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CRIMINAL OR MERELY HUMAN?: THE PROSECUTION OF NEGLIGENT DOCTORS

*Alexander McCall Smith**

I. INTRODUCTION

Following a marked growth in the number of prosecutions brought against doctors whose negligence has caused the loss of a patient's life, criminal liability for negligence is of increasing concern to the medical community.¹ This heightened concern over what may be seen as a new threat to a profession which is already under heavy pressure from increasing civil litigation warrants some discussion on a number of fundamental questions, including whether the criminal law should punish a negligent doctor. One view holds that it is inappropriate to criminally prosecute those who act with anything less than subjective recklessness. In the alternative, negligent behavior, in terms of a doctor's failure to meet an objectively determined standard of care, should have purely civil consequences. This is a somewhat radical position, and perhaps out of favor, given the current enthusiasm for professional accountability. Yet it is quite in accord with traditional criminal law values, particularly with the established, stubbornly old-fashioned notion that criminal conviction requires *mens rea*, a guilty mind.

Over thirty years ago, the distinguished American jurist, Jerome Hall, made the point that there is no justification for the criminal punishment of negligent behavior.² The essence of his argument, developed in the

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This article is dedicated to Professor Dieter Giesen, whose treatise, *International Medical Malpractice Law*, is beyond contest the most comprehensive and profound examination of medical negligence yet to appear. However, it does not deal with criminal liability, and quite properly, for it is a textbook of civil law. This article briefly discusses the implications of the imposition of criminal liability for negligent conduct by medical professionals.

1. Over the last four years there has been a spate of such prosecutions in Britain. See discussion *infra* part IV. There have been more, and on flimsier grounds, in New Zealand. See discussion *infra* part V. The conviction of Dr. Gerald Einaugler on charges of reckless endangerment, has drawn increased attention to this issue in the United States. See *People v. Einaugler*, 618 N.Y.S.2d 414 (App. Div. 1994).

2. Jerome Hall, *Negligent Behaviour Should Be Excluded from Criminal Liability*, 63 COLUM. L. REV. 632 (1963).

course of a commentary on the negligent homicide provisions of the Model Penal Code, was that the negligent actor neither manifests an intention to harm nor an attitude of indifference to the safety of others, and therefore, the actor is not morally culpable. Since the publication of Hall's article, criminal law scholarship has shown surprisingly little interest in the decriminalization of negligent conduct. That is not to say that there has been complete silence on the subject. H.L.A. Hart considers negligence in his seminal *Punishment and Responsibility*,³ where he is sympathetic to the practice of punishing negligence in order to encourage careful behavior. In a similar vein, the influential criminal law scholar, Glanville Williams, acknowledges the moral difficulty inherent in punishing people for that which they cannot help. Nevertheless, Williams endorses negligence as an appropriate ground of moral reproach.⁴ To punish one for something which one might have avoided had he thought to take precautions is justified, says Williams, on the grounds that "such punishment may cause him to act better afterwards."⁵ George Fletcher reached a similar conclusion when he wrote:

In our daily interaction with other people, we expect friends and associates to remember appointments and to be attentive to the impact of their behavior on our lives. If inattentiveness is a fault in social interaction, it is not implausible for inattentiveness to the creation of risks to constitute a form of culpability in the criminal law.⁶

In accord with Hall's position, Larry Alexander has recently emphasized the difficulties in distinguishing negligence liability from strict liability unless one can locate a prior culpable choice on the part of the accused.⁷ As far as the courts are concerned, however, this debate appears to have had little impact. There has been little judicial recognition of the moral implications of punishing negligence in the past, and the courts have continued to treat negligence and recklessness as interchangeable concepts. Plainly, however, they are not. What we need to do, then, is to ask Jerome Hall's question again, addressed this time to the

3. H.L.A. HART, *Negligence, Mens Rea and Criminal Responsibility*, in PUNISHMENT AND RESPONSIBILITY: ESSAYS IN THE PHILOSOPHY OF LAW 136 (1968).

4. GLANVILLE WILLIAMS, TEXTBOOK OF CRIMINAL LAW 91 (1983).

5. *Id.* at 93.

6. GEORGE P. FLETCHER, RETHINKING CRIMINAL LAW 263-64 (1978).

7. Larry Alexander, *Reconsidering the Relationship Among Voluntary Acts, Strict Liability, and Criminal Law*, in CRIME, CULPABILITY, AND REMEDY 84, 85 (Ellen F. Paul et al. eds., 1990).

specific context of negligent doctors. What is the justification for punishing doctors who make mistakes?

II. WHAT IS NEGLIGENT CONDUCT?

Assessing the moral implications of negligent conduct requires a clear view of the state of mind of the negligent actor. This issue may be irrelevant in the civil context because the law of tort is ultimately not concerned with the moral culpability of the defendant, even if the language of fault is used in determining the standard of care. As far as criminal liability is concerned, however, unless we are to abandon *mens rea* altogether and accept the wide application of principles of strict liability, the subjective state of mind of the accused remains a crucial consideration. The issue then is this: Does a person who acts negligently manifest such a state of mind which justifies moral condemnation? This is perhaps best answered by identifying what negligence is *not*.

Negligent conduct is not intentional wrongdoing. If an agent performs an act with the intention of achieving a result which he knows to be harmful or unlawful, then he is quite properly held accountable for that result. There is a desire to cause harm, whether to a private or public interest, and a voluntary choice is made to this end. Such action is quite properly punished by the criminal law, unless some exception to the law is identified.

Intentional action may be present in negligent conduct in the sense that the actor may well have acted purposefully with the aim of achieving a particular goal. Yet, it is not necessarily the particular goal itself which is morally reprehensible, but the manner in which the actor performs the action which is the subject of condemnation. The actor may fail to take certain precautions which are necessary for the safe performance of a procedure, the actor may fail to exercise the degree of skill necessary to avoid something going wrong with the procedure, or the actor may seek to achieve his objective by an inappropriate means. All of these actions may involve an error of judgement on the actor's part.

It is quite possible that these three varieties of negligent conduct can occur without any moral fault on the part of the actor. A failure to take precautions, for example, may result from a lack of awareness on the part of the actor that any precautions are required. The actor may not know that the circumstances of the situation require particular precautions or may believe that all relevant measures have been taken by another person involved in the procedure. These are all excuses of ignorance, a cate-

gory of excuses which has been recognized by moral philosophers since Aristotle as undeserving of moral blame. Ignorance may also explain a want of skill or the pursuit of an objective through inappropriate means.

It is possible that the person who manifests ignorance is morally responsible for this state. A failure to rectify an identified deficiency in one's knowledge can be culpable, if one knows that the deficiency may cause harm to others. A person who knows that others rely on him to be in possession of certain knowledge, but who fails to acquire this knowledge, is clearly morally culpable for this failure. A doctor who fails to acquaint himself with developments in medicine may be blamed for the results of his ignorance if he causes avoidable harm to his patients. The doctor could have acted to dispel his ignorance, but did not. He decided not to act, and therefore, made a voluntary choice for which he is morally accountable.

A deficiency in skill, based on a failure to appreciate the limits of one's competence, may also entail moral culpability. A person who knows that he does not possess the level of skill necessary to carry out certain procedures is culpable if he proceeds in spite of this awareness. In this case, as in the case of ignorance, culpability depends on the actor's knowledge. A person who believes himself to be adequately informed, or who believes himself to be sufficiently skilled, is not morally culpable if he turns out to be mistaken. This is because he does not see himself as a danger to others. He is not, therefore, a knowing agent of harm or risk.

While some examples of negligent conduct may be culpable and may fit into the analysis suggested above, many, if not the majority, do not. There are several cases in which the actor is not deficient in knowledge or skill, but for some other reason fails to meet the standard expected of him in particular circumstances. A clear example is negligent driving. Every driver is undoubtedly guilty from time to time of driving without adequate care or attention. This may be due to fatigue or distraction, or on account of numerous other factors which from time to time render our conduct less than perfect. An extremely competent driver, who is normally attentive and cautious, may misinterpret road conditions, misjudge a distance, or otherwise drive in a manner which, when viewed objectively, is considered negligent. Although a driver may be negligent, he may not be morally culpable, unless he was taking deliberate risks at the time.

The concept of negligence involves the application of an objectively-determined standard against which conduct is measured. The way in

which this standard is defined may not be related to a statistical account of human behavior—in other words, to a model of how people *typically* act, or are statistically *likely* to act at some time. Rather, the standard may be based on a notion of how an actor *should* act if adverse consequences are to be avoided. We know that the typical driver will make a number of errors in his driving career—it may even be possible to quantify these. Yet, defining the standard of the reasonably competent driver will not take his totality of errors into account. The reasonable driver is thus a hypothetical construct of the good driver at a particular time, the driver who is not tired, is not distracted, and who is not going to misjudge distances. A failure to meet this standard does not necessarily involve moral culpability. Rather, such a failure is inevitable from time to time, even among the most conscientious drivers. Of course, the statistical inevitability of lapses of attention does not excuse any particular lapse, but merely reinforces the suggestion that such lapses are less likely to be the product of culpable neglect.

The same applies in medicine. Doctors are required daily to make delicate judgments and to exercise a high degree of skill. It is inevitable that even the most skilled and careful doctor will from time to time omit to do something which should have been done. A doctor may also make errors of judgment. These omissions and mistakes may amount to negligence according to the objective standard of care, but do not necessarily reveal a careless or cavalier attitude towards others. Such errors are a statistically inevitable concomitant of ordinary human fallibility. Empirical evidence exists to confirm this. In a recent New Zealand study, a survey of anesthetists revealed that a substantial proportion (89%) of the survey participants made potentially serious errors in their practice.⁸ The fact that such a high proportion of skilled practitioners made such mistakes does not, by itself, permit the conclusion that anesthetists are, as a group, negligent. What the survey does demonstrate, however, is that almost every doctor is fallible and, on occasion, will fall below the standard of care expected by the profession and by the civil law.

There is a considerable body of studies pertaining to the way in which accidents occur.⁹ This research tends to illustrate that any human activity is likely to be affected by a relatively high frequency of errors. "Errors" can be defined loosely as "performance which deviates from the ideal."¹⁰

8. Alan F. Merry & David J. Peck, *Anesthetists, Errors in Drug Administration and the Law*, 108 N.Z. MED. J. 105 (1995).

9. M.F. Allnutt, *Human Factors in Accidents*, 59 BRIT. J. ANAESTHESIA 856 (1987).

10. *Id.*

The research also shows that in an extremely high proportion of cases there is more than one person causally involved in the sequence of events leading up to the final outcome.¹¹ This suggests that to look for a single cause of an accident amounts to blinding oneself from an accurate explanation of the cause of the accident. Equally, to treat all errors as being of the same sort is to ignore the distinction between "slips," which are endemic in everyday life and which result from the malfunction of routine methods of dealing with familiar stimuli, and "mistakes," which involve faulty decisionmaking. Errors are common and inevitable. They cannot be lumped together as incidents of culpable negligence. A far more sensitive and informed-errors analysis is required. The more sophisticated the analysis, the cruder appears the legal tendency to equate the causation of harm with moral blameworthiness.

Some errors are more culpable than others. Blame is rightfully attributed to an error of judgement made because a person has allowed himself to be distracted or because he did not allow himself sufficient time to reach an informed decision. In such cases, the actor made a prior conscious choice in relation to the way he conducts himself. By contrast, there are failures in cognitive function largely beyond the control of the actor. A "mind-set error" is unlikely to be culpable. In errors of this nature, the person sees what he thinks he is likely to see. He may misread a label, for example, mistaking one drug for another, with potentially serious results. The person who makes such an error cannot be said to have been careless. Rather, the person has merely been deceived by his senses.

The outcome of events involving a number of persons cannot be attributed solely to one of the actors involved. Medical accidents may also represent systematic failures, where the eventual outcome is attributable to a policy decision made at a level higher up in the chain of decisionmaking. For example, a failure of supervision or a failure in training may mean that a relatively inexperienced person is required to do something beyond his actual level of competence. An explanation of the accident focusing solely on the responsibility of the person who caused the final damage provides only a superficial causal explanation of the accident and avoids placing responsibility on the shoulders of those who made the decision to expose the inexperienced doctor to the risk.

11. *Id.* at 856-57.

III. WHEN WILL NEGLIGENCE BE CULPABLE?

If it is accepted that some incidence of negligence is unavoidable, even on the part of conscientious doctors, and if further negligence is sometimes explicable in terms of systematic or mind-set errors, then it is difficult to sustain the proposition that negligence necessarily entails blameworthiness. From the point of view of civil law it may be appropriate to impose liability irrespective of moral blameworthiness. This is because in civil law two questions are at issue: *Was the defendant negligent? If so, should the defendant bear the loss in this particular set of circumstances?* In most cases where negligence has been established, the answer to the second question will be in the affirmative, unless the doctrine of remoteness or lack of foreseeability militate against a finding of liability, or where there is some policy reason precluding compensation. The question in the civil context is therefore not about moral blame, even though there will be many cases where the civilly liable defendant is also morally culpable. In the context of criminal law, however, the basic question is quite different. Here the question is: *Does the accused deserve to be punished for the outcome caused by his negligence?* This is a very different question from the civil context and must be answered in terms of *mens rea*. Only if a person has acted in a morally culpable fashion can this question be answered positively, at least as far as nonstrict liability offenses are concerned.

The only state of mind which is deserving of punishment is that which demonstrates an intention to cause harm to others, or where there is a deliberate willingness to subject others to the risk of harm. Negligent conduct does not entail an intention to cause harm, but only involves a deliberate act subjecting another to the risk of harm where the actor is aware of the existence of the risk and, nonetheless, proceeds in the face of the risk. This, however, is the classic definition of recklessness,¹² which is conceptually different from negligence and which is widely accepted as being a basis for criminal liability. The reckless actor is conscious of the risk of harm to others and is culpable precisely because he values his own objectives above the safety of others. If this category of reckless conduct is morally useful, and it clearly is, then it must be distinguished from the category of negligent conduct which, as we have seen, does not involve the same morally reprehensible indifference to the safety of others.

The solution to the issue of punishing what is described loosely, and possibly inaccurately, as negligence is to make a clear distinction between

12. ANDREW ASHWORTH, PRINCIPLES OF CRIMINAL LAW 154-55 (1991).

negligence and recklessness and to reserve criminal punishment for the latter. If the conduct in question involves elements of recklessness, then it is punishable and should not be described as merely negligent. If, however, there is nothing to suggest that the actor was aware of the risk deliberately taken, then he is morally blameless and should face, at the most, a civil action for damages.

The argument may be made that negligent conduct should be punished. If the threat of a sanction will encourage people to take care, then the sanction may be justified in the interest of the community as a whole. This is the strict liability argument and is used to justify a whole range of regulatory sanctions which are necessary to safeguard the public. Justification for the conviction of a morally innocent persons is premised on the grounds that the conduct in question is otherwise impossible to regulate if defenses are available. Such an argument may be convincing in relation to offenses such as pollution or traffic offenses. It is difficult to sustain the same argument, however, in relation to offenses involving moral opprobrium. Indeed, the Canadian courts have developed the clear rule that there cannot be a conviction on strict liability grounds in respect of any offense involving the possibility of a prison sentence.¹³ To convict negligent doctors of serious criminal offenses, such as manslaughter, may indeed have the effect of encouraging others to be more careful, but only at the cost of severe injustice in individual cases. Any system of criminal justice so cynical would be difficult to defend on moral grounds.

IV. THE EMERGENCE OF GROSS OR CRIMINAL NEGLIGENCE

How far does the criminal justice system go today in punishing conduct which fails to meet a satisfactory level of competence? In English common law and other closely related systems in the common law world, a standard of criminal negligence has been developed which was intended to distinguish between those whose failure is culpable and those whose conduct, although not up to standard, is not deserving of punishment. This development came about in the mid-nineteenth century and was firmly established by the beginning of the twentieth century. Previously, English criminal law punished those who caused harm through ordinary (civil) negligence.¹⁴

The distinction between those forms of negligence which would attract

13. Alan Brudner, *Imprisonment and Strict Liability*, 40 U. TORONTO L.J. 738 (1990).

14. See G.L. Peiris, *Involuntary Manslaughter in Commonwealth Law*, 5 LEGAL STUD. 21 (1985) (providing a useful summary of the development of the law).

a criminal sanction and those which would merely give rise to a civil claim for damages was expressed in terms of the degree of negligence involved. In order to distinguish civil from criminal negligence, the courts used adjectives such as *gross*, *serious*, *wilful*, *culpable*, or *wanton*.¹⁵ These terms served to emphasize that the degree of negligence involved had to be very high before there could be any question of criminal liability. Some, if not all, of the terms also emphasize the requirement of moral wrongdoing. It is difficult to imagine, for example, how one's conduct might be described as wantonly negligent without demonstrating a reprehensible attitude towards the potential victims. Of course, it is possible that an objective test of gross or criminal negligence could still penalize a person who did not actually possess such an attitude. However, in most cases this would be very unlikely.

In the early years of this century, the consensus in the English common law was that prosecutions for manslaughter should only proceed on the basis of a special form of negligence; namely, negligence which constituted an extreme departure from the expected norm.¹⁶ In one of the earlier medical cases, *Regina v. Bateman*,¹⁷ this requirement was clearly explained by the court in the following terms:

[I]n 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.¹⁸

This is the language of subjective liability requiring proof of *disregard*, an unmistakably subjective notion. Thus, it is not surprising that the concept of recklessness should have been treated from time to time as synonymous with criminal negligence. To act recklessly is to act with indifference to the consequences for others. This is surely the mind-set one

15. *Regina v. Greisman*, 46 C.C.C. 172 (1926) (*wanton*); *Regina v. Horvath*, 1972 V.R. 533 (*gross*); *Regina v. Miller*, 82 C.C.C. 314 (1944) (*serious*); *Regina v. Savoie*, 117 C.C.C. 327 (1956) (*wilful*); *Wittig v. Regina*, 27 C.L.R. 158 (1919) (*culpable*).

16. A similar position pertains in the United States. Although the Model Penal Code speaks of negligence without qualification, state penal codes tend to require *criminal negligence* for negligent homicide convictions. See, e.g., TEX. PENAL CODE ANN. § 19.05 (West 1995) (defining the elements of criminally negligent homicide).

17. 19 Crim. App. 8 (1925).

18. *Id.* at 11-12; see also Peiris, *supra* note 14, at 27 (quoting *Bateman*, 19 Crim. App. at 11-12).

expects to find in a person said to be showing wanton or wicked negligence.

This tendency to talk of recklessness in the same breath as gross negligence—perhaps a consequence of the general failure of common law systems to identify and clarify theoretical distinctions—was bound to lead to confusion. Indeed, this confusion began to make its presence felt in the English law of manslaughter. The difficulty arose from the development in English criminal law of two tests for negligence, a subjective test and an objective test. The subjective test, called the *Cunningham* recklessness test,¹⁹ applied where the accused must have known of the existence of a risk of harm but acted nonetheless. The objective test, the *Caldwell/Lawrence* negligence test,²⁰ applied where the accused failed to address his mind to the existence of a risk *which the reasonable person would have realized existed*. The form of recklessness that was required depended on the nature of the offense. In general, serious common law crimes required proof of subjective recklessness, while statutory crimes references to recklessness could be objective.

The application of the objective test of recklessness by the House of Lords in *Regina v. Seymour*,²¹ a vehicle manslaughter case, caused confusion in the English Law. The court in *Seymour* held that there could be a conviction for manslaughter wherever conduct created an obvious and serious risk of harm to another, even if that risk was not appreciated by the accused. After this decision, it was assumed by some courts that gross negligence manslaughter had been subsumed into reckless manslaughter, while others continued to apply the law of negligent manslaughter laid down in *Andrews v. Director of Public Prosecutions*²² and *Bateman*.²³

The matter came up for consideration in a number of controversial manslaughter prosecutions, *Regina v. Prentice*,²⁴ *Regina v. Sullman*,²⁵ *Regina v. Holloway*,²⁶ and *Regina v. Adomako*,²⁷ all of which went to the Court of Appeal and one of which, *Adomako*, progressed to the House of Lords. In the cases of *Prentice* and *Sullman*, which emerged from the

19. See *Regina v. Cunningham*, [1957] 2 Q.B. 396.

20. See *Comm'r of the Police of the Metropolis v. Caldwell*, 1982 A.C. 341 (1981); *Regina v. Lawrence*, 1982 A.C. 510 (1981).

21. [1983] 2 A.C. 493.

22. 1937 A.C. 576.

23. 19 Crim. App. 8 (1925); see also Peiris, *supra* note 14, at 27 (discussing *Bateman*).

24. 4 All E.R. 935 (Eng. C.A. 1993).

25. *Id.*

26. *Id.*

27. 3 All E.R. 79 (Eng. H.L. 1994).

same incident, the two accused were junior doctors who administered a cytotoxic drug by an inappropriate route, thereby causing the death of the patient. The case is a classic one of systematic errors where the doctors misunderstood the precise scope of their responsibilities. It is difficult to view the whole matter as anything but an unfortunate accident, the type which occurs when junior staff are required to undertake procedures for which they are not properly trained. *Adomako*, by contrast, involved conduct of a more culpable sort; namely, the failure of an anaesthetist to respond to an emergency for a considerable period of time in spite of the existence of alarms which would have drawn his attention to the crisis. In disposing of the appeal in this case, the House of Lords took the opportunity to emphasize the continued applicability of the traditional test for manslaughter of this sort—gross negligence.²⁸ It was pointed out by Lord Chancellor that the term recklessness could still be used by a judge instructing a jury in such a case, but the term must be used in its everyday, nontechnical meaning rather than in any specific sense it has acquired in the law.²⁹ This means that the objective concept of recklessness enshrined in the *Caldwell/Lawrence* cases and their progeny would not be appropriate.³⁰ While this fortunately excludes an unwelcome element from this form of manslaughter, it still perpetuates the terminological confusion that surrounds this area by continuing to associate recklessness and negligence. Recklessness in its everyday sense is a subjective concept, while negligence is an objective concept. "Subjective negligence," that is, acting in the face of an understood risk of harm to others, amounts to recklessness and should be called as such.

V. AN ALTERNATIVE APPROACH

In English law the picture is clear. Although cases such as *Seymour* muddied the waters for a while, the overall position this century has been that negligent manslaughter requires conduct demonstrating a very high degree of negligence, with a strong suggestion that this is to be subjectively assessed. In other closely-related jurisdictions, the law, for the most part, has followed a similar pattern of development, with the courts requiring a manifestation of something more than mere civil negligence. In Australia, the common law states have applied a standard of gross negligence,³¹ and in the code states the courts have read in such a require-

28. *Id.* at 83-87.

29. *Id.* at 87-89.

30. *See id.* at 89.

31. *Regina v. Gunter*, 21 N.S.W. St. R. 282 (1921).

ment even though the codes speak of negligence *simpliciter*.³² In Canada, although the position has at times not been entirely clear, section 219(1) of the Criminal Code states that criminal negligence is present where a person "shows wanton or reckless disregard for the lives or safety of other persons."³³ The same is true of virtually every other Commonwealth jurisdiction, with the exception of a handful of countries, notably South Africa, Singapore, and New Zealand.

The attitude of the New Zealand courts to the issue of negligent manslaughter represents perhaps the most unambiguous rejection in any jurisdiction of the gross negligence standard. The roots of this can be found in the wording of the nineteenth century draft code which forms the basis of the current New Zealand Crimes Act 1961.³⁴ The relevant provisions of this code impose liability for manslaughter on those who, while providing surgical or medical treatment, cause death through a failure to have or use reasonable knowledge, skill, and care.³⁵ A similar provision, not specifically concerned with medical treatment, imposes liability on those who fail to show reasonable care when engaged in potentially hazardous activities.³⁶

In several early cases, the New Zealand courts were invited to interpret the meaning of the requirement of reasonable care and whether it meant a failure to show the degree of care that was required to avoid civil liability, or whether it required something more, as in the other common law jurisdictions. In the first of these cases, *Rex v. Dawe*,³⁷ a case involving the prosecution of a tram driver who had allowed his tram to collide with another, the court held that a simple test of negligence was to be applied. This view was endorsed by the Court of Appeal on appeal from *Dawe* and again in *The King v. Storey*.³⁸ Both of these decisions were guided by considerations of statutory interpretation. It is doubtful, however, whether the original framers of the law would have approved of the application of a statute designed to restrict the activities of charlatans, to be

32. *Callaghan v. The Queen*, 87 C.L.R. 115 (1952) (Austl.); *Griffiths v. The Queen*, 167 C.L.R. 372 (1989) (Austl.).

33. R.S.C., ch. C-46, § 219(1) (1985).

34. The Criminal Code Act 1893 replaced the common law of crimes in New Zealand. The 1893 Act was replaced by the Crimes Act 1908, which was replaced later by the Crimes Act 1961.

35. 1 R.S.N.Z. § 155 (1979).

36. 1 R.S.N.Z. § 156 (1970).

37. 30 N.Z.L.R. 673 (1911).

38. 1931 N.Z.L.R. 417 (1930).

used instead to punish highly-qualified conscientious doctors who have made a minor slip, even if that slip resulted in a disastrous outcome.

However, this is precisely what happened in New Zealand in a series of prosecutions against doctors and nurses for the offense of negligent manslaughter. The best known of these cases, *Regina v. Yogasakaran*,³⁹ was eventually heard on appeal by the Privy Council, which considered that it was not appropriate for the Council to interfere with a matter of policy that should be left to the New Zealand courts. Dr. Yogasakaran was an anaesthetist who noticed that his patient was experiencing difficulty breathing and decided to inject her with a drug called Dopram. He opened the right drawer of the anesthetics trolley and extracted an ampoule of a drug from the section marked with the name Dopram. Unknown to the doctor, another member of the staff had inserted the wrong drug into this section of the anesthetics trolley. As a result, the patient was injected with Dopamine which caused her death. Dr. Yogasakaran did not read the label of the drug he was injecting, assuming that it was correct because it had come from the right place in the anesthetics trolley. Expert evidence at trial led to the conclusion that an anesthetist should read the label of every drug before it is injected, even in an emergency. On this basis, Dr. Yogasakaran was held to have been negligent and was subsequently convicted of manslaughter.

The difficulty for the accused doctor in this case was that he had failed to meet the standard of care which expert witnesses were able to identify for that particular set of circumstances. Expert evidence describes the set of correct procedures constituting the norm. It has nothing to say about what mistakes might be *understandable or pardonable* in an emergency. If the question were to be rephrased, and the experts invited to say what mistakes might be made by a competent doctor who did not necessarily manifest an attitude of indifference to the patient, a very different answer would be expected. The mere fact that Dr. Yogasakaran failed in an emergency to read the label of a drug which he extracted from the right place does not necessarily indicate that he did not care whether he was subjecting his patient to a risk.

Three other medical and nursing cases resulted in the conviction of practitioners who had made various errors relating to the identity of the substance they were administering to patients. In *Regina v. Macdonald*,⁴⁰ the cause of the accident was the anaesthetist's unfamiliarity with the lay-

39. [1990] 1 N.Z.L.R. 399 (1989).

40. Unreported, Christchurch, 1982, T24/82.

out of the operating theater and his expectation, based on his previous experience that oxygen, not carbon dioxide, would be delivered from a left-hand rotameter. In *Regina v. Morrison*,⁴¹ the error was on the part of a staff member who handed a radiologist the wrong drug, setting the sequence of events in motion. Here again, the negligence of the doctor administering the drug was the doctor's failure to read the label. Finally, in *Regina v. Brown*,⁴² a nurse was convicted of manslaughter after she had set an automatic pain relief pump at a rate which was appropriate for the administration of antibiotics. This rate, however, was ten times higher than the rate required under the medical circumstances, and the patient died as a result. The nurse in this case believed that she was calibrating the antibiotic pump.

It is not surprising that the medical and nursing professions in New Zealand have felt considerable dissatisfaction with a criminal law which could result in the prosecution of people who made ordinary human errors of judgement or ordinary human slips. At the time of this writing, responding to a concerted campaign to reform the law, the government of New Zealand announced its proposal to amend the law in order to introduce a gross negligence standard for conviction of manslaughter. The arguments voiced by medical professionals in response to the proposed change in the law included not only a straightforward moral objection to labelling as criminal those who make errors which are effectively inevitable in any complex activity, but also pragmatic considerations as to the practice of defensive medicine prompted by a fear of prosecution.

Although New Zealand has been largely isolated in its application of a civil negligence standard, it is not alone in this respect. In Italy, the standard for negligent homicide prosecutions is similar to New Zealand's, despite some doctrinal opposition. The same is true under South African law. In South Africa, there is theoretically no distinction between civil and criminal negligence. Nonetheless, the courts have stressed that negligence requires clear foreseeability of a risk of causing *death*, rather than a mere risk of *harm*, effectively militating against the inference of negligent conduct.⁴³

41. Unreported, Dunedin, 1991, S7/91.

42. Unreported, Wellington, 1994, S27/94.

43. *State v. Van der Mescht*, [1962] 1 S.A. 521 (1961); *State v. Bernardus*, [1965] 3 S.A. 287; *State v. Van As*, [1976] 2 S.A. 921.

VI. PROSPECTS FOR REFORM

For the reasons proposed above, prosecution for manslaughter or related offenses of those who are negligent, in the true sense of the word, conflicts with the principle that the morally innocent should not be convicted of serious crimes. This has been avoided by the gross negligence requirement which, if properly applied, effectively limits the law to convicting those who have behaved *recklessly* (in the true, subjective sense of the word). The punitive urge to punish those who have caused harm, without any sophisticated moral assessment of the actor's state of mind, is always present in society and can easily turn the criminal law into an instrument of oppression. The medical profession is particularly vulnerable to this, as it may be perceived as exploitative or unaccountable, prompting the public to derive some pleasure from seeing members of the profession in the dock. There have been some indications of this sentiment in New Zealand. It is also significant that the enthusiastic prosecution of doctors should occur in a country such as New Zealand, where the right to sue for civil damages has been largely curtailed by the introduction of a no-fault accident compensation system. One might wonder whether the criminal law has taken over some of the functions normally provided by a tort-based system for the venting of family discontent over a medical accident.

Reform of the law to prevent the inappropriate use of criminal sanctions as a means of regulating medical practice should ideally be achieved by a more wide-ranging reform of the law relating to involuntary homicide. There is much that is unsatisfactory with English law on this subject, where a manslaughter conviction can result when death is caused by the commission of any act which is unlawful and dangerous. The test which the English courts have used to determine what is dangerous in such contexts has been an objective one; namely, whether a reasonable person would consider the act as one carrying with it some risk of harm, even if the harm is not serious.⁴⁴ In Australia, some courts favor the subjective test, which requires a showing that the accused should have perceived the risk of serious harm that would result from his act.⁴⁵ Clearly an objective test in this context sits more easily with allowing conviction for manslaughter on the basis of objectively determined negligence. Therefore, any reform of negligent manslaughter should ideally be accompanied by a critical examination of nonnegligent involuntary manslaughter.

44. *Director of Pub. Prosecutions v. Newbury*, [1976] 2 All E.R. 365.

45. *Regina v. Longley*, 1962 V.R. 137 (1961).

The way for law reform in this area is perhaps to abandon the term "negligent manslaughter" altogether and to have a single test of the *mens rea* for involuntary manslaughter. As the Law Commission in England has tentatively suggested, the test could be based on the accused's awareness of the fact that his action could cause death or serious injury, and whether his act is accompanied by conduct on his part which falls significantly or seriously below what was expected of him in the circumstances.⁴⁶ This would extend the scope of the crime of manslaughter to those who cause death in the course of a serious assault. It would not apply in cases where death occurred after a minor assault resulted in freak damage. In contexts where the unlawful act is not an act of hostility against the victim, the situations currently covered by criminal negligence manslaughter, it would effectively limit prosecution to those who are reckless. Each case would depend on a moral assessment by the court or the jury as to the blameworthiness of the accused's conduct. This assessment can be made on the basis of the following question: *Did the accused deliberately expose others to the risk of harm?* This gives some discretion to the jury to assess the accused's moral blameworthiness, and it is a significant improvement from holding the jury hostage to an objective formula—such as the test for simple, civil negligence. Jerome Hall was right.

46. THE LAW COMMISSION, *CRIMINAL LAW: INVOLUNTARY MANSLAUGHTER CONSULTATION PAPER*, No.135 (H.M.S.O. 1994).