The Criminal Culpability of Health-Care Practitioners in South Africa[1]

A Dweba
LLB LLM
Department of Criminal and Procedural Law
Nelson Mandela University, Port Elizabeth, South Africa
National Prosecuting Authority
https://orcid.org/0009-0000-2866-5440

H Lerm
B Proc LLB LLM LLD
Department of Criminal and Procedural Law
Nelson Mandela University, Port Elizabeth, South Africa
South African Medico-Legal Association
https://orcid.org/0009-0002-3388-1118

E Gumboh
LLB LLM PhD
Department of Criminal and Procedural Law
Nelson Mandela University, Port Elizabeth, South Africa
Africa Oxford Initiative Visiting Fellow, Oxford University, United Kingdom
https://orcid.org/0000-0002-9286-6869

[1] This article also draws on the unpublished LLM thesis by Ms Asavela Dweba titled "The Criminal Liability of Healthcare Practitioners for Culpable Homicide", Nelson Mandela University, Gqeberha, 21 April 2022 supervised by Prof Henry Lerm and Dr Esther Gumboh, Nelson Mandela University and amplified by other sources referred to herein.

https://doi.org/10.17159/5ab0nb45

SUMMARY

Health-care practitioners are not superhuman. They are fallible and prone to making mistakes that have legal consequences. Mercifully, given that medicine is not an exact science and that anything can happen during a surgical procedure or otherwise, mistakes are not a frequent occurrence. From a legal perspective, it remains a challenge to distinguish inadvertence from wilful disregard for consequences. Health-care practitioners are anxious about the perceived eagerness of the law-enforcement agencies, including the South African Police Service and National Prosecuting Authority, to attach criminal responsibility to health-care practitioners and to pursue criminal charges against them, apparently without regard to what type of mistake has been made, nor the degree of deviation from the expected standard of care. The circumstances under which health-care practitioners work are also relevant. This article argues that health-care practitioners, like other professionals such as engineers and architects, as well as members of the community such as motorists where the circumstances so warrant, are criminally accountable for their actions. However, our law, unlike other foreign jurisdictions, does not recognise degrees of negligence in determining criminal liability. As the law in South Africa currently stands, an accused is either negligent or they are not. Even the slightest degree of negligence would be sufficient for the National Prosecuting Authority to sustain a conviction on a charge of culpable homicide. This article advocates that the threshold for measuring criminal culpability is too low, and that, in order to avoid unfair and unreasonable results, it should be increased to the level of gross negligence or recklessness. To achieve this, it will be necessary to bring about law reform in South Africa in cases involving all forms of professional liability, and other forms of criminal liability such as that involving motorists. The South African Law Reform Commission has recently announced that it will be investigating the matter under *Project 152 Criminal Liability of Healthcare Professionals*. It is expected that the Commission will call for submissions from all interested parties to assist in its investigation. It is also anticipated that the Commission will explore whether the South African legal system is ripe for a paradigm shift, adjusting the threshold for criminal liability in cases of culpable homicide. What is suggested is that South Africa should follow the legal systems of Scotland, New Zealand, India and England, which have all changed in the last few decades. The reason these legal systems have been chosen stems from the fact that they all have the same common-law heritage. The inception and initial application of the law of negligence in those countries, especially in criminal-law matters, closely resemble steps in the South African legal system. Ordinary negligence was originally the yardstick by which criminal conduct was measured and judged. Unlike South Africa's legal system, there have been distinct threads of development in the other legal systems. Because of the principles of fairness and public interests, countries like Scotland, New Zealand, India and England have all moved away from a low threshold involving ordinary negligence, to a high threshold that includes gross negligence or recklessness.

KEYWORDS: criminal culpability, threshold, culpable homicide, gross negligence, recklessness

1 INTRODUCTION

In recent years, the legal response to death caused by medical negligence has produced considerable upheaval among health-care practitioners and notable academic debate in South Africa.[2] Incidents that have caused

[2] Lerm and Stellenberg "South African Doctors Call for Law Reform, Fearing a Harsh Penalty if Patients Die" (21 February 2022) https://theconversation.com/south-african-Doctors-call-for-law-reform-fearing-a-harsh-penalty-if-patients-die-17518 (accessed 2022-12-19);

consternation among health-care practitioners include the conviction and subsequent successful appeal of Dr Danie van der Walt, an obstetrician and gynaecologist, who was charged with culpable homicide arising from an alleged act of negligence that led to the death of a patient. It was alleged by the prosecutorial staff that the accused failed to heed the nurses' calls to render timeous medical assistance, which ultimately led to complications and the death of the patient. The accused was subsequently acquitted on appeal.[3] That case was preceded by the case of Prof Peter Beale, an anaesthetist, and Dr Abdullah Munshi, a paediatric surgeon, who were both charged with a similar offence arising from the death of a 10-year-old boy shortly after an operation.[4] More recently, in a shock move, the South African police arrested a Richards Bay surgeon on a charge of murder; Dr Avindra Dayanand appeared in court on Friday, 26 August 2022, relating to the death in 2019 of a patient after surgery.[5]

Those incidents have triggered much alarm among health-care practitioners and medical societies, including the Medical Protection Society, Association of Surgeons of South Africa, Federation of South African Surgeons, Radiological Society of South Africa, South African Medical Association, and the South African Medico-Legal Association in South Africa.[6] They fear, *inter alia*, the readiness of the National Prosecuting Authority (NPA) arbitrarily to cause the arrest and prosecution of health-care practitioners on charges of murder or culpable homicide where, for example, mistakes are made in practice, leading to the death of patients or unexpected complications over which health-care practitioners sometimes have no control. Many practitioners have expressed their unwillingness to continue practising if they face the risk of arrest for murder upon the unexpected death of a patient.[7] Other concerns expressed by health-care practitioners include fast-moving and potentially hazardous health-care environments in which practitioners are prone to errors of judgement that they fear increase the risk of being criminalised. The prospect of facing criminal investigation or charges impacts their mental health. For a medical practitioner, there can be nothing more professionally damaging, and emotionally and mentally draining, than awaiting trial in instances where they

McQuoid-Mason "Liability of Doctors Based on Negligence for Culpable Homicide: No Need to Change the Law Concerning Medical Negligence or to Establish Special Medical Malpractice Courts – Use Mediation and Medical Assessors Instead" 2022 112(3) *South African Medical Journal* 216–218.

3 *Van der Walt v S* 2020 (11) BCLR 1337 (CC).

4 The child's death occurred hours after Dr Beale performed what was meant to be a routine operation to stop reflux. Dr Munshi has since died and the charge against Professor Beale has since changed to murder. The trial against Dr Beale has started and, at the time of writing, is running in the Gauteng High Court in Johannesburg.

5 Majozi "KZN Surgeon Arrested for Murder Following Death of a Patient – *SAPPF*" (30 August 2022) https://www.politicsweb.co.za/documents/kzn-surgeon-arrested-foll (accessed 2022-12-20).

6 Medical Brief "KZN Surgeon's Murder Charge Triggers New Alarm Among Doctors" (5 October 2022) https://www.medicalbrief.co.za/kzn-surgeons-murder-charge-trigger (accessed 2022-12-20).

7 *News 24* "Richards Bay Surgeon Faces Shock Murder Charge After Death of Patient" (5 September 2022) https://www.news24.com/news24/southafrica/news/surgeon-faces-sh (accessed 2022-12-20).

have put in earnest efforts to help a patient.[8] This continues to evoke widespread fear and concern for health-care practitioners in the current climate.[9]

It has also resulted in the exodus of health professionals and an ongoing threat by some to leave South Africa. What exacerbates the position is the adverse effect of such exodus on the South African health-care system.[10]

Owing to the very low threshold in South African law for blameworthiness when a patient dies under medical care, this article advocates for a higher threshold to measure the culpability of health-care practitioners in culpable homicide cases.[11] The low threshold for criminalisation when there is a lack of clear intent to cause harm is perceived as punitive and leaves health-care practitioners vulnerable to criminal charges and heavy-handed arrests.[12] The downside of using a low threshold that includes ordinary negligence amounts to this: although the loss by families of a loved one through tragic circumstances should not be underplayed, doctors risk losing their career and liberty, sometimes owing to an error of judgement or mistake, but in circumstances where the practitioner was only interested in caring for the patient.[13]

Health-care practitioners, like other citizens in this country (for example~~,~~ motorists), are accountable for their actions. Where their conduct is culpable, they are not immune from prosecution. However, this article pleads for law reform to be introduced in South Africa where accused persons are charged with culpable homicide. It is our argument and submission that the low threshold of ordinary negligence that serves as the yardstick to measure culpability in our current criminal justice system should be replaced by a higher threshold. Both gross negligence and, alternatively, recklessness could serve as the minimum standard. Not only would such a move result in avoiding adverse outcomes (including criminal prosecutions) owing to inadvertent human errors, but it would also lead to health-care practitioners and others being treated less harshly.

Law reform is a slow process and is often influenced by various role players. Bringing about legal changes in a legal system is often met with great resistance. In this regard, it is anticipated that both the South African Police Service and the Department of Justice may contend that the law as it stands, is fair. Healthcare practitioners, like all other members of society are

---

8 *Ibid.*

9 Govender "Doctors Say They Should Not Be Criminally Charged When Patients Die Due to Errors" (5 November 2021) https://www.timeslive.co.za/news/south-africa/2021-11-05-doctors-say-they-should-not-be-criminally-charged-when-patients-die-due-to-errors/ (accessed 2021-11-06).

10 Here, the Medical Protection Society under the stewardship of Dr Graham Howarth, Head of Medical Services has been very active. See the letter sent to the Minister of Justice, Mr Ronald Lamola, by the Medical Protection Society (MPS) dated 2 October 2020. The letter can be found at the offices of the Medical Protection Society.

11 *Ibid*.

12 Howarth and Behrman "Prosecuting Healthcare Professionals for Culpable Homicide – Who Benefits?" (22 January 2020) https://www.medicalbrief.co.za/archives/prosecuting-healtcare-professionals-for-culpable-homicide-who-benefits/ (accessed 2020-10-14).

13 Govender https://www.timeslive.co.za/news/south-africa/2021-11-05-doctors-Say-they.

accountable for their actions. Why should the yardstick in measuring the culpability of professionals be different to that of the ordinary members of society? So, they may argue.

Change is driven by the need for transformation and augmented by public-policy considerations that occur from time to time. Situations that threaten the public interest or public policy may induce the courts to effect changes considered to be equitable and in line with the sense of justice of the community.[14] This article highlights the need for South Africa's jurisprudence to change the threshold to measure the culpability of healthcare practitioners and so, align our law with international trends.

In addition to the considerations highlighted herein, the South African courts may also have regard to foreign law before bringing about law reform.[15] For that reason, before any reform is introduced in South Africa, it is useful to consider foreign jurisprudence as a means to determine whether other jurisdictions have undergone similar changes. If so, guidance will be sought from those jurisdictions to establish how they coped in bringing about reform. The countries identified and the reasons for choosing them have been stated earlier. A striking feature of the reform in those countries is that they have all moved away from a low threshold involving ordinary negligence to a high threshold that includes gross negligence, alternatively recklessness, when measuring criminal liability – including culpable homicide or manslaughter cases.

The introductory part of this article takes a brief look at the increase in the number of prosecutions of health-care practitioners – especially medical doctors and specialists. It highlights the increased concern of the medical fraternity. The first part of this article focuses on the criminal-law jurisprudence in South Africa, with specific reference to the criminal liability of health-care practitioners. This includes a brief discussion on the most frequent charges that practitioners face; these include murder and culpable homicide. It also highlights what the State needs to prove to sustain a conviction. The offence of culpable homicide occupies a special and problematic position in South Africa. What this chapter highlights is that the South African criminal justice regime fails to identify the degree of fault required for criminal conduct. A practitioner charged with culpable homicide may be convicted upon the slightest degree of negligence. In South Africa, the same degree of negligence is used to prove both civil liability and criminal culpability. This part identifies how far South African legal jurisprudence lags behind when compared with Scotland, New Zealand, India and England.

The second part of this article reveals the challenges those countries faced before bringing about paradigm shifts in their legal systems, and from which South Africa can learn. The third part of this article explains how law reform in South Africa should be introduced. This provides useful information to the South African Law Reform Commission, which may endeavour to find

---

14 *Bank of Lisbon & South Africa v Ornelas* [1988] ZASCA 35; [1988] 2 All SA 393 (A).

15 S 39(1)(*c*) of the Constitution of Republic of South Africa, 1996 (the Constitution).

a long-term solution to the issue at hand.[16] What follows is an investigation into the legal position in South Africa with regard to the culpability of health practitioners.

2 THE SOUTH AFRICAN LEGAL SYSTEM

Until the recent increase in the number of prosecutions of health-care practitioners, the South African criminal-law system appeared fairly settled. South Africa does not distinguish between the culpability of ordinary citizens and health-care practitioners. An act or omission without justification, leading to the death of another human being, will lead to culpability. It is trite law that *mens rea*, is an essential element for a crime involving blame or fault.[17] Under South African criminal law, *mens rea* takes two forms, namely intention and negligence.[18]

There are two common-law crimes that health-care practitioners may face while practising medicine. These offences are murder[19] and culpable homicide.[20] When dealing with common-law crimes, fault is one of the elements needed to prove the commission of an offence.[21] Fault in the form of intention may take the form of direct intent, also known as *dolus directus*. Snyman defines *dolus directus* as comprising a person "directing his will towards achieving the prohibited result or towards performing the prohibited act".[22] A *locus classicus* includes the case of *S v Hartmann*,[23] in which the court found a medical doctor guilty of a so-called mercy killing, for terminating his father's life with direct intent, notwithstanding that his motive for killing was good. In a more recent case, *S v Tembani,*[24] fault in the form of intent was established. In this case, the Supreme Court of Appeal (SCA) held a Tembisa man liable for the murder of his girlfriend after he inflicted a life-threatening wound on her that was readily treatable. However, the treatment she received at Tembisa Hospital was sub-standard and negligent. The SCA held that where an attacker with murderous intent inflicts a wound that will ordinarily cause death, the fact that subsequent medical treatment is negligent, or even grossly negligent, does not relieve the attacker from criminal responsibility for the injured person's death. The trial judge accordingly found that the negligence of the hospital and doctors was not, in the circumstances, so overwhelming as to make the original wound merely part of the history behind the patient's presence in the hospital, and so that it could be said that the death did not flow from the wound. Applying

16 *Ibid.*

17 Snyman *Criminal Law* 6ed (2014) 145.

18 Burchell *Principles of Criminal Law* 5ed (2016) 341.

19 Snyman *Criminal Law* 6ed (2014) 437. The author defines murder as "the intentional unlawful killing of another human being".

20 Snyman *Criminal Law* 6ed (2014) 442.

21 Burchell *Principles of Criminal Law* 5ed (2016) 60–63; Snyman *Criminal Law* 6ed (2014) 145.

22 Snyman's *Criminal Law* 6ed (2014) 177.

23 1975 (3) SA 532 (C); *Stransham-Ford v Minister of Justice and Correctional Services* 2015 (6) BCLR 737 (GP).

24 2007 (2) SA 291 (SCA).

a "flexible approach to causation" – one that was "practical" rather than "over-theoretical" – the judge considered that it accorded with justice to hold, in the juridical sense, that the medical negligence had not ousted the causal connection between the shooting and the deceased's death. The appellant was accordingly convicted of murder. The Tembisa Hospital was consequently exonerated from criminal liability.

Fault in the form of intention may also take the semblance of constructive intent known as *dolus eventualis*. Here, the accused foresees that their prohibited conduct could lead to the death of another person but reconciles themselves with the ensuing result.[25] The concept of *dolus eventualis* was dealt with in the case of *S v Pistorius* [26] In this case, Oscar Pistorius was arraigned to stand trial in the Pretoria High Court on 3 March 2014, and was charged with one count of murder. Pistorius won stardom as an athlete with a disability after successfully competing in multiple Paralympic Games and the 2012 Summer Olympics. He was charged after killing his model girlfriend Reeva Steenkamp in the early hours of the morning on 14 February 2013. The incident happened at his Pretoria home when he shot the deceased behind a toilet door of his apartment. Pistorius acknowledged that he shot Steenkamp but alleged that he mistook her for an intruder. He was convicted in the court *a quo* on a charge of culpable homicide, a competent verdict to a charge of murder. Pistorius was sentenced to five years' imprisonment. The case was later heard on appeal in the SCA. The verdict was altered to murder, and the appeal court imposed a sentence of 13 years and 5 months' imprisonment. What is significant is the appeal court's approach to the doctrine of *dolus eventualis*. The SCA stated that the defence of putative private defence or self-defence cannot be sustained and was no bar to a finding that he acted with *dolus eventualis* in causing the death of the deceased.[27] Consequently, the SCA held that, on count one in the indictment, the accused ought to have been found guilty of murder on the basis that he had fired the fatal shots with criminal intent in the form of *dolus eventualis*.[28] In analysing the concept of *dolus eventualis*, the SCA referred to the case of *Sigwahla*, where Holmes JA pointed out that the distinction must be observed between what actually went on in the mind of the accused and what would have gone on in the mind of a [reasonable person] in the position of the accused.[29] The court cautioned that the distinction between subjective foresight and objective foreseeability must not become blurred.[30] The appeal court found that the issue was not whether the accused had as his direct objective the death of the person behind the door. What was required in considering the presence or otherwise of *dolus eventualis* was whether he had foreseen the possible death of the person behind the door

---

[25] Burchell, Hunt, Milton and Burchell *South African Criminal Law and Procedure: General Principles of Criminal Law* Volume 1. 2ed Juta (1983) 148.

[26] (CC13/2013) [2014] ZAGPPHC (11/09/201).

[27] See *Director of Public Prosecutions, Gauteng v Pistorius* (96/2015) [2015] ZASCA 204; [2016] 1 All SA 346 (SCA); 2016 (2) SA 317 (SCA); 2016 (1) SACR 431 (SCA) (3 December 2015) par 55.

[28] *Director of Public Prosecutions, Gauteng v Pistorius supra* par 55.

[29] *S v Sigwahla* 1967 (4) SA 566 (A) 570–571.

[30] *Ibid*.

and reconciled himself with that event.[31] The appeal court found that at the time the fatal shots were fired, the possibility of the death of the person behind the door was clearly an obvious result.[32] The court also asserted that, in firing not one but four shots, the death of the deceased became even more likely.[33]

Where an accused foresaw the possibility of harm materialising as something less than a real possibility, but, instead as a remote possibility, conscious negligence rather than *dolus eventualis* would be present and the accused would be found guilty of culpable homicide.[34] It is unlikely that health-care practitioners would be convicted of such a crime where a patient dies while being treated. The difficulty lies in the State being able to prove that the health-care practitioner foresaw the possibility of the death of the patient and reconciled themselves with the death.

The law punishes not only unlawful acts that are committed intentionally, but also unintentional acts. Therefore, negligence is part of South African criminal law, especially in cases involving culpable homicide.[35] Here, fault may take the form of negligence, otherwise known as *culpa*.[36] It is generally the only common-law crime for which proof of negligence, as opposed to intention, is sufficient.[37] In a general context, negligence means that the accused has failed to anticipate the possibility of harm befalling another person in situations where a reasonable person in the same position as the accused would have foreseen the possibility of harm occurring to another, and would have taken steps to avoid or prevent it.[38] For a finding of negligence, it must be demonstrated that the accused's conduct did not meet the standard of care required by the law in the particular circumstances, and that they acted with guilt and thus can be blamed for the deed.[39]

The SCA further observed that the rhetorical question posed by the trial court when handing down judgment indicates that the trial court found the presence of a person behind the door not to have been reasonably foreseeable; but this conflicted with its later conclusion, which stated that the

---

31 *Director of Public Prosecutions, Gauteng v Pistorius supra* par 29.

32 *Director of Public Prosecutions, Gauteng v Pistorius supra* par 50.

33 *Ibid.*

34 Burchell *Principles of Criminal Law* 5ed (2016) 583–586.

35 Snyman *Criminal Law* 6ed (2014) 442 who defines Culpable Homicide as "the unlawful, negligent causing of the death of another human being".

36 *S v Ngubane* 1985 (3) SA 677 (A); see also Burchell *Principles of Criminal Law* 5ed (2016) 62–63.

37 *Kruger v Coetzee* 1966 (2) SA 428 (A); *Oppelt v The Head: Department of Health*, *Provincial Western Cape* 2015 (12) BCLR 1471 (CC); *R v Mbombela* 1933 AD 269; *S v Ngubane supra*.

38 Burchell *Principles of Criminal Law* 5ed (2016) 416–424; Carstens "Revisiting the Maxim *Imperitia Culpae Adnumeratur* in Context of Medical Negligence – Can the Maxim Be Extended to Include the Application of *Luxuria*?" 2017 38(3) *Obiter* 613–622 https://journals.co.za/docserver/fulltext/obiter_v38_n3_a9.pdf?expires=1595603499&id=id&accname=58211&checksum=CE9860C42A206BB9D9D65840AEAC8D60 (accessed 2020-06-16).

39 *Ibid.*

accused was guilty of culpable homicide on the basis that a reasonable person in the same circumstances would have foreseen the reasonable possibility that the shots would kill the person in the toilet.[40]

Furthermore, the finding that the accused had not subjectively foreseen that he would kill whoever was behind the door and that, if he had intended to do so, he would have aimed higher than he did, combines the test of what is required to establish *dolus directus* with the assessment of *dolus eventualis*.[41]

The SCA also stated that a court, blessed with the wisdom of hindsight, should always be careful of determining that, just because an accused ought to have foreseen a consequence, they must have done so.[42] It was held that the foreseeability of death was irresistible.[43]

The charge of culpable homicide is most frequently found in South Africa among drivers for negligence resulting in the death of passengers or others.[44] In medical negligence cases, culpable homicide is the only common-law crime for which a negligent practitioner can be held liable.[45] In South African case law, culpable-homicide convictions have resulted from negligent over-prescription of medicine,[46] a blood transfusion performed on the wrong patient,[47] an excessive amount of contrast medium administered to a baby,[48] failure to correctly insert an endotracheal tube and to monitor the patient properly during anaesthesia,[49] and failure by a general practitioner to call in a specialist obstetrician when complications set in during delivery.[50]

The test for negligence in South African criminal law is the same as in civil law. Whereas negligence in the general sense is tested against the criteria of the reasonable person,[51] in a medical context, it is tested against the criteria of the reasonable medical practitioner, the reasonable specialist or the reasonable nurse in the same circumstances.[52] The standard that is

---

40 *Director of Public Prosecutions, Gauteng v Pistorius supra* par 28.

41 *Director of Public Prosecutions, Gauteng v Pistorius supra* par 29.

42 *Ibid.*

43 *Ibid.*

44 Van Oosten "Professional Medical Negligence in Southern African Legal Practice" 1986 17(5) *Obiter* 22; *S v Naidoo* [2002] ZASCA 136; [2002] 4 All SA 710 (SCA).

45 Van Oosten 1986 *Obiter* 22.

46 *R v Van Schoor* 1948 (4) SA 349 (C); *S v Mkwetshana* 1965 (2) SA 493 (N); *R v Van der Merwe* 1953 2 PH H 24 (W).

47 *S v Berman* 1996 (T) (unreported).

48 Strauss "Oormatige Toediening van Kontrasmiddel: Strafbare Manslag [Excessive Administration of Contrast Medium: Culpable Homicide]" 1987 8(1) *S Afr Prac Mgmt* 27.

49 *S v Kramer* 1987 (1) SA 887 (W).

50 Strauss "Versuim van Geneesheer om Spesialis-Verloskundige by Probleem-Bevalling in te Roep, Stel Nalatigheid Daar [Failure of General Practitioner to Call in Specialist Obstetrician in Case of Complicated Delivery Constitutes Negligence]" 1988 9(1) *S Afr Prac Mgmt* 27; see also *S v Nel* 1987 TPD.

51 *Kruger v Coetzee supra* 430; Saner *Medical Malpractice in South Africa* (2018) 2–3.

52 Dutton *Medical Malpractice in South African Law* (2015) 89; see *Van Wyk v Lewis* 1924 AD 438 quoted by Saner *Medical Malpractice in South Africa* 2–3 to 2–4; see also the criminal

required is not that of the exceptionally skilled, gifted or diligent medical practitioner, but is rather the standard of the ordinary practitioner, in the branch of the profession to which they belong, who is acting reasonably.[53] One of a practitioner's professional obligations is the duty of care they need to show towards their patients. Any deviation from the duty of care leading to the death of a patient will result in criminal culpability. The court in the seminal case of *Mitchell v Dixon*[54] held that, as a rule, a medical practitioner is expected to exercise the degree of skill and care of a reasonably skilled practitioner in their field of practice. To minimise the risk to others, the law requires that the activity be carried out carefully, prudently and circumspectly.[55] Although civil law has not developed since the case was decided over a century ago, what must be borne in mind is the core investigation in this article focuses on the development of South African law in the criminal-law sphere. One of the broad arguments raised in this article is the hardship that using slight negligence as a yardstick for criminal culpability can cause health-care practitioners. Some of the challenges are discussed below.

In establishing liability for culpable homicide, our law does not require proof that the health-care practitioner acted in disregard of the patient's life and safety and that the health-care practitioner was aware that their conduct could result in the patient's death but nevertheless continued with the course of action.[56]

A problem with the South African system is that the criminal-justice regime fails to identify the degree of fault required for criminal conduct. An accused is either negligent or not.[57] The slightest degree of negligence could lead to criminal liability. What is troublesome is that health-care practitioners are required daily to make delicate decisions and to exercise a high degree of care and skill. What is inescapable in those circumstances is that even the most skillful and prudent doctor will, from time to time, omit something that should have been done, and that leads to the death of the patient. Yet, their conduct does not necessarily manifest a careless or insouciant approach towards the patient. In the sweep of a moment, the health-care practitioner may find themself in a court of law and being criminally charged with culpable homicide. It also matters not whether the health-care practitioner acted in good faith. A lack of care and an error in judgement will result in culpability where negligence is the cause of a patient's death, unless the law regards such conduct as excusable.[58]

position in the cases of *R v Van Schoor supra* 350; *R v Van der Merwe supra* 125; *S v Kramer supra*.

53 Dutton *Medical Malpractice in South African Law* 89.

54 1914 AD 519.

55 Burchell *Principles of Criminal Law* 4ed (2005) 522.

56 Dinnie "Medical Defence Doctors and Culpable Homicide" (04-09-2019) https://www.medicalacademic.co.za/ethics/doctors-and-culpable-homicide/ (accessed 2021-06-18).

57 *R v Van der Merwe supra*.

58 Dutton *Medical Malpractice in South African Law* 109.

Like all other persons, health-care practitioners are fallible and prone to making mistakes. This article raises the argument that it seems unfair to prosecute a medical practitioner for what may be little more than a slip. Eminent writer Alexander McCall Smith views slips as endemic in the everyday lives of health-care practitioners. He indicates that they are common in practice and arise from a slight deviation in methods routinely applied by practitioners.[59] This must also be viewed against the background of medicine not being an exact science. Medical practice in this regard is filled with uncertainties, with health-care practitioners often being confronted with the risks of uncertainty in treating patients. What is worse is that some practitioners find themselves in potentially hazardous environments in which they often need to make instant decisions that could result in errors of judgement, resulting in a patient dying and practitioners being criminally charged. This has led to considerable discontent among many South African health-care practitioners and their respective professional bodies in relation to the increase in prosecutions.

Some of the scathing criticism concerning this issue include the arbitrary, unreasonably harsh and counterproductive prosecutions that may emerge.[60] Whether or not a health-care practitioner is convicted, a prosecution may be catastrophic for the practitioner and their family. Going to jail will cause the practitioner to close their practice and be deprived of freedom of movement. Even where a practitioner is acquitted, they will suffer reputational harm and are likely to be removed from the roll of medical practitioners. Removing a practitioner from the roll of practitioners, especially those who are not "bad" doctors, can be counterproductive to the medical profession. It may cause an exodus of health-care practitioners who fear that, if they make a mistake, they may walk the same path, ending up in prison. The importance of health-care practitioners to health care in South Africa cannot be overemphasised. This is not to say that a health-care practitioner should not be prosecuted where bad clinical care, or omissions where clinical care was necessary, lead to the death of a patient. What is advocated is that where gross negligence or recklessness is established, the practitioner ought to be charged.

What South Africa urgently needs is a paradigm shift, raising the threshold from slight negligence to gross negligence or recklessness as the yardstick by which the criminal conduct of medical practitioners is measured and judged.

Because the NPA does not appear to have a firm policy regarding a standard threshold for when to charge a health-care practitioner, arbitrary prosecutions could result. A major concern is that the slightest negligent mistake leading to the death of a patient could cause the NPA to set the wheels in motion to charge a health-care practitioner with culpable homicide, which may end in the practitioner receiving a jail sentence.

---

[59] McCall Smith "Criminal or Merely Human? The Prosecution of Negligent Doctors" 1995 12 *Journal of Contemporary Health Law and Policy* 131 136.

[60] Dr Howarth "Doctors in the Dock: Should Healthcare Professionals Be Criminally Charged for Medical Negligence?" (16 January 2020) https://www.medbrief.namibia.com/doctrine-in-criminally-charged-for-medical-negligence/ (accessed 2021-11-15).

It is contended in the section dealing with how reform should be introduced in South Africa that the NPA's readiness to pursue prosecutions fairly depends very much on an effective investigative mechanism, amplified by the provisions of the Inquest Act.[61]

An inquest is not a trial but rather, as the term suggests, a public inquiry presided over by a magistrate or judge. It is suggested that the magistrate or judge appointed to hold the inquiry should be assisted by an expert assessor or assessors sufficiently endowed with the necessary medical expertise to assist the presiding officer with very technical and complex matters not known to the judge or magistrate. The purpose of the inquest is to establish how the death occurred and who is to be blamed. In a medical malpractice context, an inquest may play an important role in the initiation of criminal proceedings for culpable homicide or murder against a medical practitioner who is alleged to have caused the death of a patient in a negligent or intentional manner. It can serve as a front-runner for a later criminal prosecution. As part of its investigative mechanism, the inquest may also flesh out to what degree a health-care practitioner has deviated from the standard of care and so establish whether they are culpable, especially in light of the suggested law reform that is envisaged. An inquest will also ensure that the offence of culpable homicide fairly represents an offender's wrongdoing.[62]

It should be noted that South Africa has not been alone in seeking law reform regarding medical culpable homicide because of the unfairness brought about by the low threshold for charging medical practitioners.[63] The foreign jurisdictions of Scotland, New Zealand, England and India have been chosen for a comparative study with the South African criminal legal system pertaining to the crime of culpable homicide as it affects health-care practitioners.

3 THE SCOTTISH LEGAL SYSTEM

Scottish law, like South Africa's, recognises both murder and culpable homicide as offences.[64] The offence of culpable homicide occurs when a person is killed in circumstances where the perpetrator lacks the malicious intent to kill, or the wicked recklessness required for murder.[65] The rationale for punishing a perpetrator for culpable homicide can be found in society's

61 58 of 1958.

62 Ashworth "Is the Criminal Law a Lost Cause?" 2000 (116) *Law Quarterly Review* 225.

63 Robson, Maskill and Brookbanks "Doctors Are Aggrieved – Should They Be? Gross Negligence Manslaughter and the Culpable Doctor" 2020 84(4) *The Journal of Criminal Law* https://doi.org/10.1177/0022018320946498 (accessed 2021-08-21) 312.

64 McDiarmid *Killings Short of Murder: Examining Culpable Homicide in Scots Law* (2018) https://strathprints.strath.ac.uk/66383/ (accessed 2025-01-28) 1; Bohlander, Wake, Engleby and Adams *Homicide in Criminal Law: A Research Companion* (2018) 21–36.

65 Law Society of Scotland "Culpable Homicide" (20 January 2021) https://www.lawscot.org.uk/media/wxrdpkik/2021-01-20-crim-culpable-homicide-s-bill-stage-1-briefing.pdf (accessed 2025-01-28) 6.

repugnance at the taking of someone's life, albeit not deliberate, but still reprehensible.[66]

Unlike the English legal system, the Scottish system does not recognise the offence known as gross negligence manslaughter found in England where it is used widely and not just in medical cases.[67] However, what is common to the English, Scottish and South African jurisdictions is that the Crown or the State, being responsible for criminal prosecutions, is required to prove the presence of negligence.

The Scottish standard for culpable homicide prosecutions is also said to be potentially harder to achieve than gross negligence manslaughter in England and Wales.[68] Equally, formulating the charge in Scotland has at times proved quite onerous, especially where the death of another through a mere mistake renders the agent of the death so little blameworthy that the question may be whether to prosecute at all.[69] What the Scottish Crown must show to sustain a conviction is that the defendant's conduct was unlawful and that the act was reckless or extremely careless and that the death was a direct result of the unlawful act.[70] Both recklessness and carelessness point to something more than ordinary negligence. The core nature of criminal negligence has sometimes been referred to by the courts as "grossness",[71] "wantonness",[72] or even "wickedness",[73] alternatively, "negligence seen as deserving of criminal punishment".[74] In other words, the accused's negligence showed such disregard for the lives and safety of others as to amount to a crime against the Crown and to be deserving of punishment.[75] The Scottish legal system, besides using the high bar of recklessness as the starting point for culpability, also requires that any prosecution must be in the public interest.[76] Recklessness usually involves acting in the face of a known risk of harm[77] and running the risk that these consequences materialise.[78] Social harm is posed by reckless conduct where the conduct exposes the community to the possibility of harm, even if the harm does not materialise.[79] Before recklessness can be considered culpable, it must be shown that the accused knew of the risk that their

---

66 McDiarmid https://strathprints.strath.ac.uk/66383/ 21.

67 Law Society of Scotland "Medical Death: A Case to Answer" (17 September 2018) https://www.lawscot.org.uk/members/journal/issues/vol-63-issue-09/medical-death-a-case-to-answer/ (accessed 2025-01-28).

68 *Ibid*.

69 *Ibid.*

70 *Ibid.*

71 *R v Horvath* (1972) VR 533.

72 *R v Greisman* (1926) 46 CCC 172.

73 *Moore v R* (1926) SASR 52.

74 *Ibid.*

75 Gordon *The Criminal Law of Scotland* 2ed (1978) 790.

76 Robson *et al* 2020 *The Journal of Criminal Law* 312–340.

77 McCall Smith "Criminal Negligence and the Incompetent Doctor" 1993 1 *Med L Rev* 336 340 340–341.

78 Barton "Recklessness in Scots Criminal Law: Subjective or Objective?" 2011 *Juridical Review* 143.

79 *HM Advocate v S* (unreported) (15 October 1999) High Court of Justiciary.

behaviour entailed.[80] If this requirement is met, then the accused may appropriately be called to account and be punished.[81]

Culpable and reckless conduct is said to constitute intentional behaviour where the actor exposes individuals or the public at large to danger, including death or serious injury.[82] As the crime's name signifies, the behaviour must be reckless.[83] Recklessness refers to conduct that has a total disregard for the consequences of an actor's actions.[84] The nature of the crime excludes any accidental conduct.[85]

The Scots have cardinalised the *mens rea* element for the crime of reckless endangerment. The presence of foreseeable risk is, therefore, a prerequisite.[86] The principle *actus non facit reum nisi mens sit rea* holds that an act cannot be reprehensible unless the mind is also guilty.[87] The causing of death is punishable where it violates the sanctity of life or infringes a victim's right to life. A guilty mind is a factor that determines the seriousness of culpable homicide.[88]

With regard to offences involving health-care practitioners, Scottish law, unlike its English counterpart, is not replete with reportable cases decided by its courts. Since 2018, the only case involving culpable homicide was the prosecution of a doctor, Katy McAllister, who was acquitted after the trial.[89] Most Scottish cases involve prosecutions of the National Health Services (NHS) and Health Boards under Scottish common law.[90]

To bring about greater consistency in when prosecutorial staff should charge an alleged suspect with culpable homicide, the Scottish parliament investigated possible law reform. The (Scotland) Bill was tabled in the Scottish Parliament on 1 June 2020 but was not passed. The idea was to create statutory culpable homicide offences relating to recklessness and gross negligence.[91]

Scotland, as does England, uses inquests as a mechanism to determine *inter alia* whether health practitioners should be criminally charged. The Lord

---

80 McCall Smith 1993 *Med L Rev* 336 340.

81 Alison *Principles* (1832) 92 113–126.

82 Crosbie "A Work-In-Progress Guide to Scottish Criminal Law" (undated) https://crime.scot/culpable-and-reckless-conduct/ (accessed 2021-10-01).

83 The Scottish Law Commission in 2003 in a draft Legal Code described recklessness as: "a) something is caused recklessly if the person causing the result is, or ought to be, aware of an obvious and serious risk that acting will bring about the result but nonetheless acts where no reasonable person would do so ... ."

84 *Ibid.*

85 Crosbie https://crime.scot/culpable-and-reckless-conduct/; see also McCall Smith "Criminal Negligence and the Incompetent Doctor" 1993 1 *Med L Rev* 336.

86 *Cameron v Maguire* 1999 JC 63.

87 McDiarmid https://strathprints.strath.ac.uk/66383/ 22–23.

88 *Ibid.*

89 BBC News "Doctor Acquitted Over Friend's Drug Death" (26 May 2017) https://www.bbc.com/news/uk-scotland-tayside-central-40057847 (accessed 2021-10-20).

90 Pollock and Dematagoda "Doctors in the Dock: Are the Courts Moving Towards Assigning Criminal Liability to Health Professionals?" (undated) https://peacockjohnston.co.uk/doctors-in-the-dock/ (accessed 2021-11-07).

91 *Ibid.*

Advocate is Scotland's independent prosecutor with constitutional responsibility for investigating all sudden, suspicious, unexpected and inexplicable deaths. The Crown Office and the Procurator Fiscal Service (COPFS) oversee this on behalf of the Lord Advocate.[92] Their investigation processes are the same as each other, and the result will determine what route if any, the investigation into the death should take.[93] The COPFS unit was established to promote openness in the decision-making process in both prosecutions and fatal accident inquiries in which the Lord Advocate plays an oversight role.[94] The Lord Advocate has a wide discretion in deciding *inter alia* whether it is in the public interest for a doctor to be prosecuted for culpable homicide, and/or in whether to order a fatal accident inquiry. This system also allows the Lord Advocate to decide objectively whether the death gives rise to matters of "significant public concern".[95] The role of the Lord Advocate in authorising the prosecutions of health professionals in Scotland is also noteworthy. In this regard, it is expected of the Lord Advocate to certify that it is in the public interest to charge and bring prosecutions against health practitioners.[96] It has been mooted that such an approach promotes consistency in each case in which factors such as the circumstances of the death, the sufficiency of the evidence, and what has been learned are closely considered.[97] It needs to be emphasised that the Scottish legal system requires a high degree of sufficiency of evidence before a suspect is charged.[98] That probably accounts for fewer people, including doctors, being charged with culpable homicide.

4 THE NEW ZEALAND LEGAL SYSTEM

The crime of culpable homicide is unknown in New Zealand. The comparable crime is known as negligent manslaughter. Depending on the circumstances of a case, the National Prosecuting Authority may charge an accused with a statutory offence where the offence arises from the death of a person without lawful excuse.[99] The offence is committed when, without lawful excuse, there is an unlawful act or an omission to perform or observe a legal duty or both.[100] The legal duty is imposed on motor vehicle drivers as

---

92 Hamilton "Independent Review of Gross Negligence Manslaughter and Culpable Homicide" (June 2019) https://www.gmc-uk.org/-/media/documents/independent-review-of-gross-negligence-manslaughter-and-culpable-homicide---final-report_pd-78716610.pdf (accessed 2021-10-01) 42.

93 Law Society of Scotland https://www.lawscot.org.uk/members/journal/issues/vol-63-issue-09/medical-death-a-case-to-answer/ 2.

94 Law Society of Scotland https://www.lawscot.org.uk/members/journal/issues/vol-63-issue-09/medical-death-a-case-to-answer/ 2.

95 *Ibid.*

96 Medical Protection Society "English Law on Gross Negligence Manslaughter in Healthcare Must Move Towards Scottish Position" (13 March 2018) https://www.medicalprotection.org/uk/join (accessed 2021-11-10).

97 *Ibid.*

98 *Ibid.*

99 S 155 of the New Zealand Criminal Code.

100 Robson *et al* 2020 *The Journal of Criminal Law* 322.

well as health-care practitioners, among others.[101] Negligent manslaughter was first criminalised under the Crimes Act in 1961.[102]

In a medico-legal sense, if a patient dies owing to a doctor's failure to exercise reasonable knowledge, skill and care, the practitioner may be charged with manslaughter.[103] What the Crown must show is that the actor acted unlawfully by breaching their professional duty.[104] The rationale for regarding an unlawful act as a crime stems from the promotion of public safety.[105]

Significantly, the threshold for negligent conduct before law reform was introduced in New Zealand in 1997 was low and took the form of ordinary negligence.[106] This included mistakes through carelessness or even errors arising from emergency situations.[107] Mitigating factors in the case of health-care practitioners were primarily relevant to sentencing rather than to the question of whether the doctor should be convicted. The position was the same as we experience in South Africa at present. It did, however, lead to some criticism, especially among medical practitioners and academics in New Zealand.[108] However, it was not until the case of *R v Yogasaharan*[109] that real calls for law reform within New Zealand gathered momentum.[110] The case concerned a doctor who should have administered Doxapram, but instead, and in haste, used the ampule Dopamine. The two drugs were erroneously put together in the same container. The patient sustained fatal physiological stresses and died shortly thereafter.[111] The doctor's honest mistake resulted in the death of the patient. After his conviction in the court *a quo* on a charge of negligent manslaughter*,* the Appeal Court dismissed the appeal. The court found that a reasonable anaesthetist would not have breached their duty by failing to check the packaging of the drug, regardless of the circumstances.[112]

What followed was a flurry of cases in which the New Zealand prosecutorial staff set in motion a few prosecutions against health-care

---

101 Merry "Mistakes, Misguided Moments, and Manslaughter" 2009 41(1) *J Extra Corpor Technol* 2–6; *R v Dawe* 1911 30 NZLR 673; *R v Storey* 1931 NZLR 417 432. For the more recent seminal case involving a health-care practitioner, see *R v Yogasakaran* [1990] 1 NZLR 399.

102 The Crimes Act 43 of 1961.

103 Collins "New Zealand's Medical Manslaughter" 1992 11(2) *Medicine and Law* 221.

104 See Merry and McCall Smith *Errors, Medicine and the Law* (2001) 3 with reference to s 155 of the Criminal Code, which states: "Duty of persons doing dangerous acts: Everyone who undertakes (Except in a case of necessity) to administer surgical or medical treatment, or to do any other lawful act the doing of which is or may be dangerous to life, is under a legal duty to have and to use reasonable knowledge, skill, and care in doing any such act, and is criminally responsible for the consequences of omitting without lawful excuse to discharge that duty."

105 S 160(2) of the Crimes Act 1961.

106 The Crimes Amendment Act 88 of 1997.

107 Merry 2009 *J Extra Corpor Technol* 5.

108 Merry 2009 *J Extra Corpor Technol* 4.

109 (1990) 1 N2 LR 399 (CA).

110 Merry and McCall Smith *Errors, Medicine and the Law* 3.

111 *R v Yogasaharan supra* 401.

112 *R v Yogasaharan supra* 405.

practitioners who were charged with negligent manslaughter, arising from varying degrees of culpability.[113] This caused a widespread unease among medical professionals. Those working in high-risk specialities felt particularly vulnerable.[114] What followed was the establishment of a New Zealand Medical Law Reform Group, consisting of several plastic surgeons and anaesthetists who felt particularly vulnerable.[115] The group's aim was to bring about law reform in New Zealand and to seek a proper balance between the criminal code and other means of accountability in medicine.[116] The group sought reform that was not limited to the medical profession, but included everyone, including motorists.[117]

Some of the salient arguments advanced by academics in New Zealand include the following. Robson *et al*[118] suggest that, besides criminalising negligent doctors, some may face professional disciplinary proceedings. Others concentrate on the harm imprisonment may bring to health-care practitioners – for example, the public shunning the doctor on inadequate grounds.[119] To avoid professional ruin, some critics suggest "civil action".[120]

Some of the main policy concerns were raised by Sir Duncan McMullin,[121] who promoted the equitable idea of adopting a higher threshold to prove criminal liability involving health-care practitioners charged with manslaughter. McMullin advanced the idea of practitioners being encouraged to report mistakes in order to remove the fear of punishment for minor mistakes. In his view, this would counter defensive medical practices and practitioners refusing to administer dangerous treatments.[122] McMullin also promoted the idea of aligning with foreign jurisdictions where countries had moved away from the threshold of an ordinary standard of care and adopted a gross negligence standard to measure criminal culpability involving medical mistakes.[123] He also believed that it would promote consistency among common-law jurisdictions[124] and allow judges to seek

---

113 Merry "When Are Errors A Crime? – Lessons From New Zealand" in Erin and Ost *The Criminal Justice System and Healthcare Coup* (2009) 257; see the cases of *R v Morrison* (unreported and delivered by Fraser J in the High Court Dunedin in 1991) and *R v Brown* (unreported and delivered by Gallen J on May 1994 in the High Court, Wellington 6 May on 1994) in each of which health-care practitioners were convicted – cited by Manning H *Consequences of the Yogasakaran Decision: A Review of New Zealand's Medical Manslaughter Law* (LLB (Honours) Treatise, Victoria University of Wellington) 1 September 1994 5–6.

114 Merry 2009 *J Extra Corpor Technol* 4.

115 *Ibid.*

116 The New Zealand Medical Law Reform Group Crimes Amendment Bill (No 5) 1996 "Medical Manslaughter" Submission (1997) cited in Merry 2009 *J Extra Corpor Technol* 3.

117 Merry 2009 *J Extra Corpor Technol* 4.

118 Robson *et al* 2020 *The Journal of Criminal Law* 321–322.

119 Tadros *Fair Labelling and Social Solidarity* (2012) 70.

120 Brazier and Alghrani "Fatal Medical Malpractice and Criminal Liability" 2009 25(2) *Journal of Professional Negligence* 56.

121 McMullin *Report of Sir Duncan McMullin to Hon Douglas Graham, Minister of Justice, on Sections 155 and 156 of the Crimes Act 1961* (1995) 12.3.

122 *Ibid*.

123 McMullin *Report of Sir Duncan McMullin to Hon Douglas Graham, Minister of Justice, on Sections 155 and 156 of the Crimes Act 1961* 4.2, 5.1, 6.0.

124 *Ibid.*

guidance from foreign court judgments.[125] This is a principle known to South Africa and provided for by the South African Constitution.[126] It is argued by this article that South Africa should heed McMullin's call to bring about law reform.

After much lobbying, the New Zealand Medical Law Reform Group was instrumental in having the traditional Crimes Act[127] amended in 1997. The Crimes Amendment Act[128] incorporated a new section, namely section 150A, which changed the standard of proof, raising the level to higher than just ordinary negligence. Section 150A(2) provides for "a major departure from the standard of care expected of a reasonable person".[129] A charge of manslaughter will be filed against the wrongdoer if a major departure from the prescribed standard can be demonstrated. The "major departure test" is said to be beneficial to those surgeons or other health practitioners who operate in error-ridden activities and who are exposed to the risk of prosecutions because of the vital work they do, often at the mercy of moral luck.[130] Put simply, some practitioners are just lucky that patients do not die in their hands. In those settings, criminal law should only be used in cases of deliberate harm or recklessness.[131]

Since the 1997 law reform in New Zealand, these types of case are said to have become rare.[132] Health professionals are now encouraged to report any unintended, unexpected or unplanned events to their Health Quality and Safety Commission. The Commission in turn runs an adverse-event learning programme that revisits events and shares lessons learned to improve consumer safety.[133] It is suggested that South Africa take a leaf from the law reform experience in New Zealand and adopt those principles most suitable to our own environment.

5 THE INDIAN POSITION

Because of the historical ties between the United Kingdom and India, the Indian legal system has over centuries been especially influenced by the English legal system, both in civil and criminal law. English precedent-setting cases[134] had a tremendous effect on Indian jurisprudence. The test

---

125 *R v Hamer* [2005] 2 NZLR 59.

126 S 39(1) of the Constitution of the Republic of South Africa, 1996 (Constitution).

127 43 of 1961.

128 88 of 1997.

129 S 150A of the Crimes Amendment Act 88 of 1997. The change in the law was illustrated in a New Zealand Appeal Court decision in *R v Powell* [2002] 1 NZLR. The court held in this case that the "major departure" test applied not only to manslaughter by omission to perform a legal duty, but also to manslaughter (under s 160(2)(*a*) of the Crimes Act of 1961) by an unlawful act involving either carelessness or negligence.

130 Quick "Prosecuting Gross Medical Negligence: Manslaughter, Discretion and the Crown Prosecution Service" 2006 33(3) *Journal of Law and Society* 421.

131 *Ibid.*

132 Merry and McCall Smith *Errors, Medicine and the Law* 41.

133 *Ibid.*

134 Civil terrain cases like *Donoghue v Stevenson* [1932] UKHL 100 and *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118; [1957] 1 WLR 582 have left their

established in *Bolam's* case for determining medical negligence is still valid.[135] The idea of negligence is defined differently in civil and criminal law in India. What may constitute negligence in civil law is not always negligence in the criminal-law sense. The element of *mens rea* must be present for negligence to be considered a criminal offence. The degree of negligence must also be substantially higher than ordinary negligence for a health-care practitioner's conduct to constitute a criminal act. Deviation from the standard of care towards a patient needs to be gross or extremely high for an act or omission to be considered criminal negligence. Negligence that is neither gross nor of a high degree may give rise to civil action, but cannot be used to prosecute an accused.[136]

Criminal action and the bringing of charges against health-care practitioners are regulated under the Indian Penal Code, 1860 (the Code), as amended.[137] The concept of culpable homicide is defined in section 299 of the Code.[138] According to this section:

> "A person commits culpable homicide if he or she executes an act with the intent to kill/cause the death of another person, or with the intent to cause such bodily injury that it is likely to kill another person, or with the knowledge that such acts are likely to kill another person."[139]

Section 304 of the Code expands on the idea of culpable homicide, which does not amount to murder.[140]

Although the word "gross" is not used in section 304A of the Code, it is well established that in criminal law, negligence or recklessness must be of such a high degree to be considered "gross". The phrase "rash or negligent act", as used in section 304A of the Code, must be construed with the qualifier "grossly". To prosecute a medical practitioner for negligence under criminal law, it must be demonstrated that the accused did or failed to do something that no medical professional using their usual senses and prudence would have done or failed to do in the given facts and circumstances. The risk taken by the accused doctor should have been such that the injury or death that ensued was most likely imminent. However, to be penalised for criminal negligence, the degree of negligence must be so severe that it goes beyond the need only for compensation. Insofar as the harm is concerned, it must be inflicted not only on the victim but also on

imprint on the Indian common-law position on professional negligence, especially concepts such as the "patient-doctor relationship" and the "duty of care". These set the tone for the modern requirement to prove civil negligence and more specifically, the degree of negligence. On the criminal side, cases like *Andrews v Director of Public Prosecutions* [1937] AC and *R v Lawrence* [1981] 1 All ER 974 (HL) have played a significant role in drawing a distinction between the degree of negligence required in civil matters as opposed to criminal matters in determining criminal liability.

135 *Bolam v Friern Hospital Management Committee supra* 4.

136 *Bolam v Friern Hospital Management Committee supra* 5.

137 The Indian Penal Code was promulgated in 1860.

138 The Indian Penal Code of 1860.

139 S 299 of Indian Penal Code of 1860.

140 Kanwar "Culpable Homicide" (undated) http://www.legalservicesindia.com/article/582/Culpable-Homicide.html (accessed 2021-12-01).

society, and the behaviour must disregard the patient's life and safety, and be deserving of punishment.[141]

The Indian courts have been loath to hold qualified medical practitioners criminally responsible for patient deaths that result from a mere mistake or error of judgement or inadvertent death. What must be shown is the presence of gross negligence or recklessness – for instance, the reckless dispensation of medications; outrageous negligent performance of diagnostic measures that lead to death; reckless handling of ventilators or other life-sustaining equipment; reckless administration of anaesthesia; or performing surgery under the influence of alcohol or drugs.[142] The court in *Banavarlal v State*[143] held that the mere fact that a life has been lost or that someone has been injured should not be used to infer reckless or careless behaviour. Courts in India have frequently maintained that for a qualified doctor to be found guilty of criminal negligence, the negligence must be of a severe and gross nature.[144]

In 2009, the Indian Supreme Court also developed the common law. Until then, Indian law, like current South African law, did not distinguish between the degrees of negligence required for civil and criminal liability. Since developing Indian common law, the courts now require gross negligence or recklessness to be proved in a doctor's manslaughter prosecution.[145]

In the judgment of *Jacob Mathew v State of Punjab*,[146] the honorable Apex Court explained that in the context of the medical profession, negligence necessitates a unique approach. A case of workplace negligence differs from one involving professional negligence. The court held that a simple lack of care, a lapse in judgement or the occurrence of an accident are not evidence of medical professional negligence.[147]

The rationale for introducing a higher threshold for measuring criminal culpability in a health-care practitioner that includes gross negligence or recklessness ensures that prosecutions are not arbitrary; arbitrary prosecutions lead to fear among practitioners. This position has been aptly described by Indian authorities: "A surgeon with shaky hands under fear of legal action cannot perform a successful operation and a quivering physician cannot administer the end-dose of medicine to his patient."[148]

---

141 *Ibid.*

142 Mathiharan "Criminal Medical Negligence: The Need for a Re-Look" 2002 15(6) *The National Medical Journal of India* 351.

143 (1961) 2 *Cri L J* 561.

144 Dr *Wagh v State of Maharashtra,* Criminal Appeal No 607 of 1962 (Kotwal and Chandrachud JJ) (unreported judgment of 5 December 1961 of the Bombay High Court).

145 *Martin F D'Souza v Mohd Ishfaq* (2009) 3 SCC 1.

146 AIR 2005 SC 3180 2.

147 *Ibid.* See also Mathiharan 2002 *The National Medical Journal of India* 351.

148 The Association of Surgeons "Medical Negligence – The Judicial Approach by Indian Courts" (2021) https://asiindia.org/medical-negligence-the-judicial-approach-by-indian-courts/ (accessed 2025-01-28) par 29.

6 THE ENGLISH LEGAL SYSTEM

Both the English and Welsh criminal legal systems use grades of negligence. An offence will only be punishable where there is a severe degree of negligence. In the general sense, the standard is measured against that of the reasonable man, the bar against which the conduct of the wrongdoer is measured and judged.[149] In the criminal-law systems of England and Wales, there are different levels of negligence. But it is only the highest degree of negligence that is criminally punishable.[150] In a criminal case, the negligence that would warrant a conviction must be culpable or of a higher degree, rather than a slight degree of negligence. A slight deviation from the standard of care, or a mere error of judgement leading to harm, would lead only to a civil action.[151]

The English legal system uses different grades of negligence for different criminal offences, including negligent manslaughter. The term "gross negligence" or "recklessness" is commonly used to express this distinction in practice. The distinction between gross negligence and recklessness can be quite narrow at times.[152] The position was set out in a very early English judgment of *Andrews v DPP*,[153] which stated:

> "Simple lack of care such as will constitute civil liability is not enough for the purpose of the criminal law. There are degrees of negligence, and a very high degree of negligence is required to be proved before the felony is established."

The court goes on to say:

> "The degree of negligence, which would justify a conviction, must be something more than mere omission or neglect of duty."

The English legal system clearly distinguishes between manslaughter, a less serious offence, and murder, with the difference being differing levels of fault, based on the *mens rea.* In the absence of the required *mens rea* or intent to kill, the defendant may only be charged with manslaughter.[154]

The courts have developed the condition that negligence must be "gross" to satisfy the threshold of criminal liability.[155] If the accused was aware of the risk and decided to take it, the accused was reckless[156] Gross negligence manslaughter (equivalent to the South African culpable homicide) is said to have been committed where a death is the result of a grossly negligent act

---

149 *Connor v Surrey* CC [2010] EWCA Civ 286, [2011] QB 429 66.

150 *Ibid.*

151 McCall Smith "Criminal Negligence and the Incompetent Doctor" 1993 *Med L Rev* 336–349.

152 *Ibid.*

153 *Andrews v DPP* 1937 AC 583.

154 *Ibid.*

155 *R v Adomako* [1994] UKHL 6.

156 Badar and Marchuk "A Comparative Study of the Principles Governing Criminal Responsibility in the Major Legal Systems of the World (England, United States, Germany, France, Denmark, Russia, China, and Islamic legal tradition)" 2013 24 *Crim Law Forum* https://doi.org/10.1007/s10609-012-9187-z 12–13.

or omission by the defendant.[157] The elements of manslaughter by gross negligence were stated by the English Queen's Bench Division in *R v Rudling*[158] as being

> "the breach of an existing duty of care which is reasonably foreseeable and gives rise to a serious and obvious risk of death and does in fact cause death in circumstances where, having regard to the risk of death, the conduct of the defendant was so bad in all the circumstances as to amount to a criminal act or omission."

In England and Wales, several prosecutions involving health practitioners for gross negligence manslaughter have taken place over decades.[159] Commencing with the case of *R v Bateman*,[160] the court of appeal found that

> "in order to establish criminal liability, the facts must be such that, the negligence of the accused went beyond a mere matter of compensation between subjects and disregard for the life and safety of others deserving punishment."

In the landmark case of *R v Adomako*,[161] a *locum* anaesthetist took over as the sole anaesthetist during an operation. The endotracheal tube dislodged from the ventilator. Despite attempts to resuscitate the patient, the patient suffered a cardiac arrest, causing irreversible brain damage. The patient died after six months. The health-care practitioner was charged with gross negligence manslaughter and was subsequently convicted. The court with reference to *R v Bateman*[162] and *Andrews v DPP*[163] accentuated the elements of manslaughter, *inter alia* that "the duty should be breached by gross negligence". The conviction was upheld in the House of Lords, the court agreeing that gross negligence was the proper test of criminality.[164] The court *a quo* also held that the degree of negligence must be extremely high before the conduct may be deemed criminal.[165]

The elements of manslaughter by gross negligence were stated concisely in *R v Rudling*[166] as being

> "the breach of an existing duty of care where it is reasonably foreseeable and gives rise to a serious and obvious risk of death and does, in fact, cause death in circumstances where, having regard to the risk of death, the conduct of the defendant was so bad in all the circumstances as to amount to a criminal act or omission."

---

157 *R v Adomako* [1994] UK HL 6.

158 [2016] EWCA Crim 741 18.

159 Robson *et al* 2020 *The Journal of Criminal Law* 321–322.

160 (1925) 9 L JKB 791 794.

161 [1995] 1 AC 171.

162 (1925) 19 Cr App R 8.

163 [1937] AC 576.

164 *R v Adomako* [1994] UKHL 6.

165 Legal Guidance "Gross Negligence Manslaughter" (14 March 2019) https://www.cps.gov.uk/legal-guidance/gross-negligence-manslaughter (accessed 2025-01-28).

166 *Supra*.

The Crown Prosecution Service in England has directed that the foreseeability of risk should pertain to "a serious and obvious risk of death", not just a risk of injury at the time of the breach.[167] The position was supported by the English court in *R v Rose*,[168] when the court added that "an obvious risk is a present risk which is clear and unambiguous, not one which might become apparent on further investigation".

Notwithstanding the progress made in English law, it has been mooted that the English criminal system should undergo reform and move towards the Scottish criminal system and the way Scotland deals with its comparable offence of culpable homicide. What is mooted is that the bar or threshold be raised so that charges are only brought against health-care practitioners if it can be shown that the act or omission complained of was intentional, reckless or grossly careless.[169]

The call for a paradigm shift follows two noteworthy judgments in the English courts, namely *R v Sellu*[170] and *R v Bawa-Garba.*[171] Both the legal fraternity and the Medical Protection Society called into question the judicial treatment the health-care practitioners received. Besides their exemplary work records, the practitioners were also exposed to a high-risk working environment because of adverse working conditions. Dr Rob Hendry of the Medical Protection Society argues that most medical manslaughter cases are complex, often involving system failures. He argues that those cases require greater caution before prosecutions against health practitioners are instituted.[172]

The English Medical Protection Society has suggested that law reform is needed in England and that the law surrounding medical manslaughter be aligned with the legal test for culpable homicide in Scotland. It was also mooted that before the Prosecution Authority presses charges against medical practitioners, the Crown ought to ensure that the "act was intentional, reckless or grossly careless". Part of the law reform sought in England was the raising of the threshold for culpability. What was also recommended was that the Director of Public Prosecutions assume a similar role to that of the Lord Advocate in Scotland. Critics believe that would ensure that the public interest would play a key role in considering a prosecution against a health-care practitioner.[173] What has also been suggested is that national guidelines be created for investigating health-care practitioners suspected of gross negligence manslaughter and that such investigations should be carried out by a designated specialist unit.[174]

---

167 Legal Guidance https://www.cps.gov.uk/legal-guidance/gross-negligence-manslaughter.

168 [2017] EWCA Crim 77.

169 Medical Protection Society in the United Kingdom "English Law on Gross Negligence Manslaughter in Healthcare Must Move Towards Scottish Position" (14 November 2018) https://www.medicalprotection.org/uk/join (accessed 2021-09-14).

170 [2016] EWCA Crim 1716.

171 [2016] EWCA Crim 1841.

172 Medical Protection Society https://www.medicalprotection.org/uk/join.

173 *Ibid.*

174 *Ibid.*

7 HOW SHOULD REFORM IN SOUTH AFRICA BE INTRODUCED?

For the reasons proposed here, South Africa needs law reform, especially regarding the criminal liability of health-care practitioners arising from medical mishaps leading to the death of patients. Practitioners involved are currently in danger of prosecution for culpable homicide. What has added to the woes of health-care practitioners is the very low threshold the NPA relies on to establish the blameworthiness of practitioners charged with culpable homicide. The slightest degree of negligence can lead to the prosecution of practitioners and, if convicted, a jail sentence. It could ultimately result in their losing their career and liberty. Besides being unreasonable and unfair, criminalisation in the absence of any clear intent or gross negligence is viewed as overly punitive and not in the public interest. To this end, it has been suggested before that the morally innocent should not be charged or convicted of serious crimes.[175]

Save for some recent support for law reform in this area of South African criminal-law jurisprudence, very little has been written about it for many decades. However, the writer Barlow, as long ago as 1948, suggested that "doctors should only be prosecuted in those cases where one feels a sense of shock, where the death could have been prevented by the practitioner paying more attention to the case".[176] It is submitted that the wording used by the learned writer hints at a shift in threshold towards gross negligence or recklessness.

The recent announcement by the South African Law Reform Commission to investigate criminal liability of health-care professionals under *Project 152* is to be welcomed. It will allow all interested parties to ventilate their opinions under the stewardship of the Commission. For law reform to be introduced in South Africa, it is crucial that the Law Reform Commission, when commencing its investigations, give thought to raising the bar for testing the culpability of health-care practitioners in culpable homicide matters. What is more, it is suggested that the Law Reform Commission when considering whether or not to raise the bar, should have regard to the reform approach adopted in Scotland, New Zealand, India and England. Critics in favour of change will hope that the Law Reform Commission recommends that health-care practitioners only face prosecutions for causing a patient's death through negligence if the NPA can show the presence of gross negligence or recklessness. Where it is shown that a practitioner's negligence leading to the death of a patient was slight, the practitioner should escape criminal liability. In its deliberations, the NPA should take into account any poor working conditions under which health-care practitioners work, including lack of resources, long hours and a shortage of staff.

Because the NPA does not appear to have a firm policy regarding a standard threshold for when to charge a health-care practitioner, it is

---

[175] McCall Smith 1995 *Journal of Contemporary Health Law and Policy* 131 145.

[176] Barlow "Medical Negligence Resulting in Death" 1948 11(3) *Journal of Contemporary Roman-Dutch Law* 173–190.

suggested that the Law Reform Commission's investigation should *inter alia* focus on and recommend that the NPA in consultation with the Health Professions Council of South Africa formulate guidelines covering the prosecution of health-care practitioners. Besides raising the threshold for the degree of negligence required to pursue criminal proceedings against health-care practitioners for culpable homicide, it is hoped that the Law Reform Commission will also investigate the following issues. A designated specialist unit should be established to determine whether health-care practitioners should be criminally charged. However, first the sufficiency of evidence must be compelling after careful consideration. The head of the unit would be expected to certify that it would be in the public interest to charge and bring prosecutions against health practitioners. It is also suggested that the Law Reform Commission investigate the feasibility of introducing an inquest mechanism to serve as a screening system, especially where the unit in its initial investigations finds that there is an insufficiency of evidence to establish a *prima facie* case against a health-care practitioner whose conduct is being investigated. The inquest could serve as part of the investigative mechanism to determine the circumstances of the death, the degree of negligence displayed by the health-care practitioner, and the sufficiency of the evidence for a charge of culpable homicide or murder.

8 CONCLUSION

Central to this article is an investigation into possible law reform in South Africa, more particularly the call for raising the threshold test for culpability of health-care practitioners in culpable homicide matters. The investigation takes place against the background of reform measures put in place in countries like Scotland, New Zealand, England and India. What is significant is that historically their legal systems adopted a low threshold in the form of ordinary negligence when measuring the culpability of health-care practitioners in the event of the death of their patient(s). That has been the position in South Africa for centuries and is still the position today. The degree of the accused's negligence matters not since even the slightest negligence is sufficient to sustain a conviction.[177]

Medicine is not an exact science; despite practitioners acting in good faith when treating their patients, if their conduct is measured against this low threshold, it may lead to criminal culpability. The same applies to slip-ups, mishaps and errors of judgement on the part of practitioners. Most health-care practitioners do not intend to harm or hurt their patients. Criminalising mistakes while practitioners work in often challenging and complex environments is worrisome and regarded as unfair. The failure to identify the degree of fault involved in a death is viewed by health-care practitioners as a concerning gap that leads to uncertainty and injustice. This has led to a culture of fear of arrest and prosecution by health-care practitioners.

[177] *R v Meiring* 1927 AD 41.

The legal systems in countries like Scotland, New Zealand, England and India have faced similar predicaments in the past, which led to policy changes, including the adoption of an ethos that health-care practitioners should be left to render treatment and save lives and not tremble with the fear of criminal prosecution. Those countries have also drawn clear distinctions between various forms of negligence. Accentuating gross negligence as the requirement for measuring the criminal responsibility of health-care practitioners who face a potential charge of culpable homicide/manslaughter became universal in their legal systems. This meant that a criminal sanction should only be imposed where recklessness or gross negligence may be inferred from the health-care practitioner's conduct, which must also be accompanied by a blameworthy state of mind.[178]

A similar policy should be adopted in South Africa. It is suggested that prosecutions against health-care practitioners in South Africa should only be instituted where the public interest demands it. Gross negligence or recklessness in culpable homicide matters could warrant such prosecutions.

Given the development of the law in the comparative legal systems studied, this article suggests that the South African Law Reform Commission just appointed to investigate the criminal liability of health-care practitioners in South African criminal law should bring about the necessary reform. It is recommended that gross negligence or recklessness serve as the barometer to measure criminal culpability of health-care practitioners in South Africa. It should be noted that this article does not support mandatory exoneration of criminal liability of health-care practitioners. Bad or poor medical care should be prosecuted. However, the law must clearly define the standard of culpability deserving criminal sanction.

This article also suggests that an effective investigative mechanism be put in place to investigate an incident in which a patient dies. The idea is to allow for sufficient evidence to be gathered before criminal proceedings, if any, are instituted against a health-care practitioner. Because the complainant and the investigating officer may not always have knowledge of medical science to determine whether a health-care practitioner is culpable, it is also suggested that a specialised unit within the NPA be established. Here, members of the unit, including medical experts should be well equipped to distinguish between errors of judgement or inadvertence (which are part of life's misfortunes and for which nobody is morally responsible), and wrongs amounting to culpable conduct constituting grounds for prosecution that is in the public interest.

This article suggests the adoption of a mechanism involving inquests to flesh out evidence on the degree of negligence. An inquest should precede any criminal prosecution, which should only follow after the issues have been ventilated.

Criminal prosecution should, therefore, be reserved for those who have been reckless, and where the recklessness has caused the patient's death, or for those few individuals who willfully hurt patients. It is also

[178] McCall Smith 1995 *Journal of Contemporary Health Law and Policy* 131–146 139.

recommended that the legislation should include that prosecutions only be pursued against health-care practitioners if they are in the public interest. This will avoid indiscriminate prosecution of medical practitioners for criminal negligence that is counterproductive and does not serve the interests of society.