-month-old baby. The child had been ill from birth, having been diagnosed with HIV, and had been hospitalized in various health institutions for a period of five months. The child had experienced excruciating pain as a result of gaping wounds and open sores all over the body and was always crying uncontrollably due to the endless pain. The accused had been told by medical personnel that there was no help they could offer the child and that the child was facing imminent death. The court held that the circumstances surrounding the commission of this offence cumulatively amount to extenuating circumstances and the sentence of the court was that the mother be detained until the rising of the court. The principle of law laid down in this case would also apply to a medical practitioner ending life or assisting a patient to end their life. However, Parliament could decide after extensive public consultation and debate to change the common law to allow certain forms of euthanasia. As will be seen later, so-called passive euthanasia is permissible in certain circumstances.

These cases show that because euthanasia is unlawful, a doctor, whom by a positive act deliberately causes the death of a patient in order to end their suffering, is guilty of murder. However, if the double effect doctrine is applied, there is a quasi-exception to this rule.

Double effect doctrine

As regards administration of medication to alleviate pain, the doctrine of double effect may be applied. A terminally ill patient is being given morphine to alleviate their pain but the dosage has to be progressively increased when the previous dosage is no longer effective. Finally, the stage is reached when another increase in the dosage is necessary to relieve pain, but the medical practitioner realizes that the injection of this dosage will be likely to result in the death of the patient. Under the double effect doctrine, the doctor should not attract any liability if the patient dies from the injection of the drug. This is because the doctor's primary aim is to relieve suffering and the death is simply an incidental result. Although there is no case decision in which this doctrine has been recognised in Zimbabwe, it is likely that our courts would apply this doctrine in this situation.

Doctrine of medical futility

Mason and McCall Smith[28] consider the doctrine of medical futility. They postulate how this doctrine could be applied to "death decisions" first, in cases of persons who are terminally ill and likely to die within a short period of time[29] and secondly, in cases of neonates born with severe disabilities.

Where medical treatment does not work, it can be said to be futile to continue to use that treatment. Doctors

[28] Mason and McCall Smith, Chapter 16

[29] The General Medical Council in England in its guidance on *Treatment and Care towards the end of life: good practice in decision* making says "that for the purposes of this guidance, patients are 'approaching the end of life' when they are likely to die within the next 12 months. This includes patients whose death is imminent (expected within a few hours or days) and those with: (a) advanced, progressive, incurable conditions (b) general frailty and co-existing conditions that mean they are expected to die within 12 months (c) existing conditions if they are at risk of dying from a sudden acute crisis in their condition (d) life-threatening acute conditions caused by sudden catastrophic events".

should normally not be obliged to commence or continue with a treatment that is objectively useless or totally ineffective. For instance, a doctor should not be required to keep on a ventilator a brain-dead person who is in a permanent vegetative state (PVS) and who has no hope of recovery. So, too, a doctor should not be obliged to attempt CPR where it is pointless because on a number of occasions when the patient has been revived after suffering cardiac arrests, they have gone on to have further cardiac arrests.

Far more contentious is when the issue of futility is raised in connection with the quality of life. Here the question becomes, should life sustaining treatment be used to prolong life of a patient whose chronic condition makes their quality of life so miserable that continued treatment provides no benefit to the patient but merely prolongs that person's suffering and abject existence? Here the treatment is effective only in prolonging life but there is no treatment that will cure the patient.

This raises all sorts of ethical and legal issues. Clearly, a doctor must never be allowed to end the life of a patient simply because s/he alone decides that the patient no longer has a minimum quality of life. This power would be open to terrible abuse. But what if the patient considers that their life should not be prolonged by medical treatment because their quality of life is now so poor that their existence is a misery? What if the patient with a terminal illness is unconscious and whose bodily functions are being artificially maintained, and both the doctor and the patient's relatives believe that it is in the patients' best interests to switch off the ventilator? Who decides what constitutes and qualifies as a bare minimum quality of life?

Mason and McCall Smith[30] point out that doctors will intuitively seek to prolong life as long as possible and advances in the field of medical technology have greatly increased the capacity to prolong life. However, they question whether prolongation of life is always in the best interest of a patient.

In England, guidelines have been drawn up in connection with when CPR should be applied to patients who have suffered cardiac arrest. In these guidelines the following guidelines are to be found. These are relevant not only for the resuscitation cases but also to other cases concerning whether treatment should be given that prolongs extremely poor-quality existence.

> "*Objective of medical treatment*
>
> The primary goal of medical treatment is to benefit patients, by restoring or maintaining their health as far as possible, thereby maximising benefit and minimising harm. If treatment fails, or ceases, to give a net benefit to the patient, or if an adult patient has competently refused the treatment, this goal cannot be realised and the justification for providing the treatment is removed.
>
> Prolonging a patient's life usually provides a health benefit to that patient. Nevertheless, it is not an appropriate goal of medicine to prolong life at all costs with no regard to its quality or the burdens of treatment on the patient.
>
> *''Dying process''*
>
> CPR can be attempted on any person whose cardiac or respiratory functions cease. For a person suffering from a terminal illness, the failure of these bodily functions could be considered to be part of the process of dying. When the time comes when death is inevitable, it is essential to identify patients for whom cardiopulmonary arrest represents a terminal event in their illness and in whom attempted CPR is

[30] Mason and McCall Smith p. 520.

inappropriate. It is also essential to identify those patients who do not want CPR to be attempted and who competently refuse it.[31]

Mason and McCall Smith[32] suggest that the concept of medical futility can be applied from the start of life through as a continuum from neonate to the terminally ill.

Switching off the ventilator

Criminal Law Code provisions

Obviously, a patient cannot be murdered if the patient is already dead. Section 51 of the Criminal Law Code provides that where the person has been installed on a heart-lung or ventilator machine or other life-support system, ''death is taken to occur when a competent medical practitioner, after carrying out appropriate tests, diagnoses and confirms that brain death has occurred." The switching off of the ventilator by the doctor in these circumstances does not constitute homicide as the patient is already dead.

Section 54 of the Criminal Law Code further provides for a situation where a patient's brain functions have not entirely ceased but the patient is unconscious and has no reasonable prospect of regaining consciousness; their life is being artificially sustained by the machine or system and there is no reasonable prospect that they will ever be able to survive without being on the machine or system.

Here the High Court may, on application, order that this person be removed from a heart-lung or ventilator machine or other life-support system. It can make this order if the court is satisfied, from the evidence of at least one medical practitioner, other than any medical practitioner who has been treating the person, that–

- the patient is unconscious and there is no reasonable prospect of their regaining consciousness; and
- although the person's brain functions may not have entirely ceased, their life is being artificially sustained by the machine or system and there is no reasonable prospect that they will ever be able to survive without being on the machine or system.

In such a case, the switching of the machine will hasten death.

This court application may be made–

- by the patient's a spouse, brother, sister, parent, guardian, curator or tutor
- by the person in charge of the hospital or other institution in which the patient is being kept.

In such an application, the court–

- may appoint a curator *ad litem* to represent the interests of the patient; and
- must ensure that, where practicable, every person who has an interest in the matter has been given notice of the application and has been afforded a reasonable opportunity of being heard.

No criminal liability will attach to–

- any person who terminates the life of another person pursuant to a court order; or
- an applicant for a court order; or
- the curator *ad litem.*

[31] *Decisions Relating to Cardiopulmonary Resuscitation*: a joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing http://dx.doi.org/10.1136/jme.27.5.310

[32] Mason and McCall Smith p. 520.

A court order will cease to be valid after eighteen months have elapsed from the date on which it was granted.

Advance instructions

A patient may have given written or spoken instructions to their doctor or their relatives that in the event that they have been rendered into a PVS and further treatment is futile, they should not be installed on a ventilator or, if they are already on a ventilator, it should be switched off.

The doctor should comply with this instruction if it is clear that the patient is in this condition and further medical treatment is hopeless.

Proxy consent to switching off ventilator

Where the person in a PVS has not given instructions as to what should happen to them, the Criminal Law Code sets out the persons who may apply for a court order to switch off the ventilator. These include a spouse, a sibling, a parent and the head of the hospital in which the patient is being treated.

Cases may arise where the application to switch off the ventilator may be sought by one relative but is opposed by another. For instance, an application by a parent is opposed by a spouse where the spouse believes that there is still a possibility that the patient may recover. Here the court will have to decide what course is in the best interests of the patient.

Cases on end of life

Woman on ventilator – parents wanted her removed from ventilator

In *Re Quinlan* (1976) 355 A 2d 647, Karen lay in a coma attached to a life support machine having been suddenly stricken with illness. Although she was not brain stem dead, her doctors were satisfied that there was no hope that she would ever recover a cognitive state. She was found to be in a 'chronic, persistent, vegetative condition' and was being kept alive only with the assistance of a ventilator. Karen's parents decided that it would be best for her to be removed from the life-support machine. Her father then applied to the court for him to be appointed her guardian. He claimed that, as guardian, he would be entitled to authorise the discontinuance of all 'extraordinary' medical procedures sustaining Karen's life. The court held that if Karen had been conscious and lucid, she would have had the right to discontinue a life-support treatment if it was simply prolonging for a short period a terminal condition. Her father was entitled to make a substituted decision on behalf of his daughter that she would have made had she been able to do so. With concurrence of guardian and family, if the attending doctors decided that there was no reasonable possibility of her ever emerging from her comatose condition to a cognitive state, the life support treatment was discontinued. However, this did not lead to a swift death as she died only ten long years after falling into a coma.

Adult woman on ventilator – husband wanted removed from ventilator but parents did not

Terri Schiavo[33] suffered a cardiac arrest. She was successfully resuscitated, but had massive brain damage due to lack of oxygen to her brain and was left comatose. After two and a half months without improvement, her diagnosis was changed to that of a persistent and irreversible vegetative state. Terri's husband and legal guardian argued that she would not have wanted prolonged artificial life support without the prospect of recovery and

[33] Terry Schiavo Case https://en.wikipedia.org/wiki/Terri_Schiavo_case

wanted her feeding tube to be removed so that she could be allowed to pass away. Terri's parents disputed her husband's assertions and challenged the medical diagnosis of their daughter, arguing in favour of continuing artificial nutrition and hydration. There were a prolonged series of legal challenges made by her parents to try to stop the feeding tube from being disconnected. For the next two years, doctors attempted occupational therapy, speech therapy and physical therapy. Finally, a federal court in America ordered that the feeding tube could be disconnected and Schiavo died.

Cessation of artificial feeding

A patient who is unconscious in a PVS will be fed artificially. The question arises as to whether artificial feeding can be withdrawn to hasten the patient's death because that patient has no hope of recovery. In England, there have been cases where the doctors, with the concurrence of the patient's relative, have applied to court for an order to permit the withdrawal of the artificial feeding.

In *Airedale NHS Trust v Bland* [1993] 1 All ER 81 (HL), the court was called upon to decide what should happen to the young person. At the age of 17, Anthony Bland suffered injuries by being crushed in a crowd stampede at a football stadium. He suffered catastrophic and irreversible damage to his brain. His condition was that of a permanent vegetative state. He lost all cortical (high brain) function, but his brain stem continued to function. PVS patients continued to breath independently and their digestion continues to function. Anthony was incapable of voluntary movement and could feel no pain. He could not see or hear, taste or smell. He remained alive, fed through a tube. All his excretory functions were managed mechanically. Doctors were agreed that there was no hope of recovery of any sort. He continued in this state for two years. With the concurrence of his family, the hospital applied for a declaration that they could lawfully discontinue the feeding through the tube. The House of Lords unanimously granted that declaration and Anthony was allowed to die. Anthony was not suffering an intolerable burden as he was not in pain and was not conscious. But for the parents, their child was effectively a living corpse. It was futile to continue and not in his best interests. The House of Lords said the ruling only applied to PVS patients and a declaration should be sought from the courts before treatment is discontinued.

Mentally competent adult patients wanting to die

The sort of situation in which a mentally competent patient who is conscious may seek to end their life are these:

An elderly patient has a terminal illness which will soon cause death. He believes that his life has become unbearable in his condition and with the pain he is suffering. He wants to die with dignity. He may have the additional reason for wanting to expedite his death as his continued treatment is imposing an intolerable financial burden upon his loved ones who have to pay for the ongoing expensive treatment.

In this first situation, the doctor may not cause his death at their request or provide lethal drugs for the patient to take. But the patient may decline further treatment or instruct the doctor to discontinue artificial feeding.

Some patients may not be terminally ill but are suffering from a chronic, incurable medical condition which renders their quality of life so poor that they wish to die. The sort of conditions where patients may want to end their lives, that they consider to be abject, are these—

- Motor neuron disease amyotrophic lateral sclerosis (Lou Gehrig's disease) is a fatal neurodegenerative disease that affects the motor neurones in the brain and spinal cord, which gradually paralyses the person over decades.
- Huntington's disease is a rare, inherited disease that causes the progressive degeneration of nerve cells

in the brain. It has a wide impact on a person's functional abilities and usually results in movement, thinking and psychiatric disorders.

- Dementia and Alzheimer's disease. Alzheimer's is the most common form of dementia. Changes typically begin in the part of the brain that affects learning. As Alzheimer's advances through the brain it leads to increasingly severe symptoms, including disorientation, mood and behavior changes; deepening confusion about events, time and place; unfounded suspicions about family, friends and professional caregivers; more serious memory loss and behavior changes; and difficulty speaking, swallowing and walking.
- Quadriplegia where the patient is paralyzed from the neck down, including the trunk, legs and arms. The condition is typically caused by an injury to the spinal cord that contains the nerves that transmit messages of movement and sensation from the brain to parts of the body.
- Parkinson's disease is a brain disorder that causes uncontrollable movement, such as shaking, stiffness, and difficulty with balance and coordination. Symptoms usually begin gradually and worsen over time. As the disease progresses, people may have difficulty walking and talking.
- AIDS in the terminal stage leads to mental deterioration, loss of vision, speech disturbances, inability to coordinate movements, paralysis and ultimately coma.

In this second situation there are various scenarios:

- Condition diagnosed at early stage.

The patient wants to end their life before the condition reaches the advanced stage and the person suffers the humiliation of undergoing complete personality disintegration. Such a person may give instructions that when the condition reaches the advanced stage, they want to die. However, the doctor may not cause their death or assist the patient to kill themselves.

Refusal to have medical procedure

As previously pointed out, no medical procedure may lawfully be carried out on a mentally competent adult without their informed consent to the procedure. A patient may refuse to undergo a medical procedure even though the patient knows full well that unless they receive the treatment, they will die. A terminally ill patient may decline to undergo any further surgery that will only slightly prolong their life span. A patient with terminal cancer may refuse to undergo chemotherapy because they do not want to experience the adverse effects of that therapy.

The English Court of Appeal in *Re T (Adult: Refusal of Treatment)* [1992] 4 All ER 465 emphatically stated that an adult with mental capacity has absolute right to refuse medical treatment provided that their refusal is freely made and is unequivocal. They have a right to self-determination. They can refuse to undergo a treatment even though the treatment is necessary to save or prolong their life. The doctor is acting unlawfully if they treat a mentally competent patient when the patient has refused to receive that treatment. The doctor cannot force the patient to undergo a treatment that will allow the patient to live longer.

An adult patient who is conscious and whose mental functions have not been impaired has the right to decline treatment recommended by the doctor. The doctor must abide by those instructions after satisfying themselves that the patient understands the medical consequences of not undergoing that treatment.

In *B v An NHS Trust* [2002] EWHC 429, Ms B suffered a haemorrhage in the spinal column in her neck. Her condition

deteriorated rapidly. Within two years she was paralysed from the neck down and could breathe only supported by a ventilator. Doctors told her that she was unlikely to recover. Rehabilitation programmes to allow her to live outside hospital were proposed to her. Ms B was adamant that she did not want to survive in such a condition. She instructed the doctors to switch off the ventilator. The doctors treating her refused, citing conscientious objection to such a course of action and challenging Ms B's mental capacity to refuse further treatment. The judge held that Ms B retained mental capacity. That being the case, continuing to ventilate her against her will was unlawful. She was entitled to demand that the ventilator be switched off, though not to demand an individual clinician to act contrary to their conscience.

Competent adult patient requesting doctor to stop artificial feeding

A competent terminally ill adult may seek to hasten their death by instructing the doctor to stop nutrition and hydration by medical means, usually by way of a feeding tube. If the doctor complies with the patient's instruction and the patient starves to death, has the doctor committed the crime of assisting suicide? It could be argued that at law the doctor may not provide any form of treatment against that person's wishes. The patient could have refused to be put on the drip and may also demand to be taken off the drip. If after the drip is removed, the doctor merely provides palliative care to give relief to the patient during the dying process, the doctor cannot be said to be assisting suicide.

The American case of *Bouvia v Superior Court*, 179 Cal. App. 3d 1127, 1135-36, 225 Cal. Rptr. 297. (Ct. App. 1986), review denied (Cal. June 5, 1986) illustrates the difficulties that the courts have faced in measuring the autonomous right of a patient to take action that will result in her death measured against the interest that a State has in preserving life. Elizabeth Bouvia was a mentally competent, young, quadriplegic woman who suffered from cerebral palsy, leaving her completely bedridden and dependent on others to perform all her activities of daily living. She wanted to starve to death, but a court issued a court order allowing the hospital to commence force-feeding her by inserting a nasogastric tube. Finally, she sought a court order to have the nasogastric tube removed and to stop all medical measures to which she did not consent. How the courts dealt with this situation is set out in detail in a more detailed summary of the case contained in the Annexure 5.

The situation is different where the doctors and relatives believe that artificial feeding should discontinue but the patient insists that it should be continued.

In *R (on the application of Burke v General Medical Council* [2005] 3 WLR 1132; [2005] 2 FLR 1223, the situation was that a young man, Mr Burke, suffered from the degenerative disease cerebellar ataxia which would eventually leave him unable to communicate while still retaining his mind. The doctors considered that the patient's condition was such that nothing more could be done for him medically and the sole function of the artificial feeding was to keep his body alive. They wanted to discontinue artificial feeding. They wanted to act on the basis of Guidance from the GMC[34] that it would be would be in accordance with good medical practice to withhold or withdraw artificial nutrition when the conditions were considered so severe and the prognosis so poor that providing ANH would be too burdensome for the patient in relation to the possible benefits. Mr Burke had other ideas; he challenged the Guidance provisions. He argued that the continuation of artificial feeding in his case would never be futile and it would be in his best interests to continue with the artificial feeding. no matter his

[34] General Medical Council: Treatment and care towards the end of life. https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/treatment-and-care-towards-the-end-of-life/guidance.

state of health and no matter that nothing more could be done for him medically.

The matter went to court. The trial court found that artificial feeding could lawfully be withdrawn where it was serving absolutely no purpose and was, indeed, futile. However, when the patient involved was competent, as was Mr Burke, who wanted treatment to continue and did not believe that this would impose intolerable burdens upon him, the court should judge the best interests of the patient from his perspective. There was also a strong presumption in favour of prolonging life given the sanctity of life.

Patient refuses nutrition and hydration

A competent terminally ill adult patient in hospital who has been able to take food and fluids by mouth decides that they will hasten their death by refusing to receive nutrition and hydration by way of a feeding tube save for small amounts of fluid needed for mouth comfort or to swallow medications. Death by dehydration ordinarily follows in several days to three weeks.

It would seem that if the doctor simply provides palliative care during the time that it takes for the patient to die of starvation, the doctor would not be guilty of assisting suicide as their action is to provide relief during the dying process.

If, on the other hand, the doctor believed that it was wrong to allow the patient to kill themself in this manner, the doctor's only option would be to approach the High Court for an order that the doctor be permitted to force feed the patient in order to save their life. There is no decided case on this matter and the High Court would have to decide whether to grant the order sought taking into account the competing considerations of patient autonomy and society's interest in the preservation of life. In a situation in which the patient has attempted to commit suicide is brought into hospital unconscious, the doctor will obviously try to save their life although, if the patient had been conscious, they would probably have told the doctor not to take action to resuscitate them.

Unconscious patient

An unconscious patient is incapable of deciding whether to receive or continue to receive medical treatment.

An adult patient who is suffering from a terminal disease may previously have signed a written document in which they stated that if they suffered cardiopulmonary arrest, the doctors must not attempt CPR.

There are also cases where the patient who is unconscious has given no written or spoke instructions to their doctor or relatives regarding what should be done where treatment or continued treatment appears to be futile.

Are the relatives entitled to make a judgment call as to what they believe the patient would have wanted to happen and if so, what if the relatives disagree as to whether treatment should be discontinued?

The term "wrongful life" is also sometimes applied to what are more accurately described as "wrongful living" claims alleging that doctors or hospitals failed to follow a patient's end-of-life directive and kept the patient alive longer than preferred, thereby causing unnecessary and unwanted suffering.

Do not resuscitate

Cardiopulmonary Resuscitation (CPR) can be attempted on any person whose cardiac or respiratory functions cease. The likelihood of recovery varies greatly according to individual circumstances; the average proportion of people who survive following CPR is apparently relatively low. Methods of resuscitation include–

- cardiac compression (repeatedly pushing down very vigorously on the centre of the chest);

- artificial ventilation (blowing air or oxygen into the lungs, using either a mask over the nose and mouth or a tube inserted into the throat or windpipe);
- defibrillation (electrical shock to try to restart heart)
- intubation (insertion of breathing tube into windpipe)
- injection of medicines.

Medical commentators point out that resuscitation is an "intense" and oftentimes traumatic medical procedure that elderly patients may have trouble recovering from should it be successful. Chest compressions must be applied with extreme force in order to get the blood pumping through the heart. Broken ribs, bruised lungs, or even damage to the heart itself are all potential ramifications of successful CPR. Intubation may also be used if a patient stops breathing. This invasive technique requires a tube to be rapidly inserted into the windpipe of a patient in order to manage airflow. This can lead to minor or severe complications such as damage to the esophagus and other tissue in the throat.

An elderly man is in hospital because he has a painful terminal medical condition and his death is imminent. The patient suffers a cardiopulmonary arrest. The question is whether the doctor treating him has a legal and ethical duty to apply CPR in an attempt to revive him by restarting his heart-lung functions?

This decision involves complex and sensitive ethical, moral, religious and legal considerations relating to quality of life and extraordinary measures to prolong the process of dying. The overarching consideration is always what is in the best medical interests of the patient in question.

There are basically two types of situations:

1. The elderly mentally competent patient has given a clear instruction that CPR must not be applied; or
2. The elderly patient hasn't given an instruction not to use CPR and the doctor has to decide whether or it is not in the interests of the patient to apply CPR.

Patient instructions on not to attempt CPR or DNR (a living will)

If the patient has previously freely given a clear, unambiguous express instruction which was not coerced and not withdrawn to the medical practitioners that, in the event that he has an arrest of his heart lung functions, the doctors must not attempt cardiopulmonary Resuscitation (CPR). Provided that he was a mentally competent adult when he gave this instruction, the doctors treating him must abide by this instruction. The doctor may not override the clearly expressed wishes of the patient even if the spouse or relatives try to overrule it by insisting that the doctors apply CPR. If the doctor administers CPR knowing that the patient has instructed that CPR is not to be applied and the patient is revived, the doctor has, in effect, acted wrongfully and might face a disciplinary charge before the Health Professions Council. However, as the CPR has saved the patient's life, our courts would be most unlikely to accept that there is any civil liability. Even in America the courts have rejected claims for unlawful life!

Although it is best that the Do Not Resuscitate (DNR) instruction is given in writing, the instruction could also be given orally providing it is clear and unambiguous. See Annexure 4 for a form used in the USA for DNR. The patient may also have previously told their relatives that they did not want CPR to be applied but the doctors should be cautious about proceeding on the basis of what the relatives say about such a previously expressed intimation.

A DNR order does not affect instructions for other treatments, such as pain medicine, other medicines, or nutrition. Unlike a situation where an active step is taken such as switching off a ventilator in a hopeless case, a DNR order will call upon the attendant doctors simply to refrain from attempting CPR.

Where a patient has not given a DNR instruction in advance, the attitudes of the spouse or relatives about whether or not CPR should be applied should be taken into account but are not necessarily decisive. The primary consideration of the doctor must be the best health interests of the patient. One possible situation is where the spouse or relatives who are present at the time of the arrest indicate that their relatives had told them that he did not want to have CPR applied. Another situation is where the relatives insist that the doctor perform CPR even though the doctor believes that CPR is pointless and will not revive the patient. A further situation is where the spouse or relatives instruct the doctor not to perform CPR because they cannot afford to continue to pay for expensive treatment of the patient.

In a number of other countries there is a legislative framework governing DNR orders or DNR guidelines drawn up by the body regulating medical practice. Zimbabwe should either have a legislative framework or ethical guidelines. The Health Professions Authority in Zimbabwe should urgently compile appropriate guidelines on DNR for medical practitioners. It could model these on the guidelines from other countries such as the United Kingdom. An extract from the guidelines from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing is quoted under the topic of Medical Futility above. These guidelines were intended to deal with situations of DNR so they are worth repeating here.

"*Objective of medical treatment''*

> The primary goal of medical treatment is to benefit patients, by restoring or maintaining their health as far as possible, thereby maximising benefit and minimising harm. If treatment fails, or ceases, to give a net benefit to the patient, or if an adult patient has competently refused the treatment, this goal cannot be realised and the justification for providing the treatment is removed.
>
> Prolonging a patient's life usually provides a health benefit to that patient. Nevertheless, it is not an appropriate goal of medicine to prolong life at all costs with no regard to its quality or the burdens of treatment on the patient.

''Dying process''

> CPR can be attempted on any person whose cardiac or respiratory functions cease. For a person suffering from a terminal illness, the failure of these bodily functions could be considered to be part of the process of dying. When the time comes when death is inevitable, it is essential to identify patients for whom cardiopulmonary arrest represents a terminal event in their illness and in whom attempted CPR is inappropriate. It is also essential to identify those patients who do not want CPR to be attempted and who competently refuse it.[35]

DNR Order

A Do Not Resuscitate (DNR) order (in America a Code order) is an instruction that the health care providers should not attempt to revive the patient who suffers cardiac or respiratory arrest. A DNR order does not affect instructions for other treatments, such as pain medicine, other medicines, or nutrition.

Unlike a situation where an active step is taken such as switching off a ventilator in a hopeless case, a DNR order will call upon the attendant doctors simply to refrain from attempting cardiopulmonary resuscitation (CPR).

[35] *Decisions Relating to Cardiopulmonary Resuscitation*: a joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing. http://dx.doi.org/10.1136/jme.27.5.310

Where the attending doctor considers that the condition of legally competent patient is such that it is likely that they may soon have cardiopulmonary arrest, the best course would be for the doctor to have a discussion with the patient to ascertain whether they would want the doctor to employ CPR.

1. The patient expressly instructs the doctor not to administer CPR. The patient should be made to sign a written document to this effect and CPR should not be attempted. See sample form in Annexure 4.
2. The patient verbally informs the doctor that they do not want CPR to be administered. CPR should not be attempted.

Where the patient does not want CPR, the relatives should be informed of this decision. The patient can inform the doctor orally of their instruction or by wearing a medical wristband indicating this.

No advance instruction not to resuscitate

If the patient has not given any DNR instruction and no relatives are available to indicate what the patient would have wanted, the question is whether the doctor can decide to give a DNR order (Code order) instruction in respect of that patient. What if the doctor considers that the condition of the patient is such that CPR will not succeed in reviving the patient or that it would not be in the patient's best interests? Before making a DNR order it would be essential to consider all the relevant medical information. One consideration is the harm that may be caused by attempted CPR.

Child

A DNR order can be made by doctor prepared at the request of the parents of a child where the child has a terminal condition and has no medical probability of recovery. This could be done where the child is too young to make a decision for themselves.

Such DNR orders, however, raise critical issues about the authority of parents and medical professionals to make decisions for children who often are not in a mental or physical state to comprehend the nature of the DNR order and the rights of children to continued life despite their debilitating or terminal conditions.

Mental incompetence

An adult who has been declared mentally incompetent cannot instruct a doctor to refrain from administering CPR but the fact that someone is suffering from a mental illness does not necessarily mean that the person has no competence to give instructions to their doctor about what treatment they are prepared to accept.

NEONATES WHO ARE SICK WHEN BORN

Decisions on treatment

Where a baby is sick at birth, a decision will have to be made by others for the baby but the decision must always be in the best interests of the child.

With a curable ailment, the parents can consent to the treatment recommended by the doctor. If the parents refuse for religious or other reasons to consent to the recommended treatment, a magistrate can authorise the doctor to proceed with the treatment. Where it is an emergency situation and the parents are not contactable to give consent in time, the doctor may treat the child on the basis of the doctrine of necessity.

Doctors treating babies are governed by the same legal rules as with ordinary people. A doctor is guilty of murder if they intentionally cause the death of a baby by a positive act such as administering a lethal injection. It makes no difference that the baby was in the process of dying from a terminal and painful ailment and the parents had implored the doctor to end the baby's suffering. It makes no difference that the baby was suffering from serious and permanent disabilities and the parents implored the doctor to end the baby's life with a lethal injection.

This is shown in the case of *S v Hove* 2009 (1) ZLR 68 (H) which was referred to previously. Here a young unmarried mother, killed her 5-month-old baby. The child had been ill from birth, having been diagnosed with HIV, and had been hospitalized in various health institutions for a period of five months. The child had experienced excruciating pain as a result of gaping wounds and open sores all over the body and was always crying uncontrollably due to the endless pain. The accused had been told by medical personnel that there was no help they could offer the child and that the child was facing imminent death. She was convicted of murder. She was sentenced to be detained until the rising of the court.

Very premature babies

Previously in the United Kingdom, "most extremely premature babies died at birth and many severely disabled babies survived only a few weeks or months of birth." Brazier and Cave[36] point out that advances in neonatal care "now enable doctors to prolong the lives of babies born at ever earlier stages of gestation." Further, they note that babies born later in pregnancy, but affected by severe abnormalities, can also be 'saved'. They go on to say that the evidence suggests that many of those babies whose lives have been prolonged will not survive to leave the neonatal intensive care unit and go home and a proportion of those who do survive will be affected by severe disability.

In Zimbabwe, neonatal units do not have at their disposal the range of sophisticated equipment and facilities of those in the United Kingdom. Nonetheless, they are able to prolong the lives of babies who previously would not have survived. Should they apply all possible measures to an extremely premature baby to extend its life, knowing that these measures are only likely to extend the baby's life by a short period? Should they not rather devote their energies to treating a less premature baby who has a better chance of survival and provide only palliative care to the other baby? Would a court be likely to find that such selective non-treatment of some babies was justified in order to be able devote available resources to treating less premature babies with a better chance of survival?

[36] Brazier and Cave p. 434.

Babies with severe and permanent disabilities

One of the most agonizing situations is where the baby is born with severe and permanent disabilities. Some parents will be prepared to love and nurture that child for the rest of their life despite their disabilities. These parents will want the doctors to do everything possible to ensure the survival of that baby. On the other hand, parents who had been hoping for a healthy baby may reject the infant and may prefer that the doctors refrain from taking aggressive measures to keep the child alive but rather allow nature to take its course and the child to die.

Once the baby has been born, however, the constitution provides that they have the right to life (the sanctity of life). Doctors may not intentionally end the life of a very sick baby who is likely to die within a short period time, even if it is the parents' wish that their baby's suffering be ended.

The law protects the foetus in her mother's womb (the unborn child) under the law on abortion. The crime of abortion is committed where a pregnancy is terminated otherwise than in accordance with the Termination of Pregnancy Act. This Act, however, provides that pregnancies may be lawfully terminated on certain grounds. One of these is where "there is a serious risk that the child to be born will suffer from a physical or mental defect of such a nature that he will permanently be seriously handicapped." Thus, if severe foetal abnormalities are detected during pregnancy or tests indicate there is a serious risk that the baby will be born with such abnormalities, the parents can seek to have the pregnancy ended.

But what is the position if the abnormalities had not been detected during pregnancy and the baby is born with such abnormalities and the parents, cognisant now about the baby's condition, consider that the child's life should not be extended out of compassion? Section 303 of the Criminal Procedure and Evidence Act provides that life is deemed to have commenced when a newly-born child has breathed, whether or not it has an independent circulation at that time and whether or not it is entirely separated from the body of its mother. From that time onwards the child has a constitutional right to life and anyone who intentionally ends the life of the child will be guilty of murder or, in the case of a mother who kills her child within six months of giving birth when her balance of her mind had been disturbed, will be guilty of infanticide. This applies even if the child would soon have died anyway as it is suffering from an incurable ailment; a person who hastens the end of the child's life will still be guilty of homicide.

Is the doctor obliged to take all possible medical steps to prolong the life of the baby who is suffering from a serious medical condition which is incurable and will probably lead to the death of the infant within a short space of time and will suffer badly before dying? Is the doctor entitled to decide to provide only palliative care and allow nature to take its course? Should any such decision be made only if the parents agree to this course?

Should the doctor be obliged to take all possible steps to preserve the life of that baby who is born with severe disabilities which will afflict the child for the rest of their life so that they will have a very low quality of life? The condition may not be life threatening but a miserable existence is destined for the rest of the baby's life. Who decides what disabilities will result in such a miserable existence? Should the doctor take this decision if the parents plead with the doctor to allow nature to take its course and to let the baby pass away peacefully?

Should the doctors with the agreement of the parents be legally permitted to allow a severely handicapped baby to die rather than taking aggressive medical measures to ensure its survival? Should the doctor withhold treatment because the parents believe it is best interests to allow the baby to die?

There is an absence of case law in Zimbabwe dealing with these sensitive issues. It is likely, however, that the courts would be guided by English and American case decisions.

Cases from the United Kingdom have ruled that, in certain circumstances, the doctors are entitled to decline to take aggressive medical measures to prolong the life of the dying child. They should, however, provide palliative care to relieve the child's suffering. They may also withhold or withdraw artificial feeding to accelerate the process of dying. These decisions must be taken in the best interests of the child and the parents' wishes should be taken into account.

In the case of *In Re Z (A Minor)* 1995 4 All ER 961 at 986 the court ruled—

> The decision of a devoted and responsible parent should be treated with respect … But the role of the court is to exercise an independent and objective judgment. If that judgment is in accord with that of the devoted and responsible parent, well and good. If it is not, then it is the duty of the court, after giving due weight to the devoted and responsible parent, to give effect to its own judgment.

However, the wishes of the parents may be overridden where a court decides that the parental approach is not in the best interests of the child.

In Re B (A Minor) (Wardship: Medical Treatment) [1981] 1 WLR 1421 (CA) a girl was born with Down's syndrome and an intestinal obstruction. If the child had been normal, the doctors would have been able to remove the obstruction by simple surgery with minimal risk. Without surgery, the baby with Down's syndrome would die within a few days. The baby's parents refused to authorize the operation, maintaining that nature had provided a way for the baby to be released from her suffering. This matter was taken to court for a ruling as to whether the doctors should proceed with the surgery. The court of appeal decided that the doctors must operate on the baby and allow her to live. It rejected the submission for the parents that in this type of case, the views of responsible and caring parents must be respected and that their decision should decide the matter. Rather, the matter had to be decided on the basis of the best interests of the baby.

In R v Arthur (1981) 12 BMLR 1 a paediatrician was charged with attempted murder of baby with Down's syndrome. Apart from suffering from Down's syndrome, the baby was otherwise healthy. The parents did not wish the baby to survive. The baby died 69 hours after birth. The prosecution alleged that the doctor had ordered nursing care only and had prescribed a drug to suppress the baby's appetite and so starve him to death. In the court's summing up for the jury, the judge said that no special protection is given to a doctor when they are treating a severely disabled baby. However, there was a distinction between doing something active to kill the child (such as where the doctor administers an excessive quantity of drugs that he knows will cause death) and refraining from following a particular course that might have saved the infant. The jury acquitted Dr Arthur.

As regards taking into account parental views, there could be three scenarios—

- both parents want the doctors to allow the baby to die;
- both parents want the doctors to take all necessary measures to allow their baby to survive and are prepared to raise it despite the disabilities; and
- one parent wants baby treated; one does not.

The last situation would require a ruling from the court as to what should be done.

CONTRACTS OF DOCTORS AND NURSES

Contracts of employment in public and private health institutions

Doctors and nurses can be employed either in the public or private sector. Before contracts of employment are entered into there are normally interviews, negotiations and exchanges of letters. The contracts which result from this process can be made verbally or in writing. Although in Zimbabwe an oral contract is legally binding, it is more common to draw up a written contract in which all the terms agreed upon are set out in clear and unambiguous terms. By doing so, later disputes as to the agreed terms can be avoided whereas with oral contracts there is far more scope for disagreement.

Where written contracts are concerned, employees should always read the contents carefully and make sure that they understand and accept all the terms before signing the contract. Any terms which are at variance with agreements reached during verbal negotiations should be queried. If any of the terms are not understood, the potential employer should be asked for explanation. Alternatively, a lawyer or another medical practitioner already holding that job may be approached. Often the contract is sent to the potential employee stating that they have a defined period in which to sign the contract and return it. The decision as to whether to accept the contract must be made within the set period, failing which the offer will lapse.

Contracts such as those between trainee nurses and the Ministry of Health, or a Mission Hospital are often in standard form and the Ministry or Mission Hospital will not be prepared to vary the standard terms but will simply make the offer to the employee on a non-negotiable basis. However, usually at least some of the terms of the contract, e.g. salary commensurate with experience, leave conditions, etc., will be open to discussion.

When a person is entering into a contract of employment that person must disclose to the potential employer all material facts which are known and which may significantly affect the employment decision. If this is not done the contract may later be invalidated. For example, if a doctor or nurse knows they are suffering from an infectious disease like tuberculosis, this must be disclosed. Clearly any questions asked by the potential employer such as whether the applicant has any previous criminal convictions must be answered honestly otherwise the contract which is entered into may become invalid when the true facts emerge.

Contracts may be for a fixed term. This applies particularly to contracts entered into with trainee nurses whose contracts normally expire when the training period comes to an end.

When a trainee nurse has successfully completed training and passed all required examinations, then they will usually be placed on qualified staff. The new terms should be spelled out in a fresh written contract. (It is preferable to draw up a new contract rather than simply amending the contract which applied during the training period.)

If a trainee nurse fails the final examinations at the end of a fixed training period, but is allowed to re-sit those examinations, the terms applicable to the extended training period should be stated.

If a qualified nurse such as a ward sister has taken a break in employment, on re-employment, even to a position similar to that which was held previously, a new contract specifying the current terms should be entered into. (The old terms may well have changed during the time the nurse was away.)

Part-time employment contracts should also be in writing. Normally such contracts do not entitle the employee to benefits such as sick leave, pension, annual or cumulative leave and so on.

In large institutions such as Government hospitals it is common for booklets to be issued or notices to be posted specifying the rules of the workplace. As these instructions are unilaterally imposed by the employer and are not a product of agreement, these can be changed unilaterally by the employer from time to time. However, the employer will often negotiate with the employees or representatives of the Nurses' Association and seek their agreement to these rules before implementing them.

Terms of contract result from mutual agreement between the employer and the employee and these terms can only be changed by mutual agreement between the contracting parties. If the employer refuses to abide by the agreed terms they can be sued for breach of contract. Such terms will include such matters as level of salary, bonuses, overtime rates, promotional stages, hours of work, nature of duties, leave conditions, pension schemes and so on. When entering into a contract a person may be required to be bound by a pre-established disciplinary procedure in case disciplinary action should become necessary during the period of employment.

The employer is entitled, however, to give instructions unilaterally concerning the manner in which the employee is to carry out the duties which they were employed to perform. The employer is also entitled to lay down the procedures for settling grievances provided, of course, that none of these procedures conflict with the agreed terms of contract.

In Zimbabwe, government-trained nurses are required to work in government hospitals upon graduation, and the government does not immediately release to graduates the diplomas that would allow them to get jobs elsewhere. Currently, there aren't enough nurses being trained to meet the government's target, and at the same time, there aren't enough job vacancies for trained graduates. That leaves many nurses in career limbo.

There is a compulsory supervised period [2 years for Medical Interns and 1 year for Dental Interns] in a Central Hospital or an approved Designated Health Institution so as to gain clinical experience. Internship training is an essential and indispensable component of the development of a young doctor. During that period, interns are expected to develop professional values and advance their knowledge, skills and attitudes.

Internship training provides an environment for the intern to learn whilst providing services. This follows the principle of apprenticeship where the intern is a member of a team which is responsible for the care of acute medical outpatients and relevant procedures.

Strike action by doctors and nurses

In the past, there have been numerous strikes by doctors and nurses to draw attention to what they consider to be unsatisfactory wages and poor working conditions. These have taken place on failure of negotiations to settle these issues. The situation has led to many nurses and doctors leaving the country to take up employment in other countries where the conditions of employment are far better. Those remaining in Zimbabwe have been placed under additional pressure because of staff shortages.

As from the beginning of 2023, public sector health workers (those employed by the Health Service Commission) are no longer permitted to embark on industrial action lasting more than three days. The restrictions upon on the right to strike are contained in a new section that has been inserted into the Health Service Act [*Chapter 15:13*]. The Health Service Amendment Act, 2022 inserts a new s 16A. This deems the health service to be an essential service referred to in s 65(3) of the Constitution, "notwithstanding anything in the Labour Act [*Chapter 28:01*]".

It prohibits any collective job action, whether lawful or unlawful, from continuing:

- for an uninterrupted period of 72 hours or
- for more than 72 hours in any given 14-day period and
- notice of any collective job action must be given in writing 48 hours prior to the commencement of such collective action.

Any person who is a member of the governing body of any trade union or representative body of members of the Health Service which incites or organises any job collective action for more than the prescribed period is guilty of an offence and liable to a fine not exceeding level four or to imprisonment for a period not exceeding six months or to both such fine and imprisonment.

The Amendment further provides that generally a member of the Health Service is under an obligation, whilst employed by the Commission, to provide the professional skill, expertise, care and service expected of them as a member of the profession to which they belong. Such a member is also under an obligation during any collective job action, to provide the skill, expertise, care and service to patients in a medical emergency or needing critical or intensive care. The Amendment defines "critical care" or "intensive care" to mean means medical care of any patient with a life-threatening injury or illness. It also provides that "medical emergency" means "a sudden injury or serious illness that, if not treated immediately, could cause death or serious harm to the patient.'' It goes on to lay down that if the Health Service Commission alleges that an individual member is in breach of these obligations, the commission must communicate a written complaint against that member to the disciplinary authority in accordance with the Health Service Regulations, 2006, (Statutory Instrument 117 of 2006.)

Those regulations set out in Part VIII the disciplinary process to be followed in respect of alleged misconduct.

The Minister of Health maintains that these provisions are not intended to forbid State-employed health service providers from participating in strikes, but rather "to restrict them in the public interest."

The doctors, on the other hand, maintain that the public health system has been allowed to deteriorate so badly that this has created intolerable conditions in government hospitals for doctors working in them, including having to work for totally inadequate salaries. The doctors feel that as these issues have fallen on deaf ears, the only thing left was to "down scalpels".

Maternity leave

The entitlement of pregnant females to s 39 of Health Services Regulations 2022 as read with s 18 of the Labour Act [*Chapter 28:01*] sets out the entitlement to such leave which will apply unless the contract provides for more generous maternity terms in which case the latter terms will apply.

A health worker is entitled to a total of 98 days' maternity leave on full pay if she has served for at least one year. She is only entitled to take this paid maternity leave after every two years and can only take this leave a maximum of three times with one employer.

Before she can take the 98 days paid leave, she must produce a medical certificate certifying that she is likely to give birth within the next 45 days.

In 2021 the Zimbabwe Lawyers for Human Right asked for United Bulawayo Hospitals (UBH) to reinstate a nurse who was suspended from a training programme after a pregnancy test returned after a pregnancy test returned a false positive result. Despite a second set of the pregnancy test results showing she was not pregnant the nurse had not been reinstated to continue with the nurse training programme. ZLHR argued that that the decision taken

by UBH to keep the nurse out of the training programme was grossly unreasonable and unfair and in violation of the Constitution.

A policy by a health institution to expel a trainee nurse from a training programme if she becomes pregnant may be open to legal challenge, relying on the government policy that a child must not be prevented from continuing with her schooling if she becomes pregnant.

Termination of employment

In terms of s 12B of the Labour Act an employee may not be unfairly dismissed. The employer must show either that the employee was dismissed in terms of an employment code, or when there is no such code, in terms of the model code under the Labour Act.

- An employee is deemed to have been unfairly dismissed—if the employee terminated the contract of employment with or without notice because the employer deliberately made continued employment intolerable for the employee;
- if, on termination of an employment contract of fixed duration, the employee—
- had a legitimate expectation of being re-engaged; and
- another person was engaged instead of the employee.
- In proceedings before a labour officer, designated agent or the Labour Court where the fairness of the dismissal of an employee is in issue, the adjudicating authority must, in addition to considering the nature or gravity of any misconduct on the part of the dismissed employee, consider whether any mitigation of the misconduct avails to an extent that would have justified action other than dismissal, including the length of the employee's service, the employee's previous disciplinary record, the nature of the employment and any special personal circumstances of the employee.

Part VII of the Health Professions Regulations 2022 deal with the process for dealing with misconduct by health workers in the workplace.

Disciplinary authorities

The Health Professions Regulations 2022 provide for different disciplinary authorities for different grades of employees. Where there had been an allegation of misconduct by a health worker, the respective disciplinary authority must appoint a disciplinary committee to hear the matter and make appropriate recommendations to the disciplinary authority.

Disciplinary committees

A disciplinary committee must have a chairperson and two other members and the members must be of a grade that is equivalent to or higher than that of the member who is alleged to have committed an act of misconduct.

Investigation and hearings

The Regulations then set out in detail the processes to be followed in respect of investigation of the allegation and fair hearings to be held to determine whether there has been misconduct and, if there have been, what penalties should be imposed. A hearing will be conducted without the need to observe the rules of procedure and evidence ordinarily applicable in criminal or civil proceedings but the member concerned must be afforded the opportunity to respond to every allegation of misconduct and substantial justice must be done. The member may be represented by a legal practitioner at a hearing.

Notification of findings to disciplinary authority

The disciplinary committee notifies the disciplinary authority of its findings and its recommendations, including recommendations on the penalty to be imposed if it considers there was misconduct, and the record of the proceedings.

The authority may determine whether or not there was misconduct or it may refer the matter back to the committee for a further hearing.

If it decides there was no misconduct, it will notify this finding to the relevant health authorities. If it decides there was misconduct, it must determine the penalty to be imposed and notify the member and the relevant health authority.

Where a member is convicted of a criminal offence which may constitute an act of misconduct, the head of office or disciplinary authority must endeavour to obtain a copy of the court record relating to the conviction.

Suspension of member

A disciplinary authority may at any time, by written notice, suspend from service a member who is suspected of having committed an act of misconduct or is subject to a criminal investigation or prosecution if their continued attendance at work or continued performance of their duties or service, as the case may be, would—

- be conducive to unbecoming or indecorous behaviour or further instances of misconduct; or
- seriously impair the proper administration or functioning of the Ministry or department concerned; or
- occasion prejudice to any moneys or property likely to be handled by the member in the course of their work; or
- enable the member to hinder or interfere with any investigation or evidence relating to any alleged misconduct; or
- be undesirable in the public interest or likely to lead to a loss of public confidence in the Health Service.

Where a suspension order is imposed upon a member, reasons must be given and the suspended person must be informed as to what procedures will follow. A copy of the suspension order must be sent by a disciplinary authority, other than the Board, to the Board as soon as possible after it is issued. (The suspended member must be ordered about the restriction on them during suspension such as not attending their place of work unless otherwise directed and during their suspension the member will not receive their salary unless they are ordered to carry out duties. If the member is subsequently found not guilty of misconduct they will be entitled to the salary during suspension

Penalties

Where a disciplinary authority determines that a member is guilty of misconduct, there is a long list of penalties that may be imposed ranging from discharge from the Health Service to a fine in an amount not exceeding the equivalent of two months of the members' salary, which fine may be recovered by deductions from the salary of the member.

Where a disciplinary authority determines that a member is guilty of misconduct and discharges a member from the Health Service, the disciplinary authority may direct that the payment of any terminal benefits to them will be withheld until the extent of any deficiency, destruction, loss or damage to state property has been paid.

Appeals to Board

A member who is aggrieved by a determination by the disciplinary authority, other than the Board, that they are guilty of misconduct may appeal to the Board against any penalty imposed upon on them within 14 days from the

date on which the disciplinary authority informs the member of the determination or penalty.

The Board, may within 14 days after receiving an appeal, confirm the determination or penalty or refer the matter back to the disciplinary authority for re-determination; or further hearing or further investigation. This appeal will suspend the determination or penalty sought to be reviewed.

A member who is aggrieved by a determination, or penalty imposed by, or a decision of the Board in terms of s 51 may, within 14 days of being notified of such decision, appeal against the decision to the Labour Court.

Grievances

Part IX of the Regulations provides for the procedure to be followed where a member has a grievance: that is, dissatisfaction or feeling of injustice on the part of a member, which is connected with the member's work or the member's contact with other persons in the work place.

Insurance coverage

Doctors

Doctors in Zimbabwe can obtain insurance coverage by joining the Medical Defence Union. This Union is a voluntary body which has its headquarters in the United Kingdom but which operates throughout the world except in the United States. (It does not operate in the U.S.A. because claims are unusually high and the Union cannot afford to meet these huge claims.) The branches of the Union operate under the name of the Medical Protection Society. Subscriptions are paid through the Society annually. Because of difficulties in obtaining foreign exchange in Zimbabwe, the Zimbabwe Medical Association advises all its members to join the Union and apply, through the Association, to the Reserve Bank for foreign currency allocations in order to remit subscriptions. Reserve Bank permission to remit such subscriptions is apparently always granted. Once a doctor has become a member of the Union, they are automatically covered for any liability arising out of their work. According to the Zimbabwe Medical Association, there have only been a number of small claims against doctors which have been settled out of court. There have not been any large claims.

Nurses

Qualified nurses who join the Zimbabwe Nurses Association by paying the prescribed annual fee will receive legal assistance from the Association in the event of legal action being taken against them or other legal problems arising out of the performance of their work. Financial assistance will cover the legal costs only and not damages which the nurse may be found liable to pay. It is strongly believed by the authors that it would be desirable to set up a special insurance scheme along the lines of that operating in Britain as soon as possible to cover nurses for any liability they might incur while performing their duties.

Reports on other medical staff

From time-to-time medical staff in positions of authority are required to make reports on their subordinate staff. A doctor or nurse may also be required to make a report about another staff member if a mistake has been made during the course of medical treatment or there has been an allegation of professional misconduct against another staff member.

The person making the report may fear that they may be sued for defamation if the report is critical of the person about whom it is made. In practice, certain defences may be raised to protect the compiler from any action for defamation. If the contents of the report were true, the defence of justification would apply. However, the main

defence applicable in these circumstances is the defence of qualified privilege.

For this latter defence to apply, a number of requirements must be satisfied. The content of a report on a subordinate staff member, or any staff member, must be a fair, honest and balanced report on the staff member's conduct and performance over the period concerned. If the compiler of the report maliciously included in the report false allegations in order to hinder the promotion of a competent person whom the compiler did not like, then this defence would fall away because this defence fails when there is malice.

A fair, honest and balanced report is one which fairly and accurately portrays both the strengths and weaknesses of the staff member concerned. A record of times and dates of incidents and details of incidents when, for example, reprimands have been necessary would greatly assist the compilation of such a report. Exaggerated language and overstatement should be avoided; the facts should be stated in balanced and objective fashion and emotive language should not be used.

It should also be noted that the defence of qualified privilege will apply only if the report is communicated to the person or persons who have a legal right or interest in receiving the information. The report should thus be given only to the proper persons and unauthorised persons should not be allowed access to it. The proper recipient will normally be the author's immediate superior but there may be special arrangements in the hospital, depending on the hospital hierarchy, concerning to whom the report should be given. Persons making reports should familiarize themselves with these arrangements and ensure that their reports are transmitted to the correct persons only. On no account should the report be discussed with or shown to colleagues or subordinates.

All reports should be signed and dated. Frequently, as a matter of employer's policy, it may be required that the report be shown to the person about whom it is being made and that person be given an opportunity to include their reply to the contents of the report. This is a fair procedure and should obviously be encouraged because, if a negative report is made concerning an employee, they should obviously be entitled to correct any mistakes in the report or to explain why certain things happened. This procedure does not jeopardize the author of the report provided that the contents of the report are fair and balanced.

MEDICAL PRACTICE IN THE FUTURE

Advances in the field of genetics, the use of human stem cells for organ regeneration, and development medical technology employing artificial intelligence to assist in diagnosis of patients will profoundly impact the practice of medicine. However, as many of these advances made in developed countries will be expensive, it may be some time before Zimbabwe with its limited health budget is able to make use of them. Medical personnel in Zimbabwe will also need to undergo training before they can make use of the new techniques.

Some of these developments may lead to fears that ultimately human doctors may be replaced by robots programmed with artificial intelligence. As will be seen below, this fear is unfounded.

Genetic coding

Genetic coding can now be used to for genetic modification to prevent transmission of genetic conditions but there is now a danger that it will be used to produce designer babies who are not only free of hereditary genetic conditions but are also "superior" humans with high IQs and so forth.

Gene editing can be used to cure inherited diseases. In this procedure a procedure will be used to remove cells from the affected organ, correct the inherited faults and reinfuse her cells, allowing her organ to perform its functions without the inborn errors.

The second use is in a situation where a couple who want to have a baby but who both carry a recessive gene which leads to a rare disorder. The geneticist proposes a plan for their unborn baby that after fertilisation, a few lines of the embryo's DNA will be altered to reverse the rare inherited disorder before it even starts and prevent it from being passed to their grandchildren.

For more details on these procedures, see Annexure 8.

Use of stem cells

The use of human stem cells offers great promise for new medical treatments. This is pointed out in an article posted by the American Mayo Clinic entitled "Stem cells: What they are and what they do".[37] This article is reproduced in full in Annexure 7. What follows are some extracts from this article.

> Stem cells are the body's raw materials. They are cells from which all other cells with specialized functions are generated. Under the right conditions in the body or a laboratory, stem cells divide to form more cells called daughter cells.
>
> These daughter cells become either new stem cells or specialized cells (differentiation) with a more specific function, such as blood cells, brain cells, heart muscle cells or bone. The daughter cells generate healthy cells to replace cells affected by disease (regenerative medicine). Stem cells can be guided into becoming specific cells that can be used in people to regenerate and repair tissues that have been damaged or affected by disease.

[37] American Mayo Clinic "Stem cells: What they are and what they do" https://www.mayoclinic.org/tests-procedures/bone-marrow-transplant/in-depth/stem-cells/art-20048117

People who might benefit from stem cell therapies include those with spinal cord injuries, type 1 diabetes, Parkinson's disease, amyotrophic lateral sclerosis, Alzheimer's disease, heart disease, stroke, burns, cancer and osteoarthritis.

Stem cells may have the potential to be grown to become new tissue for use in transplant and regenerative medicine. Researchers continue to advance the knowledge on stem cells and their applications in transplant and regenerative medicine.

The best source of stem cells is from 3-4-day-old embryonic stem cells which can divide into more stem cells or can become any type of cell in the body. This versatility allows embryonic stem cells to be used to regenerate or repair diseased tissue and organs.

Embryonic stem cells are obtained from early-stage embryos — a group of cells that forms when eggs are fertilized with sperm at an in vitro fertilization clinic. Because human embryonic stem cells are extracted from human embryos, several questions and issues have been raised about the ethics of embryonic stem cell research.

The National Institutes of Health created guidelines for human stem cell research in 2009. The guidelines define embryonic stem cells and how they may be used in research, and include recommendations for the donation of embryonic stem cells. Also, the guidelines state that embryonic stem cells from embryos created by in vitro fertilization can be used only when the embryo is no longer needed.[38]

Artificial Intelligence

Developments in the area of artificial intelligence (AI) are providing medical practitioners with tools to improve medical diagnosis. In an article entitled "Artificial Intelligence in Medical Diagnosis",[39] it is pointed out:

The use of Artificial Intelligence, or AI, is growing rapidly in the medical field, especially in diagnostics and management of treatment. To date there has been a wide range of research into how AI can aid clinical decisions and enhance physicians' judgement.

Accurate diagnosis is a fundamental aspect of global healthcare systems. In the US, approximately 5% of outpatients receive an incorrect diagnosis, with errors being particularly common for serious medical conditions, and carrying the risk of serious patient harm.

In recent years, AI and machine learning have emerged as powerful tools for assisting diagnosis. Healthcare is transforming at a rapid pace enabled by technology. A tech-enabled hospital information system without errors could boost patient safety to a great extent by providing more precise diagnoses.

In an article in *India Today*,[40] a prominent Indian doctor said that AI won't replace doctors but doctors who failed to use AI assisted diagnosis in the future would be in danger of finding themselves replaced. In an interview with ANI, Joint Managing Director of Apollo Hospitals Sangeeta Reddy said that nurses and doctors would always be needed since disease cannot be cured by code. She said:

[38] Available at https://stemcells.nih.gov/research-policy/guidelines-for-human-stem-cell-research
[39] *Southern Medical Association* "Artificial Intelligence in Medical Diagnosis" https://sma.org/ai-in-medical-diagnosis/
[40] *India Today* https://www.indiatoday.in/education-today/news/story/ai-wont-replace-doctors-but-doctors-who-dont-use-ai-will-be-replaced-2334653-2023-02-14

Artificial Intelligence (AI) would be a boon for the medical industry, especially for the early diagnosis of disease. It won't replace doctors though. However, an expert noted that doctors who do not know how to use AI may be replaced.

On February 5, Apollo Hospitals launched the Clinical Intelligence Engine (CIE), free for all doctors. It is an AI engine that can prompt doctors with the best and most appropriate care.

This suggests that students or young employees should upskill themselves with knowledge on how to use AI, no matter which industry they are working in, since AI is sooner or later going to be an essential aspect of everyday work.

ANNEXURES

Annexure 1: Medical Services Amendment Act of 2022

The Act incorporates the following provisions into the Act—

PART IIA General Standards and Practices Applicable in Health Care Delivery

8A Information to patients

(1) Every health care provider must inform a patient of—

(a) the patient's health status except in circumstances where there is substantial evidence that the disclosure of the patient's health status would be contrary to the best interests of the patient;

(b) the range of diagnostic procedures and treatment options generally available to the patient;

(c) the benefits, risks, costs and consequences generally associated with each option; and

(d) the patient's right to refuse health services and explain the implications, risks and obligations of such refusal.

(2) A health care provider must, where possible, inform the patient as provided in subsection (1) in a language that the patient understands and in a manner that takes into account the patient's level of literacy.

8B Consent of patient

(1) Subject to section 8D, a health service may not be provided to a patient without the patient's informed consent unless—

(a) the patient is unable to give informed consent and such consent is given by a person—

(i) mandated by the patient in writing to grant consent on their behalf; or

(ii) authorised to give such consent in terms of the law or a court order;

(b) the patient is unable to give informed consent and no person is mandated or authorised to give such consent, and the consent is given by the spouse or partner of the patient or, in the absence of such spouse or partner, a parent, guardian, an adult child of the patient, grandparent, an adult brother or a sister of the patient, in the specific order as listed;

(c) the provision of a health service without informed consent is authorised in terms of any law or court order;

(d) failure to treat the patient may result in a serious risk to public health; or

(e) any delay in the provision of the health service to the patient might result in their death or irreversible damage to his or her health.

(2) A health care provider must take all reasonable steps to obtain a patient's informed consent.

(3) For the purposes of this section "informed consent" means consent for the provision of a specified health service given by a person with legal capacity to do so and who has been informed in terms of section.

8C Participation in decisions

(1) A patient has the right to participate in any decision affecting his or her health and treatment.

(2) If the informed consent required by section 8D is given by a person other than the patient, such person must, if possible, consult the patient before giving the required consent.

(3) A patient who is capable of understanding must be informed as provided in section 8B even if he or she lacks the legal capacity to give the informed consent required by section 8C.

(4) If a patient is unable to participate in a decision affecting his or her health and treatment, he or she must be informed as provided in section 8B after the provision of the health service in question unless the disclosure of such information would be contrary to the patient's best interest.

8D Health services to children

(1) It shall be unlawful for any parent or guardian of a child to prevent a child from receiving any health service which is in the best interests of the child concerned, or to withhold consent for any health service in contravention of section 60(3) of the Constitution.

(2) Any person who contravenes subsection (1) shall be guilty of an offence and liable to a fine not exceeding level 8 or to imprisonment for a period not exceeding one year or to both such fine and such imprisonment.

8E Discharge reports

(1) A health care provider must provide a patient with a discharge report at the time of the discharge of the patient from health institution and the report shall contain such information as may be prescribed. (2) In prescribing the information in terms of subsection (1), the Minister must have regard to—

(a) the nature of the health service rendered; and

(b) the prognosis for the patient; and

(c) the need for follow-up treatment.

8F Health services for experimental or research purposes

(1) Before a health care provider provides a health service for experimental or research purposes to any patient and subject to subsection (2), the health care provider must inform the patient in the prescribed manner that the health service is for experimental or research purposes or part of an experimental or research project.

(2) A health care provider may not provide any health service to a patient for purposes of subsection (1) unless the patient, the health care provider primarily responsible for the patient's treatment, the head of any health institution concerned and any relevant health research ethics authority or any other person to whom that authority has been granted in respect of a health institution, has given prior written authorisation for the provision of the health service in question.

(3) No extraction of bodily tissue from any patient for the purposes of this section may be done without the prior written consent of the patient concerned.

(4) Subject to the Anatomical Donations and Post Mortem Examinations Act [*Chapter 15:01*], any consent or authorisation required in terms of this section shall be in the form prescribed.

8G Confidentiality

(1) All information concerning a patient, including information relating to his or her health status, treatment or stay in a health institution is confidential.

(2) Subject to subsection (3), no person may disclose any information referred to in subsection (1) unless—

(a) the patient consents to that disclosure in writing;

(b) a court order or any law requires the disclosure; or

(c) non-disclosure of the information represents a serious threat to public health.

(3) A health care provider that has access to the health records of a patient may disclose such information to any other health care provider as is necessary for any legitimate purpose within the ordinary course and scope of his or her duties where such access or disclosure is in the interests of the patient.

(4) A health care provider may examine a patient's health records for the purposes of—

(a) treatment with the consent of the patient; and

(b) study, teaching or research subject to the consent or authority granted in terms of section 8G.

(5) If the study, teaching or research referred to in subsection (4) (b) discloses no information as to the identity of the patient concerned, it shall not be necessary to obtain the consent or authorisation referred to in that subsection.

8H Protection of health records

(1) A health care provider must set up control measures, a storage facility and system to prevent unauthorised access to patients' records.

(2) Any person who does any or all of the following—

(a) fails to perform a duty imposed on them for the purposes of subsection (1);

(b) falsifies any record by adding to or deleting or changing any information contained in that record;

(c) creates, changes or destroys a record without authority to do so,

d) fails to create or change a record when properly required to do so;

(e) provides false information with the intent that it be included in a record;

(f) without authority, copies any part of a record;

(g) without authority connects the personal identification elements of a patient's record with any element of that record that concerns the patient's condition, treatment or history;

(h) gains unauthorised access to a record or record-keeping system, including intercepting information being transmitted

from one person, or one part of a record-keeping system, to another;
(i) without authority, connects any part of a computer or other electronic system on which records are kept to—
(i) any other computer or other electronic system; or
(ii) any terminal or other installation connected to or forming part of any other computer or other electronic system;
(j) without authority, modifies or impairs the operation of
(i) any part of the operating system of a computer or other electronic system on which a patent's records are kept; or
(ii) any part of the programme used to record, store, retrieve or display information on a computer or other electronic system on which a patient's records are kept; shall be guilty of an offence and liable to a fine not exceeding level 8 or to imprisonment for a period not exceeding one year or to both a fine and such imprisonment.

8I Complaints

(1) The Minister shall ensure that every health institution establishes a complaints procedure which must—
(a) be displayed in a manner that is visible for any person entering the establishment and the procedure must be communicated to patients on a regular basis; and
(b) in the case of a private health institution, allow for the complaints to be made to the head of the institution; and
(c) include provision for the acceptance and acknowledgment of every complaint; and (d) allow for the referral of any complaint that is not within the jurisdiction or authority of the health institution to the appropriate body or authority.
(2) In laying a complaint, the complainant must follow the procedure established by the institution concerned.

8J Duties of patients

A patient must—
(a) adhere to the rules of a health institution when receiving treatment or health services at the institution; and
(b) subject to section 8H, provide a health care provider with accurate information pertaining to his or her health status and co-operate with health care providers at a health institution; and
(c) treat health care providers with dignity and respect; and
(d) sign a discharge certificate or release from liability if he or she refuses to accept recommended treatment.

8K Rights of health care personnel

(1) Every health institution must implement measures to prevent—
(a) injury or damage to the person and property of health care personnel working at that institution; and (b) disease transmission.
(2) A health care provider may refuse to treat a patient who is physically or verbally abusive or who sexually harasses him or her.

Annexure 2: Consent forms from other countries

American form

PERMISSION FOR OPERATIVE PROCEDURE

I……. (patient's full name)

Hereby authorize Dr……together with his/her associates and assistants to perform the operative procedure set out below:

……

……

Provide brief details of procedure

The undersigned physician has fully explained to me the nature and expected benefits and complications (from known and unknown causes), attendant discomforts and risks that may arise, as well as possible alternatives to the proposed treatment, including no treatment.

I have been given the opportunity to ask questions, and all my questions have been answered fully and satisfactorily.

I understand that during the course of the operation or procedure unforeseen conditions may arise which necessitate procedures different from those contemplated. I therefore consent to the performance of additional operations and procedures which the above-named physician and his/her associates or assistances may consider necessary.

I consent to the administration of such anaesthetics by the Department of Anaesthesia as may be considered necessary. I recognize that there are always risks to life and health associated with the administration of anaesthesia and such risks have been fully explained to me.

I further consent to blood transfusions as may be necessary. I recognize that there are always risks to life and health associated with blood transfusions and such risks have been fully explained to me.

Name of Patient …….

Signature of Patient …….

Date……

Name of witness……

Signature of witness……..

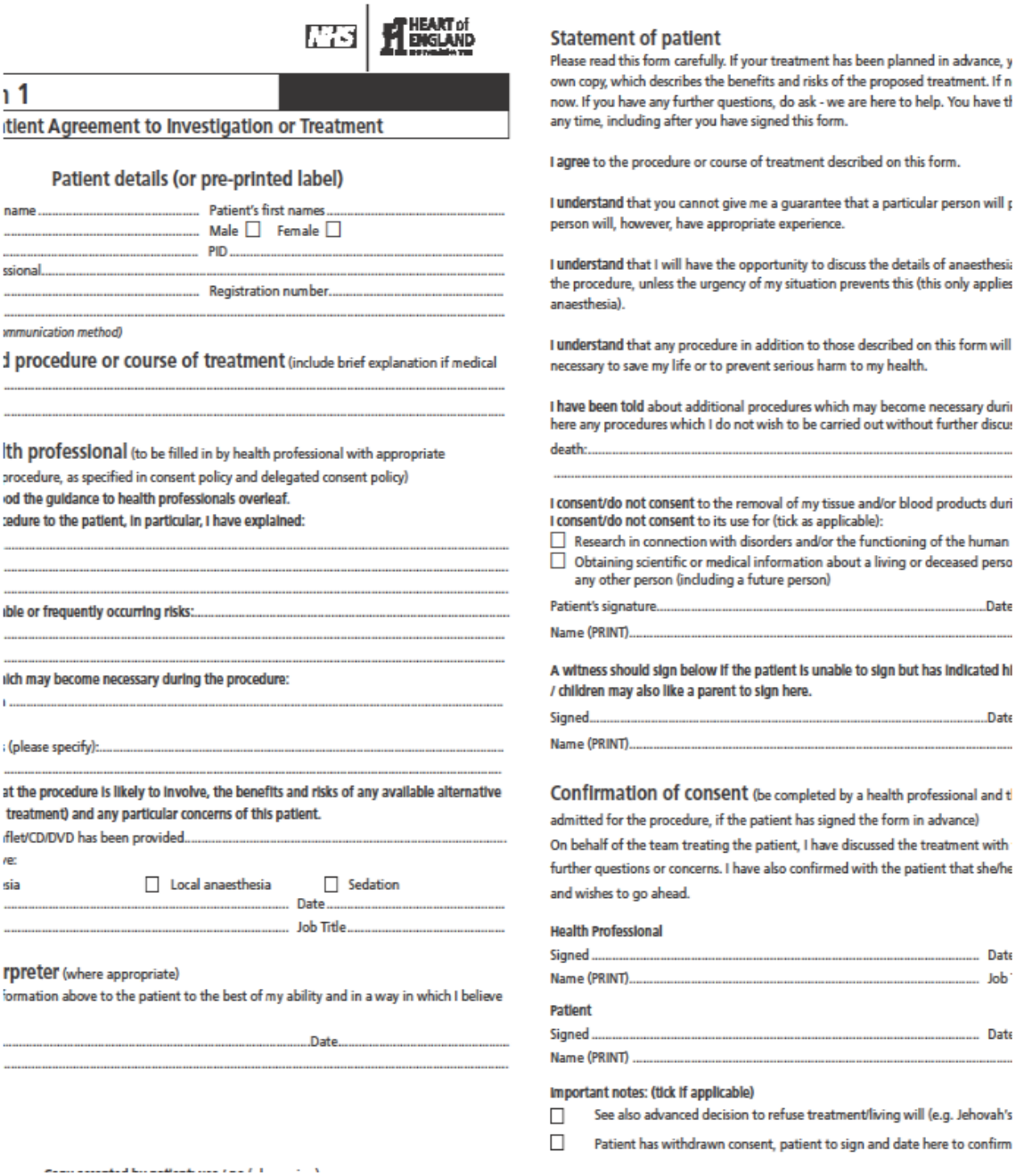
I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives the proposed procedure/operation, have offered to answer any questions from the patient and have fully answered such questions.

Name of Physician …….

Signature of Physician …….

Date……

English Consent Forms



1

tient Agreement to Investigation or Treatment

Patient details (or pre-printed label)

name ..... Patient's first names .....

..... Male ☐ Female ☐

..... PID .....

ssional.....

..... Registration number.....

.....

mmunication method)

d procedure or course of treatment (include brief explanation if medical

.....

.....

lth professional (to be filled in by health professional with appropriate

procedure, as specified in consent policy and delegated consent policy)

od the guidance to health professionals overleaf.

edure to the patient, in particular, I have explained:

.....

.....

.....

ible or frequently occurring risks:.....

.....

.....

ich may become necessary during the procedure:

.....

(please specify):.....

.....

at the procedure is likely to involve, the benefits and risks of any available alternative

treatment) and any particular concerns of this patient.

flet/CD/DVD has been provided.....

e:

sia ☐ Local anaesthesia ☐ Sedation

..... Date .....

..... Job Title.....

rpreter (where appropriate)

ormation above to the patient to the best of my ability and in a way in which I believe

.....Date.....

.....

Statement of patient

Please read this form carefully. If your treatment has been planned in advance, y
own copy, which describes the benefits and risks of the proposed treatment. If n
now. If you have any further questions, do ask - we are here to help. You have tl
any time, including after you have signed this form.

I agree to the procedure or course of treatment described on this form.

I understand that you cannot give me a guarantee that a particular person will p
person will, however, have appropriate experience.

I understand that I will have the opportunity to discuss the details of anaesthesi
the procedure, unless the urgency of my situation prevents this (this only applies
anaesthesia).

I understand that any procedure in addition to those described on this form will
necessary to save my life or to prevent serious harm to my health.

I have been told about additional procedures which may become necessary duri
here any procedures which I do not wish to be carried out without further discus

death:.....

.....

I consent/do not consent to the removal of my tissue and/or blood products duri
I consent/do not consent to its use for (tick as applicable):

☐ Research in connection with disorders and/or the functioning of the human

☐ Obtaining scientific or medical information about a living or deceased perso
any other person (including a future person)

Patient's signature.....Date

Name (PRINT).....

**A witness should sign below if the patient is unable to sign but has indicated hi
/ children may also like a parent to sign here.**

Signed.....Date

Name (PRINT).....

Confirmation of consent (be completed by a health professional and t
admitted for the procedure, if the patient has signed the form in advance)

On behalf of the team treating the patient, I have discussed the treatment with
further questions or concerns. I have also confirmed with the patient that she/he
and wishes to go ahead.

Health Professional

Signed ..... Date

Name (PRINT)..... Job

Patient

Signed ..... Date

Name (PRINT) .....

Important notes: (tick if applicable)

☐ See also advanced decision to refuse treatment/living will (e.g. Jehovah's

☐ Patient has withdrawn consent, patient to sign and date here to confirm

NHS

Royal United Hospitals NHS Foundation Trust

Consent form 4

Form for adults who are unable to consent to investigation or treatment

Patient details (or pre-printed label)

Patient's surname/family name.....

Patient's first names .....

Date of birth .....

Responsible health professional.....

Job title .....

NHS number (or other identifier).....

☐ Male ☐ Female

Special requirements .....
(eg other language/other communication method)

To be retained in patient's notes

Patient identifier/label

All sections to be completed by health professional proposing the procedure

A Details of procedure or course of treatment proposed

(NB see guidance to health professionals overleaf for details of situations where court approval must first be sought)

B Assessment of patient's capacity

I confirm that the patient lacks capacity to give or withhold consent to this procedure or course of treatment because:

☐ the patient is unable to comprehend and retain information material to the decision; and/or

☐ the patient is unable to use and weigh this information in the decision-making process; or

☐ the patient is unconscious

Further details (excluding where patient unconscious): for example how above judgements reached; which colleagues consulted; what attempts made to assist the patient make his or her own decision and why these were not successful.

C Assessment of patient's best interests

To the best of my knowledge, the patient has not refused this procedure in a valid advance directive. Where possible and appropriate, I have consulted with colleagues and those close to the patient, and I believe the procedure to be in the patient's best interests because:

(Where incapacity is likely to be temporary, for example if patient unconscious, or where patient has fluctuating capacity)

The treatment cannot wait until the patient recovers capacity because:

D Involvement of the patient's family and others close to the patient

The final responsibility for determining whether a procedure is in an incapacitated patient's best interests lies with the health professional performing the procedure. However, it is good practice to consult with those close to the patient (eg spouse/partner, family and friends, carer, supporter or advocate) unless you have good reason to believe that the patient would not have wished particular individuals to be consulted, or unless the urgency of their situation prevents this. "Best interests" go far wider than "best medical interests", and include factors such as the patient's wishes and beliefs when competent, their current wishes, their general well-being and their spiritual and religious welfare.

(to be signed by a person or persons close to the patient, if they wish)

I/We have been involved in a discussion with the relevant health professionals over the treatment of.....(patient's name). I/We understand that he/she is unable to give his/her own consent, based on the criteria set out in this form. I/We also understand that treatment can lawfully be provided if it is in his/her best interests to receive it.

Any other comments (including any concerns about decision)

Name .....Relationship to patient.....
Address (if not the same as patient.....
.....
.....

Signature ..... Date.....

If a person close to the patient was not available in person, has this matter been discussed in any other way (eg over the telephone?)

☐ Yes ☐ No

Details:

Signature of health professional proposing treatment

The above procedure is, in my clinical judgement, in the best interests of the patient, who lacks capacity to consent for himself or herself. Where possible and appropriate I have discussed the patient's condition with those close to him or her, and taken their knowledge of the patient's views and beliefs into account in determining his or her best interests.

I have/have not sought a second opinion.

Signature:..... Date .. ..
Name (PRINT) .... Job title ....

Where second opinion sought, s/he should sign below to confirm agreement:

Signature:..... Date .. ..
Name (PRINT) .... Job title ....

Guidance to health professionals (to be read in conjunction with consent policy)

This form should only be used where it would be usual to seek written consent but an adult patient (18 or over) lacks capacity to give or withhold consent to treatment. If an adult **has** capacity to accept or refuse treatment, you should use the standard consent form and respect any refusal. Where treatment is very urgent (for example if the patient is critically ill), it may not be feasible to fill in a form at the time, but you should document your clinical decisions appropriately afterwards. If treatment is being provided under the authority of Part IV of the *Mental Health Act 1983*, different legal provisions apply and you are required to fill in more specialised forms (although in some circumstances you may find it helpful to use this form as well). If the adult now lacks capacity, but has clearly refused particular treatment in advance of their loss of capacity (for example in an advance directive or 'living will'), then you must abide by that refusal if it was validly made and is applicable to the circumstances. For further information on the law on consent, see the Department of Health's *Reference guide to consent for examination or treatment* (www.doh.gov.uk/consent).

When treatment can be given to a patient who is unable to consent

For treatment to be given to a patient who is unable to consent, the following **must** apply:

- the patient must lack the capacity ('competence') to give or withhold consent to this procedure AND
- the procedure must be in the patient's best interests.

Capacity

A patient will lack capacity to consent to a particular intervention if he or she is:

- unable to comprehend and retain information material to the decision, especially as to the consequences of having, or not having, the intervention in question; and/or
- unable to use and weigh this information in the decision-making process.

Before making a judgement that a patient lacks capacity you must take all steps reasonable in the circumstances to assist the patient in taking their own decisions (this will clearly not apply if the patient is unconscious). This may involve explaining what is involved in very simple language, using pictures and communication and decision-aids as appropriate. People close to the patient (spouse/partner, family, friends and carers) may often be able to help, as may specialist colleagues such as speech and language therapists or learning disability teams, and independent advocates or supporters.

Capacity is 'decision-specific': a patient may lack capacity to take a particular complex decision, but be quite able to take other more straight-forward decisions or parts of decisions.

Best interests

A patient's best interests are not limited to their best medical interests. Other factors which form part of the best interests decision include:

- the wishes and beliefs of the patient when competent
- their current wishes
- their general well-being
- their spiritual and religious welfare

Two incapacitated patients, whose *physical* condition is identical, may therefore have different best interests.

Unless the patient has clearly indicated that particular individuals should not be involved in their care, or unless the urgency of their situation prevents it, you should attempt to involve people close to the patient (spouse/partner, family and friends, carer, supporter or advocate) in the decision-making process. Those close to the patient cannot require you to provide particular treatment which you do not believe to be clinically appropriate. However they will know the patient much better than you do, and therefore are likely to be able to provide valuable information about the patient's wishes and values.

Second opinions and court involvement

Where treatment is complex and/or people close to the patient express doubts about the proposed treatment, a second opinion should be sought, unless the urgency of the patient's condition prevents this. Donation of regenerative tissue such as bone marrow, sterilisation for contraceptive purposes and withdrawal of artificial nutrition or hydration from a patient in PVS must never be undertaken without prior

Annexure 3: Medical form for cases of sexual abuse & Sexual Assault Medical Certificate Zimbabwe

Z1024 (P.H.) 62866-6

REPORT FORM FOR ALLEGED SEXUAL ABUSE AND RAPE CASES

1 No.....

Please fill in this form as clearly as possible, using printed capital letters

201 Crime ref number	205 Hospital /place of interview and examination — INSTITUTION STAMP
202 Police station	
203 Force Number of Investigating Officer	
204 Name of examining doctor	206 Name & qualifications of interviewing nurse/counsellor

AFFIDAVIT IN TERMS OF SECTION 278(2) OF THE CRIMINAL PROCEDURE AND EVIDENCE ACT (Chapter 9: 07)

I (full name)..... do hereby make an Oath and swear that I am a registered medical ..... practitioner. I have the following qualifications ..... (year of qualification) ..... I am employed at .....

Date of medical examination 207 Day Month Year	Time 208 24 hour clock	Name of alleged victim 209
Date of birth Day Month Year *Give month and year or year alone if full date not known* 210	211 Sex Male Female	212 Child under 16 years Single Married Widowed Divorced Other *Tick as appropriate*
Race 213	Time lapsed since alleged sexual abuse (last, if several) Unknown 0-24 hours 1-3 days 4-7 days 8-30days 1-3 months >3 months 214	
Date of start of last menstrual period 215 Day Month Year	Previous genital sexual experience 216 Yes No	Adult woman: last consensual sexual intercourse (within 30 days) 217 Days ago
Pregnant now? 218 Yes No Unknown		

I made the following findings on examination:

EXTERNAL EXAMINATION

If possible for Under 16 year olds 219 Height (cm) 220 Weight (kg)

Mental development (for age) 221 Normal Impaired Retarded

Emotional state 222

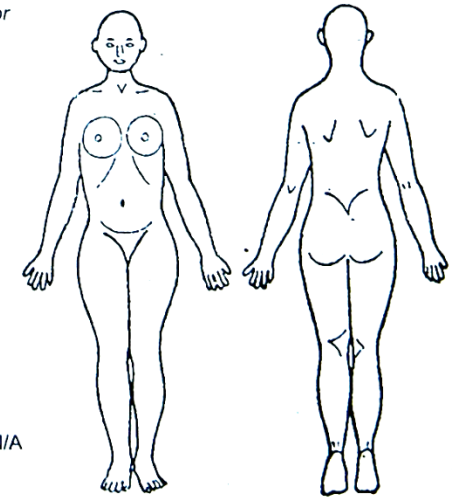
Condition of clothing 223

General state of health 224

Secondary sexual development 225 Pre-pubertal Pubertal Mature Post-menopausal

Comments if appropriate

Describe and use these diagrams for males or females. Comment on blood, debris, soil in hair or on body



226 Height of fundus weeks

No injury Exam omitted Exam N/A 227

Mouth 228 T E A R S_1 S_2 S_3 No injury 229 Exam omitted Exam N/A

Internal vaginal examination (if necessary,normally only in adults)

		T	E	A	R	S_1	S_2	S_3
451	Vaginal walls and vault							
461	Cervix							

471	Vaginal bleeding	Yes ☐	No ☐	*Other Comments*
472	Vaginal discharge	Yes ☐	No ☐	
473	Uterine tenderness	Yes ☐	No ☐	

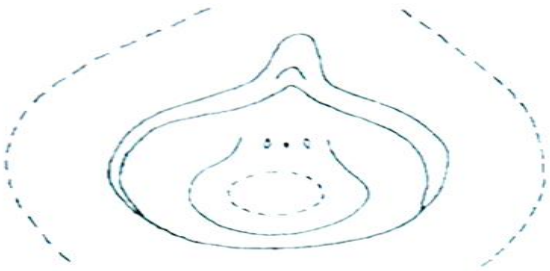
474 No injury ☐ Exam omitted ☐ Exam N/A ☐

Female external genitalia

		T	E	A	R	S_1	S_2	S_3
301	Labia majora							
311	Labia minora							
321	Vestibule/introitus							
331	Fourchette/Fossa Navicularis							
341	Perineum							
351	Urethra							
361	Other (specify)							

Description (including bleeding, infection, site and sizeof lesions)

Diagram



371 No injury ☐ Examination omitted ☐ Examination N/A ☐
eg male patient

Details of hymen

372 Oestrogenised Yes ☐ No ☐

373 Attenuated / streched Yes ☐ No ☐

Hymenal tears and/or notches

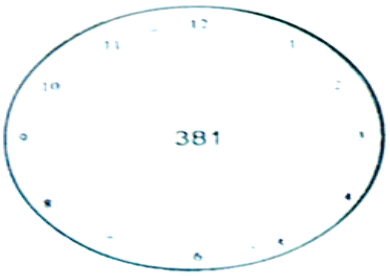
*Indicate full thickness tears as **minute hands***

*partial tears or notches as **hour hands***

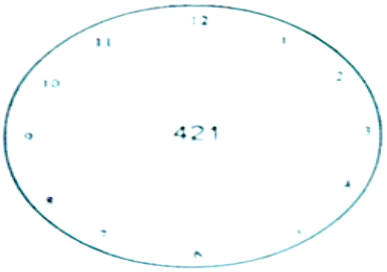
*at the appropriate **o'clock position***

Other comments

Fresh



Not fresh or healed



446 No injury ☐ Examination omitted ☐ Examination N/A ☐

ANUS

481 T E A R S_1 S_2 S_3 ☐☐☐☐☐☐☐

491 Reflex anal dilatation Yes ☐ No ☐

492 Abnormal skin folds/tags Yes ☐ No ☐

493 Venous congestion Yes ☐ No ☐

494 Anal fissures Yes ☐ No ☐

Other comments

Diagram

Anterior 12 o'clock

Posterior 6 o'clock

495 No injury ☐ Exam omitted ☐ Exam N/A ☐

Male genitalia

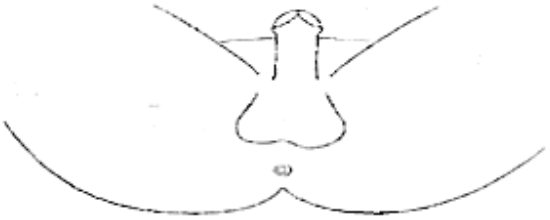
501 Foreskin

511 Glans penis

521 Penile shaft

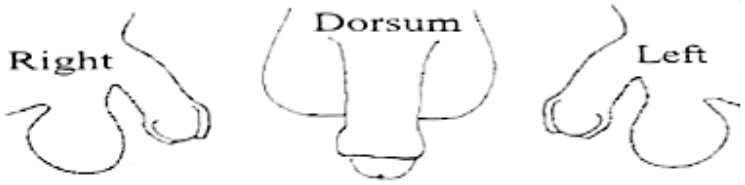
531 Scrotum

541 Urethra



Description

T	E	A	R	S_1	S_2	S_3



551 No injury ☐ Exam omitted ☐ Exam N/A ☐

EVIDENCE OF PENETRATION

Please comment

Definite	Very likely	Probable	Inconclusive but possible	No visible evidence
☐	☐	☐	☐	☐

552

553 Forensic specimens collected Yes ☐ No ☐

Signed: .....

Sworn before me this ..... day of *(month)* ..... *(year)* .....

At: .....

(Commissioner of Oaths) .....

SEXUAL ASSAULT MEDICAL CERTIFICATE

Confidential Document

Today's Date / / Time ____ : ____ | Location of medical exam

A. PATIENT INFORMATION

1. Last name | 2. Post-name | 3. First name

4. Address | 5. Gender ☐ Female ☐ Male

6. Age ☐ Not known | 7. Date of birth / / ☐ Not known | 8. Place of birth ☐ Not known

9. Marital status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Not applicable

Note: If the patient is male, skip to question 14.

10. Date of last menstrual period / / ☐ Premenarchal ☐ Post-menopausal ☐ Not known

11. Number of pregnancies | 12. Number of live births | 13. Currently pregnant ☐ Yes ☐ No ☐ Not known

14. Patient had consensual intercourse within 7 days before the exam ☐ Yes ☐ No

15. Patient had anal/vaginal wounds, injuries, diagnostic procedures or medical treatments within 60 days before the assault that could affect the interpretations of the current medical exam ☐ Yes ☐ No *If "Yes," explain :* _____

16. Date and time of the assault / / ____ : ____ ☐ Not known | 17. Place of the assault ☐ Not known

18. Use of force, threats or weapons *(check all that apply)*
☐ Physical force ☐ Use of weapons ☐ Threats to the patient ☐ Threats to others ☐ No force ☐ Not known

19. Type of force/weapons *(check all that apply)*
☐ Sticks/batons ☐ Knives ☐ Blindfold ☐ Hands ☐ Not known ☐ Other *(such as forced nudity, suspension, electrical torture, witness or participation in torture of others, etc.)* : _____
☐ Guns ☐ Restraints ☐ Gag ☐ Feet

20. Forced chemical intoxication of patient *(check all that apply)*
☐ No ☐ Drugs ☐ Alcohol ☐ Not known ☐ Other : _____

B. SUSPECT INFORMATION

1. Number of suspects
☐ One (1) ☐ Two (2) ☐ Three (3) ☐ More than three *If "More than three," specify the number :* _____ ☐ Not known

First suspect: answer questions 2 through 6.

2. Relationship of suspect to patient *(check all that apply)*
☐ Acquaintance ☐ Family member
☐ Stranger ☐ Intimate partner / ex-partner
☐ Not known ☐ Other : _____

3. Suspect gender ☐ Female ☐ Male ☐ Not known

4. Approximate age of suspect ☐ Not known

5. Suspect is ☐ Civilian ☐ Police ☐ Military ☐ Militia ☐ Not known

6. Language(s) spoken by suspect ☐ Not known

Second suspect: answer questions 7 through 11.

7. Relationship of suspect to patient *(check all that apply)*
☐ Acquaintance ☐ Family member
☐ Stranger ☐ Intimate partner / ex-partner
☐ Not known ☐ Other : _____

8. Suspect gender ☐ Female ☐ Male ☐ Not known

9. Approximate age of suspect ☐ Not known

10. Suspect is police/military/militia ☐ Civilian ☐ Police ☐ Military ☐ Militia ☐ Not known

11. Language(s) spoken by suspect ☐ Not known

If three or more suspects, answer question 12.

12. Describe the suspects in detail *(including relationships to patient, genders, approximate ages, whether suspects are police/military/rebels, languages spoken, etc.)*: _____

Name of clinician _____ N°C.N.O.M. _____
Signature of clinician _____ Date / /

SEXUAL ASSAULT MEDICAL CERTIFICATE *(continued)*

C. SUMMARY OF EVENTS REPORTED BY THE PATIENT

1. Penetration of female genitalia with:	Yes	No	Attempted	Not known	Comments:
a. penis	☐	☐	☐	☐	
b. finger(s)	☐	☐	☐	☐	
c. foreign body	☐	☐	☐	☐	

2. Penetration of anus with:	Yes	No	Attempted	Not known	Comments:
a. penis	☐	☐	☐	☐	
b. finger(s)	☐	☐	☐	☐	
c. foreign body	☐	☐	☐	☐	

3. Oral contact with genitalia:	Yes	No	Attempted	Not known	Comments:
a. supect to patient	☐	☐	☐	☐	
b. third party to patient	☐	☐	☐	☐	
c. patient to suspect	☐	☐	☐	☐	
d. patient to third party	☐	☐	☐	☐	

4. Oral contact with anus:	Yes	No	Attempted	Not known	Comments:
a. suspect to patient	☐	☐	☐	☐	
b. third party to patient	☐	☐	☐	☐	
c. patient to suspect	☐	☐	☐	☐	
d. patient to third party	☐	☐	☐	☐	

5. Genital touch / contact:	Yes	No	Attempted	Not known	Comments:
a. suspect to patient	☐	☐	☐	☐	
b. third party to patient	☐	☐	☐	☐	
c. patient to suspect	☐	☐	☐	☐	
d. patient to third party	☐	☐	☐	☐	
e. patient to self	☐	☐	☐	☐	

6. Ejaculation:	Yes	No	Not known	Comments :
a. inside body orifice of patient	☐	☐	☐	
b. outside body orifice of patient	☐	☐	☐	
c. specify location of ejaculation:				

D. POST-ASSAULT PATIENT HYGIENE

1. After the assault, the patient *(check all that apply)*

☐ Ate ☐ Drank ☐ Brushed teeth ☐ Showered ☐ Took a bath ☐ Urinated ☐ Not known

E. PATIENT ACCOUNT OF EVENT

Provide a summary of the key elements of the assault as described by the patient. (If there are additional facts or observations that are not otherwise represented in this form, please attach a typed narrative.)

F. GENERAL PHYSICAL EXAM OF THE PATIENT

1. Blood pressure /	2. Pulse	3. Respiration	4. Temperapture (Celsius)	5. Weight	6. Height

5. Behavior and psychological state *(check all that apply)*

☐ fear ☐ withdrawn ☐ sad ☐ ashamed ☐ impaired mental status

☐ angry ☐ shocked ☐ crying ☐ mute ☐ anxious

REMEMBER TO: COLLECT EVIDENCE *(wet and dry secretions, stains, clothing and foreign materials from the patient's body)*; USE RAPE KIT *(when available)* AND CHAIN OF CUSTODY FORMS; and TAKE PHOTOGRAPHS

Name of clinician _____ N°C.N.O.M. _____

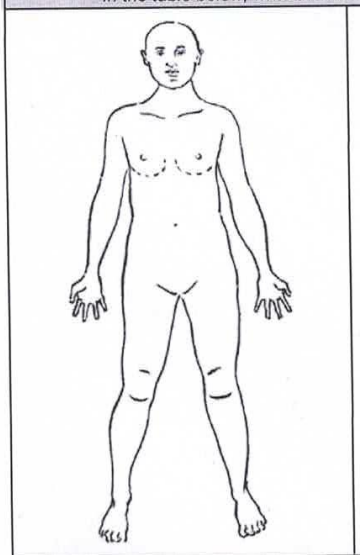
Signature of clinician _____ Date ____/____/____

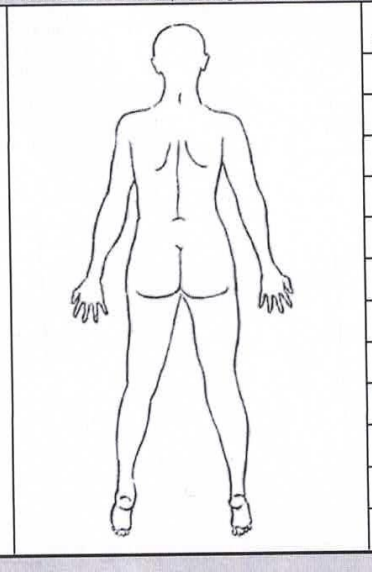
F. GENERAL PHYSICAL EXAM OF THE PATIENT *(continued)*

Legend: Findings

A Abrasion	**BI** Bite	**BU** Burn	**DB** Debris	**DF** Deformity	**DS** Dry secretion	**EC** Ecchymosis (bruise)	**ER** Erythema (redness)	**FB** Foreign body (describe)
FI Fiber (include hair)	**G** Gunshot wound	**I** Incision	**L** Laceration	**M** Moist secretion	**O** Other injury (describe)	**P** Sensitivity (include pain)	**S** Swelling	**V** Vegetation (include soil, dirt)

Number each discrete injury/finding on the diagrams below.
In the table below, write the number with the corresponding abbreviation for the type of finding (see table of findings above).



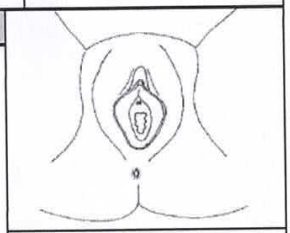


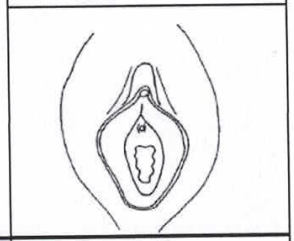
Location on the body	Findings	Comments :

G. GENITAL EXAM (FEMALE)

Use the legend above to identify and localize elements of the genital exam.
Examine the inner thighs, external genitalia, and perineal and anal areas (check the boxes if there are relevant sexual assault findings)

1. Inner thigh injury ☐ Yes ☐ No
2. Periurethral / urethral meatus injury ☐ Yes ☐ No
3. Perineum injury ☐ Yes ☐ No
4. Labia majora injury ☐ Yes ☐ No
5. Labia minora injury ☐ Yes ☐ No
6. Hymen injury ☐ Yes ☐ No
7. Clitoris/surrounding area injury ☐ Yes ☐ No
8. Buttocks / anal verge / folds / rugae injury ☐ Yes ☐ No
9. Vagina injury ☐ Yes ☐ No
10. Cervix injury ☐ Yes ☐ No
11. Exam position used
    - ☐ Supine
    - ☐ Knee-chest
    - ☐ Other

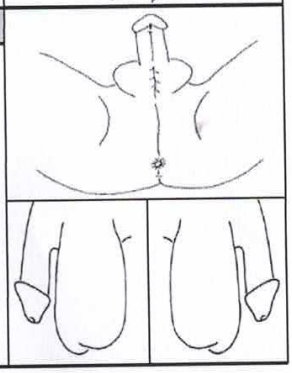




H. GENITAL EXAM (MALE)

Examine the inner thighs, external genitalia, and perineal and anal areas (check the boxes if there are relevant sexual assault findings)

1. Inner thigh injury ☐ Yes ☐ No
2. Glans penis or penile shaft injury ☐ Yes ☐ No
3. Scrotum injury ☐ Yes ☐ No
4. Testes injury ☐ Yes ☐ No
5. Patient is circumcised ☐ Yes ☐ No
6. Buttocks / anal verge / folds / rugae injury ☐ Yes ☐ No
7. Rectal bleeding ☐ Yes ☐ No



Name of clinician _____ N°C.N.O.M. _____

Signature of clinician _____ page 3 of 4 Date ____/____/____

I. LABORATORY AND OTHER TESTS

PERFORMED:	Yes	No	*RESULTS:*	*PERFORMED:*	Yes	No	*RESULTS:*
1. HIV serology	☐	☐	_____	6. Urinary analysis	☐	☐	_____
2. Syphilis	☐	☐	_____	7. Wet mount for sperm / infection	☐	☐	_____
3. Hepatitis B	☐	☐	_____	8. Ultrasound	☐	☐	_____
4. PAP smear	☐	☐	_____	9. Other testing	☐	☐	_____
5. Pregnancy test	☐	☐	_____	_____			

J. TREATMENT / PLAN

	Yes	Non	Comments:
1. Post-exposure Prophylaxis (PEP)			
a. PEP	☐	☐	_____
2. Medications	**Yes**	**No**	**Comments:**
a. Antibiotics	☐	☐	_____
b. Pain medicine	☐	☐	_____
c. Emergency contraception	☐	☐	_____
d. Other	☐	☐	_____
3. Referrals	**Yes**	**No**	**Comments:**
a. Patient will be referred to specialist today	☐	☐	_____
4. Police requisition	**Yes**	**No**	**Comments:**
a. Police requisition completed	☐	☐	_____
b. *If 4a is "No,"* does the patient want to report to the police?	☐	☐	_____
c. *If 4b is "No,"* was the patient counseled on the value of a police investigation?	☐	☐	_____

K. EVALUATION FINDINGS

1. History of event: _____
2. Behavioral observations: _____
3. Physical findings: _____
4. Laboratory tests: _____
5. Completed documents attached to this certificate:
   ☐ Laboratory test results ☐ Written narrative (preferably typed) ☐ Photographs ☐ Not applicable

L. EVALUATION CONCLUSIONS

1. The medical evaluation findings are: *(choose only one option)*
   ☐ **CONSISTENT** with
   ☐ **HIGHLY CONSISTENT** with
   ☐ **DIAGNOSTIC** of
   ☐ **NOT CONSISTENT** with
   SEXUAL assault.

2. The medical evaluation findings are: *(choose only one option)*
   ☐ **CONSISTENT** with
   ☐ **HIGHLY CONSISTENT** with
   ☐ **DIAGNOSTIC** of
   ☐ **NOT CONSISTENT** with
   PHYSICAL assault.

M. CLINICIAN OATH

I have provided informed consent to the patient for the evaluation, photographs, and transfer of affidavit to the legal system or law enforcement.

☐ Yes ☐ No

I hereby solemnly swear that the information provided in this form is true and complete to the best of my knowledge and belief.

Name of clinician _____
Signature of clinician _____
Date _____ / _____ / _____

Name of clinician _____ **N°C.N.O.M.** _____
Signature of clinician _____ **Date** _____ / _____ / _____

Annexure 4 Reform proposals on contraception and abortion after rape

Alternative 1

A medical practitioner, a nurse or a clinical officer who is trained to perform a termination of pregnancy may perform a termination on the ground that the pregnancy was the result of rape, provided that the procedures below have been followed–

(a) The female must have laid a complaint of rape with the police.

(b) The complainant must be required, with the assistance of the police, to swear an affidavit before a police officer of or above the rank of Assistant Inspector affirming that her pregnancy resulted from such rape.

(c) As soon as possible after the lodging of a complaint of rape the police must organize for the complainant to be medically examined.

(d) If the complaint was made soon after the rape, a police officer must immediately accompany the female to a medical practitioner or nurse who will be able to administer emergency contraception to prevent pregnancy.

(e) If, on the basis of the medical report and available facts, the police form the opinion that it is reasonably possible that a rape has occurred, a police officer of or above the rank of Assistant Inspector must certify in writing that the complainant has lodged a complaint of rape and that it is reasonably possible that she has been raped.

(f) If the complainant states that she wishes to have her pregnancy terminated, the police officer must then, without delay, submit copies of the medical report, the police certificate and the female's affidavit to a magistrate.

(g) If the police decline to issue the certificate provided for in subsection (e) and the complainant maintains that she was raped and wishes to have a termination of her pregnancy, the police must, as soon as possible, lay the matter before a magistrate, providing copies of the medical report and the complainant's affidavit for determination as to whether there was a reasonable possibility that the pregnancy was the result of rape.

(h) The magistrate receiving the documentation relating to the complaint from the police must, without delay, decide on the basis of the documentation or with such additional interrogation of the complainant and other persons as necessary whether, on a balance of probabilities, that the woman has been raped and there is a reasonable possibility that the pregnancy is the result of the rape.

(i) If the magistrate decides that there is a reasonable possibility that the pregnancy is the result of rape, the clerk of court must as soon as possible notify the woman concerned of this decision and provide her with an authenticated copy of the determination by the magistrate and give her a list of medical institutions in which she can have her pregnancy terminated and advise her to take the magistrate's determination, as soon as possible, to the person in charge of a medical institution.

(j) On receipt by person in charge of the medical institution of the magistrate's determination at medical institution, arrange for a termination to be performed as soon as possible, provided that it is still safe to perform the termination.

(k) If the magistrate decides that they are not satisfied that there was a reasonable possibility that the pregnancy was the result of rape, the complainant must immediately be notified of the determination. They must submit the matter immediately for review by a judge of the High Court accompanied by the documentation that was placed before them; with the reasons for this determination and the complainant must be given the opportunity to submit reasons why in her opinion the magistrate's determination was wrong.

(l) Within one week of receiving the case for review, the judge must decide either to uphold the determination of the magistrate or to set it aside and substitute an authorisation for the complainant to have a termination of her pregnancy in terms of this Act.

Alternative 2

A medical practitioner, a nurse or a clinical officer who is trained to perform a termination of pregnancy may perform a termination of pregnancy on the ground that the pregnancy was the result of rape, provided that the procedures below have been followed–

(a) The female must have laid a complaint of rape with the police.

(b) The complainant must be required, with the assistance of the police, to swear an affidavit before a police officer of or above the rank of Assistant Inspector affirming that her pregnancy resulted from such rape.

(c) As soon as possible after the lodging of a complaint of rape the police must organize for the complainant to be medically examined.

(d) If the complaint was made soon after the rape, a police officer must immediately accompany the female to a medical practitioner or nurse who will be able to administer emergency contraception that will prevent the pregnancy of the complainant.

(e) If, on the basis of the medical report and available facts, the police form the opinion that it is reasonably possible that a rape has occurred, a police officer of or above the rank of Assistant Inspector must certify in writing that the complainant has lodged a complaint of rape and that it is reasonably possible that she has been raped.

(f) If the police decline to issue the certificate provided for in subparagraph (e) and the complainant maintains that she was raped and wishes to have a termination of her pregnancy, the police, as soon as possible, must lay the matter before a magistrate for determination as to whether there was a reasonable possibility that the pregnancy was the result of rape.

(g) If the police have issued a police certificate provided for in paragraph (e) and the complainant states that she wishes to have her pregnancy terminated, the police officer must immediately arrange for the complainant to be conveyed in the presence of a police officer to the nearest medical institution at which it is permitted to perform a lawful termination and must arrange for her to be seen by the person in charge of that institution.

(h) On receipt by person in charge of the medical institution of the police certificate and the attached complainant's affidavit, the person in charge must arrange for a termination to be performed as soon as possible, provided that it is still safe to perform the termination.

Annexure 5 Proposed new legislation on abortion

Prevention and Termination of Pregnancy Act [*Chapter …*]

Note.

The title of the Act has been changed to encapsulate that the Act will deal with the prevention of pregnancy and termination of pregnancy.

Introduction

A new provision was inserted in the 2013 Constitution that was not in the pre-2013 Constitution. Under the right to life guarantee there is this provision:

> s 48(2) An Act of Parliament must protect the lives of unborn children, and that Act must provide that pregnancy may be terminated only in accordance with that law.

The current Act is the Termination of Pregnancy Act [*Chapter 15:10*]. When making proposals for changes to the Act the constitutional provision requiring protection of the unborn child must be taken into account but that provision must be balanced against the rights of pregnant women; these include the right to life (s 48), the right to bodily and psychological integrity which includes the right, subject to this Constitution, to make decisions concerning reproduction (s 52) and the right of women not to be discriminated against on the grounds of sex, gender or pregnancy. (s 56).

In this draft Act several changes to the existing Act are proposed. The new Act will:

1. incorporate provisions on post-coitus contraception;
2. expand the grounds for lawful termination of pregnancy to include termination on the grounds of-
   a) termination because the continued pregnancy posed a serious threat to mental health of the pregnant mother;
   b) termination on the ground of pregnancy resulting from "statutory rape";
   c) termination on the ground of pregnancy resulting from marital rape;
3. contain provisions to address how to deal with termination of the pregnancy of a female who is mentally incompetent;
4. provide a streamlined procedure to ensure that a rape survivor who has been impregnated will be able to obtain a lawful termination if she wishes this;
5. have provisions on the administration of post-coitus emergency contraception.

1. Name of Act

This Act may be cited as the Prevention and Termination of Pregnancy Act [*Chapter 15:10*].

Note.

It is proposed that the Act should cover not only termination of pregnancy but also emergency contraception to avoid pregnancy where the female has been the victim of unlawful sexual intercourse; hence the proposed change to the title of the Act. It will also seek to clarify the legal position of the administration of emergency contraception to females other than rape survivors.

2 Interpretation

(1) In this Act —

"Criminal Law Code" means the Criminal Law (Codification and Reform) Act [*Chapter 9:23*]

"emergency contraception" means a contraceptive administered to prevent pregnancy but does not include use of medicines to induce an abortion after pregnancy has ensued;

Note.

The antiprogestin mifepristone (also known as RU-486) is a low-dose or mid-dose emergency

contraceptive tablet, effective up to 120 hours after intercourse and provides a high percentage chance of preventing pregnancy.

However mifepristone is also a medication typically used with misoprostol to bring about an abortion. This combination is more than 95% effective during the first 50 days of pregnancy. It is also effective in the second trimester of pregnancy.

Thus a distinction needs to be drawn between when mifepristone is being used to try to avoid pregnancy and when it is being used to terminate pregnancy.

"embryo" means an human organism from fertilization to the beginning the third month of pregnancy;
"foetus" means the unborn child from the beginning of the third month of pregnancy until the live birth of that child;
"health practitioner" means a nurse, a midwife and clinical officer who is trained to administer emergency contraception or to perform a termination of pregnancy that is lawfully permitted in terms of this Act.
"medical institution" means a State hospital or clinic or private hospital or clinic or such other medical institution as may be declared to be a medical institution for the purposes of this Act;
"medical practitioner" means a medical practitioner who is registered in terms of the Medical, Dental and Allied Professions Act [*Chapter 27:08*] as a medical practitioner;
"Minister" means the Minister of Health and Child Welfare or any other Minister to whom the President may, from time to time, assign the administration of the Act;
"pregnancy" means an intra-uterine pregnancy where the foetus is alive;
"Secretary" means the Secretary of the Ministry for which the Minister is responsible for health matters;
"termination of pregnancy" means a termination of a pregnancy otherwise than with the intention of delivering a live child.
"unlawful sexual intercourse" means—

(a) rape, including sexual intercourse with a mentally incompetent female;
(b) sexual intercourse with a girl under the age of 16 in contravention of section 70 of the Criminal Law Code (sexual intercourse with a young person);
(c) sexual intercourse within a prohibited degree of relationship, other than sexual intercourse with a person referred to in paragraph (i) or (j) of subsection (2) of section 75 of the Criminal Law Code. [*first or second cousins and ascendants or descendants or spouse or former spouse to a marriage under Marriage Act, Customary Marriage Act or an unregistered customary union.*]

Notes

Section 4 of the Act read with the definition section, section 2, presently permits termination of pregnancy of a female who has been raped but does not permit termination if the pregnancy results from–

(a) Marital rape;
(b) Unlawful consensual sexual intercourse with a girl under the age of sixteen in contravention of section 70 of the Criminal Law (Codification and Reform) Act [*Chapter 9:23*] (so-called "statutory rape").

Regarding **marital rape**, a man can be charged with rape of his spouse as the marital rape exemption has been abolished. (section 68(a) of the Criminal Law Code.) It is open to question whether a wife who has been impregnated as a result of being raped by her husband should always be denied the right to terminate the pregnancy if she so wishes. For instance, should this apply where the spouses are separated but not divorced and the husband breaks into the house where his wife is living and brutally rapes her and she becomes pregnant with a child she did not want? What if the wife has been medically advised that she should not have more children, but she is raped and impregnated by her brutal husband? However, in the latter instance she would probably be able to have a lawful abortion in the grounds of threat to her physical health

Regarding **statutory rape**, this crime is committed if a man has consensual sexual intercourse with a girl under the age of 16 but if the girl is 12 or under it will be rape because a girl who is 12 or under is deemed to be incapable of giving consent.

The purpose of the offence of statutory rape is to protect young girls against sexual exploitation and against the harmful health effects of early sexuality such as pregnancy at an age where such pregnancy can carry health risks to the girls. Thus if a young girl has been sexually exploited and becomes pregnant despite the attempts by law to prevent this, it would seem appropriate to deal with the consequences of this pregnancy by allowing the girl, with parental approval, to have a lawful abortion. This is also in line with the impending law which will criminalise child marriage. Here again if man commits a crime by marrying an under-age girl and he has impregnated her before he is arrested for this crime, there is a strong argument for allowing the girl to have a lawful termination. However, there is a problem of deciding who would consent to a termination on this ground. The impregnated girl may be too young to give meaningful consent. The parents or guardians may refuse consent. Thus it would be necessary to require both the consent of the girl and of her parents. If the girl wishes to have a termination but the parents refuse to give consent, there would have to be a provision that allows the High Court to be approached and for the court to decide as upper guardian whether the termination should take place.

Further, the present Act does not have specific provisions dealing with the impregnation of **mentally incompetent females**. Sexual intercourse with a mentally incompetent female would constitute rape as such a female would lack the capacity to consent to the sexual act and she would qualify for a termination of pregnancy on the grounds of rape. However, the mentally incompetent would not be able herself to seek a termination and the question is whether the relatives of the female or the person in charge a mental institution in which the female is being held could apply to a magistrate for the termination of the pregnancy.

3. Medical institutions in which terminations may be performed

(1) A termination that may lawfully performed in terms of this Act may be carried out in a State hospital or clinic or private hospital or clinic or such other medical institution as may be declared to be the Minister to be a medical institution at which a lawful termination of pregnancy may be performed.

(2) The Minister may, by statutory instrument, declare any hospital, clinic or other institution to be a medical institution for the purposes of this Act and must specify the person who will be deemed to be the person in charge of that institution.

4. Persons who may perform terminations of pregnancy

Except where it is stated that a termination of pregnancy must be carried out by a medical practitioner, a termination of pregnancy may be performed either by a medical practitioner or a nurse, a midwife and clinical officer who is trained to perform a termination of pregnancy that is lawfully permitted in terms of this Act.

5. Circumstances in which pregnancy may be terminated

(1) Subject to this Act, a pregnancy may be terminated—

(a) where the termination of the pregnancy is necessary to save the life of the mother or prevent seriously harm to her physical or mental health; or

Note.

The original provision has been expanded to include to prevent serious harm to her mental health. This provision should be read together with section 7(2) which deals with what is necessary before a pregnancy can be terminated on this ground.

(b) where there is a serious risk that the child to be born will suffer from a physical or mental defect of such a nature that he will permanently be seriously handicapped; or

(c) where there is a reasonable possibility that the foetus is conceived as a result of unlawful intercourse.

Note

This section does not include a provision which would allow for termination on socio-economic grounds. Before including such a provision there would have to be widespread public consultation as to whether such a provision is necessary and desirable.

6. Consent of female required

No pregnancy may be terminated unless the female person whose pregnancy is to be terminated has consented to such termination; provided that—

(a) in the case of a female person who is unconscious and who has not previously indicated that she does not consent to a termination of her pregnancy, the termination can be performed without her consent if the continuation of her pregnancy constitutes an immediate threat to her life or a serious threat to her physical health;

(b) in the case of a girl under the age of sixteen who is pregnant, a parent or guardian of the female may consent to the performance of the termination upon her provided that the pregnant girl herself wishes to have the termination and where the girl wishes to have a termination but the parents do not consent, a ruling by the High Court must be sought as to whether the termination should take place despite the lack of consent on the part of the parents;

(c) in the case of a female person who has been declared to be mentally incompetent, the guardian of the female has consented to the termination or the High Court has authorised the termination.

7. Termination to save mother's life or prevent serious harm to her physical or mental health

(1) A medical practitioner may perform a termination which is immediately necessary to save the mother's life or prevent serious harm to her physical health.

(2) A medical practitioner may terminate a pregnancy where there is a real possible that the continued pregnancy will result in serious harm to the mental health of the female person, provided that a psychiatrist or a psychiatric nurse must certify in writing that in his or her opinion the continued pregnancy will cause serious harm to the mental health of the female person.

8. Termination on ground that that child will be born with serious handicap

A medical practitioner may terminate a pregnancy on the ground that the medical practitioner considers that there is a serious risk that the child will be born with physical or mental defect that will permanently and seriously handicap him or her, provided that a second medical practitioner also certifies that in his or her option such a serious risk exists.

9. Emergency contraception after unlawful sexual intercourse

(1) Where a medical practitioner or nurse is satisfied that unlawful sexual intercourse may have taken place upon a female and there is a risk that the female may become pregnant as a result, the medical practitioner may, with the consent of the female or, if she is incapable of giving consent, with the consent of her parents or guardians, administer such contraceptive medication as may approved by the Ministry of Health for this purpose.

(2) Where a female person or her parents or guardians have laid a complaint with the police that unlawful sexual intercourse has taken place, the police must immediately arrange for the female to be examined by a medical practitioner or nurse to determine whether it is still possible to avoid pregnancy by administration of emergency contraception and, if it is, such contraception may be administered by the doctor or nurse.

(3) If it is too late to avoid the pregnancy by such emergency post-coital contraception and the female person is already pregnant, the medical practitioner must advise the persons stated below that the pregnancy may be lawfully terminated on the grounds for termination set out in this Act-

(a) a female over the age of 18;

(b) a female under the age of 18 and her parents or guardian;

10. Termination on ground that reasonable possibility foetus conceived as result of unlawful sexual intercourse

- (a) Immediately after a female person has laid a complaint with the police of unlawful sexual intercourse, the police officer receiving the complaint must arrange for a medical examination to be carried out on the complainant and for a medical report to be compiled.

(b) The police officer then must advise the complainant that the law provides that, if she so wishes, she is entitled to have her pregnancy lawfully terminated on the ground that the pregnancy was the result of unlawful sexual intercourse.
(c) If the complainant states that she wishes to have her pregnancy terminated, the police officer must advise the complainant that she must as soon as possible swear an affidavit that the pregnancy was the result of unlawful sexual intercourse and the police office must assist her to draw up and swear this affidavit.
(d) Immediately after the female has sworn the affidavit, a police officer of or above the rank of Assistant Inspector must certify in writing that the complainant has lodged a complaint of unlawful sexual intercourse.
(e) The police must immediately arrange for the complainant to be conveyed in the presence of a police officer to the nearest medical institution at which it is permitted to perform a lawful termination and arrange for her to be seen by the person in charge of that institution and must hand to the person in charge of the institution the complainant's sworn affidavit, the police affidavit and the medical report to the complainant.
(f) On receipt by person in charge of the medical institution of the police certificate and the attached affidavit, the person in charge must arrange for a termination to be performed as soon as possible provided that it is still safe to perform the termination.
(g) A medical practitioner, a nurse, a midwife or a clinical officer who is trained to perform a termination of pregnancy may perform a termination of pregnancy on the ground that the pregnancy was the result of unlawful sexual intercourse, provided that the procedures below have been followed.
(h) The medical institution in which a termination of pregnancy is to be performed must arrange for psychological counselling of the woman who is to undergo a termination of pregnancy.

Notes

The proposed procedure for termination on the grounds of pregnancy resulting from unlawful sexual intercourse would dispense with the requirement that there must be a magisterial certificate. In rural areas magistrates courts are often considerable distances away and obtaining magisterial certificates may lead to inordinate delays in the process. The reason for requiring a magistrate certificate was to guard against a woman obtaining a termination by falsely claiming that she was raped. It is suggested that it is a sufficient safeguard to require the woman to make a report to the police and swear an affidavit that she was raped.

It would seem to be unnecessary to involve a magistrate in this process because the doctor who carried out the examination after the rape and the police who dealt with the complainant are in the best position to decide whether there was a reasonable possibility that the pregnancy resulted from rape or other unlawful sexual intercourse. The magistrate would usually only confirm that this is the case based on the police and medical reports. In any event it is highly unlikely that a female will go to the police and falsely claim that she has been raped in order to be able to obtain a lawful termination.

It should be noted that Botswana allows a lawful termination during the first 16 weeks of pregnancy if a medical practitioner carrying out the operation is satisfied, by acceptable evidence, that the pregnancy is the result of rape …and the abortion is requested by the victim, or, where the victim lacks the capacity to make such request, by her next of kin or guardian or the person *in loco parentis*. (Section 160 of the Botswana Penal Code.) This is also the position in Ethiopia.

The police and the health authorities would have the legal obligation to comply with these requirements and failure to do so could potentially result in civil liability to the aggrieved female person.

10. Offences

Any person who

(a) terminates a pregnancy otherwise than in accordance with this Act;

(b) procures a termination of pregnancy under the Act by providing false information;

(c) provides a false certificate for the purposes of facilitating a termination of pregnancy;

-
- will be guilty of an offence and liable to a fine not exceeding level ten or to imprisonment for a period not exceeding five years or to both such fine and such imprisonment.

11. Information to be forwarded to Secretary

(1) A person in charge of a medical institution at which a lawful termination has been performed must submit to the Secretary within fourteen days a report of the reasons for such a termination.

(2) The Secretary may at any time in writing or through any person designated by him require a person in charge of a medical institution or a medical practitioner who may have knowledge of the termination of a pregnancy to provide any information in regard to that termination of pregnancy which he or she may specify, whether or not this Act has been complied with.

(3) Any person who contravenes subsection (1) or (2) will be guilty of an offence and liable to a fine not exceeding level five or to imprisonment for a period not exceeding six months or to both such fine and such imprisonment.

12. Report by Secretary

Where the Secretary is of the opinion that—

(a) an offence has been committed, he or she must submit a report to the Attorney-General together with such information which it is in his power to give in regard thereto; or

(b) any medical practitioner or any other person has been guilty of any conduct, act or omission referred to in subsection (1) of section 56 of the Medical, Dental and Allied Professions Act [*Chapter 27:08*],

he or she must submit a report to the Registrar of the Health Professions Council together with any information which it is in his power to give.

13. No person to be required to participate or assist in termination of pregnancy

Notwithstanding any law or agreement to the contrary, no medical practitioner or nurse or person employed in any other capacity at a medical institution will be obliged to carry out or participate or assist in the termination of a pregnancy; provided that no medical practitioner may refuse to perform a termination that is necessary to save the life of the female person and provided that, in other cases, if the refusal to perform the termination means that the termination cannot be carried out at that medical institution, the female person must be transported immediately to a medical institution at which the termination can take place.

14. Fees

A medical institution may charge only the fee prescribed for performing a lawful termination of pregnancy, provided that no fee may be charged for performing a termination on the ground of pregnancy resulting from unlawful sexual intercourse.

15. Regulations

The Minister may by regulation provide for all matters which by this Act are required or are permitted to be prescribed or which in his opinion are necessary or convenient to be provided for in order to carry out or give effect to this Act.

Annexure 6: Do Not Resuscitate Form (DNR) (America)

State of _____

DO NOT RESUSCITATE (DNR)

Patient's Full Legal Name: _____ **Date:** _____

PHYSICIAN STATEMENT

I, the undersigned, state that I am the physician of the patient named above and I affirm this order is consistent with the patient's wishes. I hereby direct any and all qualified health care personnel to withhold or withdraw cardiopulmonary resuscitation (cardiac compression, intubation and other advanced airway management, artificial ventilation, defibrillation, and other related procedures) from the patient in the event of the patient's cardiac or respiratory arrest. I further direct such health care personnel to provide comfort care to the patient such as intravenous fluids, oxygen or other therapies deemed necessary to provide comfort and alleviate pain. A copy of this order is in the patient's medical records.

_____ _____

Physician Signature Date

_____ _____

Physician Printed Name Phone Number

PATIENT STATEMENT

I, the undersigned, being of sound mind and legal age, willfully and voluntarily make this declaration to state my desires and direct that resuscitation be withheld or withdrawn in the event of my cardiac or respiratory arrest. It is my intention that this order be honored by my family, my physicians, and all others who may partake in my health care.

_____ _____

Patient Signature Date

_____

Patient Printed Name

➢

Annexure 7: The American case of Elizabeth Bouvia

Bouvia v Superior Court, 179 Cal. App. 3d 1127, 1135-36, 225 Cal. Rptr. 297. (Ct. App. 1986), review denied (Cal. June 5, 1986).

This American case illustrates the difficulties that the courts have faced in measuring the autonomous right of a patient to take action that will result in her death measured against the interest that a State has in preserving life.

"Elizabeth Bouvia was a mentally competent, young, quadriplegic woman who suffered from cerebral palsy, leaving her completely bedridden and dependent on others to perform all her activities of daily living. Despite having a college degree, she was financially unable to support herself, did not have a stable living situation, and relied on public assistance for all aspects of her care. In 1983, at age 26, she expressed a desire to end her life. Ms Bouvia then attempted to accomplish this by self-starvation in a California public hospital, an act which was widely publicized in the media.

A California court denied Ms Bouvia judicial assistance to starve herself to death and issued a court order allowing the hospital to commence force-feeding her by inserting a nasogastric tube. After several unsuccessful attempts to find a publicly funded apartment with visiting nurses to provide care, Ms Bouvia once again became a patient in a public hospital, and in 1986 she was eventually transferred to High Desert Hospital (HDH), another public facility. When Ms Bouvia could no longer be spoon-fed without nausea and vomiting HDH inserted a nasogastric tube against her will to avert potential starvation. The medical staff acted against Ms Bouvia's wishes because of her life-threatening condition, her previous efforts to starve herself, and her prognosis which indicated she could survive an additional 15 to 20 years with adequate nutrition. Her caregivers believed that the state's interests in preserving life compelled such an action.

Ms Bouvia sued the hospital and its staff, seeking a court order from the Superior Court of Los Angeles County, to have the nasogastric tube removed and to stop all medical measures to which she did not consent.

The trial court denied Ms Bouvia's request, stating that her prognosis justified the state's interest in preserving her life. The court said that to rule otherwise would be tantamount to aiding and abetting suicide, since Ms Bouvia's motive for refusing treatment was to die. Ms Bouvia immediately appealed the trial court decision.

The appellate court acknowledged that a competent adult has the right, in the exercise of control over his or her own body, to determine whether and to what extent to submit to medical treatment. A competent patient also has a basic and fundamental right to refuse any medical treatment, even if it may save or prolong his or her life. Although the questions of refusing and withdrawing treatment are often considered in the context of terminal prognoses (which Ms Bovia did not have), the right nevertheless exists under both the state and federal constitutions and is not limited to 'terminal' patients.

Physicians may establish the medical diagnoses and prognoses of patients, but the competent patient is entitled to make the ultimate decision about what care will be rendered, with the 'patients interests and desires…the key ingredients of the decision-making process.'

The court further recognised that a patient's right to self-determination regarding medical treatment is based upon the patient's being mentally competent and able to understand the consequences of withdrawal or refusal of care. The court noted that Ms Bouvia was mentally competent, understood the risks involved in refusing nasogastric tube feeding, and, hence, any objections to her refusal of the feeding could not be based on those grounds.

The hospital staff argued that the interests of the state should prevail over the rights of the patient to refuse

treatment. Traditionally, viable state interests include—

- preserving life,
- preventing suicide,
- protecting innocent third parties, and
- maintaining the ethical standards of the medical profession, including supporting the right of physicians to effectively render necessary and appropriate medical services.

The court decided that these interests, although valid, were insufficient to overcome Ms Bouvia's right to refuse medical treatment. The appellate court concluded that the trial court had erred in deciding that, just because Ms Bouvia could live an additional 15 to 20 years with sufficient feeding, the state's interest in preserving her life for that period prevailed over her individual right to autonomy. The appellate court emphasized that the trial court's focus on the potential additional *years* of life available to Ms Bouvia without considering her *quality* of life during those years had been erroneous. Indeed, quality is an equal, if not more significant, consideration to be weighed by the court.

The appellate court noted on this basis, that it is not the policy of the state to preserve every life. In this case, if treated against her wishes, Ms Bouvia would have to endure 15 to 20 years of a severely diminished quality of life. The court stated that '[i]n Ms Bouvia's view, her quality of life has been diminished to the point of hopelessness, uselessness, unenjoyability, and frustration. She, as the patient, lying helplessly in bed, unable to care for herself, may consider her existence meaningless.' Since it is 'patient's interests and desires [that] are the key ingredients of the decision-making process,' the court concluded the decision to forgo medical treatment belonged solely to Ms Bouvia. As an important component to her perception of a high quality of life, Ms Bouvia had the right to live out the remainder of her life in dignity and peace as she herself defined it.

The appellate court also addressed the issue of suicide, holding that Ms Bouvia's decision to exercise her right to refuse treatment and accept the consequences of that refusal was not equivalent to an election to commit suicide with the hospital staff aiding and abetting this act. The appellate court ruled that no assessment of the 'motive' behind Ms Bouvia's decision should be performed, and the trial court had been wrong to do so. The appellate court noted that Ms Bouvia could exercise her right to refuse medical treatment regardless of her motive, and no criminal or civil liability would attach to caregivers when honoring a competent, informed patient's refusal of medical services. However, the court stated that the hospital and staff were free to provide the care to which Ms Bouvia consented, such as alleviation of her pain.

In sum, the appeals court reversed the trial court's determination and held that Ms Bouvia had the right to have the nasogastric tube removed because: (1) she had a fundamental right to refuse medical treatment; (2) her rights superseded the state's interests; (3) quality of life was a valid and essential consideration; and (4) fulfilling the patient's desire to refuse treatment was not equivalent to assisting the patient in committing suicide. After the appellate court's ruling, the feeding tube was removed and Ms Bouvia was eventually discharged from the facility. In the months that followed, Ms Bouvia continued to lose weight and suffer increasing discomfort from arthritis and other ailments. She then entered a private convalescent hospital, agreeing not to attempt starvation.

As a postscript to the case, Ms Bouvia's attorney and personal confidant, Richard Scott, who led the high-profile fight to give Ms Bouvia the right to refuse treatment, committed suicide six years after the decision. Ms Bouvia indicated then that she still wanted to die, but, after receiving pain control for secondary diagnoses, the process of starvation proved too physically painful to carry out. Although she considered herself a 'reluctant survivor' and was living the life she dreaded.' It was reported that she was still alive in 2008.

This detailed summary the case is taken verbatim from ''*Bouvia v Superior Court*: Quality of Life Matters''.[41]

[41] Bryan A. Liang, MD, PhD and Laura Lin MBA, ''*Bouvia v Superior Court*: Quality of Life Matters''. For the further commentary of the authors, see the online article; https://journalofethics.ama-assn.org/article/bouvia-v-superior-court-quality-life-matters/2005-02

Annexure 8 Health Professions: [*Chapter 27:19*]

MEDICAL AND DENTAL PRACTITIONERS' COUNCIL Medical practitioners Dental practitioners Dental technicians Dental therapists Dental hygienists Radiologists	**ALLIED HEALTH PRACTITIONERS' COUNCIL** Clinical assistants Clinical social workers Dieticians Dyslexia therapists E.C.G. technicians Electroencephalographic technicians Hospital food service supervisors Instrument technicians Medical physicists Operating theatre technicians Para-medicals Psychologists Radiographers Remedial gymnasts X-ray operators
NURSES COUNCIL General registered nurses Maternity/Midwifery nurses Paediatric nurses Psychiatric nurses State certified maternity nurses State certified nurses State certified traumatology nurses	**NATURAL THERAPISTS' COUNCIL** Acupuncturists Ayurvedic practitioners Chiropractors Homeopathic practitioners Naturopaths Osteopathy practitioners
PHARMACISTS COUNCIL Dispensing opticians Hearing aid specialists Optometrists Orthoptists Pharmacists Pharmacy technicians	**MEDICAL LABORATORY AND CLINICAL SCIENTISTS' COUNCIL** Cyto technicians Medical laboratory scientists Medical scientists State certified blood transfusion technicians State certified medical laboratory scientists

Annexure 9: Stem cells: What they are and what they do

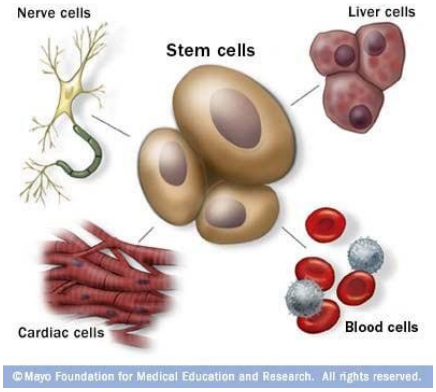
Extract from The Mayo Clinic[42]

Stem cells offer great promise for new medical treatments. Learn about stem cell types, current and possible uses, and the state of research and practice.

You've heard about stem cells in the news, and perhaps you've wondered if they might help you or a loved one with a serious disease. You may wonder what stem cells are, how they're being used to treat disease and injury, and why they're the subject of such vigorous debate.

Here are some answers to frequently asked questions about stem cells.

What are stem cells?



Stem cells: The body's master cells

Stem cells are the body's raw materials — cells from which all other cells with specialized functions are generated. Under the right conditions in the body or a laboratory, stem cells divide to form more cells called daughter cells.

These daughter cells become either new stem cells or specialized cells (differentiation) with a more specific function, such as blood cells, brain cells, heart muscle cells or bone cells. No other cell in the body has the natural ability to generate new cell types.

Why is there such an interest in stem cells?

Researchers hope stem cell studies can help to:

- **Increase understanding of how diseases occur.** By watching stem cells mature into cells in bones, heart muscle, nerves, and other organs and tissue, researchers may better understand how diseases and conditions develop.

[42] The Mayo Clinic https://www.mayoclinic.org/tests-procedures/bone-marrow-transplant/in-depth/stem-cells/art-20048117

- **Generate healthy cells to replace cells affected by disease (regenerative medicine).** Stem cells can be guided into becoming specific cells that can be used in people to regenerate and repair tissues that have been damaged or affected by disease.

  People who might benefit from stem cell therapies include those with spinal cord injuries, type 1 diabetes, Parkinson's disease, amyotrophic lateral sclerosis, Alzheimer's disease, heart disease, stroke, burns, cancer and osteoarthritis.

  Stem cells may have the potential to be grown to become new tissue for use in transplant and regenerative medicine. Researchers continue to advance the knowledge on stem cells and their applications in transplant and regenerative medicine.

- **Test new drugs for safety and effectiveness.** Before using investigational drugs in people, researchers can use some types of stem cells to test the drugs for safety and quality. This type of testing will most likely first have a direct impact on drug development for cardiac toxicity testing.

  New areas of study include the effectiveness of using human stem cells that have been programmed into tissue-specific cells to test new drugs. For the testing of new drugs to be accurate, the cells must be programmed to acquire properties of the type of cells targeted by the drug. Techniques to program cells into specific cells are under study.

  For instance, nerve cells could be generated to test a new drug for a nerve disease. Tests could show whether the new drug had any effect on the cells and whether the cells were harmed.

Where do stem cells come from?

There are several sources of stem cells:

- **Embryonic stem cells.** These stem cells come from embryos that are 3 to 5 days old. At this stage, an embryo is called a blastocyst and has about 150 cells.

  These are pluripotent (ploo-RIP-uh-tunt) stem cells, meaning they can divide into more stem cells or can become any type of cell in the body. This versatility allows embryonic stem cells to be used to regenerate or repair diseased tissue and organs.

- **Adult stem cells.** These stem cells are found in small numbers in most adult tissues, such as bone marrow or fat. Compared with embryonic stem cells, adult stem cells have a more limited ability to give rise to various cells of the body.

  Until recently, researchers thought adult stem cells could create only similar types of cells. For instance, researchers thought that stem cells residing in the bone marrow could give rise only to blood cells.

  However, emerging evidence suggests that adult stem cells may be able to create various types of cells. For instance, bone marrow stem cells may be able to create bone or heart muscle cells.

  This research has led to early-stage clinical trials to test usefulness and safety in people. For example, adult stem cells are currently being tested in people with neurological or heart disease.

- **Adult cells altered to have properties of embryonic stem cells.** Scientists have successfully transformed regular adult cells into stem cells using genetic reprogramming. By altering the genes in the adult cells, researchers can reprogram the cells to act similarly to embryonic stem cells.

  This new technique may allow use of reprogrammed cells instead of embryonic stem cells and prevent immune system rejection of the new stem cells. However, scientists don't yet know whether using altered adult cells will cause adverse effects in humans.

  Researchers have been able to take regular connective tissue cells and reprogram them to become functional heart cells. In studies, animals with heart failure that were injected with new heart cells experienced improved heart function and survival time.

- **Perinatal stem cells.** Researchers have discovered stem cells in amniotic fluid as well as umbilical cord blood. These stem cells have the ability to change into specialized cells.

  Amniotic fluid fills the sac that surrounds and protects a developing fetus in the uterus. Researchers have identified stem cells in samples of amniotic fluid drawn from pregnant women for testing or treatment — a procedure called amniocentesis.

Why is there a controversy about using embryonic stem cells?

Embryonic stem cells are obtained from early-stage embryos — a group of cells that forms when eggs are fertilized with sperm at an in vitro fertilization clinic. Because human embryonic stem cells are extracted from human embryos, several questions and issues have been raised about the ethics of embryonic stem cell research.

The National Institutes of Health created guidelines for human stem cell research in 2009. The guidelines define embryonic stem cells and how they may be used in research, and include recommendations for the donation of embryonic stem cells. Also, the guidelines state that embryonic stem cells from embryos created by in vitro fertilization can be used only when the embryo is no longer needed.

Where do these embryos come from?

The embryos being used in embryonic stem cell research come from eggs that were fertilized at in vitro fertilization clinics but never implanted in women's uteruses. The stem cells are donated with informed consent from donors. The stem cells can live and grow in special solutions in test tubes or petri dishes in laboratories.

Why can't researchers use adult stem cells instead?

Although research into adult stem cells is promising, adult stem cells may not be as versatile and durable as are embryonic stem cells. Adult stem cells may not be able to be manipulated to produce all cell types, which limits how adult stem cells can be used to treat diseases.

Adult stem cells are also more likely to contain abnormalities due to environmental hazards, such as toxins, or from errors acquired by the cells during replication. However, researchers have found that adult stem cells are more adaptable than was first thought.

What are stem cell lines and why do researchers want to use them?

A stem cell line is a group of cells that all descend from a single original stem cell and are grown in a lab. Cells in a stem cell line keep growing but don't differentiate into specialized cells. Ideally, they remain free of genetic defects

and continue to create more stem cells. Clusters of cells can be taken from a stem cell line and frozen for storage or shared with other researchers.

What is stem cell therapy (regenerative medicine) and how does it work?

Stem cell therapy, also known as regenerative medicine, promotes the repair response of diseased, dysfunctional or injured tissue using stem cells or their derivatives. It is the next chapter in organ transplantation and uses cells instead of donor organs, which are limited in supply.

Researchers grow stem cells in a lab. These stem cells are manipulated to specialize into specific types of cells, such as heart muscle cells, blood cells or nerve cells.

The specialized cells can then be implanted into a person. For example, if the person has heart disease, the cells could be injected into the heart muscle. The healthy transplanted heart muscle cells could then contribute to repairing the injured heart muscle.

Researchers have already shown that adult bone marrow cells guided to become heart-like cells can repair heart tissue in people, and more research is ongoing.

Have stem cells already been used to treat diseases?

Yes. Doctors have performed stem cell transplants, also known as bone marrow transplants. In stem cell transplants, stem cells replace cells damaged by chemotherapy or disease or serve as a way for the donor's immune system to fight some types of cancer and blood-related diseases, such as leukemia, lymphoma, neuroblastoma and multiple myeloma. These transplants use adult stem cells or umbilical cord blood.

Researchers are testing adult stem cells to treat other conditions, including a number of degenerative diseases such as heart failure.

What are the potential problems with using embryonic stem cells in humans?

For embryonic stem cells to be useful, researchers must be certain that the stem cells will differentiate into the specific cell types desired.

Researchers have discovered ways to direct stem cells to become specific types of cells, such as directing embryonic stem cells to become heart cells. Research is ongoing in this area.

Embryonic stem cells can also grow irregularly or specialize in different cell types spontaneously. Researchers are studying how to control the growth and differentiation of embryonic stem cells.

Embryonic stem cells might also trigger an immune response in which the recipient's body attacks the stem cells as foreign invaders, or the stem cells might simply fail to function as expected, with unknown consequences. Researchers continue to study how to avoid these possible complications.

What is therapeutic cloning, and what benefits might it offer?

Therapeutic cloning, also called somatic cell nuclear transfer, is a technique to create versatile stem cells independent of fertilized eggs. In this technique, the nucleus is removed from an unfertilized egg. This nucleus contains the genetic material. The nucleus is also removed from the cell of a donor.

This donor nucleus is then injected into the egg, replacing the nucleus that was removed, in a process called

nuclear transfer. The egg is allowed to divide and soon forms a blastocyst. This process creates a line of stem cells that is genetically identical to the donor's cells — in essence, a clone.

Some researchers believe that stem cells derived from therapeutic cloning may offer benefits over those from fertilized eggs because cloned cells are less likely to be rejected once transplanted back into the donor and may allow researchers to see exactly how a disease develops.

Has therapeutic cloning in people been successful?

No. Researchers haven't been able to successfully perform therapeutic cloning with humans despite success in a number of other species.

However, in recent studies, researchers have created human pluripotent stem cells by modifying the therapeutic cloning process. Researchers continue to study the potential of therapeutic cloning in people.

Annexure 10: Gene editing scenarios: current & future

Extracted from Colin Baker 'Can gene editing kill deadly diseases?'
https://www.aljazeera.com/features/2023/4/11/can-gene-editing-eliminate-deadly-diseases

The article points out that gene editing can be used either to cure deadly diseases or to prevent their transmission.

The first use of gene editing is for a patient suffering from a rare inherited disease. One of her genes encodes for a protein that doesn't perform its functions normally, and her degenerative ailment is most likely fatal.

Her option is a procedure that will remove cells from the affected organ, correct the inherited faults and reinfuse her cells, allowing her organ to perform its functions without the inborn errors.

This use of gene therapy is being tried worldwide and has some remarkable success. In the United States, more than two dozen such gene-editing therapies have been approved to tackle blindness, rare immune and genetic disorders, and some cancers.

However, it is very expensive, requiring a payment plan over a decade financed by a start-up, followed by chemotherapy and a hospital stay. Thus, it is only within the reach of a very small portion of the population. However, it is a one-time fix and, if side-effects appear later, doctors will study them.

The second use is in a situation where a couple who want to have a baby but who both carry a recessive gene which leads to a rare disorder. The geneticist proposes a plan for their unborn baby that after fertilisation, a few lines of the embryo's DNA will be altered to reverse the rare inherited disorder before it even starts and prevent it from being passed to their grandchildren.

In-embryo edits, leading to changes that would be replicated into reproductive cells and passed to future generations are presently banned by many governments.

But either or both of these applications of gene editing could become more common in the coming years. Although some gene-editing therapies are already available, a new generation of tools could refine and expand the search for cures to rare and serious inherited diseases. But making gene-editing treatments affordable and accessible to more than a few patients remains a challenge, and critical ethical and safety-related questions still need answers.

Sickle cell disease is a genetic disease affecting millions of people mostly in Africa and the US. The disease emerges from a single mutation in the human DNA and can shorten life expectancy by decades. In a clinical trial a person was cured by treatment with a CRISPR-enabled gene therapy for sickle cell disease. This person is among the first people ever to have been effectively "cured" of sickle cell anaemia, Therapies for sickle cell disease have not progressed much in years, and patients still look to painkillers, antibiotics and dietary supplements to manage their pain. The first "cure" by genome editing is expected to be approved by the US Food and Drug Administration in the next several months.

Research scientists are developing treatments for dozens of illnesses that were until recently thought to be only manageable, including genetic degenerative blindness, blood disorders that slow the body's ability to nourish itself and inherited cystic fibrosis that blocks the functioning of the lungs.

CRISPR is a genomic editing tool that combines genetic fragments with powerful proteins to find and alter targets on the human genome precisely. Urnov believes that the rarest of diseases will be treatable in the future but emphasises the complexity of the new method whilst he believes that the approach is now inevitable.

Urnov envisions a treatment protocol for rare, serious diseases that can be prepared for small disease populations or individual children. However, the vision is not yet reality and still requires technological and regulatory hurdles to be crossed.

Not all genetically inherited diseases can be attacked equally. Sickle cell anaemia lurks in the bone marrow, where red blood cells are made. The patient's bone marrow can be removed, its cells edited, the remaining cells cleared and corrected stem cells replenished into the body. Blindness in retina cells in the eye can be reached by eye injection (and eventually even an eye drop).

However, reaching cells in the brain or in muscle is more challenging although progress is being made quickly. And while most gene therapies have been delivered by modified viruses, which are tuned by evolution to find and alter a host's genome, new methods of delivery by small particles are on the horizon.

Genetic intervention therapies require a rethink of the role of medicine. Most are one-time infusions or extractions that alter the way a body makes cells, and they last for a lifetime. These genetic changes are irreversible and thus should be reserved for very specific conditions. Urnov states that CRISPR is for … "devastating disease for which there are no therapeutic options" and should not be used "to treat chronic conditions that currently can be managed with existing medication."

Urnov said that CRISPR interventions have been observed for only just over three years and will require monitoring for decades.

There are other ethical issues involved, such as that the highest burden of sickle cell disease, for instance, is in Africa, which is also where the newest treatments are likely to arrive last. That concern comes in part from a history of discriminatory healthcare practices involving how healthcare systems operate, how research infrastructures operate, how the scientific endeavour operates.

In the US, sickle cell patients are disproportionately Black, and the burden of the disease is high, costing health systems millions of dollars over the person's lifetime and countless years of lost productivity.

"It really is wound up in notions of exclusion, structural racism and how healthcare systems operate, how research infrastructures operate, how the scientific endeavour operates."

The first potential sickle cell disease cure is likely to reach tens of thousands of patients in the US and Europe. That is still a fraction of the about 100,000 people in the US only who suffer from the condition. Globally, more than 300,000 babies are born with serious blood disorders like sickle cell anaemia and beta thalassemia every year, most of them in Africa.

The treatment will provide a one-time cure for diseases that will otherwise cost patients and health systems several million dollars over a lifetime. Thus, Creary opines that consideration must be paid to "populations at hand that have access or don't have access to these technologies."

Ambroise Wonkam heads a pan-African research effort, H3Africa, which is building a database of genetic information from – and for – people who live on the world's most genetically diverse continent. One of H3Africa's goals is to identify the genetic targets that will fit the tailored medicines of the near future, in the way that a vaccine based on genomic sequence was delivered across the world to treat COVID-19.

"When COVID-19 shut down the whole world, no one would imagine we would develop a vaccine based on a

genomic sequence, an mRNA vaccine, and deliver across the world," Wonkam told Al Jazeera. "I can only imagine that if we have a similar programme, a really large programme that includes not only research but also equity, we could accelerate access the way COVID-19 access was done in weeks." This plan requires political will, policy and massive investment to allow it to happen.

Equity in vaccine distribution has previously been lacking. Africa had to wait too long for COVID-19 vaccines as shortages continued despite surplus stock in the Global North. Yet three years into the pandemic, mRNA-vaccine-making hubs have been launched in six countries in Africa to respond to future needs.

At present, many gene-editing regimes for sickle cell and other diseases are done *ex vivo*, or outside the body, in facilities run by specialists. Human cells are removed, edited and replaced. As *in vivo* – inside the body – techniques are refined, in which a one-time infusion or shot corrects a faulty gene, the technology could be scaled up and delivered to more recipients. Charitable groups are supporting research towards *in vivo* techniques for curing blood disorders and mitigating the burden of HIV infection.

Although only one CRISPR-based therapy is in front of American regulators at the moment, there are thousands of rare genetic diseases that could be targeted with CRISPR or similar methods, and millions of potential patients could benefit. Wonkam states that approval of the sickle cell therapy could speed up progress towards treatments for these other diseases.

Kevin Flanigan, a practicing neurologist and researcher, sees an end to inherited muscular disorders. Flanigan's clinic treats patients with Duchenne muscular dystrophy (DMD), a devastating genetic disease. It affects mostly boys and causes muscles to deteriorate from an early age, leading to serious complications. It is also a target for new interventions by gene therapies, including but not limited to CRISPR, to correct the inherited genetic code that causes a vital muscular protein to form incorrectly.

Still, that momentum carries its own risks, including creating public expectations that might be unreasonable. Some of the genetic interventions that Flanigan's team is working on will not reach the trial stage for several years, although families of patients are already asking for them in preference to standard treatment therapy.

Flanigan's team tackles a difficult scientific challenge too. Muscle is about half of a human's body mass, "an enormous number of [cell] nuclei we have to get into" with any potential gene-editing therapy. Additionally, the gene that his team is aiming to correct is one of the largest in the human genome: 2.4 million base pairs on the X chromosome.

Many beneficiaries of these cutting-edge therapies have been part of academic trials conducted in partnerships with drug companies to receive life-changing cures with the financial help of large institutions.

Others have developed trials for themselves or their family members. Families have raised enormous funds to treat their children. And safe, successful results are far from guaranteed. In 2022, two young people died after receiving a multimillion-dollar treatment for the fatal disease spinal muscular atrophy due to a known side-effect of the drug.

Drug companies, insurers and regulators do not yet have clear models for how to price one-time cures that cost immense sums and serve small sets of patients, and drugs have been pulled from markets after facing uncertainty over how to sell them.

Most scientists insist that the field is simply not ready for some of the more far-reaching approaches that in theory

are possible – such as the scenario of a family asking to edit an embryo to correct a genetic fault and prevent a disease before it starts.

Urnov considers that known risks “that we cannot mitigate are so severe that to even tempt human beings with this idea, it’s unethical.”

Those dangers are manifold: How does one gene function across the many stages of development as a zygote transforms into a child? How does it function over a lifetime? What if an edit misses its target? What if some cells are affected while others are not? By the time negative downstream effects are noticed, after a few cells became trillions, it could be too late to intervene.

“We’re tempting our fellow human beings with not just something untested, with something that’s unnecessary and where the risks extraordinarily outweigh the potential benefits,” Urnov said.

Indeed, as new treatments emerge – and previously untreatable conditions can be cured – those risks might be unnecessary.

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