

## NOTES / AANTEKENINGE

### REVISITING THE MAXIM *IMPERITIA CULPAE ADNUMERATUR* IN CONTEXT OF MEDICAL NEGLIGENCE – CAN THE MAXIM BE EXTENDED TO INCLUDE THE APPLICATION OF *LUXURIA*?

#### 1 Introduction

In any given context, negligence means that the defendant or the accused failed to foresee the possibility of harm (bodily/mental injury or death) occurring to another in circumstances where the reasonable person (*diligens paterfamilias*) in the defendant's or accused position would have foreseen the possibility of harm occurring to another and would have taken steps to avoid or prevent it. The generic test for negligence is thus one of foreseeability and preventability. Although the test for negligence is fundamentally objective, it does contain subjective elements when the negligence of an expert is assessed. Where the defendant or accused is an expert, the standard of negligence is upgraded from the reasonable layperson to the reasonable expert. Where the expert is a medical practitioner, the standard is that of the reasonable medical practitioner in the same circumstances (see *Mitchell v Dixon* 1914 AD 519; *Van Wyk v Lewis* 1924 AD 438; *S v Kramer* 1987 (1) SA 887 (W) 893; *Pringle v Administrator, Transvaal* 1990 (2) SA 379 (W); *Michael v Linksfield Park Clinic (Pty) Ltd* 2001 (3) SA 1188 (SCA); *Van der Walt v De Beer* 2005 (5) SA 151 (C); *Lee v Minister of Correctional Services* 2013 (2) SA 144 (CC); *Goliath v MEC Health Eastern Cape* 2015 (2) SA 97 (SCA); see also the discussion by Strauss and Strydom *Die Suid Afrikaanse Geneeskundige Reg* (1967) 265ff; Strauss *Doctor Patient and the Law* (1991) 243ff; Carstens and Pearmain *Foundational Principles of South African Medical Law* (2007) 619ff; Van Oosten "Professional Medical Negligence in Southern African Practice" 1986 *Medicine and Law* 18; see also Boberg *Law of Delict* (1984) 346: "Obviously the ordinary reasonable man test of negligence cannot be applied to an activity calling for expertise that the ordinary man does not possess. One cannot judge a surgeon's conduct by asking how a *diligens paterfamilias* would have operated, for either he would not have operated at all (which is the most likely) or, if he would have operated (in some rare emergency), he would no doubt have done worse than even the most barbarous surgeon"; cf Scott "Die Reel Imperitia Culpae Adnumeratur as Grondslag vir die Nalatigheidstoets vir Deskundiges in die Deliktereg" in Joubert (ed) *LC Steyn*

*Gedenksbundel* (1981) 124 126; McKerron *The Law of Delict* (1971) 38; Van der Merwe and Olivier *Die Onregmatige Daad in die Suid Afrikaanse Reg* (1989) 142; Van der Walt *Delict: Principles and Cases* (1979) 70; Neethling, Potgieter and Visser *The Law of Delict* (2014) 137; also of the general statement by Rumpff CJ in *S v Van As* 1976 (2) SA 921 (A) 928D–E). It is to be noted that the standard of care and skill, in context of medical negligence, required of a general practitioner is to be distinguished from the standard and care and skill required of a medical specialist. Simply stated, if the physician is a *general* medical practitioner, the test is that of the reasonable general practitioner. If the physician is a *specialist*, the test is that of the reasonable specialist with reference to the specific field of medical specialisation (see Strauss and Strydom *Die Suid Afrikaanse Geneeskundige Reg* 268; Van Oosten “Medical Law in South Africa” in Blanpain (ed) *International Encyclopaedia of Laws* (1996) 83 par 158). This principle is of particular significance as it has definite implications for the practice of medicine in a developing country as South Africa. Due to the shortages of medical services and qualified health care practitioners and/or compromised medical services, particularly in rural areas, health care practitioners (inclusive of doctors, nurses and paramedics) are often called upon to perform medical services for which they are, strictly speaking, not qualified to undertake – for example, a general practitioner in a small rural hospital may be required to administer anaesthesia to a patient despite not being a qualified anaesthetist; a nurse might be required to assist with the extraction of a tooth without being a dentist. The question arises, according to which yardstick they should be judged in instances of alleged negligence? The locality of practice and the *imperitia culpa adnumeratur* – rule are clearly also relevant factors in answering this question.

In view of the aforesaid, it is the aim of this note to revisit the meaning and application of the maxim *imperitia culpa adnumeratur* and its possible link with conscious negligence (*luxuria*) in context of medical negligence. It is to be noted, for purposes of this discussion, that the test for medical negligence is exactly the same in civil law as it is in the criminal law – it makes no difference whether a medical practitioner is sued civilly for damages or by a patient who alleges that he has been negligently treated or is prosecuted by the state. The burden of proof in criminal cases though, is heavier than in civil cases since in the latter the plaintiff must only prove his case on a balance of probability, whereas in the former negligence must be proven beyond reasonable doubt (see *R v Meiring* 1927 AD 41; *R v Van Schoor* 1948 (4) SA 349 (C); *R v Van der Merwe* 1953 2 PH H124 (W)).

## **2 The meaning and application of the maxim *imperitia culpa adnumeratur***

Although various South African writers have briefly discussed the meaning and application of the maxim in context of medical negligence (either in delict or criminal law) (see Barlow “Medical Negligence Resulting in Death” 1948 *THRHR* 175; Strauss and Strydom *Die Suid Afrikaanse Geneeskundige Reg* 267; Boberg *Law of Delict* 347ff; Neethling, Potgieter and Visser *The Law of Delict* 147; Claassen and Verschoor *Medical*

*Negligence in South Africa* (1992) 16; Van Oosten in Blanpain (ed) *International Encyclopaedia of Laws* 83; De Wet and Swanepoel *Strafreg* (1985) 159; Carstens and Pearmain *Foundational Principles of South African Medical Law* 628; Snyman *Criminal Law* (2014) 215), it is the research and analysis of the origin, scope, application and development of the maxim by Scott that is the most comprehensive and instructive and beyond contest (see Scott in Joubert (ed) *LC Steyn Gedenksbundel* 124ff). From this research it is to be noted that the maxim determines that want of training, knowledge, experience, skill competence or diligence is judged to amount to negligence (see Voet 9 2 23: "Lack of skill in an art on the part of one who puts that art up to sale or profess it is accounted as negligence... It follows that doctors, sellers of drugs and midwives who operate unskilfully, prescribe medicine to drink or inject poison, instead of medicine, are also held liable under this law" (Gane's translation)). Therefore, except in the case of emergency interventions, a medical practitioner who engages in an undertaking that requires a certain degree of training, knowledge, experience, skill, competence or diligence, well knowing that he or she lacks such qualities, will likewise be bound by his or her undertaking and judged accordingly. The principle also strikes at a medical practitioner who professes or pretends to be a medical specialist. Clearly, the rule's direct translation is misleading. Lack of skill can never in itself amount to negligence, for no one can be skilful at everything. *However, it may be negligent to undertake work requiring a certain expertise without possessing the necessary degree of competence* [authors' own emphasis]. It is also to be noted that the *imperitia*-rule (by implication) resonates and finds application in the Ethical Rules of Conduct for Practitioners Registered under the Health Professions Act (56 of 1974. In terms of GN R717 dated 4 August 2006, repealing GN R2278 dated 3 December 1976 and GN R1379 dated 12 August 1994, as amended by GN R1405 dated 22 December 2000). Annexure 6 of the said rules pertaining specifically to the medical professions state the following in terms of section 1 thereof:

"A medical practitioner or medical specialist – (a) shall perform acts only in the field of medicine in which he or she was educated and trained and in which he or she has gained experience, regard being had to both the extent and the limits of his or her professional expertise".

The abovementioned ethical rule in its most recent amended form (now rule 21 of the ethical rules of the Health Professions Council of South Africa [HPCSA]) now reads as follows:

"A practitioner shall perform, except in an emergency, only a professional act: (a) for which he/she is adequately educated, trained and sufficiently experienced; and (b) under proper conditions and in appropriate surroundings".

It is to be noted that the ethical rule of the HPCSA (Rule 27A inserted by r. 11 of GNR.68 of 2 February 2009) relating to the general responsibilities of a health practitioner, in context, is equally important in the assessment of the maxim. Rule 27A stipulates as follows:

"Main responsibilities of health practitioners – A practitioner shall at all times – (a) act in the best interests of his or her patients; (b) respect patient

confidentiality, privacy, choices and dignity; (c) maintain the highest standards of personal conduct and integrity; (d) provide adequate information about the patient's diagnosis, treatment options and alternatives, costs associated with each such alternative and any other pertinent information to enable the patient to exercise a choice in terms of treatment and informed decision-making pertaining to his or her health and that of others; (e) keep his or her professional knowledge and skills up to date; (f) maintain proper and effective communication with his or her patients and other professionals; (g) except in an emergency, obtain informed consent from a patient or, in the event that the patient is unable to provide consent for treatment himself or herself, from his or her next of kin; and (h) keep accurate patient records".

### 3 Application in case law

The rule/principle/maxim was invoked for the first time in South African law in 1916 in the context of medical negligence in the case of *Coppen v Impey* (1916 CPD 309). In this case, a physician took X-rays of a patient and through his incompetence caused severe burns to the patient. The court applied the *imperitia*-rule and Kotze J observed (314):

"Unskilfulness on his part is equivalent to negligence and renders him liable to a plaintiff, who sustained injury therefrom, the maxim of law being *imperitia culpa adnumeratur* (Inst 4 3 7); Van Leeuwen *Het Rooms-Hollandsche Recht* 4 39 4; Voet *Commentarius ad Pandectas* 9 2 23). The English law agrees with our own, as may be gathered from what was said by the great master of the common law of England, Tindal CJ in *Lamphier v Phipos* (8 C & P 475), and from numerous other decisions".

Another illustration of the application of the rule is the case of *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 himself by averring that he tried his best in accordance with his abilities and professional knowledge. If he is

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incompetent to treat a patient's specific illness he is obliged to refer the patient back to a specialist. A general practitioner will not however, be blamed for his lack of knowledge, training or experience if he undertakes specialist work in an emergency. This is a clear case of *imperitia culpa adnumeratur* i.e. where lack of skill is reckoned as a fault.

The case of *S v Mkwetshana* (1965 (2) SA 493 N) is often quoted as the best precedent for the application of the *imperitia*-rule in criminal law. A regional magistrate convicted the appellant, a medical practitioner, of culpable homicide. At the time of the incident in question, he was serving his internship for the 12 months succeeding his qualifying in his profession. In treating a female patient, he diagnosed a severe acute form of asthma and ordered 20 ccs of aminophylline – a recognised drug for treatment of asthma. He said that he administered this intravenously and waited for some five to seven minutes, but that, contrary to what one would expect, it did not relieve her condition. He then thought that this might be epileptic convulsions, which were not previously diagnosed, and he consequently decided to treat her with paraldehyde. The appellant ordered and administered 20 ccs of this drug intravenously. He watched the patient and said that her condition improved. However, the patient died shortly afterwards. The staff nurse said she died about 15 minutes after the administration of the paraldehyde that turned out to have been an overdose. The court commented that either the appellant knew insufficient about the drug and, nevertheless, took the risk – and imposed on his patient the risks involved in it – or he was aware of the risks and that it was a dangerous drug to use in the manner in which he was using it, in which case, equally, he would be guilty of negligence. Knowing nothing from his experience, and recollecting nothing from his training, he administered the drug in a quantity and in a manner that was dangerous for the patient, and indeed negligently caused her death. Consequently said the court, in those circumstances, the appeal failed.

It is submitted that this case is also consistent with the decision of the court in *R v Van Schoor (supra)*. It reinforces the legal precedent created by the latter. If one attempts a task for which one does not have the requisite knowledge, training or skill, one assumes the risk of adverse consequences arising from such lack of training, knowledge or skill.

The most recent example of the application of the *imperitia*-rule in the case law is that of *McDonald v Wroe* (2006 (3) All SA 656 (C)): The plaintiff consulted the defendant, a general dental practitioner, in regard to an infection she was experiencing in the area of her wisdom teeth. After examining the plaintiff, the defendant advised her that extracting three of her impacted wisdom teeth surgically under general anaesthesia was necessary. Subsequent to this surgical procedure, the plaintiff experienced numbness and a sensation of "pins and needles" when touching the left side of her face, as well as a feeling of numbness in the area of teeth 32 and 36. The medical experts all agreed that the said *sequelae* are permanent and have resulted in trauma caused to the inferior alveolar nerve on the left side of the mandible in the region of the extracted wisdom tooth 38. It is common cause that the roots of the wisdom tooth 38 were very close, if not on, the inferior

alveolar canal in which the said nerve is located. The plaintiff instituted a claim against the defendant for her damages that she allegedly suffered as a result of the damage caused to the said inferior alveolar nerve. The plaintiff's case, according to the pleadings, relied on the following grounds of negligence: a) that the defendant negligently failed to offer to refer the plaintiff to a specialist maxillo-facial and oral surgeon for the removal of her wisdom teeth; and/or b) that the defendant negligently failed to inform the plaintiff of the possible complications and risks of the planned procedure, save to inform her that there might be considerable swelling. In his original plea and amended plea, the defendant admitted that he did not offer to refer the plaintiff to a specialist surgeon, but denied that he was required to do so.

In its judgment, the court considered, *inter alia*, the application of the *imperitia*-rule (see par 6 of the judgment). Significant was the testimony of the specialist surgeons who testified on behalf of the plaintiff (Drs Ostrofsky and Berezowksy) who opined that the defendant ought to have referred the plaintiff to a specialist surgeon to perform the planned procedure, as this was not a straightforward case. The court also found that even if the plaintiff has consulted a general dentist at a later date, such general dentist, on the probabilities, would have referred her to a specialist surgeon. Although it was submitted by counsel for the defence that even if a specialist surgeon performed the procedure, the risk of permanent nerve damage would have remained the same, this submission, on acceptance of the testimony if the court rejected the plaintiff's expert witnesses. These expert witnesses were adamant that a specialist surgeon would have been better qualified than the defendant in dental surgery and therefore better equipped to deal with the surgical removal of wisdom teeth without damaging the inferior alveolar nerve. The court accordingly concluded that the defendant was liable for the damages that the plaintiff has suffered resulting from his wrongful and negligent omission.

This judgment illustrates the correct application of the *imperitia*-rule. In the context of the practical application thereof, it may be observed that it is imprudent for a general practitioner to venture onto a field of specialisation without having the necessary qualifications, skill and experience as required of a specialist. Irrespective of whether one applies the yardstick, if the "reasonable general dental practitioner" (as in this case) or the yardstick of the "reasonable maxillo-facial and oral surgeon" in the same circumstances to the interventions of the defendant, the result is the same: a reasonable general dental practitioner in the same circumstances would not have performed the surgery in question, and would have referred the plaintiff to a specialist. The reasonable maxillo-facial and oral surgeon in the same circumstances would have operated with more caution, bearing in mind the complexity of the surgery involving the inferior alveolar nerve. In essence, a reasonable maxillo-facial and oral surgeon would have foreseen the possibility of damage to the inferior alveolar nerve and would have taken steps to prevent any damage. It is for this reason that the imprudent undertaking by the defendant to perform surgery for which he was not qualified should be tested against that of the reasonable maxillo-facial and oral surgeon, and falling short of this standard, his actions are negligent.

#### 4 The nature of *luxuria*

Although *luxuria* (conscious negligence) has been recognised in delict (compare in general Neethling, Potgieter and Visser *The Law of Delict* 137ff), this form of fault (*mens rea*) has of late experienced a resurgence in criminal law as a result of judicial scrutiny of the relationship between intention and negligence (more in particular between *dolus eventualis* and *luxuria*) in context of the crimes of murder and culpable homicide. In this regard, more often than not, the nature and application of *luxuria* is explained/defined with reference to the nature and application of *dolus eventualis* (see *S v Ngubane* 1985 (3) SA 677 (A) 687E–I; *S v Qeqe* 2011 3 All SA 570 (ECG); *S v Humphreys* 2013 (2) SACR 1 (SCA); *S v Maarahanye* 2015 (1) SACR 337 (GJ); Snyman *Criminal Law* 218: see also *S v Ramagaga* 1992 (1) SACR 455 (B) 465–466; *S v Seymore* 1998 (1) SACR 66 (T); *S v Jara* 2003 (2) SACR 216 (TK); also compare Burchell *Principles of Criminal Law* (2013) 414; Louw “*S v Ngubane* 1985 (3) SA 677 (A): Strafreg – Die Oorvleueling van Opset en Nalatigheid” 1987 *De Jure* 173). It is, however, trite law that the crime of culpable homicide postulates an absence of *dolus* and the presence of *culpa* (see *S v Naidoo* 2003 (1) SACR 347 (SCA); compare De Wet and Swanepoel *Strafreg* 160). Reference can be made to the following explanatory *dictum* by Jansen JA in *S v Ngubane* (*supra* 685A–H):

“A man may foresee the possibility of harm and yet be negligent in respect of that harm ensuing, eg by unreasonably underestimating the degree of possibility or unreasonably failing to take steps to avoid that possibility... The concept of conscious (advertent) negligence (*luxuria*) is well known on the Continent and has in recent times often been discussed by our writers... Conscious negligence is not to be equated with *dolus eventualis*. The distinguishing feature of *dolus eventualis* is the volitional component: the agent (the perpetrator) ‘consents’ to the consequence foreseen as a possibility, he ‘reconciles himself’ to it, he ‘takes it into the bargain’... Our cases often speak of the agent being ‘reckless’ of that consequence, but in this context it means consenting, reconciling or taking into the bargain... and not the ‘recklessness’ of the Anglo American systems nor an aggravated degree of negligence. It is the particular, subjective, volitional mental state in regard to the foreseen possibility which characterises *dolus eventualis* and which is absent in *luxuria*.”

Clearly, both these forms (*dolus eventualis* and *luxuria*) of fault contain an element of actual subjective foresight of possible death/harm/personal injury ensuing as a result of the medical intervention, but there the similarity ends: the second leg of *dolus eventualis* entails a subjective reconciliation (or recklessness) to the possibility of death/harm/personal injury ensuing, while the second leg of *luxuria* entails that the accused/defendant doctor *unreasonably* decides that the result (death/harm/personal injury) will not ensue, while a reasonable person/reasonable doctor or medical specialist in the same circumstances would have foreseen such a result. *Luxuria* is still a form of negligence, not of intention. Seen in this way, the main difference between *dolus eventualis* and *luxuria* is not to be found in the presence or absence of the *foresight* of the result (the so called cognitive element), but whether or not the accused reconciled himself/herself to the foreseen possibility (result) (the so called volitional element) (see *S v Ngubane supra*

685D–F; also compare *R v Hedley* 1958 1 362 (N); *S v Beukes* 1988 (1) SA 511 (A) 521–522; *S v Maritz* 1996 (1) SACR 405 (A) 415b–416f–g; also see Burchell *Principles of Criminal Law* 408; Bertelsmann “What Happened To Luxuria?” 1975 *SALJ* 62; Labuschagne “Dolus Eventualis: Die Filosofiese Onderbou’ 1988 *SASK* 436; Loubser and Rabie “Defining Dolus Eventualis: A Voluntary Element” 1988 *SACJ* 415; Paizes “Dolus Eventualis Reconsidered” 1988 *SALJ* 636; see specifically the fierce academic debate preceding the decision of *S v Ngubane* (*supra*) with reference to Van Oosten “Dolus Eventualis en Luxuria – Nog ’n Stuiwer in die Armbeurs” 1982 *THRHR* 183; Morkel “Die Onderskeid Tussen Dolus Eventualis en Bewuste Nalatigheid: ’n Repliek” 1982 *THRHR* 321; Van Oosten “Weer Eens Dolus Eventualis en Luxuria: ’n Verduideliking Weens ’n Repliek” 1982 *THRHR* 423; Morkel “Weer Eens Dolus Eventualis en Luxuria” 1983 *THRHR* 87; also compare Hugo “Can Murder and Culpable Homicide Overlap?” 1973 *SALJ* 334; Van der Merwe “Moord en Strafbare Manslag: Laat Barabas Aan die Pen Ry” 1983 *THRHR* 82). The material distinction between *dolus eventualis* and *luxuria* is also fraught with difficulties when attempting formally to prove the presence or absence thereof in a court of law. This is usually achieved by way of inferential reasoning (*S v Sigwaha* 1967 (4) SA 566 (A) 570 (per Holmes JA): “Subjective foresight, like any other factual issue, may be proved by inference”).

## 5 Practical application

In view of the aforesaid it is submitted that the following practical example best illustrates the possible link to *luxuria* by invoking the maxim of *imperitia culpa adnumeratur*, in context of medical negligence: Dr Z, a recently qualified general medical practitioner, undertakes to perform a complicated tonsillectomy operation on N, a patient. Dr Z is aware of the fact that generally this operation should rather be performed by a surgeon and that he (Z), although having performed similar but less complicated surgical procedures as a registrar during his hospital year does not have sufficient experience and skill to perform the operation. However, feeling competent and confident, Dr Z nevertheless proceeds to perform the operation. As a result of the complications due to the operation unskillfully performed by Dr Z, N dies during the operation.

In determining Dr Z’s potential liability on account of medical negligence, it is submitted that the maxim of *imperitia culpa adnumeratur* should, in context, be invoked. Such invocation will inevitably point to the application of ordinary unconscious negligence (*culpa*) on one level, and conscious negligence (*luxuria*) on another level. It is apparent on the above facts, on the level of *culpa*, that Dr Z not having the necessary skill and experience to perform this operation is under a legal and ethical duty (see ethical rule 21 and 27A of the HPCSA) to refer the patient to a specialist surgeon. Failure to do so amounts to an omission and would also be negligent measured against the yardstick of the average competent reasonable medical practitioner in the same circumstances – in this regard it is to be noted that Dr Z’s failure to refer the patient on this level is not measured/assessed against the reasonable specialist surgeon as the duty to refer emanates from the doctor-patient



relationship on a primary level of contract/delict to refer the patient to an appropriate medical specialist where such referral in clinically and professionally indicated. The referral will undoubtedly also be in the best interest of the patient (as per Rule 27A of the HPCSA). In regard, the negligence of Dr Z is to be assessed against the reasonable general medical practitioner in the same circumstances.

On another level and in the undertaking/performance of the operation itself without the necessary skill and experience, it is argued that in this sense the maxim can be invoked to establish conscious negligence (*luxuria*) on the part of the defendant/accused-doctor. By applying the two-prong test for *luxuria* to Dr Z's conduct the formulation is as follows: First question: Did Dr Z subjectively foresee the possibility of death or injury to the patient due to his lack of skill and experience by nevertheless performing the surgery? Arguably the answer to this question has to be positive and the presence of subjective foresight will at the very least be proven by way of factual inference/inferential reasoning (as per *S v Sigwhala supra*); Second question: Did Dr Z fail to reconcile himself to such an eventuality/possibility of death or injury to the patient (telling himself that it will not happen and/or failing to take steps to prevent it), while a reasonable *specialist surgeon in the same circumstances* would have reconciled himself to such eventuality/possibility (it could happen in the hands of an unskilled and inexperienced general practitioner like Dr Z undertaking complicated surgery for which he is not qualified). Dr Z is negligent (on the basis of *luxuria*) because he subjectively foresaw the possibility of the patient's death/injury as a result of his undertaking of complicated surgery for which he is not qualified but he did not reconcile himself with that possibility while a reasonable surgeon in the same circumstances would have. It is to be noted for this level of negligence (*luxuria*) for which the maxim is invoked, that Dr Z's conduct is now not tested with the yardstick of the reasonable general practitioner in the same circumstances but with the speciality which skills and expertise he professed to have had, and that is the reasonable specialist surgeon in the same circumstances. The test is still objective but is "subjectified" to the professed level of the medical speciality. Consequently, Dr Z will be convicted of culpable homicide.

## 6 Conclusion

It is submitted that revisiting the maxim of *imperitia culpa adnumeratur* in context of its application in medical negligence law gives rise to a few considerations that may be instructive. In conclusion, it may be observed that the maxim (rule or principle) can be an assumption of medical negligence, but is not *in itself necessarily* indicative of medical negligence and not to be invoked in the air or in the abstract. A doctor (such as Dr Z in the above illustration) may still rely on a "reasonable error of clinical judgment" to escape liability (see the discussion by Carstens and Pearmain *Foundational Principles of South African Medical Law* 640ff). However, where the maxim's application is relevant, it ultimately serves to propel the attending defendant/accused-doctor's conduct/omission either through *culpa* or *luxuria* (as a form of fault) to establish liability (on the proven evidence). It

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is submitted that the case law is indicative that the courts have thus far accepted the application of the maxim to find liability of the attending doctor solely on the basis of *culpa* (or unconscious negligence) – hence the maxim *imperitia culpa adnumeratur* with the emphasis on *culpa*. It is to be noted that no South African case law could be sourced where the maxim was invoked in the context of medical negligence where the liability of the attending doctor was established on the basis of *luxuria* (or conscious negligence). However, there is no reason, in principle, why the maxim should not find the application on the basis of *luxuria*. After all, *luxuria* is still a variant of the generic *culpa* as opposed to *dolus*. It is submitted (as is apparent from the above practical illustration), that more often than not, the actions/omissions of the attending unskilful, inexperienced or incompetent doctor will incur liability on the basis of *luxuria* in context of the application of the maxim, while a failure to refer the patient to a medical specialist is an integral part of the maxim and will lead to legal liability (and ethical sanction) on the basis of *culpa*.

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