LAWS 489
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CONSEQUENCES OF THE YOGASAKARAN DECISION: A REVIEW OF NEW ZEALAND'S MEDICAL MANSLAUGHTER LAW.

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I INTRODUCTION

Three convictions in New Zealand for medical manslaughter since 1989 highlights a trend which has medical professionals alarmed. Collectively, the medical profession feels their numbers are being placed under an unreasonable amount of pressure. Recent prosecutions have focused media and public attention on the law in question, and fueled the debate as to whether the law in New Zealand should be realigned with the law of other Commonwealth jurisdictions.[1]

At issue is the standard of negligence which must be proved before a prosecution for medical manslaughter can be sustained in criminal proceedings. The first option, currently the law in New Zealand, is that of 'mere' negligence, "[t]hat is, a breach of the standard of care which is sufficient to establish civil liability is also sufficient to render the doctor criminally liable...".[2] The standard adopted by other Commonwealth jurisdictions requires criminal or gross negligence to be proved.

This paper examines the concerns raised by medical professionals regarding the current law. It considers whether a change to the law is warranted, weighing up arguments for change against those who consider the law is good as it stands. On the basis of these arguments, conclusions are offered as to whether law reform is necessary; and if necessary, what potential form these changes might take. Initially, the relevant law in New Zealand and other Commonwealth countries will be examined and compared.

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[1] See for example: "Operating at the knife edge" *Sunday Times*, 21 November 1993,6; "Manslaughter law worries medical professor" *Dominion*, Wellington, 4 April 1994,3; "Doctors in dock over fatal errors" *Sunday Star Times*, Wellington, 17 April 1994, C6;
"Professor opposes calls to change manslaughter law" *Evening Post*, Wellington, 28 April 1994, 3.

[2] Michael Gorton, "Medical Manslaughter in Australia" Australian and New Zealand College of Anaesthetists, Melbourne, 25 March 1994, 2; reflecting on the decision of the New Zealand Court of Appeal in R v Yogasakaran [1990] 1 NZLR 399.

II THE LAW IN NEW ZEALAND

1. HISTORICAL BACKGROUND

a. The Common Law prior to 1893

It appears the Common Law was divided on the issue of which standard to apply. Some early 19th century authorities suggest that the civil standard of negligence would be enough to sustain a conviction for manslaughter at Common Law.[3] Other cases indicated a requirement for something more than simple negligence. For instance, in R v Spencer, Willes J held that to sustain a conviction for manslaughter by negligence, the prosecution had to show "...such gross and culpable negligence as would amount to culpable wrong, and show an evil mind."[4]

b. The Criminal Code Act 1893 and Crimes Act 1908

The criminal law was codified in New Zealand by the Criminal Code Act 1893, the relevant provisions remaining largely unchanged by the Crimes Act 1908. In the Crimes Act, the provisions establishing general duties were section 170 (Duties of persons doing dangerous acts), and section 171 (Duties of persons in charge of dangerous things). Section 171 read:

> **171. Duty of persons in charge of dangerous things-**
> Every one who has in his charge or under his control anything whatever, whether animate or inanimate, or who erects, makes, operates, or maintains anything whatever, which, in the absence of precaution or care, may endanger human life is under a legal duty to take reasonable precautions against and to use reasonable care to avoid such danger, and is criminally responsible for the consequences of omitting without lawful excuse to discharge such duty.

Section 171 was first tested in the case of R v Dawe.[5] The defendant was a tram driver who had driven his vehicle into another tram, killing the other driver. A majority of the Court of Appeal found that the presence of the word 'reasonable' in section 171 overruled any Common Law rule that gross negligence was required, concluding that: "...to sustain an indictment for manslaughter, it is not necessary for the Crown to prove gross negligence."[6]

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[3] For example Tessymond's Case (1829)1 Lew CC 164; Nancy Simpson's Case (1829) 1 Lew CC 262.

[4] (1867) 10 CoxCC 525, 528.

[5] (1911) 30 NZLR 673.

[6] Above n5, 687. Note the partial dissent of Chapman J, who said at p688: "I do not consider that the wording of section 171 necessarily excludes the distinction long observed between mere negligence and culpable negligence." He believed that the difference between these standards was not something to be defined, but rather something to be left to the latitude or discretion of the jury.

In 1931, this interpretation was unanimously adopted by the Court of Appeal in R v Storey,[7] not following the English decision[8] which had approved a requirement for gross negligence. Chief Justice Sir Michael Myers felt bound by the provisions of the Crimes Act, and the concept of reasonableness. In deciding what 'reasonableness' meant, he said[9]:

> This term cannot be defined, but the standard must be set in each particular case by the jury by applying their commonsense to the evidence as to the facts of the case and any admissible expert evidence that is adduced. The standard should be neither too high nor too low: it should be a 'reasonable' standard, the standard of skill and care which would be observed by a reasonable man. ...There is no distinction in New Zealand between negligence as the foundation of criminal liability and negligence as the foundation of civil liability.

2. SECTION 155 OF THE CRIMES ACT 1961

Virtually identical in wording, sections 155 and 156 replaced sections 170 and 171 respectively. Section 155 contains the duty which doctors, like other members of society doing dangerous acts, must observe:

> **155. Duty of persons doing dangerous acts**-Every one who undertakes (except in the 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.

This section is not exclusively aimed at the medical profession: "In recent years, charges have been laid against an aircraft pilot[10], a bungi operator who failed to ensure the rubber bands were properly connected[11], and a deer hunter who neglected to check his target[12]."[13]

The first conviction for medical manslaughter this century involved an Australian doctor unfamiliar with New Zealand operating theatres, who administered carbon

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7 [1931] NZLR 417(CA).

8 R v Bateman (1925) 19 Cr App R8 (CA); see below.

9 Above n7, 435.

10 R v Nicholson Unreported CA 397/91.

11 R v Collet Unreported T 122/90.

12 R v Carroll Unreported T 9/91.

13 *Sunday Star Times*, 17 April 1994, C6.

dioxide rather than oxygen to his patient. The doctor was fined $2500, and later deregistered from medicine in New Zealand by the Medical Council.[14]

3. THE YOGASAKARAN CASE

R v Yogasakaran[15] is the leading case in New Zealand regarding the standard of culpability required to sustain a conviction for manslaughter by negligence.

Operating at Te Kuiti hospital in 1987, Dr Yogasakaran, an English anaesthetist, noticed his patient was having difficulty breathing during a gall bladder operation. Acting quickly given the emergency situation, Dr Yogasakaran reached into the drugs trolley, and pulled out a packet from the drawer marked "Dopram". He hastily injected the contents of the ampoule, without checking the label. What was in fact injected was a drug fatal to the patient: "Dopamine". Both drugs are clear substances, and in England "Dopram" is marketed in containers similar to those in which "Dopamine" is found in New Zealand.

Dr Yogasakaran appeared before the High Court in Hamilton, charged with manslaughter based on a breach of the duty arising under s155 of the Crimes Act 1961.[16] The trial judge directed the jury to convict if they were satisfied "...there was an omission by the doctor to exercise such care as was reasonable in all the circumstances."[17] The jury convicted Dr Yogasakaran, who was discharged without penalty.

Dr Yogasakaran appealed the decision on the basis that section 155 required gross or criminal negligence. Delivering the judgment of the Court of Appeal, Cooke P reviewed New Zealand authorities and those of other Commonwealth jurisdictions, observing that "[t]he fact that New Zealand law has been out of line with such a widespread trend must give one pause before reaffirming it."[18] Nevertheless, he considered that the law in New Zealand was at least straightforward, and commented

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[14] R v McDonald Unreported Roper J HC Christchurch, T 24/82.

[15] R v Yogasakaran [1990] 1NZLR 399.

[16] Under s160(2)(b) of the Crimes Act, "Homicide is culpable when it consists in the killing of any person- ...

(b)By an omission without lawful excuse to perform or observe any legal duty."

Section 171 states: "...culpable homicide not amounting to murder is manslaughter."

[17] Above n15, 405.

[18] Above n15, 404.

"[w]e are not aware of any case, including the present, in which the long-standing rule in New Zealand has produced an unjust result."[19]

The Court found no reason to depart from the earlier decisions of Dawe and Storey , holding that section 155 should be given its natural and ordinary meaning; proof of mere negligence is sufficient to justify a conviction for manslaughter based on a breach of section 155.[20]

Applying this law to the facts, the Court heard evidence from expert medical witnesses as to the practice which would be considered proper by a responsible body of medical opinion.[21] Based on a concession by a defence witness during cross examination, the Court concluded:[22]

> ...even in the kind of emergency that arose, the practice of reasonably skilled or careful anaesthetists would be to make at least a quick check of the labelling or packaging on the drug to be injected.

Dr Yogasakaran's appeal against conviction was dismissed. The case was ultimately brought before the Privy Council who ruled that the decision of the Court of Appeal was one of policy, and declined to interfere with a 'policy' decision of the New Zealand Courts.[23]

4. POST YOGASAKARAN CASES

Since Yogasakaran, there have been two more convictions for medical manslaughter. In R v Morrison,[24] a Dunedin radiologist also injected the wrong drug. Most recently, in May 1994, a Wellington health professional was convicted for breach

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[19] Above n15, 404.

[20] Note, however, the different standard of proof required in criminal and civil cases. In the former, negligence involving a breach of duty must be proved beyond reasonable doubt. In the latter, a breach need only be established on the balance of probabilities:

"Medical Manslaughter" Justice Department Brief, Wellington, 15 February 1994, 2.

[21] For medical professionals, the test of reasonable skill and care is measured according to practice considered proper by a responsible body of medical opinion, although other doctors might adopt different procedures:

Sidaway v Board of Governors of the Bethlem Royal Hospital [1985] AC 871.

[22] Above n15, 406.

[23] D B Collins *Medical Law in New Zealand* (Brooker & Friend, Wellington, 1992)196.

[24] Unreported Fraser J, High Court Dunedin Registry S7/91.

of duty under s155, having administered a drug in quantities 10 times too powerful.[25] In both cases, the defendant pleaded guilty, and was discharged without penalty.

More investigations are underway. Currently the police are trying to extradite Keith Ramstead from England, a former cardiothoracic surgeon at Christchurch Hospital, who has been charged with four counts of medical manslaughter.[26]

5. NEGLIGENCE AS A BASIS FOR CRIMINAL LIABILITY

With the exception of sections 155 and 156, the requirement for gross negligence in other Crimes Act duties was established in R v Burney.[27] In that case, the appellants were charged under what is now section 151, for omitting without lawful excuse to provide the necessaries of life to their child. North P found that the mere negligence standard in Storey "...is not to be treated as of general application, but is to be confined to cases where the statute itself defines the standard of care, as s171 of the Crimes Act 1908 did in that case."[28] Thus the mere negligence standard required to sustain a breach of the duties under sections 155 and 156 is an exception to the general rule that to sustain a criminal charge, gross or criminal negligence is required.[29]

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[25] R v Brown Unreported Gallen J, 6 May 1994, High Court Wellington S27/94.

[26] *The Evening Post*, Wellington, 28 April 1994, 3.

[27] [1958] NZLR 745.

[28] Above n27, 754.

[29] New Zealand authorities have not yet embarked upon a definition of gross negligence. Above n20, 2.

III LAW IN OTHER COMMONWEALTH JURISDICTIONS

1. THE UNITED KINGDOM

Health professionals in England have also been raising concerns over the law of medical manslaughter, given recent events: "The 1990's are signalling a new and worrying trend for doctors, in the form of a series of prosecutions for causing death by recklessness in the course of their medical practice."[30] Between 1926 and 1990 there were no convictions for medical manslaughter. Since 1990, there have been four.[31]

a. The traditional test

In the absence of statute, the Common Law provides the standard of culpability necessary to justify a conviction for manslaughter by negligence. A classic statement of the law can be found in R v Bateman, where Lord Chief Justice Hewart said:[32]

> In explaining to juries the test which they should apply to determine whether the negligence in the particular case amounted to or did not amount to a crime, judges have used many epithets such as 'culpable', 'criminal', 'gross', 'wicked', 'clear', 'complete'. But, whatever epithet be used or not, in order to establish criminal liability the facts must be such that, in the opinion of the jury, the negligence of the accused went beyond a mere matter of compensation between subjects and showed such disregard for the life and safety of others as to amount to a crime against the State and conduct deserving punishment. ... It is in a sense a question of degree and it is for the jury to draw the line... .

R v Bateman was approved by the House of Lords in 1937, in the case of Andrews v DPP,[33] where it was suggested that the epithet 'reckless' probably best covered what was meant by criminal negligence.

b. The Caldwell recklessness test

The concept of recklessness traditionally implied a subjective standard of an actor who was aware of an unreasonable risk, but still took it. However, in 1982 Lord Diplock proposed a test of objective recklessness in the House of Lords judgments of R v Caldwell,[34] and R v Lawrence.[35] Under this test, a person could be reckless if they acted in such a manner as to create an obvious and serious risk of causing harm to some other person, and failed to give any thought to the possibility of such a risk, or

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[30] D Brahams "Death of Remand Prisoner"The Lancet, Vol 340 12 December 1992, 1462.

[31] Above n2, 2.

[32] (1925) 19 Cr App R 8 (CA), 11.

[33] [1937] AC 576 (HL).

[34] [1982] AC 341.

[35] [1982] AC 510.

being aware of that risk, still took it. This objective test as the basis for criminal negligence was subsequently applied by the House of Lords[36] and the Privy Council.[37]

c. Recent developments

In 1993, the English Court of Appeal in R v Prentice and Others[38] distinguished between cases of negligent manslaughter arising from a breach of legal duty, (such as the duty imposed by s155 of the New Zealand Crimes Act) and other cases of negligent manslaughter. Three appeals were being considered together. The first appellants were two young doctors who had incorrectly administered a drug intrathecally (through the spine) instead of intravenously, with fatal results. The second appellant was an anaesthetist who had failed to notice the disconnection of an endotraceal tube, which cut off the supply of oxygen to the patient, causing cardiac arrest.[39] The Court held:[40]

> ...the Lawrence/Caldwell recklessness approach is... inappropriate in this case. ...[E]xcept in motor manslaughter, the ingredients of involuntary manslaughter by breach of duty which need to be proved are:
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> (1) the existence of the duty;
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> (2) a breach of the duty causing death; and
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> (3) gross negligence which the jury consider justifies a criminal conviction.

Acknowledging that a standard definition of gross negligence covering all cases was not possible, Lord Chief Justice Taylor proposed a non-exhaustive list of scenarios which might justify a finding of gross negligence:[41]

> (a) Indifference to an obvious risk of injury to health; or
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> (b) Actual foresight of the risk coupled with the determination nevertheless to run it; or
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> (c) An appreciation of the risk coupled with an intention to avoid it but also coupled with such a high degree of negligence in the attempted avoidance that the jury considers it justifies a conviction; or
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> (d) Inattention or failure to advert to a serious risk which went beyond "mere inadvertence" in respect of an obvious and important matter which the defendant's duty demands he or she should address.

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36 R v Seymour [1983] 2 AC 493.

37 Kong Cheuk Kwan v The Queen (1985) 82 Cr App R18.

38 [1993] 3 WLR 927(CA).

39 See R v Adomako below, n42. The third appellant was not a medical professional, but had also been charged with negligent manslaughter.

40 Above n38, 937.

41 Above n34, 937.

Applying this test of gross negligence, the two junior doctors had their convictions quashed, but the second appellant was unsuccessful. He appealed to the House of Lords, admitting he had been negligent, but not to a gross degree warranting criminal conviction. On 30 June 1994, the House of Lords also dismissed the appeal, endorsing the Court of Appeal decision.[42] Lord Mackay considered that the Bateman and Andrews tests still provided the best statement of the law, having never been overruled.[43] The Lord Chancellor admitted that these tests involved an element of circularity, but considered this inevitable with such a test of degrees to be decided by a jury:[44]

> To make it obligatory on trial judges to give directions in law which are so elaborate that the ordinary member of the jury will have great difficulty in following them... is of no service to the cause of justice.

The House of Lords concluded:[45]

> In cases of manslaughter by criminal negligence involving a breach of duty, it is a sufficient direction to the jury to adopt the gross negligence test set out by the Court of Appeal in the present case following R v Bateman 19 Cr. App. R8 and Andrews v Director of Public Prosecutions [1937] AC 576 and it is not necessary to refer to the definition of recklessness in R v Lawrence [1982] AC 510, although it is perfectly open to the trial judge to use the word "reckless" in its ordinary meaning as part of his exposition of the law if he deems it appropriate in the circumstances of the particular case.

These latest cases clearly reaffirm the requirement for gross negligence before a criminal charge arising from breach of duty can be sustained.

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[42] R v Adomako Unreported House of Lords 30 June 1994, 9-10. Judgment delivered by Lord Mackay of Clashfern, Lord Chancellor.

[43] Above n42, 7.

[44] Above n42, 10.

[45] Above n42, 9-10.

2. AUSTRALIA

To date, there have been no convictions for medical manslaughter in Australian law. The relevant laws are on a State rather than Federal level.

a. The Common Law States: Victoria, New South Wales and South Australia, and Australian Capital Territory

There are no criminal codes in these States; the Common Law prevails. English authorities such as the Court of Appeal in Prentice, and the latest House of Lords judgment in Adomako, are very persuasive. The requirement for gross negligence in cases of manslaughter was recognised in New South Wales as early as 1921, in R v Gunter[46], where it was said: "...that negligence which is essential before a man can be criminally convicted must be culpable, exhibiting a degree of recklessness beyond anything required to make a man liable for damages in a civil action."[47]

As yet, no Court has embarked upon a comprehensive definition of gross or criminal negligence[48].

b. The Code States: Queensland, Western Australia, and Tasmania

These States have criminal codes, the relevant provisions imposing a duty on persons doing dangerous acts almost identical to the duty imposed under s155 of the New Zealand Crimes Act.[49]

In R v Callaghan,[50] a motor manslaughter case, the High Court of Australia was called upon to determine the level of culpability required to sustain a conviction under section 266 (duty of persons in charge of dangerous things) of the Western Australia statute. Considering precedents from both England and New Zealand, the Court found themselves unable to accept the New Zealand interpretation in Dawe and Storey, despite the almost identical provisions. The Court considered the context of the provision to be of great importance:[51]

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[46] (1921) 21SR (NSW) 282.

[47] Above n46, 286.

[48] Although in Nydam v The Queen [1977] VR 430,445 criminal negligence was defined as "such a great falling short of the standard of care which a reasonable man would have exercised... that the doing of the act warranted criminal punishment."

[49] Queensland Criminal Code Act 1899, s288; Western Australia Criminal Code Act 1913, s265; Tasmania Criminal Code Act 1924, s149.

[50] (1952) 87 CLR 115.

[51] Above n50, 124.

It is in a criminal code dealing with major crimes involving grave moral guilt. ...[W]e think it would be wrong to suppose that it was intended by the Code to make the degree of negligence punishable as manslaughter as low as the standard of fault sufficient to give rise to civil liability. ...The standard set by section 266 should... be regarded as that set by the Common Law in cases where negligence amounts to manslaughter.

The recent House of Lords decision in Adomako reaffirms the position of the Australian High Court.

3. CANADA

Under the Canadian Criminal Code[52] there is an offence of criminal negligence causing death, distinct from manslaughter. Criminal negligence is defined in section 219:

219.(1) Every one is criminally negligent who

(a) in doing anything, or

(b) in omitting to do anything that it is his duty to do,

shows *wanton or reckless disregard* for the lives or safety of other persons.

The material provision regarding the duty of medical professionals is section 216:

216. Every one who undertakes to administer surgical or medical treatment to another person or to do any other lawful act that may endanger the life of another person is, except in the cases of necessity, under a legal duty to have and to use reasonable knowledge, skill and care in so doing.

Canadian Courts have struggled over the interpretation of the words 'wanton or reckless disregard'. In Le Blanc[53] the Supreme Court of Canada considered that a person could only be found criminally negligent in cases of advertent negligence, i.e where a risk of substantial harm is foreseen and unjustifiably taken, showing a disregard for the life and safety of others. This decision has been criticised by leading criminal law texts,[54] and in 1989, the Supreme Court reached a different decision in R v Tutton.[55]

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[52] Revised Statutes of Canada 1985, Vol III, Ch C-46.

[53] (1975) 29 CCC (2d) 97.

[54] For example, Mewitt & Manning *Criminal Law* (Butterworths, Toronto, 1978).

[55] (1989) 48 CCC(3d) 129.

On analysis of the words 'wanton or reckless disregard, the Court said:[56]

> The test is that of reasonableness, and proof of conduct which reveals a marked and significant departure from the standard which could be expected of a reasonably prudent person in the circumstances will justify a conviction of criminal negligence.

This test has been approved in two subsequent Supreme Court decisions.[57] Thus it appears well established that the words 'wanton or reckless disregard' include both advertent negligence (recklessness) and inadvertent (gross) negligence.

4. SUMMARY OF OTHER COMMONWEALTH JURISDICTIONS

England, Australia and Canada each have their own method of defining the level of culpability required to sustain a conviction for manslaughter. Despite the differences in their respective laws, all have one common thread. They all require some form of culpability greater than the reasonable person standard in civil negligence, whether it be defined as recklessness, or left largely undefined, as gross or criminal negligence.

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[56] Above n55, 140, per MacIntyre J.

[57] R v Hundal(1993) 79 CCC(3d) 97; R v Creighton(1993) 83 CCC(3d) 346.

IV EXPLAINING THE INCREASE IN MEDICAL MANSLAUGHTER CHARGES AND CONVICTIONS

With the Court of Appeal's interpretation of section 155, New Zealand law does not require gross negligence. This is what worries medical professionals; that they can be criminally charged for negligently making a mistake, despite acting in good faith.[58]

Medicine, and on a specialist level, anaesthesia, is safer than ever, given continuing developments in technology, and the ever increasing pool of knowledge.[59] An increase in charges cannot be blamed on a less skilled profession. So why has there been such an increase in the number of charges in the last 5 years, given that interpretation of the duty under section 155 and its predecessors has remained virtually unchanged since 1911? No one explanation can be found; it appears several factors may be contributing to this increase.

a. Lack of faith in medical disciplinary procedures[60]

The Cervical Cancer saga, where one of the key doctors was fined only $1000, has led to calls that doctors are judging their own too leniently.[61] A disgruntled public may be approaching the police and encouraging criminal investigation, turning their backs on the internal disciplinary system which is perceived as failing to do justice.

b. Growing awareness of patients rights

The Cervical Cancer Inquiry in 1988 finally dispelled any myths of doctor inviolability. Previously, family members of the deceased may have hesitated before questioning doctors actions. Now, with the trend towards public accountability of professionals, families are more aggressively seeking to learn the true cause of death, and are "...prepared to lay a complaint with police if medical negligence seems to have been involved."[62]

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58 "A Review of the Attitudes of Anaesthetists to Medical Manslaughter and its Consequences for the Speciality." Speech of the first chairman of the Anaesthetic Mortality Assessment Committee, 19 November 1993, 4.

59 Mortality figures for anaesthesia 15 years ago were quoted at 1 in every 10,000 patients. Now the figure is estimated at 1 in every 100,000 patients. Personal communication with Stuart Henderson, Director of Anaesthetists, Wellington Hospital, 5 July 1994.

60 *The Dominion*, Wellington, 4 April 1994, 3.

61 Although this is the maximum penalty currently able to be imposed: Medical Practitioners Amendment Act 1983, s58A(2)(c).

62 Ron Paterson "Medical Manslaughter-The Myths" Auckland, 19 April 1994, 5. Two current police investigations have been initiated by members of the public. Below n67.

c. Impact of the statutory bar to civil claims

Under the Accident Compensation Scheme, doctors cannot be sued for negligence in civil cases.[63] Although the victim is compensated, doctors are not being punished for their negligent act. Aggrieved members of the public seeking punitive measures must find another forum to fulfill their aim. This forum may be section 155 of the Crimes Act: "Since ACC has superceded an action in tort, now a criminal conviction because of manslaughter, even if no fine is imposed, might take over the function of redress inherent in an action in tort."[64]

The Court in Yogasakaran excluded the statutory bar to civil claims as a relevant factor in interpreting section 155.[65] Yet David Collins thinks that the Crimes Act may be being used to fill the void left by the abolition of civil claims.[66]

d. Change in police policy

The Police have had a standard homicide plan for the last 20 years and deny any change to police policy.[67] In response to Waikato anaesthetists claims that police investigations have become more aggressive, the police feel they have been hampered in performing their duty, by uncooperative medical staff and in some cases, the disappearance of vital evidence.

Under section 4 of the Coroners Act 1988, every death occurring during a medical, surgical, dental or anaesthetic procedure must be reported to the police.[68] The police have a statutory duty to report the death to the Coroner,[69] and to assist in all necessary inquiries and investigations.[70] As well as assisting the Coroner, the police may pursue criminal investigations as they see fit. Although under the Coroners Act 1951 it is possible not all of these medically related deaths would have reached them, the police say the increase in prosecutions is not attributable to this new legislation.[71]

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63 Although exemplary damages are not barred by this legislation:
Donselaar v Donselaar [1982] 1 NZLR 97.

64 E Deutsch "Professional Negligence: A Comparative View."(1990) 20 VUWLR 287, 292.

65 Above n15, 404.

66 D B Collins "New Zealand's Medical Manslaughter"(1992) 11 MedLaw 221, 225.

67 Personal Communication with Dave Kerr, Police Legal Section, 6 July 1994.

68 Coroners Act 1988, s4(1)(c).

69 Above n68, s5(4).

70 Above n68, s37.

71 Above n67.

e. Change in public attitude

The Crown Law Office has commented that there has been an increasing number of prosecutions for manslaughter by negligence, not only of doctors, but of others doing dangerous acts:[72]

> This seems to reflect an increasing desire in the community to hold people accountable for their actions. It also seemed to coincide with a trend to seek greater accountability from professionals, including health professionals and the giving of a greater prominence in the legal process to victims and victims' families.

In the absence of civil liability for doctors, and a somewhat inadequate disciplinary structure, doctors are being held accountable by means of criminal charges. It is a significant trend, and not simply a statistical deviation from the norm. This trend has doctors worried. The concerns of the medical profession are addressed below.

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[72] Above n20, 11.

V CONSEQUENCES OF THE LAW IN NEW ZEALAND

1 CONCERNS OF THE MEDICAL PROFESSION

Medical professionals are taking the threat of conviction under section 155 of the Crimes Act very seriously. Anaesthetists in particular are on edge: "The conviction for a criminal act of a professional acting in good faith for a mistake arising in the course of normal duties, has seemed to anaesthetists to be grossly inappropriate."[73] They claim such mistakes will always occur, no matter how well educated the professionals are or how advanced the technology is.

Most, if not all anaesthetists are aware of the current state of the law following the Yogasakaran case.[74] More recently, their concerns have become public, as debate over this law has received media coverage, locally and overseas.[75]

Although section 155 applies to all medical professionals doing 'dangerous acts', some seem to be more vulnerable than others, particularly procedural specialists, radiologists and anaesthetists.[76] The following concerns have been raised by anaesthetists, although many are felt by the medical profession in general.

a. Practice of defensive medicine

Defensive medicine is practised when:[77]

> ...a physician changes his or her method of practice in ways that are not likely to benefit the patient, but are believed to reduce the risk that the physician will be prosecuted, or that if prosecuted, the case can be more easily defended. Some examples are unnecessary tests, longer hospital stays, additional consultations... .

Medical professionals admit that this style of medicine is favoured by many of their peers, who fear the possibility of a criminal conviction for mere negligence. The phenomenon is most apparent at Waikato Hospital, where misunderstandings between the police and doctors have created much suspicion, and consequently far greater caution on the part of the doctors.[78] Defensive medicine has wider implications for society, given its time consuming and expensive nature.

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[73] Above n58, 4.

[74] Above n59.

[75] For example, Sandra Coney "Medical Manslaughter in New Zealand" The Lancet, Vol 343, 30 April 1994, 1091.

[76] Hugh Clarkson, President New Zealand Society of Anaesthetists "When Are Your Actions a Crime?" Institute for International Research, Medico-Legal Conference 1993, 4.

[77] Rupert Cook "Attitudes of Physicians to Medical Malpractice Litigation in Canada" (1992) 11 MedLaw 557, 563.

[78] Above n59.

b. Refusal to treat

Anaesthetists Society President Hugh Clarkson claims patients have died, because doctors have refused to administer anaesthetics to those considered 'high risk'.[79] Such a stance is extreme and may be limited largely to Waikato Hospital, given current mutual suspicion between police and doctors. Further, this concern seems unfounded, given that the high risk status of a patient will be a consideration in determining what is a reasonable standard of care in the circumstances. Thus Peter Skegg observes "...there is little evidence to support the view that doctors are especially at risk of negligence when dealing with a high risk patient."[80]

Most anaesthetists (and doctors in general) would not support the withholding of treatment, purely from a moral perspective.[81] Further, refusal to treat may itself be subject to criminal sanction, under section 151 of the Crimes Act: "Duty to provide necessaries of life". A breach of this duty resulting in death is culpable homicide.[82] Although a breach and subsequent conviction has never been proved against a medical professional, it has been held that 'necessaries of life' includes medical care, and hospital treatment.[83]

However, the Society of Anaesthetists has supported the decision of some of their peers refusing epidural pain relief to women in labour, in hospitals with limited resources and personnel.[84] In the past, the procedure was frequently performed, but with the defensive attitude of many anaesthetists, it is now considered too risky, in terms of potential criminal charges if something goes wrong.

c. Shortage of medical professionals

At least one senior anaesthetist from Waikato Hospital has already left New Zealand, preferring to practice in Australia. In Australia, he will not be convicted of medical manslaughter unless he is grossly negligent. Two other anaesthetists are also seriously considering leaving the country to practice in other Commonwealth jurisdictions.[85]

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79 Above n13.

80 Above n62, 10.

81 The first duty under the New Zealand Medical Association Code of Ethics is: "Consider the health and wellbeing of your patient to be your first priority." Above n23.

82 Crimes Act 1961, s160(2)(b).

83 R v Burney [1958] NZLR 745. For general discussion, see above n20, 193.

84 "Operating at the knife edge" *Sunday Times*, Wellington, 21 November 1993, 6.

85 Above n59.

Conversely, growing awareness of the medical manslaughter law is acting as a deterrent against foreign practitioners coming to practice in New Zealand.[86] If the trend worsens, emigration of local medical professionals, combined with reduced immigration of their foreign counterparts could result in a severe shortage of doctors, particularly anaesthetists.[87]

d. Breach of obligation under the Hospital Amendment Act 1981.

In 1979, anaesthetists persuaded the Minister of Health to establish an Anaesthetic Mortality Assessment Committee. This was achieved by the Hospitals Amendment Act 1981.[88] The aim of the Committee was to assess deaths that may have been related to anaesthesia, or any anaesthetic procedure, for educational purposes. Anaesthetists were under an obligation to report such deaths, giving their name, address and *opinion as to the cause of death.*[89] Although no penalty was stated for breach of this duty, the Medical Council of New Zealand has found an anaesthetist guilty of 'disgraceful conduct', for failing to report a death.[90]

Information divulged to the Committee was to be confidential, except "...for the purpose of the investigation of any alleged crime...".[91] Using this section, the police subpoenaed Dr Yogasakaran's report to the Committee during their criminal investigation of him.[92]

This had a profound effect on the working of the Committee. Although anaesthetists remain under an obligation to report these deaths, they are not doing so, because "...speculation as to a cause and effect relationship between an event and its consequences may be used by the police as implying that the postulated reasons were an acceptance of responsibility for the event."[93]

At present, the Committee is no longer convening, meaning the loss of a valuable means of education. Yet anaesthetists may still face disciplinary proceedings for failure to report.

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[86] Above n75.

[87] Above n13.

[88] Hospitals Amendment Act 1981, s13A.

[89] Above n88, s13B.

[90] Above n59.

[91] Above n88, s13E.

[92] "...although none of the facts which led to Dr Yogasakaran's conviction were established from [this information]." Above n58.

[93] Above n58.

2. RECOMMENDATIONS OF THE MEDICAL PROFESSION

a. Amendment of s155 of the Crimes Act 1961

Representations favouring law reform have been made to the Minister of Justice by the Royal College of Surgeons, the Royal College of Physicians, Australian and New Zealand College of Anaesthetists, the Medical Council of New Zealand, and the New Zealand Medical Association.[94]

The medical profession is not seeking an exemption from the duty attaching to those doing dangerous acts, but simply believe that mistakes made while acting in good faith should not be punished criminally.

An amendment bringing the current law into line with other Commonwealth jurisdictions is what is sought: some form of gross or criminal negligence. A recent proposal recommended altering the last sentence of section 155 to: '...and is criminally responsible for the consequences of *recklessly* omitting to discharge that duty'.[95]

b. Amendment of the Medical Practitioners Act 1968

Medical professionals are well aware of their protection from civil liability for medical misadventure under the Accident Compensation legislation. However, they consider internal disciplinary proceedings to be the appropriate forum for punishment of negligent acts and that the criminal law should be reserved for cases of gross negligence.[96]

Recently there has been public dissatisfaction over the sanctions the medical disciplinary hierarchy have been imposing upon their peers.[97] The maximum fine that can be imposed is $1000, a symbolic rather than punitive fine.[98] Although a finding of guilt in these proceedings does carry much stigma within the profession, the public does not see this punitive factor. Hence an increase in monetary fines for a doctor who

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[94] Dr Bruce Rudge "Medical Manslaughter. An Overview of the Crimes Act 1961 and Its Implications to Medical Practitioners". Memorandum for medical professionals, Department of Anaesthesia, Waikato Hospital, 19 November 1993, 4.

[95] Above n94, 5.

[96] Above n64, 292.

[97] For example, Dr Bonham, one of the doctors at the centre of the Cervical Cancer Inquiry, who was fined $1000 (the maximum) by the Medical Council.

[98] Although under s58A(2)(f) of the Medical Practitioners Amendment Act 1983, a guilty doctor may be liable to pay substantial costs of the disciplinary proceedings. To date, the maximum costs ordered by the Medical Council has been $208,000. Personal communication with Dr David Collins, Barrister, Wellington, 19 July 1994.

acts negligently causing death is recommended, imposing a significant financial penalty on the doctor involved.

On a procedural level, it is recommended that the processing of complaints be much more efficient, particularly the Medical Council, where complaints can take up to 2 years to process.[99]

While there are shortcomings in the existing Medical Practitioners Act, doctors consider there is already adequate machinery for due process in the disciplinary structure to deal with negligent doctors.

c. Amendment of Hospitals Amendment Act 1981

Anaesthetists consider that enquiries under the Coroners Act 1988[100] already provide enough avenues for investigating anaesthesia related deaths. In order to preserve the valuable educational purpose of the Committee, there should be complete confidentiality: "[P]eer review of the type conducted by the Anaesthesia Mortality Assessment Committee should not be assessable in any form to outside bodies."[101]

3. THE PRACTICAL DIFFERENCE BETWEEN MERE AND GROSS NEGLIGENCE

Ron Paterson, Senior Lecturer of Law at Auckland University, argues that juries may find little difference between mere and gross negligence, because the difference is semantic: "...who is to say that the failure to check the label of a drug before administering it is a mere error or a gross error?"[102]

Similarly, another academic considers the outcome may ultimately be the same: "It is possible that some of the New Zealand cases would have resulted in a finding of gross negligence or medical manslaughter overseas."[103] If these views are correct, seeking a reform of the law to gross negligence may be of symbolic rather than practical value.

Medical professionals contest this view.

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[99] Above n98.

[100] Above n68; above n69.

[101] Above n58, 7.

[102] Above n62, 14.

[103] "Manslaughter law worries medical professor" *The Dominion*, Wellington, 4 April 1994, 3.

a. The case of Dr McDonald

In 1982, Dr McDonald, an Australian anaesthetist, was the first medical professional to be convicted in New Zealand for manslaughter arising from a breach of the section 155 duty.[104] On his return to Australia, the Medical Assessment Tribunal of the Medical Board of Queensland was obliged to review his medical registration. Invited to accept the New Zealand verdict as evidence, Mr Justice Campbell of the Tribunal said: "I cannot possibly accept this; either the law in New Zealand is abhorrently strange, or [the] doctor may have been wrongly convicted."[105]

Concluding, the judge said:"From the evidence we have heard...I myself doubt that there would be even a prima facie case of manslaughter made against Dr McDonald."[106]

His registration upheld, Dr McDonald continues to practice in Australia.

b. The Canadian case of Giardine

The outcome of a Canadian case with facts almost identical to the case of Yogasakaran suggests that the difference between gross and mere negligence may not be semantic.

In R v Giardine,[107] during a non-emergency situation, a doctor injected the wrong drug, with fatal results. The mistaken drug and correct drug were the same colour, the ampoules were the same size, and they were packaged in a similar manner. The judge considered that while this may have established civil negligence, on the facts there was no criminal negligence: "When the ampoule was handed to the accused, he did not notice the label, taking for granted that it was the drug he had ordered."[108]

It would appear from this case that had Yogasakaran been tried under Canadian law, he would not have been found guilty.

On the basis of this evidence, it is argued that there is a clear practical distinction between mere and gross negligence.

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[104] Above n14.

[105] Dr Macdonald "Re Medical Manslaughter" Letter to the editor, Australian and New Zealand College of Anaesthetists Bulletin, Vol 3, Melbourne, March 1994, 38.

[106] Above n105.

[107] (1939) 71 CCC 295.

[108] Above n107, 297.

VI SUPPORT FOR MAINTAINING THE CURRENT LAW

Support for reform of the medical manslaughter law is not universal. The Court of Appeal declined to interpret section 155 as requiring anything more than ordinary negligence. Headlines such as "Professor opposes calls to change manslaughter law"[109] indicate some academics also reject the need for reform. The police consider there is a sound policy basis for retaining the distinction between inherently dangerous conduct which results in death, and the standard of negligence in other manslaughter prosecutions.[110] In addition, the Justice Department have considered and rejected any amendments in the near future.

1. REASONS FOR MAINTAINING THE STATUS QUO

a. The law in New Zealand is uncomplicated

It has been noted that "Courts in Australia, Canada and the United Kingdom have struggled to come up with a meaningful definition of 'gross' negligence, and have tied themselves up in knots in the process."[111] The tests proposed for gross negligence have been criticised as circular; the jury being told to convict if they think a crime has been committed.[112] An advantage in retaining the current interpretation is that "...the New Zealand law as hitherto understood, has at least been straightforward."[113]

b. No unjust convictions

The Court of Appeal in Yogasakaran felt the traditional interpretation of section 155 had yielded no unjust results, because "(j)uries do not lightly find manslaughter by negligence and there is exceptionally wide judicial discretion as to penalty."[114]

Medical professionals will not be convicted merely because they made a mistake. The prosecution must show that not only did a mistake of error of judgment occur, but that this error amounted to a failure to exercise reasonable skill and care: "A mere mistake or error of judgment which should in a civil action prevent an act or omission from being imputed as negligence is equally good as a defense in a criminal charge involving negligence."[115]

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[109] Above n26.

[110] Above n20,14.

[111] Above n62, 14.

[112] This element of circularity has recently been dismissed by the House of Lords in Adomako, their Lordships having approved the test proposed by Hewart CJ in Bateman. Above n44.

[113] R v Yogasakaran [1990] 1 NZLR 399, 404.

[114] Above n113, 404.

[115] R v Storey [1931] NZLR 417(CA), 435.

The standard of reasonable skill and care is flexible, and dependent on surrounding circumstances. Where a high risk patient is being treated in an emergency, the standard required will be that of a reasonable doctor in that emergency situation.[116]

c. Difficulty in obtaining a conviction

Despite an increase in the number of prosecutions of doctors over the last 5 years, risk of prosecution remains very slight. In order to obtain a conviction for a breach of duty under section 155, the Crown must prove beyond reasonable doubt that the doctor in administering surgical or medical treatment, failed to use reasonable knowledge, skill and care. There is no onus on the defendant to prove anything. Two factors hamper successful prosecutions, even where prima facie evidence of medical negligence may exist.[117]

i. Proving a failure to exercise reasonable skill and care

This standard of care "...protects doctors who act in accordance with a responsible body of medical opinion, even though a majority of doctors might adopt a different practice."[118] In order to establish what a responsible body of medical opinion considers reasonable, expert medical witnesses are needed. These witnesses are proving hard to find. During one prosecution, the police had to seek expert medical evidence from Australia, because of the extreme reluctance of their New Zealand counterparts.[119]

ii. Problems of causation

A case from police files illustrates the difficulties in establishing a link between the negligent act and the death. Patient T died after renal dialysis from gastrointestinal haemorrhaging. During the dialysis, cleaning fluid rather than the required drug had been administered. The autopsy revealed three possible causes of death, and "...although the temporal proximity between the negligence and death was suggestive, it was impossible to establish that it was the administration of the cleaning fluid which had caused the death."[120]

Another problematic scenario arises where a number of different errors occur, cumulatively causing the death of the patient, although each mistake in isolation would not have had fatal consequences.[121]

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[116] Above n80.

[117] Above n20, 8.

[118] Ron Paterson "What to Expect When a Careless Doctor Kills." NZ Doctor, 20 May 1991, 31.

[119] Above n67.

[120] Above n20, 9.

[121] Above n20, 8.

d. Limited liability of doctors

Given the statutory bar on civil actions for medical misadventure, it is arguable that "...in many ways, New Zealand doctors are the most fortunate in the world."[122] In other countries where no such statutory bar exists, the risk of legal liability is far greater. To avoid this, foreign doctors must pay financially crippling insurance cover.[123]

In New Zealand, legal liability for negligent doctors is largely confined to criminal charges, proof of which is much harder than in civil litigation.

e. Interpretation of section 155 is consistent with the growing demand for public accountability.

More than ever before, the public is demanding that professionals take responsibility for their actions, whether they be lawyers, doctors, police or civil servants. The establishing of the Police Complaints Authority is one example of the greater scrutiny those in the public sector are now subject to.[124] In this era of accountability for one's actions, the making of unreasonable mistakes in the course of an inherently dangerous activity is simply unacceptable. This is reflected by the Court of Appeal's interpretation of section 155.

Plausible arguments exist on both sides as to whether a change in the law is warranted. The police believe that the law is fair as is, but support the recommendations of the Crimes Consultative Committee in the longer term.[125] The Justice Department advise the best option is to maintain the policy of having a lesser standard of liability for activities that are inherently dangerous. They believe no change is necessary, but if a change is to be made, it should be along the lines of the Crimes Consultative Committee recommendations. These are discussed below.

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[122] Above n13.

[123] Above n62, 12.

[124] Above n67.

[125] See 'Part VII Recommendations', below.

VII RECOMMENDATIONS

1. CRIMES CONSULTATIVE COMMITTEE

In 1989, a Committee headed by Sir Maurice Casey was appointed to review the Crimes Act. It proposed a complete reform of the law of homicide. The Committee recommended that manslaughter be divided into two categories:[126]

(1)culpable homicide- where reckless or or intentional infliction of injury causes death; and

(2)negligent killing- where death is caused by a negligent act that constitutes "a major departure from the standard of care of a reasonable person."[127]

Culpable homicide and negligent killing would carry a maximum penalty of life imprisonment and 5 years imprisonment respectively. However, like the police, the Committee considered that *sections 155 and 156 should continue to have a standard of mere negligence applying*, because "...inherently dangerous activities warrant strict adherence to a standard of reasonable care."[128]

2. MINISTRY OF HEALTH RECOMMENDATION

The Ministry of Health proposed introducing a special statutory scheme for medical practitioners similar to those prescribed for careless or dangerous drivers in the Transport Act 1962. Under this Act, a driver causing death may be charged with different offences: careless driving, and reckless or dangerous driving.[129] However, these charges are an alternative and not a replacement for a manslaughter charge under the Crimes Act.

While such a scheme may have its advantages, the logistics of the reform may outweigh the potential benefits it might provide.

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[126] *Report of the Crimes Consultative Committee on the Crimes Bill 1989*, 29 April 1991, 46-47.

[127] Above n26, 93.

[128] Above n126, 15.

[129] Transport Act 1962, ss55-57.

VIII CONCLUSIONS

At present, the law in New Zealand imposing a duty on those doing inherently dangerous acts under section 155 is causing much concern. Whether their fears are justified or tinged with paranoia, the medical profession clearly feel threatened by the law. They consider the possibility of a criminal conviction for manslaughter for making an unreasonable mistake is placing them under undue pressure. The consequences of this law affect the wider public in general, because when defensive medicine is practised, it is the taxpayer who collects the bill.

On the other hand, the police and the Justice Department are inclined to think doctors are perhaps being a little oversensitive, that the law is fair, and doctors in New Zealand run a much lower risk of being held liable for medical negligence than their foreign counterparts. They believe it is sound policy to apply a lesser standard of negligence for those engaging in inherently dangerous activites.

It appears the growing demand for accountability of professionals, coupled with a greater willingness to question doctors actions are the main factors explaining the increase in medical manslaughter charges over the past 5 years. For this reason, perhaps it is time the public were consulted over whether they think reform is necessary.

In the absence of public opinion on this issue, a few personal recommendations are offered.

a. Reform of section 155

i. A change to section 155 of the Crimes Act 1961 is necessary. With increasing numbers of prosecutions under this section, medical professionals are becoming more apprehensive, as they perceive an increase in the risk of criminal charges. It is arguable that some doctors found guilty in New Zealand would not receive the same verdict if tried in an overseas jurisdiction, and this has led to calls for change. The current defensive frame of mind affects not only the medical profession, but also the wider public, in terms of time and monetary expenses.

On a legal angle I would respectfully adopt the reasoning of the High Court of Australia in Callaghan,[130] that the context of section 155 is a criminal code 'involving grave moral guilt'. The criminal law should apply only to persons acting culpably. Mere negligence should not be sufficient to sustain a criminal conviction.

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[130] Above n51.

ii. The inappropriate term of manslaughter should be discarded. The proposal of the Crimes Consultative Committee to split manslaughter into two offences is supported. By breaking up the offence, those persons acting culpably are recognised as being more blameworthy than those who are inadvertently negligent.

iii. There should be a standard of criminal negligence applicable to all activities that may give rise to the offence of negligent killing, *including those acts covered by section 155 and 156.* Historical judicial interpretation rather than legislative direction has given rise to the distinction between the lesser standard of negligence applying to inherently dangerous activities, and gross negligence, which applies to all other activities.

iv. An attempt should not be made to define the standard of criminal negligence beyond the direction given in Bateman as approved in Adomako.[131] Ultimately it is a question of degree to be decided by the jury.

b. Reform of the Medical Practitioners Act 1968

v. Medical professionals should be accountable for their negligent actions, by means of the disciplinary structure as established by the Medical Practitioners Act 1968. Fines for negligent doctors should be increased, so as to impose some clear financial penalty. This punitive measure may help restore some lost public faith in the system, and redirect complaints to this internal regulatory body, away from 'citizen initiated' police investigations.

vi. The Disciplinary Committees should be given discretion to order a negligent doctor to pay a percentage of their fine as reparation to the victim or family of the victim. This may satisfy those family members who wish to see the negligent doctor penalized in some way, providing a means of bypassing the doctor's immunity from civil claims for medical misadventure.

c. Reform of the Hospitals Amendment Act 1981

vii. The Hospitals Amendment Act 1981 should also be amended. To preserve its valuable educative function, reports made by anaesthetists should be completely confidential. Sufficient avenues of inquiry are already afforded to the police under the Coroners Act 1988.

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[131] Above n45.

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