

**RESPONSIBILITY FOR IATROGENIC DEATH IN
AUSTRALIAN CRIMINAL LAW**

DAVID J CARTER

A THESIS SUBMITTED FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

FACULTY OF LAW

UNIVERSITY OF TECHNOLOGY SYDNEY

2017

CERTIFICATE OF ORIGINAL AUTHORSHIP

I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

This research is supported by a Quentin Bryce Law Doctoral Scholarship.

Production Note:

Signature removed prior to publication.

29 September, 2017

‘In gross negligence manslaughter, the jury...finds justice where the law cannot guide it.’¹

- Alan Norrie

‘Nobody ever said that care would be easy’.²

- Annemarie Mol

¹ Alan Norrie, *Crime, Reason and History: A Critical Introduction to Criminal Law* (Cambridge University Press, 2001) 45.

² Annemarie Mol, *The Logic of Care: Health and the Problem of Patient Choice* (Routledge, 2008) 87.

ABSTRACT

Iatrogenic harm is harm, including death, that arises in the course of medical or healthcare treatment and is caused by the application of treatment itself, rather than by the underlying disease or injury. Each year, some 27,000 deaths in Australian acute care hospitals are associated with iatrogenic harm. Such harm in its iatrogenic form raises for us, in an urgent contemporary setting, some of the perennial questions associated with moral and legal answerability and questions of the limits of medicine, the difficulty of healing and of the politics of care.

Criminal law, in the form of manslaughter by criminal negligence, has been heavily criticised whenever its deployment has been contemplated as a response to iatrogenic death. And yet, the doctrine both remains in place, and exerts a significant influence on the regulation and conduct of medicine and healthcare. To understand why criminal law, despite its rare use, has been subject to such strident critique, I focus upon the assemblage of ways of knowing (epistemology), of deciding (ethics) and of acting (praxis) known as the 'healthcare quality and safety sciences', or more simply, the 'patient safety' movement, that has been its chief interlocutor.

In response to the charge made by the patient safety movement that criminal prosecution is both unhelpful and unjust, I argue that these calls for rejection of manslaughter by criminal negligence have not been sufficiently attentive nor responsive to the actual practices of criminal law in this field; not to the history of its use, to its particular understanding of human action in health care, or to its mobilisation in the courtroom. As this thesis shows, when these foundational aspects of law's actual practice in the field are more fully and critically engaged, they seriously destabilise the validity of claims that manslaughter by criminal negligence is unhelpful or unjust when applied to iatrogenic harm in the Australian setting.

In light of the new research presented here, it can be no longer said that the offence of manslaughter by criminal negligence is overused in Australia in response to iatrogenic harm. Nor can it be said that law, and specifically criminal law, has been wholly unhelpful for progressing the agenda of the healthcare quality and safety sciences, or that manslaughter by criminal negligence operates with an understanding of human action and agency that is incompatible with the quality and safety disciplinary project. Finally, it can no longer be said that manslaughter by criminal negligence represents an unjust imposition of liability by imposition of standards alien to those of medicine and healthcare.

CONTENTS

Introduction.....	1
The Use of Manslaughter by Criminal Negligence in Australian Legal History	43
The ‘Discovery’ of Iatrogenic Harm	109
Care & Choice: Responses to Iatrogenic Harm	157
The Affinity Between Quality and Safety Improvement and the Logic of Care.....	191
The Doctrinal Openness and Flexibility of Manslaughter by Criminal Negligence	223
Conclusion	267
Appendix A.....	281
Bibliography	285

DETAILED CONTENTS

Introduction.....	1
Iatrogenic Death & the Criminal Law.....	1
Locating the Thesis	14
Thesis Overview & Chapter Summary	33
Scope, Assumptions and Limitations.....	39
The Use of Manslaughter by Criminal Negligence in Australian Legal History	43
Introduction	43
The Stability of Prosecution Rates.....	46
Extending the Case Law.....	64
Analysis of Extended Australian Case Law.....	77
Conclusion	106
The ‘Discovery’ of Iatrogenic Harm:	109
Introduction.....	109
The ‘Discovery’ of Iatrogenic Harm.....	113
The Expulsion of Law.....	134
A False Dichotomy	148
Conclusion	152
Care & Choice: Responses to Iatrogenic Harm.....	157
Introduction.....	157
Theoretical Framework: The Logic of Care & The Logic of Choice	161
How the Logic of Choice is Enacted in the Discourse of Quality and Safety Science..	173
Implications.....	184

Conclusion	188
The Affinity Between Quality and Safety Improvement and the Logic of Care	191
Introduction	191
The Discipline of Quality and Safety Science’s Understanding of Human Action	193
The Shared Contours of the Improvement Practices of the Quality and Safety Sciences and of the Logic of Care	211
Implications	218
The Doctrinal Openness and Flexibility of Manslaughter by Criminal Negligence...	223
Introduction	223
Background	225
Manslaughter by Criminal Negligence in Australia	234
Method and Scope	244
Implications	263
Conclusion	265
Conclusion	267
The Question of Iatrogenic Death and Criminal Law	267
Responsibility for Iatrogenic Death in Australian Criminal Law	270
Conclusion	278
Appendix A.....	281
Bibliography.....	285

LIST OF FIGURES

Figure 1: Number of prosecution (UK) vs Finished Consultant Episodes (FCE) per annum 1976–2005 (Ferner and McDowell, 2006)	54
Figure 2: Number of convictions (UK) vs Finished Consultant Episodes (FCE) per annum 1976–2005 (Quick, 2006)	55
Figure 3: Number of incidents investigated (UK) vs Finished Consultant Episodes (FCE) per annum 1976–2005 (Quick, 2006)	55
Figure 4: Regression analysis – prosecutions (UK) vs FCEs (Ferner and McDowell, 2006)	57
Figure 5: Regression analysis – prosecutions (UK) vs healthcare expenditure (£ billion) ..	58
Figure 6: Regression analysis – prosecutions (UK) vs NHS medical and dental staff	58
Figure 7: Regression analysis – convictions (UK) vs FCEs	59
Figure 8: Incidents/Investigations (UK) vs FCEs	59
Figure 9: Prosecutions (UK) per 1 million FCEs	60
Figure 10: Prosecutions (UK) per £1 billion healthcare expenditure	61
Figure 11: Convictions (UK) per £1 billion healthcare expenditure	62
Figure 12: Investigations (UK) per £1 billion healthcare expenditure	62
Table 1: Australian Medical and Para-Medical Manslaughter Cases	73

PUBLISHED WORKS

Chapter 1 of this thesis incorporates original published work arising from research undertaken during candidature that has been published in a peer reviewed journal: Carter, David J, ‘Correcting the Record: Australian Prosecutions for Manslaughter in the Medical Context’ (2015) 22(3) *Journal of Law and Medicine* 588.

ACKNOWLEDGEMENTS

Care is ‘a matter of various hands working together (over time)’.³ So too are theses. Completing this thesis would not have been possible without the support of so many, only a handful of whom I can acknowledge here.

It is both a privilege and delight to have been able to work with Professor Katherine Biber and Associate Professor Penny Crofts as supervisors for this thesis. My hope is that you both can see the fruits of your generosity in the pages as clearly as I see it. I have been formed and reformed as a scholar, colleague and friend in numerous ways because of your supervision. None of what is written here can be disentangled from that ‘persistent tinkering’ and practical ‘doctoring’ we have undertaken together. Thank you.

Associate Professor Angus Corbett has been an abiding influence on my intellectual development. His friendship and intellect has decisively shaped this thesis and will, no doubt, continue to shape what flows hereafter. Thank you also to Anita Stuhmcke for her longstanding support and occasional supervision. I acknowledge and thank Matthew Sidebotham and Margy Thomas for their editorial assistance.

I am especially grateful for the material support and community that being named one of the inaugural Quentin Bryce Law Doctoral Scholars and Teaching Fellows of the Faculty of Law at the University of Technology Sydney has gifted me. Professor Lesley Hitchens, Professor Jill McKeough and Professor Jenni Millbank deserve significant thanks and recognition for their work to establish and support this essential and precious scheme. I am especially lucky to have found myself on this journey alongside Anthea, Elyse, Starla and Rachel. Sharing an office and our intellectual projects has been a gift.

I was attracted to the question of iatrogenic harm and criminal negligence because it concerns our relationships. It is fitting then that my own relationships be acknowledged, especially those that have figured as the basis for this work and my ability to undertake it. Thank you to my colleagues and friends for all that they have contributed. For those who I have had the honour to work alongside in the many and varied hospitals, general practices and places of community for people living on and around the streets, thank you for teaching me what the practical task of care means in the face of our responsibility to care for strangers. For conversations about the thesis and for guidance and support, particular thanks goes to Rachel Bolton, Deborah Debono, Erol Dulagil, Bonnie Faulkner, Starla Hargita, Sam Hartridge, Joanna Hayes, Robyn Horner, Celia Langton, Cath Leary, Graham Long, Katrina Mathieson, Elyse Methven, Julie Morgan, Lynette Reeves, Richard Shepherd, Alecia Simmonds, Carla Saunders, Keren Toomey, Josephine Touma, Joanne Travaglia and Anthea Vogl. Each of you, in numerous ways, has a claim on this thesis beyond just the words on the page.

To my family, you remain the reason why I can attempt any of the things that I do. Thank you Lyn, Les and Michael for your constancy, your patience and for knowing me so well. Most especially, for his quiet way of care, confidence and love not merely in support of this work but for the world, my greatest thanks goes to Mark.

³ Ibid 20.

RESPONSIBILITY FOR IATROGENIC DEATH IN AUSTRALIAN CRIMINAL LAW

INTRODUCTION

I IATROGENIC DEATH & THE CRIMINAL LAW

Iatrogenic harm is harm that arises due to the application of healthcare treatment rather than from an underlying disease or injury.¹ This form of harm associated with healthcare provision constitutes a grave problem with serious consequences. At least ten per cent of admissions to acute care hospitals are associated with an ‘adverse event’² in which a person receiving healthcare is harmed, including 1.7% of admissions associated with a major iatrogenic disability, and 0.3% of admissions with death.³ Despite significant efforts by a range of health system participants, these rates of iatrogenic harm have not measurably improved at a system level for fifty years.⁴ The result is a shocking scale of suffering; approximately 152,000 people are left with major disability and approximately 27,000 people die from iatrogenic harm each year in Australian hospitals.⁵ Though not

¹ World Health Organization, *Conceptual Framework for International Classification for Patient Safety* (World Health Organization, Final Technical Report, Version 1.1, 2009) 22, 106.

² Like law, healthcare quality and safety has its own restricted and specific vocabulary. Adverse Events (AEs) are defined as an ‘incident in which harm resulted to a person receiving health care’, iatrogenic pertains to ‘arising from or associated with healthcare rather than the underlying disease or injury’ harm, whilst maintaining various legal and ordinary language definitions, is understood within quality and safety writing to include ‘disease, injury, suffering, disability and death’. William B Runciman, ‘Shared Meanings: Preferred Terms and Definitions for Safety and Quality Concepts’ (2006) 184 *Medical Journal of Australia*; note, however, that definitional questions are central to the various landmark studies that describe the nature and scale of iatrogenic harm, the QAHCS study, for instance, defines an adverse event as that ‘an unintended injury or complication which results in disability, death or prolonged hospital stay and is caused by health care management’. Ross M Wilson et al, ‘The Quality in Australian Health Care Study’ (1995) 163(9) *Medical Journal of Australia* 458.

³ William Runciman and J Moller, *Iatrogenic Injury in Australia* (Australian Patient Safety Foundation, 2001) 17; these rates are now regarded as consistent across both advanced and developing healthcare systems, see Angus Corbett, Jo Travaglia and Jeffrey Braithwaite, ‘The Role of Individual Diligence in Improving Safety’ (2011) 25(3) *Journal of Health Organization and Management* 247, 248; John D Hamilton, Robert W Gibberd and Bernadette T Harrison, ‘After the Quality in Australian Health Care Study, What Happened?’ (2014) 201(1) *The Medical Journal of Australia* 23; RM Wilson et al, ‘Patient Safety in Developing Countries: Retrospective Estimation of Scale and Nature of Harm to Patients in Hospital’ (2012) 344 *BMJ* e832.

⁴ Jeffrey Braithwaite, Robert L Wears and Erik Hollnagel, ‘Resilient Health Care: Turning Patient Safety on Its Head’ (2015) 27(5) *International Journal for Quality in Health Care* 418, 419; Robert L Wears, Kathleen M Sutcliffe and Eric Van Rite, ‘Patient Safety: A Brief But Spirited History’ in Lorri Zipperer (ed), *Patient Safety: Perspectives on Evidence, Information and Knowledge Transfer* (Ashgate Publishing, Ltd., 2014) 3.

⁵ Runciman and Moller report a figure of 10,000 deaths in Australia per annum on 1992 figures, however, it is unclear from this report the exact source of this figure: Runciman and Moller, above n 3, xv; the earlier QAHCS findings in Australia found 230,000 preventable iatrogenic injuries in 1992, of which 13,000 were associated with death Eric J Thomas et al, ‘A Comparison of Iatrogenic Injury

wholly settled, landmark studies in the area find that between 50 and 80 per cent of all adverse events are potentially preventable.⁶

The existence of iatrogenic harm has precipitated a fraught legal and regulatory debate. Particularly animated has been discussion surrounding the potential for criminal liability in response to iatrogenic harm that has led to the death of a patient. Where prosecuted, such deaths are likely to constitute a charge of manslaughter by criminal negligence or a cognate offence,⁷ often referred to as ‘medical manslaughter’.⁸ Applicable only to iatrogenic deaths that result from the most ‘gross’,⁹ ‘culpable’,¹⁰ ‘criminal’,¹¹ ‘complete’¹²

Studies in Australia and the USA I: Context, Methods, Casemix, Population, Patient and Hospital Characteristics’ (2000) 12(5) *International Journal for Quality in Health Care* 371, 372; although hospital activity reporting is almost uniformly reported as separations (which includes discharges, transfer or statistical type changes) it seems the analysis of the incidence of iatrogenic in the landmark studies during the 1990’s was based upon ‘discharge’ (home). As such, the estimate of 27,000 iatrogenic deaths per annum is based on an extrapolation of the widely agreed 0.3% incidence of iatrogenic death applies to discharge (home or to place of usual residency including residential aged care) which in 2013-14 accounted for 8,969,032 of 9,702,304 total separations (26,907 per annum) Australian Institute of Health and Welfare, ‘Admitted Patient Care 2013–14, Australian Hospital Statistics’ (No 60 Cat. HSE 156, 2015) (Table 5.37) 134 <<http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129550480>>; this assumes, per Braithwaite et al, that these rates have not materially shifted since their accounting in the early 1990’s and 2000’s, see Braithwaite, Wears and Hollnagel, above n 4, 419.

⁶ The 1994-95 Australian QAHCS study reported: ‘Preventability was not strongly associated with age, sex or insurance status, nor was it associated with the level of disability, except for death (in which 70% of Adverse Events showed high preventability). Only 1.2% of AEs in the “no preventability” category resulted in death, compared with 4.1% in the “low preventability” category and 6.5% in the “high preventability” category. Some of this association between preventability and death could be ascribed to outcome bias’, Wilson et al, above n 2; the QAHCS study reported 51% preventability across all adverse events, see Runciman and Moller, above n 3, 22; see also the QAHCS results reinterpreted where: ‘all adverse events were re-classified as to whether they fell into one of two categories, “potentially preventable”, or “not preventable with current medical knowledge” rather than using the six-point scale in the QAHCS, it was found that 80% of adverse events fell into potentially preventable categories’, William Runciman, MJ Edmonds and M Pradhan, ‘Setting Priorities for Patient Safety’ (2002) 11(3) *Quality and Safety in Health Care* 224.

⁷ See Chapter 5 for a more detailed overview of the specifics of the offence and its variants which exist in various Australian jurisdictions.

⁸ See for examples of the use of this shorthand for the offence see Rebekah Callahan and Stanley Yeo, ‘Negligence in Medical Manslaughter Cases’ (1999) Volume 6 *Journal of Law and Medicine*; Ian Dobinson, ‘Medical Manslaughter’ (2009) 28 *University of Queensland Law Journal* 101; Nikita Tuckett, ‘Balancing Public Health and Practitioner Accountability in Cases of Medical Manslaughter: Reconsidering the Tests for Criminal Negligence-Related Offences in Australia after R v Patel’ (2011) 19(2) *Journal of Law and Medicine* 377; Danielle Griffiths and Andrew Sanders, ‘The Road to the Dock: Prosecution Decision-Making in Medical Manslaughter Cases’ in Danielle Griffiths and Andrew Sanders (eds), *Bioethics, Medicine and the Criminal Law: Medicine, Crime and Society* (Cambridge University Press, 2013) vol 2, 117.

⁹ Seeking to refine the test various epithets or adjectives such as “culpable”, “criminal”, “gross”, “wicked”, “clear” and “complete” have been employed when referring to the degree of negligence required, *Andrews v DPP* [1937] AC 576.

¹⁰ *R v Gunter* (1921) 21 SR (NSW) 282, 286 (Cullen CJ); *R v Taktak* (1988) 14 NSWLR 226, 351, 353.

or ‘wicked’ breach of duty,¹³ the application of this particular criminal offence has been subject to substantial critique both in Australia and elsewhere. The field is dominated by scholarly and professional literatures that reject the use of the offence on two main grounds: that it is unhelpful and that it is unjust. This critique is so strong that the vast majority of scholarship on the topic concludes that both the safety of patients and justice itself would best be served by abolition or non-prosecution of the offence.¹⁴

The discipline most engaged in this debate is the healthcare quality and safety sciences and those allied to its way of approaching iatrogenic harm.¹⁵ This discipline emerged from efforts at systematic quality improvement by particular medical specialties,¹⁶ and by various early champions of quality and safety,¹⁷ that attempted to measure and analyse

¹¹ *R v Shields* [1981] VR 717; see for example Judicial College of Victoria, *Victorian Criminal Charge Book* (Judicial College of Victoria, Electronic Edition, 2016) [7.2.5.1] <<http://www.judicialcollege.vic.edu.au>>.

¹² *Andrews v DPP* [1937] AC 576.

¹³ McClellan CJ at CL and Howie AJ in their joint judgement provide a comprehensive account of what might constitute a ‘gross’ breach of duty, *Burns v The Queen* (2011) 205 A Crim R 240, 240 (McClellan CJ at CL at [1], Schmidt J at [167], Howie AJ at [1]).

¹⁴ The critique of criminal negligence is mirrored outside the healthcare context, where scholars of criminal law and jurisprudence remain divided about the worth and justifiability of criminal negligence in general, albeit with less uniform opposition and more diversity in the positions they hold.

¹⁵ As to an understanding of this ‘field’ see, Joanne F Travaglia and Jeffrey Braithwaite, ‘Analysing the “Field” of Patient Safety Employing Bourdieusian Technologies’ (2009) 23(6) *Journal of Health Organization and Management* 597.

¹⁶ Namely anaesthetics. See the influential study by Beecher and Todd in the mid-1950’s, that was followed by developments which have been understood to have been driven by financial/insurance and ‘malpractice crises’, see Travaglia and Braithwaite’s brief summary of the chronology given in this way, *ibid* 599; in the Australian context, the ‘malpractice crises’ of the 1990’s is commonly understood to be the driver of research and action in relation to iatrogenic harm. Angus Corbett’s work during and after that period recounts many of the legal features and responses to that alleged crisis, whilst my work in Chapter 2 works to raise questions about the orthodox understanding of that period and its relationship to both civil/tortious negligence doctrine, of litigation rates and of indemnity systems of the time. In relation to Corbett’s work see principally, Angus Corbett, ‘Regulating Compensation for Injuries Associated with Medical Error’ (2006) 28(2) *Sydney Law Review* 259; Angus Corbett, ‘Australia: An Integrated Scheme for Regulating Liability for Medical Malpractice and Indemnity Insurance Markets That Does Not Include the Goal of Improving the Safety and Quality of Health Care’ (2011) 4 *Drexel Law Review* 199; for a range of more recent, and critical accounts of that period, see Cane, Cashman and, perhaps most importantly Ipp, the author of many of the tort reform proposals of that era, Peter Cane, ‘Reforming Tort Law in Australia: A Personal Perspective’ (2003) 27 *Melbourne University Law Review* 649; Peter Cashman, ‘Tort Reform and the Medical Indemnity “Crisis”’ (2002) 25 *University of New South Wales Law Journal* 888; D Ipp, ‘The Politics, Purpose and Reform of the Law of Negligence’ (2007) 81(7) *Australian Law Journal* 456.

¹⁷ This is how Wears et al understand the pre-history of the quality and safety movement prior to the ‘breakout’ period of the late 1990’s, Wears, Sutcliffe and Van Rite, above n 4 but compare some of their claims with those made in this thesis in Chapter 2, particularly in relation to the influence of law and the timing of the ‘breakout’ period in Australia.

iatrogenic harm in limited settings.¹⁸ This work received a significant boost during the 1990's by the 'discovery'¹⁹ of how systematic and widespread the presence of iatrogenic harm in hospital services was across the healthcare system.²⁰ And as with all such developments of a new knowledge base and expertise,²¹ a disciplinary discourse, or project, coalesced around these issues.²² Self-consciously formed to solve the problem of the unnecessary suffering of patients undergoing healthcare treatment, the resulting 'patient safety movement', and its disciplinary project of 'healthcare quality and safety science', worked by regulating space, time, behaviour and activities through the establishment of new norms of clinical work and health services provision.²³

¹⁸ Ibid; Travaglia narrates the development of healthcare quality and safety in a succession of 'waves', with the most recent beginning in the 1950's, Joanne Francis Travaglia, *Locating Vulnerability in the Field of Patient Safety* (PhD Thesis, University of New South Wales, 2009).

¹⁹ Corbett et al rightly question the narrative that holds iatrogenic harm was in any sense 'discovered' during this time, as if for the first time, see Corbett, Travaglia and Braithwaite, above n 3, 247.

²⁰ I argue too, that this impact was magnified by ongoing pressure to prevent harm brought to bear by civil litigation. See Chapter 2 in particular where I contribute an original reading of the place of civil litigation and other legal responsibility practices in the advancement of the quality and safety agenda during the 1990's.

²¹ In an unpublished thesis, Paula Rowland presents the fundamentally disciplinary nature of the quality and safety discipline. She writes that her argument '...displaces the notion of patient safety as constructed from a neutral, objective, and ahistorical safety science. Instead, this argument brings attention to how patient safety discourses intersect with professional discourses in ways that produce certain truths about practice, require particular subjectivities from clinicians and patients, and therefore have implications for the relationships between clinicians and managers, between clinicians from different professions, and between clinicians and patients. The final discussion frames patient safety discourses as forms of disciplinary logic, acting as modes of organizing at an institutional level while intersecting with advanced liberal modes of governing operating at the level of society'. Paula Rowland, *Power/Knowledge, Identity and Patient Safety: Intersections of Patient Safety and Professional Practice Discourses in a Canadian Acute Care Hospital* (PhD Thesis, Fielding Graduate University, 2013) iii; Justin Waring makes a similar case utilising the work of Foucault, drawing closer, however, to the impact of the quality and safety discipline on the government of clinical work, arguing that it introduces a 'disciplinary expertise within the health service that provides managers with the knowledge and legitimacy to survey and scrutinise medical performance, made real through procedures for incident reporting and root-cause analysis'. His critical work on the discipline has been influential in shifting some of the scholarly engagement to a more critical footing. Justin Waring, 'Adaptive Regulation or Governmentality: Patient Safety and the Changing Regulation of Medicine' (2007) 29(2) *Sociology of Health & Illness* 163.

²² Whilst I do not develop this claim at length here, the formation of the patient safety movement, and in particular its sub-discipline of quality and safety 'science' represents a disciplinary formation in ways envisioned by Foucault. So too does its establishment as a specifically clinical sub-discipline provide it with many of the characteristics that Foucault, and others who have written after him, identified as part and parcel of the clinical gaze and other facets of clinical/medical practice identified primarily in *The Birth of the Clinic*. As to disciplinary formation see, Michel Foucault, *Discipline and Punish: The Birth of the Prison* (Vintage Books, 1977); As to the 'work' undertaken by the discipline of healthcare quality and safety generally, see for example Travaglia and Braithwaite, above n 15, 589–599; Wears, Sutcliffe and Van Rite, above n 4; see also Illich's initially influential, and now almost forgotten work on the topic first published in 1976, Ivan Illich, *Limits to Medicine: Medical Nemesis: The Expropriation of Health* (M. Boyars, 1995).

²³ See Jones and Porter's discussion of disciplinary power and the plague for example, where the plague gives rise to 'disciplinary projects' of public health medicine and dentistry for example, Colin Jones and Roy Porter, *Reassessing Foucault: Power, Medicine and the Body* (Routledge, 2002) 78; Paula

Characterised by its liberal-positivism and scientific rationalism, orientated to problem solving by forward-looking action and guarded by an ends–means rationality of utility, quality and safety science responds to the challenge of iatrogenic harm by situating the aggregated patient population as the centre of its way of knowing (epistemology), of deciding (ethics) and of acting (praxis). From its inception, the discipline has set out to forge practical solutions to what it defined as technical problems. Programmes of work were instituted to re-organise and re-tool healthcare service delivery according to the science of ‘human factors’²⁴ and with regard to the newly theorised ‘systemic nature of harm’.²⁵ Practical solutions for surgical safety, medication error, infection control and unnecessary variation in diagnosis and treatment regimens flowed from the discipline. Whilst not the only response to quality and safety in healthcare, quality and safety science’s distinctive ways of approaching iatrogenic harm, and the types of knowledge, strategies, and technologies mobilised to address this problem,²⁶ became established as the orthodox paradigm,²⁷ and set the agenda in the field.²⁸

Rowland on the other hand utilises the concept of a ‘disciplinary logic’ of patient safety discourses. For Rowland, the work of patient safety discourses intersect with professional discourses in the clinical setting, and she argues in that moment, patient safety discourse forms a disciplinary logic, acting as a ‘mode[] of organising at an institutional level while intersecting with advanced liberal modes of governing operating at the level of society’ Rowland, above n 21, iii Both positions are not, strictly speaking, at odds.

²⁴ MF Allnutt, ‘Human Factors in Accidents’ (1987) 59(7) *British Journal of Anaesthesia* 856; Sidney Dekker, *Patient Safety: A Human Factors Approach* (CRC Press, 1st ed, 2011).

²⁵ Dekker, a leading proponent of this shift to include human factors and systemic readings of harm and its aetiology provides a key overview of this thinking in his work, see Sidney Dekker, *Drift into Failure: From Hunting Broken Components to Understanding Complex Systems* (Ashgate Publishing Company, 2011).

²⁶ The discipline makes use of the traditions of human factors engineering, cognitive psychology and insights from high reliability organizations in other high risk settings. This safety science has been accompanied by an ensemble of technologies, such as root cause analysis and critical incident reporting. See the work of Justin Waring in particular for a critical view of the discipline, Justin Waring et al, ‘Healthcare Quality and Safety: A Review of Policy, Practice and Research’ (2016) 38(2) *Sociology of Health & Illness* 198; I do not argue that the IOM report itself was the source of these innovations. Rather, that the IOM report itself is a helpful illustration or display of these key concepts within the discipline of healthcare quality and safety science and the patient safety movement more broadly. In fact, as shown in Chapter Two especially, there is a far longer pre-history to this view, built up at least since the 1980’s and 1990’s in Australia and elsewhere. See also the often forgotten, and still highly controversial contribution of Ivan Illich, Illich, above n 22; Ivan Illich, ‘Medical Nemesis’ (2003) 57(12) *Journal of Epidemiology and Community Health* 919.

²⁷ Waring et al, above n 26, 202 (‘The contemporary wave of interest in quality and safety has been predominantly framed by concepts and theories found within medical science, social psychology, ergonomics, human factors and resilience engineering. Rather than seeing errors as the result of individual mistake or failure, which tends towards blaming and encouraging secrecy, the prevailing view is that individual or group performance is conditioned by a variety of upstream factors located in the wider system of care, such as the quality of teamwork or communication, the allocation of tasks, workload scheduling, equipment and resource management, and broader service cultures.’).

Embedded in this programme of work was the concern with critique and reform of legal and extra-legal responsibility practices on the basis that the success of quality and safety interventions was stymied by such blaming; ‘the safety of our patients and the satisfaction of our [healthcare] workers require an open and non-punitive environment where information is freely shared and responsibility broadly accepted’.²⁹

Criminal law formed one aspect of this work. Indeed, scholars in this field generally maintain that manslaughter by criminal negligence should not be prosecuted, with many claiming that criminal prosecution promotes the very harm it purports to address. The first cluster of arguments mounted against criminal prosecution of iatrogenic harm claim that it is unhelpful or ineffective. As the argument goes, the threat of prosecution reduces transparency and discourages the reporting of error, consequently choking off the ‘error wisdom’³⁰ that would otherwise be collected from such instances of harm or ‘near-misses’.³¹ By stifling this valuable error wisdom – the ‘gold standard’ of data for quality improvement – the criminal law needlessly obstructs quality and safety science-led efforts to reduce harm.³² In so doing, the criminal law *itself* is said to produce, or at least worsen,

²⁸ Davina Allen et al, ‘Towards a Sociology of Healthcare Safety and Quality’ (2016) 38(2) *Sociology of Health & Illness* 181, 182. I accept that there are multiple and various traditions of work within the patient safety movement and quality and safety. However, as noted by Waring et al, what I term the quality and safety sciences or the discipline of quality and safety is the orthodox and dominant mode of engaging with iatrogenic harm. See my discussion of this at IV below.

²⁹ Lucian L Leape and Donald M Berwick, ‘Safe Health Care: Are We up to It?’ (2000) 320(7237) *BMJ: British Medical Journal* 725, 726; this remained a widespread attitude that is accounted for in more detail below. Other writers argued against blaming on more normative grounds too, see for example Sidney Dekker, *Just Culture: Balancing Safety and Accountability* (Ashgate, 2nd Edition, Kindle Version, 2012).

³⁰ James Reason, ‘Beyond the Organisational Accident: The Need for “Error Wisdom” on the Frontline’ (2004) 13(suppl_2) *Quality and Safety in Health Care* ii28, ii31; Dekker, *Just Culture*, above n 29.

³¹ But see in relation to civil liability and its effect, Simon Taylor, *Medical Accident Liability and Redress in English and French Law* (Cambridge University Press, 2015) 169 and generally. See for a detailed overview of this argument the discussion in Chapter Three.

³² Judith Healy, *Improving Health Care Safety and Quality: Reluctant Regulators* (Ashgate Publishing, Ltd., 2013) e.g. 247, 268-269; Alan Merry and Alexander McCall Smith, *Errors, Medicine and the Law* (Cambridge University Press, 2001) e.g. 216-217, 243; Danielle Griffiths and Andrew Sanders, *Bioethics, Medicine and the Criminal Law: Medicine, Crime and Society* (Cambridge University Press, 2013) 5; the fear has been likened to that of being ‘in the closet’ by Quick, (‘Experts have preferred to closet errors, fearing loss of trust and status should they “come out”’), Oliver Quick, ‘Outing Medical Errors: Questions of Trust and Responsibility’ (2006) 14(1) *Medical Law Review* 22, 27; This view formed a background assumption of much of the debate in relation to the introduction of the duty of candour in Australian jurisdictions and in the UK, see for instance, David M Studdert and Mark W Richardson, ‘Legal Aspects of Open Disclosure: A Review of Australian Law’ (2010) 193(5) *Med J Aust* 273; Julian L Rait and Elizabeth H Van Ekert, ‘Legal Aspects of Open Disclosure II: Attitudes of Health Professionals—findings from a National Survey’. (2011) 194(1) *The Medical Journal of Australia* 48; Michael Faure, *Tort Law and Economics* (Edward Elgar Publishing, 2009) 354; Margaret Brazier, *Medicine, Patients and the Law: Revised and Updated Fifth Edition* (Penguin,

the very iatrogenic harm it aims to prosecute. Criminal prosecution is said to deter life-saving but risky medical practice and exact undue costs from practitioners, with doctors described as the ‘second victim’³³ of iatrogenic harm. So serious is this effect that criminal law is thought to be wholly incompatible with the practices of the quality and safety sciences.³⁴

The second cluster of arguments against criminal prosecution assert that it is unjust. Leading scholars Alan Merry and Alexander McCall Smith, for example, argue criminal prosecution should be based upon conscious and willed contributions to harm, all of which must arise due to a positive choice, or reckless disregard, on the part of the defendant-practitioner.³⁵ However, manslaughter by criminal negligence not only eschews such subjective forms of mens rea as the prerequisite for criminal liability but, Merry and McCall Smith claim, continues to apply outdated and unscientific understandings of human action and control when it is applied. When healthcare is understood as a complex, adaptive and socio-technical system, as the best learning of quality and safety science has it, no individual agent can avoid or prevent iatrogenic harm in a morally or legally relevant way.³⁶ When the literature holds that what we are responsible for can only be based upon what we choose, criminal culpability is impossible to imagine, it being impossible for practitioners to prevent harm, for they cannot ‘control’ nor really ‘choose’ within a self-organising, complex and adaptive system.³⁷ Critique extends to analysis of the doctrinal

2011) [8.19]; as to the incidence of defensive medicine in response to legal threat, see Maurizio Catino, ‘Blame Culture and Defensive Medicine’ (2009) 11(4) *Cognition, Technology & Work* 245.

³³ The term seems to have originated with Wu’s influential article, Albert W Wu, ‘Medical Error: The Second Victim - the Doctor Who Makes the Mistake Needs Help Too’ (2000) 172(6) *Western Journal of Medicine* 358; see also its use by others, Sidney Dekker, *Second Victim: Error, Guilt, Trauma, and Resilience* (CRC Press, 2013); Tom Delbanco and Sigall K Bell, ‘Guilty, Afraid, and Alone — Struggling with Medical Error’ (2007) 357(17) *New England Journal of Medicine* 1682; Charles R Denham, ‘TRUST: The 5 Rights of the Second Victim’ (2007) 3(2) *Journal of Patient Safety* 107; Massimiliano Orri, Anne Revah-Lévy and Olivier Farges, ‘Surgeons’ Emotional Experience of Their Everyday Practice - A Qualitative Study’ (2015) 10(11) *PLoS ONE* e0143763; Susanne Ullström et al, ‘Suffering in Silence: A Qualitative Study of Second Victims of Adverse Events’ (2014) 23(4) *BMJ Quality & Safety* 325; Albert W Wu and Rachel C Steckelberg, ‘Medical Error, Incident Investigation and the Second Victim: Doing Better but Feeling Worse?’ (2012) 21(4) *BMJ Quality & Safety* 267.

³⁴ See the extended discussion of this claim both in Chapter 2 and, particularly, Chapter 3.

³⁵ This argument is made primarily in their extended work Merry and McCall Smith, above n 32; also now in its second edition Alan Merry and Warren Brookbanks, *Merry and McCall Smith’s Errors, Medicine and the Law* (Cambridge University Press, Kindle Edition, 2017).

³⁶ As to sociotechnical systems, see particularly J Braithwaite, WB Runciman and AF Merry, ‘Towards Safer, Better Healthcare: Harnessing the Natural Properties of Complex Sociotechnical Systems’ (2009) 18(1) *Quality and Safety in Health Care* 37; Braithwaite, Wears and Hollnagel, above n 4.

³⁷ As these writers rely upon the liberal choosing subject of the subjectivist orthodoxy, one who forms a fault-bearing intention or culpable advertence towards risk of death and on that basis causes the death

form and material itself. Critics of manslaughter by criminal negligence charge that it is a doctrine devoid of content, ‘circular’ in logic and construction, whilst defined in ‘innumerable shadings of grey’.³⁸ Moreover, they argue, the doctrine imposes standards dangerously alien to the reality of medical practice, demanding practitioners live up to impossible standards in the delivery of healthcare.

We thus have two separate, but interrelated objections to criminal prosecution of iatrogenic death. On the one hand is the argument of disutility, where the threat and availability of criminal prosecution stifles error wisdom, blocking the central path from less safe to more safe healthcare. On the other hand is the argument of injustice, that no culpability can be made out or justified due to defendant-practitioners’ entanglement in complex sociotechnical systems. These arguments for decriminalisation dominate the scholarly and professional literatures and have led to significant law reform in the area of tortious negligence,³⁹ to wide-ranging quality and safety confidentiality and privilege provisions,⁴⁰ and now to ongoing law reform debate in relation to criminal law.

However, this thesis claims that these arguments for the rejection of manslaughter by criminal negligence have not been sufficiently attentive nor responsive to the actual practices of criminal law in this field; not to the history of its use, to its particular understanding of human action in health care, or to its mobilisation in the courtroom. As this thesis shows, when these foundational aspects of law’s actual practice in the field are more fully and critically engaged, they seriously destabilise the validity of claims that manslaughter by criminal negligence is unhelpful or unjust when applied to iatrogenic harm.

This effect is particularly pronounced in the Australian context, where we lack even the most fundamental information about criminal law’s actual conduct in this field, such as knowledge of the frequency of prosecutions.⁴¹ On this basis, the key arguments for the

of another. See Chapter Three and Four for a deeper engagement with this conflict and its implications.

³⁸ *State v. Randol*, 597 P.2d 672,677 (Kan. 1979).

³⁹ See Chapter Two for an account of tort reform in Australia and its relation to the emergence of iatrogenic harm.

⁴⁰ In relation to confidentiality provisions, see *Health Insurance Act 1973* (Cth) see for example s 124X the subject of forthcoming research.

⁴¹ Dobinson, above n 8, 102 (where Dobinson highlights the paucity of available literature for both convictions and prosecutions more generally, noting that ‘it is very difficult to be certain’ about the specific number of cases); Ian Dobinson, ‘Doctors Who Kill or Harm Their Patients: The Australian

rejection of manslaughter by criminal negligence made by those allied with the quality and safety sciences have been conditioned by views of the criminal law that are underdeveloped, faulty or entirely absent in the Australian context. This inattention to the actual use of manslaughter by criminal negligence has, in some respects, continued to fuel misconceptions about it, and this undermines the legitimacy of the law reform project that the quality and safety sciences and its allies set out to achieve.

Given the influence that the doctrine of manslaughter by criminal negligence exerts upon the regulation and conduct of medical and healthcare practice, the objective seriousness of the offence, and the urgency of eliminating avoidable iatrogenic harm, fashioning claims about manslaughter by criminal negligence and iatrogenic harm without sufficient attentiveness to foundational areas of knowledge is imprudent, even reckless. As such, this thesis aims to overcome some of the most urgent and significant gaps in our knowledge by contributing new historical, theoretical and doctrinal accounts of manslaughter by criminal negligence as it applies to iatrogenic harm, largely in the Australian setting.

A *Overview of the Argument*

This thesis proposes a reading of medical manslaughter in the Australian setting radically different from the dominant view proposed by the orthodox paradigm of quality and safety science. My position is that the arguments mounted for the rejection of manslaughter by criminal negligence are based in large part upon an insufficient understanding of the criminal law in this field. This thesis begins to rectify this situation by offering significant and original historical, theoretical and doctrinal analyses of criminal law that are attentive to the actual practices of law in the Australian setting and thus function as correctives to the orthodox paradigm's misrepresentations of manslaughter by criminal negligence as it applies to iatrogenic harm.

Experience' in Danielle Griffiths and Andrew Sanders (eds), *Bioethics, Medicine and the Criminal Law: Medicine, Crime and Society* (Cambridge University Press, 2013); Tuckett, above n 8; in work published from this thesis I provide a greatly extended account of prosecutions in the Australian jurisdiction, see both Chapter One, and David J Carter, 'Correcting the Record: Australian Prosecutions for Manslaughter in the Medical Context' (2015) 22(3) *Journal of Law and Medicine* 588.

The thesis builds its argument in three sections, each providing a new account of the actual practices of criminal law in this field: firstly, as to the history of its use in Australia; secondly, as to its fundamental and animating ‘logic’; and finally, as to its mobilisation in the Australian courtroom.

First, the thesis greatly extends previous work on the topic by developing new historical material. In Australia, we have simply not known the scale of criminal prosecution for iatrogenic death. Drawing on my own archival research, I formulate a new and extended history of prosecution for manslaughter in the healthcare context. The extension of the case law presented here is noteworthy; from four known prosecutions, an additional thirty-three unacknowledged prosecutions are presented, revealing a far longer and more active engagement with the law than is reflected in existing literature. The newly expanded account of its prosecution that I provide here challenges claims of prosecutorial overreach, speaking instead to criminal law’s judicious and consistent capacity to distinguish between culpable and non-culpable instances of harm. Given that the criminal law’s actual use over the past two centuries of Australian legal history has been successful, by any measure, and has not been met with serious or sustained opposition by practitioners or others outside of non-specialist contexts, the thesis then explores how it is that we find ourselves burdened with a view of criminal law quite at odds with the reality of the offence’s actual use and reception of it: that its use is unhelpful, unsuccessful and somehow opposed to advancing healthcare safety. By offering an historical analysis of the emergence of iatrogenic harm in Australia during the 1990’s, I show that, contrary to the dominant perspective of the literature, criminal negligence and the patient safety movement – and its disciplinary project of healthcare quality and safety science – are in fact neither incompatible nor autonomous: rather, their histories demonstrate that they exist in a highly dynamic, mutually constitutive relationship, one that is productive for both the formation of the field of quality and safety practice, and of its ‘object’, iatrogenic harm. In the contemporary moment, ‘law’, far from being simply opposed to advancing healthcare safety, has been productive of it.

Second, the thesis offers a highly original theoretical engagement with the conflict between criminal law and its chief interlocutor, the discipline of quality and safety science. Given that the historical record speaks to a different reality of criminal law’s use, and of a more dynamic and productive relationship between it and the healthcare safety agenda, the

thesis's second section analyses what might be at the core of the ongoing conflict surrounding criminal law and its application to iatrogenic harm. Adapting the innovative ethnographic work of Annemarie Mol, I show that what the quality and safety discipline regards as preferable, practical and ethical is imbued with a quite particular ideal, a whole 'logic of choice'⁴² that dominates the quality and safety discipline's conception of responsibility for healthcare-related harm. Upon that basis, I show how specific responsibility practices either condemned or supported by the literature on healthcare-related harm attract that condemnation or support based on their reliance upon choice to understand agency, action, causation and responsibility. Criminal negligence, which stridently opposes the use of 'choice' as the definitive marker of criminal culpability, is rejected on this basis. Yet, I argue, this mobilisation of choice is quite curious – and particularly so for proponents or supporters of the quality and safety sciences; for, taken as a whole, the discipline's major contribution has been to theorise the emergent properties of iatrogenic harm, human agency and action in a manner that denies the health practitioner's ability to choose as an autonomous subject, subject as they are to control by external forces, and existing in a state of severely attenuated freedom. In short, choice is simply not part of the discipline's way of seeing the world, however, that same literature uses criminal negligence's own rejection of choice (as the definitive marker of culpability) as reason to reject it. Using choice in this way, to deny the legitimacy of criminal law, represents a worrying slippage or dissonance internal to this literature, one that I argue represents a deep betrayal of its more fundamental commitments. However, in this inconsistency I see positive potential. I argue that this dissonance offers the opportunity to recognise that both the doctrine of manslaughter by criminal negligence and the discipline of quality and safety sciences itself – aside from its argumentation against criminal prosecution – have a great deal in common. Both eschew the centrality of choice, and instead theorise human agency, action and healthcare-related harm in a manner deeply suspicious, if not in outright denial, of the relevance or availability of personal, subjective control or choice. If it is true that criminal negligence shares much in common with the discipline of quality and safety science, then there exists an opportunity to reconsider the place and operation of manslaughter by criminal negligence in this field. Moreover, demonstrating that the doctrine 'fits' in a coherent manner with the practices of healthcare delivery and quality and safety improvement means that the doctrine itself, long rejected, may be recognised as

⁴² Annemarie Mol, *The Logic of Care: Health and the Problem of Patient Choice* (Routledge, 2008).

a productive resource for healthcare quality and safety practice, forging better ways to conceive of our responsibility for the care of strangers, and to render visible those moments when a lack of care turns into neglect.

Third, and finally, the thesis develops a novel reading of the deep workings of the doctrinal material itself. The doctrinal material or structure of the offence of manslaughter by criminal negligence has been charged with being problematically devoid of content, and circular in logic. I accept these descriptions of the doctrinal material as accurate. However, in the final section of the thesis I argue that these aspects of the doctrine are not fatal flaws, but instead a significant strength. In support of this argument, I present a theory of criminal negligence and of negligent culpability that emerges from these very ‘inadequacies’ of the doctrine. Closely reading the workings of the doctrine in recent case law, I argue that the doctrine of criminal negligence develops its very form and content through a process of drawing into itself the practices and standards of the area of human activity with which it engages; borrowing, reflecting and thus reinforcing what is particular to the field of practice, rather than imposing standards alien to it. At the same time, the doctrine maintains normative solidity and coherence by drawing upon its own ‘internal normativity’, all the while continuing to actively re-affirm the underlying values of the area of human activity with which it is engaged: in this case, medicine and healthcare practise.

Taken together, these three contributions demonstrate that our understanding of the doctrine and its use in this context is severely underdeveloped and, at times, faulty. Collectively, the findings here unsettle the main foundations upon which the literature rejects the use of manslaughter by criminal negligence. In light of this work, it can be no longer said with such certitude that the offence is overused in Australia, or that it has been wholly unhelpful for progressing the agenda of healthcare quality and safety science. Nor can it be said that the doctrine understands human action and agency in a manner so different to what constitutes good medicine or the insights of the quality and safety sciences that it represents an unjust imposition of liability by imposition of standards alien to those of medicine and healthcare. On that basis, I conclude that we have engaged in too swift and uncritical a rejection of manslaughter by criminal negligence in the context of its application to iatrogenic death in the Australian jurisdiction, and I argue against the claims

that manslaughter by criminal negligence is unhelpful and unjust when applied to iatrogenic harm.

The motivation for this focus and method is the sense that the existing literature has not yet engaged sufficiently with the reality of manslaughter by criminal negligence's history and particular view of human action, or with the doctrine's mobilisation in the Australian courtroom, and suffers for having not done so. In many ways, this is understandable.⁴³ A focus on *progress* and what is *practical* remains central to a field tasked with implementing relatively urgent and decisive action in the face of widespread, unnecessary and preventable harm and death. Given that context, the focus on the applied and practical – such as the potential effect of criminal prosecution on open disclosure of errors – rather than more fundamental questions, such as those posed here about underlying historical, jurisprudential or doctrinal foundations, seems a natural way of proceeding. However, the pursuit of 'practical' answers has meant a too uncritical rejection of manslaughter by criminal negligence.⁴⁴ Developing a more critical stance in relation to the historical, jurisprudential and doctrinal foundations of the claims made about manslaughter by criminal negligence and iatrogenic harm creates the potential for a new conversation about the role of criminal law in matters of iatrogenic harm; one that might give cause to re-evaluate the current denial of its suitability, which is near-universal in the scholarly and professional literature.

Furthermore, this work is urgent and necessary. For despite opposition to it, manslaughter by criminal negligence remains 'on the books' in Australia, and in many other countries besides. It continues to be used, albeit I argue judiciously, in the Australian context, and its presence exerts an influence on the regulation and conduct of medical and healthcare

⁴³ And is urged on by the policy and scholarly literature, with calls to focus on doing what works. See for example the influential Institute of Medicine (US) Committee on Quality of Health Care in America, *Crossing the Quality Chasm: A New Health System for the 21st Century* (National Academy Press, 2001).

⁴⁴ Such an uncritical rejection risks very many aspects that are too important to be so swiftly rejected. These include democratic support and authority for criminal law, but also what might be best expressed by Michael Welker's understanding of law as 'bearer of paradigmatic memory', see Michael Welker, 'The Power of Mercy in Biblical Law' (2014) 29(2) *Journal of Law and Religion* 225; As to the democratic support and authority of criminal law, Guyora Binder makes a claim that has also influenced by position. He argues in relation to Felony Murder/Constructive Murder that despite criticism, the persistence of the offence in the US legal system requires that an adequate account of the doctrine and justification for its use be developed, see generally Guyora Binder, *Felony Murder* (Stanford University Press, Kindle Book, 2012); see also Guyora Binder, 'Making the Best of Felony Murder' (2011) 91 *Boston University Law Review* 403.

practice. In light of the persistence of the doctrine in our legal system, an adequate account of its doctrine and its use should be advanced, one that makes better sense both of its basic requirements and of its doctrinal operation.⁴⁵

In the remainder of this introduction, I locate the thesis by describing in schematic form the nature of iatrogenic harm, the emergence of the patient safety movement, and the rejection of criminal law by practitioners and academics aligned with the quality and safety sciences. Following that contextual material, I provide an overview of the thesis by way of a chapter-by-chapter summary. Finally, I lay out the scope, significance, assumptions and limitations of the thesis.

II LOCATING THE THESIS: IATROGENIC HARM, THE PATIENT SAFETY MOVEMENT, QUALITY AND SAFETY SCIENCE AND THE CRIMINAL LAW

That healthcare treatment represents a source of potential harm is not controversial. Medicine has been understood as an ‘inherently risky enterprise’⁴⁶ for millennia.⁴⁷ However, not all harm has been morally or legally neutral, excused because of its seeming inevitability. Instead, certain forms and instances of harm have represented morally relevant injury since at least the Hippocratic injunction against deliberate or accidental infliction of harm upon patients.⁴⁸

Perhaps because of these dual possibilities – harm in healthcare that might arise due to inherent risk and harm, or for which a practitioner might be responsible or culpable – the true extent of iatrogenic harm was not established until the latter part of the twentieth century. It took until the late 1990s for pioneering research to indicate that between 10 and 16 per cent of all hospital admissions resulted in some form of iatrogenic harm.⁴⁹ Initially

⁴⁵ In this I follow the lead of Guyora Binder, who writes about another no-less misunderstood and unpopular criminal offence in his work on Felony Murder, or Constructive Murder as it is referred to in the Australian jurisdiction, see Binder, above n 44.

⁴⁶ Charles Vincent, *Patient Safety* (John Wiley & Sons, 2011) 1.

⁴⁷ Travaglia and Braithwaite, above n 15, 598.

⁴⁸ This tradition is not, of course, restricted to the Hippocratic source, although this still wields very significant influence today. So too were other significant shifts in that understanding brought about more recently with the work/specialty of public health medicine, most notably contributing a sense of both population/aggregation of harm, and of harm and prevention in new and significant ways, see Mooney’s recent work for an excellent example of the influence of public health practice(s), Graham Mooney, *Intrusive Interventions: Public Health, Domestic Space, and Infectious Disease Surveillance in England, 1840-1914* (Boydell & Brewer, 2015).

⁴⁹ See in the specifically Australian and New Zealand context, Wilson et al, above n 2; PB Davis et al, ‘Adverse Events in New Zealand Public Hospitals: Principal Findings from a National Survey’ (Number 3, December 2001)

a highly controversial claim,⁵⁰ it is now well-accepted that at least 10 per cent of admissions to acute care hospitals are associated with an adverse event, including 0.3 per cent associated with iatrogenic death and 1.7 per cent with a major iatrogenic disability.⁵¹

The scale of the harm is difficult to appreciate without the use of a more ‘everyday’ metaphor. Sidney Dekker provides one in the following terms:

Put the numbers on iatrogenic harm in another context. After a flight from, say, New York to Miami, with an aeroplane that carried 150 passengers, only 148 are to live. Two passengers have died simply because they were on the aeroplane. The flight alone caused a heart attack in one and turbulence induced blunt forced head trauma in another. Four have developed infections because of being packed inside the hypoxic tube with bad air filtration and cabin crew who refused to wash their hands before serving snacks. Two of these infections are beyond the reach of antibiotics and will debilitate these people for life. One of these passengers has no choice: he will have to remain on board the aeroplane for the rest of his life. Two passengers have been poisoned by badly mixed seven dollar cocktails, which cause permanent liver damage in one and stripped the stomach lining of the other. One has lost a leg from the hip down unnecessarily, because it got trapped in the seat in front, another passenger had her common bile duct severed by a stag seatbelt, and yet another has suffered permanent brain damage because of oxygen supply problems near her seat. One child was electrocuted because of a short in the entertainment electronic circuit box mounted by her left ankle. Now, imagine the arrivals hall. What would the scene look like? Passengers are stumbling out in various states of disability and disease. Some never going to come out. And this is not just one flight. It happens on every flight, every day, by every airline.⁵²

Dekker’s rhetorical question ends the account: ‘Who would still fly?’⁵³

More significant – and controversial – than the raw incidence of iatrogenic harm is the associated revelation that most of this newly ‘discovered’⁵⁴ iatrogenic harm is potentially

<<https://www.health.govt.nz/system/files/documents/publications/adverseevents.pdf>>; Peter Davis et al, ‘Adverse Events in New Zealand Public Hospitals I: Occurrence and Impact’ (2002) 115(1167) *New Zealand Medical Journal* <<http://www.nzma.org.nz/journal/115-1167/271/>>; Runciman and Moller, above n 3; Peter Davis et al, ‘Adverse Events in New Zealand Public Hospitals II: Preventability and Clinical Context’ (2003) 116(1183) *New Zealand Medical Journal* U624.

⁵⁰ See the detailed account of the reception of the landmark studies in the Australian context provided in Chapter 2 particularly.

⁵¹ Runciman and Moller, above n 3, 17; these rates are now regarded as consistent across both advanced and developing healthcare systems, see Corbett, Travaglia and Braithwaite, above n 3, 248; Hamilton, Gibberd and Harrison, above n 3; Wilson et al, above n 3.

⁵² Dekker, *Patient Safety*, above n 24, 34.

⁵³ Ibid.

⁵⁴ Corbett et al rightly question the narrative that holds iatrogenic harm was in any sense ‘discovered’ during this time, as if for the first time, see Corbett, Travaglia and Braithwaite, above n 3, 247.

preventable.⁵⁵ This feature of contemporary iatrogenic harm calls directly into question the presumed balance between the dual possibilities of inherent risk or culpable cause: is iatrogenic harm an unavoidable – and thus tragic – outcome of the limits of medicine and of our embodied state, or is it amorally relevant injury,⁵⁶ something for which a practitioner might be responsible or culpable, a violation of that long Hippocratic tradition?

A The Discipline of Healthcare Quality and Safety Science Emerges

As previewed above, earlier efforts at systematic quality improvement by particular medical specialties and by individual early champions of quality and safety that had attempted to measure and offer analysis of iatrogenic harm in limited settings was given a significant boost by the ‘discovery’⁵⁷ of how systematic and widespread the presence of iatrogenic harm in hospital services was across the health system. Within this setting the ‘patient safety movement’, and its disciplinary project of ‘healthcare quality and safety science’, began to form.

From its inception, the movement understood its focus to be the forging of practical solutions to harm, which it defined as a technical problem.⁵⁸ It did so according to the specific disciplinary logic of its quality and safety discourse or ‘science’.⁵⁹ Programmes of work were instituted to re-organise and re-tool healthcare service delivery according to the

⁵⁵ The 1994-95 Australian QAHCS study reported that ‘Preventability was not strongly associated with age, sex or insurance status, nor was it associated with the level of disability, except for death (in which 70% of Adverse Events showed high preventability). Only 1.2% of AEs in the “no preventability” category resulted in death, compared with 4.1% in the “low preventability” category and 6.5% in the “high preventability” category. Some of this association between preventability and death could be ascribed to outcome bias’, Wilson et al, above n 2; the QAHCS study reported 51% preventability across all adverse events, see Runciman and Moller, above n 3, 22; see also the QAHCS results reinterpreted where ‘all adverse events were re-classified as to whether they fell into one of two categories, “potentially preventable”, or “not preventable with current medical knowledge” rather than using the six-point scale in the QAHCS, it was found that 80% of adverse events fell into potentially preventable categories’, Runciman, Edmonds and Pradhan, above n 6.

⁵⁶ This question has arisen for me in the context of many years work managing health services in Australia.

⁵⁷ Corbett, Travaglia and Braithwaite, above n 3, 247.

⁵⁸ Travaglia et al writes that, partially at least, the technical and epidemiological understandings of iatrogenic harm were/are ascendant within this discipline, see Travaglia and Braithwaite, above n 15.

⁵⁹ See above for more detail on the characterisation of the quality and safety discourse a disciplinary discourse rather than a ‘natural’, ‘objective’ or ahistorical ‘safety science’. There I support views of the quality and safety disciplinary discourse that see it as advancing liberal modes of government.

‘science’ of ‘human factors’⁶⁰ and with regard to the newly theorised ‘systemic’⁶¹ and ‘sociotechnical’⁶² nature of harm and its cause/source. Public, media and official policy pressure was brought to bear on the unacceptable rates of harm. ‘Crossing the quality chasm’⁶³ became the focus of activity. Due to these efforts, the existence of iatrogenic harm broke out of the confines of specialist or ‘cult’⁶⁴ attention to achieve much wider acknowledgement,⁶⁵ whilst the disciplinary logic of quality and safety science become ever more embedded as the dominant logic, increasing its influence as a shift towards ‘implementation’⁶⁶ became the order of the day. Practical solutions for surgical safety, medication error, infection control and unnecessary variation in diagnosis and treatment regimens flowed from the discipline,⁶⁷ whilst significant capital (of all forms) began to flow into it.⁶⁸

As attention to quality and safety failures rose to the forefront of healthcare policy and research,⁶⁹ so too did the influence of the discipline and its specific ways of approaching the problem of iatrogenic harm. It was at this time that the literature forged by the disciplinary logic of quality and safety science began to confront criminal law.

B *Disciplinary Critique of Criminal Law and Liability Emerges*

With health policy and practice now increasingly dominated by the disciplinary logic of quality and safety science, conflict began to sharpen between quality and safety activities and the various ‘responsibility practices’⁷⁰ that govern healthcare; from professional

⁶⁰ Allnutt, above n 24; Dekker, *Patient Safety*, above n 24.

⁶¹ Dekker, a leading proponent of this shift to include human factors and systemic readings of harm and its aetiology provides a key overview of this thinking in his work, see Dekker, *Drift into Failure*, above n 25.

⁶² Braithwaite, Runciman and Merry, above n 36.

⁶³ Institute of Medicine (US) Committee on Quality of Health Care in America, above n 43.

⁶⁴ Wears et al classifies the history of the patient safety movement in three periods, of which the ‘cult period’ is their middle period, defined in these terms, see Wears, Sutcliffe and Van Rite, above n 4, 4.

⁶⁵ See Chapter 2 for an overview of this process as it occurred in Australia specifically. In that chapter I recount the media and political reception of iatrogenic harm during the 1990’s and early 2000’s.

⁶⁶ Notable in the shift between the two landmark reports of the field, Institute of Medicine, *To Err Is Human: Building a Safer Health System* (National Academy Press, 2000) <www.nap.edu/readingroom>; Institute of Medicine (US) Committee on Quality of Health Care in America, above n 43.

⁶⁷ See Wears, Sutcliffe and Van Rite, above n 4.

⁶⁸ Travaglia and Braithwaite trace this process in particular, something often left in the background of other brief historical accounts that have been published, Travaglia and Braithwaite, above n 15.

⁶⁹ Waring et al, above n 26.

⁷⁰ I draw this concept most directly from the work of Peter Cane *Responsibility in Law and Morality* (Hart Publishing, 2002) see especially 57.

misconduct through to legal liability in tort and criminal law, as well as the full range of extra-legal responsibility practices.⁷¹ Comments published by Lucian Leape and Donald ‘Don’ Berwick, influential figures in the movement, are exemplary in this regard. In what was to become a canonical text, they wrote in the *British Medical Journal*, (complete with an image of a dramatic and violent airplane crash on its cover),⁷² that ‘the safety of our patients and the satisfaction of our workers require an open and non-punitive environment where information is freely shared and responsibility broadly accepted’.⁷³ This claim implied that responsibility practices were properly subordinate to the disciplinary logic of the quality and safety discipline, and that their (mis)use threatened the integrity of patient safety efforts and, thus, the safety of patients.⁷⁴

This line of argument, calling for the subordination of responsibility practices to the disciplinary logic of the quality and safety science, sharpened and intensified as it developed. The influential view of Sidney Dekker, for example, expresses this intensification quite clearly. He argued that all forms of responsibility practice effected a ‘pigeonholing [of] human acts’⁷⁵ that did not progress the cause of creating a just culture within organisations. More radically still, he argued that the epistemological and moral validity of responsibility ascription was groundless: ‘somebody still needs to decide what category to assign behaviour to, and that means that somebody will have got the power to do so... such assignments are nothing more than somebody’s attribution’.⁷⁶ This line of critique was to become mainstream in the quality and safety literature. When it was eventually applied to the criminal investigation, trial or appeal of manslaughter offences for iatrogenic death,⁷⁷ the criminal law and its processes were characterised as ‘not about

⁷¹ See Chapter 2 in particular in relation to the interplay between quality and safety disciplinary knowledge and practices and the liability question during the 1990’s in particular.

⁷² The oft-used metaphor for the impact of iatrogenic harm.

⁷³ Leape and Berwick, above n 29, 726.

⁷⁴ For a more developed reading of this dynamic, present in other relationships of disciplinary power to law, see my David J Carter, ‘HIV Transmission, Public Health Detention and the Recalcitrant Subject of Discipline: Kuoth, Lam v R and the Co-Constitution of Public Health and Criminal Law’ (2016) 25(2) *Griffith Law Review* 172.

⁷⁵ Dekker, *Just Culture*, above n 29, location 69.

⁷⁶ *Ibid* location 77.

⁷⁷ Conflict between healthcare and various legal practices was not new of course, even during this period. Tortious or civil negligence had been ongoing source of similar criticism and debate in a range of jurisdictions in the period leading up to and even beyond the emergence of the conflict between the disciplinary logic of quality and safety science and criminal law. This, however, had been couched for the most part in terms unrelated to patient safety. See Chapter 2 for a sustained reflection on this history in the Australian context. Many of the arguments rehearsed in the battle over tort ‘reform’ found their way into a new debate on criminal liability. This time, however, coinciding with the rising dominance of the quality and safety discipline, concern for prosecutorial activity’s impact upon its

truth'.⁷⁸ They were, according to Dekker, 'about procedure and legal interpretation... the truth is secondary'.⁷⁹

C *Manslaughter by Criminal Negligence is Interpreted According to the
Disciplinary Logic of Quality and Safety Discourse*

Manslaughter by criminal negligence is the criminal offence with which the literature is most concerned, even where it does not name it explicitly. In Australia, this homicide offence exists in some form in each State and Territory.⁸⁰ The common-law definition of manslaughter by criminal negligence remains the dominant conception of it. I provide a much more detailed engagement with the specifics of the doctrine in chapters 3, 4 and especially 5, including its status in the various Australian jurisdictions.⁸¹ However, by way of background, the leading Australian statement of the law given in the Victorian case of *Nydam v The Queen*⁸² suffices for an introduction to the offence.⁸³

In order to establish manslaughter by criminal negligence, it is sufficient if the prosecution shows that the act which caused the death was done by the accused consciously and voluntarily, without any intention of causing death or grievous bodily harm but in circumstances which involved such a great falling short of the standard of care which a reasonable man [sic] would have exercised and which involved such a high risk that death or grievous bodily harm would follow that the doing of the act merited criminal punishment.⁸⁴

newly ascendant disciplinary project was foregrounded. 'Safety' became the single most significant grounds for critique and manslaughter by criminal negligence was its target.

⁷⁸ Dekker, *Just Culture*, above n 29, location 177.

⁷⁹ Ibid.

⁸⁰ *Criminal Code 2002* (ACT) pt 2.2; *Crimes Act 1900* (ACT) s 15; *Criminal Code Act* (NT) s 43AL, see also ss 149-153; *Criminal Law Consolidation Act 1935* (SA) s 13, although see also s 14; *Criminal Code Act 1899* (QLD) s 291, may also be based on a breach of duty as described in Chapter 27 or in relation to the 'preservation of life' see ss 285-290; *Criminal Code Act Compilation Act* (WA) 1913, s 268, see also ss 262-267; *Criminal Code Act 1924* (Tas) s 156(2)(b), see also ss 144-151.

⁸¹ See Ian Dobinson's account of the Australian law of manslaughter by criminal negligence in the medical context, Dobinson, above n 8, 103-107; see also the account of English law, that has been influential on the Australian position, Margaret Brazier and Neil Allen, 'Criminalizing Medical Malpractice' in Charles A Erin and Suzanne Ost (eds), *The Criminal Justice System and Health Care* (Oxford University Press, 2007).

⁸² [1977] VR 430 ('*Nydam*'); confirmed by the High Court of Australia in *R v Lavender* (2005) 222 CLR 67, at [17], [60], [72], [136]; *Burns v The Queen* (2012) 246 CLR 334, per French CJ at [19].

⁸³ As Ian Dobinson correctly notes, the *Nydam* formulation is adopted almost completely in both the Northern Territory and Australian Capital Territory legislative/criminal code formulations of the offence in those jurisdictions Dobinson, above n 8, 104 n.17.

⁸⁴ *Nydam* [1977] VR 430, 445; this formulation was of course influenced by the lineage of cases extending from *R v Bateman* (1925) 19 Cr App R 8; and *Andrews v DPP* [1937] AC 576; the *Nydam*

The offence has often been described as ‘something less than murder and of being something more than tortious killing.’⁸⁵ This differentiation rests on the absence of intention or advertent recklessness as to death or grievous bodily harm on the part of the defendant,⁸⁶ and of the necessity for a ‘gross’ (that is, a higher degree of negligence) for the crime, one that brings the killing ‘beyond a mere matter of compensation’.⁸⁷ As I explain in detail in Chapter 5, there are four core elements of the offence in addition to the death of the victim:⁸⁸ a legal duty of care; a standard of care; a breach of that duty by a gross departure from the standard of care; and, finally, that in so breaching their duty, the defendant’s act or omission involved such a high risk that death or grievous bodily harm would follow that the doing of the act merits criminal punishment. Even presented in this elemental fashion, the complexity of the offence formulation is evident. There has been an instability as to the definition of gross negligence manslaughter in common law jurisdictions at times.⁸⁹ This has generally been the results of attempts, successful or otherwise, to reinterpret the doctrine as requiring some greater role for subjective elements in the offence structure.⁹⁰ This has been ‘emphatically’⁹¹ rejected by Australian law.

Opposition to the offence is no mere quirk of medical jurisprudence.⁹² The offence remains one of the most controversial of criminal legal doctrines, even outside its healthcare context.⁹³ It is widely criticised by writers for its purported impact on otherwise beneficial – but dangerous – activities, and as a fundamentally unjust and wrong-headed approach to criminal culpability.⁹⁴

formulation was confirmed in *R v Lavender* [2004] NSWCCA 120 (21 May 2004). See Chapter 5 for a more complete account of the doctrine and for my reading of its detailed operation in the context of iatrogenic harm. .

⁸⁵ David Lanham et al, *Criminal Laws in Australia* (Federation Press, 2006) 208.

⁸⁶ In Australia there is a divergence regarding the status of intention or foresight of the possibility or probability of grievous bodily harm in homicide. In New South Wales, for example, it is only foresight (advertent recklessness) of the probability of death (and not of grievous bodily harm) which will suffice, see *Crimes Act 1900* (NSW) s 18; *R v Crabbe* (1985) 156 CLR 464.

⁸⁷ *R v Bateman* (1925) 19 Cr App R 8, 11; see also *Andrews v DPP* [1937] AC 576, 583; in Australia, see *Callaghan v R* [1952] HCA 55 (1952) [17].

⁸⁸ Address the offence in an elemental fashion has resulted in a range of different expressions. Fairall, for example, synthesises the elements into three, Paul Fairall, *The Laws of Australia: Homicide* (Thomson Reuters, Online, 2012) Section 10.1.2130.

⁸⁹ See Chapter 5 for an overview of this instability, especially see the discussion of ‘Caldwell recklessness’.

⁹⁰ See Jeremy Horder, ‘Gross Negligence and Criminal Culpability’ (1997) 47(4) *The University of Toronto Law Journal* 495.

⁹¹ Lanham et al, above n 85, 208; see in particular the response to the case of *R v Holzer* [1968] VR 481.

⁹² As to the position in Australia, see *He Kaw Teh v The Queen* (1985) 157 CLR 523.

⁹³ See for example, Alan Norrie, *Crime, Reason and History: A Critical Introduction to Criminal Law* (Cambridge University Press, 2014) 83–87.

⁹⁴ See particularly Chapters 3 and 4.

The first Australian literature emerged in relation to iatrogenic harm and the criminal law in healthcare in 2003.⁹⁵ This followed in the aftermath of the landmark Institute of Medicine report ‘*To Err is Human*’⁹⁶ in 1999 and the Bristol Royal Infirmary inquiries,⁹⁷ as well as, by then, over a decade of Australian work on the task of measuring and reporting the level of iatrogenic harm in our own system.⁹⁸

The 2003 jointly-authored article – written by pioneering Australian anaesthetist and quality and safety academic William ‘Bill’ Runciman and New Zealand anaesthetist and quality and safety writer Alan Merry with lawyer and consumer advocate, Fiona Tito⁹⁹ – established the ‘Antipodean Perspective’ on quality, safety and criminal responsibility. Their work was the culmination of some years of reflection on these questions for Tito, Merry and Runciman. The three authors were significant figures in Australian and worldwide attention being drawn to iatrogenic harm, and particularly the initial Australian consideration of it. In their article, they argue that blaming and punishing errors ‘that are made by well-intentioned people working in the healthcare system drives the problem of iatrogenic harm underground and alienates people who are best placed to prevent such problems from occurring’.¹⁰⁰ Their argument against criminal culpability is a statement, in composite, of the two core oppositions to criminal responsibility practices in this field. First, criminal prosecution (blaming and punishing) works to drive iatrogenic harm ‘underground’, preventing much-needed work to prevent such events from occurring. Second, criminal prosecutions blame and punish those who are ‘well-intentioned’ – that is, not bearing the central marker of moral and criminal fault of a subjective ‘guilty mind’, such as intention to kill or recklessness as to death. Their claim relating to ‘correctly’ assigned blame, then, is limited to those who intentionally, or perhaps recklessly, undertake to harm a patient, a truly rare occurrence.

⁹⁵ William B Runciman, Alan F Merry and Fiona Tito, ‘Error, Blame, and the Law in Health Care-an Antipodean Perspective’ (2003) 138(12) *Annals of Internal Medicine* 974.

⁹⁶ Institute of Medicine, above n 66.

⁹⁷ See below.

⁹⁸ See Runciman and Moller, above n 3, 2–5.

⁹⁹ Fiona Tito was also to chair the Federal Professional Indemnity Review, see Fiona Tito, ‘Compensation and Professional Indemnity in Health Care, Review of Professional Indemnity Arrangements for Health Care Professionals: Final Report’ (November 1995).

¹⁰⁰ Runciman, Merry and Tito’s article states also an important counter-argument, however briefly. This is that the reverse is also true, and that failure to correctly assign blame when it is warranted is in fact is also undesirable, Runciman, Merry and Tito, above n 95.

The critique of criminal negligence within the specific domain of healthcare quality and safety science takes place at two levels of generality. The first, and most general, is a critique of the potential use of *any* criminal offence in relation to healthcare. This is a critique of criminal liability in general, focused largely on its alleged effects upon healthcare practitioners and safety improvement. The second, more specific, level tackles the doctrinal specifics of manslaughter by criminal negligence as the offence that had been, and would be, most likely to apply to instances of iatrogenic harm leading to death.¹⁰¹ Summarised schematically, there are two heads of opposition. The first relates to conceptions of what I term ‘right and wrong’. What practitioners can be fairly held morally or criminally responsible for, and the relationship between those domains of responsibility, forms this head of opposition. The second basis of opposition focuses on what I term the ‘practical and impractical’ in the realm of responding to iatrogenic harm. This collection of arguments focuses on the ‘good’ of reducing iatrogenic harm, and demands the decriminalisation or non-prosecution of the offence on the basis that it represents an unhelpful, ineffective, or even harmful practice in relation to reducing iatrogenic harm in ways aligned to the disciplinary logic of the quality and safety agenda. I provide slightly more detail of each of these two heads of opposition here.

1 ‘Right and Wrong’

In relation to the first – what I have termed matters of ‘right and wrong’ – the focus of the majority of the literature is on the offence structure’s eschewal of the otherwise widespread expectation that forms of mens rea may only be ‘subjective’. Subjective forms of mens rea include intention (to kill) or recklessness (as to death),¹⁰² whilst manslaughter by criminal negligence relies on what is termed an ‘objective’ form of mens rea or fault – namely ‘a great falling short of the standard of care which a reasonable man [sic] would have exercised’.¹⁰³ Subjective approaches to mens rea have become – in jurisprudence and

¹⁰¹ The literature dealt only lightly with the potential for a charge of murder on grounds of intention. The status of murder on grounds of recklessness is more complex, as much of the literature emanated from the United Kingdom, where the definition of recklessness was undergoing significant strain and reinterpretation. The situation in Australia has been far more sedate with regards to the (re)interpretation of recklessness. See the very recent treatment of this area of law and reform by Findlay Stark, Findlay Stark, *Culpable Carelessness: Recklessness and Negligence in the Criminal Law* (Cambridge University Press, 2016).

¹⁰² Andrew Hemming, ‘Reasserting the Place of Objective Tests in Criminal Responsibility: Ending the Supremacy of Subjective Tests’ (2011) 13 *University of Notre Dame Australia Law Review* 69.

¹⁰³ *Nydam* [1977] VR 430, 445.

legal theory at least – a form of orthodoxy;¹⁰⁴ however, those writing within the discipline of quality and safety science raise their concerns in ways specifically related to healthcare practice. The first such concern is related to ‘control’ and ‘choice’, the second to what standard a practitioner (or any other person) can be justly held accountable.

With regard to ‘control’ and ‘choice’, key writers argue forcefully against imposing liability where control or choice – fundamental requirements of culpability ascription according to subjectivist forms of mens rea – cannot be exercised by relevant practitioner-defendants¹⁰⁵ because of the complex, sociotechnical system that is the context for, if not the very nature of, healthcare practice.¹⁰⁶ The quality and safety literature argues that healthcare is not a process or cluster of social practices amenable to top-down decision making or control by individual agents. Rather, the ‘world’ of healthcare is imagined to ‘consist *a priori* of systems in which entities and their non-living environments are intrinsically connected by characteristic functional interdependencies, interdependencies that self-regulate the system as a functioning unit’.¹⁰⁷ In these terms, the healthcare system is understood as an objectively existing and functionally integrated unit. These are the ‘complex systems’ that dominate the work of quality and safety scholars, the ‘natural properties’¹⁰⁸ of which ‘are formed by relationships among clinicians which rest on mutual (often implicit) agreements to participate’,¹⁰⁹ that ‘respond poorly or not at all to conventional management or control measures... [and] emerge spontaneously and function

¹⁰⁴ Alan Norrie, *Crime, Reason and History: A Critical Introduction to Criminal Law* (Cambridge University Press, 2001) 58–9; Andrew Ashworth, *Positive Obligations in Criminal Law* (A&C Black, 2014); Celia Wells and Oliver Quick, *Lacey, Wells and Quick Reconstructing Criminal Law: Text and Materials* (Cambridge University Press, 2010); Penny Crofts, *Wickedness and Crime: Laws of Homicide and Malice* (Routledge, 2013) 231; Alan Norrie, *Law & the Beautiful Soul* (Routledge, 2013); such a focus upon the subjective forms of fault is present too in the formation of the Australian Model Criminal Code (MCC), where the Committee confirmed the centrality of such forms of fault, and operated according to a presumption in favour of subjective fault elements, see Model Criminal Code Officers Committee of the Standing Committee of Attorneys-General, ‘Discussion Paper: Model Criminal Code Chapter 5 - Fatal Offences Against the Person’ 2 <[http://www.ema.gov.au/www/agd/rwpattach.nsf/VAP/\(03995EABC73F94816C2AF4AA2645824B\)~modelcode_ch5_non-Fatal_offences_report.pdf/\\$file/modelcode_ch5_non-Fatal_offences_report.pdf](http://www.ema.gov.au/www/agd/rwpattach.nsf/VAP/(03995EABC73F94816C2AF4AA2645824B)~modelcode_ch5_non-Fatal_offences_report.pdf/$file/modelcode_ch5_non-Fatal_offences_report.pdf)>; Law Council of Australia, ‘Review of Chapter 2 Model Criminal Code’ (2012 03 21 Sub re Review of Chapter 2 Criminal Code, 23 March 2012) 4 <<https://www.lawcouncil.asn.au/>>.

¹⁰⁵ See for example, Merry and McCall Smith, above n 32; see also Chapter Three which provides a detailed overview of the arguments put forward by Merry, Mccall Smith and others.

¹⁰⁶ Braithwaite, Runciman and Merry, above n 36.

¹⁰⁷ Marc Welsh, ‘Resilience and Responsibility: Governing Uncertainty in a Complex World’ (2014) 180(1) *The Geographical Journal* 15.

¹⁰⁸ Braithwaite, Runciman and Merry, above n 36, eg 37, 38 Table 1.

¹⁰⁹ Ibid 37.

with little or no externally imposed structure'.¹¹⁰ Under such conditions, the dominant response has been to require a 'shifting from individual blame to a systems perspective'.¹¹¹ Whilst it remains true that '[p]eople make errors...[and] errors can cause accidents... [and] in healthcare, errors and accidents result in morbidity and adverse outcomes and sometimes in mortality',¹¹² from the systems perspective medical error emerges from an accretion of conditions rather than the more standard causal chain. Patient *harm*, rather than patient safety, is itself understood as the naturally emergent phenomenon of healthcare-as-complex-system.¹¹³ In such a domain, individual responsibility,¹¹⁴ and thus blame, cannot be 'made out'. So embedded and 'debased'¹¹⁵ is such a subject/agent, so lacking in the ability to alter the emergent causation caused by the flow of events,¹¹⁶ that the question of whether individual agency is something that healthcare organisations should even direct attention to has become a live question.¹¹⁷ For this literature and field of practice, the criminal law's focus on individual actors proximate to harm is an unintelligible and 'prehistoric'¹¹⁸ practice, the result of nothing more than the exercise of brute power in aid of satisfying the base desire for blame. On this basis, it is clear why the question of criminal culpability has become so controversial for those who support this view of healthcare and the limits of human agency within it.

The related, but specifically doctrinal, expression of this issue centres on the role of subjective forms of *mens rea* in defining what a practitioner may rightly be held accountable for. The literature dealing directly with the translation of the quality and safety

¹¹⁰ Ibid.

¹¹¹ Corbett, Travaglia and Braithwaite, above n 3, 248.

¹¹² Philip G Boysen, 'Just Culture: A Foundation for Balanced Accountability and Patient Safety' (2013) 13(3) *The Ochsner Journal* 400, 400.

¹¹³ Corbett, Travaglia and Braithwaite, above n 3, 248; Corbett et al cites John Øvretveit, 'Understanding and Improving Patient Safety: The Psychological, Social and Cultural Dimensions' (2009) 23(6) *Journal of Health Organization and Management* 581.

¹¹⁴ Which as will be seen still relies upon a liberal conception of the choosing and isolated subject, despite the radical rejection of that form of subjectivity by the same writers, see Chapter 3 and 4.

¹¹⁵ Julian Reid, 'The Disastrous and Politically Debased Subject of Resilience' [2012] (58) *Development Dialogue* 67.

¹¹⁶ See generally on this conception emanating from regulatory studies, with which I largely agree, Healy, above n 32, xvii.; Judith Healy and John Braithwaite, 'Designing Safer Health Care through Responsive Regulation' (2006) 184 *Medical Journal of Australia* S56; see also Julia Black, 'Critical Reflections on Regulation' (2002) 27 *Australian Journal of Legal Philosophy* 1; see also in relation to iatrogenic harm and tort specifically Corbett, 'Regulating Compensation for Injuries Associated with Medical Error', above n 16.

¹¹⁷ Corbett et al write 'the problem of whether health care organisations should direct attention to creating the conditions for encouraging individual diligence' Corbett, Travaglia and Braithwaite, above n 3, 248.

¹¹⁸ Dekker, *Patient Safety*, above n 24, 38.

science view of human action into its criminal doctrinal implications argues that only subjective forms of mens rea are understood to play a role in properly linking the offender's act with moral censure and the imposition of criminal culpability and punishment.¹¹⁹ In short, without exhibiting a form of subjective mens rea, a defendant-practitioner cannot be said to be culpable in strong enough a manner to justify criminal liability or to bear the significant opprobrium communicated by that finding. This analysis of action, agency and the conditions of responsibility is made in reliance upon cognitive properties and inherent capacities said to mark the rational and free agent of the defendant-practitioner.¹²⁰ This vision of human agency and action means, in practice, an acceptance of causal responsibility and criminal culpability only where the defendant-practitioner can be shown to have personally, subjectively intended the relevant harm or, at the very least, to have been (knowingly) reckless as to the consequences of their actions.

2 'Practical and Impractical'

In relation to the second head of opposition – what I have termed matters of the 'practical and impractical' – the most significant body of literature alleges that threatened or actual prosecution impacts negatively on open, effective discussion of the causes of harm. Put simply, regardless of the correctness of prosecution (factually, doctrinally or ethically) it is argued that the threat of prosecution forces healthcare practitioners into a defensive posture that limits their engagement in improvement efforts,¹²¹ instantiating a perverse cycle of failure, followed by cover-up, and then progressively deepening failure. The literature contends that the use of criminal prosecution erects structural, material and psychological barriers against the open and continuous disclosure of risks,¹²² 'near-misses'

¹¹⁹ See Griffiths and Sanders, above n 8, 127; Margaret Brazier and Suzanne Ost, *Bioethics, Medicine and the Criminal Law: Medicine and Bioethics in the Theatre of the Criminal Process* (Cambridge University Press, 2013) 77–94; see 'level four blaming' Merry and McCall Smith, above n 32, 147; for an overview of the position on this question in the United States, a jurisdiction that is outside the scope of this thesis, see for example James A Filkins, "'With No Evil Intent": The Criminal Prosecution of Physicians for Medical Negligence' (2001) 22(4) *Journal of Legal Medicine* 467.

¹²⁰ See particularly Chapter 3 and 4 for more detail.

¹²¹ Merry and McCall Smith, above n 32, 215–16; Griffiths and Sanders, above n 32, 5, 154–7; Suzanne Ost, *The Criminal Justice System and Health Care* (Oxford University Press, 2007) 2, 93, 133; See a discussion of the issue, however, in relation to tortious liability in the United States, Studdert DM et al, 'Defensive Medicine among High-Risk Specialist Physicians in a Volatile Malpractice Environment' (2005) 293(21) *JAMA* 2609.

¹²² This preference for open and continuous disclosure is an outflowing of a more general use of transparency in the form of governance erected by quality and safety science. The concept of transparency has been a signal feature of neoliberalism, a theme I take up principally in Chapter Four. There I show the role that transparency plays in both the theorisation and practices of alternative accountability regimes in healthcare quality and safety, see for an example in a broader context,

or harm by practitioners.¹²³ Faced with the threat of criminal prosecution, such disclosures are thought to cease.¹²⁴ Some argue that these disclosures cease due to the usual human propensity to avoid blame, but many argue also that this occurs because such accusations are themselves unjust and unfair.¹²⁵

The claim that blaming practices like criminal negligence prosecution render iatrogenic harm prevention and rectification efforts difficult or impossible is a major theme of the literature.¹²⁶ This assertion is rooted in a longer tradition of questioning tortious negligence claims in relation to their impact upon iatrogenic harm.¹²⁷ One early review of the landmark US Institutes of Medicine ('IOM') report, *To Err is Human*¹²⁸ is worth quoting at length in this regard:

An interpretation of the IOM findings as 98,000 deaths [per annum in the United States] due to blunders and a cycle of inaction could give impetus to legislation requiring greater public disclosure, which in turn would lead to more lawsuits...Therein lies the key problem overlooked by the IOM report. Any effort to prevent injury due to medical care is complicated by the dead weight of a litigation system that induces secrecy and silence. No matter how much we might insist that physicians have an ethical duty to report injuries resulting from medical care or to work on their prevention, fear of malpractice litigation drags us back to the status quo.¹²⁹

Whilst *To Err is Human* succeeded in drawing attention to the extent of iatrogenic harm like no other event in the history of the discipline, so too did its publication manage to

Afshin Mehrpouya and Marie-Laure Djelic, 'Transparency: From Enlightenment to Neoliberalism or When a Norm of Liberation Becomes a Tool of Governing' (SSRN Scholarly Paper ID 2499402, Social Science Research Network, 1 September 2014) <<http://papers.ssrn.com/abstract=2499402>>.

¹²³ Brazier and Allen, above n 81; Sidney WA Dekker, 'Just Culture: Who Gets to Draw the Line?' (2008) 11(3) *Cognition, Technology & Work* 177; Dekker, *Just Culture*, above n 29; Sidney WA Dekker and Thomas B Hugh, 'A Just Culture after Mid Staffordshire' (2014) 23(5) *BMJ Quality & Safety* 356; Lynn V Monrouxe and Charlotte E Rees, "'It's Just a Clash of Cultures": Emotional Talk within Medical Students' Narratives of Professionalism Dilemmas' (2012) 17(5) *Advances in Health Sciences Education* 671.

¹²⁴ This, despite safe-harbour structures for the use of quality improvement information and data. But see, New Zealand and its experience of no-fault compensation schemes on error and adverse event disclosure.

¹²⁵ Dekker, *Just Culture*, above n 29.

¹²⁶ See the discussion below for an overview of the scale of this perspective.

¹²⁷ For an overview of this tradition, especially as it occurred in Australia, see Chapter Three.

¹²⁸ Institute of Medicine, above n 66.

¹²⁹ Troyen A Brennan, 'The Institute of Medicine Report on Medical Errors—could It Do Harm?' (2000) 342(15) *New England Journal of Medicine* 1123.

concentrate and intensify opposition to legal blaming.¹³⁰ By the time of the report's release, it had already been established as a matter of orthodoxy within the quality and safety discipline that tortious negligence liability induced fear and silence,¹³¹ and thus choked-off 'error wisdom',¹³² the most valuable data about harm that is gained from analysis of an error or 'near miss'. And so arguments for the elimination or radical re-balancing ('reform') of tortious liability in favour of medical practitioners in particular, became a major focus of the literature, and a feature of law reform efforts in a range of jurisdictions.¹³³

This same response, first developed in relation to tortious negligence, found itself applied, *mutatis mutandis*, to criminal negligence. Emblematic of this cross-over between tortious and criminal negligence in the scholarly literature is the work of Sidney Dekker.¹³⁴ Dekker, a leading scholar on questions of quality and safety improvement practices as they

¹³⁰ See for example, Lucian L Leape and Donald M Berwick, 'Five Years after To Err Is Human: What Have We Learned?' (2005) 293(19) *Jama* 2384; Robert M Wachter, 'The End of the Beginning: Patient Safety Five Years After "To Err Is Human"' (2004) 23 *Health Affairs* W4; Carolyn Clancy, 'Improving Patient Safety-Five Years After the Iom Report' (2004) 351(20) *The New England Journal of Medicine* 2041; Patrick S Romano, 'Improving the Quality of Hospital Care in America' (2005) 2005(353) *New England Journal of Medicine* 302; Randall R Bovbjerg and Laurence R Tancredi, 'Liability Reform Should Make Patients Safer: "Avoidable Classes of Events" Are a Key Improvement' (2005) 33(3) *The Journal of Law, Medicine & Ethics*; Julianne M Morath and Joanne E Turnbull, *To Do No Harm: Ensuring Patient Safety in Health Care Organizations* (John Wiley & Sons, 2005); see more generally, Lawrence Gostin, 'A Public Health Approach to Reducing Error: Medical Malpractice as a Barrier' (2000) 283(13) *JAMA* 1742.

¹³¹ David M Studdert, Michelle M Mello and Troyen A Brennan, 'Medical Malpractice' (350) 283, 286 ('Considered as a whole, the evidence that the [malpractice] system deters medical negligence can be characterised as limited at best.');

Studdert DM et al, above n 121; David M Studdert et al, 'Negligent Care and Malpractice Claiming Behavior in Utah and Colorado' [2000] *Medical Care* 250; Merry and McCall Smith, above n 32, 48–51; Annas argues that a legal right would be productive for patient safety, however notes the general consensus is for an ejection of law as a barrier to safety improvement, George J Annas, 'The Patient's Right to Safety-Improving the Quality of Care through Litigation against Hospitals' (2006) 354(19) *New England Journal of Medicine* 2063, 2063 ('Most patient-safety experts continue to believe that the threat of liability is the primary barrier to the development of effective and comprehensive patient-safety programs in hospitals.');

Allen Kachalia et al, 'Legal and Policy Interventions to Improve Patient Safety' (2016) 133(7) *Circulation* 661; for a specifically Australian consideration, see Corbett, 'Regulating Compensation for Injuries Associated with Medical Error', above n 16; Corbett, 'Australia', above n 16; But see the recent work of Frakes et al, and Boehm which begins to re-assess the impact of negligence and other forms of legal liability on the practice of medicine, Michael Frakes and Anupam Jena, 'Does Medical Malpractice Law Improve Health Care Quality?' [2016] *Journal of Public Economics* <DOI: 10.1016/j.jpubeco.2016.09.002>; Michael D Frakes, 'The Surprising Relevance of Medical Malpractice Law' [2015] *The University of Chicago Law Review* 317; Geoff Boehm, 'Debunking Medical Malpractice Myths: Unraveling the False Premises behind Tort Reform' (2005) 5 *Yale Journal of Health Policy, Law, and Ethics* 357.

¹³² Reason, above n 30, ii31; Dekker, *Just Culture*, above n 29.

¹³³ In relation to the Australian experience, its main architect was Ipp, see Ipp, above n 16.

¹³⁴ For his principal works, see Dekker, *Patient Safety*, above n 24; Dekker, *Drift into Failure*, above n 25; Dekker, *Just Culture*, above n 29; Dekker, *Second Victim*, above n 33.

relate to blaming,¹³⁵ argues that criminal and tort law alike,¹³⁶ fails to offer a way of providing satisfactory explanation of failure, nor an opportunity to make progress towards safer practice.¹³⁷ For Dekker, '[a]s with criminal trials (which do not deter people from making mistakes but *do* deter people from talking about their mistakes), tort law promotes defensive practice rather than high quality care.'¹³⁸ Dekker was not alone in this linking of tortious blame with criminal blame. Hindle et al, for instance, expressed the same concerns as Dekker, concluding that a prosecutorial approach,¹³⁹ if 'overused or employed bluntly, would likely have undesirable consequences; clinicians, especially doctors, will be less likely to participate in change initiatives'.¹⁴⁰ They wrote that

[h]ardly anyone in these cases knowingly or deliberately tried to harm anyone. The actors in the cases were not like Dr Shipman, the British general practitioner who systematically killed at least 250 patients in a cold blooded, calculating manner...¹⁴¹

Comparison between the notorious doctor and serial killer, Harold Shipman, and other doctors, underscores the conceptual separation developed in this period regarding criminal culpability. In the mainstream of the literature, separation was enacted between instances where patients were harmed or died due to the 'knowing' or 'deliberate' choice of the defendant-practitioner. Culpability in this instance adheres to the primacy of the logic of choice and very few oppose the validity of criminal or tortious negligence claims in those circumstances.¹⁴² On the other hand, where culpability might be employed outside of that subjectivist orthodoxy, undesirable consequences were said to follow. The undesirable consequences of most concern were the practical impacts of criminal prosecutorial activity

¹³⁵ Dekker, *Just Culture*, above n 29; see especially his application of those principles to the Mid-Staffordshire quality and safety disaster in healthcare where he writes with Hugh, that 'To promote safety and quality, we encourage a sensitivity to the differences between understanding, satisfying demands for justice, and avoiding recurrence', Dekker and Hugh, above n 123.

¹³⁶ For his clear summary see Dekker, *Just Culture*, above n 29, 111–112.

¹³⁷ Ibid 111 Dekker is, of course, not alone in this view. He summarises and points to the body of literature which supports this view.

¹³⁸ Ibid 112.

¹³⁹ Such an approach is not limited to the criminal law, but, in the context of their writing includes approaches taken by public inquiries.

¹⁴⁰ Don Hindle et al, 'Patient Safety: A Comparative Analysis of Eight Inquiries in Six Countries.' (2006) 9; see also Jeffrey Braithwaite, 'Hunter-Gatherer Human Nature and Health System Safety: An Evolutionary Cleft Stick?' (2005) 17(6) *International Journal for Quality in Health Care* 541.

¹⁴¹ Hindle et al, above n 140, 8–9.

¹⁴² But see Dekker, who goes further than most in his critique of blaming practices in any circumstance. Dekker, 'Just Culture', above n 123.

said to have upon a practitioner's willingness to engage in change initiatives. Alan Merry makes this concern clear in his use of the same 'Shipman contrast' to establish the binary between acceptable culpability, and the consequences of culpability outside of that subjectivist orthodoxy:

Sending Shipman to jail achieved the objective of punishment, and did presumably save the lives of some patients who might otherwise have been murdered. This was essential, but how effective was it in addressing the overall problem of the harm caused by doctors, most of which is entirely unintentional? Not very.¹⁴³

In this literature then, the criminal law is granted jurisdiction over intentional homicide like that committed by Shipman. However, where criminal negligence retains jurisdiction over what is often termed 'normal medical practice' – where death may arise outside of the intention or recklessness of the defendant-practitioner – the consequences are said to be a failure to affect the overall problem of the harm caused by doctors. Simply put, this narrative suggests that the use of criminal negligence is incompatible with effective quality and safety science interventions for the reduction of iatrogenic harm.

The literature considers the personal toll of prosecution as the basis of its explanation as to how criminal negligence prevents progress towards reducing iatrogenic harm and death. Doctors are described as the 'second victim'¹⁴⁴ of iatrogenic harm. This victimisation includes the fear of (unjust) criminal prosecution after the emergence of an error which causes harm. It is this fear which is said to induce a 'closed-shop' in relation to harm and near-misses. That is, in response to the threat or activation of criminal prosecution for criminal negligence – even of distant colleagues – transparency and the open reporting of error closes down.¹⁴⁵

¹⁴³ Alan Merry, 'When Are Errors a Crime?—Lessons from New Zealand' in Charles A Erin and Suzanne Ost (eds), *The Criminal Justice System and Health Care* (Oxford University Press, 2007) 94.

¹⁴⁴ The term seems to have originated with Wu's influential article, Wu, above n 33; see also Dekker, *Second Victim*, above n 33; Delbanco and Bell, above n 33; Denham, above n 33; Orri, Revah-Lévy and Farges, above n 33; Ullström et al, above n 33; Wu and Steckelberg, above n 33.

¹⁴⁵ Healy, above n 32, e.g. 247, 268-269; Merry and McCall Smith, above n 32, e.g. 216-217, 243; Griffiths and Sanders, above n 32, 5; the fear has been likened to that of being 'in the closet' by Quick, ('Experts have preferred to closet errors, fearing loss of trust and status should they 'come out)'), Quick, above n 32, 27; This view formed a background assumption of much of the debate in relation to the introduction of the duty of candour in Australian jurisdictions and in the UK, see for instance, Studdert and Richardson, above n 32; Rait and Van Ekert, above n 32; Faure, above n 32,

Merry illustrates how criminal prosecution acts as a mechanism to shut down open reporting. It is in the form of a chilling effect. He writes that ‘[p]eople are less likely to report [error or harm] fully, frankly, and promptly if they fear that the consequences of doing so might include criminal charges.’¹⁴⁶ Fear and subsequent silence or active ‘cover-up’ are for Merry a wholly rational response enacted to avoid the personal cost and lived experience which a criminal prosecution with its ‘strong connotations of serious moral opprobrium’.¹⁴⁷ This view is well illustrated by Merry’s ‘granny test’.¹⁴⁸ He asks whether informing one’s ‘granny’ of a particular charge would result in her understanding it as an ‘unfortunate, but relatively normal transaction between individuals’¹⁴⁹ or something else entirely. For Merry, a civil case, or disciplinary proceeding, would be interpreted ‘as primarily a professional matter...’,¹⁵⁰ whereas, ‘it may be difficult to persuade [granny] that being prosecuted by the State for a serious crime does not imply that one is (at least allegedly) a bad person.’¹⁵¹

Criminal blaming is not simply an unpleasant lived experience. For Merry, the fear and silence brought about by blame culture is intensified by the sense that such prosecution is unjustified in relation to medical practitioners:

...[t]he name of the [practitioner-]defendant at a deposition hearing will often be included on a list of other people charged with crimes, and these crimes are likely to be of an obviously egregious nature, such as rape, theft, and assault.¹⁵²

To Merry’s mind, the homicide by criminal negligence of a patient is not cause for such labelling. Only those who intend to kill, the absolute highest form of culpability in the criminal law, are justifiably so-labelled.¹⁵³ Despite the objectively lower level of seriousness for the victim, crimes such as theft and assault are ‘obviously egregious’, and the medical practitioner charged with homicide by virtue of criminal negligence is out of

354; Brazier, above n 32, [8.19]; as to the incidence of defensive medicine in response to legal threat, see Catino, above n 32.

¹⁴⁶ Merry, above n 143, 94.

¹⁴⁷ Merry, above n 143.

¹⁴⁸ Ibid 68–69.

¹⁴⁹ Merry, above n 143.

¹⁵⁰ Ibid 69.

¹⁵¹ Ibid.

¹⁵² Merry, above n 143.

¹⁵³ See Chapter 3 for an overview of Merry and McCall Smith’s arguments in relation to this claim.

place in their company. Wu's highly cited article, from which the influential 'second victim' epithet seems to have originated, makes the same point. He writes that '...there is no place for mistakes in modern medicine. Society has entrusted physicians with the burden of understanding and dealing with illness...patients...have colluded with doctors to deny the existence of error' creating an unforgiving system, which, in the absence of 'mechanisms for healing', physicians find 'dysfunctional ways' to protect themselves, including anger, projection of blame, acting defensively or callously, including blaming the patient and other members of their team.¹⁵⁴

The seriousness, moral opprobrium and lived experience of the criminal blaming process comes together in these arguments about how criminal negligence prosecution comes to shut-off error wisdom. Criminal negligence prosecution is unpleasant but also wholly objectionable when applied to medical practitioners.¹⁵⁵ Being charged by the State with a serious criminal offence might be deserved in cases which are of an 'obviously egregious nature',¹⁵⁶ however, for Merry and others, medical manslaughter does not deserve that label. In these circumstances, avoiding this serious, unpleasant and unjust process is only a rational response.

That humans would attempt to avoid criminal prosecution – deserved or otherwise – is not particularly noteworthy. However, in relation to iatrogenic harm, the stakes are far higher. For '[i]f the health care system is to be improved, it is essential that workers report accidents, and also their insights into why the accidents occurred.'¹⁵⁷ The problem of this chilling effect of criminal prosecution is that effective approaches to the reduction of iatrogenic harm rely upon open and free disclosure of near-misses and errors. Without this information, it is argued, we decrease – or even halt – the ability of quality and safety science to reduce harm.¹⁵⁸ For this reason, the regimes of quality and safety intervention and criminal law are incompatible.

¹⁵⁴ Wu, above n 33.

¹⁵⁵ This includes criminal negligence liability predicated on the usual criminal standard, as opposed to the earlier civil standard of plain negligence which applied in New Zealand at the time of Merry's earliest writing on this question.

¹⁵⁶ Merry, above n 143.

¹⁵⁷ Ibid 93.

¹⁵⁸ But see Quick, who correctly notes that the evidence of this mechanism being relieved by the introduction of no-fault system in New Zealand, the system most similar to our own in Australia (culturally, legally and medically), in relation to tortious negligence (where this concern is most pronounced in the literature), Oliver Quick, *Regulating Patient Safety* (Cambridge University Press,

Considerable significance had been attached to this issue of ‘fear of blame, or the “culture of blame”’.¹⁵⁹ So widespread is the phrase, that it has become no longer attributable or attributed to individuals, passing over, in the words of Joanne Travaglia, into ‘doxa’.¹⁶⁰ Waring too notes that the concept was widespread, and its use based on arguments that practitioners would be ‘disinclined to be open and honest about their experiences of error, because of the deep-seated assumption that they will be found at fault and held individually responsible or punished for the event’.¹⁶¹ For his part, James Reason – one of the earliest and most influential theorists of quality improvement – directs attention to the primacy accorded to individual autonomy in Western thinking arguing that for error management to work, this culture of autonomy needed to be overcome. It was necessary to end the ‘blame cycle’ and enter into a ‘reporting culture’.¹⁶² Again, Alan Merry argues by example that the silencing effect of blame is clear and swift, and its result devastating to the flow of data about error:

In New Zealand, before [criminal prosecution of anaesthetist Dr Namsivayam Yogasakaran], anaesthetic deaths were reported on a confidential basis to a review committee which analysed the circumstances, gave feedback to those reporting, and published reports containing recommendations for greater safety. In Yogasakaran, the police subpoenaed one of these reports. Mortality reporting stopped forthwith, and has not so far been re-established.¹⁶³

The majority of the literature falls away at this point, having established the dominant claim that criminal negligence drives iatrogenic harm underground and in so doing prevents effective measures aimed at reducing iatrogenic harm. On this basis, a distinct contrast between the two regimes is established. Criminal negligence is not compatible

2017) 99–100; but see in relation to civil liability and its effect, Taylor, above n 31, 169 and generally.

¹⁵⁹ Justin J Waring, ‘Beyond Blame: Cultural Barriers to Medical Incident Reporting’ (2005) 60(9) *Social Science & Medicine* 1927, 1928.

¹⁶⁰ Travaglia, above n 18, 84; see also Hindle et al, above n 140; see also Travaglia and Braithwaite, above n 15.

¹⁶¹ Waring, above n 159, 6.

¹⁶² James Reason, *Managing the Risks of Organizational Accidents* (Routledge, 2016).

¹⁶³ Merry, above n 143, 94; see also *R v Yogasakaran* [1990] NZLR 399 (‘*Yogasakaran*’); There is also some doubt that reporting has returned in light of the introduction of no-fault compensation system as a tort reform measure, or of the wholly suitable reform of the definition of criminal negligence which applies in New Zealand from that of plain or civil negligence to one which more closely matches the Australian position, see for example Quick, above n 158.

with quality and safety science interventions, and nor are quality and safety science interventions compatible with a criminal law response, except in the most limited of circumstances.¹⁶⁴ Whilst this may in fact be true, this claim is highly instrumental. It ignores the law's normative and expressive role, arguing for a form of wilful blindness or decriminalisation justified by reference to the greater good of reducing iatrogenic harm. The argument proposes that effective safety interventions rely upon open and transparent disclosure of harm or error. Criminal law, it continues, threatens the flow of this 'error wisdom'. Because of this threat to the effective reduction of harm, criminal law must be neutralised or rendered subordinate to the (effective) quality and safety sciences. The flow of this argument makes very little reference to the question of the validity of the criminal doctrine, nor the moral status of the harm which the law would otherwise ascribe blame. Instead, it strictly measures the law's 'success' by its instrumental contribution to eliminating harm and promoting quality care. For those who make this kind of critique, criminal law can be nothing other than a social and intellectual 'monstrosity, of which no sense can be made, and by which, of necessity, no justice can be done'.¹⁶⁵

On the analysis mounted so far, criminal negligence is accused of preventing meaningful reductions of iatrogenic harm. On this basis, criminal negligence is received in a highly critical fashion, and is characterised as wholly incompatible with the successful reduction of iatrogenic harm. There is, however, a portion of the literature which undertakes deeper analysis, asking 'why' criminal negligence is so radically incompatible and even detrimental to efforts of quality and safety improvement. This part of the literature asks 'why' it is that this incompatible operation of criminal law and quality and safety improvement exists. In answer, it proposes that this incompatible operation occurs because criminal negligence labours under a false view of human action, agency and the emergence of error.

For healthcare imagined as a complex sociotechnical system, this effect, regardless of its cause, is particularly concerning, for the exposure of 'threats' in the form of failure or near misses (regardless of whether harm results) is, as in any natural system, thought by adherents of the disciplinary logic of quality and safety science to be 'a constitutive

¹⁶⁴ Namely, intentionally caused harm or death, like the example of Dr Harold Shipman.

¹⁶⁵ As JB White described that perspective, one which he does not share, James Boyd White, *Heracles' Bow: Essays on the Rhetoric and Poetics of the Law* (University of Wisconsin Press, 1989) 193.

process in the development [of that system]'.¹⁶⁶ In a world where failure and harm are naturally emergent properties of the healthcare system, where failure is 'inevitable', quality and safety science argues that it should be embraced. Failure in this setting is used productively, as an opportunity for growth, rather than as a final judgement.¹⁶⁷ By stifling this valuable 'error wisdom',¹⁶⁸ the 'gold standard' of data for quality improvement, the criminal law needlessly obstructs improvement of quality and safety in healthcare. In sum, the criminal law *itself* is said in effect to produce, or at least worsen, the very iatrogenic harm it aims to prosecute.

III THESIS OVERVIEW AND CHAPTER SUMMARY

The thesis proceeds in three sections, each providing a new account of the actual practices of criminal law in this field: firstly, as to the history of its use in Australia; secondly, as to its particular understanding of human action; and finally, as to its mobilisation in the Australian courtroom. The first section (chapters 1 and 2) focuses on the working of criminal law itself, with new historical accounts of the prosecution of iatrogenic death Australia, and of the more recent history of attempts to expel (criminal) law from the field of iatrogenic harm. The second section (chapters 3 and 4) extends this engagement by theorising the conflict between the criminal law and the healthcare quality and safety sciences as one rooted in their expression of conflicting understandings of human action and of healthcare, explored as conflicting 'logics' of care and of choice. The final section (Chapter 5) begins to retrieve criminal doctrine in the light of this historical and theoretical work by bringing to the surface how the doctrine is mobilised in the Australian courtroom, at the same time reconstructing its features according to the demands of care.

A *Chapters One and Two: History*

Most scholars argue that criminal negligence prosecutions for 'medical manslaughter' are inappropriate both because the doctrine punishes where culpability does not truly exist,

¹⁶⁶ Reid, above n 115, 71.

¹⁶⁷ 'Emergent understandings of disasters and the rise of real time Big Data approaches, which take on board post-epistemic assumptions and tend to lack the modernist causal framings that enabled failure to be key to political contestation.' David Chandler, 'How the World Learned to Stop Worrying and Love Failure: Big Data, Resilience and Emergent Causality' (2016) 44(3) *Millennium-Journal of International Studies* 391.

¹⁶⁸ Reason, above n 30.

and because such prosecution promotes the very harm it purports to address. Yet, not only have these debates been framed in dubiously instrumentalist terms; they have also, particularly in the Australian jurisdiction, occurred in a sort of vacuum: only four cases of prosecution have been reported in the scholarly literature from the past two centuries. In the absence of an adequate history of medical manslaughter prosecutions in the Australian jurisdiction, and of iatrogenic harm incidents more generally, it is unclear how frequently such incidents have occurred over the past two centuries or how these incidents have been handled by the criminal law. Under what circumstances have instances of iatrogenic harm been prosecuted, and what have been the outcomes? How have outcomes been shaped by the social practices, processes and forces surrounding individual cases? And, perhaps most urgently, what insights do these cases yield regarding the criminal law's capacity to successfully distinguish culpable from non-culpable instances of harm? Only by addressing such questions can we hope to tackle the scholarly and practical challenge of adjudicating on the correctness, viability and impact of criminal manslaughter prosecutions for iatrogenic harm.

Chapter 1 provides a basis for addressing these questions by reconstructing the history of criminal legal engagement with iatrogenic harm in Australia and exploring the nature of that engagement. First, drawing on archival research, the chapter formulates a new and extended history of prosecution for manslaughter in the healthcare context. The extension of the case law presented here is noteworthy; from four known prosecutions, an additional thirty-three unacknowledged prosecutions are presented, revealing a far older and more active engagement than is reflected in existing literature. Second, based on this extended case law, the chapter considers what insights this body of cases yields in addressing the questions above. In so doing, I find that the criminal law demonstrates a consistent capacity to distinguish between culpable and non-culpable instances of harm; the most egregious violations of duty of care lead to findings of guilt, and the least obviously egregious violations of that same duty are most often not successfully prosecuted. However, there are also instances that seem to speak to a kind of failure of the criminal process, where criminal law seems unable to maintain its jurisdiction or grasp over cases of iatrogenic harm. These slippages arise in a range of cases throughout the history of prosecution. I read these 'failures' as an expression of a flexibility that has not been attributed to the criminal law in the past. In those cases, the law seems to be attending in

an open and responsive way to social practice and the practice of medicine – radically modifying the law itself to different circumstances (e.g., gender of defendant or victim; or the need for doctors in small communities).

Chapter 2 explores the manner in which the prevalence of iatrogenic harm in the Australian healthcare system was first ‘discovered’ by the public and the medical community in the 1990s. In response, the new discipline of quality and safety science coalesced around the goal of reducing the incidence of iatrogenic harm. Deeming the law an inappropriate and unhelpful tool in the pursuit of this goal, those in the quality and safety movement opposed criminal blaming in cases of iatrogenic harm. Section II develops a critical account of this pivotal period in the history of Australian engagement with iatrogenic harm, tracing key events and debates in the discovery of iatrogenic harm, as well as responses to it by the public and the medical community. My account traces the development of a dichotomy between law and the quality and safety discipline, whereby these two forms of rule came to be construed as autonomous and incompatible. As quality and safety science pursued the reduction of iatrogenic harm, the (criminal) law was expelled from this project. In Section III, following this critical account of the ‘discovery’ of iatrogenic harm, the chapter then explicates the assumptions about law and responsibility that motivated and justified the expulsion of law from quality and safety science: (a) that tort law was to blame for problems with the medical indemnity system and thus should not be available as a form of redress; (b) that criminal law was similarly associated with unproductive blame; (c) quality and safety disciplines were associated with productive learning and improvement; (d) that adverse events were largely unpreventable and should rarely if ever be construed as acts of negligence; and (e) that all law required reform in order to cohere with the productive activities and goals of quality and safety science. In Section IV, I argue that, contrary to the conclusion reached at the end of this period, law and quality and safety are in fact neither incompatible nor autonomous: rather, they exist in a highly dynamic, mutually constitutive relationship, one that is productive for both the formation of the field of quality and safety practice, and of its ‘object’, iatrogenic harm. I demonstrate the role that law played in the discovery of iatrogenic harm, in the conceptual task of defining iatrogenic harm as failure, in the influx of capital that enabled the solidification of the quality and safety movement, and in the arrogation of failure as the rightful purview of the quality and safety movement. In this way, I show that

law is in fact instrumentally productive for reducing iatrogenic harm and that it has an appropriate role to play in the quality and safety discipline.

B *Chapters Three and Four: Care and Choice*

The doctrine of medical manslaughter is understood by writers in the field to be incomplete, inadequate and riven by contradiction, whilst the special features of healthcare and healthcare harm are thought to render the operation/prosecution of the offence unhelpful, even potentially harmful, to efforts aimed at ending iatrogenic harm.

In Chapter 3, I lay out how this opposition to criminal negligence has been constructed in the literature emanating from the healthcare quality and safety discipline. I argue that opposition to prosecution for criminal negligence finds its source in the primacy awarded to ‘choice’ by practitioners of the quality and safety discipline. I make this argument by examining the rhetorical practices employed by quality and safety texts on criminal liability. These texts consistently draw upon an ideal or ‘logic’ of choice to understand human action and to distinguish between good and bad. In contrast, the doctrine of criminal negligence vociferously opposes the use of ‘choice’ as the definitive marker of criminal culpability. In its place, the doctrine proposes that it is a gross failure of ‘care’ (and not a culpable choice) that is a reasonable basis for criminal culpability and blaming.

This work is an explicit attempt to examine fundamental and conceptual matters in this debate. No-one in the quality and safety discipline has yet articulated the logics of care and choice in relation to iatrogenic harm. More specifically, no-one has yet done so with an eye to how these logics find their expression in the question of whether, and how, we might find ourselves criminally responsible for harm to those we care for. Understanding this more fundamental terrain brings with it significant explanatory power in relation to the debate itself. So too does it aid our thinking about healthcare itself, about human action, and about responsibility in relation to iatrogenic harm. This is the new and unique contribution that this chapter makes.

Those who write on the doctrine of manslaughter by criminal negligence and its application to iatrogenic harm almost universally reject its suitability for use in this field. There are two main reasons for this view. The first is that the doctrine rejects choice as the fundamental marker of criminal culpability, instead, proposing that a gross failure to

‘care’, rather than a culpable choice, is a reasonable basis for criminal culpability and blaming. The second reason advanced for rejection of the doctrine is that both its existence and application are said to undermine the effective operation of quality and safety science methods for the prevention and rectification of iatrogenic harm. Simply put, this narrative suggests that criminal prosecutions undermine quality and safety science’s prevention and improvement response, and, conversely, the practices of quality and safety science improvement are said to undermine the appropriateness of a criminal legal response except in very unusual circumstances. So fundamental is this incompatibility thought to be, that much of the quality and safety writing on criminal responsibility argues that the mere spectre of criminal negligence prosecution perversely causes the very harm it seeks to punish.

In Chapter 4 I engage with this second reason for rejection of the doctrine, revisiting its claim of incompatibility. I argue that rather than being wholly incompatible, the criminal doctrine and quality and safety science interventions share a great deal in common. They both eschew the centrality of choice, and instead theorise human agency, action and healthcare-related harm in a manner deeply suspicious, if not in outright denial, of the relevance or availability of personal, subjective control or choice. Both regimes of criminal negligence and of the quality and safety science imagine a world where choice, or being in charge or in control, are not dominant experiences, where individual agency might not be fully possible, where the things we choose are not the only source of serious obligation and where action is not best understood by reference to particular states of mind. Moreover, I find that their mutual decentring of the liberal choosing subject and of dominant understandings of the act and significance of ‘choosing’ are all commensurate with the logic of care.

To do so requires that I first differentiate the discipline of quality and safety science’s substantive work on quality and safety improvement from the discipline’s stream of work on criminal responsibility. We have failed to make this differentiation thus far, paying too little attention to the dissonance and slippage as between the markedly different logic that motivates these two streams of quality and safety scholarship. Given that the most original and important contribution of the discipline is made in its substantive work on improvement, rather than upon criminal responsibility – which merely repeats well-known subjectivist orthodoxies – thinking about questions of compatibility between criminal

negligence and the discipline should take the discipline's substantive contribution on improvement as normative when assessing the differences and similarities between how the doctrine constructs the social world, human agency and action and how the quality in safety science work on improvement does so.

C *Chapter Five: Doctrine*

Critics of manslaughter by criminal negligence charge that it is a doctrine devoid of content, 'circular' in logic and construction, and defined in 'innumerable shadings of grey'. Upon that basis, those same critics argue that justice would best be served by abolition of the offence. I admit that these critics are correct in their assertion that the doctrine is devoid of content. Yet, I differ from their view that this is a fatal flaw. I argue that these 'weaknesses' of the doctrine are in fact its greatest strength. In support of this argument, I present a theory of criminal negligence and of negligent culpability that emerges from these very 'inadequacies' of the doctrine; terming criminal negligence 'normatively closed, but cognitively open'. Through doctrinal-theoretical work, I show that the doctrine of criminal negligence develops its very form and content through a process of drawing into itself the practices and standards indigenous to the area of human activity with which it engages; borrowing, reflecting and thus reinforcing what is particular to the field of practice, rather than imposing standards alien to it. At the same time, the doctrine maintains normative solidity and coherence by drawing upon its own 'internal normativity', all the while continuing to actively re-affirm the underlying values of the area of human activity with which it is engaged: in this case, medicine and healthcare practice. I conclude that this dialectical structure is an example par excellence of law's relational nature, and a reflection, too, of our own relational ontology. The existing doctrine thus provides open and practical potential for working through the proper exercise of our duties demanded by criminal law in relation to the care of strangers; duties that must be exercised in the context of the diffuse, complex sociotechnical system that is contemporary healthcare.

IV SCOPE, ASSUMPTIONS AND LIMITATIONS

This thesis provides an original interpretation and reconstruction of the conduct of criminal law, in the form of manslaughter by criminal negligence, in relation to iatrogenic harm in the contemporary Australian healthcare setting. Within this frame of inquiry, the criminal

law has been almost universally rejected. However, there are a small number who do argue that criminal negligence prosecution is, or would potentially be, appropriate at times. Notably, Commissioner Robert Francis in his report on the Mid-Staffordshire NHS Trust wrote that '[t]he argument that the existence of a criminal sanction inhibits candour and cooperation is not persuasive'.¹⁶⁹ For him, '[s]uch sanctions have not prevented improvements in other fields of activity'.¹⁷⁰ Anthony Harvey argues that criminal liability must be considered when other methods (civil litigation and self-regulation) of regulating iatrogenic harm and the practice of medicine fail.¹⁷¹ And Karen Yeung and Jeremy Horder argue that '[t]he criminal law has an important role to play in the healthcare context'.¹⁷² Outside of the specific frame of criminal law, we can add the recent emergence of strong voices of dissent to the orthodox views of tortious negligence in the United States who have begun to claim not only that civil claims might not be suppressing improvements in healthcare quality or safety, but in fact that actions in tort may in fact have a positive impact on healthcare quality and safety improvement.¹⁷³ This limited, but persistent, dissenting tradition points to the potential for a revision of the otherwise universal opposition to legal

¹⁶⁹ Robert Francis QC, *The Mid Staffordshire NHS Foundation Trust Public Inquiry. 2013* (2013) vol Executive Summary, 61 <www.midstaffspublicinquiry.com>.

¹⁷⁰ Ibid.

¹⁷¹ Anthony Harvey, 'Doctors in the Dock: Criminal Liability for Negligent Treatment Resulting in the Death of a Patient' (1994) 16(2) *Liverpool Law Review* 201, 205; see also Kara M McCarthy, 'Doing Time for Clinical Crime: The Prosecution of Incompetent Physicians as an Additional Mechanism to Assure Quality Health Care' (1997–1998) 28 *Seton Hall Law Review* 569.

¹⁷² Karen Yeung and Jeremy Horder, 'How Can the Criminal Law Support the Provision of Quality in Healthcare?' [2014] *BMJ Quality & Safety* 002688, 1.

¹⁷³ The work of Black and Frakes in particular offers a much needed and much more detailed engagement with law's instrumental effects on the micro-practices and quality and safety outcomes of medical care. The point here is rather more foundational, but nonetheless important, that the relationship has been productive in a range of ways (which deregulation and law reform in fact effaces and threatens), see for example Karl Y Bilimoria et al, 'Association Between State Medical Malpractice Environment and Surgical Quality and Cost in the United States': (2016) 263(6) *Annals of Surgery* 1126; Myungho Paik, Bernard Black and David A Hyman, 'The Receding Tide of Medical Malpractice Litigation: Part 1-National Trends' (2013) 10(4) *Journal of Empirical Legal Studies* 612; Myungho Paik, Bernard Black and David Hyman, 'The Receding Tide of Medical Malpractice Litigation: Part 2-Effect of Damage Caps' (2013) 10(4) *Journal of Empirical Legal Studies* 639; Daniel P Kessler, 'Evaluating the Medical Malpractice System and Options for Reform' (2011) 25(2) *The Journal of Economic Perspectives: A Journal of the American Economic Association* 93; Frakes, above n 131; Steven A Farmer, Bernard Black and Robert O Bonow, 'Tension Between Quality Measurement, Public Quality Reporting, and Pay for Performance' (2013) 309(4) *JAMA* 349; Myungho Paik, Bernard Black and David A Hyman, 'Do Doctors Practice Defensive Medicine, Revisited' <<https://www.scholars.northwestern.edu/en/publications/do-doctors-practice-defensive-medicine-revisited>>; Myungho Paik, Bernard S Black and David A Hyman, 'The Direct and Indirect Effects of Medical Malpractice Reforms: Evidence from the Third Reform Wave' [2012] (No 13-20) *Northwestern Law and Economics Research Paper* <<http://www.ssrn.com/abstract=2110656>>; Zenon Zabinski and Bernard S Black, 'The Deterrent Effect of Tort Law: Evidence from Medical Malpractice Reform' [2013] *SSRN Electronic Journal* <<http://www.ssrn.com/abstract=2161362>>; Frakes and Jena, above n 131.

and specifically criminal prosecutorial activity in this context. This thesis contributes towards the growth and advancement of that tradition of caution and dissent.

Whilst this thesis adds to that emerging dissenting tradition, it is also explicitly a contribution to the emerging body of critical quality and safety scholarship. Thus far in the broad context of patient safety research, scholarship and practice aimed at understanding iatrogenic harm and improving patient safety had fallen into ‘two largely parallel paths’.¹⁷⁴ On the one hand there has been the ‘orthodox paradigm’¹⁷⁵ dominated by a way of knowing (epistemology), of deciding (ethics) and of acting (praxis) characterised by liberal-positivism and scientific rationalism, orientated to problem-solving by forward-looking action and guarded by a means-ends rationality of utility. Such a way of being in the world risks construction of a technocratic version of a ‘politics without politics’,¹⁷⁶ of human knowledge and thought without their embedding in regimes of power. On the other hand there has been the less dominant sociologically-influenced work on all manner of foundational aspects of harm and healthcare quality and safety practices. The hope of scholars and proponents of this less-dominant paradigm of work has been to systematically engage with dominant discourses surrounding iatrogenic harm and practices associated with its reduction in a more ‘critical and nuanced’ manner.¹⁷⁷ The material in this thesis adds another element to that more critical path of quality and safety scholarship, namely, law. Thus far, law has been understood to serve no productive or helpful role in the engagement with iatrogenic harm. Yet, this thesis demonstrates that this assumption has been based on a limited or incorrect understanding of the conduct of law in this field and that the tradition of law has something to offer the question of iatrogenic harm and our responsibility for it.

There are a range of different bodies of literature and practice which engage with iatrogenic harm, the doctrine of manslaughter by criminal negligence and with other related fields such as theories of punishment, theories of criminal law, or of the whole

¹⁷⁴ Waring et al, above n 26, 199.

¹⁷⁵ Ibid 202 (‘The contemporary wave of interest in quality and safety has been predominantly framed by concepts and theories found within medical science, social psychology, ergonomics, human factors and resilience engineering. Rather than seeing errors as the result of individual mistake or failure, which tends towards blaming and encouraging secrecy, the prevailing view is that individual or group performance is conditioned by a variety of upstream factors located in the wider system of care, such as the quality of teamwork or communication, the allocation of tasks, workload scheduling, equipment and resource management, and broader service cultures.’).

¹⁷⁶ Jodi Dean, ‘Politics without Politics’ (2009) 15(3) *Parallax* 20.

¹⁷⁷ Waring et al, above n 26, 199.

variety of clinical practices. There is scope for serious and sustained work in and across these multiple traditions of scholarship and practice. However, this thesis concerns itself specifically with the contemporary conflict about manslaughter by criminal negligence and its application to instances of iatrogenic harm, particularly as it plays out in the Australian context. As such, it restricts its focus to the literature, practices and debates which emerge out of that specific conflict, namely, those who write from or adhere to the discipline of quality and safety science in their engagement with criminal negligence.

Whilst my contribution focuses on the specific debate about manslaughter by criminal negligence, it does not, however, purport to somehow solve or fully resolve the question of whether or not manslaughter by criminal negligence is appropriate, workable, or even a defensible practice in the field of patient safety or as a response to iatrogenic harm. To be clear, manslaughter by criminal negligence should only ever be applied to instances of iatrogenic harm that causes death that is the result of the most ‘gross’,¹⁷⁸ ‘culpable’,¹⁷⁹ ‘criminal’,¹⁸⁰ ‘complete’¹⁸¹ or ‘wicked’ breach of duty.¹⁸² Only a mere fraction of the current burden of iatrogenic deaths will ever or should be amendable to criminal prosecution. Resolving the broader question regarding prosecution is work for another time, and will likely turn on individual cases. For now, it is important to undertake preliminary work that might alter the conditions for that broader debate, for it has become clear to me that many of the foundational or received assumptions from which the debate about criminal liability for iatrogenic harm has been waged are either faulty, in need of further development, or are missing entirely. As such, before seeking out what that law might say to iatrogenic harm and our duties surrounding it, an engagement in the difficult preliminary work of ‘ground-clearing’ is required.

¹⁷⁸ Seeking to refine the test various epithets or adjectives such as “culpable”, “criminal”, “gross”, “wicked”, “clear” and “complete” have been employed when referring to the degree of negligence required, *Andrews v DPP* [1937] AC 576.

¹⁷⁹ *R v Gunter* (1921) 21 SR (NSW) 282, 286 (Cullen CJ); *R v Taktak* (1988) 14 NSWLR 226, 351, 353.

¹⁸⁰ *R v Shields* [1981] VR 717; see for example Judicial College of Victoria, *Victorian Criminal Charge Book* (Judicial College of Victoria, Electronic Edition, 2016) [7.2.5.1] <<http://www.judicialcollege.vic.edu.au>>.

¹⁸¹ *Andrews v DPP* [1937] AC 576.

¹⁸² McClellan CJ at CL and Howie AJ in their joint judgement provide a comprehensive account of what might constitute a ‘gross’ breach of duty, *Burns v The Queen* (2011) 205 A Crim R 240, 240 (McClellan CJ at CL at [1], Schmidt J at [167], Howie AJ at [1]).

THE USE OF MANSLAUGHTER BY CRIMINAL NEGLIGENCE IN AUSTRALIAN LEGAL HISTORY

CHAPTER ONE

I. INTRODUCTION

Most scholars argue that criminal negligence prosecutions for ‘medical manslaughter’ are inappropriate.¹ Various reasons are given for this position. Some argue that the doctrine punishes where culpability does not truly exist, others that prosecution is overused and promotes the very harm it purports to address, whilst yet another group maintains that the doctrine is unjustly vague and unclear in its construction. Not only have these debates been framed in dubiously instrumentalist terms; they have also, particularly in the Australian jurisdiction, occurred in a sort of vacuum: only four cases of prosecution have been reported in the scholarly literature from the past two centuries.² In the absence of an adequate history of medical manslaughter prosecutions in the Australian jurisdiction, and of iatrogenic harm incidents more generally, it is unclear how frequently such incidents have occurred over the past two centuries or how these incidents have been handled by the criminal law. We simply do not know how many prosecutions have taken place in Australian jurisdictions. Nor do we understand their facts, contexts or findings. Many fundamental questions remain unanswered: Under what circumstances have instances of iatrogenic harm been prosecuted, and what have been the outcomes? How have outcomes been shaped by the social practices, processes and forces surrounding individual cases? And perhaps most urgently, what insights do these cases yield regarding the criminal law’s capacity to successfully distinguish between culpable and non-culpable instances of harm? Only by addressing

¹ See the discussion in the Introduction to this thesis as to the key arguments mounted against prosecution of manslaughter by criminal negligence in this context. Some of the material presented in this chapter was previously published in David J Carter, ‘Correcting the Record: Australian Prosecutions for Manslaughter in the Medical Context’ (2015) 22(3) *Journal of Law and Medicine* 588.

² Ian Dobinson, ‘Doctors Who Kill or Harm Their Patients: The Australian Experience’ in Danielle Griffiths and Andrew Sanders (eds), *Bioethics, Medicine and the Criminal Law: Medicine, Crime and Society* (Cambridge University Press, 2013); Ian Dobinson, ‘Medical Manslaughter’ (2009) 28 *University of Queensland Law Journal* 101; Nikita Tuckett, ‘Balancing Public Health and Practitioner Accountability in Cases of Medical Manslaughter: Reconsidering the Tests for Criminal Negligence-Related Offences in Australia after R v Patel’ (2011) 19(2) *Journal of law and medicine* 377; Carter, above n 1.

these questions can we hope to tackle the scholarly and practical challenge of adjudicating on the correctness, viability and impact of criminal manslaughter prosecutions for iatrogenic harm.

The aim of this chapter is to establish a clear picture of the actual use and incidence of criminal prosecution in Australia. Doing so will both ‘set the scene’ for broader discussion of the appropriateness of criminal negligence prosecution, and provide the ‘raw material’ for doctrinal, policy and quality and safety debates about the criminal law’s use. As no robust account of the prosecutorial experience in Australia thus far exists, I begin in Section II by reviewing the prosecutorial experience in England and Wales that has formed such an influence on the debate, both in Australia and globally.³ There I argue that, contrary to claims of dramatic increase in prosecutions, the recent history of prosecution in those jurisdictions speaks to a relative stability in prosecutorial activity when interpreted alongside contextual factors, such as health service intensity, the size of the medical workforce and healthcare expenditure. Whilst not aiming to resolve the question of whether the prosecution of iatrogenic death in that jurisdiction is overused, this analysis does challenge the legitimacy of views that see prosecutorial overreach or overuse of prosecutions.

In Section III, I turn to the case law on iatrogenic harm in the Australian jurisdiction. First, I summarise the four known cases that form the current Australian literature on the question. I then present the main findings of this chapter: thirty-three additional cases, newly discovered through my archival research, and that constitute an important expansion of the case law.

Finally, in Section IV, I analyse this newly extended case law in order to reconstruct how the Australian criminal law has engaged with iatrogenic harm over time. The conclusion I draw is that the newly expanded account of prosecution I provide here conforms to a relatively stable set of themes or characteristics, many of which are congruent with the experience in other jurisdictions. So, too, does this new historical account challenge claims of prosecutorial overreach in the Australian setting, speaking instead to criminal law’s ability to distinguish between culpable and non-culpable

³ See my commentary below for supporting arguments for this and other claims made in this introductory material.

instances of harm. On balance, the criminal law has demonstrated it does generally differentiate between culpable and non-culpable instances of harm in the Australian setting. The second observation relates to a conspicuous absence or discontinuity between the Australian experience and that of other jurisdictions. This is that the kind of pressing and sustained criticism of individual cases, or of trends or experiences of criminal prosecution, that we see in other jurisdictions is absent from this Australian experience.⁴ The Australian experience simply does not demonstrate the kind of criticism seen in the United Kingdom or New Zealand, nor, I argue, has there been cause for it.⁵

Given this situation, where the experience of the use of manslaughter by criminal negligence in response to iatrogenic death has been both successful, and overwhelmingly received as such by relevant participants in the healthcare system, it seems an open question as to how we now find ourselves labouring under the misapprehension that criminal prosecution is unhelpful, unsuccessful and somehow inimical to advancing healthcare safety. The source of that view must be traced somewhere other than the actual experience of criminal prosecution of iatrogenic death in Australia. This is a matter I take up in Chapter 2.

This chapter makes a significant and original contribution by reconstructing the history of prosecutions of manslaughter by criminal negligence in the medical context in Australia. So, too, does it contribute a new reading of that material, re-defining criminal law's role in iatrogenic harm in the Australian context by demonstrating that criminal law does in fact successfully discern culpability in these cases and that the dominant view that criminal prosecution in some way represents a particularly controversial response to iatrogenic harm does not apply to the Australian experience.

⁴ Namely, the United Kingdom and New Zealand where significant conflict has emerged about the use of criminal prosecution as a response to iatrogenic death.

⁵ The single exception might be the prosecution of Jayant Patel, discussed below. However, criticism there is not of the same character as that experienced overseas; rather, that series of cases has been criticised – albeit lightly – for the Crown's *failure* to successfully prosecute cases related to Patel's time at Bundaberg Base Hospital.

II. THE STABILITY OF PROSECUTION RATES

Scholarship that engages with the prosecution of manslaughter by criminal negligence generally begins with an account of the historical incidence of prosecution or with a recent and noteworthy case. This is true of the most influential work in this field; Merry and McCall Smith's *Errors, Medicine and the Law*.⁶ Sidney Dekker⁷ and Oliver Quick⁸ also locate their analysis by reference to the historical record of prosecution,⁹ each referencing a rising trend or increased frequency of prosecution. This view of prosecutorial activity has become the standard and accepted understanding of the phenomena – that criminal prosecutions of iatrogenic harm have drastically increased over the past four decades.

In both the literature on criminal prosecution itself, and in wider consideration of medico-legal matters, this alleged increase is interpreted as a warning sign that prosecutorial overreach is pervasive, leading to the unfair and unjust punishment of individual healthcare practitioners in ways that are damaging to the project of quality and safety improvement. Alan Merry, for example, studying the situation in both New Zealand and the UK, claims there has been a 'trend towards using the criminal law as an instrument for regulating normal medical practice'.¹⁰ He longs for 'the way things used

⁶ Alan Merry and Warren Brookbanks, *Merry and McCall Smith's Errors, Medicine and the Law* (Cambridge University Press, Kindle Edition, 2017) 60 (where the authors note the increasingly 'tougher' stance taken in many jurisdictions), 325-326 (where UK and New Zealand prosecutions have 'at certain times occurred at a much higher rate than in comparable jurisdictions' and a 'disconcerting increase in the number of doctors charged with manslaughter in England and Wales since 1990' reported by Ferner and McDowell).

⁷ See for example Sidney Dekker, *Just Culture: Balancing Safety and Accountability* (Ashgate, 2nd Edition, Kindle Version, 2012) 87 (where Dekker reports-as the first sentence in his consideration of criminal prosecution of human error-that healthcare and other fields of safety-critical practice are seeing an increase in the 'criminalisation of human error').

⁸ See especially, Oliver Quick, 'Medical Manslaughter: The Rise (and Replacement) of a Contested Crime' in Charles A Erin and Suzanne Ost (eds), *The Criminal Justice System and Health Care* (Oxford University Press, 2007); most recently, see Oliver Quick, *Regulating Patient Safety* (Cambridge University Press, 2017) 110 (where Quick begins his analysis of medical manslaughter by writing 'Historically, criminal law has played a limited role in responding to patient safety incidents').

⁹ Ferner and McDowell's work is central to establishing the historical record in England and Wales, Robin E Ferner and Sarah E McDowell, 'Doctors Charged with Manslaughter in the Course of Medical Practice, 1795-2005: A Literature Review' (2006) 99(6) *Journal Of The Royal Society Of Medicine* 309; Sarah E McDowell and Robin E Ferner, 'Medical Manslaughter' (2013) 347(7926) *BMJ* f5609, 1 ('prosecutions were rare until the 1990s...[but that] number of doctors tried for gross negligence manslaughter, and the number of convictions, seems to have fallen recently') see my analysis below.

¹⁰ Alan Merry, 'When Are Errors a Crime?—Lessons from New Zealand' in Charles A Erin and Suzanne Ost (eds), *The Criminal Justice System and Health Care* (Oxford University Press, 2007)

to be’,¹¹ where a doctor who ‘practises to a reasonable standard has little to fear from the criminal law’.¹² Such an idyll seems to have disappeared in the 1970s, according to Merry, with the rise of various types of actions against doctors, from civil claims to disciplinary processes to criminal prosecution.¹³ In a later study with McCall Smith, Merry argues that the trend is a recent one: ‘the perceived need to fear the criminal law as a result of the accidents which can sometimes occur during normal clinical work is a recent development for doctors’.¹⁴ Merry and McCall Smith are not alone in these claims; their interpretation is supported or repeated by Sidney Dekker¹⁵ and a range of other writers,¹⁶ eventually surfacing in policy and law reform discussion, including formal State consideration of the implications of the alleged trend for the quality and safety of healthcare.¹⁷

Writers largely rely upon the influential work of Ferner and McDowell, Quick, and Skegg to make these claims about increased prosecutorial activity.¹⁸ Ferner and McDowell present a literature review of doctors charged with manslaughter between

68; see also Alan Merry and Alexander McCall Smith, *Errors, Medicine and the Law* (Cambridge University Press, 2001) 4, 7, 15.

¹¹ Merry, ‘When Are Errors a Crime?—Lessons from New Zealand’, above n 10, 69.

¹² Ibid.

¹³ Merry and McCall Smith, above n 10, 40; compare Michael Calnan et al, ‘Trust in the Context of Patient Safety Problems’ (2006) 20(5) *Journal of Health Organization and Management* 397.

¹⁴ Merry and McCall Smith, above n 10, 68.

¹⁵ See for example, Dekker, above n 7, 87, see also his broader claim in summary at 10.

¹⁶ See for example those who cite the work of Ferner and McDowell below.

¹⁷ The Mid Staffordshire NHS Foundation Trust Inquiry, ‘Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust January 2005 - March 2009’ (HC375–II, 24 February 2010)

<http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113018>; Robert Francis QC, *The Mid Staffordshire NHS Foundation Trust Public Inquiry. 2013* (2013) vol Executive Summary <www.midstaffpublicinquiry.com>; Commission for Healthcare Audit and Inspection (the ‘Healthcare Commission’), ‘Investigation into Mid Staffordshire NHS Foundation Trust’ (Investigation Report, March 2009) <www.healthcarecommission.org.uk>; Sidney WA Dekker and Thomas B Hugh, ‘A Just Culture after Mid Staffordshire’ (2014) 23(5) *BMJ Quality & Safety* 356; see in particular my discussion of the Camden and Campbelltown Hospitals Inquiry in Chapter Two, New South Wales Government, Health Care Complaints Commission, *Investigation Report Campbelltown and Camden Hospitals Macarthur Health Service* (Health Care Complaints Commission, 2003) <<http://pandora.nla.gov.au/tep/40205>>; New South Wales. Special Commission of Inquiry into Campbelltown and Camden Hospitals and Bret Walker, ‘Final Report of the Special Commission of Inquiry into Campbelltown and Camden Hospitals’ <<http://trove.nla.gov.au/version/45513599>>.

¹⁸ Ferner and McDowell, above n 9; Quick, ‘Medical Manslaughter: The Rise (and Replacement) of a Contested Crime’, above n 8; PDG Skegg, ‘Criminal Prosecutions of Negligent Health Professionals: The New Zealand Experience’ (1998) 6(2) *Medical Law Review* 220; see also the earlier RE Ferner, ‘Medication Errors That Have Led to Manslaughter Charges’ (2000) 321(7270) *BMJ* 1212; see also McDowell and Ferner’s later extension to their data analysis, McDowell and Ferner, above n 9.

1795 and 2005 in the UK,¹⁹ a study that has become the most significant influence on subsequent writing on the topic.²⁰ They conclude that ‘the number of doctors’²¹ prosecuted for manslaughter has ‘risen steeply’²² since 1990, whilst the proportion of such prosecutions that result in conviction remains low. Along similar lines, Skegg reviews the recent prosecutorial experience in New Zealand, presenting eight cases that had reached the High Court of New Zealand.²³ Noting the important distinction that, in New Zealand criminal law, criminal negligence could be found at the relevant time

¹⁹ Ferner and McDowell, above n 9.

²⁰ Their work is extensively cited from publication to the present day in at least sixty subsequent studies, including SM White, ‘Confidentiality, “No Blame Culture” and Whistleblowing, Non-Physician Practice and Accountability’ (2006) 20(4) *Best Practice and Research: Clinical Anaesthesiology* 525; RE Ferner, SE McDowell and AK Cotter, ‘Fatal Medication Errors and Adverse Drug Reactions - Coroners’ Inquests and Other Sources’ in *Pharmacovigilance* (John Wiley & Sons, Ltd, 2nd ed, 2007) 635; J Lilleyman, ‘The Trouble with Safety in the National Health Service: A Personal View’ (2008) 14(3) *Clinical Risk* 101; I Lapsley, ‘Accountingization, Trust and Medical Dilemmas’ (2007) 21(4–5) *Journal of Health, Organisation and Management* 368; VH Harpwood, *Medicine, Malpractice and Misapprehensions* (Routledge-Cavendish Taylor & Francis Group, 2007); Natasha Kay et al, ‘Should Doctors Who Make Clinical Errors Be Charged with Manslaughter? A Survey of Medical Professionals and Members of the Public’ (2008) 48(4) *Medicine, Science, and the Law* 317; Oliver Quick, ‘Medical Killing: Need for a Specific Offence?’ in *Criminal Liability for Non-Aggressive Death* (Ashgate Publishing Ltd, 2013) 155; Merry, ‘When Are Errors a Crime?—Lessons from New Zealand’, above n 10; AF Merry, ‘How Does the Law Recognise and Deal with Medical Errors?’ in *Health Care Errors and Patient Safety* (Wiley-Blackwell, 2009) 75; E Duncanson et al, ‘Medical Homicide and Extreme Negligence’ (2009) 30(1) *American Journal of Forensic Medicine and Pathology* 18; Margaret Brazier and Neil Allen, ‘Criminalizing Medical Malpractice’ in Charles A Erin and Suzanne Ost (eds), *The Criminal Justice System and Health Care* (Oxford University Press, 2007); RE Ferner, ‘The Epidemiology of Medication Errors: The Methodological Difficulties’ (2009) 67(6) *British Journal of Clinical Pharmacology* 614; R Baker and B Hurwitz, ‘Intentionally Harmful Violations and Patient Safety: The Example of Harold Shipman’ in *Health Care Errors and Patient Safety* (Wiley-Blackwell, 2009) 33; TM Cook et al, ‘Litigation Related to Anaesthesia: An Analysis of Claims against the NHS in England 1995–2007’ (2009) 64(7) *Anaesthesia* 706; A Sanders, ‘Victims’ Voices, Victims’ Interests and Criminal Justice in the Healthcare Setting’ in *Bioethics, Medicine and the Criminal Law Volume II: Medicine, Crime and Society* (Cambridge University Press, 2010) 81 <DOI: 10.1017/CBO9781139109376.008>; B Hurwitz, ‘Healthcare Serial Killings: Was the Case of Dr Harold Shipman Unthinkable?’ in *Bioethics, Medicine and the Criminal Law Volume II: Medicine, Crime and Society* (Cambridge University Press, 2010) 13 <DOI: 10.1017/CBO9781139109376.004>; Danielle Griffiths and Andrew Sanders, ‘The Road to the Dock: Prosecution Decision-Making in Medical Manslaughter Cases’ in Danielle Griffiths and Andrew Sanders (eds), *Bioethics, Medicine and the Criminal Law: Medicine, Crime and Society* (Cambridge University Press, 2013) vol 2, 117; H Quirk, ‘Sentencing White Coat Crime: The Need for Guidance in Medical Manslaughter Cases’ (2013) 2013 *Criminal Law Review* 871; Oliver Quick, ‘Expert Evidence and Medical Manslaughter: Vagueness in Action’ (2011) 38(4) *Journal of Law and Society* 496; J Miola, ‘The Impact of the Loss of Deference towards the Medical Profession’ in *Bioethics, Medicine and the Criminal Law Volume I: The Criminal Law and Bioethical Conflict: Walking the Tightrope* (Cambridge University Press, 2010) 220; Quick, ‘Medical Killing: Need for a Specific Offence?’; Liam J Donaldson, ‘Shadow of the Law in Cases of Avoidable Harm’ (2016) 355 *BMJ* <<http://dx.doi.org/10.1136%2Fbmj.i6268>>; D Hubbeling, ‘Medical Error and Moral Luck’ (2016) 28(3) *HEC Forum* 229.

²¹ Ferner and McDowell, above n 9, 309.

²² Ibid.

²³ Skegg, above n 18, 226.

upon ‘ordinary’ negligence, i.e. mirroring the civil standard, Skegg concludes that New Zealand had a ‘remarkably large’²⁴ number of prosecutions when compared with other Commonwealth jurisdictions. Yet, he also concludes that at the same time the number is ‘remarkably small’,²⁵ given the number of occasions on which New Zealand health professionals may have caused death or injury by negligence, with studies indicating that approximately 1500 patients may be killed each year by medical negligence in New Zealand hospitals alone.²⁶

Oliver Quick adds to this collection of empirical work with his more wide-ranging analysis of UK media reporting of the investigation and trial of negligent healthcare practitioners, rather than medical practitioners alone.²⁷ Quick draws upon the data provided by Ferner and McDowell but also relies on his own archival research of newspaper and other media outlets to claim that, in the UK over the past thirty years, ‘the incidence of “medical manslaughter” prosecutions has increased notably... and dramatically during the last decade’.²⁸ To be clear, Quick does not make quite the same claims as Ferner and McDowell; he contextualises his analysis by noting that the contemporary environment is marked by important factors that may be influencing prosecutorial activity. These include a

heightened awareness of risk in society, and the new realisation within health care about the scale of medical harm and the variety of factors affecting this, such as individual clinical performance, the effectiveness of teamwork, mechanisms for monitoring quality, and the prevailing cultures of safety.²⁹

In their foundational paper, which has germinated so much of the work on criminal liability for iatrogenic harm, Ferner and McDowell note a similar limitation to their work in that the data on prosecutorial activity are not normalised. They write that

[t]he results are presented without consideration to the actual number of practising doctors or the number of interactions between doctor and patient... They therefore do not

²⁴ Ibid 234.

²⁵ Ibid.

²⁶ Ibid 235.

²⁷ Oliver Quick, ‘Prosecuting “Gross” Medical Negligence: Manslaughter, Discretion, and the Crown Prosecution Service’ (2006) 33(3) *Journal of Law and Society* 421, 424.

²⁸ Quick, ‘Medical Manslaughter: The Rise (and Replacement) of a Contested Crime’, above n 8.

²⁹ Ibid 32.

provide insight into the actual proportion of doctors charged with manslaughter or the proportion of patients whose death led to charges of manslaughter.³⁰

Yet their conclusions lack something of this same care. There, they argue that there is a ‘dramatic increase’ in the number of doctors charged with manslaughter, that ‘more and more doctors are being prosecuted for gross negligence’,³¹ coupling that claim with another: that ‘the Crown Prosecution Service charges too many doctors’.³² Without taking into consideration the actual (rising) number of practising doctors or the actual (rising) number of interactions between doctor and patient that surround the phenomenon of prosecution – contextual data that their study explicitly acknowledges as being excluded – their data and its analysis can only support a more limited claim.³³ The raw number of prosecutions of medical practitioner might be greater from one point in time to another; however, any conclusion that this represents a dramatic increase or that more and more doctors are being prosecuted risks being seriously misinterpreted. The conclusions drawn from this data should be expressed with far more circumspection. There is further work to be done before making these claims regarding manslaughter prosecutorial activity.

Unfortunately, various authors use Ferner and McDowell’s work to advance claims that should be softened and more restrained in their conclusions. One study reports an ‘increasing prevalence of convictions for manslaughter amongst doctors (particularly anaesthetists)’,³⁴ where ‘[a]naesthetists are at increased risk of successful prosecution for manslaughter... compared with other clinicians’,³⁵ where ‘[i]n the UK... the likelihood that a fatal hospital error will result in prosecution for manslaughter may have increased in recent years [referencing Ferner and McDowell’s findings] even though the relevant law has remained unchanged over this period... probably

³⁰ Ferner and McDowell, above n 9, 314.

³¹ Robin E Ferner and Sarah E McDowell, ‘Doctors and Manslaughter—response from the Crown Prosecution Service Authors’ Reply’ (2006) 99(11) *Journal Of The Royal Society Of Medicine* 544.

³² Ferner and McDowell, above n 9, 314; see also the response from the Crown Prosecutorial Service and Ferner and McDowell’s authors’ response for a debate on these claims, Stephen O’Doherty, ‘Doctors and Manslaughter—Response from the Crown Prosecution Service’ (2006) 99(11) *Journal Of The Royal Society Of Medicine* 544; Ferner and McDowell, above n 31.

³³ A factor I believe Ferner and McDowell are themselves aware of, as their disclaimer early in their paper makes clear.

³⁴ Cook et al, above n 20.

³⁵ Stuart M White, Nicky Deacy and Sandeep Sudan, ‘Trainee Anaesthetists’ Attitudes to Error, Safety and the Law’ (2009) 26(6) *European Journal of Anaesthesiology (EJA)* 463, 463.

reflect[ing] a change in prosecution policy'.³⁶ On these readings of Ferner and McDowell's work, a change in prosecutorial policy or behaviour is targeted as the likely cause of the (purported) increase in likelihood of prosecution for medical practitioners. The reporting of their work in the influential medical press is similarly problematic, with a burst of attention from medical and general media when they were first published reporting that manslaughter charges were on the 'increase', that charges were on the 'rise' and that 'more doctors end up in the dock'.³⁷

Within the literature that draws on Ferner and McDowell's work, the consequences of the alleged increase in prosecution may be summarised into three claims. The first is that an increasing frequency of prosecution justifies a review of prosecutorial practice.³⁸ Is it that medical practice is itself more frequently failing to properly exercise the duty of care? Or is there a failure or misapplication of the doctrine itself, a growing pressure and willingness to prosecute, or some combination of all three? Second, the effect of increased prosecution is said to contribute to a shutting down of openness and disclosure of error in important internal medical fora.³⁹ Fearful of triggering criminal investigation or prosecution, health practitioners are said to exhibit (a growing) resistance to engagement in improvement practices that rely on discussion or openness about error. Third, and finally, in response to the consequence of increased prosecutorial activity, the practice of medicine itself risks deterioration.⁴⁰ That is, in response to legal

³⁶ AF Merry, 'How Does the Law Recognize and Deal with Medical Errors?' (2009) 102(7) *Journal of the Royal Society of Medicine* 265, 265.

³⁷ See for example 'GP Manslaughter Charges Increase since 1990s' *The Guardian*, 1 June 2006 <<https://www.theguardian.com/society/2006/jun/01/health.medicineandhealth1>>; 'Doctor Manslaughter Charges Rise' *BBC*, 1 June 2006 <<http://news.bbc.co.uk/2/hi/health/5033198.stm>>; Lyndsay Moss, 'The Scotsman: More Doctors End up in the Dock as Bereaved Families Seek Retribution' *The Scotsman*, 1 June 2006 16.

³⁸ See Quick's very interesting work on prosecutorial attitudes and behaviours, Quick, 'Prosecuting "Gross" Medical Negligence', above n 27; Ferner and McDowell, above n 31; McDowell and Ferner, above n 9, 1 (where the Crown's record-keeping arises); O Quick, 'Medicine, Mistakes and Manslaughter: A Criminal Combination?' (2010) 69(1) *Cambridge Law Journal* 186, 190–191 (where Quick argues that 'the prosecution recipe is still kept secret').

³⁹ Flowing, in a sense, from the early and central claims made by the discipline of quality and safety regarding the necessity of openness regarding error and near misses, see especially Lucian L Leape and Donald M Berwick, 'Safe Health Care: Are We up to It?' (2000) 320(7237) *BMJ: British Medical Journal* 725, 726; although Merry and McCall Smith's work, followed by its second edition by Merry and Brookbanks, is perhaps the clearest statement of this problematic, Merry and Brookbanks, above n 6, see for example their argument found in Chapter Eight of their work, (not only that an 'excessive focus on fault may be unjust and counter-productive to the improvement of safety', but that elimination of blame and blame culture is ultimately better for patients/victims of iatrogenic harm and injury).

⁴⁰ See for example, Dekker, above n 7, 43, 67, 81, 112 (specifically regarding tort); see also David Studdert's empirical legal work in relation to tort, Studdert DM et al, 'Defensive Medicine among

and regulatory responses of this nature, health practitioners engage more frequently in defensive practices that are not evidence-based, not directed primarily at the patient's wellbeing, and not sustainable for the health system as a whole.

These consequences would be very troubling, if true. Were the criminal law increasingly being used to govern normal medical practice, it could represent potential prosecutorial overreach and justify some of the hand-wringing so pronounced in the literature surrounding medical manslaughter prosecutions.⁴¹ I am, however, sceptical as to the interpretation of their data offered by Ferner and McDowell and even more sceptical as to the veracity of subsequent interpretation and argument made by others relying on that same empirical work.

I am not alone in my concern regarding potential overreach in interpretation and analysis. Brazier and Ost strongly question the adequacy of the orthodox narrative of prosecutorial activity and its implications. In recent writing, they interpret Ferner and McDowell as arguing that 'rates of prosecution had risen and would rise dramatically, and that the [Crown Prosecutorial Service] had an appetite for exacting retribution against unlucky doctors'.⁴² However, Brazier and Ost query whether the contention that 'doctors... [were] facing an increased risk of ending up in the dock'⁴³ is spurious. In support of their claim, they cite the work of Griffiths and Sanders,⁴⁴ who reviewed UK Crown Prosecutorial Service files from 2004–09, showing that there is indeed evidence of a 'significance increase'⁴⁵ in the number of fatal medical errors investigated by the police and referred to prosecutors, but that prosecutorial standards requiring that there be a high level of evidence meant that doctors may, in fact, have been treated 'more kindly' than others.⁴⁶ Griffiths and Sanders themselves extend this argument, writing that 'the concerns that our research have uncovered are equally worrying [to the concern of

High-Risk Specialist Physicians in a Volatile Malpractice Environment' (2005) 293(21) *JAMA* 2609.

⁴¹ Although, on a more general point, see my comments in Chapter Two in relation to the productive (for medicine) relationship between criminal and tort law and the quality and safety sciences.

⁴² Margaret Brazier and Suzanne Ost, *Bioethics, Medicine and the Criminal Law: Medicine and Bioethics in the Theatre of the Criminal Process* (Cambridge University Press, 2013) 73.

⁴³ *Ibid* 74.

⁴⁴ Griffiths and Sanders, above n 20.

⁴⁵ *Ibid* 262.

⁴⁶ Brazier and Ost, above n 42, 74.

unfairly targeting doctors, namely that]: numerous cases of gross neglect or recklessness are not prosecuted...'.⁴⁷

Whilst this work of Brazier and Ost and Griffith and Sanders is support for healthy scepticism as to the true picture of prosecutorial activity in the United Kingdom, it does not propose a revised interpretation of the prosecutorial data presented by Ferner and McDowell. My analysis presented below, whilst quite straightforward, addresses this omission, showing that, contrary to the position in much of the literature, prosecutorial activity in relation to medical manslaughter in the United Kingdom is unremarkable.

A *Contextualising UK Prosecutorial Activity*

The analysis presented here of both Ferner and McDowell's and Oliver Quick's data shows that, notwithstanding the increased incidence of prosecutorial activity (investigations and/or prosecutions) during the 1990s in the United Kingdom, this activity has in fact proceeded at a stable rate. I demonstrate this point by reinterpreting the findings of Ferner and McDowell and of Quick considering appropriate contextual data.

There are limitations to this approach. Some are due to the method of analysis I have chosen, whilst others flow from the data itself. The core issue is that the data points are quite few, and the method I have used (largely regression analysis) would provide more robust results were there more data points and it could be supported by other, more sophisticated, statistical methods.⁴⁸ However, my aim at this point is simply to test the claim of a dramatic rise in criminal prosecution made by the literature in broad terms. Specifically, it is to test whether the incidence of prosecutions or prosecutorial activity might be better understood once contextualised. For that limited purpose, the approach used here is suitable, especially given the limited data available, the limitations of that

⁴⁷ Danielle Griffiths and Andrew Sanders, *Bioethics, Medicine and the Criminal Law: Medicine, Crime and Society* (Cambridge University Press, 2013) vol 2, 156.

⁴⁸ The key issues with utilising regression analysis here is that the sample size of prosecutions is not large enough to provide a very precise estimate of the strength of the relationship between prosecution(s) and other factors (e.g. health system activity). This means that measures that normally speak to the strength of the relationship (such as R-Squared and R-Squared Adjusted as reported below) should not be relied upon to provide a precise estimate of the relationship. What is clear is that there remains quite a good 'fit' between the various contextual data and prosecutions – in other words, we can conclude that there is parallel movement between these prosecution(s) and other contextual factors.

data,⁴⁹ and the simple fact that we are, in raw terms, dealing with very small numbers of prosecutions.

To begin, the first set of figures chart the number of prosecutions reported by Ferner and McDowell (Figure 1) and Quick (Figure 2).⁵⁰ Prosecutorial activity increases throughout the reference periods. Figure 1 shows prosecutions from Ferner and McDowell (blue series),⁵¹ Figure 2, Quick's conviction data (blue series) and, finally, Figure 3 shows Quick's total number of incidents investigated (blue series), each rising by varying degrees over time.

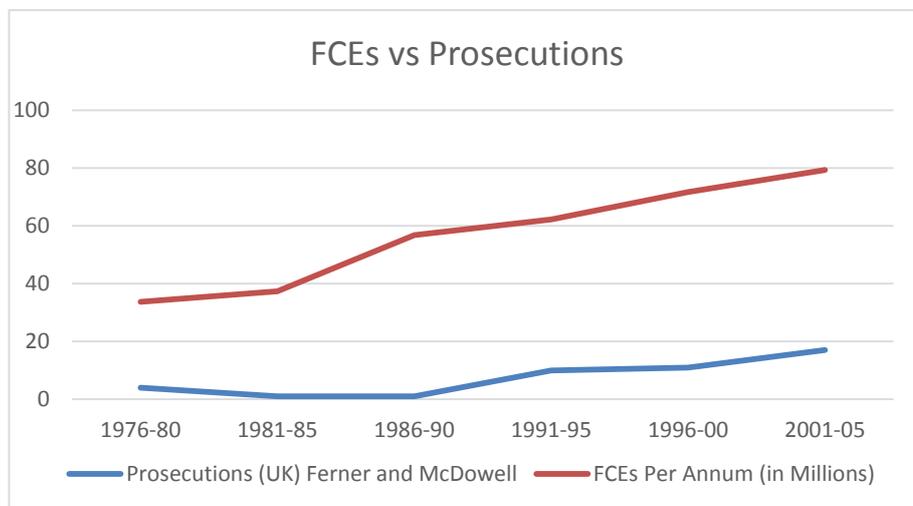


Figure 1: Number of prosecution (UK) vs Finished Consultant Episodes (FCE) per annum 1976–2005 (Ferner and McDowell, 2006)

⁴⁹ Namely, that the data is reported in five year increments rather than with the year of prosecution.
⁵⁰ I acknowledge and thank Matej Marek for his generosity in discussions and guidance surrounding the statistical design of the first three figures presented here.
⁵¹ Ferner and McDowell, above n 9.

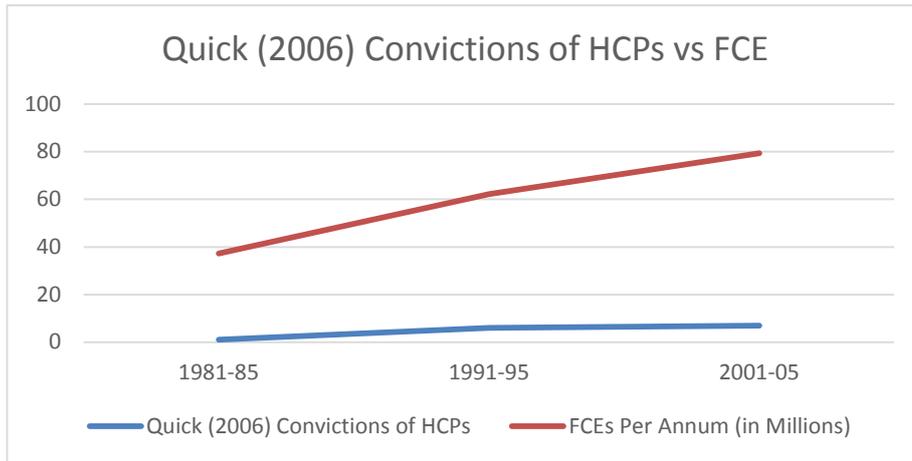


Figure 2: Number of convictions (UK) vs Finished Consultant Episodes (FCE) per annum 1976–2005 (Quick, 2006)

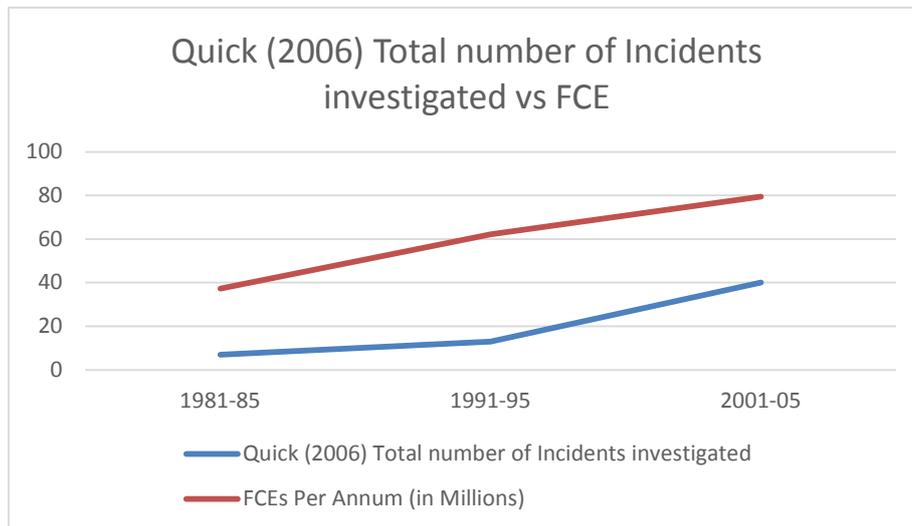


Figure 3: Number of incidents investigated (UK) vs Finished Consultant Episodes (FCE) per annum 1976–2005 (Quick, 2006)

Whilst the increase in the total number of prosecutorial activities is clear, this needs to be viewed with perspective to truly understand what the data means. To do so, I have presented time series data of National Health Service (NHS) hospital separations (known as Finished Consultant Episodes or FCEs in NHS terminology)⁵² in red in

⁵² Finished Consultant Episode: The point at which a patient is discharged from the care of a particular consultant (specialist hospital-based medical practitioner who is responsible for the care of a patient). A patient might have more than one FCE in a single admission to hospital. For example, they may be under the care of an orthopaedic surgeon for a hip replacement, however, during the care they develop a cardiac condition. They remain admitted for the treatment of both conditions, however, after one week, the orthopaedic physician ends their care, and hands over responsibility to a cardiologist. This would be a single (1) admission, with two (2) FCEs. The FCE

Figures 1–3. FCEs are one measure of health system activity in terms of both volume and intensity, representing the level of contact between in-patient and medical practitioner within the NHS. A ‘consultant episode’ is a period within which a patient is under the care of a specialist medical practitioner (consultant). Such an episode of care may be completed by discharge from the hospital or facility to home or other place of healthcare or aged care, or by transfer from one consultant to another within a single admission, or by death. FCEs are also increasing over time, as health system intensity and activity increases. This increase may be driven by any number of factors, from population growth, availability of enhanced or new hospital-based treatments, community and primary care failures to stem the development of chronic disease leading to greater demand for hospital treatment, enhanced access, greater burden of disease or changing broad cultural practices associated with presentation and admission to hospital.

Both FCEs and prosecutorial activity rise during the period. To understand whether there was a relationship between these two items, I performed a regression analysis.⁵³ Having done so, the relationship/dependency can be visualised in a scatter plot. The scatter plot displayed immediately below (Figure 4) visualises the dependency by plotting FCEs (in millions) along the x-axis and prosecutions along the y-axis:

is the Finished Consultant Episode of care (the time spent under the care of one consultant). An admission, or spell, is defined as a continuous period of time spent as a patient within a trust or hospital, and may include more than one FCE, see National Health Service, United Kingdom, Health and Social Care Information Centre, ‘NHS Data Model and Dictionary - NHS Business Definitions - Supporting Information: Consultant Episode (Hospital Provider)’ <[http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/c/consultant_episode_\(hospital_provider\)_de.asp?shownav=1](http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/c/consultant_episode_(hospital_provider)_de.asp?shownav=1)>.

⁵³ Minitab, Inc, ‘Minitab 17 Statistical Software’ <www.minitab.com>.

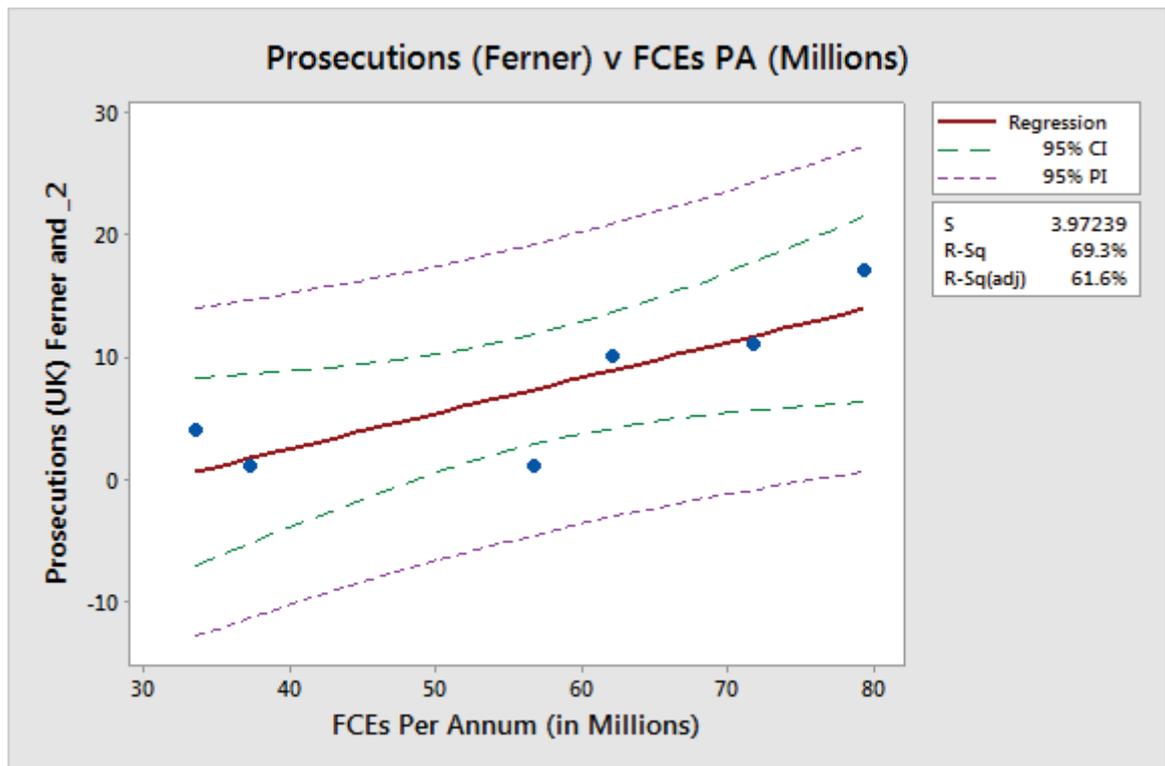


Figure 4: Regression analysis – prosecutions (UK) vs FCEs (Ferner and McDowell, 2006)

Figure 4 shows a linear dependency between FCEs and, in this case, prosecutions reported by Ferner and McDowell. The linear regression equation displayed in the top left corner of Figure 4 indicates that if variable x is increased by 1, variable y increases by 0.29.⁵⁴ Applied to the specific data here, if the number of FCEs are increased by 1 million, the number of prosecutions rises by 0.29 on average.

This idea can be developed further by applying different contextual data. Below, I bring together Ferner and McDowell’s prosecutorial data with total healthcare expenditure (£ billion) per annum (Figure 5) and with total medical and dental staff headcount in the NHS (Figure 6).⁵⁵

⁵⁴ See Appendix A.

⁵⁵ Number of Medical and Dental staff employed in NHS hospitals and community services Full Time Equivalent from 1990 onwards, Emma Hawe and Office of Health Economics (London England), *Compendium of Health Statistics 2009* (Radcliffe Publishing, 2008) 146 [Table 3.3].

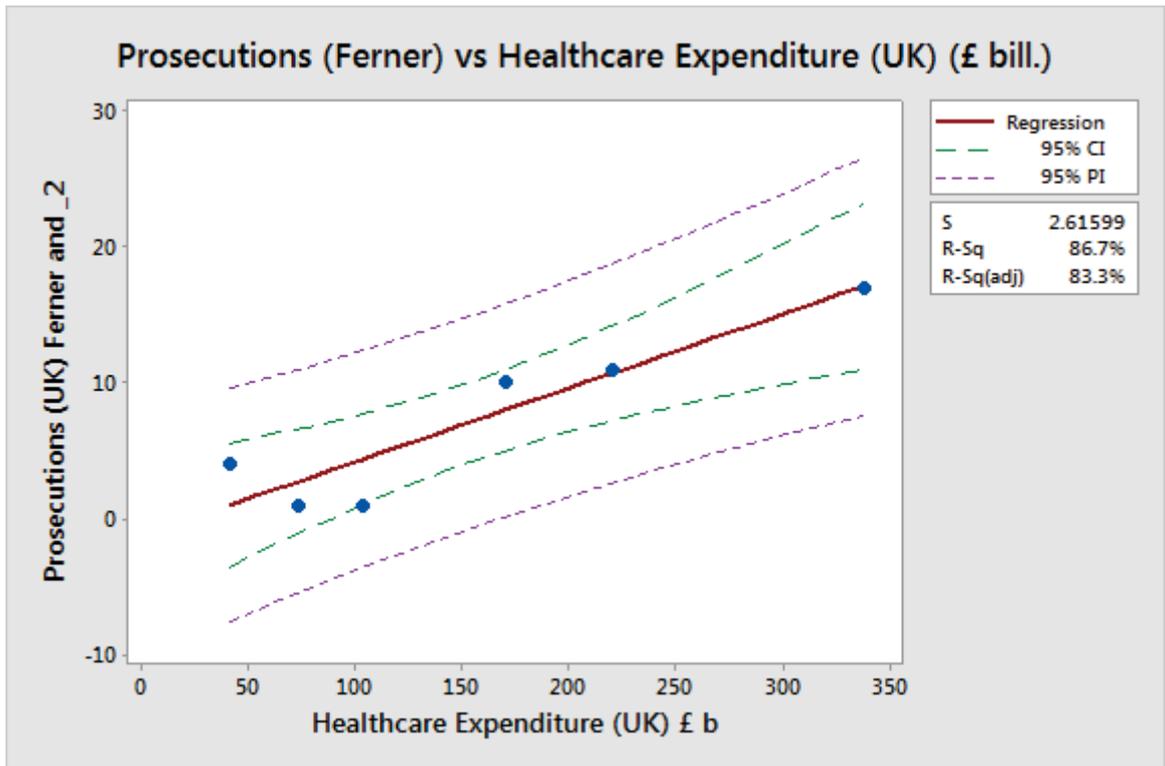


Figure 5: Regression analysis – prosecutions (UK) vs healthcare expenditure (£ billion)

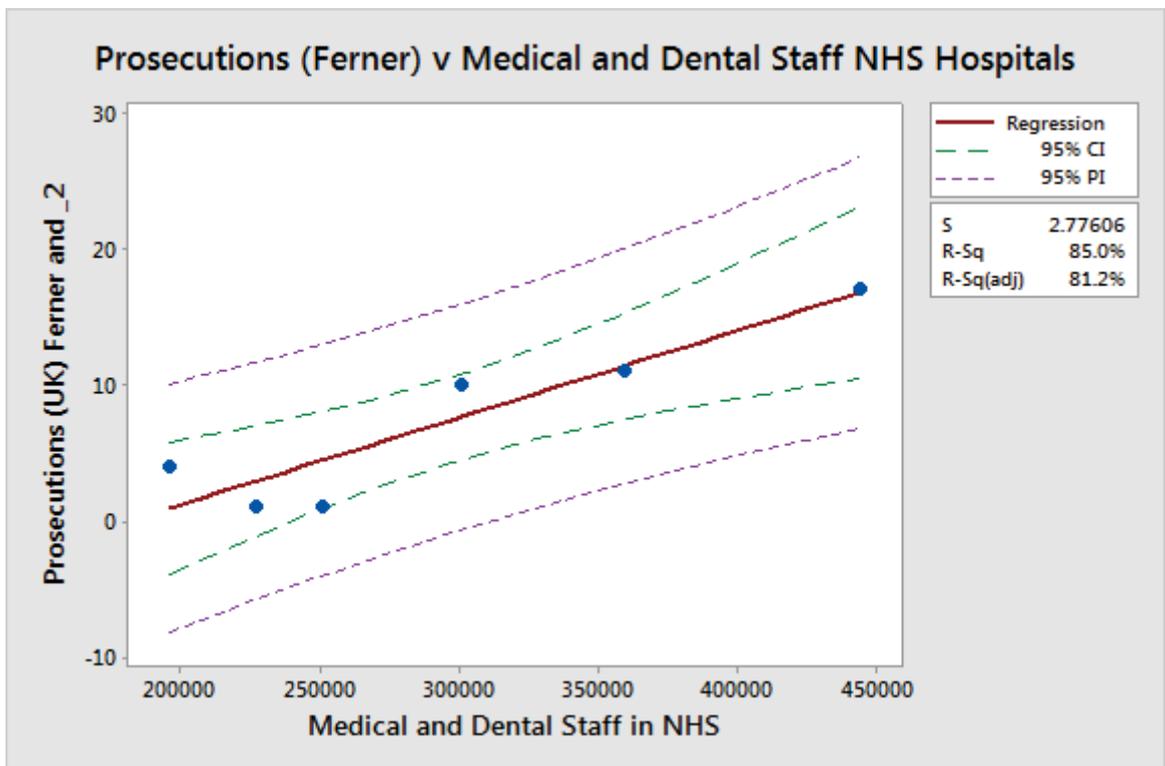


Figure 6: Regression analysis – prosecutions (UK) vs NHS medical and dental staff

Similarly, for Quick's prosecutorial data I provide an analysis, first of convictions of healthcare practitioners (Figure 7), and then total number of incident investigations reported in his media analysis (Figure 8), both brought together with total FCEs.

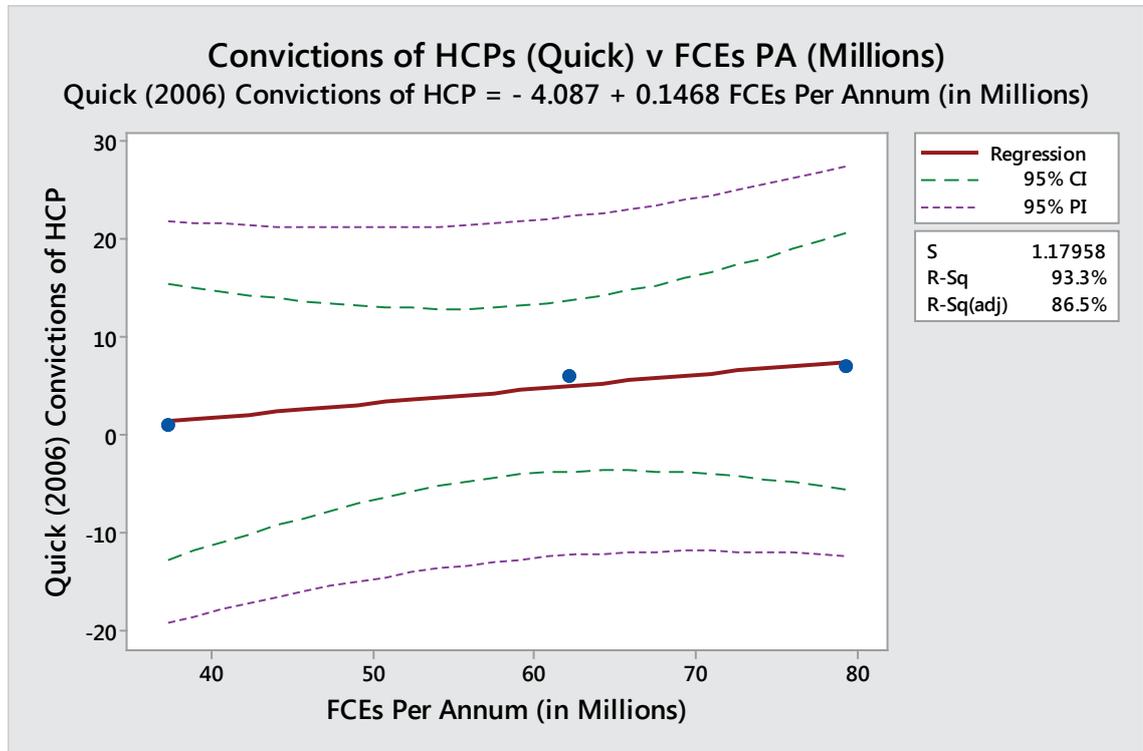


Figure 7: Regression analysis – convictions (UK) vs FCEs

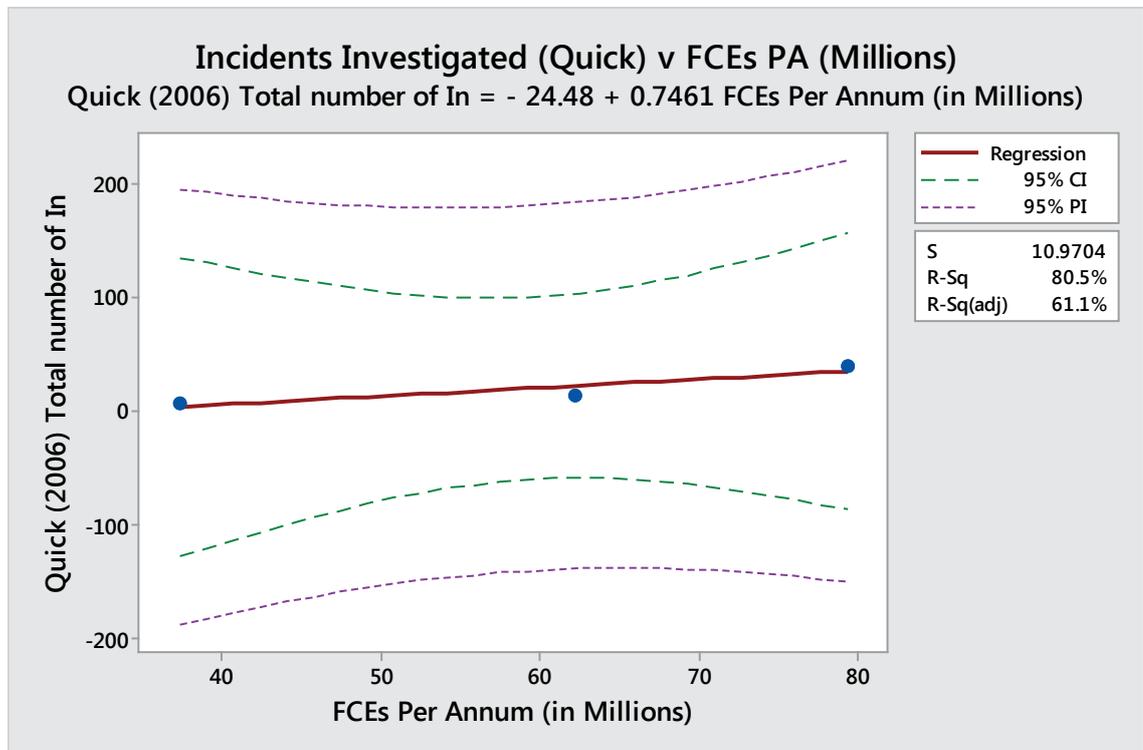


Figure 8: Incidents/Investigations (UK) vs FCEs

The same dependencies exist in relation to both Ferner and McDowell’s and Quick’s data on the incidence of prosecution and prosecutorial activity when compared with total healthcare expenditure and total FCEs respectively. The data indicates that prosecutions rise as other measures of healthcare activity rise. For example, as healthcare expenditure rises by £1 billion (Figure 10), here a measure of healthcare sector size or activity only, we see prosecutions rise by 0.05 on average.⁵⁶ So too for Quick’s data: FCEs rising by one million corresponds to an increase in convictions of healthcare practitioners of 0.14 (Figure 7), and an increase in investigations of healthcare practitioners reported in the media by 0.74 (Figure 8).⁵⁷

A final stage of analysis assists in clarifying the true meaning of prosecutorial activity data for the UK. Prosecutorial activity is highly variable over time. Normalising this variability can assist in interpreting the activity itself. Here I present prosecutorial activity as a relative variable, contextualising it with FCEs and healthcare expenditure. Figure 9 shows the first output of this process. In it, prosecutions are expressed per million FCEs delivered in NHS hospitals (blue series) as is the average of prosecutions per million FCEs over the period (red series).

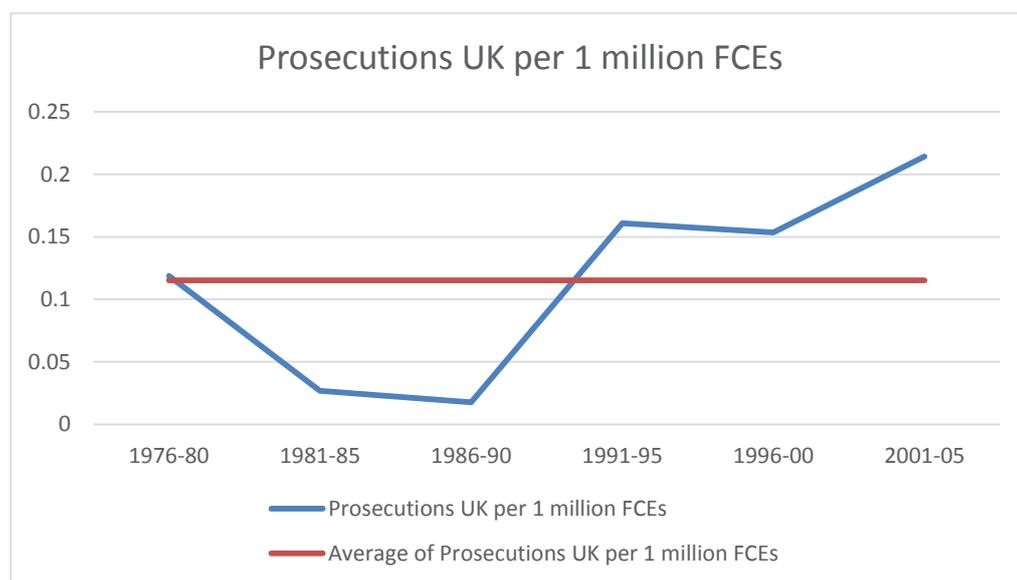


Figure 9: Prosecutions (UK) per 1 million FCEs

The relative variable oscillates around its long run average (0.12 prosecutions per million FCEs). The movement of this variable does not rise above its standard deviation. In other words, the standard deviation of prosecutions per million FCEs is

⁵⁶ $Y = -1.287 + 0.05443 X$. See Appendix A.

⁵⁷ See Appendix A.

0.08, which means that on average the variable (number of prosecutions per million FCEs) deviates by 0.08 from its mean of 0.11. In 2001–05, the highest number of prosecutions per million FCEs was experienced. At that point in time there were 0.21 prosecutions per million FCEs. Whilst at the outer limit of its standard deviation, it does not fall notably beyond it, almost matched by the earlier drops in prosecutions experienced during the 1980s.

The same approach applied to total health expenditure over the period ends in the same outcome, with no clear trend discernible (Figure 10).

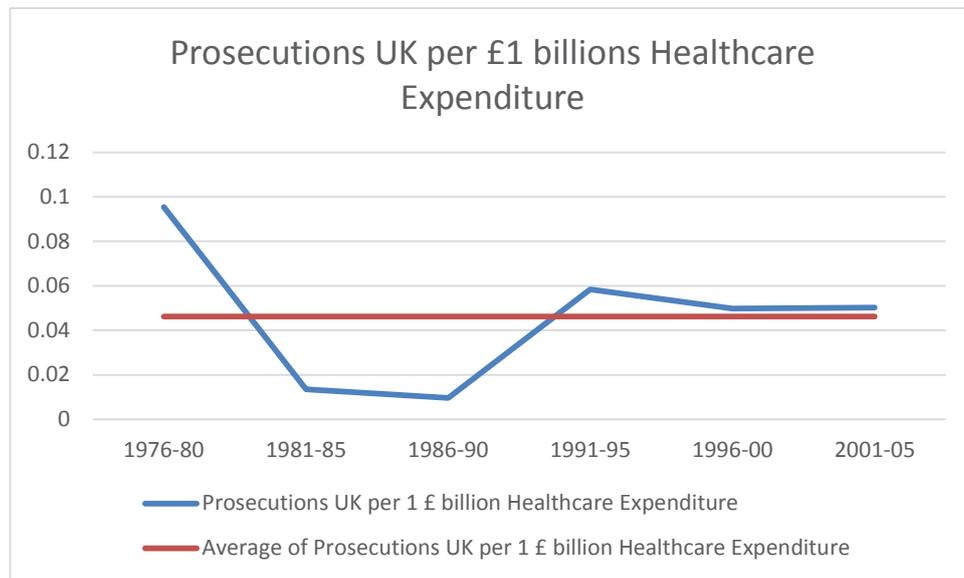


Figure 10: Prosecutions (UK) per £1 billion healthcare expenditure

For completeness, the same analysis is here applied to the data provided by Oliver Quick. Both convictions of healthcare practitioners (Figure 11) and investigations reported in the press (Figure 12) demonstrate no significant increase in relative variables, nor a discernible trend towards growing investigation or prosecution.

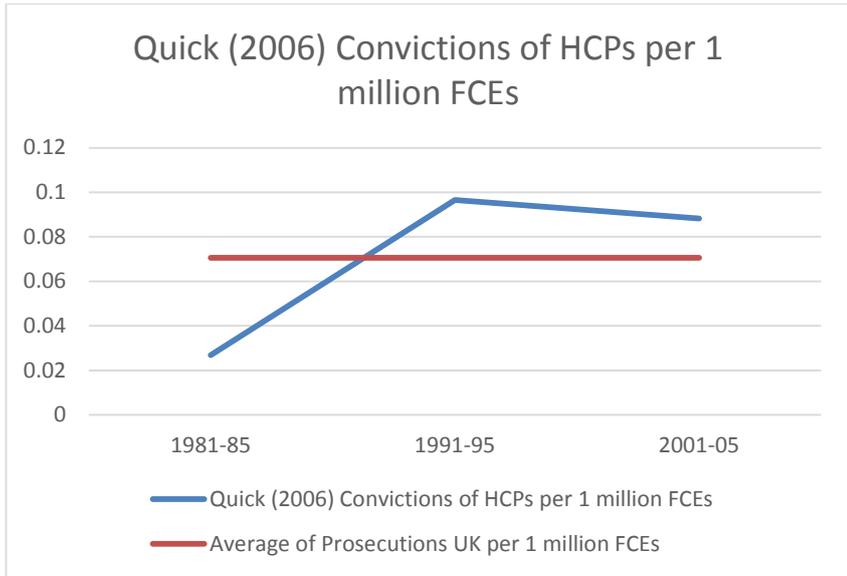


Figure 11: Convictions (UK) per £1 billion healthcare expenditure

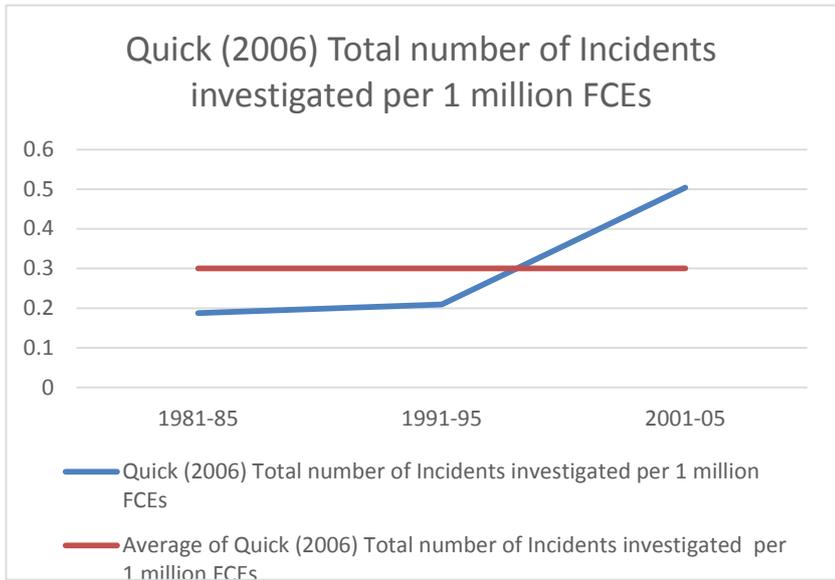


Figure 12: Investigations (UK) per £1 billion healthcare expenditure

In summary, when expressed by reference to important contextualising factors such as healthcare system activity/intensity, health practitioner headcount, or healthcare expenditure, the actual incidence of prosecution reported by Ferner and McDowell and Quick, or investigation activity reported by Quick alone, resembles and is correlated with these broader trends. On this basis, there is no evidence that prosecutions are in any way more likely, increasingly utilised or a growing trend on the reported data alone. This finding stands in sharp contrast to the consistent interpretation of Ferner and McDowell's data by the authors themselves, or subsequently by others as described

above. On this basis, the dominant view of prosecutorial activity related to medical practice in the UK should be revised, and made subject to further analysis.

Claims that criminal prosecutions for iatrogenic harm have been rising in the UK and New Zealand have been widely cited in the literature, including the medical and general press. So, too, have these results fed into the broader cultural phenomena surrounding liability, litigation, litigiousness and risk.⁵⁸ These reports were all based on the landmark empirical work of Ferner and McDowell, Quick or Skegg. However, the interpretation overlaid upon their data has been incautious. The analysis above makes clear that this data has been incorrectly interpreted. Prosecutions of medical or health practitioners have a clear relationship to measures of health services delivery. This re-contextualisation problematises the reporting of prosecutorial activity as it is presented in the scholarly literature.⁵⁹ Thus, given the available data on the UK, prosecutorial overreach or rising prosecutorial activity is not the danger some scholars claim it to be. It is, rather, correlated with broader health system trends.⁶⁰

Whilst this advances the issue in relation to the situation in the United Kingdom, what of the Australian situation? That prosecution in the UK has been stable over recent decades leaves the question of criminal law's engagement in Australia unresolved. Whilst the analysis above should serve as a corrective to future writing on the question of criminal prosecution for iatrogenic harm in those jurisdictions, the Australian situation is marked by a dearth of case law. Where the UK reports a reasonably large number of cases, the Australian literature reports only a handful over two hundred years. Until the situation in this jurisdiction is more accurately known, any assessment of doctrinal, policy and quality and safety practices related to manslaughter by criminal negligence in Australia will lack much of the required 'raw material'. To correct this situation, in the following section I follow the example of Quick and present an entire cohort of Australian cases unknown to the literature, thereby greatly expanding the available material on Australian prosecutorial experience of medical manslaughter.

⁵⁸ See Chapter Two where I provide a more detailed treatment of this process as it played out in the Australian media during the 1990's in particular.

⁵⁹ Despite this important finding, my brief analysis does not make claims as to the adequacy of the rates of prosecution themselves, but simply that change in those rates have unacknowledged connections to other areas of criminal justice and health care practice.

⁶⁰ Note, not caused.

III. AUSTRALIAN MEDICAL MANSLAUGHTER PROSECUTIONS: EXTENDING THE CASE LAW

The significant cohort of medical manslaughter cases recorded in other common-law jurisdictions, as surveyed in the previous section, presents a striking contrast to the Australian setting. During the period for which Quick⁶¹ and Ferner and McDowell⁶² reported a significant cohort of cases in the United Kingdom and New Zealand, the Australian literature does not report a single successful prosecution.⁶³ Indeed, the extant literature on criminal prosecutions for medical or healthcare-related manslaughter in Australia is quite small, encompassing just five cases, Valentine,⁶⁴ Reimers,⁶⁵ Pegios,⁶⁶ Ward,⁶⁷ and Patel,⁶⁸ all of which, apart from Valentine, were unsuccessfully prosecuted.⁶⁹

R v Valentine [1842] TASSupC 4 (7 January 1842) was the earliest case known to the literature.⁷⁰ In this nineteenth century Tasmanian case, Valentine had prescribed and dispensed a medicine mixed with laudanum rather than a less noxious substance as was intended. The Attorney General who prosecuted the case spoke directly of his wish to ‘impress upon the minds of the jury, in the strongest language, that he admitted to the fullest extent, that the awful mistake which Dr. Valentine committed was, as a moral fact, perfectly accidental’,⁷¹ yet, ‘it was necessary for the law to allege that it was done

⁶¹ Quick, ‘Prosecuting “Gross” Medical Negligence’, above n 27; Quick, ‘Medical Manslaughter: The Rise (and Replacement) of a Contested Crime’, above n 8.

⁶² Ferner and McDowell, above n 9; see also Ferner’s initial work, Ferner, above n 18.

⁶³ Dobinson wrote that charges against Dr Bruce Ward were laid in 2007, with these subsequently dropped whilst in New South Wales, Dr Gerrit Reimers was acquitted in 2001, see Dobinson, ‘Doctors Who Kill or Harm Their Patients: The Australian Experience’, above n 2, 256.

⁶⁴ *R v Valentine* [1842] TASSupC 4 (7 January 1842).

⁶⁵ See Dobinson, ‘Medical Manslaughter’, above n 2, 110.

⁶⁶ *R v Pegios* [2008] NSWDC 105 (2008) (*‘Pegios’*).

⁶⁷ Dr Bruce Ward was charged and then had his charges dropped before trial, see Dobinson, ‘Medical Manslaughter’, above n 2, 102; see also, *Inquest into the Death of Nardia Annette Cvitic* [2007] Brisbane Coroner’s Court COR/02 2727 (29 October 2007).

⁶⁸ *R v Patel* [2010] QSC 233; conviction confirmed in *R v Patel; ex parte A-G (Qld)* [2011] QCA 81 (21 April 2011) (*‘Patel 3’*); all convictions overturned in the High Court appeal on the basis of a serious miscarriage of justice, *Patel v The Queen* (2012) 247 CLR 531 (*‘Patel’*); Patel was to be re-tried on each previous count of homicide in separate trials, however, this strategy was later aborted, and Patel was found guilty of a series of criminal fraud charges, see *R v Patel* [2013] District Court of Queensland Indictment No 1701 of 2013 (21 November 2013).

⁶⁹ Dobinson, ‘Medical Manslaughter’, above n 2; Dobinson, ‘Doctors Who Kill or Harm Their Patients: The Australian Experience’, above n 2; Nikita Tuckett, ‘Balancing Public Health and Practitioner Accountability in Cases of Medical Manslaughter: Reconsidering the Tests for Criminal Negligence-Related Offences in Australia after *R v Patel*’ (2011) 19(2) *Journal of Law and Medicine* 377.

⁷⁰ *R v Valentine* [1842] TASSupC 4 (7 January 1842).

⁷¹ *Ibid* 1.

feloniously'. With this the jury agreed, eventually finding Valentine guilty. The judge in the trial '[t]aking into consideration [the jury's] recommendation to mercy as also the palliating circumstances of the case',⁷² passed sentence of 'a fine of twenty-five pounds to the crown'.⁷³

A stretch of almost 160 years separates the case of Valentine from that of Gerrit Reimers, the next case of medical manslaughter known to the literature. Reimers, an anaesthetist, was acquitted in 2001 of the manslaughter of Shirley Byrne. Mrs Byrne was undergoing an operation with Reimers administering the anaesthetic; she ceased breathing, and consequently suffered severe brain damage and later died. Reimers had failed to notice that his patient had stopped breathing. In related disciplinary hearings held by the NSW Medical Tribunal, he admitted that he may have been under the influence of drugs at the time of the incident. Reimers was suspended for ten years from medical practice for his drug use and failure to correctly monitor patients. He was denied re-registration as a medical practitioner in 2015.⁷⁴

Dr Bruce Ward was the next practitioner known to the literature to be charged with manslaughter.⁷⁵ Ward, a gynaecologist practicing in gynaecological oncology, had performed a radical hysterectomy and associated surgery on Nardia Cvitic at the Mater Hospital in Brisbane in 2002. Ms Cvitic died three days after surgery, having lost half her total blood volume from internal bleeding. Dr Ward had misdiagnosed pulmonary embolism and attempted to administer a double-dose of blood thinning medication, a decision overruled by worried colleagues who had been called on to intervene.⁷⁶ The misdiagnosis and administration of a usual dose hastened her death. At the inquest into Ms Cvitic's death, evidence was described in media reports that 'the bloodied operating theatre at one point resembled the aftermath of the Granville train disaster in NSW in the 1970s'.⁷⁷ During early hearings, Justice Fryberg had advised that a jury could not

⁷² Ibid 5.

⁷³ Ibid.

⁷⁴ *Reimers v Medical Council of NSW* [2015] NSWCATOD 38 (2015).

⁷⁵ See Dobinson, 'Doctors Who Kill or Harm Their Patients: The Australian Experience', above n 2.

⁷⁶ Sean Parnell, 'Surgeon Charged with Manslaughter' *The Australian* (Online Edition), 0 October 2007
<<http://www.news.com.au/national/surgeon-charged-with-manslaughter/news-story/7bdf021c6cfa3ff9f52487df6d75cbcf>>.

⁷⁷ Ibid.

convict Dr Ward, and that the conviction would be overturned on appeal.⁷⁸ Charges were then dropped by the Director of Public Prosecutions.

Shortly after this case, Dr George Pegios, a Sydney dentist, was charged with manslaughter of a patient under his care.⁷⁹ In a judge-only trial, Pegios was found not guilty.⁸⁰ Pegios had administered a large dose of sedative to a patient during dental surgery, and had failed to monitor and respond to the patient's oxygen saturation adequately in the context of so high a dose. The patient's oxygen depletion was so severe that the patient suffered brain damage and died. Like many of the cases known to the literature, Dr Pegios's case revealed a complex set of issues with his practice, and he was deregistered for five years.⁸¹

Finally, the series of cases concerning Dr Jayant Patel form part of the most sustained and controversial medical manslaughter events in Australian history.⁸² Patel faced prosecution in a series of cases following initial whistleblowing by Bundaberg Base Hospital staff, one aborted and one completed public inquiry, and extradition proceedings from the United States.⁸³ The completed inquiry, the Davies Commission, found amongst other things that as a result of negligence on the part of Patel, 13 patients he had operated on whilst Director of Surgery at Bundaberg Base Hospital in rural Queensland had died.⁸⁴ Both reports recommended that Patel be investigated for either murder or manslaughter and, as is the practice of the media in cases of this nature, Patel

⁷⁸ Tony Keim, 'Doctor Death Charges Dropped' *Courier Mail* (Brisbane, Qld.), 0 August 2009 <<http://www.couriermail.com.au/news/dr-bruce-ward-walks-free-after-manslaughter-charges-dropped/news-story/75aec26bc50c366d8ad1f584ea10fc05>>.

⁷⁹ *Pegios* [2008] NSWDC 105 (2008).

⁸⁰ *Ibid.*

⁸¹ *HCCC v Pegios (No 3)* [2010] NSWDT 2 (15 September 2010); see also *HCCC v Pegios (No 1)* [2009] NSWDT 1 (16 October 2009); *HCCC v Pegios (No 2)* [2010] NSWDT 1 (18 June 2010).

⁸² For an in-depth introduction and overview of the complex background to the cases, see the introduction in James Dunbar, Prasuna Reddy and Stephen May, *Deadly Healthcare* (Australian Academic Press, 2011); see also the important account by Thomas Hedley Thomas, *Sick to Death: A Manipulative Surgeon and a Health System in Crisis-- a Disaster Waiting to Happen* (Allen & Unwin, 2007); finally, the High Court provides an overview of the case at first instance and appeal, see especially the account by Heydon J, *Patel* (2012) 247 CLR 531.

⁸³ See my account of this process in Carter, above n 1.

⁸⁴ Commissioner Davies reported in his final report evidence that 'there were 13 deaths in which an unacceptable level of care on the part of Dr Patel contributed to the adverse outcome; and there were a further 4 deaths in which an unacceptable level of care by Dr Patel may have contributed to the outcome. He found, in addition, 31 surviving patients where Dr Patel's poor level of care contributed to or may have contributed to an adverse outcome', see Hon Geoffrey Davies, 'Queensland Public Hospitals Commission of Inquiry ("The Davies Commission")' (30 November 2005) ⁴ <<http://www.parliament.qld.gov.au/documents/tableOffice/TabledPapers/2005/5105T5305.pdf>>.

was labelled with the epithet ‘Dr Death’, a nickname that had been given to him by his own colleagues at Bundaberg.⁸⁵ Patel went on to face multiple manslaughter charges for his role at Bundaberg.⁸⁶ He was first found guilty, and then, upon retrial following a miscarriage of justice,⁸⁷ not guilty.⁸⁸ Set to be re-tried in separate trials, each for an individual patient under his care, Patel was found not guilty in the initial stages of this prosecutorial strategy. The subsequent decision by the Director of Public Prosecutions to cease pursuing Patel in late 2013 was described as a ‘major disappointment’⁸⁹ to patients and their families. He ended the almost decade-long legal process with a guilty plea in relation to four counts of fraud and promptly left the jurisdiction.⁹⁰ He returned to the United States, where he had been resident prior to his time at Bundaberg. He had earlier been severely disciplined – with his ability to perform surgery restricted – in the United States, a fact that was missed in his initial recruitment to the position at Bundaberg. This was famously reported by journalist Hedley Thomas who, after speaking with key whistleblower Toni Hoffman, a senior nurse at Bundaberg, had simply ‘googled’ Patel’s name and found a trail of disciplinary issues stretching back to 1984.⁹¹

Whilst these cases have been known to the literature, they have been largely used to situate analysis of the doctrinal structure of manslaughter by criminal negligence, with some treatment of the broader policy questions prosecution raises. Writing in this vein, Australian criminal law academic Ian Dobinson rightly highlights the paucity of available literature for convictions and for prosecutions more generally, noting that ‘it is

⁸⁵ Reported by Radio National’s Background Briefing, the Morris Inquiry heard from a key witness, Toni Hoffman, a nurse in the Bundaberg ICU, that ‘the hospital’s chief anaesthetist dubbed Dr Patel ‘Dr Death’. And that his incompetence was so well known among hospital staff they’d say, “If I have an accident on the weekend, fly me out to Brisbane, don’t let Dr Patel touch me.”’ Radio National, Australian Broadcasting Corporation, ‘Bundaberg’s Dr Death’, *Radio National*, 7 June 1000 <<http://www.abc.net.au/radionational/programs/backgroundbriefing/bundabergs-dr-death/3451382>>.

⁸⁶ *R v Patel* [2010] QSC 233; *Patel 3* [2011] QCA 81 (21 April 2011); *Patel* (2012) 247 CLR 531; *R v Patel* [2013] District Court of Queensland Indictment No 1701 of 2013 (21 November 2013); see for an overview of the prosecutions of Patel, Carter, above n 1.

⁸⁷ *Patel* (2012) 247 CLR 531.

⁸⁸ *R v Patel* [2013] District Court of Queensland Indictment No 1701 of 2013 (21 November 2013).

⁸⁹ Australian Broadcasting Corporation, ‘Dr Jayant Patel Case Leaves Legacy of Change in Health’, *AM*, 16 November 1100 (comments by Professor Andrew Wilson, former Deputy Director of Queensland Health) <<http://www.abc.net.au/am/content/2013/s3892392.htm>>.

⁹⁰ *R v Patel* [2013] District Court of Queensland Indictment No 1701 of 2013 (21 November 2013) [4] (‘...you are the author of all of the misfortune that has resulted from your totally undeserved employment in Queensland.’).

⁹¹ Thomas, above n 82; Dunbar, Reddy and May, above n 82, 1–3.

very difficult to be certain but there is a strong likelihood that only three doctors and [one] dentist have ever been charged since Dr Valentine [in 1843]’.⁹² His account of this area of prosecution proposes that the 1843 case of Dr Valentine⁹³ was likely the only successful prosecution for medical manslaughter, with Jayant Patel⁹⁴ (whose case was ongoing at the time of Dobinson’s writing) having had his original verdict overturned on appeal to the High Court of Australia and being found not guilty on subsequent retrial.

There is a clear need to more completely account for the incidence of prosecution of manslaughter by criminal negligence in the healthcare setting. In what follows, I provide a new account of the use of the charge of manslaughter by criminal negligence in the Australian healthcare context. I do so by returning to archival sources. I apply the method used by Quick, by drawing upon on media accounts of investigations and prosecutions. Specifically, I conducted a systematic search using both the National Library of Australia’s ‘Trove’ service, which indexes, catalogues and stores digitised images of Australian newspapers and magazines from the 18th century to the late 20th century.⁹⁵ More recent holdings of media reports held by Factiva were also searched. Following the method adopted by Quick, a keyword search on the material was made utilising key words: ‘manslaughter, coroner, medical, doctor, hospital, and error’. The results were narrowed to cases of prima facie medical manslaughter. Recently, the Australasian Legal Information Institute (AustLii) has begun to recover colonial cases from similar sources for the Australasian Colonial Legal History Library and the Trove service continues to expand the reach and depth of its digitised coverage.⁹⁶ These expansions mean that more cases may be uncovered in time. In using this method, the chief limitation I faced was in the use of media publications to establish the aetiology of the prima facie manslaughter.⁹⁷ Whilst many of the media reports are extensive, including long stretches of what is reported to be verbatim digests of evidence or court

⁹² Dobinson, ‘Medical Manslaughter’, above n 2, 102.

⁹³ *R v Valentine* [1842] TASSupC 4 (7 January 1842).

⁹⁴ *Patel* (2012) 247 CLR 531.

⁹⁵ National Library of Australia, *Trove* National Library of Australia <www.trove.nla.gov.au>.

⁹⁶ *AustLii* - *Australasian Legal History Libraries* <<http://www.austlii.edu.au/au/special/legalhistory/>>; as to the possibilities that this expanding digital archive provides for legal scholarship see David J Carter, James Brown and Adel Rahmani, ‘Reading the High Court at a Distance: Topic Modelling the Legal Subject Matter and Judicial Activity of the High Court of Australia, 1903-2015’ (2016) 39 *University of New South Wales Law Journal* 1300.

⁹⁷ Ferner and McDowell, above n 31, 544.

procedure, they remain a single source. To echo Dobinson, it remains very difficult to be certain about the total number of cases because coverage of those cases in news media is driven by factors that preclude their use as a completely robust record. Newspapers are not, in the end, Court documents or law reports, although in Australian legal history, they are form a singularly important source for understanding legal history.⁹⁸ Stephen O’Doherty of the UK Crown Prosecution Service has similarly cited media reporting as ‘notoriously unreliable’ in communicating evidence and the true nature of a case.⁹⁹ Nevertheless, the newly digitised newspaper archive affords access to cases that would likely never otherwise come to light.

Notwithstanding the complexities and limitations of the newspaper method, the results reported here extend the Australian literature significantly. From a base of four prosecutions of doctors and one dentist previously known in the literature, my research uncovered a further 33 relevant prosecutions.¹⁰⁰ They encompass earlier precedent, with the 1839 case of Dr Durie of Tasmania,¹⁰¹ as well as more contemporary prosecutions, including the case of Dr Arthur Garry Gow of New South Wales in 2004.¹⁰² Twenty-six of these cases resulted in a trial, with four guilty verdicts and nine acquittals; of the remainder, either charges were withdrawn or the result is unknown. Cases include early coronial inquests where the practice of finding both cause of death and prima facie finding of guilt for manslaughter were followed by committal for trial.¹⁰³

⁹⁸ Bruce Kercher, ‘Recovering and Reporting Australia’s Early Colonial Case Law: The Macquarie Project’ (2000) 18(3) *Law and History Review* 659, (who explains the use of newspapers as a source of early Australian legal history, noting that case reports are found mainly in newspapers, yet noting also accuracy issues).

⁹⁹ Ferner and McDowell, above n 31, 544.

¹⁰⁰ This excludes the vast majority of cases that were related to the provision of termination services by medical practitioners, nurses, midwives and unregistered or other non-professionals (see below for discussion of these cases).

¹⁰¹ Various factors conspire to render access to these cases difficult. All are unreported and most exist now only in the form of newspaper reports of the time. For this reason, where a citation can be given to helpfully locate case materials, it is given in the usual format. For the cases that are discoverable only through media reports, reference to reports and cases are notated by the year of prosecution in brackets following the surname of the defendant. See ‘Coroner’s Inquest.’ *Launceston Advertiser* (Launceston, Tas.), 18 July 1839 3; ‘Inquests.’ *The Cornwall Chronicle* (Launceston, Tas.), 20 July 1839 1; ‘Wednesday, Oct. 9.’ *Launceston Advertiser* (Launceston, Tas.), 10 October 1839 3; ‘Wednesday, October 9.’ *The Cornwall Chronicle* (Launceston, Tas.), 12 October 1839 3.

¹⁰² *Health Care Complaints Commission v Arthur Garry Gow* [2008] NSWMT No 40011; ‘Doctor given Suspended Sentence over Death of Patient’ *AAP News*, 27 October 2006.

¹⁰³ This is commensurate with the study by Quick that is the foundation of this article’s method for seeking out prima facie cases of manslaughter by criminal negligence. See Quick, ‘Prosecuting “Gross” Medical Negligence’, above n 27, 426.

My research extends the historical record in key ways. The case of Dr Durie (1839) is now the earliest case of prosecution known to have occurred in Australia.¹⁰⁴ Dr Degner (1861) replaces Dr Gerrit Reimer (acquitted 2001) as the earliest known charge and trial in New South Wales legal history. Similarly, in Queensland, where the 2002 case of Dr Bruce Ward was understood to be the first trial for manslaughter in that jurisdiction,¹⁰⁵ it is now clear Dr Margaret Joy Pearce (2000) was the first doctor to be tried. She is also the first to be found guilty of manslaughter in that jurisdiction.¹⁰⁶ In this extension of the case law, the most significant point is the addition of four previously unknown medical manslaughter convictions. Whereas the prior case law acknowledged only one conviction for medical manslaughter in Australia (*R v Valentine*), we now know of *Hornbook* [1864], *Zimmler* [1871], *R v Pearce*¹⁰⁷ and *R v Gary Gow*.¹⁰⁸ This is significant because they provide much needed ‘raw material’ for the analysis of the Australian experience of manslaughter prosecution in healthcare settings. With their addition, it becomes clearer how frequently such incidents have occurred over the past two centuries and how these incidents have been handled by the criminal law.

In presenting the expanded cohort of cases below, I focus on ensuring that the case histories are recorded. This is significant and important work in the Australian setting for two main reasons. Firstly, our accepted understanding of the history of prosecution in this jurisdiction is that prosecution is a rarity. Whilst Dobinson, in the most developed account of this history, records that we are unlikely to ever fully know the history of prosecution in this area, he also argues (as noted above) that there is ‘a strong likelihood that only three doctors and [one] dentist have ever been charged [with manslaughter] since Dr Valentine’.¹⁰⁹ Secondly, the specific facts and experiences of prosecutions have been, and continue to be, used to advance arguments surrounding the correctness or otherwise of utilising manslaughter by criminal negligence in response to iatrogenic death. For this reason, ensuring that not merely the number of prosecutions

¹⁰⁴ Replacing the prosecution of Dr Valentine as the earliest known case.

¹⁰⁵ Dobinson, ‘Doctors Who Kill or Harm Their Patients: The Australian Experience’, above n 2, 257.

¹⁰⁶ Although this fact was not unknown to the Supreme Court of Queensland who considered Dr Pearce’s case in relation to the sentence of Dr Patel: *R v Pearce* [2000] Queensland Supreme Court Indictment No 96 of 2000 (15 November 2000) (*‘Pearce’*); cited in *Patel 3* [2011] QCA 81 (21 April 2011) [204].

¹⁰⁷ *Pearce* [2000] Queensland Supreme Court Indictment No 96 of 2000 (15 November 2000); *Medical Board of Queensland v Pearce* [2001] QHPT 004 (20 July 2001).

¹⁰⁸ [2006] NSWDC 78 (27 October 2006) (*‘Gow’*).

¹⁰⁹ Dobinson, ‘Medical Manslaughter’, above n 2, 102.

but the specific histories of each case are recorded is necessary. I do not, however, stop at simply recounting the histories. I attempt to draw out something of what unites the history of medical manslaughter in Australia and some of the common taxonomical categories used in quality and safety science analysis of preventable adverse events more generally.¹¹⁰ Both doctrine and the operation of investigative and judicial processes have evolved significantly over time. There were, and are, significant differences in doctrine and offence structure between jurisdictions. Moreover, healthcare regulation and the conduct of healthcare itself have changed dramatically over time. For this reason, some cases presented here might be understood in some jurisdictions to represent negligence-related manslaughter offences rather than what could be properly described as manslaughter by criminal negligence.¹¹¹ Care also been taken not to overstate similarity between cases or the cohesion of the expanded cohort; however, where there remains a pronounced consistency, I note this. Such consistencies include the propensity for prosecutions to fail in securing a conviction. So, too, is there a consistency in the ‘clustering’ of facts around a set of persistent characteristics, including the type of adverse event, error or behaviour concerned, the role of the coroner, the characteristics of victims and defendants and the issue of recidivism and repeat offending.¹¹²

An approach used by Ferner and McDowell in their presentation of UK precedent was to apply taxonomies to classify the underlying error present in each criminal prosecution. These taxonomies are drawn out of the quality and safety discipline rather than the criminal law. In fact, such taxonomies are a signal feature of the quality and safety discipline’s engagement with cases with which the criminal law engages. A

¹¹⁰ James Reason, *Human Error* (Cambridge university press, 1990); Ferner and McDowell utilise this schema, and as such, I have adopted it in order to provide some comparative alignment with their own approach, despite significant misgivings about the taxonomy itself and its use (see Part V below), Ferner and McDowell, above n 9.

¹¹¹ See for instance the treatment of Queensland “criminal negligence-related offences” in Tuckett, above n 69.

¹¹² To maintain a sense of the original media report from which most cases are drawn, the reports are paraphrased and summarised using the original language employed by the writer rather than attempting to update or reinterpret dated or unclear reporting of the event. This approach means that descriptions of medical procedures, treatment and diagnoses in this article may at times seem at odds with contemporary usage or knowledge and that expressions used by the reporters, coroners or courts find their way into the descriptions of cases discussed here. As the cases extend over such a significant period of time, the practice of medicine, its language and techniques shift significantly. In recounting these cases, the aim is to maintain, where possible, the language in which the cases were described, including medical terminology of the time.

widely used taxonomy, first proposed by James Reason and used by Ferner and McDowell in their study of UK charges and prosecutions, classifies cases based on the underlying facts as mistakes, slips (or lapses), technical errors, or violations.¹¹³ According to that classificatory logic, *mistakes* are errors in the planning of an action; *slips* are errors in the execution of an action, often resulting from distraction or momentary failure of concentration; *technical errors* occur when there is a failure to carry out an action successfully even if the plan of action and technique are appropriate; and *violations* involve a deliberate deviation from safe practices.¹¹⁴ Undergirding the taxonomy is the use of intent and conscious risk taking as the criterion for determining culpability of the accused. A violation stands as an ‘understandable’ reason for prosecution because of the *deliberateness* of deviation from safe practices. In applying the quality and safety discipline-derived taxonomy to criminal cases, Ferner and McDowell contrast ‘deliberately violating rules’ with the ‘unconscious’ (and thus non-culpable) errors that ‘are an inescapable consequence of human actions and [in relation to which] prosecution of individuals is unlikely to improve patient safety’.¹¹⁵ The implications for criminal doctrine are quite clear. Only subjective forms of mens rea (such as intention to kill or recklessness as to death) are sufficient to ground culpability. Criminal negligence, no matter how gross, wicked or total it may be, cannot *ever* suffice as grounds for culpability because it lacks the vital element of deliberate choice (to deviate from safe practice). The effect of the taxonomy’s application to criminal cases is to risk exculpating defendants, not on the basis of criminal doctrine, but on the basis of the quality and safety taxonomy of human action and error. It nullifies the duty, demand and burden placed upon doctors, health practitioners and many others to care for others, without directly addressing this burden itself. For this reason, I cannot adopt the taxonomy un-problematically. Thus, while I do consider how the taxonomy might classify these newly discovered cases, my focus is on the content of the cases themselves, and what they tell us about the criminal law’s engagement with iatrogenic harm over time.

¹¹³ Ferner, above n 18; Reason, above n 110.

¹¹⁴ See also Merry and McCall Smith, above n 10.

¹¹⁵ Ferner and McDowell, above n 9, 309.

Table 1: Australian Medical and Para-Medical Manslaughter Cases

Accused	Potential Termination of Pregnancy	Year	Prof.	Victim	Error Categorisation	Inquest	Inquest Outcome	Trial	Trial Outcome	Juris
Dr Durie	No	1839	Doctor	James Lovett	Violation		Acquittal	No		TAS
Dr Degner	No	1861	Doctor	Lucy Hellings	Slip/Lapse	Yes	Reprimand	No		NSW
Dr Frederick Hillman Hornbrook	No	1864	Doctor	Levi Smith Angel	Violation	Yes	Charged with Manslaughter	Yes	Guilty	NSW
Dr Charles Zimmerler	No	1871	Druggist	Mary Redmond	Violation	Yes		Yes	Guilty	NSW
Dr Heeley	No	1876	Doctor	Eliza Jane Davis	Mistake	Yes	Charged with Manslaughter	Yes	Committal Quashed	NSW
Lubienski	No	1893	Unqual. Practicing as a doctor	Child of Woods	Violation			Yes	Quashed on Appeal	NSW
Dr Henry Marshall Fenwick	No	1895	Doctor	Mary Beekman	Violation			Yes	Acquittal	VIC
Dr Spark and 'Professor' Davis	No	1897	Doctor and Herbalist	Margaret Steel	Violation	Yes	Charged with Manslaughter	Yes	Acquitted	VIC
Dr Spark and Professor Davis	No	1897	Doctor and Herbalist	Margaret Beames	Violation	Yes	Charged with Manslaughter	Yes	Nolle Prosequi	VIC
Dr Frederick William Marshall	Yes	1904	Doctor	Euphemia Franklin	N.A. (Termination)			Yes		
Dr Frederick William Marshall	Yes	1904	Doctor	Ethel Ogilvie April 5 1904	N.A. (Termination)			Yes		

Dr Frederick William Marshall	Yes	1905	Doctor	Amelia Lynch , 23 March 1905	N.A. (Termination)	Yes	Charged with Manslaughter	Yes	Acquittal	NSW
Dr Frederick William Marshall	Yes	1905	Doctor	Martha Frances Walker died Nov 17 1905	N.A. (Termination)			Yes		
Dr Herbert Buxton Ludlow	No. Potentially post- operative treatment for termination.	1908	Doctor	Maria Hedges (also Hodges)	Technical Error	Yes	Charged with Manslaughter	Yes	Acquittal	NSW
Dr Hermann Emil Kugelmann	No	1908	Herbalist		N.A. (Herbalist)	Yes		Yes	Not Guilty	SA
Dr Francis Stanislaus Loughnan	No	1911	Doctor	Elizabeth Bell	Violation	Yes	Caution on behaviour.	No	Coronial	VIC
Dr Leonard Cyril Lade and Henry Cornell (Chemist)	No	1915	Doctor and Chemist	Elizabeth Brown	Violation	Yes	Charged with Manslaughter	Yes	Acquittal	VIC
Dr Sarsfield Cassidy	Yes	1921	Doctor	Isabel d'Arganille	N.A. (Termination)	Yes	Guilty - what?	No	Not pursued.	NSW
Dr Sarsfield Cassidy	Yes	1921	Doctor	Glass	N.A. (Termination)	Yes	Guilty - What?	Yes		
Drs Turner, Steven and Hussey		1921	Doctor	Charles Webb	Technical Error	Yes		Yes	Withdrawn	SA
Dr Adrian Ward Farmer	No	1939	Doctor	Lottie Mack	Technical Error	Yes	Causation - Misadventure	No	NA	WA
Dr Berthold Hiller	No	1941	Doctor	Garnet Gordon Graham	Slip/Lapse	Yes	Charged with Manslaughter	Yes	Aborted	TAS
Dr Franklin Christian Richards	Yes	1941	Doctor	Winifred Pretoria O'Brien	N.A. (Termination)	Yes	Charged with Manslaughter	Yes	Acquittal	NSW
Dr Gerald Russell Featherston	No	1944	Doctor	Walter J Ding	Technical Error	Yes	Charged with Manslaughter	Yes	Acquittal	VIC

Dr Alan Gray	No	1946	Doctor	Ann Elizabeth Aitken	Slip/Lapse	Yes	Charged with Manslaughter	Yes	Acquittal	WA
Dr Miriam Lebanon	No	1946	Doctor	Dorothy Peters	Technical Error	Yes	Accidental Death	No		NSW
Dr Henry Cecil Rutherford	No	1950	Nil							
Dr George Stanley Thomson	Yes	1952	Doctor	Lorna Grace Kane	N.A. (Termination)			Yes	Acquittal	NSW
Dr John Tennant Herron	No	1976	Doctor	Manslaughter of a patient and two counts of GBH.	Violation	Yes & Royal Comm.			Permanent Stay of Disciplinary Proceeding s. DPP did not proceed after stay of Gill's criminal charges.	NSW
Dr John Ewan McDonald Gill	No	1977	Doctor	Manslaughter of patient John Adams. Died 10 days after admission for sixth deep sleep therapy. +GBH.	Violation	Yes & Royal Comm.				NSW
Dr Atlee Clarke	No	1996	Doctor	Jean Halligan		Yes	Morphine toxicity listed as cause of death.	Yes	Charges Potentially Dropped	NSW
Dr Oakley Robert Small	No	1999	Doctor	Desi Jackson English	?Violation	Yes	Prima Facie Manslaughter	Yes	Aborted	QLD
Dr Margaret Pearce	No	2000	Doctor	Carmen Rachann Currie	Violation		Morphine toxicity.	Yes	Guilty	QLD

Dr Bruce Ward	No	2002	Doctor	Nardia Annette Cvitic	N.A.		Prima Facie Manslaughter	Yes	Aborted.	QLD
Dr Garry Gow	No	2006	Doctor and Homeopath	Wayne Ritchie	Violation			Yes	Guilty	NSW
Dr Ellison	No	1886	Doctor	Earnest Hoffman (Child)	Slip/Lapse?			Yes	Discharged	QLD
Dr Harry Bailey	No	1963 - 1979	Doctor	Manslaughter.	Violation	Yes & Royal Comm.	Prima Facie Cases of Negligence		Dismissed.	NSW
Dr Jayent Patel	No	2010 - 2013	Doctor	Multiple: Manslaughter on 3 counts	Violation			Yes (2x)	Guilty/Overturned – Retrial Not Guilty	QLD

IV. ANALYSIS OF EXTENDED AUSTRALIAN CASE LAW

This newly extended case law provides the opportunity to reconstruct and to analyse how the Australian criminal law has engaged with iatrogenic harm over time. My analysis in this section is oriented around two key observations. The first relates what is *present* in the newly identified cases whilst the second as to what is *absent* from the cohort.

First, as to what is *present* in the cases. I review the body of newly unearthed cases and ask, What patterns or themes might be discerned from within the cases? In these cases, are there consistent settings or facts associated with prosecution? Can we conclude that the criminal law can and does distinguish between culpable and non-culpable instances of harm on its own terms, and those imposed by the debate surrounding its use made by proponents of the quality and safety sciences? In addressing these questions, I present observations concerning settings, facts and medical practices as they relate to criminal legal outcomes in these cases. I focus on what patterns or lessons can be drawn from the body of cases regarding who is being found guilty and not guilty; who is tried, who is convicted, and what sentences are applied. Whilst I look obliquely to the way contemporary quality and safety science might classify the underlying factual scenario, I do so largely for the sake of contributing to the potential for a discussion between Australian and UK prosecutorial experience that has been presented in that way, rather than as a definitive classification of the case. Instead, my primary approach is ‘naturalistic’, in the sense that, rather than arbitrarily imposing taxonomical classification upon the cases, I instead attempt to read from the cases the themes and issues they raise. The conclusion I reach in relation to this first part of my analysis is that the cases do ‘cluster’ around a set of persistent characteristics. Moreover, I find that there is a pronounced consistency between these characteristics or themes in the Australian experience and those unearthed by Ferner and McDowell in the United Kingdom. I conclude that the criminal law can and does distinguish between culpable and non-culpable instances of harm. The actual experience of criminal law prosecution in Australian history, then, challenges claims of prosecutorial overreach, speaking instead to criminal law’s judicious and consistent capacity to distinguish between culpable and non-culpable instances of harm. On balance, the experience of criminal prosecution in

Australia has demonstrated a successfully and sustainable differentiation between culpable and non-culpable instances of harm.

In addressing the second question, as to what is *absent* from the experience of prosecution in Australia, I observe that the kind of pressing and sustained criticism of individual cases or of prosecutorial action in general that we see in other jurisdictions is conspicuously absent in the Australian experience.¹¹⁶ The Australian experience simply does not demonstrate the kind of criticism seen in the United Kingdom or New Zealand, nor, I argue, has there been cause for it.¹¹⁷ Given this situation, where the experience of the use of manslaughter by criminal negligence in response to iatrogenic death has been both successful and overwhelmingly received as such by relevant participants in the healthcare system, it seems an open question as to how we have come to labour under the view that criminal prosecution is unhelpful, unsuccessful and somehow inimical to advancing healthcare safety.

Before I reach this point, however, I begin by turning to the first issue concerning settings, facts and medical practices as they relate to criminal legal outcomes in these cases. In this first section, I look to see what patterns or lessons can be drawn from the body of cases regarding who is being found guilty and not guilty. Most importantly, I find that the cases adhere to a quite stable and defined set of themes.

B *Consistency: Settings, Facts and Criminal Outcomes*

This section considers the cohort of newly unearthed Australian cases in themselves. Here I present observations concerning patterns that can be discerned. I find that cases tend to ‘cluster’ around a set of persistent characteristics, including the type of adverse event, error or behaviour concerned, the characteristics of victims and defendants and, finally, the issue of recidivism and repeat offending. Ferner and McDowell, in their important study of the incidence of manslaughter prosecution in the United Kingdom between 1795 and 2005,

¹¹⁶ Namely, the United Kingdom and New Zealand where significant conflict has emerged about the use of criminal prosecution as a response to iatrogenic death.

¹¹⁷ The single exception might be the prosecution of Jayant Patel, discussed below. However, criticism there is not of the same character as that experienced overseas; rather, that series of cases has been criticised – albeit lightly – for the Crown’s *failure* to successfully prosecute cases related to Patel’s time at Bundaberg Base Hospital.

describe a similar tendency of their cases to conform to a relatively stable set of themes.¹¹⁸ Those themes identified by Ferner and McDowell are, in fact, remarkably consistent with those in the Australian cohort. Moreover, in both cohorts those themes recur throughout time, rather than one theme or particular type of adverse event appearing only during particular periods.

In both the UK and Australian cohorts, cases cluster around the themes of licensed and unqualified medical practitioners, obstetric practice and the termination of pregnancy, medication management and, finally, several cases that involved drunkenness or brutal lack of skill.¹¹⁹ I present the cases as they relate to these important themes.

1 *Incompetence, Recidivism & 'Unregistered' Practitioners*

The presence of untrained or otherwise unregistered practitioners is notable in a select group of early cases. These cases provide a view into the shifting status of training, professionalisation and control as well as a range of challenges for the regulation and practice of medicine at a time when registration or licensing, and the dominance of the medical profession were not as settled as they are today.

The importance of questions of registration is not limited to professional politics. The question of the status of different health practitioners and the standard to which they needed to be held in these cases was an active concern. Barrow J, who was presiding over an early case in the newly expanded cohort put the matter succinctly:

[It did not matter whether a man] was the president of the College of Physicians, the President of the College of Surgeons, or any other medical practitioner, if he gave another man [sic] a tumbler of laudanum to drink and sent him into another world, he was liable to prosecution for manslaughter.¹²⁰

The case of 'Professor' Davis and Dr Spark (1897)¹²¹ illustrates the various links between effective healthcare practice and licensing or registration particularly well. Davis and

¹¹⁸ See Ferner and McDowell, above n 9; see also Ferner, above n 18.

¹¹⁹ Ferner and McDowell, above n 9, 313.

¹²⁰ In the case of Hornbrook, 'Manslaughter by a Medical Practitioner'. *Empire* (Sydney, NSW), 8 March 1864 8.

¹²¹ The Australian Medical Pioneers Index provides a detailed listing of Dr Spark's postings and life in Australia: see the entry for "Sidney Walter Spark" (last updated 31 January 2012), Noel David

Spark were charged and tried for the manslaughter of Margaret Steel, whom they had treated for cancer of the breast.¹²² Spark was himself a qualified physician,¹²³ whilst 'Professor' Davis was not formally trained/qualified in medicine but held himself out to be a cancer specialist.¹²⁴ During the associated coronial inquest, the husband of the deceased described Davis' treatment, alleging that he had applied a plaster informing his wife that it would not give pain, but that the cancer would come away in a lump from the body. Post-mortem evidence showed that there was a cancerous growth on the left breast, the skin having been completely eaten through by a strong corrosive. The immediate cause of death was described as a 'flabby heart and engorged lungs'.¹²⁵ A report regarding both a piece of cloth smeared with ointment and a piece of flesh that had been taken for analysis showed the ointment to have been a strong arsenical preparation.¹²⁶ Moreover, the treatment had in fact caused significant pain.¹²⁷ In evidence to be given at the later criminal trial, the physician who undertook the post-mortem examination noted that arsenic would have been absorbed into the body from the ointment used by Spark and Davies and that the deceased may have died from poisoning that would account for the ulceration.¹²⁸ Dr Spark gave evidence to the inquest denying that the preparation used on the plaster contained arsenic.¹²⁹

The tension here between effective or safe treatment and the status of the medically trained practitioner is clear. Dr Spark, for instance gave evidence that Davis had been acting under his instruction, Spark being a qualified medical practitioner, in an attempt to exonerate the conduct of Davis, as acting under medical authority, but also to give weight to the efficacy and correctness of treatment. The coronial jury found that the deceased had died from

Richards, *Sidney Walter Spark* (2 February 2014) Australian Medical Pioneers Index <<http://www.medicalpioneers.com/cgi-bin/index.cgi?detail=1&id=2080>>.

¹²² 'Charged with Manslaughter. Committed for Trial. Melbourne, Thursday.' *Launceston Examiner* (Launceston, Tas.), 23 April 1897 6; 'Latest Telegrams. Melbourne, Thursday Night.' *The Horsham Times* (Vic.), 23 April 1897 2; 'Unregistered Medicoes in Trouble. Committed for Manslaughter. [by Telegraph] Melbourne, Thursday Afternoon.' *Barrier Miner* (Broken Hill, NSW), 23 April 1897 1; 'Colonial. Medical Manslaughter. Melbourne, Friday.' *The Mildura Cultivator* (Mildura, Vic), 24 April 1897 5.

¹²³ Richards, above n 121.

¹²⁴ Here I reflect the language used in my sources. There are important issues surrounding the status of the medical profession, training, qualification(s) and registration that the contemporaneous sources are not always sensitive to.

¹²⁵ 'Latest Telegrams. Melbourne, Thursday Night.', above n 122.

¹²⁶ *Ibid.*

¹²⁷ *Ibid.*

¹²⁸ *Ibid.*

¹²⁹ *Ibid.*

improper treatment by Spark and Davis, and that both were prima facie guilty of manslaughter, the coroner also noting Davis' previous sentence of imprisonment for the manslaughter of a 'certain woman in the past'.¹³⁰ Both were committed to trial. The same question of medical and scientific authority entered the criminal trial, concluded on 30 June 1897. At trial, Horten J allowed evidence of alleged cures of cancer previously effected by Davis.¹³¹ It was reported in the press that the judge summed up strongly in favour of the accused and the jury returned a verdict of not guilty. Newspaper commentary magnified the tensions surrounding authority and efficacy. Writing in the *Mercury*, an unnamed correspondent from Melbourne wrote of knowing Davis, a 'self styled cancer specialist',¹³² before he had 'blossomed out into the professional dignity of a cancer specialist' as an 'enterprising builder of villas more ornate than substantial'.¹³³ There the role of coroner Dr Youl is key. Described as holding long-standing horror in the face of quackery, Coroner Youl had reportedly declared 'how delighted he would be to order... [a] magnetic healer be publically flogged'.¹³⁴ Youl, it is reported, had in fact intervened of his own volition in the case. He had been monitoring the practice of Davis, and then moved to order that the burial of Davis and Spark's victim be halted, the body removed and the death certificate reconsidered. Dr Spark had signed the certificate, and Youl had instead committed them to a coronial inquiry, and eventually to trial for manslaughter. The correspondent worries that one of the two is as a doctor 'fully qualified'¹³⁵ as the coroner, and that whilst the coroner may be 'right',¹³⁶ 'it is a fearful power for any man to wield... and the coroner who treats his office as loosely as did the grave-digger in *Hamlet*... does not always wield [his office] judiciously'.¹³⁷

The case of Spark and Davis is embedded in this broader movement around the shifting and developing of professional boundaries and the emerging authority of the medical profession. In part because of this, they both appear repeatedly in the case law, alongside

¹³⁰ Ibid.

¹³¹ 'Trial for Manslaughter. the Accused Acquitted. Melbourne, June 30'. *The Advertiser* (Adelaide, SA), 1 July 1897 5.

¹³² 'Our Melbourne Letter' *The Mercury* (Hobart, Tas.), 6 May 1897 4.

¹³³ Ibid.

¹³⁴ Ibid.

¹³⁵ Ibid.

¹³⁶ Ibid.

¹³⁷ Ibid.

other non-medical practitioners.¹³⁸ Spark and Davis were again committed to trial for manslaughter of another patient, Margaret Beamish, shortly after the trial and acquittal in relation to Steel.¹³⁹ Whilst treating Beamish for cancer of the tongue, reports stated that plasters containing arsenic were again used by Spark and Davis.¹⁴⁰ The deceased developed septic pneumonia, which was reported to have resulted from the ‘treatment’.¹⁴¹ The inquest again found both guilty of manslaughter and again both were committed to trial, this time for murder. The case ended with the prosecution entering a *nolle prosequi* in connection with the preferred charge of murder against Davis and Spark.¹⁴² Shortly after this trial, Spark continued his practice, placing advertisements in the *Sydney Morning Herald* in 1899 offering to demonstrate the success of his non-surgical cancer techniques to medical men at the Langham Hotel, Wynyard, in inner-city Sydney.¹⁴³

Tensions between the qualified and unqualified and the question of recidivism were not wholly restricted to alternative health practices or only to non-medical defendants. Charles Zimmler (1871), demonstrates a similar ‘recidivist’ thematic, despite his formal medical training.¹⁴⁴ Reported to have been a medical practitioner from Germany, Zimmler operated a pharmacy from which he had dispensed ammonia for the treatment of a child, Mary Redmond, aged 11 months.¹⁴⁵ Zimmler was brought before the court for having ‘killed and slain’ her on 14 June 1871¹⁴⁶ and found guilty the following year.¹⁴⁷ Other sources extend Zimmler’s criminal history. Zimmler was again involved in an inquest¹⁴⁸ into the death of

¹³⁸ See for example Zimmler, ‘The Committal of Mr. Zimmler for Manslaughter.’ *The Maitland Mercury & Hunter River General Advertiser* (Newcastle, NSW), 22 June 1871 4.

¹³⁹ ‘A Suspicious Death. Melbourne, Monday Night.’ *The Horsham Times* (Horsham, Victoria), 24 August 1897 3; ‘A Charge of Manslaughter. Melbourne, August 27.’ *The Advertiser* (Adelaide, SA), 28 August 1897 7.

¹⁴⁰ ‘Victoria. Alleged Manslaughter. Melbourne, August 27’. *The Daily News* (Perth, WA), 28 August 1897 3.

¹⁴¹ Ibid.

¹⁴² ‘Latest Intelligence. a Nolle Prosequi. Melbourne, Thursday Night’. *The Horsham Times* (Vic.), 1 October 1897 3.

¹⁴³ ‘Advertising: Cancer, Cancer, Cancer’ *The Sydney Morning Herald* (Sydney, NSW), 27 March 1899 2.

¹⁴⁴ Zimmler’s pharmacy in Gulgong in the central tablelands of New South Wales was the subject of a photograph by the American & Australasian Photographic Company in 1870. American & Australasian Photographic Company, Gulgong Dispensary Chemist & Druggist Dr Zimmler (State Library of New South Wales, 1870).

¹⁴⁵ ‘Incautious Use of Ammonia’ *The Sydney Morning Herald* (Sydney, NSW), 20 June 1871 4.

¹⁴⁶ ‘Chronicle of Events, 1871. January.’ *The Sydney Morning Herald* (Sydney, NSW), 30 December 1871 5.

¹⁴⁷ ‘The Circuit Courts. Bathurst.’ *Australian Town and Country Journal* (Sydney, NSW), 27 April 1872 5; ‘The Committal of Mr. Zimmler for Manslaughter.’, above n 138.

¹⁴⁸ Held on 21 December 1871.

John Millard; evidence was given that Millard had died of a strangulated hernia, and that Zimmer's misdiagnosis and treatment hastened Millard's death.¹⁴⁹ It seems no charges were laid for his part in the death, but in 1873, Zimmer was again a witness in an inquest, this time into the death of Patrick Shannon, a butcher. Zimmer had dispensed six grains of strychnine to the deceased,¹⁵⁰ reporting that he had known the deceased for some time, had initially refused to sell the poison, but had done so after Shannon reported it was for his employer to destroy cats.¹⁵¹

Alongside Zimmer, earlier cases in this cohort include a range of persons who dispensed medicines or herbal remedies in this era of unregulated pharmacy practice and who were also subject to multiple trials.¹⁵² One significant figure was Mr HE Kugelmann (1908), a herbalist who was charged, tried and acquitted over the manslaughter of farmer Harry Ratten of Mount Templeton, South Australia, in 1908.¹⁵³ Kugelmann had dispensed a medicine for Ratten's daughter a year prior; Ratten subsequently took the medicine without the authorisation of Kugelmann and died.¹⁵⁴ One newspaper wrote that the injustice of prosecution was comparable to that of the prosecution of Pasteur,¹⁵⁵ a view no doubt aided by Kugelmann's own advertising ascribing to himself a skill in healing 'unsurpassed in modern history'.¹⁵⁶

¹⁴⁹ 'General News.' *The Maitland Mercury & Hunter River General Advertiser* (NSW), 21 December 1871 3; 'Chronicle of Events, 1871. January.', above n 146.

¹⁵⁰ 'Gulgong. August 7'. *Australian Town and Country Journal* (NSW), 16 August 1873 7.

¹⁵¹ Like Spark and Davis, Zimmer continued to practise, also enjoyed a long and developing civil and political career. Returning to practise as a pharmacist in Gulgong after serving his goal time for manslaughter of Redmond, Zimmer was subsequently elected mayor at least four times over. A full decade after being convicted, Zimmer was appointed a magistrate by the New South Wales government, 'New Magistrates.' *The Sydney Morning Herald* (Sydney, NSW), 6 October 1882 5; The appointment later occasioned some debate in the Legislative Assembly between Henry Parkes and others regarding Zimmer's character and fitness for the position. Copies of all documents relating to his appointment were requested by at least one member of the House, see 'New South Wales. [from Our Own Correspondents.] Sydney, February 6.' *The South Australian Advertiser* (Adelaide, SA), 7 February 1883 5; Zimmer was subsequently removed from the commission of the peace. Seeming to enjoy local support for his Mayoral election and elevation to the magistracy, the local member for the area where Zimmer lived continued to formally protest his removal, 'The New South Wales Parliament.' *Argus* (Melbourne, Vic.), 17 February 1883 12.

¹⁵² Including Dr Charles Zimmer who is discussed below. See for example the case of Lubienski, who was found guilty at first instance (later quashed by the New South Wales Supreme Court) of the malicious injury to a child during the delivery of the child. The child had died during a difficult (breach) delivery at which Lubienski, practising as a doctor but not legally qualified as such, attended, *R v Lubienski* [1893] NSWLawRp 11 (3 March 1893).

¹⁵³ 'Kugelmann Acquitted' *Evening News* (Sydney, NSW), 3 December 1908 5.

¹⁵⁴ 'The Kugelmann Prosecution' *The Newsletter: an Australian Paper for Australian People* (Sydney, NSW), 21 November 1908 9.

¹⁵⁵ *Ibid.*

¹⁵⁶ 'Mr. H. E. Kugelmann' *The Register* (Adelaide, SA), 6 June 1912 6.

The tension between the qualified and unqualified were not always quite as complex. ‘Dr’ Cecil Rutherford Darling (1950), for example, was posted to Sofala General Hospital in New South Wales. Approximately 80 years of age, he was interviewed in Sofala by New South Wales police for falsely representing himself as a medical practitioner and other alleged offences.¹⁵⁷ After being interviewed and released to collect his credentials, Darling went missing. A decade earlier he had been convicted for manslaughter when acting as locum tenens at Stoke-on-Trent Maternity Hospital in Britain;¹⁵⁸ at that time, it was revealed that he was not in fact a qualified medical practitioner and was described by British police as a ‘callous, unscrupulous, persistent rogue’.¹⁵⁹ Sentenced to 10 years gaol,¹⁶⁰ his real name was reported to have been Andrew John Gibson, and he had admitted to posing as ‘Harry Cecil Rutherford Darling’, a medical practitioner from Australia. He had done so since 1923, changing his name by deed poll.¹⁶¹ In remarks at sentence, Hallett J at the Stafford Assizes, commented that he ‘had capped a long and extremely wicked career with about the worst case of manslaughter by negligence I can imagine. I am going to do my best to see that you kill no one else’.¹⁶²

Seemingly at the completion of his sentence arising from his conviction of manslaughter in Stoke-on-Trent, ‘Darling’ seems then to have travelled to Australia, posing again as a doctor and using the same adopted name. Australian police stated that ‘Darling’ had numerous previous convictions, including for posing as a Presbyterian minister in which role had ‘had a great influence over women’.¹⁶³ Police had compiled a detailed record of his activities over a period of 57 years, which noted approximately 40 pseudonyms, a bride in Sydney whom he deserted for a second bride in Brisbane,¹⁶⁴ whom in turn he had taken to America and then abandoned in Canada.¹⁶⁵ Described as one of the ‘most daring

¹⁵⁷ “‘Doctor’ World Impostor?’ *The Courier-Mail* (Brisbane, Qld.), 26 May 1950 1; ‘Man Posed as Doctor for Six Weeks’ *The Argus* (Melbourne, Vic.), 29 May 1950 3.

¹⁵⁸ ‘Bogus Doctor Kills Woman London, Thursday’. *The Daily News* (Perth, WA), 12 July 1940 3.

¹⁵⁹ Ibid.

¹⁶⁰ Ibid.

¹⁶¹ The judge in the United Kingdom had questioned Gibson as to why he chose the specific name, revealing that he had done so in order to be mistaken for another highly qualified doctor of the same name. The real Dr Darling practised at Macquarie Street in Sydney and had no connection with Gibson

¹⁶² ‘Bogus Doctor Kills Woman London, Thursday.’, above n 158.

¹⁶³ Ibid.

¹⁶⁴ ‘Had About 40 Aliases Sofala’s Bogus Medico’ *Townsville Daily Bulletin* (Townsville, Qld.), 27 May 1950 5.

¹⁶⁵ This woman subsequently approached a Brisbane newspaper to recount the story of her abandonment, “‘He Was Brilliant’ Married ‘Bogus Doctor’” *The Courier-Mail* (Brisbane, Qld.), 29 May 1950 1.

imposters, bogus doctors, and deceivers of women in the history of crime’,¹⁶⁶ he had spent more than 40 years in gaols in America, England and Australia.¹⁶⁷ In relation to his arrest in 1950, police would not reveal the charge contained in the warrant, stating that they did not want Darling to know what he would be charged with until he was arrested.¹⁶⁸

The question of cross-jurisdictional movements of unqualified or unregistered practitioners continues to plague the Australian healthcare system at times. The leading manslaughter case of Jayant Patel involved just such a movement, being de-registered in the United States, and yet, being registered in Australia, with Australian authorities none-the-wiser. So too has NSW been host to Shyam Acharya, who successfully posed as a doctor for eleven years across multiple hospitals,¹⁶⁹ and most recently the case of Jie Shao, who is alleged to have performed a breast enhancement procedure as an unregistered health practitioner in a Sydney beauty clinic.¹⁷⁰

2 *Botched Abortions*

Cases of manslaughter by criminal negligence by virtue of a death associated with a termination of pregnancy represent the most significant part of prosecution in Australia. Their presence and large numbers seem to be due to the intersection between properly iatrogenic factors and a legal apparatus that criminalised the undertaking of the procedure at the time.¹⁷¹ To provide a sense of the type of case found in this termination of pregnancy-related cohort, I present the cases of Dr Frederick William Marshall (two

¹⁶⁶ ‘Women Swear by Bogus Doctor of 80’ *Sunday Mail* (Brisbane, Qld.), 28 May 1950 3.

¹⁶⁷ This may have included a finding of guilt for forgery in South Africa, and in 1938 another forgery charge under his own name in Sydney, Australia: ‘Had About 40 Aliases Sofala’s Bogus Medico’, above n 164; ‘Expert Forger. Sent to Gaol for Life. Johannesburg, October 19.’ *The Advertiser* (Adelaide, SA), 20 October 1916 9; ‘Doctor of Medicine Remanded. Charge of Forgery. Sydney. Tuesday.’ *The Muswellbrook Chronicle* (Muswellbrook, NSW), 25 January 1938 2; ‘Man Posed as Doctor for Six Weeks’, above n 157.

¹⁶⁸ ‘Man Posed as Doctor for Six Weeks’, above n 157.

¹⁶⁹ Kate Aubusson, ‘Fake Doctor Shyam Acharya Worked at Royal North Shore, Mona Vale Hospitals’ *The Sydney Morning Herald* (Sydney, NSW), 23 March 2017 <<http://www.smh.com.au/national/health/fake-doctor-shyam-acharya-worked-at-royal-north-shore-mona-vale-hospitals-20170323-gv4ty5.html>>.

¹⁷⁰ *Woman Dies after Botched Breast Surgery at Sydney Beauty Salon* (1 September 1000) ABC News <<http://www.abc.net.au/news/2017-09-01/woman-who-underwent-botched-procedure-dies/8864854>>.

¹⁷¹ The cases relating specifically to the provision of termination services will be the subject of future publication. To-date they exceed some sixty cases of ‘illegal operations’ that resulted in the death of the patient and that were prosecuted with a manslaughter-related charge. Because of their number, and the complexity of their relationship to the criminalization of abortion rather than iatrogenic factors alone, I excluded the vast majority of these cases from consideration.

instances in 1904 and two in 1905) and Dr Sarsfield Cassidy (1921) and Elizabeth Taylor (aka Elizabeth Pears/Nurse Pears) (1882, 1885, 1886, 1891, 1909) as illustrative cases.¹⁷²

Marshall's is one of earlier termination-related manslaughter cases found in this study. He was subject to three retrials in one matter, in addition to a further three inquests and trials for separate allegations of manslaughter. His alleged guilt was based on the performance of what newspapers at the time referred to in-part euphemistically as an 'illegal operation'. On 23 March 1905, Marshall was charged with the manslaughter of Amelia Lynch, 26, of Young, New South Wales, in consequence of an illegal operation performed on 27 August 1904 in Sydney.¹⁷³ Like most of the termination-related cases, the victim was a young woman, and a coronial inquest featured as a prelude to the criminal trial. At the inquest into Lynch's death, it was revealed that Lynch had died at the house of a nurse after the operation,¹⁷⁴ and Marshall was sent to stand trial for manslaughter. At trial, Marshall entered a plea of not guilty, however, the jury was initially unable to reach a verdict. The trial judge Simpson J addressed the jury in relation to a memorandum sent to him the previous afternoon. That memorandum revealed that a number of jurors had not understood the question that they were asked to determine. The jury was asked to deliberate again but returned confirming that it was not able to reach consensus.¹⁷⁵ A retrial was ordered, under circumstances that are not completely clear from available records.

Marshall's first retrial began in 1905 under Murray AJ at Central Local Court.¹⁷⁶ The jury was again unable to reach a consensus.¹⁷⁷ A second retrial, concluding on 7 June 1905,

¹⁷² In a significant number of cases, nurses and lay-women were prosecuted for manslaughter, or in some cases both the person identified as the practitioner and the patient's husband or partner.

¹⁷³ 'Suspicious Circumstances. the Inquest Adjourned. [by Telegraph.] Sydney, Friday'. *Singleton Argus* (NSW), 3 September 1904 5.

¹⁷⁴ Ibid.

¹⁷⁵ 'Central Criminal Court. (before Mr. Justice Simpson and a Jury of 12.) the Solicitor-General (Mr. Hugh Pollock) Prosecuted for the Crown. Alleged Manslaughter. Dr. F. W. Marshall's Trial. Jury Disagree.' *The Sydney Morning Herald* (Sydney, NSW), 30 September 1904 7.

¹⁷⁶ 'Charge of Man-Slaughter. Dr. F. Marshall on Trial. the Death of Amelia Lynch'. *Evening News* (Sydney, NSW), 20 March 1905 4.

¹⁷⁷ Ibid.

resulted in an acquittal.¹⁷⁸ In a statement, Marshall said that his ‘certificates and diplomas were of the highest character’¹⁷⁹ and that:

I risked my liberty to try to save life, and because I did so I am persecuted by three trials, and at a time when I met with serious accident [sic] because after the last trial I got spinal meningitis, and when I returned home it was only to see my wife die. In less than four weeks from the time of her death I am ordered to present myself again for trial on a charge of which I am entirely innocent.¹⁸⁰

Marshall had in fact previously been tried on a number of occasions, each in relation to termination-related complications.¹⁸¹ He had been tried earlier in 1904 for the death of Euphemia Franklin, 28.¹⁸² A verdict of ‘wilful murder’ was returned at the inquest into Franklin’s death, with another person, Thomas Ireland, named as an accessory, having ‘kept company’¹⁸³ with the deceased. Both were committed to trial; the result unknown. Marshall was also charged with alleged unlawful use of an instrument to procure a miscarriage upon Ethel Ogilvie, ‘a married woman’.¹⁸⁴ Dr Walter AR Sharp, resident medical officer of the Coast Hospital at Little Bay,¹⁸⁵ had called on Ogilvie and treated her for severe bleeding after Marshall had allegedly performed the procedure. Marshall was committed for trial at the Central Criminal Court on 5 April 1904, was released on bail, the result of the trial unknown. A further inquest was held into another death related to Marshall in 1905. Martha Frances Walker, 30, had died on 17 November 1905 at the Sydney Hospital after being admitted four days earlier.¹⁸⁶ The inquest was held with Marshall, Andrew Moorehead (warder at Gladesville Asylum where the deceased had been

¹⁷⁸ ‘Central Criminal Court. (before Mr. Justice Simpson and a Jury of 12.) the Solicitor-General (Mr. Hugh Pollock) Prosecuted for the Crown. Alleged Manslaughter. Dr. F. W. Marshall’s Trial. Jury Disagree.’, above n 175.

¹⁷⁹ Ibid.

¹⁸⁰ Ibid.

¹⁸¹ Dr Marshall had also been the subject of a civil case in 1897 brought by Lawrence McGrath, a publican, for the recovery of 500 pounds from Marshall for the use of his hotel for an “immoral purpose”. It was found that Marshall had presented to the hotel with a woman whom he reported to be his wife. After it was discovered that the couple were in fact not married, he was ordered out of the hotel. The doctor had offered a defence that he was simply attending to the woman as her physician and denied the charge of undue intimacy. The jury found for the plaintiff assessing damages at 20 shillings.

¹⁸² ‘Dr. Marshall Again. [by Telegraph.] Sydney, Wednesday’. *Barrier Miner* (Broken Hill, NSW), 2 June 1904 4.

¹⁸³ Ibid.

¹⁸⁴ ‘In Trouble Again’. *The Raleigh Sun* (Bellingen, NSW), 25 March 1904 2.

¹⁸⁵ Later renamed Prince Henry Hospital.

¹⁸⁶ ‘New South Wales. Another Victim. Sydney, Saturday’. *Morning Post* (Cairns, Qld.), 20 November 1905 3.

employed as a nurse) and Catherine Steppe all present. Marshall was committed to trial for ‘using an instrument on Martha Frances Walker’, with Moorehead and Steppe both charged with procuring an operation.¹⁸⁷ They were each charged with murder.¹⁸⁸ The Crown (Mr Pollock) submitted that the evidence was insufficient to secure a conviction and recommended the court not proceed with the case.¹⁸⁹ Like many other cases of this type, the abrupt end of the prosecution is left relatively unexplained. Whilst cessation of prosecution is not unusual in itself, it occurs repeatedly in termination-related cases, and is left unexplained.

This repeated absence of detail in termination-related cases is coupled with numerous cases containing conflicting reports on basic evidentiary facts. For example, Dr Andrew Sarsfield Cassidy of Sydney was discharged from custody on 10 February 1922 when police stated they had no fresh evidence to offer after the Attorney-General directed them not to proceed with prosecution.¹⁹⁰ This case was in connection with the death of Isabel Dargaville, a young nurse, on 12 December 1921.¹⁹¹ The coroner found that the cause of death was septic pericarditis ‘following a certain event, which he was unable to say how or by whom that event was brought about’.¹⁹² The media reported that, following the inquest, Cassidy was brought before the Central Police Court on a charge of feloniously and maliciously slaying Dargaville, at which time the magistrate reportedly remarked that ‘he had no doubt that the Attorney-General would take a certain course of action if no fresh evidence is forthcoming’.¹⁹³ On a number of occasions, Dargaville’s death was described both as occurring at the Coast Hospital, but also as occurring at a private hospital in Darlinghurst.¹⁹⁴ Such unclear and conflicting detail is not uncommon in the reporting of

¹⁸⁷ Although the reports of the time also refer to the charge being that of murder.

¹⁸⁸ ‘Charge of Murder’. *Clarence and Richmond Examiner* (Grafton, NSW), 9 December 1905 4; ‘New South Wales. Break-down of a Murder Trial. Sydney, March 27’. *The Mercury* (Hobart, Tas.), 28 March 1906 3.

¹⁸⁹ ‘Dr. Marshall Acquitted Dying Depositions Rejected. Sydney, March 27’. *The Advertiser* (Adelaide, SA), 28 March 1906 8.

¹⁹⁰ ‘Death of a Girl. Dr. Cassidy Discharged’. *The Argus* (Melbourne, Vic.), 10 February 1922 12.

¹⁹¹ Isabel Dargaville is also variously referred to as Isabel d’Argaville, ‘Nurse’s Death. An Open Verdict.’ *The Sydney Morning Herald* (Sydney, NSW), 7 January 1922 14.

¹⁹² ‘Death of Isabel Dargaville [Sic] Sydney Doctor Remanded on Manslaughter Charge Sydney, Friday’. *Barrier Miner* (Broken Hill, NSW), 6 January 1922 1.

¹⁹³ Ibid.

¹⁹⁴ The Coast Hospital of the time was largely an infectious diseases and quarantine hospital, later renamed Prince Henry Hospital, in Little Bay. Reports conflict as to the location and/or name of the hospital in question, naming the Coast Hospital as a private hospital in Darlinghurst.

these cases, yet this difficulty seems not to have been a characteristic of reporting of non-termination cases in the same cohort.

Adding to the effect of this unclear and conflicting reporting of termination-cases is the constant repeat – often overlapping – offending and prosecution of particular practitioners. For instance, Dr Cassidy, along with a Dr Albert Reginald McLeod, had been a key person of interest in another coronial inquest held earlier in 1921 in relation to the death of Gwendoline Campbell Glass, 20, at the Coast Hospital on 27 November 1920.¹⁹⁵ Cassidy was committed to trial for murder by the coroner; McLeod was discharged.¹⁹⁶ Reports indicate Cassidy was acquitted of murder relating to this death in March 1922.¹⁹⁷ These multiple and overlapping criminal justice processes, with charges and trial running into one another is not unusual in the cohort of termination-related cases. Many dozens of cases were unearthed in this research process, and the vast majority were for practitioners who, whilst often operating with very little skill or care, were subject to multiple criminal charges.¹⁹⁸ These charges could extend over significant periods of time.

Elizabeth Taylor who was also known as Elizabeth Pears and ‘Nurse Pears’ is perhaps the most obvious case of an entire career of engagement with various manslaughter and other homicide charges over almost thirty years. Taylor/Pears served two years’ hard labour for manslaughter in 1886 in Melbourne¹⁹⁹ and was again charged and found guilty of manslaughter in another termination-related case, this time in Perth.²⁰⁰ In passing sentence

¹⁹⁵ ‘No Title (Albert Reginald McLeod (40) and Sarsfield Cassidy (55))’ *Queanbeyan Age and Queanbeyan Observer* (NSW), 29 November 1921 3; ‘Alleged Malpractice Charge Against Two City Doctors. (by Telegraph.) Sydney, Monday.’ *Singleton Argus* (Singleton, NSW), 13 December 1921 2. These termination of pregnancy cases exhibit a shared texture due to the way in which newspapers reported such cases; the use of euphemism and a blurring of the facts of the cases characterised the tone of the reporting. This seems also to be the character of the cases at trial, with cases often presenting conflicting evidence and unclear timelines. Many of the cases involve multiple retrials, successive acquittals and registered physicians, midwives, nurses and untrained persons subject to prosecution.

¹⁹⁶ ‘Young Woman’s Death. a Doctor Committed. Sydney, Dec. 12’. *The West Australian* (Perth, WA), 13 December 1921 7.

¹⁹⁷ ‘Doctor Acquitted. Sequel to Young Woman’s Death. Sydney, March 23.’ *The Register* (Adelaide, SA), 24 March 1922 9. There are conflicting media reports that state that this earlier of the two charges was in fact dropped due to the more serious charge of murder being laid in relation to the later death of Dargaville.

¹⁹⁸ Emmaline Florence Glover for example was subject to multiple trials for the manslaughter a patient, ‘A New Trial Ordered Sydney, Saturday’. *Barrier Miner* (Broken Hill, NSW), 2 June 1928 2.

¹⁹⁹ Emmaline Florence Glover for example was subject to multiple trials for the manslaughter a patient, *ibid.*

²⁰⁰ ‘Case of Nurse Pears. Seven Years’ Imprisonment. “An Abominable Trade.” Perth, May 5.’ *Kalgoorlie Miner* (Kalgoorlie, WA), 6 May 1908 5.

in Perth, Justice McMillan said he had not only to think of the offence for which she had been convicted, but of her past offences.²⁰¹ He found that she was a woman who carried on an ‘abominable trade that did the greatest injury to the community’.²⁰² He stated that in 1882 and 1885 Nurse Pears had been tried for two separate cases of manslaughter but was eventually discharged in each case. In 1886 Nurse Pears was again found guilty of manslaughter with criminal negligence and sentenced to two years’ imprisonment. In 1891 Nurse Pears was again before a jury, who found her guilty of murder.²⁰³ She had a sentence of death passed on her which was, however, commuted to fifteen years’ imprisonment.²⁰⁴ Justice McMillan stated he believed it was impossible to reform the woman, and stated that the only point that he intended to allow to influence him was her ‘extreme age’.²⁰⁵ His Honour then passed a sentence of seven years’ imprisonment with hard labour on Nurse Pears.²⁰⁶ On 25 September 1909 Taylor/Pears died in Fremantle Hospital after being conveyed there from Fremantle Prison.²⁰⁷

The coverage of Taylor/Pears was just as conflicting and unclear as in other termination-related cases. In her research on woman defendants, Debra Fletcher notes, for instance, that the coverage that her trial had received was unusually favourable to Taylor/Pears:

The *West Australian* covered the case with no emotion nor editorialising and the *Truth* which usually revelled in sensational coverage and moral outrage, appeared to be defending Nurse Pears on the grounds that she was a kindly, gentle looking woman, loved by the neighbours, despite the fact that she had a long history as a convicted abortionist.²⁰⁸

Yet Pears had been elsewhere described as someone who ‘would flagrantly drive around the streets of Melbourne in her hansom cab’, having been ‘brought to trial [in Victoria] no fewer than seven times’.²⁰⁹

²⁰¹ Ibid.

²⁰² Ibid.

²⁰³ Ibid.

²⁰⁴ Ibid.

²⁰⁵ Ibid.

²⁰⁶ ‘Nurse Pears Sentenced’ *Sunday Times* (Perth, WA), 10 May 1908 5 S.

²⁰⁷ ‘Death of Nurse Pears’. *The Daily News* (Perth, WA), 25 September 1909 13.

²⁰⁸ Debra A Fletcher, *The Woman in the Dock Is a Monster: An Investigation of Female Criminality in the Hearings of the Perth Supreme Court, 1890-1914* (PhD Thesis, Edith Cowan University, 1995) 167 <<http://ro.ecu.edu.au/theses/1194/>>.

²⁰⁹ Kathy Laster, ‘Arbitrary Chivalry: Women and Capital Punishment in Victoria, Australia 1842-1967’ (1994) 6(1) *Women & Criminal Justice* 67, 78.

3 Medication Error

Medication error plays a significant role in iatrogenic harm today,²¹⁰ and it appears as a key theme in the cases uncovered by both Ferner and McDowell and those presented here. In many instances, prosecutions related to medication errors are received by the broader literature on liability for iatrogenic harm as examples of the inadequacy of the criminal law's understanding of human action and agency.²¹¹ Being found guilty of a death resulting from a medication error, it is argued, is unjust, as such an error is 'natural', occurring so often that prosecution reflects a cruel form of moral luck.²¹² Yet, the cohort of cases uncovered by this Australian research undercuts the veracity of claims that law unfairly targets such cases. Instead, in the cases prosecuted in Australia, the Court and the jury are at pains to exculpate practitioners for such errors, even in some of the most extraordinary of circumstances.

The case of Dr Degner (1861) is one such case. The earliest case in NSW, Degner was subject to a coronial inquest relating to the death of an infant,²¹³ Lucy Hellings, aged six months.²¹⁴ Degner was a doctor attached to a lodge of which the deceased's father was a member.²¹⁵ The deceased had been unwell, apparently suffering from a cold. Degner

²¹⁰ Two to 3% of all hospital admissions in Australia are medication-related and hospital incident reporting shows that incidents with medication are the second most common type reported following patient falls. Half of the cases described here involve medication error.

²¹¹ See for example, Dekker's analysis of the doctrinal aspects of manslaughter by criminal negligence in his extended narrative case study of 'Mara', a Swedish paediatric ICU nurse, charged with a manslaughter offence involving medication administration. This narrative and the case is dealt with in Chapter Five of this thesis. 'Dekker, above n 7, Prologue; Known to the Court as 'EH', in the case generally referred to as the 'Kalmar case', see *B2328-05* 2006 NJA 228 ('Case of "EH"'); see also 'Decision of the Swedish Supreme Court (Högsta Domstolen) in the Matter of EH (b 2328-05)' <http://www.hogstadamstolen.se/Domstolar/hogstadamstolen/Avgoranden/2006/2006-04-19_B_2328-05_dom.pdf>.

²¹² See for example, Merry and Brookbanks, above n 6, 22, n 28; Sidney Dekker, 'The Criminalization of Human Error in Aviation and Healthcare: A Review' (2011) 49(2) *Safety Science* 121; Brazier and Ost, above n 42, 79–80.

²¹³ Coronial inquests were very often held in hotels/pubs, due in part to the ready access to cool basements for storage of the body. Marc Trabsky writes, for instance, that in Australia at around this time, 'Coroners at first would carry corpses from one public house to another, hoping to find a hospitable innkeeper willing to let a room for holding a coronial inquest'. Marc Trabsky, 'The Custodian of Memories: Coronial Architecture in Nineteenth-Century Melbourne' (2015) 24(2) *Griffith Law Review* 199, 199.

²¹⁴ 'Death by Poisoning', *The Sydney Morning Herald* (NSW), 13 July 1861 5.

²¹⁵ The provision of medical services through friendly societies, organised into local lodges, was commonplace, and a source of significant tension in medical politics until the mid-twentieth century. These arrangements created a system of contract practice for general practitioners, who were remunerated by payment of capitation fees. The BMA (Australian doctors remained members of the Australian branch of the BMA) eventually won a battle to end this approach to provision of medical

examined the child and made up a bottle of medicine he believed contained potash, tartaric acid and water, but that was in fact made up of potash, tartaric acid and sulphuric acid. Degner had several bottles of ingredients placed in the area where he mixed prescriptions. A new surgery was being constructed at the time and some bottles had been recently moved; amongst these were two identical gin bottles, both unlabelled, one containing water and the other sulphuric acid.²¹⁶ Degner selected the bottle containing sulphuric acid and made up the medicine. The deceased's mother administered the mixture and after a few hours the child convulsed and began to vomit. The deceased's mother reported that the 'froth which issued from the child's mouth caused blisters to rise under its nose'.²¹⁷ After discovering the mistake, Degner threw the remainder of the medicine out of the window and sent for magnesia as an antidote to the acid. The child never recovered. Degner did not deny that his actions had caused the death of the child, and it was reported that on more than one occasion the coroner cautioned Degner against self-incrimination. The jury at the inquest deliberated for some time, recalling one witness to describe how the bottles of medicines were kept in the house. They returned a verdict as follows:

We the undersigned, mutually agree in opinion that the mixture administered to the child by order of Dr Degner was the immediate cause of death. At the same time, we are of the opinion that Dr Degner is highly censurable in allowing the acid to be kept in a bottle resembling the one in which the water was kept, there being no label to distinguish one from the other. We exonerate Dr Degner from any wilful attempt to destroy life, but think him deserving of the severest reprimand for not exercising due caution.²¹⁸

This response by an early coronial jury is one that is relatively common in the cohort of cases. So too is the same kind of mercy present even in contemporary criminal trials. In handing down his judgment in the contemporary case of Dr Gow (2004), for instance, Berman DCJ expressed an almost identical sentiment to the coronial jury of the mid-nineteenth century in his discussion of the medical error at the heart of that case. In that case, Dr Gow mistakenly prescribed five ampoules of morphine tartrate to his patient instead of the less potent morphine sulphate.²¹⁹ The patient, who was to self-administer this substance as part of a pain management regime for chronic back pain, died after

services. See the excellent overview by Gillespie, James A Gillespie, *The Price of Health: Australian Governments and Medical Politics 1910-1960* (Cambridge University Press, 2002) 7 *infra*.

²¹⁶ 'Death by Poisoning', above n 214.

²¹⁷ *Ibid.*

²¹⁸ *Ibid.*

²¹⁹ *Gow* [2006] NSWDC 78 (27 October 2006).

injecting 120 milligrams of the substance. Gow admitted he had failed to prescribe the correct substance and had not provided the patient with dosage instructions. He pleaded guilty to manslaughter and was given a suspended sentence. Gow was described by the trial judge as deeply remorseful. In suspending his sentence, Berman DCJ noted the failure of systems designed to stop such a ‘catastrophic’ medical error, including review by the dispensing pharmacist. This was ‘not to excuse Dr Gow’s errors... but... to recognise that people, even professional people make mistakes’.²²⁰

The distinctive expression of mercy towards defendant-practitioners who are charged with manslaughter on the basis of medication error is expressed by Berman DCJ, and the coronial jury in the case of Degner, in quite measured terms. However, the same sentiment is expressed in less measured ways in other cases unearthed in this research. In the mid-twentieth century, for example, Dr Berthold Hiller (1941) was found to have negligently caused the death of a patient by injecting too high a dose of novocaine and adrenalin during an operation. Hiller stated in an affidavit that he was unaware before the death of the patient that the solution contained too large a quantity of adrenalin.²²¹ Hiller performed 500 or 800 operations each year, of which 150 would ‘be on the nose’.²²² He stated, ‘I have never, at any time, in my practice, authorised or prescribed a prescription of novocaine and adrenalin containing more than 15 minims of adrenalin to the ounce’.²²³ This was contradicted, however, by evidence from employees of the chemist who had dispensed the solution on Hiller’s orders. They noted that a written prescription had been received ‘some time after’²²⁴ detectives had visited their pharmacy to investigate the death in question.²²⁵ One employee gave evidence that the written prescription differed from that recorded over the telephone from Hiller.

Despite the questionable honesty of Hiller, the highly active jury at his trial had forced the prosecution to withdraw the charges. Hiller had taken the stand, but still awaited cross-examination when the jury expressed directly to the court that they had unanimously

²²⁰ Ibid.

²²¹ ‘Doctor on Manslaughter Case’. *Townsville Daily Bulletin* (Qld.), 30 August 1941 8, (The solution contained in excess of 15 minims of adrenalin.).

²²² ‘Doctor on Manslaughter Case.’, above n 221.

²²³ Ibid.

²²⁴ ‘Doctor on Trial Error Alleged in Injection Used at Operation’ *The Mercury* (Hobart, Tas.), 27 August 1941 6; ‘Prescriptions by Phone & Letter Did Not Agree’ *The Courier-Mail* (Brisbane, Qld.), 28 August 1941 7.

²²⁵ The prescription was alleged to have been accidentally disposed of.

formed an opinion that a conviction could not be recorded against Hiller based on the evidence presented.²²⁶ As the defendant had yet to be cross-examined, the Crown requested that the jury be discharged and Hiller held in remand until the next sitting of the court, arguing that the jury had formed a conclusion prior to all the evidence being presented. The Solicitor-General, Mr Beedham, who was running the case, noted that a jury had never expressed an opinion during the course of a trial in his experience.²²⁷ The Chief Justice refused the application to discharge the jury, noting that the jury had merely expressed an opinion, one that might fluctuate during the case.²²⁸ The Solicitor-General responded that in his opinion the jury's mind had not simply fluctuated but had called a halt. Feeling it his duty, the Crown entered a *nolle prosequi*.²²⁹

Medication error involving oversight by a dispensary responding to verbal orders is a feature in several other cases, albeit without the dishonesty exhibited by Hiller in this case.²³⁰ Yet, again, these cases never ended in a verdict of guilty. Walter Henry Cornell (a chemist) and Dr Leonard Cyril Lade (1915), for instance, were subject to inquest and trial for manslaughter in Ballarat, Victoria, in relation to the death of Elizabeth Brown of Waubra on 25 August 1915.²³¹ The coroner found that both the 'chemist and the doctor had blundered in an extraordinary way in not taking proper precautions in handling a deadly drug which had caused the death of Mrs Brown and at present he could not find any excuse for them'.²³² The deceased had died from ingesting strychnine 50 times the strength ordered.²³³ The Crown alleged that Cornell was grossly negligent in dispensing the prescription, and Lade in that he left a verbal order instead of a written prescription.²³⁴ The Crown adduced evidence as to Lade's misgivings about the ingredients of the medicine

²²⁶ 'Doctor's Trial. Unexpected Ending. Crown Enters Nolle Prosequi'. *The West Australian* (Perth, WA), 30 August 1941 6.

²²⁷ Ibid.

²²⁸ Ibid.

²²⁹ 'Prescriptions by 'Phone & Letter Did Not Agree', above n 224; 'Charge Against Doctor' *The Argus* (Melbourne, Vic.), 28 August 1941 5. 'Prescriptions by Phone. Letter did not Agree', *The Courier-Mail* (Brisbane) (28 August 1941) p 7; 'Charge Against Doctor', *The Argus* (Melbourne) (28 August 1941) p 5.

²³⁰ Such as that of Dr Leonard Cyril Lade (1915) and Walter Henry Cornell (Chemist) (1915).

²³¹ 'A Woman's Death.' *Scone Advocate* (Scone, NSW), 31 August 1915 4.

²³² 'Verdict of Manslaughter. Doctor and Chemist Committed for Trial. Ballarat, Friday'. *The Ararat advertiser* (Vic.), 28 August 1915 2.

²³³ Ibid; 'Charge of Manslaughter. Making up a Prescription'. *Northern Star* (Lismore, NSW), 7 October 1915 4.

²³⁴ 'Doctor and Chemist on Trial Both Get Off. Melbourne, Oct. 5.' *Kalgoorlie Western Argus* (Kalgoorlie, WA), 12 October 1915 8, (In addition, Lade did not satisfy himself that the order was correctly taken down.)

supplied when he observed that it was contained in a green bottle worded ‘poison’ with the words ‘not to be taken’ blown into the glass. Lade had scratched off the direction ‘not to be taken’ and then handed it to the patient.²³⁵ Both Lade and Cornell were acquitted. The detail of argument is lacking, but it is known that the judge directed the jury to return a verdict of not guilty, which was done.²³⁶

The consistent finding by coronial and criminal courts has been that medication error alone will not be sufficient for a finding of manslaughter. Criminal juries also have, in more recent cases, maintained this perspective where the intimate relationship between medication error, systems failure and of breakdown in clinical procedures is evident. This includes deviating from the finding of coronial inquests, such as occurred in the case of Perth surgeon Dr Alan Gray (1946). Gray was committed to trial after Coroner FEA Bateman found Gray had been negligent in his treatment of a patient, leading to her death. Ann Elizabeth Aitken, of Cannington in Western Australia,²³⁷ died on 16 May 1946 whilst at Perth Hospital undergoing a tonsillectomy.²³⁸ The cause of death was medication error – the injection of pantocaine instead of procaine – causing cardiorespiratory failure. Gray, her surgeon, was committed for trial for manslaughter, after a coronial inquest where the coroner, reflecting on Gray’s performance, noted that ‘it is the duty of the medical practitioner to use proper skills and caution in the treatment of all patients’.²³⁹ Gray was tried in the Supreme Court before Sawyer CJ and found not guilty of manslaughter.²⁴⁰ It was reported that the surgeon almost fainted when informed of the verdict.

²³⁵ ‘Doctor and Chemist on Trial Both Get Off. Melbourne, Oct. 5.’, above n 234.

²³⁶ ‘Alleged, Manslaughter. Doctor and Chemist Acquitted. Melbourne, Wednesday’. *Barrier Miner* (Broken Hill, NSW), 6 October 1915 2; ‘Doctor Acquitted of Manslaughter’. *The North Western Advocate and the Emu Bay Times* (Tas.), 7 October 1915 3.

²³⁷ Aitken is the only person in the cohort for whom a picture accompanies the reporting of the trial associated with their death: ‘Surgeon Almost Faints When Found Not Guilty Of Manslaughter Of Young Girl Patient’ *Mirror* (Perth, WA), 17 August 1946 11.

²³⁸ Dr Gray was also a medical officer on HMAS Sydney, whose action in performing an urgent appendectomy whilst Sydney was dive-bombed in the Mediterranean was recounted in another article of the time, ‘Perth Doctor Operates With Dive-Bombers Attacking Ship’ *Mirror* (Perth, WA), 29 April 1944 18.

²³⁹ ‘“Accident Every Surgeon Dreads” Cost Girl’s Life’ *Mirror* (Perth, WA), 13 July 1946 18.

²⁴⁰ ‘Surgeon Almost Faints When Found Not Guilty Of Manslaughter Of Young Girl Patient’, above n 237.

While it seems relatively easy to understand the various actions and errors at the centre of these newly unearthed Australian cases, even from the mid-nineteenth century, some cases seem almost unreadable within contemporary expectations and practices of medicine. The case of Dr Loughnan (1911) is illustrative. A coronial inquest was held at the Daylesford Hospital in Victoria into the circumstances surrounding the sudden death of Elizabeth Ann Bell on 20 November 1911.²⁴¹ The coroner found that the death was due to heart failure ‘induced by influenza, hard work and worry’.²⁴² Loughnan had been called to consult on the patient either at a late hour or in other circumstances wherein he claimed that it was medical etiquette not to consult. Commenting on Loughnan’s refusal to attend the patient when called, the coroner said that ‘if that was medical etiquette, the sooner it was amended the better’,²⁴³ noting that he was not placing blame for the death on Loughnan, but that in cases of life and death it would be better if medical etiquette were set aside. Whether Loughnan’s case is best understood as sheer callous disregard for the life of a patient, or punctilious regard to the limits of his duty, is unclear.²⁴⁴

Dr Frederick Hillman Hornbrook, sentenced at the Goulburn Assizes in April 1864 to two years’ imprisonment for the manslaughter of Levi Angel Smith, had administered an overdose of sulphuric acid at Araluen on 27 February 1864. The case for the Crown was that the patient had been administered 210 drops of sulphuric acid rather than sixteen drops, which was the full dose for an adult. When Hornbrook had been called on to

²⁴¹ “‘Medical Etiquette.’ Strong Remarks by Coroner’. *Barrier Miner* (Broken Hill, NSW), 29 November 1911 2.

²⁴² *Ibid.*

²⁴³ *Ibid.*

²⁴⁴ In a strange turn of events, Loughnan himself was to become the victim himself to death at the hands of a doctor some 25 years later. In 1936, Dr Bothamley entered a police station and announced that “I have killed Dr Loughnan in my surgery”, ‘Doctor’s Death After Struggle in Surgery. Coroner’s Finding of Manslaughter. Melbourne, Friday.’ *The Sydney Morning Herald* (Sydney, NSW), 14 December 1935 18; At the surgery, Bothamley said to police: ‘we had a few words about an agreement. I was giving him a post-dated cheque when he called me a ----, and grabbed me by the throat. He nearly choked me. When we got up, Loughnan rushed at me. I hit him two or three times with a tyre lever.’; Bothamley produced the agreement for the purchase of the practice where Bothamley agreed to pay Loughnan 1,000 pounds by 3 May 1935 and 1,125 pounds in four half-yearly instalments. Bothamley told Loughnan that he might delay for three months writing out a post-dated cheque to 1 January 1936. He denied that he had post-dated the cheque because he did not have the money, stating that he had only done so because Dr Loughnan had not kept to his agreement. He claimed self-defence from the choking attack. He was found not guilty of manslaughter, ‘Manslaughter Charge. Melbourne Doctor Acquitted. Melbourne, Friday.’ *The Western Champion* (Barcaldine, Qld.), 21 March 1936 12.

attempt to revive the victim, he was found outside Lucio's public house, and according to the witness appeared to be sober, but looked as if he had had some alcohol.

The doctor proceeded to the chemist where he wrote out a prescription for Angel. It was reported that the person who was asked to dispense the medicine hesitated and queried the amount of sulphuric acid to be dispensed. Hornbrook, in the meantime, went across the road to a nearby pub, ordered three nobblers of brandy, and then returned to the chemist. The chemist had not made up the medicine; Dr Hornbrook then spoke to the chemist, at which point he took a small bottle and filled it about one-third full of liquid. Hornbrook left with the bottle to attend to Angel. The following day, a witness reported visiting Angel, noting that a black bottle stood on a nearby table filled with brandy. Hornbrook took a drink from the bottle while he attended to Angel. Once Hornbrook had left the house, the deceased was reported to have said to the witness that Hornbrook had been drunk and had given him two teaspoonfuls of the sulphuric acid medicine, noting that he had a burning pain in his chest, with another witness noting that Hornbrook was 'so drunk he could not walk straight'.²⁴⁵

5 *Failure to Convict & Sentences*

The dominant theme of Australia's history of prosecuting manslaughter by criminal negligence in the healthcare setting is the overwhelming failure to secure conviction. Including *R v Valentine*,²⁴⁶ my work to reconstruct the history of medical manslaughter prosecution adds merely four successful convictions to the literature: *Hornbrook* [1864], *Zimmler* [1871], *R v Pearce*,²⁴⁷ and *R v Gary Gow*.²⁴⁸

Australian prosecutorial activity and the incidence of successful prosecutions falls well below other jurisdictions where data is available. During a similar time period, the UK, for example, experienced twenty-five convictions – some five times the number of convictions (albeit since 1795 and with an exponentially larger pool).²⁴⁹ Comparative data from more recent times gleaned from Quick's investigation of prosecutions in that jurisdiction showed that from 1976, for example, fourteen healthcare practitioners were convicted in

²⁴⁵ 'Manslaughter by a Medical Practitioner.', above n 120.

²⁴⁶ [1842] TASSupC 4 (7 January 1842).

²⁴⁷ *Pearce* [2000] Queensland Supreme Court Indictment No 96 of 2000 (15 November 2000); *Medical Board of Queensland v Pearce* [2001] QHPT 004 (20 July 2001).

²⁴⁸ *Gow* [2006] NSWDC 78 (27 October 2006).

²⁴⁹ Ferner and McDowell, above n 9.

the UK, compared to just two in Australia.²⁵⁰ Again, the Australian experience falls well behind that in the United Kingdom.

Drawing conclusions based on a simple comparison with the prosecutorial experience of the UK, a jurisdiction with a far larger population and different legal and healthcare systems and culture, is perhaps unwise. However, a more valid conclusion remains available without the need of comparison; Australian prosecutorial activity as a whole has been predominantly unsuccessful.

The distinct lack of success in prosecution is a feature from the earliest cases right up to the most recent. For instance, whilst *R v Gow* and *R v Pearce* are two successful prosecutions of recent times, they are joined by a string of unsuccessful prosecutions. These unsuccessful prosecutions include *R v Pegios*,²⁵¹ Dr Gerritt Reimers,²⁵² Dr Bruce Ward,²⁵³ Dr Oakley Robert Small,²⁵⁴ Dr Atlee Clarke,²⁵⁵ Drs John Ewan McDonald Gill and John Tennant Herron, both of the Chelmsford Hospital disaster,²⁵⁶ and, in particular, the various Patel cases.²⁵⁷

²⁵⁰ Quick's analysis took into account all healthcare practitioners, whilst my study focused on medical practitioners, no other practitioner was found to have been found guilty during that period. Quick, 'Medical Manslaughter: The Rise (and Replacement) of a Contested Crime', above n 8, 33.

²⁵¹ *Pegios* [2008] NSWDC 105 (2008).

²⁵² See Dobinson, 'Medical Manslaughter', above n 2, 110.

²⁵³ Dr Bruce Ward was charged and then had his charges dropped before trial, see *ibid* 102; see also, *Inquest into the Death of Nardia Annette Cvitic* [2007] Brisbane Coroner's Court COR/02 2727 (29 October 2007).

²⁵⁴ 'Doctor Asks Court to Drop Death Charge' *The Cairns Post* (Cairns, Qld.), 15 February 2003 027.

²⁵⁵ *The Matter of Dr Atlee Louis Clarke* [2000] Medical Tribunal of New South Wales No. 40029\98 (15 June 2000).

²⁵⁶ Chelmsford Hospital was a small cottage hospital in the Northern suburbs of Sydney where, during the 1960s and 1970s, four doctors administered "Deep Sleep Therapy", resulting in the death of 26 patients and the suicide of a further 22. A Royal Commission was called and various disciplinary charges were laid. Criminal charges against Dr Bailey in 1985, ended with his suicide shortly afterwards. Disciplinary proceedings against Drs Herron and Gill ceased with the High Court upholding a permanent stay of proceedings due to protracted delays brought about by virtue of extended legal disputes launched by the defendants. So too were criminal charges similarly dropped, with the Director of Public Prosecutions choosing not to proceed with manslaughter charges against Drs Herron and Gill after the Supreme Court issued a stay of criminal proceedings citing concern that they would not be able to receive a fair trial. See New South Wales, *Report of the Royal Commission into Deep Sleep Therapy* (1990).

²⁵⁷ *R v Patel* [2010] QSC 233; conviction confirmed in *Patel 3* [2011] QCA 81 (21 April 2011); all convictions overturned in the High Court appeal on the basis of a serious miscarriage of justice, *Patel* (2012) 247 CLR 531; Patel was to be re-tried on each previous count of homicide in separate trials, however, this strategy was later aborted, and Patel was found guilty of a series of criminal fraud charges, see *R v Patel* [2013] District Court of Queensland Indictment No 1701 of 2013 (21 November 2013).

This lack of success remains clear even when we consider the five cases that were in fact successfully prosecuted. Most notable in this regard is the 1864 case of Dr Hornbrook, who administered sulphuric acid at some thirteen times the maximum dose.²⁵⁸ As described above, Hornbrook was so drunk ‘he could not walk straight’ at the time,²⁵⁹ was found guilty, and served approximately one month of his two-year sentence.²⁶⁰ Even in this early case of a successful prosecution, Hornbrook was released by virtue of a vice-regal pardon.²⁶¹ Notably, the pardon followed post-sentence lobbying of the trial judge by the local private medical fraternity of Goulburn,²⁶² a campaign to which a letter to the editor by an anonymous ‘lover of justice’ attests.²⁶³ It seems that even of the very limited five convictions now known to the literature, only four prosecutions were truly successful.

For those few who were convicted, sentences were delivered with a profound sense of regret and of mercy in each of the successful prosecutions. The case of Valentine, which is known to the literature, resulted in a fine of £25 rather than a custodial sentence.²⁶⁴ The Attorney-General of Tasmania, who prosecuted the case, spoke of Valentine’s moral blamelessness and the heavy and difficult burden of conviction. This pattern extends to cases much closer to our own time. Dr Margaret Pearce (2000), Queensland’s first conviction, and Dr Gary Gow (2006),²⁶⁵ both received sentences that included custodial terms – Gow receiving an 18-month suspended sentence and Pearce a five-year sentence with six months of incarceration.²⁶⁶ Pearce had administered 15 milligrams of morphine to a 15-month-old child; the correct dosage was 1.5 to 3 milligrams.²⁶⁷ She had not taken a medical history of the child, nor had she advised the type of drug being administered or any risks associated with it.²⁶⁸ In a submission to re-open her case after sentence, the Crown argued that at the time of the manslaughter Pearce was facing disciplinary

²⁵⁸ ‘Manslaughter by a Medical Practitioner.’, above n 120.

²⁵⁹ Ibid.

²⁶⁰ ‘Goulburn. Wednesday’. *Empire* (Sydney, NSW), 28 April 1864 4.

²⁶¹ ‘The Empire: The Case of Dr. Hornbrook’ *Empire* (Sydney, NSW), 2 September 1864 4.

²⁶² Ibid; ‘To the Editor of the Queanbeyan Age.’ *Queanbeyan Age and General Advertiser* (Queanbeyan, NSW), 1 September 1864 2.

²⁶³ ‘To the Editor of the Herald and Chronicle.’ *The Goulburn Herald and Chronicle* (Goulburn, NSW), 30 April 1864 5.

²⁶⁴ *R v Valentine* [1842] TASSupC 4 (7 January 1842).

²⁶⁵ *Gow* [2006] NSWDC 78 (27 October 2006).

²⁶⁶ ‘Doctor given Suspended Sentence over Death of Patient’, above n 102.

²⁶⁷ *Medical Board of Queensland v Pearce* [2001] QHPT 004 (20 July 2001) (O’Brien J, Dr Richards, Dr Doughty, Member Langley) [3].

²⁶⁸ *Pearce* [2000] Queensland Supreme Court Indictment No 96 of 2000 (15 November 2000); ‘She Went to the Clinic with a Burnt Hand - the Next Day She Was’ *Adelaide Advertiser* (Adelaide, SA), 10 July 1999 28.

proceedings for self-administering pethidine during 1998 and 1999 and was not permitted to keep a range of drugs in her surgery, including morphine,²⁶⁹ a drug that she had to hand, administered, and that caused the slow death of her patient. In New South Wales at that time, 96.2 per cent of all convictions for manslaughter received a prison sentence; the average aggregate sentence was seven years with an average minimum of 4.5 years.²⁷⁰ Yet, Gow was able to practise medicine after being found guilty of manslaughter with restrictions on his practice.²⁷¹ Pearce, who had voluntarily de-registered herself in 2000 after being found guilty of manslaughter, was entitled to practise after having served a suspension of two years.²⁷² The Queensland Health Practitioners Tribunal noted that the manslaughter finding and inability to practise medicine ‘had a devastating effect on her life’.²⁷³ The tribunal noted the ‘public shame and humiliation’²⁷⁴ associated with the court proceedings, as well as financial suffering that had caused her to ‘find employment as a taxi driver’.²⁷⁵ She received a two-year suspension of her registration running from the date of criminal sentence. A new registration was granted in March 2003, while she was still serving a suspended sentence for manslaughter.

6 *Successful Prosecution: Violations*

What are we to make of this cohort of newly unearthed cases, some of which I have recounted here? I see primarily that they demonstrate a quite remarkable level of consistency both with the UK’s historical experience, and in their tendency to cohere around a limited number of themes. Ferner and McDowell report that their cases fall into the same themes as I find here. Of the numerous possibilities from which negligent death might arise, it is these specific themes that dominate the criminal prosecution of them. Why this might be the case is something that could be better explained in a further study.

Like Ferner and McDowell in their study of UK charges and prosecutions, I have attempted to classify the Australian cases as predominantly caused by mistakes, slips (or

²⁶⁹ Byron Vale, ‘GP Known for Taking Painkillers, Court Told’ *The Courier-Mail* (Brisbane, Qld.), 18 November 2000.

²⁷⁰ Isabel Taussig, ‘Sentencing Snapshot: Homicide and Related Offences’ (Bureau Brief Issue Paper no. 76, February 2012) 2–3
<<http://www.bocsar.nsw.gov.au/agdbasev7wr/bocsar/documents/pdf/bb76.pdf>>.

²⁷¹ *Health Care Complaints Commission v Arthur Garry Gow* [2008] NSWMT No 40011.

²⁷² *Medical Board of Queensland v Pearce* [2001] QHPT 004 (20 July 2001).

²⁷³ *Ibid* [9].

²⁷⁴ *Ibid*.

²⁷⁵ *Ibid*.

lapses), technical errors, and violations.²⁷⁶ As described earlier, according to that taxonomy, *mistakes* are errors in the planning of an action; *slips* are errors in the execution of an action often resulting from distraction or momentary failure of concentration; *technical errors* occur when there is a failure to carry out an action successfully even if the plan of action and technique are appropriate; and *violations* involve a deliberate deviation from safe practices. One significant problem with this taxonomy is that the key criterion for determining culpability is the intent, or rational choice, of the accused. Merry and McCall Smith develop and rely on a very similar taxonomy and they, like others in this field, support criminal prosecution only where a ‘violation’ occurs.²⁷⁷ For Ferner and McDowell, too, a violation represents an ‘understandable’ reason for prosecution, whilst the others do not. For them, ‘deliberately violating rules’ contrasts with the ‘unconscious’ (and thus non-culpable) errors that ‘are an inescapable consequence of human actions and [in relation to which] prosecution of individuals is unlikely to improve patient safety’.²⁷⁸ Because of this structuring of the taxonomy, by necessity very many instances of action understood to be negligent – that is without a ‘conscious’ violation of the rules – will fail to be regarded as culpable. The taxonomy maps relatively closely – albeit in language other than that used by the criminal law – to the subjectivist/objectivist divide in criminal law.²⁷⁹ Yet it does so in a way at odds with the actual requirements of manslaughter by criminal negligence. It attempts to separate culpable intentional violations of rules from all other (non-culpable) forms of action causing death. This situates both the subjective intention of the practitioner and the notion of ‘choice’ at the centre of culpability ascription. In contrast, consideration of culpability by manslaughter by criminal negligence is unconcerned with the conscious or unconscious basis of the practitioner’s relevant act or omission, focusing instead upon whether that act or omission itself demonstrates, in the words of Berman JCD in the case of *R v Gow*, the ‘objective gravity’²⁸⁰ that a ‘gross breach... of what is required of [the practitioner]’²⁸¹ represents.²⁸²

²⁷⁶ Ferner, above n 18; Reason, above n 110.

²⁷⁷ Merry and McCall Smith, above n 10; Merry and Brookbanks, above n 6.

²⁷⁸ Ferner and McDowell, above n 9, 309.

²⁷⁹ See especially the discussion of this divide as it maps onto the debate in relation to iatrogenic harm in Chapters 3-5 especially.

²⁸⁰ *Gow* [2006] NSWDC 78 (27 October 2006) [25].

²⁸¹ *Ibid* [27].

²⁸² This matter I take up more fully in later chapters.

Subject to that important disclaimer, what does the extended body of Australia cases show us about culpability according to the taxonomy? Of the 27 manslaughter charges, 16 resulted from violations; of those 16, four resulted in findings of guilt. No findings of guilt have been made for any other category of error (slip/lapse, technical error, and mistakes) in the Australian cohort of cases as unearthed and extended here. It seems then that, indeed, the most egregious category of cases lead to findings of guilt, and the least egregious never do. Moreover, manslaughter convictions have only occurred in cases of deliberate deviation from safe practices.

In conclusion, the newly unearthed cases presented here do ‘cluster’ around a set of persistent characteristics. Moreover, there is a pronounced consistency between these characteristics or themes in the Australian experience and those unearthed by Ferner and McDowell in the United Kingdom. Furthermore, using the classification widely used in the field – slips, lapses and violations – these Australian cases seem to demonstrate that criminal law can and does distinguish between culpable and non-culpable instances of harm, even on the more restricted limits set by that taxonomy.

C *Inconsistency: The Absence of Pressing & Sustained Criticism of Individual Cases or of Prosecutorial Action in the Australian Experience*

In the section above, I was able to classify the newly unearthed Australian cases of manslaughter by criminal negligence according to a persistent set of characteristics or themes. These characteristics or themes were consistent with those used by Ferner and McDowell to classify their cohort of prosecutions in their own jurisdictional context. I concluded that this speaks to a consistency not only within the cohort of cases, but also between the prosecutorial experiences of these different jurisdictions.

In this section, I wish to highlight what is absent from the cohort of cases and the history of prosecution in Australia – namely, that the kind of pressing and sustained criticism of individual cases or of prosecutorial action in general that we see in other jurisdictions, and within the literature about criminal prosecution for iatrogenic harm, is conspicuously absent from the Australian experience.²⁸³ The Australian experience simply does not generate the kind of criticism seen in the United Kingdom or New Zealand, as described in

²⁸³ Namely, the United Kingdom and New Zealand where significant conflict has emerged about the use of criminal prosecution as a response to iatrogenic death.

the opening sections of this chapter. Nor, I believe, does the history of prosecution in this jurisdiction give cause for it.²⁸⁴

Recall that at the opening of this chapter I wrote about the centrality of the historical record of prosecutions for scholarship to the question of criminal responses to iatrogenic death. I wrote there that scholarship that engages with the prosecution of manslaughter by criminal negligence generally begins with an account of the historical incidence of prosecution, or with a recent and noteworthy case. The role of the entire body of cases and of those ‘recent and noteworthy’ examples is to provide both justification for reviewing the situation of criminal prosecution, and fuel for the arguments against its use. A range of writers provide arguments surrounding the ‘harsh implications of criminal punishment’²⁸⁵ and its overuse based in this way. Within that group, Sidney Dekker provides some of the most sustained reflection upon the personal cost of iatrogenic harm and prosecution, explicitly situating a major part of this critical project as focused directly upon criminal law’s narrativisation by analysing particular cases. The case of Mara²⁸⁶ – a Swedish paediatric ICU nurse who was charged with a form of negligent manslaughter – forms the centre of his reading of the criminal law.²⁸⁷ Following that criminal case, he concludes that the criminal legal system

constructs an account from its own pick of the evidence. It makes its own story. It is interesting that society may turn increasingly to their legal systems to hand out that story, to provide accountability after a terrible outcome. There must be something in that account that we find terribly attractive; more enticing than what the people have to say who were actually there.²⁸⁸

²⁸⁴ The single exception might be the prosecution of Jayant Patel, discussed below. However, criticism there is not of the same character as that experienced overseas; rather, that series of cases has been criticised – albeit lightly – for the Crown’s *failure* to successfully prosecute cases related to Patel’s time at Bundaberg Base Hospital.

²⁸⁵ Merry, ‘When Are Errors a Crime?—Lessons from New Zealand’, above n 10, 68 see also #.

²⁸⁶ Known to the Court as ‘EH’, in the case generally referred to as the ‘Kalmar case’, see *Case of ‘EH’* 2006 NJA 228; see also ‘Decision of the Swedish Supreme Court (Högsta Domstolens) in the Matter of EH (b 2328-05)’, above n 211.

²⁸⁷ The narrative forms the prologue to his major work on accountability and safety, *Just Culture*. The entire narrative is well-worth reading, particularly for the tone developed by Dekker, which is difficult to reproduce, Dekker, above n 7.

²⁸⁸ *Ibid* location 367.

For Dekker, this case shows how ‘[p]aradoxically, when the legal system gets involved, things seem to get neither more just, nor safer... In fact, with the evidence in hand, you could argue that the opposite happens’.²⁸⁹

If the case of Mara is emblematic for Dekker, then the case of *R v Yogasakaran* performs the same role for Alan Merry.²⁹⁰ Dr Yogasakaran was an anaesthetist who had anaesthetised a high-risk patient in a small peripheral hospital in New Zealand for removal of their gall bladder.²⁹¹ With a complication emerging at the end of the anaesthetic, Dr Yogasakaran chose to administer a neurological stimulant to hasten arousal. Dr Yogasakaran instead injected a highly-concentrated dose of dopamine, which caused cardiac arrest. The patient ‘went on to die’ (as Merry puts it) after resuscitation efforts and transfer to an ICU at the base hospital. The dopamine had been stocked in the usual place of the neurological stimulant Doxapram. Yogasakaran was charged with manslaughter, and was found guilty.

Merry cites the High Court of New Zealand’s reference to the Crown case (‘The Crown says Dr Yogasakaran is a highly trained, experienced, responsible man whom the Crown says made a mistake, through carelessness, on this one occasion’)²⁹² and then concludes that ‘[t]his seems an extraordinary basis for convicting a doctor of (arguably) one of the worst crimes on the books’.²⁹³ In reading this particular case, Merry complains that in rejecting the question of a defence on grounds of necessity, the Court of Appeal ‘appears to take the position (in effect) that emergencies do not occur in hospitals, but only in situations such as (for example) motor vehicle accidents at the side of the road’.²⁹⁴ The Court was clear, however,

[t]hat exception [of necessity] is plainly intended to cover the case of persons unqualified or insufficiently qualified who in emergencies undertake surgical or medical treatment or the like. It is not intended to emancipate a professional medical practitioner from the exercise of

²⁸⁹ Ibid location 547.

²⁹⁰ [1990] NZLR 399 (‘*Yogasakaran*’).

²⁹¹ Merry and McCall Smith, above n 10, 12–15, 146.

²⁹² *Yogasakaran* [1990] NZLR 399; See especially the discussion at [4.2] of Merry, ‘When Are Errors a Crime?—Lessons from New Zealand’, above n 10, 77.

²⁹³ Merry, ‘When Are Errors a Crime?—Lessons from New Zealand’, above n 10, 72.

²⁹⁴ Ibid 74–75.

reasonable professional care and skill in an emergency... The statutory exception... was needlessly introduced into the present case.²⁹⁵

Yet, for Merry, this case stands as a significant part of a ‘change of pace’²⁹⁶ for medical-related manslaughter prosecutions. By 2004, he writes, ten New Zealand health professionals had been charged with manslaughter.²⁹⁷ Merry argues that they faced charges for activities that were in the normal conduct of their work and that the ‘remarkable point is that these were not crimes in the common sense’,²⁹⁸ citing fraud, rape or assault as exemplars of ‘crimes’.²⁹⁹

Writing in a *British Medical Journal* review of Merry and McCall-Smith’s significant work on the topic,³⁰⁰ Neville W. Goodman, an anaesthetist, demonstrates the elision of concerns for the impact and outcome of tortious and criminal negligence. He writes that the ‘present state of medico legal matters offends for many reasons and at many levels’.³⁰¹ The nature of the entire picture of ‘legal regulation’ of medicine is one that offends against the principle of distributive justice ‘a way for a few to take resources from the many’,³⁰² where, perhaps taking some license, ‘large swathes of the US [are now] with no obstetricians’.³⁰³ This claim was made amidst the high profile cases of *R v Adomako*,³⁰⁴ and *R v Misra*,³⁰⁵ which have operated as significant flash-points in the debate regarding manslaughter by criminal negligence prosecutions for iatrogenic death in the UK.

However, the Australian experience of criminal prosecution has been far more muted. The first scholarly writing on the topic of criminal prosecution, co-authored by Alan Merry and other leading figures in the field,³⁰⁶ does not call out the Australian prosecutorial experience as unsatisfactory, or find in it a source of controversial cases like that of Mara,

²⁹⁵ *Yogasakaran* [1990] NZLR 399, 405.

²⁹⁶ Merry, ‘When Are Errors a Crime?—Lessons from New Zealand’, above n 10, 74.

²⁹⁷ *Ibid.*

²⁹⁸ *Ibid.*

²⁹⁹ *Ibid.*

³⁰⁰ NW Goodman, ‘Book: Errors, Medicine and the Law’ (2002) 324(7332) *BMJ* 304.

³⁰¹ *Ibid.*

³⁰² *Ibid.*

³⁰³ *Ibid.*

³⁰⁴ *R v Adomako* [1995] AC 171 (1995) (‘*Adomako*’).

³⁰⁵ *R v Misra and Srivastava* (2005) 1 Cr. App. R. 21 (‘*Misra*’); *R v Misra and Srivastava* [2004] EWCA Crim 2375 (2004) (‘*Misra*’).

³⁰⁶ William B Runciman, Alan F Merry and Fiona Tito, ‘Error, Blame, and the Law in Health Care—an Antipodean Perspective’ (2003) 138(12) *Annals of Internal Medicine* 974. See the discussion of this paper and the surrounding context in Chapter Two.

Yogasakaran, Misra or *Adomako*. In the historical sources consulted for this chapter, the newspaper reports do not reflect or respond to widespread, serious or sustained critique of the Courts, nor of the prospect or experience of prosecuting medical practitioners. Importantly, this includes the more recent case law, for attitudes may have shifted over time. Instead, if anything, the most recent cases of *Gow, Pearce, Pegios* and *Patel* are all reported by the general medical media in a manner free of the pronounced critique similar prosecutions have produced in other jurisdictions.

V. CONCLUSION

This account of cases of manslaughter in the medical context generated in Australia is significant. From five known prosecutions of doctors and one of a dentist, there is now access to an expanded case history of 33 previously little-known narratives of iatrogenic death that engaged coronial and judicial processes. This is an original and important contribution to our knowledge of the prosecution of this complex crime, in an important area of its use.

There are two main conclusions I draw from this newly expanded account of the actual experience of prosecution in the Australian context. First, there a consistent ‘clustering’ of cases around a set of persistent characteristics, including the type of adverse event, error or behaviour concerned, the role of the coroner, the characteristics of victims and defendants and the issue of recidivism and repeat offending. In particular, the question of qualified/unqualified practitioners, unsafe abortions, and medication error are key themes. Second, prosecutions frequently fail to secure conviction. Including the single successful conviction already known to the literature, *R v Valentine*,³⁰⁷ we now know of just four additional convictions: *Hornbook* [1864], *Zimmler* [1871], *R v Pearce*,³⁰⁸ and *R v Gary Gow*.³⁰⁹ From all the cases that reached charges and trial, only five led to conviction.

Whilst I hold some reservations regarding the application of a taxonomy drawn from quality and safety science to criminal cases – particularly without the benefit of their entire case history and evidence – ‘violations’ form the absolute heart of prosecutions in

³⁰⁷ [1842] TASSupC 4 (7 January 1842).

³⁰⁸ *Pearce* [2000] Queensland Supreme Court Indictment No 96 of 2000 (15 November 2000); *Medical Board of Queensland v Pearce* [2001] QHPT 004 (20 July 2001).

³⁰⁹ *Gow* [2006] NSWDC 78 (27 October 2006).

Australia. Expressed in terms of individual victims/cases, violations accounted for 18 of 29 individual cases (62%).³¹⁰ It appears the majority of criminal prosecutions in Australia relate to violations,³¹¹ the one category for which the majority of the broader literature supports the availability of criminal prosecution. Compared with Ferner and McDowell, who report a minority of prosecuted cases being violations, this is a distinct pattern. The place of violations at the heart of the prosecutorial experience in Australia bears out under further, more detailed, analysis. For example, the only previously known conviction, that of Dr Valentine (1843), is joined now by that of Dr Hornbrook (1864),³¹² Charles Zimmer (1871), Dr Margaret Pearce (2000) and Dr Arthur Garry Gow (2004). Each of these ‘new’ convictions is classified as a violation. Thus, every successful conviction in Australia relates to an instance the literature would likely classify as a violation. Across such violation cases, only four of twelve defendants or co-defendants (33 per cent) were found guilty, suggesting that even the most seriously failed behaviour does not automatically or directly lead to conviction.

On balance, the Australian criminal law and its associated prosecutorial processes have demonstrated they can successfully and sustainably differentiate between culpable and non-culpable instances of harm. Yet this conclusion risks leaving the picture of the Australian experience too neatly stated. The ‘historical record’ presented here is really only the record of attempted prosecutions that were able to be recovered from available sources. It is not a ‘record’ of prosecutorial decision-making, or even a ‘record’ of the nature and scale of medical malpractice, or of iatrogenic harm, or of the complete engagement of the criminal justice system with iatrogenic death. Whilst what has been uncovered represents something very important, it is also crucial not to misstate what we can learn from it.

³¹⁰ Again, excluding those reported with involved the provision of a termination of pregnancy. Note also that some practitioners were charged with multiple counts or multiple times (e.g. Patel, Spark and Davies). Here I report simply on defendants or co-defendants for each of comparison with the Ferner and McDowell. For a case-by-case analysis, see Table 1 at Part IV. Note well, that this modifies results in a particular way, that is, particularly for Patel and Spark and Davies who were subjects of multiple cases, this increases the percentage of cases that were violations, but where the defendants were found not guilty. This is an approach to analysis that errs on the side of lowering support for my contentions made here, and thus reduces the sense by which data are being manipulated to support an argument.

³¹¹ Compare with Ferner and McDowell who report a minority of prosecuted cases being violations.

³¹² Who was later pardoned. See above.

As stated in the introduction to this thesis, my position is that the arguments mounted for the rejection of manslaughter by criminal negligence are based in large part upon an insufficient understanding of the criminal law in this field; of its history, its view of human action, and its mobilisation in the courtroom. This new historical analysis of actual practices of criminal law in the Australian setting offers a significant contribution to filling out our understanding of the use of criminal negligence in this setting over time. It also functions as a corrective to the orthodox paradigm's representations of manslaughter by criminal negligence as it applies to iatrogenic harm, seriously destabilising claims – as have been made in relation to other jurisdictions – that criminal negligence prosecutions represent a controversial or contentious practice.

Given this situation, where the experience of the use of manslaughter by criminal negligence in response to iatrogenic death has been able, on balance, to differentiate between culpable and non-culpable instances of iatrogenic death and has been marked by a lack of serious or sustained criticism, it seems an open question as to how we have come to labour under the understanding that criminal prosecution is unhelpful, unsuccessful and inimical to advancing healthcare safety, as proposed by the dominant view in the quality and safety science literature. Examining why this might be so is a challenge I take up in the next chapter.

THE ‘DISCOVERY’ OF IATROGENIC HARM: LAW’S ROLE IN THE QUALITY AND SAFETY MOVEMENT

CHAPTER TWO

I. INTRODUCTION

I showed in the previous chapter that the criminal law has been both rarely and judiciously deployed in cases of iatrogenic death in Australian legal history.¹ The actual prosecutorial experience in response to iatrogenic death in Australia demonstrates an ability, on balance, to differentiate between culpable and non-culpable instances of iatrogenic death and has been marked by a lack of the kind of pressing and sustained criticism of individual cases or of prosecutorial action in general seen in other jurisdictions. Based on that reading of the newly uncovered case law, I raised the seeming inconsistency between the actual experience of prosecution in Australia and calls for the rejection of criminal negligence prosecution. I asked how it was that we had now come to labour under the idea that criminal prosecution is unhelpful, unsuccessful and somehow opposed to advancing healthcare safety, as argued by the dominant view in the quality and safety science literature, when the history of its use was well-accepted, seemingly unremarkable and essentially unremarked.

In this chapter, I turn to the history of the discipline of healthcare quality and safety science itself to reconsider how ‘law’, and specifically criminal law, has been framed by and within the history of that discipline as the agenda-setting ‘orthodox paradigm’² for engaging with iatrogenic harm. Within that disciplinary context, the law has commonly been framed in terms of blame and punishment and has been deemed harmful, threatening, grossly unhelpful or even counterproductive to the challenge of stemming the tide of

¹ See Chapter 1.

² Justin Waring et al, ‘Healthcare Quality and Safety: A Review of Policy, Practice and Research’ (2016) 38(2) *Sociology of Health & Illness* 198, 202 (Specifically they write, ‘The contemporary wave of interest in quality and safety has been predominantly framed by concepts and theories found within medical science, social psychology, ergonomics, human factors and resilience engineering. Rather than seeing errors as the result of individual mistake or failure, which tends towards blaming and encouraging secrecy, the prevailing view is that individual or group performance is conditioned by a variety of upstream factors located in the wider system of care, such as the quality of teamwork or communication, the allocation of tasks, workload scheduling, equipment and resource management, and broader service cultures.’).

iatrogenic harm and death in contemporary healthcare settings.³ From this premise, I work through how it is that the quality and safety movement and criminal law have come to be in such deep and currently intractable conflict. In common with the overarching claim of this thesis, I conclude that the arguments for the rejection of manslaughter by criminal negligence have not been sufficiently attentive or responsive to the history of the law's use in this field. In particular, the history of the discovery of iatrogenic harm and the responses to it during the 1990s in Australia demonstrate how and, in a sense, why criminal law has come to be regarded as so unhelpful and unsuccessful.

First, the chapter presents a history of the 'discovery'⁴ of iatrogenic harm in Australia during the 1990s and early 2000s. This represents the first known critical historical account of the discovery of iatrogenic harm and responses to law that it engendered in Australia.⁵ This is a pivotal period in the history of Australian engagement with iatrogenic harm, and I have drawn on a variety of archival sources to piece together key events and debates in the discovery of iatrogenic harm, as well as responses to it by the public and the medical community. My analysis draws to the surface how the dichotomy between the law and the quality and safety discipline developed, such that these two forms of rule came to be construed as autonomous and incompatible. As quality and safety science pursued the reduction of iatrogenic harm, the (criminal) law was expelled from this project.

Following this new historical account of the 'discovery' of iatrogenic harm, the second part of this chapter asks in more detail how law and its relationship to these adverse events in the healthcare system was constructed. It analyses how the events and debates of the period coalesced in a view that a shared jurisdiction over iatrogenic harm between law and

³ See Chapter One for a more detailed account. See also Chapter Three for a detailed reading of this process in the literature of the Quality and Safety Sciences.

⁴ I use this term following Corbett et al and Wears et al, Angus Corbett, Jo Travaglia and Jeffrey Braithwaite, 'The Role of Individual Diligence in Improving Safety' (2011) 25(3) *Journal of Health Organization and Management* 247; Robert L Wears, Kathleen M Sutcliffe and Eric Van Rite, 'Patient Safety: A Brief But Spirited History' in Lorri Zipperer (ed), *Patient Safety: Perspectives on Evidence, Information and Knowledge Transfer* (Ashgate Publishing, Ltd., 2014) 3, 4.

⁵ As I discuss below, others have also worked on the history and tensions of this period, however, very few have focused specifically on the question of medicine, and even fewer on the emergence of iatrogenic harm. Some, notably Peter Cashman, Thomas Faunce and Angus Corbett have provided analyses or argument that focuses on the false claims and false basis of tort reform based on medical indemnity pressures, however, none have provided a complete telling of the history as I do here, nor have focused on iatrogenic harm and the quality and safety sciences in this manner. See for example Peter Cashman's short, but absolutely clear indictment of claims in relation to a medical negligence crisis, Peter Cashman, 'Tort Reform and the Medical Indemnity "Crisis"' (2002) 25 *University of New South Wales Law Journal* 888.

the quality and safety sciences was unsustainable. I argue that the events of this important period in Australia forged the view still dominant in the literature: that (all forms of) law and the healthcare quality and safety disciplines remain autonomous, separately constituted, independent powers, the operation of which are wholly at odds with one another and that law reform is required to remove law's jurisdiction over iatrogenic harm.⁶ The key elements in this argument are that the period demonstrates shifting but finally successful efforts to establish (a) that tort law was to blame for problems with the medical indemnity system and thus should not be available as a form of redress; (b) that criminal law was similarly associated with unproductive blame; (c) that quality and safety disciplines were associated with productive learning and improvement; (d) that adverse events were largely unpreventable and should rarely if ever be construed as acts of negligence; and (e) that all law required reform in order to cohere with the productive activities and goals of quality and safety science. Locating these claims at the point of their historical origins, however, highlights their genesis in a medical politics centred upon the avoidance of liability or responsibility, a pre-judgment of law, and a profound and potentially wilful ignorance of reality.

After forming this new history of the discovery of iatrogenic harm and analysing the emergence of a dichotomy between law and the quality and safety movement, the conclusion to this chapter briefly highlights how this dichotomy is a false one. Contrary to the conclusion reached at the end of this period, I argue that law and quality and safety are in fact neither incompatible nor autonomous: rather, they exist in a highly dynamic, mutually constitutive relationship, one that is productive for both the formation of the field of quality and safety practice, and of its 'object', iatrogenic harm. To do so, I simply highlight the role that law played in the discovery of iatrogenic harm, in the conceptual task of defining iatrogenic harm itself, in the influx of capital that enabled the solidification of the quality and safety movement, and in the 'carve-out' of failure as the rightful purview of the quality and safety movement. In this way, I point to how law is in fact instrumentally productive for reducing iatrogenic harm and has a role to play in the quality and safety discipline.

⁶ See the Introduction to this thesis for an overview of this claim. See also Chapter Three for a development of it in relation to its implications for understanding human action, agency and control.

This is a novel and unique analysis of the history of this period. This is the only account known to exist that presents the major events that precipitated revelations of the scale and scope of iatrogenic harm, as well as the public debate and political aftermath in the Australian setting. So, too, is it a contribution to a more critical reading of the history of the contemporary quality and safety field, which has been historiographically underserved, dominated by accounts of ‘patient safety heroes’⁷ and ‘visionaries, mavericks, and revolutionaries with impeccable pedigrees and experience in some of the most prestigious hospitals in the world’.⁸ Like others who bring a critical perspective to the field, I trust that offering a more critical reading will offer a complementary view to those more mainstream accounts on important questions about ‘the role of social inequality, power and control’⁹ in the understanding of healthcare quality and safety and the role of the criminal law.

This is a period I believe to be crucial in understanding the Australian engagement with iatrogenic harm, and of contemporary engagements between it and criminal law. Highlighting the history of the discovery of iatrogenic harm and the establishment of the quality and safety sciences in Australia shows that much of the reasoning for law’s expulsion from the field of iatrogenic harm was unrelated to the actual conduct of law and that its conduct was in fact highly productive for the discipline that has attempted to displace it. These productive roles that law has played have not been previously addressed in the scholarly literature, even that small subset of literature that has entertained the possibility of a productive relationship between law and healthcare quality and safety improvement.¹⁰ Based on this finding, there is reason to consider how law might be rehabilitated and reintegrated into the engagement with iatrogenic harm and death.

⁷ Oliver Quick, *Regulating Patient Safety* (Cambridge University Press, 2017) 33.

⁸ Charles Kenney, *The Best Practice: How the New Quality Movement Is Transforming Medicine* (PublicAffairs, 2008) 13.

⁹ Waring et al, above n 2, 1.

¹⁰ The work of Black and Frakes in particular offers a much needed and much more detailed engagement with law’s instrumental effects on the micro-practices and quality and safety outcomes of medical care. The point here is rather more foundational, but nonetheless important, that the relationship has been productive in a range of ways (which deregulation and law reform in fact effaces and threatens), see for example Karl Y Bilimoria et al, ‘Association Between State Medical Malpractice Environment and Surgical Quality and Cost in the United States’: (2016) 263(6) *Annals of Surgery* 1126; Myungho Paik, Bernard Black and David A Hyman, ‘The Receding Tide of Medical Malpractice Litigation: Part 1-National Trends’ (2013) 10(4) *Journal of Empirical Legal Studies* 612; Myungho Paik, Bernard Black and David Hyman, ‘The Receding Tide of Medical Malpractice Litigation: Part 2-Effect of Damage Caps’ (2013) 10(4) *Journal of Empirical Legal Studies* 639; Daniel P Kessler, ‘Evaluating the Medical Malpractice System and Options for Reform’ (2011) 25(2) *The Journal of Economic Perspectives: A Journal of the American Economic Association* 93; Michael D Frakes, ‘The Surprising Relevance of Medical Malpractice Law’ [2015] *The University of Chicago*

II. THE 'DISCOVERY' OF IATROGENIC HARM

The extent of iatrogenic harm in Australia was first accounted for during the early 1990s. It was 'discovered'¹¹ as an unexpected by-product of a government inquiry into the sustainability of the medical indemnity insurance system.¹² At the time, civil negligence claims were said to be exploding in number and medical indemnity costs were rising.¹³ The medical community, arguing that the system was buckling under the senselessness of healthcare practitioners being held to account for harm through law, pushed for tort reform, including the possibility of a no-fault indemnity scheme. However, in that attempt to avoid legal liability for negligence, far greater levels of harm than had been imagined were revealed. So, too, were claims of a legal source of the medical and indemnity system's woes revealed to be baseless. In fact, it was the indemnity provider's own mismanagement that was the source of their troubles. Despite this evidence being available at the time, reform of the allegedly broken legal system and its practices of blaming still occurred. What emerged was a wholesale 'reform' of civil liability across the nation, and the continued rejection of criminal law's validity in relation to cases of iatrogenic harm.¹⁴ This reform, however, was misguided, based as it was upon failure or refusal to respond to the realities of the legal terrain.

The narrative just told summarises the findings of this chapter. Whilst this history of iatrogenic harm and responses to it are only a part of a much broader history of law,

Law Review 317; Steven A Farmer, Bernard Black and Robert O Bonow, 'Tension Between Quality Measurement, Public Quality Reporting, and Pay for Performance' (2013) 309(4) *JAMA* 349; Myungho Paik, Bernard Black and David A Hyman, 'Do Doctors Practice Defensive Medicine, Revisited' <<https://www.scholars.northwestern.edu/en/publications/do-doctors-practice-defensive-medicine-revisited>>; Myungho Paik, Bernard S Black and David A Hyman, 'The Direct and Indirect Effects of Medical Malpractice Reforms: Evidence from the Third Reform Wave' [2012] (No 13-20) *Northwestern Law and Economics Research Paper* <<http://www.ssrn.com/abstract=2110656>>; Zenon Zabinski and Bernard S Black, 'The Deterrent Effect of Tort Law: Evidence from Medical Malpractice Reform' [2013] *SSRN Electronic Journal* <<http://www.ssrn.com/abstract=2161362>>; Michael Frakes and Anupam Jena, 'Does Medical Malpractice Law Improve Health Care Quality?' [2016] *Journal of Public Economics* <DOI: 10.1016/j.jpubeco.2016.09.002>.

¹¹ As noted above I use this term following Corbett et al and Wears et al, Corbett, Travaglia and Braithwaite, above n 4; Wears, Sutcliffe and Van Rite, above n 4, 4.

¹² See for example, Dr Jonathan Burdon, 'Medical Indemnity Insurance in Australia' in Roy G Beran (ed), *Legal and Forensic Medicine* (Springer Berlin Heidelberg, 2013) 629 (note that the author is an employee of Avant Mutual, a medical indemnity insurer).

¹³ See for example Cashman, above n 5; Fiona Tito Wheatland, 'Medical Indemnity Reform in Australia: First Do No Harm' (2005) 33 *Journal of Law, Medicine and Ethics* 429.

¹⁴ Less obvious, however, is the more sustained movement to modify the discursive framing of all legal responsibility claims in this field, by re-thinking 'failure' in the literature and policy work that followed.

insurance and politics of the time,¹⁵ the history recounted here differs markedly from the dominant narrative available to us today whilst demonstrating how it was that we have come to see law as harmful, threatening, grossly unhelpful or even counterproductive to the challenge of stemming the tide of iatrogenic harm and death. The dominant narrative of this period recollects a crisis in the insurance industry brought on by an unsustainable and unjustifiable rise in negligence claims and the size of damages.¹⁶ The ‘explosion of negligence cases before Australian courts’¹⁷ and complaints of ‘excessive litigation’¹⁸ made by the press and politicians were mirrored in the scholarship of the time. Former Chief Justice, Sir Gerard Brennan, himself described in 1996 how

courts are overburdened, litigation is financially beyond the reach of practically everybody but the affluent, the corporate or the legally aided litigant; governments are anxious to

¹⁵ I discuss some of the broader literature below which questions the veracity of the dominant narrative in relation to civil liability more generally. This literature, however, focuses either on aspects outside of healthcare, such as recreational accidents (Corbett) or deals with the history of medical indemnity in passing. Certainly none of the literature available to me has analysed the particular history and process of medical indemnity, tort and criminal law and iatrogenic harm as is done here. For broader commentary which deals with the medical context see especially Faunce, Thomas Faunce, ‘Disclosure of Material Risk as Systems-Error Tragedy: *Wallace v Kam* (2013) 87 ALJR 648; [2013] HCA 19.’ (2013) 21(1) *Journal of Law and Medicine* 53; see the work of Corbett, especially authored at the time, for a critical reading of tort law and negligence doctrine, Angus Corbett, ‘(Self)Regulation of Law: A Synergistic Model of Tort Law and Regulation, The’ (2002) 25 *University of New South Wales Law Journal* 616; Angus Corbett, ‘Regulating Compensation for Injuries Associated with Medical Error’ (2006) 28(2) *Sydney Law Review* 259; Angus Corbett, ‘Australia: An Integrated Scheme for Regulating Liability for Medical Malpractice and Indemnity Insurance Markets That Does Not Include the Goal of Improving the Safety and Quality of Health Care’ (2011) 4 *Drexel Law Review* 199; see the personal reflections of Justice David Ipp himself, D Ipp, ‘The Politics, Purpose and Reform of the Law of Negligence’ (2007) 81(7) *Australian Law Journal* 456; as well as Peter Cane, who was a member of the Ipp Review’s Panel of Eminent Persons, Peter Cane, ‘Reforming Tort Law in Australia: A Personal Perspective’ (2003) 27 *Melbourne University Law Review* 649.

¹⁶ Corbett, ‘(Self)Regulation of Law’, above n 15, 616 (Corbett recounts the consensus as he read it at the time (2002) ‘There appears to be a consensus that the law of negligence is out of balance. There is a sense abroad that tort law in general, and the tort of negligence in particular, has been allowed to drift into conflict with major social institutions, including insurance markets, and with basic community values’.).

¹⁷ David Nason, ‘Crisis Can Be Traced to a Snail’ *Weekend Australian* (Sydney, NSW), 1 March 2002 30; Wolff and Anlea and Prest cite this also, see Leon Wolff, ‘Litigiousness in Australia: Lessons from Comparative Law’ (2013) 18 *Deakin Law Review* 271; Sharyn L Roach Anleu and Wilfrid R Prest, ‘Litigation: Historical and Contemporary Dimensions’ in Wilfrid R Prest and Sharyn L Roach Anleu (eds), *Litigation: Past and Present* (UNSW Press, 2004) 1, 10.

¹⁸ Ted Wright and Angela Melville, ‘Hey, But Who’s Counting? The Metrics and Politics of Trends in Civil Litigation’ in Wilfrid R Prest and Sharyn L Roach Anleu (eds), *Litigation: Past and Present* (UNSW Press, 2004) 96, 96–97, cited in Leon Wolff, ‘Litigiousness in Australia: Lessons from Comparative Law’ (2013) 18 *Deakin Law Review* 271, 273.

restrict expenditure on legal aid and the administration of justice. It is not an overstatement to say that the system of administering justice is in crisis.¹⁹

Yet, this dominant narrative is faulty. When subjected to accounts of the actual activity of law at the time, the validity of these claims withers. For instance, the claims of a crisis were tested by the Australian Law Reform Commission, which found ‘no “litigation explosion”’ to speak of,²⁰ and, as tort and health law scholar Angus Corbett argued during the height of tort reform, in relation to the broad accusations made against tort law outside of the healthcare setting,

[t]he perception that there is an uncontrolled expansion in tort law is wrong and unhelpful. There are, of course immediate and practical problems caused by the current trough in the insurance market... [however] these problems are not in any real sense ‘caused’ by tort law. Rather, they are the result of the interaction of a broad matrix of institutional and legal concerns. These include changes in regulation and in understandings of institutional responsibility, for example expectations of markets, regulators and of significant public and private institutions responsible for the delivery of goods and services in the community. The problems generated by these institutional and regulatory changes should be addressed with reference to this matrix of factors and not via a surrogate — tort law.²¹

In the same way, I claim that the dominant narrative of the Australian history of iatrogenic harm and responses to it is similarly faulty. What we remember is a system burdened by overzealous litigation, rising insurance premiums and unfair and greedy targeting of doctors.²² When exposed to an account of the actual history, and in that history see how it was that the conduct of law was shaped and re-shaped during the period, it shows that we have been inheritors of a faulty and invalid set of ideas about law’s history and contribution to the governance of iatrogenic harm. Consistent with my overarching claim in this thesis, when the actual practices of law in this field are more fully and critically

¹⁹ Gerard Brennan, ‘Key Issues in Judicial Administration’ in *AIJA Annual Conference, Wellington, NZ* (1996).

²⁰ Australian Law Reform Commission, ‘Managing Justice: A Review of the Federal Civil Justice System’ (ALRC 89, 2000) 75 [1.48] <<http://www.alrc.gov.au/sites/default/files/pdfs/publications/ALRC89.pdf>>; see also, Faunce, above n 15, 63 (where Faunce concludes, ‘It remains questionable whether there was, in fact, any increase in the volume of civil liability litigation or related size of verdicts in Australia in this period. It appears equally likely that the insurance liquidity problems were due to poor management decisions in the industry’).

²¹ Corbett, ‘(Self)Regulation of Law’, above n 15, 616. Angus Corbett’s work on this question has, like Corbett himself, been a major and abiding influence on my work in this Chapter, my understanding of this area and time and of my scholarship more generally.

²² See for example, Anleu and Prest, above n 17, 10; Cashman, above n 5, 888–893.

engaged, they seriously destabilise the validity of claims that manslaughter by criminal negligence is unhelpful or unjust when applied to iatrogenic harm.

To begin, in this first section of the chapter I construct a new and unique history of the period using a variety of archival materials. This is a history intimately shaped by large-scale scientific studies, official inquiries, tensions surrounding scientific method and statistics. For this reason, presenting a readable or even engaging history whilst respecting the true sources of conflict is a challenge, even when the stakes are so high. Even so, this history shows how it was that iatrogenic harm and law have come to be framed by the quality and safety sciences in a way that sees them as fundamentally at odds and undermining of the sustainability of the medical system. In this section particularly, I show how the first systematic revelation of the extent of iatrogenic harm in the early 1990s was brought on by talk of an impending medical indemnity insurance disaster. Blame was placed squarely upon law for constructing a tort ‘crisis’; whilst misguided and based upon partial and faulty understanding of the legal terrain, this narrative led to widespread reform of tort. This was followed by attempts to replicate a similar pattern of reform in relation to criminal law, a process at present unfinished. Whilst we are yet to succumb to calls for criminal law reform in Australia; criminal law is widely, if not universally, critiqued by the medical and quality and safety literature on the basis of views of its action and behaviour formed in and through the events I narrate here. A critical analysis of the history that led to this moment is, then, pressing and timely.

A *The Quality in Australian Health Care Study (QAHCS)*

In April 1991, the Federal Government established the Review of Professional Indemnity Arrangements for Health Care Professionals (*Professional Indemnity Review*), led by lawyer Fiona Tito.²³ Tito was tasked with reviewing the functioning of indemnity insurance systems and assessing the potential for a ‘no-fault’ compensation system, an approach that was preferred by many stakeholders.²⁴ The review was a response to

²³ Fiona Tito, ‘Compensation and Professional Indemnity in Health Care, Review of Professional Indemnity Arrangements for Health Care Professionals: Final Report’ (November 1995).

²⁴ A concept that the report was eventually to reject. See also Senator Helen Coonan’s comments a decade later about the experience of such a scheme in New Zealand, where its implementation meant that ‘there is really no risk to anybody apart from the person who gets injured’. ‘No Quick Fix for Medical Indemnity Insurance Crisis’, *Insiders*, 28 April 2002 <<http://www.abc.net.au/insiders/content/2002/s541902.htm>>.

increasingly intense calls from the medical profession in relation to tortious liability.²⁵ Civil negligence claims were said to be exploding and medical indemnity costs were rising.²⁶

One stream of research commissioned by Tito, named the Quality in Australian Health Care Study ('QAHCS'),²⁷ investigated the scale and scope of harm produced by the healthcare system. The study was designed to establish the parameters for a discussion of a no-fault system by establishing the potential call upon indemnity insurers should such a system be introduced.²⁸ To do so, the study aimed to quantify the level of risk and harm present within the Australian healthcare system. This approach followed the pattern established by the earlier Medical Insurance Feasibility Study (1974) undertaken in the United States, which had developed the very first assessment of iatrogenic harm in the same policy context (of indemnity crisis and consideration of a no-fault approach to compensation).²⁹ The QAHCS was the first study of its kind in Australia, adopting a well-established methodology from the Harvard Medical Practice Study ('*The Harvard Study*').³⁰ QAHCS was to become the landmark study of iatrogenic harm in Australia.

The QAHCS proceeded by reviewing a random sample of 14,000 patient records, from across 28 hospitals, for instances of preventable adverse events.³¹ It found that 16.6 per cent of hospital admissions were associated with a preventable adverse event.³² This represented a result six times higher than comparator studies in the United States,

²⁵ See for example, Burdon, above n 12 (note that the author is an employee of Avant Mutual, a medical indemnity insurer).

²⁶ See for example Cashman, above n 5; Wheatland, above n 13.

²⁷ Ross M Wilson et al, 'The Quality in Australian Health Care Study' (1995) 163(9) *Medical Journal of Australia* 458. The study's somewhat unfortunate acronym ('QAHCS') was also used by the study's authors.

²⁸ Although the research was designed (initially at least) to do so by describing the total burden of iatrogenic harm on the Australian healthcare system by investigating the annual rate of adverse events.

²⁹ Don Harper Mills, John S Boyden and David S Rubsamen, 'Report on the Medical Insurance Feasibility Study' (1977).

³⁰ Troyen A Brennan et al, 'Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study I' (1991) 324(6) *New England Journal of Medicine* 370; Lucian L Leape et al, 'The Nature of Adverse Events in Hospitalized Patients: Results of the Harvard Medical Practice Study II' (1991) 324(6) *New England Journal of Medicine* 377; A Russell Localio et al, 'Relation between Malpractice Claims and Adverse Events Due to Negligence: Results of the Harvard Medical Practice Study III' (1991) 325(4) *New England Journal of Medicine* 245.

³¹ Wilson et al, above n 27.

³² Ibid.

including the Harvard Study from which it drew its design.³³ Extrapolating from the QAHCS sample to all ‘separations’³⁴ occurring in Australian acute-care hospitals at that time resulted in a figure of 18,000 patients dying and 50,000 being permanently disabled each year at that time.³⁵ This was leading to approximately 470,000 additional admissions, in total, some 3.3 million additional bed days.³⁶ When all adverse events reported by the QAHCS were re-classified into one of two categories, of ‘potentially preventable’ or ‘not preventable with current medical knowledge’,³⁷ 80 per cent of adverse events were classified as potentially preventable.³⁸

The message was clear and shocking: Australians were not receiving the kind of safe care they expected. In Australia, being a patient in an acute-care hospital brought with it a more than ‘40-fold greater risk of dying from the care process than from driving in traffic, and a 400-fold greater risk than working in the chemical industry’.³⁹ In short, the QAHCS unexpectedly exposed a far more widespread and substantial burden of iatrogenic harm in the Australian healthcare system than had been imagined or acknowledged. Moreover, the quest to negate fault for a culpable failure to exercise adequate care by particular health system participants had, unexpectedly and unwittingly, revealed a much greater burden of culpable failure in healthcare.

The findings of the QAHCS were incendiary. Dr Carmen Lawrence, then the Commonwealth Minister for Health, decided to table the preliminary findings of the study in parliament.⁴⁰ The researchers reportedly expressed fears that an early release would

³³ See particularly the discussion by Runciman et al in William B Runciman et al, ‘A Comparison of Iatrogenic Injury Studies in Australia and the USA II: Reviewer Behaviour and Quality of Care’ (2000) 12(5) *International Journal for Quality in Health Care* 379, 385; Eric J Thomas et al, ‘A Comparison of Iatrogenic Injury Studies in Australia and the USA I: Context, Methods, Casemix, Population, Patient and Hospital Characteristics’ (2000) 12(5) *International Journal for Quality in Health Care* 371.

³⁴ A ‘separation’ includes discharges, transfer or statistical type changes of inpatients, it thus is a broader category than ‘discharge’.

³⁵ Murray Hogarth, ‘Killed in Error’ *The Sydney Morning Herald* (Sydney, NSW), 11 May 1996 6.

³⁶ Ibid; Minister Lawrence stated in Parliament, that ‘a reasonable estimate of the cost of these bed-days would be around \$650 million’ see, Commonwealth, Parliamentary Debates, House of Representatives, 1 June 1995, 911-915 (Hon. Dr Carmen Lawrence MP).

³⁷ John J McNeil and Stephen R Leeder, ‘How Safe Are Australian Hospitals?’ (1995) 163(9) *The Medical Journal of Australia* 472, 472-473.

³⁸ William Runciman, MJ Edmonds and M Pradhan, ‘Setting Priorities for Patient Safety’ (2002) 11(3) *Quality and Safety in Health Care* 224; William Runciman and J Moller, *Iatrogenic Injury in Australia* (Australian Patient Safety Foundation, 2001) 22.

³⁹ Runciman and Moller, above n 38, xiii.

⁴⁰ Ibid 3; Commonwealth, Parliamentary Debates, House of Representatives, 1 June 1995, 911-915, above n 36.

cause significant damage, leaving little time for the usual processes of scrutiny,⁴¹ and may ‘poison’ doctors against the work the researchers had completed.⁴² However, Minister Lawrence ultimately decided to publically reveal the initial findings, arguing that the community had a right to know ‘as soon as possible’.⁴³ Minister Lawrence noted that if the rate of adverse events found by the study were applied to public and private hospital admissions in 1992, about 230,000 Australians would have suffered a preventable adverse event.⁴⁴ In tabling the preliminary findings, Minister Lawrence noted that:

The human implications of these results are clearly a matter of considerable concern to me, as I am sure they will be for all of you and for other health ministers in Australia... I have decided to release them now, so that they can be a trigger for effective action. There will be a closer examination of the study when it is published, but I believe that the evidence is sufficiently stark to warrant immediate action.⁴⁵

That ‘effective action’, however, was never to properly surface.⁴⁶

The release of the QAHCS findings drew ‘substantial’⁴⁷ media coverage.⁴⁸ The results of these studies were reported in the general media as a form of ‘political shock-treatment

⁴¹ Such as peer review.

⁴² Hogarth, above n 35; Dr Lawrence dismissed this view as a ‘convenient’ excuse, Melissa Sweet, ‘Hospital Dangers: A Tale of Inaction - Health Care Safety: A Three Year Wait’ *The Sydney Morning Herald* (Sydney, NSW), 27 February 1998 10.

⁴³ Hogarth, above n 35.

⁴⁴ Minister Carmen Lawrence, cited in Peter Robinson, ‘Red Herring Hospitals’ *The Sun Herald* (Sydney, NSW), 4 June 1995 34.

⁴⁵ Minister Carmen Lawrence, cited in *ibid*; Commonwealth, Parliamentary Debates, House of Representatives, 1 June 1995, 911-915, above n 36.

⁴⁶ I mean this in relation to what occurred after the release of the QAHCS data (as described in this chapter), but also in relation to iatrogenic harm more generally. Despite significant efforts by a range of health system participants, these rates of iatrogenic harm have not measurably improved at a system-level for fifty years. See, Jeffrey Braithwaite, Robert L Wears and Erik Hollnagel, ‘Resilient Health Care: Turning Patient Safety on Its Head’ (2015) 27(5) *International Journal for Quality in Health Care* 418, 419; Wears, Sutcliffe and Van Rite, above n 4.

⁴⁷ Runciman and Moller, above n 38, 3.

⁴⁸ See for example, Gareth Boreham, Joanne Painter and Steve Dow, ‘Hospital Mistakes Kill 14,000 a Year - Report’ *Age, The/The Sunday Age (Melbourne, Australia)*, 2 June 1995 1; Padraic P McGuinness, ‘Australia’s Sickly Health System Cries out for a Remedy’ *Age, The/The Sunday Age (Melbourne, Australia)*, 2 June 1995 12; Alecia Larriera, ‘Hospital Errors Kill 14,000 a Year’ *The Sydney Morning Herald* (Sydney, NSW), 2 June 1995 1; ‘Little Surprise Among Those in the Front Line’ *The Sydney Morning Herald* (Sydney, NSW), 2 June 1995 8; Steve Dow, ‘Taskforce to Tackle Hospital Deaths’ *The Age* (Melbourne, Vic.), 3 June 1995 3; Alicia Larriera, ‘Patients Get Right to See Medical Records’ *The Sydney Morning Herald*, 3 June 1995 1; but see ‘Hospitals Report Deserves Much Closer Analysis’ *The Sydney Morning Herald* (Sydney, NSW), 7 June 1995 16; Robinson, above n 44; Fiona Tito herself describes the coverage, particularly after 2002 and the collapse of the largest medical defense organisation as ‘high political and social drama’, with coverage occurring ‘almost daily’ all against a background of lobbying and a broader public relations campaign about public liability insurance, see Wheatland, above n 13, 429.

[for the] closed medical world'.⁴⁹ Newspaper headlines at the time ran with 'Hospital errors kill 14,000 a year'.⁵⁰ A level of public alarm followed, with reports surfacing of some patients even cancelling appointments and hospital admissions.⁵¹ Ross Wilson, the QAHCS research leader, commented at the time that 'the size of the problem we have revealed is substantial enough for everybody to take notice of'.⁵²

The reaction of the medical profession, too, was swift. Dr David Weedon, President of the Australian Medical Association ('the AMA') during the period,⁵³ suggested that the report was overblown. He recounted that 'it was to me an example where politics and science met, and science came out the worst'.⁵⁴ However, this was not a surprise for Tito. According to Tito the medical community had taken a dismissive stance toward the QAHCS from early in the research process. In a frank media interview, Tito recounted meeting with the AMA early in the life of the Medical Indemnity Review. Tito recounted that '[t]he AMA guy said [the QAHCS] was "a waste of time", because, "[t]here are not preventable mistakes, and if there are, revealing them will undermine confidence in the health system"'.⁵⁵ Merrilyn Walton, who was at the time the NSW Health Care Complaints Commissioner,⁵⁶ highlighted a theme of secrecy and denial in describing the 'closed-shop' mentality that characterised the medical and healthcare field. In public comments, she described the Australian healthcare system as inward-looking and dominated by medical practitioners:

⁴⁹ Hogarth, above n 35.

⁵⁰ Boreham, Painter and Dow, above n 48, 000; Larriera, 'Hospital Errors Kill 14,000 a Year', above n 48, 14; as to the reception see for example 'Hospitals Report Deserves Much Closer Analysis', above n 48; compare with headlines in 2015, Julia Medew, 'Hospital Errors Killing Hundreds of Thousands' *The Sydney Morning Herald*, 2015-02-19T02:50:18+0000 <<http://www.smh.com.au/national/health/hospital-errors-killing-hundreds-of-thousands-20150218-13irpo.html>>.

⁵¹ Sweet, above n 42, 10.

⁵² Hogarth, above n 35, 6.

⁵³ The Australian Medical Association (AMA) is a highly influential professional membership organisation and politically effective lobbyist. It is the equivalent, broadly speaking, of the British Medical Association, of which it was a sub-branch. See Tito's reflections on the campaign sustained by the AMA in Wheatland, above n 13.

⁵⁴ Hogarth, above n 35, 6.

⁵⁵ Hogarth, above n 35.

⁵⁶ This is the independent statutory healthcare complaints and investigation body in NSW. It remains operational today.

[t]he high degree of overt medical control over the health system influences how the system is designed, who it protects, who and what behaviour is disciplined, how complaints are processed, (and) how injured patients are compensated'.⁵⁷

What the QAHCS research uncovered, in a public and aggregated form, was something that had been known to insiders for many years: significant harm was occurring in the health system, and the delivery of health services in Australia was far less safe than had been widely acknowledged to date.⁵⁸ To AMA president Dr David Weedon, the abrupt drawing back of the veil offered nothing more than 'an opportunity to embarrass the medical profession'.⁵⁹ However, he conceded, if in fact 'the figures were really true, it was Royal Commission stuff'.⁶⁰

In the months after the initial release of QAHCS findings, Tito worked to complete the broader inquiry of which QAHCS was a key element. Her final report, published in November 1995,⁶¹ noted that whilst there were some 230,000 potentially preventable adverse events, approximately 30 per cent of these resulted in a disability that prevented a return to work or normal activities for up to 12 months.⁶² Up to 20 per cent of those incidents resulted in permanent disability or death.⁶³ However, despite such high rates of harm, the report also noted a low incidence of tort claims: fewer than 2000 tort claims per annum.⁶⁴ The report found the majority of these appeared to be won by the health professional.⁶⁵ As a result, Tito concluded, the vast bulk of the costs of medical negligence are externalised. When patients were harmed, the costs of that harm were being borne by the community, the victims of negligence, and their families: 'lost income is met through sick leave, social security and, in some cases, simply doing without, whilst services required and costs relating to disability are met through a broad range of community

⁵⁷ Hogarth, above n 35.

⁵⁸ See particularly the discussion of Prus-Butwilowicz, medical education by Bruce Armstrong, Mike Ragg and Ross Wilson's discussion of errors and iatrogenic death, ABC Television, 'Dead and Buried', *Four Corners*, 7 July 1998 <<http://www.abc.net.au/4corners/stories/s11793.htm>>.

⁵⁹ Hogarth, above n 35.

⁶⁰ Ibid.

⁶¹ It is worth noting here that the only available copy of Tito's final report of the Professional Indemnity Review had to be prepared from penultimate electronic drafts held by Fiona Tito herself some years later. As she notes in this version, 'no electronic copies of the published version were retained by the Commonwealth...and no reprints of the Report are otherwise available'. Tito, above n 23, 2.

⁶² Ibid 13.

⁶³ Ibid.

⁶⁴ Tito, above n 23.

⁶⁵ Ibid.

services'.⁶⁶ Moreover, it was neither law nor the legal system that was the cause of the sustainability or dysfunction in the health system as had been asserted. It was, Tito asserted, the health system's own failings that were the source.

Despite presenting evidence to the contrary, Tito's report and its aftermath remained intimately bound up with the tort 'crisis', especially in the figure of Medical Defence Organisations ('MDOs'). These mutual organisations were traditionally not-for-profit organisations.⁶⁷ Alongside State and Territory governments and private insurers, these organisations offered medical indemnity cover to their members.⁶⁸ At the time, most doctors received indemnity protection through MDOs, most of which was provided to members on a discretionary basis rather than through 'captive insurance vehicles'⁶⁹ that issued insurance policies to members.

The leadership of these mutual organisations, which were very large and influential professional organisations, was amongst the most vocal advocates for tort reform at the time. However, the Professional Indemnity Review's findings were in direct and stark contradiction to claims made by MDOs in relation to both the indemnity system and the role of tort. On that count, the already strong tensions between Tito's Professional Indemnity Review and the MDO system reached a new level of intensity. Tito's findings had questioned the hegemony of MDOs and the truthfulness of their rhetoric, especially where it had positioned civil negligence law as unjust, producing a deleterious effect on the functioning of the Australian healthcare system. Tito's conclusions as to the financial health of MDOs are worth quoting at length in this regard:

⁶⁶ Ibid.

⁶⁷ Commonwealth of Australia, The Treasury, 'Review of Competitive Neutrality in the Medical Indemnity Insurance Industry' (March 2005) [Current state of the medical indemnity industry] <https://archive.treasury.gov.au/documents/965/HTML/docshell.asp?URL=03_state.asp>; see also Jerome Davidson, Susan Dudley and Ann Palmer, 'Medical Indemnity (Competitive Advantage Payment) Bill 2005 Medical Indemnity Legislation Amendment (Competitive Neutrality) Bill' (Bills Digest No. 15–16, 2004–05, 2005).

⁶⁸ Medical Indemnity Insurance Association of Australia, 'Medical Indemnity Insurance: An Introduction' 1 ('They were established as friendly societies and mutual funds which were owned by their members and provided indemnity to doctors on a discretionary basis.') <http://www.miaa.com.au/_files/f/879/Medical%20Indemnity%20Insurance%20An%20Introduction.pdf>.

⁶⁹ Win-Li Toh, Linda Satchwell and Jonathan Cohen, 'Medical Indemnity – Who's Got the Perfect Cure?' (Paper presented at the 12th Accident Compensation Seminar, The Institute of Actuaries of Australia 22-24 November 2009) 11 [3.3] <https://www.actuaries.asn.au/Library/ACS09_Paper_Toh%20et%20al..pdf>.

The evidence for a so-called claims crisis is scant - while the reporting of incidents has increased, this has been in response to direct efforts by MDOs to get early notice of potential claims, and does not, thus far, appear to be reflected in increased legal claims. Some MDOs have been making such claims publicly without the production of data to substantiate them. However, they do not appear to be basing their premiums on such increases, as premium rates in these same organisations have remained steady. The fostering of such a crisis mentality can serve to deflect attention from irresponsible financial management by such MDOs, and can be used to disguise later rises in contributions which have, in fact, arisen because of this financial improvidence. Such improvident strategies can also be used by an organisation to increase cash-flow at the expense of longer-term financial viability, if an organisation is short of funds. While these are all possible explanations, there is no publicly available data on the operations of MDOs against which to judge these possibilities.⁷⁰

The report concluded, *inter alia*, that strong competition between medical defence organisations led to doctors' membership/subscription dues in the 1980s being set unrealistically low, well below private insurance market premiums. Such artificial and systematic underfunding of MDOs was widespread. The Medical Defence Association of Western Australia noted, for example, that such underfunding could 'easily be dismissed as the result of claims costs being unpredictably high... the legal profession... also targeted as an additional cause... [h]owever, underfunding may also be caused by poor business operations and inadequate advice on subscription pricing'.⁷¹ Tito named the increasing indemnity costs for what they were, insurers needing to 'catch-up' on unsustainable business decisions taken in the 1980s.⁷²

Rather than confirming the MDO's claims of a legal source of the indemnity system's woes, it was in fact the indemnity provider's own mismanagement that was the source. This included specific consideration of tortious and criminal negligence. In relation to tortious negligence, this is made clear from the evidence produced by the Professional Indemnity Review, which was unequivocal: tort law was not the cause of the medical indemnity industry's woes. In relation to criminal law, previous criminal prosecutions for iatrogenic harm had been very limited, and had proceeded without notable opposition.⁷³ The effect of the report was, however, a flurry of publicity and fractious debate, largely the

⁷⁰ Tito, above n 23, 14.

⁷¹ Cited in Janine Mace, 'Making Sense of the MDO Market' *Australian Doctor*, 23 February 2001 43, 45.

⁷² Tito, above n 23; see also Paul Henderson, 'Why Barricades? - Doctors Are Not Under Legal Siege' *The Age/The Sunday Age (Melbourne, Australia)*, 10 July 1995 12.

⁷³ See Chapter One.

result of a sustained public relations campaign and lobbying by vested interests,⁷⁴ rather than what it was meant to have been, and indeed should have been – a response to the difficult reality of iatrogenic harm, failing indemnity systems, or the facts that the Tito Report and the QAHCS had revealed.

In light of Tito's findings, the tort 'crisis' and related medical indemnity catastrophe that had triggered the Professional Indemnity Review and its QAHCS research looked to be a false crisis. In fact, in light of these findings, the unexpected revelation of the vastly more significant extent of iatrogenic harm was the real crisis faced by the Australian healthcare system. The conduct of law, exonerated by the report, should have been accepted in the aftermath. This history shows that law was not the cause of any of the difficulties facing the healthcare and medical industries or their MDOs. However, as I show in the next section of this chapter, this fact failed to take hold. The eventual result was that 'law' (both tort and criminal) and effective action on improving quality and safety were constructed as autonomous and separately constituted, and their achievement or operation wholly at odds with one another.

B *The Aftermath of QAHCS and the Professional Indemnity Review: Inaction and Dissent*

While the initial release of QAHCS findings caused a burst of publicity and conflict, that activity did not include acceptance or productive action on matters central to the review and its report. For example, one healthcare journalist recounted at the time that 'a close analysis would suggest that the flurry of publicity [in relation to indemnity and iatrogenic harm] owes more to the powerful, practised and professional hand of the medical lobby hard at work, than hard facts'.⁷⁵ Indeed, neither medical indemnity, the issue that had initially motivated the report, nor iatrogenic harm, the issue that the report had unexpectedly exposed, received immediate reform or response. I deal with how inaction

⁷⁴ Even at the time, at least one journalist recounted in detail how the obstetric 'crisis' of the prior year (1993) was, for him at least, yet another 'cleverly stage-managed event...that constituted major efforts to fool most of the people most of the time', John Archer, 'Doctors Cry Wolf Much Too Often - John Archer Finds That Looking Back Can Prove an Enlightening Experience When It Comes to the Medical Profession' *The Canberra Times* (Canberra, ACT.), 15 August 1994 13; Tito summarises this perspective in 2005, a perspective that the events between her report and the collapse of the medical indemnity system bears out, Wheatland, above n 13.

⁷⁵ Sally Loane, 'Hidden Agenda to Obstetrician "Shortage"' *The Sydney Morning Herald* (Sydney, NSW), 17 August 1993 12.

and dissent marked the aftermath of the Professional Indemnity Review and the QAHCS for both its findings in relation to indemnity and iatrogenic harm in turn.

First, I explore the issue of indemnity, and whether Australia's indemnity system required reform, or indeed was even sustainable. The Tito review had concluded that litigation fears were largely mythical, and that indemnity systems – notably the MDOs – were the cause of their own troubles. This was met with responses of both denial and misinformation. For instance, Dr Richard Tjiong, then chairman of Australia's largest medical indemnity insurer at the time, United Medical Defence (known as 'UMD', which was later to become 'UMP' following a merger),⁷⁶ claimed in comments made to *The Sydney Morning Herald*, that Tito's approach and recommendations did not provide a focused or detailed treatment of medical indemnity issues. He attacked the veracity of the findings, saying that the 'figures [used in the report] come from two small studies conducted by Flinders University and the University of Wollongong and have been extrapolated into national figures'.⁷⁷ These views present a misguided and misinformed understanding of the research. The QAHCS data about which he was commenting was a very large study, reviewing 14,000 medical records. Indeed, Tjiong even misnames the universities involved in the study,⁷⁸ undermining the sense that he was attempting to genuinely engage with the findings produced by Tito and her team. Tito attempted to counter his claims, stating that 'I think it is a bit rich for [Tjiong] to criticise the figures now when he promised to provide me with data on the subject but failed to deliver',⁷⁹ but without necessarily addressing all factors represented in the deeply flawed perspective that Tjiong was attempting to establish.⁸⁰

⁷⁶ Richard Tjiong, 'Medical Indemnity Industry in Australia' <<http://www.richardtjiong.com.au/medical-indemnity/dr-richard-tjiong-medical-indemnity-industry-in-australia/>> (Medical Defence Society of Queensland merged with NSW Medical Defence, formerly known as New South Wales Medical Defence Union, which as United Medical Protection Limited [UMP]. Finally, in 2009, UMP merged with the Medical Defence Association of Victoria to form AVANT.).

⁷⁷ Wilson et al, above n 27; Tito, above n 23. His criticism lacked reference to the realities of indemnity issues in a report that was roundly critical of the operation of organisations like his. Not only was the study conducted by the University of Adelaide and the University of Newcastle for the Professional Indemnity Review, but, twenty-eight hospitals had participated reviewing 14,179 admissions.

⁷⁸ The Professional Indemnity Review final report notes that the QAHCS was conducted by 'a consortium involving the Universities of Newcastle and Adelaide...selected to carry out the study in June 1993', Tito, above n 23, 58.

⁷⁹ Ian Verrender, 'Chelmsford Victims Call for Action on Insurance' *The Sydney Morning Herald* (Sydney, NSW), 19 March 1996 4.

⁸⁰ Ibid.

The stalemate continued until November 1995, when, the day after the release of the Tito Inquiry's final report, the AMA warned that doctors would be increasing patient fees if the Commonwealth adopted the report's recommendations.⁸¹ And so, the report and its recommendations were dropped. Instead of heeding Tito's findings, which amongst other things had warned of the ill-preparedness and financial precariousness of the MDOs, the report was effectively shelved.⁸² No action was taken in relation to MDO reform at that time.⁸³

Those that undertook to criticise the findings still had significant incentive to blame the legal system by way of deflecting the blame that had been sheeted home to MDOs and to the health system and its significant rates of iatrogenic harm. And so, with a sense of inevitability, despite Tito's many stark warnings and her review's clear description of the perilous state of Australia's medical indemnity system, a 'crisis meeting' was held between the AMA and presidents and delegates from key medical specialties – including surgery, anaesthetics, obstetrics and gynaecology, emergency medicine, ophthalmology and dermatology in response to 'wildly escalating damages awards'.⁸⁴ In what the AMA described as 'an unprecedented move',⁸⁵ a joint call from medical colleges and medical representative bodies was made for 'wide ranging [law] reform... to stop spiralling medical insurance costs'.⁸⁶ It was prompted, it seems, by the announcement made by UMD, Tjiong's medical defence organisation, for a call on 'members for an additional payment equivalent to a full year's subscription'.⁸⁷

Shortly after this announcement, UMD/UMP, Australia's largest indemnity provider, dramatically collapsed.⁸⁸ Tjiong, still at the head of UMD/UMP, and who had so roundly criticised the Tito Report, oversaw a failure on the part of UMD/UMP to make adequate

⁸¹ Gareth Boreham, 'Doctors' Compo Fee Threat' *The Age*, 13 January 1996 5.

⁸² Sweet, above n 42.

⁸³ So effective was that shelving, that in an interesting twist, the Commonwealth Department of Health and Ageing retained no electronic or print copies of the Tito Report, it having to be re-compiled in 2003 from a penultimate copy held in the personal archive of Fiona Tito, Tito, above n 23, 2.

⁸⁴ *Doctors Fight Back on Soaring Indemnity Costs* (0 December 2000) Australian Medical Association <<https://ama.com.au/media/doctors-fight-back-soaring-indemnity-costs>>.

⁸⁵ Ibid.

⁸⁶ Ibid.

⁸⁷ Ibid.

⁸⁸ Cashman, above n 5; 'The Gory Detail Behind the UMP Disaster' *Crikey* (Online Edition), 0 May 2002 <<https://www.crikey.com.au/2002/05/03/the-gory-detail-behind-the-ump-disaster/>>; 'Fatal Blow' *Sydney Morning Herald*, 4 May 2002 <<http://www.smh.com.au/articles/2002/05/03/1019441434022.html>>.

provision for indemnity payouts, or to account adequately for known or estimated future liabilities, especially in relation to so-called ‘incurred but not reported claims’.⁸⁹ UMD/UMPs entering into administration resulted in an unprecedented crisis for the entire healthcare system, a crisis ‘resolved’ by the Commonwealth Government effectively nationalising the MDO system, causing broad-based socialisation of all medical indemnity risk through the use of bail-outs and sovereign guarantees.⁹⁰

Reflecting on that time, Stuart Bolan, former board member of UMD/UMP, who would eventually chair what was to become of Tjong’s MDO (resurrected as Avant Mutual), summed up the period succinctly: ‘Unless you were involved, the history of the Medical Indemnity Industry between 1993 and May 2002 when UMP was placed in provisional liquidation seems more like fiction than fact’.⁹¹ So too did others summarise the aftermath, with the collapse of UMP a ‘tale of catastrophe foretold’⁹² for one journalist, where for another the ‘early diagnosis of a medical [indemnity] “trauma”’⁹³ had been clearly identified by the Tito review seven years earlier. Tito had warned at that time that the vast burden of medical negligence was being externalised, borne by the community, the victims of negligence, and their families.⁹⁴

As with the Tito’s conclusions on indemnity, the Professional Indemnity Review’s findings on iatrogenic harm also attracted criticism and generated denial. However, whilst the review had concluded that indemnity systems were the cause of their own troubles, and that litigation fears were largely mythical, medical error was another matter entirely. Tito’s review had demonstrated the very real significance of such error through its QAHCS data.

⁸⁹ ‘UMP did not made any provision for IBNR liabilities in its financial accounts published to 2001’, Cashman, above n 5.

⁹⁰ Prompted by the appointment of a provisional liquidator to the country’s largest medical defence organisation, UMP insurance, in May 2002, the Commonwealth introduced a range of measures, including significant and ongoing financial support to the medical indemnity system, Australian Government Department of Health and Ageing Acute Care Division, ‘The Australian Government Medical Indemnity Package’ <<http://www.health.gov.au/internet/main/publishing.nsf/Content/health-medicalindemnity-faq-package.htm>>; see also the analysis prior to winding back these measures for an account of the support given by the Commonwealth, Davidson, Dudley and Palmer, above n 67; Commonwealth of Australia, The Treasury, above n 67.

⁹¹ Stuart Boland, Former Chair of Avant Mutual, Former Board Member UMP, Former President of the NSW Branch of the Australian Medical Association, Stuart Boland, ‘Retirement Dinner Speech given by Associate Professor Stuart Boland the Former Chairman of Avant Mutual’ <<http://www.avant.org.au/news/20140828-stuart-bolland-farewell-speech-by-former-chairman-of-avant-mutual/>>.

⁹² Andrew White, ‘A Tale of Catastrophe Foretold’ *The Australian* (Sydney, NSW), 4 May 2002 001.

⁹³ Andrew White, ‘Early Diagnosis of a Medical Trauma - Inside Story’ *The Australian* (Sydney, NSW), 4 May 2002 001.

⁹⁴ Tito, above n 23, 13.

Specifically, the QAHCS study reported results that showed a level of harm an almost six times higher than the key comparator study in the United States.⁹⁵ The incidence of iatrogenic harm, and its preventability in particular, was well beyond what had been understood in the past.⁹⁶ However, the early release of the QAHCS component of the Professional Indemnity Review fed a cycle of denial and the beginning of a systematic ignorance of iatrogenic harm. As Tito forcefully noted

Because we weren't ready to release [the QAHCS data] when it was released, we didn't have the public information so people were able to say it was a crock of shit before anything could be shown to them to demonstrate that it wasn't.⁹⁷

This is demonstrated in an interview with Bill Runciman, one of the report's researchers, who was questioned by the media about the extent of harm discovered in the QAHCS. He pointed out that '[a]ll the manifestations of risk in the health system have never been put in a pile before'⁹⁸ and later noted that, such was the systematic denial of iatrogenic harm at the time, the most widely-used medical text of the time, which had been translated into over 10 languages, dealt with iatrogenic injury in one quarter of a page out of a total of over 2500 pages.⁹⁹

Appreciating the depth and context of the systemic denial of iatrogenic harm assists in understanding how meaningful action in response to the Tito review was prevented over the next several years. A sequence of roadblocks and inaction followed. Minister Lawrence created a task force, led by Professor Bruce Armstrong, then director of the Australian Institute of Health and Welfare, to engage with the implications of the QAHCS data.¹⁰⁰ However, members of the task force reported their work was 'hindered by lack of

⁹⁵ Wilson et al, above n 27; The QAHCS study returned a rate of 16.6% of admissions were associated with an adverse event, whilst the Utah, Colorado Study reported a rate of 2.9%. See particularly the discussion by Runciman et al in Runciman et al, above n 33, 385; Thomas et al, above n 33.

⁹⁶ The Medical Insurance Feasibility Study reported a 4.6% incidence for all measured classes of "potentially compensable events" occurring in 1974,2 and the 1984 Harvard Medical Practice Study (HMPS), reported by Brennan and colleagues, showed that adverse events occurred in 3.7% of hospitalisations, with 27.6% of these being caused by medical negligence and 69% by human error Mills, Boyden and Rubsamen, above n 29; Brennan et al, above n 30.

⁹⁷ Sweet, above n 42.

⁹⁸ Hogarth, above n 35.

⁹⁹ A Fauci, *Harrison's Principles of Internal Medicine* (McGraw-Hill, 13th ed, 1994); Runciman and Moller, above n 38, 2.

¹⁰⁰ Bruce Konrad Armstrong, *The Final Report of the Taskforce on Quality in Australian Health Care* (Australian Health Ministers' Advisory Council, 1996).

resources and bureaucratic support'.¹⁰¹ Then, in 1996, Carmen Lawrence was replaced by Dr Michael Wooldridge as Commonwealth Minister for Health following a change of government. The shape of the discourse shifted again at this moment. Minister Wooldridge seemed less enthusiastic about being identified with the QAHCS/Medical Indemnity Review reports commissioned by Lawrence, his Labor predecessor.¹⁰² Indeed, the AMA established a successfully lobbying campaign against key recommendations of the taskforce led by Bruce Armstrong.¹⁰³ The taskforce's report and its recommendations were, according to one journalist, subsequently 'shunted to one side'.¹⁰⁴ Armstrong reportedly felt that a significant opportunity was being lost,¹⁰⁵ as (yet another) inquiry was commissioned by Commonwealth and State health ministers.¹⁰⁶

By 1997, frustrated by the inaction, Ross Wilson, the leader of the QAHCS research project, published an editorial in *The Medical Journal of Australia* with his colleagues, criticising lack of 'national systemic action'¹⁰⁷ to improve healthcare safety. The Minister, Dr Wooldridge, immediately cast the editorial in a press release as 'appalling, ill-informed self-serving' and 'divisive'.¹⁰⁸ In Wilson's defence, influential health journalist Dr Norman Swan interpreted this as a 'personal attack' on Wilson by Minister Wooldridge. Coining a memorable paraphrase of the Minister's comments while interviewing Wilson, Swan asked '[w]hy is the Minister so sensitive to this? He [the Minister] responded to your recent editorial in the Medical Journal of Australia by saying that you've penned "an alarmist, incorrect and bitchy little missive"'.¹⁰⁹ Wilson replied drily, '[w]ell it would be fair to say that the Minister and I disagree on the nature of the editorial that he refers to'.¹¹⁰

Still more time elapsed without meaningful action being taken to address the harm uncovered by the QAHCS report. By 1998, some three years after Minister Lawrence had

¹⁰¹ Sweet, above n 42.

¹⁰² Ibid.

¹⁰³ The AMA were not included on the task force, a factor that Armstrong was said to have been a mistake, *ibid.*

¹⁰⁴ According to Andrew Fowler, journalist, see ABC Television, above n 58.

¹⁰⁵ Ibid.

¹⁰⁶ Ibid.

¹⁰⁷ Ross M Wilson and Bernadette T Harrison, 'Are We Committed to Improving the Safety of Health Care?' (1997) 166(9) *Medical Journal of Australia* 452.

¹⁰⁸ As reported in Sweet, above n 42; See Michael Wooldridge, 'Australia's Health Ministers Are Acting on Quality Issues. Press Release MW 40/97 5 May 1997'.

¹⁰⁹ ABC Radio National, 'Quality in Australian Health Care', *The Health Report*, 7 July 1997 <<http://www.abc.net.au/science/kelvin/files/s177.htm>>.

¹¹⁰ Ibid.

tabled the early QAHCS data, the Australian Broadcasting Corporation's *Four Corners* programme concluded that 'since the original studies, an estimated 30,000 people have been killed by the system. While little or no action is taken, the body count grows higher every day'.¹¹¹ The Commonwealth Health Minister, Dr Michael Wooldridge, had refused to provide comment for their story.¹¹² Professor George Rubin, the former Chief Health Officer of NSW commented at the time that 'we don't need more committees and reports. We want action',¹¹³ and Professor Armstrong, chair of the initial Lawrence-appointed taskforce, concluded that '[a]n opportunity to really do something about the safety of healthcare in Australia has been lost'.¹¹⁴

C *Action or Further Research on Iatrogenic Harm*

What had occurred with indemnity seemed destined to be repeated in relation to iatrogenic harm; inaction, further harm and externalisation or socialisation of the damage. Controversially, debate about methodological or data issues came to take centre stage, rather than direct action on reducing iatrogenic harm. Bill Runciman, who was one of the QAHCS authors, became a more active player in the period that followed. Runciman argued that the Professional Indemnity Review and its QAHCS study had made iatrogenic harm out to be more preventable than it actually was. Acknowledging that the 'data was quite surprising',¹¹⁵ he offered an analysis at this point that differed from others in the research team of which he had been a member. This difference was centred on the definition and use of 'preventability'. He said at the time:

If something was just over 50 per cent preventable, the [QAHCS] study called it "of high preventability". Doctors intuitively know that is wrong. Medicine is not like running a factory. It is more like fighting a war or mounting a rescue mission. In most things in medicine you take a risk. We are talking about things with up to a 20 or 30 per cent death risk.¹¹⁶

¹¹¹ ABC Television, above n 58.

¹¹² Ibid.

¹¹³ Sweet, above n 42.

¹¹⁴ Ibid.

¹¹⁵ Hogarth, above n 35.

¹¹⁶ Ibid. Note well, that despite adverse events befalling those who are aged or quite ill already, they still do cause otherwise avoidable harm, and hasten death. There is a risk in failing to acknowledge this factor, that so often is covered over by reference to a patient's otherwise advanced age, frailty or approaching death from other causes.

Runciman's critique was aimed at the specifics of the QAHCS research methodology, arguing that it had caused the study to misinterpret reality in its definition of preventability. Minister Wooldridge took up a similar theme, claiming that the QAHCS data, and thus subsequent reporting by the taskforce, were not sufficiently rigorous. On a visit to Harvard University, visiting the team that had performed the Harvard Study upon which the QAHCS had based its methodology, Wooldridge formed the opinion that researchers there did not trust the QAHCS's conclusions.¹¹⁷ Runciman would later contest this claim. In 2000, Runciman wrote that discussion at the Harvard School of Public Health regarding the alleged discrepancy had concluded with a 'consensus' that the discrepancy between the QAHCS and Harvard studies was 'unlikely to be real, and was likely due, at least in part, to methodological differences... although these appeared ostensibly to be the same'.¹¹⁸ Indeed, as far back as 1997, the lead author of the QAHCS study, Ross Wilson, had noted that he had discussed and had figures analysed by 'Professor Brennan's group at the Harvard School of Public Health [who completed the Harvard Medical Practice Study, upon which the Australian study was based]'.¹¹⁹ Wilson acknowledged that there were methodological differences between the two studies, with the Australian study focusing on preventability... rather than the Harvard Study's focus on negligence.¹²⁰ He said in reference to the research groups that '[t]hey're quite comfortable that our data has been collected accurately, analysed and reported accurately'.¹²¹ With the quality of data and methodology of the QAHCS research exposed to criticism of this type, it is unsurprising that the study and the report within which it was contained led to very little real action on iatrogenic harm, despite the urgent need for action.

That these discussions about data and method had come to take centre stage irritated some of the members of the earlier Lawrence-appointed taskforce led by Armstrong, whose report and recommendations had been pushed aside and against which the AMA had

¹¹⁷ Dr Norman Swan, well-respected health and healthcare reporter for the ABC narrated the position in the 'voice' of Wooldridge as 'I don't trust the data; I've been to Harvard University, who've done a similar study and they've said they don't trust the findings' ABC Radio National, above n 109; Runciman and Moller, above n 38, 4.

¹¹⁸ Runciman and Moller, above n 38, 4.

¹¹⁹ ABC Radio National, above n 109.

¹²⁰ A factor that Tito provides a detailed accounting of, driven by an early review conducted by the Australian Institute of Health and Welfare, who felt that a focus on preventability was preferable to one focused upon prima facie negligence, as had been the case with the Harvard Study, Tito, above n 23.

¹²¹ ABC Radio National, above n 109.

lobbied.¹²² They believed debate about the original findings diverted attention from the need for action. Dr John Royle, who was the Royal Australian College of General Practitioners' representative on the early taskforce, put it clearly: 'To hell with whether we're better or not better than Harvard... If we've got a problem, we should fix it'.¹²³ A survey of the literature shows that others read into the differences between the two nations, with Professor Armstrong himself saying at the time that '[t]here is no doubt in my mind that we have a bigger problem than in the US',¹²⁴ but that action was what was required, rather than further study. Still others felt that focusing on iatrogenic harm was foolhardy, with the Australian Medical Association's Federal President, Dr Keith Woollard, describing the attempt to eliminate iatrogenic harm as 'an impossible dream',¹²⁵ arguing it would be more fruitful to develop new treatments instead of concentrating on errors – preferring to focus on the potential of some yet-to-be discovered innovation rather than accept that doctors could improve patient care by addressing the causes that drive their own errors.¹²⁶

In the face of this criticism, Minister Wooldridge commissioned further studies to understand the underlying drivers of divergences between the Australian and US studies. The leading study was to be conducted by Runciman, who had voiced a dissenting opinion about the conduct of the QAHCS study. He undertook to compare the Australian QAHCS data with that in the United States.¹²⁷ To do so, data from the QAHCS was re-analysed according to the methods and definitions of a recently completed US study of iatrogenic harm.¹²⁸ This international comparator study, the Utah and Colorado Medical Practice Study ('*UTCOS*'),¹²⁹ shared a methodological heritage with the QAHCS, based as they both were upon the Harvard Study.¹³⁰

¹²² As stated above, the AMA were not included on the task force, a factor that Armstrong was said to have been a mistake. Sweet, above n 42.

¹²³ Ibid.

¹²⁴ Ibid.

¹²⁵ Ibid.

¹²⁶ Ibid.

¹²⁷ Thomas et al, above n 33; Runciman et al, above n 33; Runciman and Moller report that 'Overall, QAHCS used more reviewers and wider inclusion criteria with respect to the likelihood of causation by medical management, the timing of the adverse events in relation to the randomly selected admission, and the type and severity of event' Runciman and Moller, above n 38, 17.

¹²⁸ See 'Stage 2' of the international benchmark design, Thomas et al, above n 33.

¹²⁹ Eric J Thomas et al, 'Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado' [2000] *Medical Care* 261; David M Studdert et al, 'Negligent Care and Malpractice Claiming Behavior in Utah and Colorado' [2000] *Medical Care* 250.

¹³⁰ Thomas et al, above n 33, 372.

The results of this comparison by Runciman and colleagues of the Australian QAHCS data and the US UTCOS study altered the picture of iatrogenic harm presented by QAHCS – but not by the margin perhaps hoped for. When Australian QAHCS data were re-analysed according to the UTCOS protocol,¹³¹ the results showed that 10.6 per cent of the re-analysed Australian/QAHCS admissions were counted as adverse events compared with 16 per cent as found in the original QAHCS study itself. However, the re-analysed Australian QAHCS data still returned a rate of adverse events approximately three times greater than in the US comparator study; merely 3.2 per cent of US/UTCOS admissions had been classified as adverse events compared with the approximately ten per cent in the Australian admissions.¹³² Regardless, it was concluded that ‘at least’ ten per cent of admissions to Australian acute-care hospitals were associated with an adverse event,¹³³ rather than the 16 per cent of the earlier study, whilst 0.3 per cent of admissions were associated with an iatrogenic death and 1.7 per cent with major iatrogenic disability.¹³⁴ These figures remain unchallenged as the Australian incidence of iatrogenic harm in hospitals,¹³⁵ with other studies confirming this rate in New Zealand shortly afterwards.¹³⁶ To date, no large scale, medical record-based analysis has been completed since the QAHCS study and its re-analysis by Runciman in Australia.

At the end of that long and tumultuous decade, between calls for an inquiry into the tort crisis through Runciman’s comparator study, what remained true was that the incidence of

¹³¹ Note well that this is not strictly accurate, as the UTCOS/QAHCS benchmarking study did not utilise original medical records, but clinical summaries of QAHCS index admissions, and applied the UTCOS methods after nurse screening. See *ibid* 374–375.

¹³² Thomas et al, above n 33.

¹³³ Runciman and Moller, above n 38, 4.

¹³⁴ *Ibid* 17.

¹³⁵ So too have they been confirmed by the experience in other jurisdictions. In New Zealand, for example, Davis and Lay-Yee et al reported on a national survey of adverse events in New Zealand public hospitals, PB Davis et al, ‘Adverse Events in New Zealand Public Hospitals: Principal Findings from a National Survey’ (Number 3, December 2001) <<https://www.health.govt.nz/system/files/documents/publications/adverseevents.pdf>>.

¹³⁶ Initial results of this first study were that 4.5% of all admissions in New Zealand public hospitals were associated with highly preventable adverse events. *Ibid* iii; Results published a year later showed the proportion of hospital admissions associated with an adverse event was 12.9% (incidence rate, 11.2%), of which nearly one fifth had occurred outside a public hospital (mainly doctor’s rooms, patient’s home, rest home, or private hospital). Most adverse events had minor patient impact, with less than 15% associated with permanent disability or death. Peter Davis et al, ‘Adverse Events in New Zealand Public Hospitals I: Occurrence and Impact’ (2002) 115(1167) *New Zealand Medical Journal* <<http://www.nzma.org.nz/journal/115-1167/271/>>; see also, Davis et al, ‘Adverse Events in New Zealand Public Hospitals’, above n 135; Peter Davis et al, ‘Adverse Events in New Zealand Public Hospitals II: Preventability and Clinical Context’ (2003) 116(1183) *New Zealand Medical Journal* U624.

iatrogenic harm was still very high. Australian data showed iatrogenic harm occurring at three times the rate in the US, and the incidence of iatrogenic harm led to as many as 50,000 permanent disabilities and 10,000 deaths per annum.¹³⁷ Iatrogenic harm in healthcare could no longer be understood as the ‘fairly isolated events’ that had been the dominant perception of them in the past.¹³⁸ Instead, this work throughout the 1990s had shown that harm associated with the healthcare process was not rare but, rather, was ‘common, systematic, ubiquitous, and, all too often, severe’.¹³⁹ It had taken a decade to get to this point, in which very little had really been achieved, save that Australian data had been revised, showing harm now occurred at a rate three, rather than six, times the rate of the United States – a Pyrrhic victory indeed.

Ross Wilson, the lead author of the original QAHCS study, put it plainly: ‘to admit that [there is a problem with the quality of healthcare in Australia] suggests that we might alter the confidence of patients, or we might threaten the professional standing of individual healthcare providers’.¹⁴⁰ Whilst this might be ‘a difficult starting point’, as he put it, the truth is far more difficult; there truly was, and remains, a problem with the quality of healthcare in Australia and plainly any reduction in public confidence or professional standing is duly warranted. Wilson’s summation, however, makes clear that within contours of the medical politics of the time; real, urgent action was impossible. The path of iatrogenic harm seemed destined to mirror that of indemnity insurance and, as with indemnity insurance, law was to be blamed, with ‘reform’ the solution in both cases.

III. THE EXPULSION OF LAW

In the previous section, I constructed a new and original history of ‘discovery’ of iatrogenic harm, tracing the crucial moments that forced debate, changed policy and shaped the ways of speaking about iatrogenic harm and law in Australia. This section asks in more detail how law and its relationship to these adverse events in the healthcare system was constructed in and through those events. The deployment and circulation of various ideas at the time fashioned law as fundamentally different from quality and safety science

¹³⁷ Runciman and Moller, above n 38, xv. The total population of Australia at this time was approximately 19 million.

¹³⁸ For example, see William B Runciman, Alan F Merry and Fiona Tito, ‘Error, Blame, and the Law in Health Care-an Antipodean Perspective’ (2003) 138(12) *Annals of Internal Medicine* 974, 975.

¹³⁹ Ibid.

¹⁴⁰ ABC Radio National, above n 109.

and incompatible with its operation.¹⁴¹ The purpose of this section is to elucidate several of those key ideas: (a) that tort law was to blame for problems with the indemnity system and thus should not be available as a form of redress; (b) that, like tort, criminal law was associated with unproductive blame while quality and safety disciplines were associated with productive learning and improvement; (c) that adverse events were largely unpreventable and should rarely if ever be construed as acts of negligence; and (d) that law required reform in order to cohere with the productive activities and goals of quality and safety science. Together, these four ideas served to motivate and justify the expulsion of law from the quality and safety discipline's endeavours to address iatrogenic harm. I deal with each in turn.

D *The Scapegoating of Tort Law*

Tort law was blamed for problems with the indemnity system. The Professional Indemnity Review and its QAHCS research was conducted in the first place because tort law was being (incorrectly) blamed for a developing medical indemnity crisis. As shown above, in the years leading up to the collapse of the MDO system, law's responsibility for health system dysfunction remained a persistent theme in public and scholarly discussions. Australian legal scholar Peter Cane, for example, recounts in an analysis from shortly after the collapse of the MDO system that the law was characterised at the time as feeding into the difficulties of indemnity and the indemnity system:

Central to debates about the insurance crisis were assertions of a positive correlation between the rules and principles of tort law and their application in the tort system, and the sudden blowout in the cost of liability insurance... In this, as in many other respects, perceptions are at least as important as reality.¹⁴²

So, too, was law then thought of as requiring expulsion from the scene of iatrogenic harm. As medical scholarship structured the conflict at the time,

[m]edical decision-making is based upon mathematical probability in determining the significance of variables involved. Truth is often not absolute and medical decisions often

¹⁴¹ See Frakes and Jena, above n 10; Michael Frakes, 'The Impact of Medical Liability Standards on Regional Variations in Physician Behavior: Evidence from the Adoption of National-Standard Rules' (2013) 103(1) *The American Economic Review* 257; Frakes, above n 10.

¹⁴² Cane, above n 15 Cane writes that sufficient data does not exist to truly assess the veracity of these claims, I believe that this is not the case. see also Cashman, above n 5.

require reconsideration of information, reanalysis and possible change. Litigation based upon error negates the ordinary practice of medicine.¹⁴³

So many of the events of the period were interpreted as evidence of law's failure, and cause for its expulsion. This, even when the evidence pointed to factors apart from law as the 'culprits'. The collapse of UMD/UMP in 2002 and the broader MDO system is a prime example of this pattern. When UMD/UMP collapsed, it was not interpreted, as one might expect (or hope), as a vindication of Tito or her inquiry, that had proffered clear and detailed warnings of the risk of collapse and its causes. Nor was it taken as a sobering confirmation that law was not the sole cause of the indemnity system's volatility. Instead, UMD/UMP's demise became another opportunity to frame law as the cause, not only of the MDO system's dysfunction, but also of the dysfunction in the health system more generally. Not only this, it developed into an opportunity to frame harmed patients themselves in the same manner; their seeking redress for injuries through tort was criticised on the same grounds as tort itself.¹⁴⁴

Comments made at the time by the minister responsible for the portfolio, Senator Helen Coonan, are emblematic of this wilful re-interpretation of the MDO collapse and the blame-shifting to tort and harmed patients who utilised it. Senator Coonan presented the collapse as a collision of tort law with healthcare, despite ample evidence to the contrary, and engaging in an unfortunate display of victim-blaming, with injured patients presented as the cause of the dysfunction of the health system.¹⁴⁵

¹⁴³ C Wood, 'The Mismatch of Litigation in Medical Practice' (1998) 38(4) *The Australian & New Zealand Journal of Obstetrics & Gynaecology* 365.

¹⁴⁴ At that time, and still today, the only available remedy apart from reliance on private and family support, finance or, now, provision through the NDIS. See, however, Harold Luntz, 'Compensation Recovery and the National Disability Insurance Scheme' (2013) 20 *Torts Law Journal* 153; Jason Taliadoros, 'Eligibility for Lifetime Care and Support under the NDIS Act: Lessons from Accident Compensation Schemes in Victoria' in *Australasian Compensation Health Research Forum, 10-11 October 2013, Sydney* (Deakin University, School of Law, 2013).

¹⁴⁵ See also for example the rise of the discourse of an overly litigious Australian community in 2002 especially, Tim Besley, 'Fear of Risk Is as Much a Risk as Risk Itself' *The Age* (Melbourne, Vic.), 24 December 2002 11; 'Council Blamed for Diving Mishap - \$5m Damages Bill a Sign of the Times' *The Gold Coast Bulletin* (Southport, Qld), 21 December 2002 006; Steve Perkin, 'Sink or Swim' *Herald Sun/Sunday Herald Sun/Home Magazine* (Melbourne, Australia), 21 December 2002 027; James Chessell, 'Greed' *The Age* (Melbourne, Vic.), 11 December 2002 16; 'Rights Gone Wrong' *Northside Chronicle* (Brisbane, Australia), 4 December 2002 006; Fiona Anson, 'In a Limbo Lock' *Daily Telegraph/Sunday Telegraph/Sunday Style Magazine* (Sydney, Australia), 12 November 2002 032; 'Social Fabric in Danger' *Mosman Daily* (Sydney, Australia), 7 November 2002 009; Catherine Henry, 'Bill Hits Victims Not the Lawyers' *Newcastle Herald* (Australia), 29 October 2002 9; Chee Chee Leung and Larissa Dubecki, 'End in Sight for Victoria's Insurance Nightmare - Public Liability' *The Age* (Melbourne, Vic.), 10 October 2002 6; 'Time to Rethink Insurance' *Canberra Times*, *The*

[T]here is no doubt that the way in which claims have been handled and the way in which Australia has become so much more litigious, has been a huge factor in this kind of blow-out.... We are now living with a culture of blame and Australians pretty soon, I think, have to decide whether or not you want to go to a good doctor – if you happen unfortunately to be injured, that your needs are met, but not that there are these open-ended claims so that \$15 million will almost bankrupt a medical indemnity insurer.¹⁴⁶

Coonan's post-collapse commentary had been previewed in Wooldridge's own interpretation of law some years earlier. For him, the improvement of safety standards was hampered by a culture of blame surrounding errors and accidents:

I think the legal system harms [quality and safety improvement] rather than helping it...I think it's quite negative... It's no good trying to blame individual doctors, nurses or hospitals[,] that's been shown to be completely counterproductive.¹⁴⁷

(Australia), 2 October 2002 21; 'Insurance Blow-Out' *Newcastle Herald* (Newcastle, NSW), 26 September 2002 5; Tim Besley, 'Even Turtles Stick Their Necks Out' *The Australian* (Sydney, NSW), 9 September 2002 011; Bina Brown, 'Ensure Thy Will Be Done on Earth' *The Australian*, 31 August 2002 033; Ruth Ostrow, 'Dissatisfaction Guaranteed' *The Australian* (Sydney, NSW), 10 August 2002 R31; Fiona Anson, 'Avoid Being Sued' *Daily Telegraph/Sunday Telegraph/Sunday Style Magazine* (Sydney, Australia), 6 August 2002 034. A media scan reveals that in 2002, Australian newspapers (indexed by NewsBank) reported 'litigious, insurance' in 238 articles. This was the peak of a rise beginning in approximately 1996 (11), but a sharp increase from 2001 (92) and 2003 (61) from which point the mentions reduce sharply to 2008 (5). AAP, 'Warnings of Dead Babies Slammed' *Sunday Tasmanian* (Hobart, Tas.), 4 August 2002 006.

¹⁴⁶ above n 24; See also in relation to the place of harmed patients and their alleged fault for indemnity and system function woes, Henry, above n 145; Australian Associated Press Canberra Bureau, 'Lives at Risk' Over Premiums' *Cairns Post, The Australian*, 3 August 2002 010; 'AMA's Taxpayer-Funded No-Fault Plan 'ludicrous'' *The Cairns Post* (Cairns, Qld.), 29 July 2002 009; Lisa Gilby, 'Litigious' Patients Under Fire' *Courier Mail, The/Sunday Mail, The/QWeekend Magazine* (Brisbane, Australia), 1 July 2002 002; Craig Johnstone, 'Ducking for Cover' *Courier Mail, The/Sunday Mail, The/QWeekend Magazine* (Brisbane, Australia), 9 May 2002 019; Michelle Grattan, 'A Tail Goes in Search of a Donkey' *The Sydney Morning Herald* (Sydney, NSW), 3 May 2002 11; Miranda Devine, 'Lawyers Delivered This Mess' *The Sydney Morning Herald* (Sydney, NSW), 2 May 2002 13; 'Another Health Burden for Taxpayers' *Advertiser, The (Adelaide, Australia)*, 1 May 2002 017; 'Crisis Catches Government on the Hop' *The Courier Mail* (Brisbane, Qld.), 1 May 2002 012; 'Down Scalpels - Doctors Warn Lives Could Be in Danger Surgeons Cancel Work as Crisis Deepens - Medical Indemnity Crisis' *Illawarra Mercury* (Wollongong, Australia), 1 May 2002 1; 'Medicos Fear Insurance Loss' *The Cairns Post* (Cairns, Qld.), 30 April 2002 002; Amanda Place, 'When Sorry Is the Hardest Word - Health' *Age, The/The Sunday Age* (Melbourne, Australia), 29 November 2003 26; Steve Dow, 'Bedside Manners' *The Sydney Morning Herald* (Sydney, NSW), 23 October 2003 1; Simon Kearney, 'Doctors Take Cake, Then Want Icing' *Sunday Times/Home Publication/Prestige Property/Sunday Style* (Perth, Australia), 12 October 2003 064; Anthony Fisher OP, 'Blame Is Not a Game You Win - The Moral Maze' *The Sun Herald* (Syd), 14 September 2003 64; Clara Pirani, 'Patients and Taxpayers Will Foot the Medical Bill' *The Australian*, 16 August 2003 C14.

¹⁴⁷ Annabel Crabb, 'Council Tackles Hospital Deaths - Errors Include Surgeons Bungling Operations' *The Adelaide Advertiser* (Adelaide, SA), 22 January 2000 002.

On this point, Minister Wooldridge was blunt: ‘I can’t pass a law saying [iatrogenic harm] won’t happen’.¹⁴⁸

The seemingly intractable jurisdictional dispute between tortious and criminal negligence and quality and safety science over iatrogenic harm reached new heights as the conflict became cast as one between lawyers and doctors. In one opinion piece in the midst of the tension, for example, a prominent negligence lawyer wrote ‘Why the barricades? – Doctors are Not under Legal Siege’.¹⁴⁹

[T]he self-serving view of doctors under siege is not sustainable, and it is unacceptable that doctors should seek to place themselves above the rest of the community, by asking that medical litigation be taken out of the common law system. Why should doctors, unlike any other professionals, be immune from the consequences of negligent mistakes?¹⁵⁰

Another article signed-off: ‘[m]eanwhile, perhaps surgeons who feel cheated by the law could accelerate reform by giving judges, lawyers and parliamentarians a sharp dose of the adversarial system when they get them on the table’,¹⁵¹ complete with a cartoon illustrating a surgeon exacting their revenge upon the body of a lawyer lying on the operating table.¹⁵² This drew a retort in the letters pages that included the following provocation in response to the article and its inflammatory cartoon:

What’s the real gripe...? Lose a girl to a lawyer? Bullied at school by someone who became a lawyer? Rolled in the Family Court? Didn’t get the grades to get into law school? If you’ve got an objective message, let’s hear it - otherwise, please stop grinding the axe.¹⁵³

All this commentary flew in the face of the evidence delivered by Tito. However, the deployment of this idea of a legal cause of indemnity failures, and the greed-induced blaming culture of harmed patients, had a significant pedigree. It was a continuation of a trope dominant even before the Professional Indemnity Review and QAHCS. As discussed above, that trope had in fact brought on and justified the work of Tito. Yet, without fear or

¹⁴⁸ Ibid.

¹⁴⁹ Henderson, above n 72. Paul Henderson was a Partner of Slater & Gordon, a large plaintiff firm.

¹⁵⁰ Ibid.

¹⁵¹ Evan Whitton, ‘Practitioners Sick of Legal Medicine’ *The Australian*, 5 November 1998 015.

¹⁵² Described as an ‘inflammatory cartoon’ by Sydney Barrister Dr Richard Pincus, see Richard Pincus, John Watts and Tony Sowden, ‘Letters, Medical Negligence and the Law’ *The Australian/Weekend Australian/Australian Magazine*, 9 November 1998 012.

¹⁵³ Written by Tony Sowden, a Queensland Solicitor, *ibid.*

action of law, the Professional Indemnity Review and its QAHCS programme of research would never have occurred.¹⁵⁴ The Professional Indemnity Review had undermined the validity of the law-blaming trope and the attempt to escape legal liability and shift blame for health system dysfunction, showing that the MDO system was the cause of its own instability, and had exposed a far greater problem with iatrogenic harm than had been acknowledged to date. For this reason, the continued mobilisation of these ideas was a direct contradiction of the underlying reality as expressed by Tito in her Professional Indemnity Review.

Regardless, following the ‘unprecedented move’,¹⁵⁵ in 2000 by medical colleges and medical representative bodies to call for ‘wide ranging [law] reform... to stop spiralling medical insurance costs’,¹⁵⁶ proposals for the reform of tort law began to be made concrete.¹⁵⁷ Terms of reference were written for a major review of the civil liability system, to be led by Justice David Ipp – the Review of the Law of Negligence, known generally as the Ipp Review. As scholar of medicine and law Thomas Faunce astutely observes, those terms of reference *required* Ipp and his ‘Panel of Eminent Persons’¹⁵⁸ to examine the law of negligence with the ‘objective of limiting liability and quantum of damages arising from personal injury and death’.¹⁵⁹ The Ipp Review was instructed, in the words of Faunce, that it ‘*must* assume it was “desirable” to limit the responsibility of people who behaved recklessly *and* limit the amounts that their insurers should pay to those harmed by their careless conduct. It was prevented from examining the true nature of

¹⁵⁴ Data was not required to ground tort reform in relation to its specific medical aspects, nor more generally. As Write notes, ‘[d]etailed statistical data on civil litigation trends in Australia [was] not readily available’, and ‘[i]ndeed, the decision to establish the Ipp [Review] and the policy decisions recommended by it and implemented by state and territory governments were made largely in the absence of such data’, EW Wright, ‘National Trends in Personal Injury Litigation: Before and After “Ipp”’ (26 May 2006) 7 <<http://www.nswbar.asn.au/circulars/Prof%20Wright%20report%20May%2006.pdf>>; see also EW Wright, ‘National Trends in Personal Injury Litigation: Before and After “Ipp”’(2006)’ 14 *Torts Law Journal* 233.

¹⁵⁵ *Doctors Fight Back on Soaring Indemnity Costs*, above n 84.

¹⁵⁶ *Ibid.*

¹⁵⁷ As Faunce writes, ‘A major factor encouraging these massive restrictions on the capacity of injured patients to receive fair compensation was the threatened bankruptcy of the largest medical indemnity defence organisation in Australia, United Medical Protection (UMP)’, Faunce, above n 15, 62.

¹⁵⁸ The Review was conducted by the so-called ‘Panel of Eminent Persons’ consisting of Justice David Ipp, Associate Professor Donald Sheldon, Mr Ian Macintosh and Professor Peter Cane. The Panel’s final report — incorporating its first report, published in August 2002, was presented in September 2002, Panel of Eminent Persons, ‘Review of the Law of Negligence: Final Report’ (September 2002) (‘The Ipp Review’) <<https://www.treasury.gov.au/ConsultationsandReviews/Reviews/2002>>.

¹⁵⁹ Faunce, above n 15, 62.

the insurance market and the factors responsible for the insurance “crisis”.¹⁶⁰ This was, as Corbett wrote, ‘a one-dimensional model as the basis for proposing reform of tort law’.¹⁶¹

The result of the Ipp Review was to severely curtail the availability of civil negligence remedies in all but the most incomprehensibly extreme cases of harm, with statutes restricting the rights of citizens to bring civil liability claims introduced in each Australian jurisdiction,¹⁶² whilst damages were limited to approximately \$500,000 in the process.¹⁶³ Justice Ipp has since commented on the reforms of which he was a key architect, stating:

Judges at the highest level have expressed unease. The legal profession and victims’ associations are unhappy and are clamouring for change. They are conducting a well-orchestrated campaign for reform. This brings about an atmosphere of uncertainty and instability... There is a clear clash of values and interests between the different participants in the politics of negligence.¹⁶⁴

A ‘politics of negligence’ it certainly was.

E *The Shift Towards Criminal Law*

Nonetheless, the law-critical theme not only continued but gathered momentum, eventually gaining enough traction to cause wholesale reform of tortious negligence and the continued rejection of criminal law’s validity in relation to cases of iatrogenic harm. The radical civil liability reform of that era, largely justified as a response to the mythical insurance crisis faced by organised medicine,¹⁶⁵ significantly reduced the ability of victims of iatrogenic harm to seek redress.¹⁶⁶ After the battles waged in the ensuing ‘tort-wars’,¹⁶⁷

¹⁶⁰ Ibid.

¹⁶¹ Corbett, ‘(Self)Regulation of Law’, above n 15, 641.

¹⁶² *Civil Law Wrongs Act 2002* (ACT); *Civil Liability Act 2002* (NSW), (WA), (Tas), (Qld); *Personal Injuries (Liability and Damages) Act 2003* (NT); by amendment to the *Wrongs Act 1958* (Vic), similarly, by amendment to the *1936* (SA).

¹⁶³ Cashman, above n 5, 888.

¹⁶⁴ Ipp, above n 15.

¹⁶⁵ Henderson, above n 72.

¹⁶⁶ See Thomas Faunce’s summary of the views of senior members of the Judiciary, Faunce, above n 15, 62–63 (where Faunce quotes Paul de Jersey, Chief Justice of Queensland at the time, who regarded the reforms as having ‘brought about marked erosion of a fundamental human right to personal safety and security and to receive adequate compensation’).

¹⁶⁷ Joel Levin, *Tort Wars* (Cambridge University Press, 2008); Michael Legg, *Tort Wars: Class Actions Set to Increase as Laws Wind Back* The Conversation <<http://theconversation.com/tort-wars-class-actions-set-to-increase-as-laws-wind-back-32707>>; Cashman, above n 5; Cane, above n 15; Barbara McDonald, ‘Legislative Intervention in the Law of Negligence: The Common Law, Statutory Interpretation and Tort Reform in Australia’ (2005) 27 *Sydney Law Review* 443; Barbara McDonald,

tort was left as a misshapen area of law, too weighted in favour of tortfeasors to offer justice to those harmed.¹⁶⁸ A shift towards attention to criminal law followed closely behind the end of tort reform. Like tort, this shift of attention from tort to criminal law was again facilitated by the deployment of the idea of law as fundamentally different from quality and safety science and incompatible with its operation¹⁶⁹ and highlighting the centrality of blame to the practice of criminal law.

An alleged dramatic rise in the criminal prosecution of medical practitioners in major centres related to the Australian context through shared medical, legal and political history and culture (New Zealand and the UK) drove this focus on the criminal law in discussion of healthcare quality and safety. In New Zealand, anaesthetist and academic Alan Merry had been a vocal reporter and critic of prosecutions of medical practitioners made on this anomalously low negligence standard over successive years.¹⁷⁰ His critique was aimed initially at the anomalous use in New Zealand of the civil or ‘ordinary’ negligence standard in their definition of manslaughter by criminal negligence.¹⁷¹ As law reform rightly arrived in New Zealand, his writing about the prosecutions of doctors in that jurisdiction shifted. Merry came to characterise the New Zealand experience of prosecution as part of a rising trend of prosecutions during the 1990s, rather than as a result of the anomalously low standard required to run afoul of the criminal law.¹⁷² At this point, Merry began to argue for an urgent re-thinking of the availability and use of criminal prosecution on broader grounds. In particular, he focused upon the suitability of legal liability and blame in instances that involved human error, which he understood to be a ‘completely normal and necessary part of human cognitive function’¹⁷³ and thus unworthy of blame or legal liability.

‘The Impact of the Civil Liability Legislation on Fundamental Policies and Principles of the Common Law of Negligence’ (2006) 14(3) *Torts Law Journal* 268.

¹⁶⁸ McDonald, Ipp personal reflection article.

¹⁶⁹ See Frakes and Jena, above n 10; Frakes, above n 141; Frakes, above n 10.

¹⁷⁰ Alan Merry, ‘When Are Errors a Crime?—Lessons from New Zealand’ in Charles A Erin and Suzanne Ost (eds), *The Criminal Justice System and Health Care* (Oxford University Press, 2007) 95; see also PDG Skegg, ‘Criminal Prosecutions of Negligent Health Professionals: The New Zealand Experience’ (1998) 6(2) *Medical Law Review* 220.

¹⁷¹ Merry, above n 170; see also the work of Patterson for an excellent overview of the reform process in New Zealand, Ron Patterson, ‘From Prosecution to Rehabilitation: New Zealand’s Response to Health Practitioner Negligence’ in Danielle Griffiths and Andrew Sanders (eds), *Bioethics, Medicine and the Criminal Law: Medicine, Crime and Society* (Cambridge University Press, 2013) vol 2, 229.

¹⁷² Merry, above n 170, 95; see also Skegg, above n 170.

¹⁷³ MF Allnutt, ‘Human Factors in Accidents’ (1987) 59(7) *British Journal of Anaesthesia* 856; cited in Merry, above n 170, 67.

Merry's own shift of attention was an expression of a more widespread shift at this time from consideration of tort to criminal law. Most of this consideration occurred in the United Kingdom, where the death of a teenage cancer patient, Wayne Jowett,¹⁷⁴ resulted in a high-profile criminal prosecution of UK oncologist Dr Feda Mulhem.¹⁷⁵ Mulhem had supervised a more junior doctor in the administration of a course of Vincristine – a cytotoxic drug – by injection into the patient's cerebrospinal fluid by lumbar puncture. This drug was meant to be delivered by intravenous route.¹⁷⁶ Mulhem pleaded guilty, and was given an eight month custodial sentence.¹⁷⁷ When interviewed by police in relation to the death, Mulhem had said at the time, 'I know it's a lame excuse, but I am a human being'.¹⁷⁸ This sense of the injustice of punishing human error became a central feature of criticism of criminal law and part of the significant attention that this prosecution generated. Serious and wide-ranging public inquiries in relation to large-scale failures in quality and safety took place in that jurisdiction that further put pressure on the question of iatrogenic harm and its prevention. Against that background Ferner's, and then Ferner and McDowell's, highly influential accounts of the history of criminal prosecution of medical practitioners in the UK were published. They argued in their major work on the topic that whilst four doctors had been charged with manslaughter between 1970 and 1989, 17 were charged during the 1990s.¹⁷⁹ The conclusion from Ferner, McDowell and others was that criminal prosecution was on the rise, and unfairly targeting doctors like Mulhem.¹⁸⁰

¹⁷⁴ This occurred in the same year as victim at the centre of the landmark case of Lavender was killed in NSW, *R v Lavender* [2004] NSWCCA 120 (21 May 2004); In relation to Lavender and its importance see, Penny Crofts, *Wickedness and Crime: Laws of Homicide and Malice* (Routledge, 2013).

¹⁷⁵ The case of Wayne Jowett has been a landmark case in the history and reception of patient safety and the quality and safety in healthcare. Clare Dyer, 'Junior Doctor Charged with Manslaughter after Medical Error' (2002) 325(7365) *BMJ* 616; Simon Dyer, 'Gross Negligence Manslaughter: The Facts of R v Mulhem' (2004) 10(1) *Clinical Risk* 28; Paul Balen, 'Gross Negligence Manslaughter: Wayne Jowett (Deceased)' (2004) 10(1) *Clinical Risk* 25.

¹⁷⁶ Mulhem had not reviewed the patient's records or clinical details and had failed to notice written instructions on the side of a syringe, which warned specifically that the drugs were not to be injected into the spine. Wayne Jowett died a month later, enduring a slowly spreading paralysis of the body causing, eventually, his heart to stop. His death was the twelfth-known fatality caused by maladministration of vincristine during the fifteen years prior in the United Kingdom alone. See Elise Springer, *Communicating Moral Concern: An Ethics of Critical Responsiveness* (MIT Press, 2013).

¹⁷⁷ Dyer, 'Gross Negligence Manslaughter', above n 175.

¹⁷⁸ Norfolk A. Doctor admits fatal blunder over cancer boy. *Times* 2003, September 23:p 7 cited in Jon Holbrook, 'The Criminalisation of Fatal Medical Mistakes' (2003) 327(7424) *BMJ* 1118.

¹⁷⁹ RE Ferner, 'Medication Errors That Have Led to Manslaughter Charges' (2000) 321(7270) *BMJ* 1212, 1212; this was to be the basis of a much wider-ranging review, see Robin E Ferner and Sarah E McDowell, 'Doctors Charged with Manslaughter in the Course of Medical Practice, 1795-2005: A Literature Review' (2006) 99(6) *Journal Of The Royal Society Of Medicine* 309.

¹⁸⁰ See Chapter One for a detailed overview of the arguments made by Ferner and McDowell and their reception.

As described in Chapter 1, this new account of the history and alleged recent dramatic rise in the criminal prosecution of medical practitioners in the UK drew increased attention to criminal law. Why was there an alleged ‘shift from tort to crime’¹⁸¹ being observed at this time? Was the tort ‘crisis’ about to be repeated? Were doctors set to become the victims of criminal law as they understood themselves to have been in relation to tort? In a highly cited editorial in the *British Medical Journal* (*BMJ*),¹⁸² British barrister Jon Holbrook argued that ‘[a] social intolerance of medical mistakes has caused them to be criminalised’.¹⁸³ He was reflecting upon a decision by the BMJ in 2001 to ban the word ‘accident’ from its pages. In that editorial, the BMJ justified its stance on the basis that ‘most [iatrogenic] injuries and their precipitating events are predictable and preventable’, and this meant that the word ““accident” should not be used to refer to “injuries or the events that produce them””.¹⁸⁴ Iatrogenic injury was no longer unpredictable and so the epithet ‘accident’ should no longer be applied. Holbrook interpreted this decision as symbolic of a broader shift, arguing that it, and the perspective it represented, contributed to what he discerned as a trend in recent years of medical mistakes becoming ‘tragedies calling for criminal investigation’.¹⁸⁵

Whilst some, like Holbrook, argued that the alleged shift in the meaning of human action and responsibility that the removal of ‘accident’ from the BMJ symbolised stood to potentiate the use of these authoritative blaming practices, others now bemoaned how the *lack* of tortious negligence actions was, they felt, leading to increased ‘use’ of the criminal law. Robert Wheeler, UK paediatric and neonatal surgeon, provides a neat example in his writing at the time that:

[i]ndividual patients have trusted their doctors to a variable extent, for years, relying on civil remedies [i.e. tort] when misadventure occurs. Increasingly frustrated by the closed ranks of the medical profession, the lack of forthcoming explanations, and the lack of apologies claimants are relying on actions in [criminal] negligence.

With changes having been made to tort, reducing its effectiveness and reach in the UK and elsewhere, damages were, according to Wheeler, no longer sufficient to be ‘regarded as

¹⁸¹ Robert Wheeler, ‘Medical Manslaughter: Why This Shift from Tort to Crime?’ (2002) 152 *New Law Journal* 593.

¹⁸² With fifty-five citations at present: <scholar.google.com.au >

¹⁸³ Holbrook, above n 178.

¹⁸⁴ Ronald M Davis and Barry Pless, ‘BMJ Bans “Accidents”’ (2001) 322(7298) *BMJ* 1320.

¹⁸⁵ Holbrook, above n 178.

punitive... accountability cannot be laid firmly at the door of the transgressor, [whereas]... a prosecution for manslaughter changes all of that'.¹⁸⁶ Wheeler wrote, however, that in this shift, the fundamental driver was a 'greater opportunity for revenge' rather than – as he had admitted – a reduced availability of civil remedy, closed ranks of the medical profession, and potentially the loss of trust between doctor and patient.¹⁸⁷

Even if acquitted [of a criminal charge], the hospital doctor's career will be over; professional life may still be tenable, but in a significantly reduced state. Conviction will almost certainly lead to punishment in all conceivable spheres of life. Imprisonment will be simultaneously accompanied by the revocation of medical registration, with automatic and permanent dismissal from post. Financial and social and personal ruin may all flow from this.¹⁸⁸

These discussions in the UK and New Zealand filtered into the Australian medical press and consciousness. Absent any more Australian-specific material upon which to base analysis, and subject to the continued sidelining of the work of Tito and the QAHCS, what failed to register in this bringing of criminal law into the 'firing line', was the constructed nature of both the tort and criminal law 'crises' upon which many of the claims and debate had been based. In Australia, at least, it was clear that Tito had been correct, that there was simply no crisis of indemnity, and the indemnity and medical defence industry itself had been the cause of its own downfall.

So fabricated were these 'crises' that tort's overactive *and* underactive use was cause for its eradication. For example, Runciman et al wrote that the 'hope'¹⁸⁹ that tortious action would assist in the promotion of high standards and to provide compensation for patients who are harmed or injured has not been achieved:¹⁹⁰ 'less than 1% of people suffering preventable harm receive any compensation through the tort system, and there is little relationship between successful litigation and the degree to which negligent practice has

¹⁸⁶ Wheeler, above n 181.

¹⁸⁷ Ibid.

¹⁸⁸ Ibid; the Australian case of Pearce undermines the validity of this claim, with Pearce applying for and being re-registered following her conviction for manslaughter, *Medical Board of Queensland v Pearce* [2001] QHPT 004 (20 July 2001).

¹⁸⁹ Runciman, Merry and Tito, above n 138.

¹⁹⁰ Corbett argues reform has been marked by 'a failure to articulate a connection between tort law reform and medical indemnity insurance reform and the goal of improving the safety and quality of health care'. Corbett, 'Australia', above n 15, 215; see also Corbett, 'Regulating Compensation for Injuries Associated with Medical Error', above n 15; compare Frakes and Jena, above n 10.

contributed to harm'.¹⁹¹ Quite remarkably, now it seemed that a *low* rate of tortious claiming, and low rate of success in receiving compensation through those means,¹⁹² caused further reduction in the availability of tortious negligence to harmed patients through reform of civil liability. From a threat of overwhelming magnitude, tort law was now re-framed once again, still as a failure, but this time as failing to provide an adequate level of tortious claiming and success for patients. Runciman and Moller recommended at the time that:

Given the gross inequities with respect to access [to the tort system], the traumatic nature of the process and the high costs (less than half of which end up with a successful plaintiff), it would seem that reform should be placed back on the agenda, a proposal for which there is some support by the Medical Defence Organisations.¹⁹³

Tort was characterised only a few years earlier as so effective in its extraction of damages for harmed patients that it needed to be reformed away. Now, it was a weak and ineffective means of extracting damages – and thus required to be reformed away.

So, too, was the hand-wringing of the MDO system admitted to be merely a smokescreen, with voices like Stuart Boland, former Chair of Avant Mutual – the successor organisation of both UMD/UMP and the Medical Defence Association of Victoria ('*MDAV*') – commenting later that in joining the indemnity industry in the mid-1990s, he had 'gradually learned just how *bloated*, how *cottage industry* and how *dysfunctional* the Medical Indemnity environment was at that time...' [emphasis in original]¹⁹⁴ and that it was an industry fully aware of the truth of the claims Tito had made:

I believe there is evidence, that the industry was aware of the underfunding that Tito had suggested and there was recognition of the need for consolidation in the industry, for subscription increases and for Tort reform. But any coherent industry response was not forthcoming because at every turn, ego and vested interest always got in the way of rational decisions.¹⁹⁵

¹⁹¹ Runciman, Merry and Tito, above n 138, 974.

¹⁹² Whilst somehow still resulting in 'rapidly escalating litigation costs', Runciman and Moller, above n 38, xvi.

¹⁹³ Runciman and Moller, above n 38.

¹⁹⁴ Emphasis in original, Boland, above n 91.

¹⁹⁵ Ibid.

In the United States, too, there have emerged some voices who have very recently begun to question and undo the received wisdom about the tort crisis there. Rahmati and colleagues are one voice amongst a growing group who question the orthodoxy of the tort crisis. Following analysis of approximately thirty years of medical malpractice claims data from Illinois, they write that:

Tort reform may be a good idea or a bad idea. However, tort reform is aimed at a problem that has little to do with the malpractice crises that prompted Illinois to take action in the first instance. In other work, we find that damage caps have limited, if any, potential to reduce health-care spending and attract physicians. Those looking for a magic bullet for the ills that beset the health-care system would be well advised to look elsewhere.¹⁹⁶

As with the illusory tort crisis, the shift in blame from tort to criminal law for the ills of the healthcare system was based on a misreading of the reality of criminal prosecution. As shown in Chapter 1, interpretation of criminal prosecutorial data as demonstrating a rising trend in the UK was at best overstated, and at worst plainly incorrect.¹⁹⁷ Whatever ‘rising trend’ had been observed was fully accounted for by contextualising it with other factors, most notably the increased scale and intensity of in-patient health services delivery in the United Kingdom. In Australia, there was no increase in criminal prosecutions for iatrogenic death, and the contemporary era has seen more acquittals than findings of guilt for the few cases that have been prosecuted. Instead of a crisis of tortious indemnity or of criminal blaming, there was in fact a crisis of iatrogenic harm and a concerted effort to avoid liability. Despite efforts to normalise it, there were far too many patients being unnecessarily harmed, seriously disabled or killed by preventable adverse events.

Notwithstanding the questionable basis on which law was blamed for medicine’s dysfunction, the framing of tortious and then criminal law resulted, in 2003, in the first Australian scholarship that called specifically for the eradication of criminal blame in

¹⁹⁶ Mohammad Rahmati et al, ‘Insurance Crisis or Liability Crisis? Medical Malpractice Claiming in Illinois, 1980-2010: Insurance Crisis or Liability Crisis?’ (2016) 13(2) *Journal of Empirical Legal Studies* 183; Rahmati and colleagues join others including Black, Zabinski, Frakes and Jena who have come to look with fresh eyes at the data in recent years, see Bernard S Black, Wagner and Zenon Zabinski, ‘The Association between Medical Malpractice Risk and Healthcare Quality: Evidence from Texas’ [2011] (No. 11-20) *Northwestern Law and Economics Research Paper*; Frakes, above n 10; Frakes and Jena, above n 10.

¹⁹⁷ See Chapter 1. There I show how figures reported by Ferner, McDowell and Quick, all of whom trace this ‘rising trend’ are better expressed by normalising them in accordance with data showing the parallel rise of health system intensity, the number of practising physicians, and trends in criminal prosecution and arrest more generally.

relation to iatrogenic harm. That paper, jointly written by those key figures of the Australian story of iatrogenic harm, Bill Runciman, Alan Merry and Fiona Tito, called for a rejection of criminal blaming on the grounds of negligence to advance patient safety:

For it is that when things go wrong, the usual human response is to apportion blame, demand retribution and compensation, and seek assurance that the error will not occur again. Such redress is usually done through the legal system...¹⁹⁸ Wrongly blaming health care professionals is very damaging.... [and] [a]t an organizational level, the process for ensuring accountability must be dissociated from that for obtaining the necessary information for system improvement.¹⁹⁹

Here, the figure of the law-as-blame is positioned simply as an ‘other’ to that of the (effective) quality and safety disciplines.²⁰⁰ This is a continuation of the theme of law’s responsibility for system dysfunction, and of the intractable jurisdictional dispute between law and quality and safety over iatrogenic harm. Coupled now with the ‘time for action and not (legal) blame’ narrative, the interpretation of the foregoing decade of work on iatrogenic harm and indemnity was woven together with renewed, programmatic force in this article, the first Australian writing on criminal blame.

The history of healthcare quality and safety in Australia in the 1990s reveals the source of dominant views about the role and effectiveness of criminal law that are still felt to this day. In a sense, we remain stuck in the moment after the successful campaign for the eradication of tortious liability for iatrogenic harm, but before the conclusion of that same campaign with the eradication of criminal negligence liability. Stuck in this moment, the accepted but faulty view amongst medical and much legal scholarship remains that tort failed to provide a positive influence,²⁰¹ that tortious action ends up being ‘grossly wasteful of resources... time-consuming, threatening, and unpleasant for both the plaintiff and defendant’.²⁰² Accepted also is the view that criminal law is simply a theatre for revenge, with its engagement in the same blaming practices as tort law an ineffective dead-end with regards to reducing iatrogenic harm. In this dominant narrative, both doctrines thus remain a barrier to quality and safety improvement holding central place in the

¹⁹⁸ Runciman, Merry and Tito, above n 138, 974.

¹⁹⁹ Ibid 976.

²⁰⁰ Ibid 974.

²⁰¹ Ibid 976–8 (‘many commentators’).

²⁰² Ibid 974; Bill Runciman, Alan Merry and Merrilyn Walton, *Safety and Ethics in Healthcare: A Guide to Getting It Right* (Ashgate Publishing, Ltd., 2007) 83–84.

‘culture of blame’.²⁰³ Whilst these ideas continue to circulate, both tort and criminal law will remain subject to demands for their subordination to the control and needs of medicine, and at present to the discipline of quality and safety science, for the sake of patient safety.

IV. A FALSE DICHOTOMY

In the section just completed, I have outlined how law – first tort and then criminal law – was framed by the various activities of the period. What emerged during that period was a dichotomy between law and the quality and safety movement. What I have sought to make clear is not only how this emerged, but also that this was based on a false understanding of law and its conduct in relation to iatrogenic harm. However, in this final section, I wish to extend that argument slightly. Rather than resting with the claim that law had been mischaracterised, misunderstood and even unfairly blamed for the dysfunction of the medical system, I want to highlight how, contrary to the conclusion reached at the end of this period, law was in fact productive for both the formation of the field of quality and safety science, and of its ‘object’, iatrogenic harm. To do so, I simply highlight the role that law played in the discovery of iatrogenic harm, in the conceptual task of defining iatrogenic harm itself, in the influx of capital that enabled the solidification of the quality and safety movement, and in the ‘demarcation of failure as the rightful purview of the quality and safety movement. In this way, I point to how law is, in fact, instrumentally productive for reducing iatrogenic harm and has an appropriate role to play in the quality and safety discipline. Neither legal nor quality and safety scholarship has yet adequately addressed this clear structural and operational relationship between law and the quality and safety disciplines in relation to iatrogenic harm. This final section provides a critical reading of that relationship in order to highlight the varied ways in which the hegemonic framing of law and healthcare quality and safety were productive for healthcare quality and safety. To do so, I highlight how, rather than being disastrous for healthcare, the very failure to deliver safe treatment was in fact productive for healthcare itself.²⁰⁴

²⁰³ See Waring who provides an excellent overview of the role that the ‘culture of blame’ concept plays in medicine, but also argues that other factors are significant in preventing engagement with the quality and safety disciplines, Justin J Waring, ‘Beyond Blame: Cultural Barriers to Medical Incident Reporting’ (2005) 60(9) *Social Science & Medicine* 1927.

²⁰⁴ In this I am influenced by the work of Travaglia and Braithwaite in particular, see Joanne F Travaglia and Jeffrey Braithwaite, ‘Analysing the “Field” of Patient Safety Employing Bourdieusian Technologies’ (2009) 23(6) *Journal of Health Organization and Management* 597.

A point that might be easily missed in reviewing the account of this period is the particular ways in which law and regulation exist in a highly dynamic, mutually constitutive relationship, one that is productive for the quality and safety sciences. It is true that major parts of the debate formed and focused on expelling law from the governance of iatrogenic harm, and that this conflict developed a sense of acute separation and even incompatibility between legal blaming and the advancement of healthcare quality and safety. Law and quality and safety were framed as incompatible and autonomous. Yet this misses an important aspect of their relationship. Note how the debate and process surrounding the discovery of iatrogenic harm and responses to it focused so intensely on legal and regulatory questions.²⁰⁵ In fact, it was fundamentally shaped by and around legal questions; fear of legal intervention and desire to escape liability were the core drivers of the development of quality and safety science in healthcare.²⁰⁶

This focus on law can be seen in two major features of the period and its activity. Firstly, the data extraction/collection method using retrospective medical record review was developed in the context of the Californian medical litigation crisis in the 1970s with their *Medical Insurance Feasibility Study*.²⁰⁷ The entire ‘genealogy’ of studies, up to and including the landmark Australian QAHCS, relied on these methods; the initial Californian study begat the Harvard Study, which begat both the UTCOS and the QAHCS each sharing the two-stage medical record review methodology. In each of these landmark

²⁰⁵ In the Kennedy report into the Bristol Royal Infirmary, for example, the issue of legal liability for negligence – both civil and criminal – was a central organising theme of the inquiry. The report of the inquiry stressed at repeated times in its report, that ‘to a very great extent’ the failures outlined in its pages were to be properly located ‘within the hospital, its organisation and culture, and within the wider NHS as it was at the time’. However, the report also named individuals who in the view of the inquiry ‘could and should on occasions have behaved differently’ having ‘displayed flaws in their approach to management...[demonstrating] a lack of leadership and insight [or] failed to treat patients with appropriate respect and candour.’ This lack of candour was central to Kennedy’s recommendations, which included that ‘[h]ealthcare professionals should have a duty of candour to patients’. To achieve this, Kennedy recommended that ‘[c]linical negligence litigation, as a barrier to openness, should be abolished’, and that to incentivise reporting, immunity from disciplinary action – by both the NHS and professional bodies – be granted to healthcare professionals who report a sentinel event within 48-hours. The single area which was carved out of this incentive mechanism was the area of criminal offences committed by the reporter, for ‘[o]nly where there is criminal behaviour (which is thankfully rare), will there be a place for blame’, *The Bristol Royal Infirmary Inquiry, ‘The Report of the Public Inquiry into Children’s Heart Surgery at the Bristol Royal Infirmary 1984-1995: Learning from Bristol’* (CM 5207(I), July 2001) 9–11, 368.

²⁰⁶ This result of pressure brought to bear by tortious action is often missed in accounts that (otherwise correctly) critique the value of tort and litigation for the driving of quality and safety improvements in healthcare, see on that count for instance, Corbett, ‘Australia’, above n 15.

²⁰⁷ Mills, Boyden and Rubsamen, above n 29; Don Harper Mills, ‘Medical Insurance Feasibility Study: A Technical Summary’ (1978) 128(4) *Western Journal of Medicine* 360.

studies, their field of inquiry was directly and intimately shaped by legal definitions, identifying as they did in the earlier studies ‘potentially compensable events’²⁰⁸ – that is, events that were prima facie cases of civil negligence. The Harvard Study and the later UTCOS project were structured to make judgments about negligence as the relevant standard to include in the study.²⁰⁹ The QAHCS study differentiated itself from those studies on this single ground, by making judgments about preventability rather than negligence.²¹⁰ Law’s own concepts, knowledge and schemas supplied the foundational ‘definitional work’ for iatrogenic harm. This I mean quite directly, for when we speak of the rates of ‘iatrogenic harm’ we are, in fact, making a direct, but now effaced, reference to cases of ‘potentially compensable events’,²¹¹ that is prima facie cases of negligence at its lowest level of seriousness.

Secondly, the Australian history was profoundly, even wholly, driven by the question of law and legal liability. In the Australian context, the direct justification for the Professional Indemnity Review and its QAHCS research was tightly bound to the question of (escaping) legal liability. The longer-term reception of these important studies into iatrogenic harm studies continued to be deeply bound-up with the various ‘crises’ of legal responsibility that emerged or were constructed later: of civil litigation, insurance, tort and negligence. Deep irony accompanies the fact that the wave of data that exposed for the first time the true scale and preventability of iatrogenic harm – and thus the increased exposure to legal liability – had arisen as a response to the ‘fear mongering’²¹² of significant healthcare sector stakeholders about medical negligence litigation and other legal responsibility practices like criminal prosecution.²¹³ Without the spectre of legal liability, the Professional Indemnity Review would never have occurred, nor would Tito have had the opportunity to commission the QAHCS study. Whether the scale of Australian iatrogenic harm would have come to light without the impetus of legal action is

²⁰⁸ Runciman and Moller, above n 38, 1; see also Mills, above n 207.

²⁰⁹ Runciman and Moller, above n 38, 42.

²¹⁰ Ibid.

²¹¹ A potentially compensable event is an event that results in disability caused by healthcare management: disability is an impairment of physical or mental function (including disfigurement) or economic loss; causation is established when the disability is more probably than not attributable to healthcare management, which includes acts of both commission and omission, whether or not such actions or inactions constitute legal fault, see Mills, Boyden and Rubsamen, above n 29.

²¹² Hogarth, above n 35.

²¹³ L Hancock, ‘Addressing the “Problem Doctor”’ in Peter Lens and GA van der Wal (eds), *Problem Doctors: A Conspiracy of Silence* (IOS Press, 1997) 164.

something we might never know.²¹⁴ Since the QAHCS, no Australian study has reviewed the incidence and form of iatrogenic harm in the same manner or scale.²¹⁵ Importantly, the widespread ‘discovery’ of iatrogenic harm that was prompted by attempts to escape legal liability caused significant capital (in all forms) to flow swiftly into healthcare, forming and solidifying the new ‘field’ of patient safety, and the quality and safety disciplines.²¹⁶

Not only is iatrogenic harm and the discipline of quality and safety science rooted in the conduct of law from its very beginning, and not only was failure to deliver safe care productive of the field through attraction of capital flows, but so too did it contribute to solidifying the field through a successful ‘carve-out’ of ‘failure’ itself as properly belonging to the domain of healthcare quality and safety disciplines, of patient safety movement and of medicine. This was achieved most obviously by positioning law and the quality and safety disciplines as incompatible. The result of these three principal moves was to establish the quality and safety discipline, and to do so as autonomous and incompatible with law and regulation, a view that remains dominant in the literature on the topic. Such a process has a range of effects. For one, patients themselves became systematically excluded from the field of *patient* safety.²¹⁷ Instead, failure by the healthcare system to deliver care that was safe and of acceptable quality, was transformed into an opportunity to re-inscribe the same (failed) healthcare system’s dominance of the field.²¹⁸

²¹⁴ The impetus for similar studies in other jurisdictions was in response to legal challenge, and so without legal challenge these studies may not have occurred there either.

²¹⁵ Although see the excellent Care Track study, led by Bill Runciman, which has engaged in understanding the adherence/non-adherence of medical care/treatment to evidence-based standards (rather than iatrogenic harm as such). This is very important work the impact of which is still unfolding, William B Runciman et al, ‘CareTrack: Assessing the Appropriateness of Health Care Delivery in Australia’ (2012) 197(2) *Medical Journal of Australia*.

²¹⁶ In this I follow Travaglia and Braithwaite particularly. I discuss their work at length below, see Travaglia and Braithwaite, above n 204.

²¹⁷ A factor many have reported, including for example *ibid*; Josephine Enyonam Ocloo, ‘Harmed Patients Gaining Voice: Challenging Dominant Perspectives in the Construction of Medical Harm and Patient Safety Reforms’ (2010) 71(3) *Social Science & Medicine* 510; Josephine E Ocloo and Naomi J Fulop, ‘Developing a “Critical” Approach to Patient and Public Involvement in Patient Safety in the NHS: Learning Lessons from Other Parts of the Public Sector?’ (2012) 15(4) *Health Expectations* 424; Tara Lamont and Justin Waring, ‘Safety Lessons: Shifting Paradigms and New Directions for Patient Safety Research’ (2015) 20(1 suppl) *Journal of Health Services Research & Policy* 1; Waring, ‘Beyond Blame’, above n 203; Justin J Waring, ‘Constructing and Re-Constructing Narratives of Patient Safety’ (2009) 69(12) *Social Science & Medicine* 1722; Justin Waring, ‘Getting to the “Roots” of Patient Safety’ (2007) 19(5) *International Journal for Quality in Health Care* 257.

²¹⁸ One is reminded of Foucault’s reading of the perverse relationship between discipline and its reliance upon and production of resistance to itself, where the ‘prison has always been offered as its own remedy: the reactivation of the penitentiary techniques as the only means of overcoming their

It was the conduct of law that prompted the first accounting of iatrogenic harm, and in this way and others, law, blaming and other legal responsibility practices have been productive for both the formation of the field of quality and safety practice, and its ‘object’, iatrogenic harm.

V. CONCLUSION:

I ended the previous chapter with a question. There, I had shown that criminal law had been both rarely and judiciously deployed in cases of iatrogenic death in Australian legal history,²¹⁹ and that its reception had been marked by a lack of the kind of pressing and sustained criticism of individual cases or of prosecutorial action in general that we see in other jurisdictions. Based on that reading of the newly uncovered case law, I asked how the actual history of prosecution could be squared with the dominance of calls for the rejection of criminal negligence prosecution on the basis that it had been somehow a failure? The critical historical work of this chapter was undertaken in order to understand how that contradiction developed; how it was that we had come to labour under the idea that criminal prosecution is at odds with advancing healthcare safety, as is proposed by the dominant view of it in the quality and safety science literature.

By bringing together official, media, scholarly and professional sources to form a new critical history of the discovery of iatrogenic harm in Australia, I have been able to reconsider how ‘law’, and specifically the criminal law, has been framed by and within that history. My analysis makes clear how much of the reasoning for law’s expulsion from the field of iatrogenic harm was unrelated to the actual conduct of law, and that the latter’s conduct was in fact highly productive for the discipline that has attempted to displace it.

This was the period when iatrogenic harm broke out of the confines of specialist, or ‘cult’²²⁰ attention so that, for the first time, the attention of non-specialists and the broader political community was brought to bear upon the problem. As I have shown, this development was an unintended consequence of an investigation into the failing medical indemnity system, and presumed tort ‘crisis’, all of which precipitated the most complete

perpetual failure; the realisation of the corrective project as the only method of overcoming the impossibility of implementing it’. This is a matter I take up below.

²¹⁹

See Chapter One.

²²⁰

Wears et al classifies the history of the patient safety movement in three periods, of which the ‘cult period’ is their middle period, defined in these terms, see Wears, Sutcliffe and Van Rite, above n 4, 4.

accounting of the scale and scope of healthcare-related harm made in Australia to date.²²¹ Blame was located and then continuously re-located upon the legal system in response to the unprecedented revelations regarding the extent of iatrogenic harm in the Australian healthcare system and the impending failure of the medical indemnity system. What emerged was a complete and rapid ‘reform’ of civil liability across the nation, and the continued rejection of criminal law’s validity in relation to cases of iatrogenic harm.²²²

However, the repeated re-allocation of blame to the legal system, and the resulting reform, was misguided, based as it was upon partial and faulty understandings of the legal terrain. There was in fact no tort ‘crisis’, and the failures of the medical indemnity system had nothing to do with tort, but everything to do with inadequate indemnity arrangements, mismanagement of medical defence organisations, and the medical politics of the time. Through this accretion of events, criminal law – like tort law before it – became cast as an unwelcome interloper in the field of patient safety—one that threatens unjust, inaccurate and otherwise unhelpful punitive action.²²³ Once established, the binary developed between criminal law and quality and safety science can only be resolved by law’s conceding of jurisdiction and final subordination to the quality and safety disciplines. This

²²¹ The sense in which iatrogenic harm, which has always existed, was then ‘discovered’ is problematic. Rather, I follow others such as Corbett et al who reflect accurately how this was, in fact, really an acknowledgement and accounting of such harm. Corbett, Travaglia and Braithwaite, above n 4; The harm was of course known about for a far longer period of time, and at least since the mid-twentieth century accounted for in iatrogenic terms, see for example Ivan Illich, *Limits to Medicine: Medical Nemesis: The Expropriation of Health* (M. Boyars, 1995); see also Beck and Melo and their accounting for the pre-history of risk in relation to the quality management aspects of contemporary healthcare S Melo and M Beck, *Quality Management and Managerialism in Healthcare: A Critical Historical Survey* (Springer, 2014) 32.

²²² Less obvious, however, is the more sustained movement to modify the discursive framing of all legal responsibility claims in this field, by re-thinking ‘failure’ in the literature and policy work that followed, a matter I take up in the next chapter.

²²³ In relation to civil litigation, see for example, Wood, above n 143; Corbett, Travaglia and Braithwaite, above n 4; Corbett, ‘Regulating Compensation for Injuries Associated with Medical Error’, above n 15; Corbett, ‘Australia’, above n 15; Studdert et al, above n 129; Studdert DM et al, ‘Defensive Medicine among High-Risk Specialist Physicians in a Volatile Malpractice Environment’ (2005) 293(21) *JAMA* 2609; Thomas et al, above n 129; compare for example more recent work by Frakes and colleagues, Frakes, above n 10; Frakes and Jena, above n 10; See for example in relation to criminal law specifically, (#pages needed from lit review), Merry, above n 170; AF Merry, ‘How Does the Law Recognize and Deal with Medical Errors?’ (2009) 102(7) *Journal of the Royal Society of Medicine* 265; Sidney Dekker, *Just Culture: Balancing Safety and Accountability* (Ashgate, 2nd Edition, Kindle Version, 2012); Sidney WA Dekker, ‘Eve and the Serpent: A Rational Choice to Err’ (2007) 46(4) *Journal of Religion & Health* 571; Sidney Dekker, ‘The Criminalization of Human Error in Aviation and Healthcare: A Review’ (2011) 49(2) *Safety Science* 121; Sidney WA Dekker, ‘Criminalization of Medical Error: Who Draws the Line?’ (2007) 77(10) *ANZ Journal of Surgery* 831; O Quick, ‘Medicine, Mistakes and Manslaughter: A Criminal Combination?’ (2010) 69(1) *Cambridge Law Journal* 186; Oliver Quick, ‘Prosecuting “Gross” Medical Negligence: Manslaughter, Discretion, and the Crown Prosecution Service’ (2006) 33(3) *Journal of Law and Society* 421.

dichotomous view, and its subordination of the law, has dominated the scholarly and professional literature regarding iatrogenic harm since this time, and has profoundly shaped the reception of criminal law in the field.²²⁴

Yet, as I indicated in the final section of this chapter, neither the healthcare quality and safety discipline, nor even its object – healthcare ‘harm’ itself – are in any sense autonomous from law. They are simply not historically, factually nor conceptually separable from one another; the history and shape of iatrogenic harm and quality and safety responses to it is replete with law. For these reasons, I concluded that despite a disjunction between these two powers, the operation of law and healthcare quality and safety science are not wholly at odds, but have been mutually co-constitutive.²²⁵ As I have stated already, it was the conduct of law that prompted the first accounting of iatrogenic harm and, in this way and others, law, blaming and other legal responsibility practices have been productive for both the formation of the field of quality and safety practice, and of its ‘object’, iatrogenic harm.

This is a history that has not been told until now. Still too recent, and perhaps still too politically sensitive, the emergence of iatrogenic harm, the break-out of knowledge about its existence into wider circulation and the connections with medical indemnity, tort and criminal law reform are new and original contributions to the literature and understanding of the history of this period. So, too, is this an important contribution to the small but promising critical literature on both iatrogenic harm and the quality and safety sciences in their contemporary guise. It highlights aspects of the discipline’s history and its relationship to law that have failed to be addressed in patient safety research thus far.²²⁶

²²⁴ See for example, Dekker, *Just Culture*, above n 223, 112; Danielle Griffiths and Andrew Sanders, *Bioethics, Medicine and the Criminal Law: Medicine, Crime and Society* (Cambridge University Press, 2013) vol 2, 154, 211.

²²⁵ As to this dynamic, see the following for a more detailed account in the realm of HIV transmission control David J Carter, ‘HIV Transmission, Public Health Detention and the Recalcitrant Subject of Discipline: Kuoth, Lam v R and the Co-Constitution of Public Health and Criminal Law’ (2016) 25(2) *Griffith Law Review* 172; see also Ben Golder, ‘The Distribution of Death: Notes towards a Bio-Political Theory of Criminal Law’ in Matthew Stone, Illan rua Wall and Costas Douzinas (eds), *New Critical Legal Thinking: Law and the Political* (Taylor & Francis, 2012) 91; and see more generally Ben Golder and Peter Fitzpatrick, *Foucault’s Law* (Routledge Cavendish, 2009).

²²⁶ Justin Waring et al speaks of this issue within the field more generally, writing that ‘...past and recent scandals unearth familiar sociological issues around the construction of social problems..., moral panics..., professional dominance..., the caring division of labour..., rationing..., organisational complexity..., regulatory burden...and cultural issues for staff reporting concerns about colleagues..., all of which consistently fail to be addressed in mainstream patient safety research and policy’. Waring et al, above n 2, 201.

New Zealand anaesthetist Dave Chamley, writing during the tensions of the period, stated that ‘the furore over medical manslaughter is a case of severely mistaken diagnosis. The problem is not a major flaw in the law, the problem is a major flaw in us, in our assumption of immunity from accountability’.²²⁷ In many ways, this description by Chamley speaks to important facets of the historical experience of law and iatrogenic harm recounted here. As I indicated above, efforts to escape liability had revealed less liability than imagined, but far more harm that had been admitted. Chamley is correct in naming what this history makes clear, a pronounced effort to be rendered immune from accountability. Attempts to re-frame tortious negligence as first failing because it was mobilised, and then failing because it wasn’t mobilised enough, is a stark example of the politics of the period, and what I see to be a moving and twisting bid for immunity in spite of evidence that indicated that legal accountability was never the problem it was constructed to be.

However, there are also undertones in this history of a more profound undercurrent. The rejection of criminal blaming is not, solely, the result of attempts to avoid accountability. Rather, many writers, scholars and practitioners truly believe that accountability is misplaced in relation to iatrogenic harm. This underlying conflict is one that I propose is fruitfully understood as driven by and structured according to the primacy granted to either ‘choice’ or ‘care’²²⁸ in our ‘specific mode[s] of organising action and interaction; of understanding bodies, people and daily lives; of dealing with knowledge and technologies; of distinguishing between good and bad and so on’.²²⁹ In the chapter that follows, I argue that the healthcare quality and safety literature is infused with the ideal of choice, an entire logic that orientates its adherents in a fundamentally different way to that demanded by the doctrine of manslaughter by criminal negligence, which awards primacy to the ‘logic of care’²³⁰ proposing that it is a lack of care, rather than culpable choice, which is a reasonable basis for criminal culpability and other practices of legal blame.²³¹ Whilst not hermetically sealed off from one another, insofar as quality and safety science and the

²²⁷ Dr Dave Chamley, cited in Patterson, above n 171, 245.

²²⁸ In this, I draw on the work of Annemarie Mol primarily. See Annemarie Mol, *The Logic of Care: Health and the Problem of Patient Choice* (Routledge, 2008).

²²⁹ Ibid 8.

²³⁰ I draw specifically on the work of Annemarie Mol who developed in her work of medical anthropology perhaps the most developed sense of these two logics, and specifically how they relate to the practices of medicine, Mol, above n 228.

²³¹ Moreover, it demands that we actively attend to those who are within our care, rather than simply to avoid doing harm.

doctrine of manslaughter by criminal negligence continue to express a primacy of conflicting logics, one in the tradition of 'care' and the other in the tradition of 'choice', their conflict will continue to run deep.

CARE & CHOICE: RESPONSES TO IATROGENIC HARM

CHAPTER THREE

There are innumerable tensions inside medicine but clashes between fully fledged paradigms are rare.

— Annemarie Mol, *The Body Multiple*.¹

I. INTRODUCTION

The previous two chapters worked together to establish the history of the use of manslaughter by criminal negligence as a response to iatrogenic harm in the Australian context. Together, they showed how it was that, despite the relatively successful experience of prosecution across time, we now labour under the dominance of calls for the rejection of criminal negligence prosecution on the basis that it has been somehow a failure. In common with the overarching claim of this thesis, I concluded that the arguments for the rejection of manslaughter by criminal negligence have not been sufficiently attentive or responsive to the history of the law's use in this field. In particular, the history of the discovery of iatrogenic harm and the responses to it during the 1990s in Australia demonstrates how, and in a sense why, the reasoning for law's expulsion from the field of iatrogenic harm was less related to the actual conduct of law itself and more to the politics of medicine of the time.

The thesis builds its argument in three sections, each providing a new account of the actual practices of criminal law in this field: firstly, of the history of its use in Australia; secondly, of its particular animating 'logic'; and finally, of its mobilisation in the Australian courtroom. This chapter begins the second of those sections, the particular fundamental logic that manslaughter by criminal negligence is oriented by and expresses. In this chapter, I propose that it is fruitful to understand the conflict over manslaughter by criminal negligence as one driven by and structured according to the primacy granted to

¹ Annemarie Mol, *The Body Multiple: Ontology in Medical Practice* (Duke University Press, 2002) 178.

either ‘choice’ or ‘care’.² Specifically, when the healthcare quality and safety literature argues against criminal law, it is infused with the ideal of choice, an entire logic that orientates its adherents in a fundamentally different way to that demanded by the doctrine of manslaughter by criminal negligence, which awards primacy to the ‘logic of care’,³ proposing that it is a particularly serious lack of care, rather than culpable choice, that is a reasonable basis for legal blame.⁴ ‘Care’ and ‘choice’, I argue, form two traditions that bring with them a ‘specific mode of organising action and interaction; of understanding bodies, people and daily lives; of dealing with knowledge and technologies; of distinguishing between good and bad and so on’.⁵ Whilst not hermetically sealed off from one another, insofar as the discipline of quality and safety science and the doctrine of manslaughter by criminal negligence assert the primacy of conflicting logics, their conflict will continue to run deep. Most importantly, in the specific context of the debate about iatrogenic harm, the implications of the ascent of the logic of choice, thanks to the discipline of quality and safety science, include an inability or failure to capture the complexities of living with a disease, whilst rendering neglect invisible.

Before I engage in the diagnostic work of describing the conflict in terms of the competing logics of choice and care, I offer a brief background to the work of Annemarie Mol.⁶ I then theorise this situation by drawing upon the work of Mol, focusing on the work that the logic of choice performs within the debate between healthcare quality and safety and the criminal law. In her landmark anthropological reading of diabetes treatment, Mol names the ‘logic of care’ and ‘logic of choice’ as two incompatible ideals that drive the practices of medicine more broadly.⁷ I adapt her work to trace how the literature on criminal responsibility for iatrogenic harm reads criminal law according to a ‘logic of choice’, and how that logic conflicts with the ‘logic of care’. The central diagnostic work begins at this point, where I make a detailed reading of the rhetorical practices employed by quality and safety-motivated texts on criminal liability. This reading shows both how that literature is

² In this, I draw on the work of Annemarie Mol primarily. See Annemarie Mol, *The Logic of Care: Health and the Problem of Patient Choice* (Routledge, 2008).

³ I draw specifically on the work of Annemarie Mol who developed in her work of medical anthropology perhaps the most developed sense of these two logics, and specifically how they relate to the practices of medicine, *ibid.*

⁴ Moreover, it demands that we actively attend to those who are within our care, rather than simply to avoid doing harm.

⁵ Mol, above n 2, 8.

⁶ Mol, above n 2.

⁷ *Ibid.*

infused with the logic of choice, and how adherence to the primacy of choice operates as the fundamental motivation and reasoning for rejection of criminal negligence. I conclude by claiming that the doctrine of manslaughter by criminal negligence is an expression of the logic of care, and proposing that, insofar as it is an expression of that alternative orthodoxy, any engagement with iatrogenic harm motivated by a logic of choice risks failing to understand that doctrine's operation and appreciate its legitimacy.⁸

I conclude the chapter by indicating the work which I take up in the following chapter to round out my engagement with Mol and the vision of human action which manslaughter by criminal negligence expresses. In this final section, I indicate how the adherence to the logic of choice by the quality and safety literature that rejects criminal law is a kind of betrayal of the discipline's far more fundamental commitments and practices. The distinctive foundation of the discipline of quality and safety science consists of a theorisation of human agency, action and harm itself that denies the health practitioner's ability to choose as an autonomous subject, subject as they are to control by external forces.⁹ In short, whilst the literature on criminal negligence mobilises choice to reject the validity of criminal negligence, the discipline's substantive understanding of quality and safety improvement rejects choice.

This is the first time the debate about criminal negligence for iatrogenic harm has been couched within a frame of the logic of care or of choice. So, too, is it the first time Mol's work has been applied to the question of iatrogenic harm.¹⁰ These are the most important, and original, contributions to knowledge that this chapter offers. This chapter does not aim to contribute to an analysis of the operation and effect of criminal negligence prosecution. That is the work of subsequent chapters and of contributions that may be made by others. However, that subsequent work is made possible (and I believe more effective) by this foundational work. This foundational work shows that what the quality and safety discipline regards as preferable, practical and ethical is imbued with a quite particular ideal, a whole 'logic' of choice that, because of its dominance in late modernity, has come

⁸ How criminal negligence is an expression of the logic of care is a topic I develop more fully in Chapter Four where I examine the obligations demanded or expressed by the doctrine of criminal negligence, namely, that we must actively care, rather than simply not cause harm.

⁹ See my Introduction for an overview of key elements of the discipline.

¹⁰ Mol's work indirectly relates to iatrogenic harm, in so far as it works to describe what constitutes 'good care'. Mol herself does not dwell on harm in healthcare, and I am unaware of any other literature which does so by using her work.

to be naturalised. Such a logic is, in reality, merely one option amongst a plurality, one part of our tradition of thinking about human actors, action and responsibility.

In this chapter, I am not concerned with a direct or point-for-point rebuttal or critique of the anti-manslaughter literature. I am especially unconcerned to do so on grounds established by the disciplinary logic itself.¹¹ To reiterate the aim stated above, I am concerned with attempting to render visible the underlying or foundational ideal or logic that drives and shapes the quality and safety discipline's critique of manslaughter by criminal negligence. This logic of choice includes specific ways of knowing (epistemology), of deciding (ethics) and of acting (praxis). It produces particular ways of 'organising action and interaction; of understanding bodies, people and daily lives; of dealing with knowledge and technologies; of distinguishing between good and bad'.¹² But, most of all, it is a distinctive apparatus that unites the otherwise plural and multiple positions taken up by authors who are critical of the doctrine, the offence and its use.

This logic of choice, however, is not the only tradition of thinking about right and wrong, practical and impractical. An alternative logic, the logic of care, has always been a part of the Western tradition.¹³ Mol argues, however, that this logic of care has been 'internally colonised'¹⁴ by the logic of choice. This does not mean that the care tradition is unorthodox. It is, rather, an *alternative orthodoxy* to that of choice, one currently suppressed by the tradition of choice. By offering in this chapter a reading of the debate about criminal responsibility in terms of its alignment with these two logics, we learn something instructive about the disciplinary logic of quality and safety and what it demands of us. This renewed visibility of the logic of choice at work will hopefully begin a new conversation about the clash of these 'fully fledged paradigms'¹⁵ within healthcare, prompting the work of relocating criminal negligence for iatrogenic harm within its correct frame, the logic of care; a task the remainder of the thesis takes up.

Before exploring in detail how the literature is infused by the logic of choice, it is important to establish the theoretical framework of the logics of care and of choice that Mol's work provides. I provide an overview of that framework in the next section.

¹¹ Reasons for this which relate to the discipline itself are outlined in the Introduction to this thesis.

¹² Mol, above n 2, 8.

¹³ As Mol terms it.

¹⁴ Mol, above n 2, 5.

¹⁵ Mol, above n 1, 178.

II. THEORETICAL FRAMEWORK: THE LOGIC OF CARE & THE LOGIC OF CHOICE

Annemarie Mol's *The Logic of Care* is a work of medical anthropology.¹⁶ The work is not concerned with iatrogenic harm or quality improvement.¹⁷ Instead, building on ethnographic fieldwork in a Dutch diabetes clinic and influenced by practice theory,¹⁸ Mol proposes that there are two ways of *enacting* disease,¹⁹ the body, and its treatment. These logics subsist in the world of medicine and healthcare, embedded in the ways that 'medicine attunes to, interacts with, and shapes its objects in its various and varied practices'.²⁰ These two paradigms or 'logics' at work in healthcare are the logic of care and the logic of choice. In this section, I develop a more specific understanding of what Mol means both by a 'logic' and, specifically, by a 'logic of care' and a 'logic of choice'.

Mol does not argue that these two logics are equal traditions of medicine or 'the West',²¹ as she puts it,²² the sub-title to her book, *Health and Problem of Patient Choice*,²³ signals her view. She argues that amongst the 'amalgam of ideals'²⁴ that circulate, 'good care'²⁵ is one, but that this care tradition has been subject to an 'internal colonisation'²⁶ by the elevation of choice to a place of primacy,²⁷ a shift I regard as borne out in the increasing dominance of subjective forms of mens rea in criminal law theorising.²⁸

¹⁶ Mol, above n 2; see also her related work, Mol, above n 1.

¹⁷ Although Mol notes that 'in real life, good care co-exists with other logics as well as with neglect and errors', choosing in this instance, however to distill a 'pure form out of mixed events' by leaving out consideration of 'such noise', see Mol, above n 2, 10.

¹⁸ Mol is heavily influenced by a particular reading of practice theory, although in this work she does not engage with that broader methodological literature at length. See Schatzki, Nicolini or Reckwitz for influential works on the nature of practice Karin Knorr Cetina, Theodore R Schatzki and Eike von Savigny, *The Practice Turn in Contemporary Theory* (Routledge, 2005); Davide Nicolini, *Practice Theory, Work, and Organization: An Introduction* (Oxford University Press, 2013); Andreas Reckwitz, 'Toward a Theory of Social Practices: A Development in Culturalist Theorizing' (2002) 5(2) *European journal of social theory* 243; See also the challenging short essay by Sarah Coakley for an alternative view of practice research, 'Deepening Practices', in Sarah Coakley, *The New Asceticism: Sexuality, Gender and the Quest for God* (Bloomsbury Publishing, 2015).

¹⁹ I mirror the language employed by Mol in relation to the use of 'disease' in this chapter rather than employing other terms such as illness, sickness, infection or otherwise.

²⁰ Mol, above n 1, vii.

²¹ Mol writes of 'the West', 'wherever it may begin or end', Mol, above n 2, 5.

²² Ibid 74.

²³ Mol, above n 2.

²⁴ Ibid 5.

²⁵ Ibid.

²⁶ Ibid.

²⁷ Ibid.

²⁸ Even though most criminal law made today violates the subjectivist orthodoxy.

For Mol, one tradition amongst many – choice – has been positioned as the ideal; however, the attempted homogenisation of tradition by the dominant logic of choice is a false rendering of both current practice and the history of that tradition. On the one hand, falsely homogenising a plurality of traditions into one simplifies the multiple traditions that, in reality, continue to circulate and shape the enactment of the objects of healthcare’s concern and treatment. On the other hand, granting primacy to *choice* specifically reinforces a false impression that the logic of choice has been the dominant paradigm in healthcare (‘which, by declaring it to be dominant, is made to be so ever more’).²⁹ Most significant for Mol, and our context here, is that the result of the false homogeneity and domination wrought by the paradigm of choice does not offer a superior way of living ‘to the life that may be led in the world infused by the alternative’³⁰ of care. Rather, for Mol, the increasing primacy of the logic of choice means that good care has been frustrated, contributing to the marginalisation of patients, making it ‘difficult to think about, let alone attend to, the body and its diseases’.³¹

Many others have written on the question of care,³² including some in relation to law.³³ However, out of that larger tradition I have selected Mol’s work as the central dialogue partner. Mol is an anthropologist who works primarily on the anthropology of the body. Her work of most relevance to this thesis involves long-term ethnographic studies with fieldwork in Dutch healthcare settings.³⁴ Whilst influential in parts of health care scholarship concerned with care, technology and practice-oriented methodologies, as yet, her work seems not to have been used in studies of health law and regulation, nor widely used in work focused on healthcare quality and safety.³⁵ I have selected her work for two particular reasons. First, her work pays direct attention to the practices of healthcare and

²⁹ Mol, above n 2, 5 These two observations could equally apply to the tradition of criminal law jurisprudence too with the predominance of the subjectivist approach to mens rea.

³⁰ Ibid 7.

³¹ Ibid 5.

³² Carol Gilligan, *In a Different Voice* (Harvard University Press, 2009); Mary Jeanne Larrabee, *An Ethic of Care: Feminist and Interdisciplinary Perspectives* (Routledge, 2016); Daryl Koehn, *Rethinking Feminist Ethics: Care, Trust and Empathy* (Routledge, 2012); Michael Slote, *The Ethics of Care and Empathy* (Routledge, 2007); James William Walters, *Martin Buber and Feminist Ethics: The Priority of the Personal* (Syracuse University Press, 2003).

³³ See for example, Heather Douglas et al, *Australian Feminist Judgments: Righting and Rewriting Law* (Bloomsbury Publishing, 2014) 107; Jonathan Herring, *Caring and the Law* (A&C Black, 2014); Robin West, *Caring for Justice* (NYU Press, 1999).

³⁴ Specifically, in the diabetes clinic of a Dutch hospital in the case of *The Logic of Care*, Mol, above n 2.

³⁵ I thank Angus Corbett for introducing me to Annemarie Mol’s work through discussions of his own engagement with it in forthcoming research.

medicine.³⁶ This is a field of practice and inquiry we share, and it is her attention to healthcare practice that grounds the diagnosis of the two logics that I draw upon to make sense of the quality and safety discipline's writing on criminal law.³⁷ Second, by working from a shared terrain, built out of what constitutes good medicine, but now applied to debates about law, I hope that the potential for some form of dialogue – and even rapprochement – between a divided criminal law and medicine might emerge. For what constitutes good medicine is good care, and what constitutes good law in this setting might be good care too. To say this does not mean there is no place for choice but, rather, that practices of care might represent the fullest expression of what medicine is when it is practiced at its best, and the same of law. Viewed in this way, the legal doctrine is not alien to the social practice of medicine but is instead cut from the very same cloth.

The first step towards achieving these aims involves developing a more specific understanding of what Mol means both by a 'logic', and specifically a 'logic of care' and a 'logic of choice'. I deal with each in turn.

A 'Logic'

The term 'logic' is a 'resource' for Mol. It best evokes the sense of a rationality, or more accurately the 'rationale',³⁸ of the practices of healthcare to which she attends. Drawn from its usage in philosophy – but not, she hopes,³⁹ communicating a coherence to practice that does not exist – the term 'logic' is meant to resonate with the concept of discourse, in that 'events somehow fit together, there are affinities between them',⁴⁰ which makes them 'comprehensible'⁴¹ when 'words, materialities and practices hang together in a specific, historically and culturally situated way'.⁴² In highlighting this resonance, Mol explicitly draws on the Foucauldian tradition, noting in particular his usage of *discours* to

³⁶ In this case the practices associated with diabetes in a hospital in the Netherlands.

³⁷ '...start out from daily life with diabetes in the Netherlands, but seek to interfere not only with health care, but also with emptied out versions of technology, all too beautiful dreams about Reason, and one-dimensional clichés about 'the West' Mol, above n 2, 6.

³⁸ Ibid 7.

³⁹ Ibid 9.

⁴⁰ Ibid.

⁴¹ Ibid.

⁴² Ibid; Mol's use of 'logic' recalls in particular Fredric Jameson's landmark work Fredric Jameson, *Postmodernism, Or, The Cultural Logic of Late Capitalism* (Duke University Press, 1991).

denote both language and materialities together.⁴³ Mol, however, deliberately chooses the term ‘logic’ to describe her analysis, wanting to draw attention away from socio-material ordering and how such ordering comes into being and establish itself, and instead focus on the rationale of the practices she studies, the local and fragile yet still coherent *logic* that denotes what ‘is appropriate or logical to do in some site or situation, and what is not’.⁴⁴

Despite her reticence about describing her work as a discursively-centred analysis,⁴⁵ Mol is not shy about acknowledging that the logics of choice or of care are productive. The ‘different logics push and pull in different directions... they turn us into something different’.⁴⁶ This view coheres with the principal insight of Foucault on the nature of power in modernity, that it is productive. What is produced differs markedly between the two logics, however, and to describe the logic of care and the logic of choice, Mol proceeds by contrasting what each logic is productive of, be it specific modes of ‘organising action and interaction; of understanding bodies, people and daily lives; of dealing with knowledge and technologies; of distinguishing between good and bad and so on’.⁴⁷ This is the way I, too, proceed in the brief overview of each logic below.

B *The Logic of Care*

Like much of the broader ethics of care literature, Mol’s logic of care is not based on universal principles, instead drawing on the experiences of everyday life and the moral problems and practices of humans in their ordinary lives. The primary concern of the ethics of care is to recognise our relational ontology and its effects on particular, ‘context-specific relationships of care’.⁴⁸ In recognising relationality as the primary ground as the starting point about moral reasoning there need a different relationship to formal structures and rules. Mol’s work maintains this stance, holding that there is ‘no such thing as an (argumentative) ethics that can be disentangled from (practical) doctoring’.⁴⁹ Care ethics more broadly, in this sense, maintains its focus on the network of relationships that

⁴³ Mol, above n 2, note 15. In a similar vein to Mol, Foucault understood his work in part to be an analysis of ‘regimes of practice’, rather than analysis of ideologies.

⁴⁴ Ibid 10.

⁴⁵ Another potentially helpful term with which Mol’s work resonates is that of ‘ideology’, although she herself does not use this term.

⁴⁶ Mol, above n 2, 79.

⁴⁷ Ibid 8.

⁴⁸ Sacha Ghandeharian, *Moral Distanciation: Modernity, Distance, and the Ethics of Care* (MA Thesis, Carleton University Ottawa, 2014) 11 <<https://curve.carleton.ca/system/files/theses/31771.pdf>>.

⁴⁹ Mol, above n 2, 90–91.

constructs particular individuals' lives, and at different times, in different ways, makes that life possible.

The ethics of care respects rather than removes itself from the claims of particular others with whom we share actual relationships... The compelling moral claim of the particular other may be valid even when it conflicts with the requirement usually made by moral theories that moral judgments be universalizable [sic].⁵⁰

This non-universalizability of care contributes to the difficulty of providing a wholly concrete definition of care. Care is, for Mol, necessarily a 'mode' or 'style', a rationale or 'logic' that produces specific care practices. Yet her aim in writing is to 'articulate the specificities of good care so that we can talk about it',⁵¹ and so, despite the difficulty, she provides an attempt to articulate care:

Care is a process: it does not have clear boundaries. It is open-ended. This is not a matter of size; it does not mean that a care process is larger, more encompassing than the devices and activities that are part of it. Instead it is a matter of time. For care is... a matter of various hands working together (over time) towards a result... an interaction in which the action goes back and forth (in an ongoing process).⁵² Care is an interactive, open ended process that may be shaped and reshaped depending on its results.⁵³

At the broadest level, good care improves the lives of patients with disease and delays death. On a more specific level, care involves activities. For example, care may be the activity of regulating the amount of sugar in the blood within a particular range. Such care practices are shared practices. They are, as stated above, 'various hands working together (over time) towards a result'.⁵⁴

Care cannot be calculated ahead of time, or at all. Instead, it is something that is attuned to reality along the way. Practices like testing and monitoring blood sugar levels, and either

⁵⁰ Virginia Held, 'Feminist Transformations of Moral Theory' (1990) 50 *Philosophy and Phenomenological Research* 321, 11; cited in Ghandeharian, above n 48.

⁵¹ Mol, above n 2, 2.

⁵² Ibid 18.

⁵³ Ibid 20.

⁵⁴ Ibid 18; the excellent work of Mary Dixon-Woods and Peter Pronovost interestingly utilises a similar metaphor to Mol in their paper on the 'problem of many hands'. In their paper they write, 'one neglected reason why the safety problem has proved so stubborn is that healthcare suffers from a pathology known in the public administration literature as the problem of many hands.' Bringing together their 'problem' of many hands, and the view that care in fact requires 'many hands' would be a fruitful area for future work. Mary Dixon-Woods and Peter J Pronovost, 'Patient Safety and the Problem of Many Hands' [2016] *BMJ Quality & Safety* 485.

injecting the appropriate amount of insulin or ingesting high-sugar food, begin in the clinic; however, patients who live with diabetes must learn to carry out these practices on their own, finding ways of working them into the fabric of their daily lives. Patients' lives are not all the same, however, and they will encounter different types of problems as they face the task of caring for themselves. When different tasks, such as monitoring blood sugar and injecting insulin, conflict with other practices of daily living (like work, for example), good care involves attuning these variables to one another. It is in these moments that patients and healthcare providers must decide together what is most important. Some things must give way to others.

Mol 'rehabilitates'⁵⁵ the term 'doctoring' to refer to the multiple ways healthcare providers and patients attend to this attuning of variables. Doctoring, Mol suggests, is somewhat like 'tinkering'⁵⁶ – it involves experimenting, attuning the variables of life and care to each other, and 'being attentive, inventive, persistent and forgiving'.⁵⁷ Such 'giving way' through 'doctoring' or 'tinkering' is well-illustrated by her treatment of 'target values' for blood sugar.⁵⁸ Target values can be understood pieces of 'neutral information'; 3.9mmol/L is the standard 'target value' for a patient's blood sugar, supported by a vast clinical literature. Yet, Mol argues, such target values are not 'neutral' 'facts'. In the practice of good care/good medicine, target values change, depending on whether or not patients (and/or healthcare teams) can achieve the specific values in practice. Mol observes first-hand how circumstances, such as a type of employment that makes continual testing and monitoring of blood sugars near to impossible, mean not only that the practices change but that so can the targets at which the practices aim. The healthcare provider and the patient, after communication about difficulties of testing and monitoring, agree that the patient should test and monitor blood sugars less frequently and at different times of the day. In implementing this adaptation – this 'tinkering' – the blood-sugar level they strive for also changes; it is no longer (nor ever was) a neutral fact. This is part of a logic of care. As Mol articulates, 'within the logic of care, identifying a suitable target value is not a condition for, but a part of, treatment. Instead of establishing it before you engage in action, you keep on searching for it while you act'.⁵⁹ Target values, then, are themselves both a

⁵⁵ Mol, above n 2, 55.

⁵⁶ Ibid 56.

⁵⁷ Ibid 55.

⁵⁸ Ibid 46.

⁵⁹ Ibid.

product of a particular mode of understanding the body, for example, and in their use are reproductive of that same particular mode of understanding the body, disease or interaction. When blood sugar is approached from within the logic of care, it is this particular mode that enacts/produces and is reproduced by tinkering and doctoring practices related to blood sugar measurement and management, practices that reshape the very meaning of mmol/L and ‘target values’ by taking time to listen, to understand and to see blood sugar in a patient’s own context and daily life.

Yet, this is not always the case. Target values can be understood as neutral ‘facts’ and in this moment, care fails. When we fail to engage in care – when care fails – it fails in specific ways. Mol names the failure to care ‘neglect’⁶⁰. This neglect, or negligence, is the reverse of the logic of care, its inverse: ‘care is bad... when there is not enough time to listen... when physical parameters are isolated from their context... when patients’ daily lives are not taken into consideration’.⁶¹ Inadequate practices of care are characterised by a lack of attention, lack of receptivity and inappropriate or inadequate response. Care demands that the carer ‘wonder what to do next and do not give up... then try once more to act’.⁶² This negligent care is not the same as the logic of choice; rather, negligence is facilitated, and then concealed, by the application of choice. Mol demonstrates that ‘autonomy’ and ‘choice’ work as ‘euphemisms for social practices of neglect, as responsibility is placed on the individual for her own care’⁶³ concealed by the construction of situations of choice. In the following section, I delve deeper into how it is that choice works to cover-over neglect.

C *The Logic of Choice*

In the healthcare setting, concern for autonomy of the individual has been adopted most forcefully in response to concerns regarding medical paternalism. Mol herself traces the logic of choice to attempts to provide patients with a greater voice and more power over what happens to them in the healthcare setting. In medicine, it is with this shift that, as one doctor puts it, ‘we have given up one cliché, the doctor knows best, in favour of another,

⁶⁰ See for example, *ibid* xi, 5, 84.

⁶¹ *Ibid* 84.

⁶² *Ibid*.

⁶³ João Biehl, ‘Care and Disregard’ in Didier Fassin (ed), *A Companion to Moral Anthropology* (John Wiley & Sons, 2014).

the customer is always right'.⁶⁴ The shift in cliché is apt, as Mol observes that, when viewed according to the logic of care, those living with a disease are imagined through a variety of practices either as customers, who choose medical services available in a healthcare market, or as citizens, who contract with healthcare providers as equals. These are two variants of the logic of care.⁶⁵ In the first, the market/customer variant,⁶⁶ people seeking help are understood to be customers instead of 'patients', a term Mol notes is etymologically related to 'passive'.⁶⁷ Patient-consumers are invited to enter into a market and to purchase products they find attractive; 'they buy their care in exchange for money'.⁶⁸ While the logic of care starts with something negative ('you would prefer not to have diabetes'⁶⁹), the logic of choice in its consumer variant offers 'splendid panoramic views',⁷⁰ with language of the market using only positive terms, where you 'hope for health'⁷¹ rather than 'live with a disease'.⁷² In its second variant, the logic of choice understands patients as citizens. Like patient-consumers, patient-citizens also make choices; however, their subjectivity and actions are governed according to civic conceptions of equality, rights and duties that allow for enactment of relations according to a particular form of social contract. In the consulting room, transformed by conceptions drawn from the civic or public sphere, no longer selling consumers a product, doctors and patients are now equals, imagined as citizens in the agora; 'as citizens, after all,' Mol reflects, 'we are not subjected to decisions, but [are] subjects who can choose... citizens have no overlords: they are their own rulers'.⁷³ Yet, like the framing of healthcare according to the market variant of the logic of choice, which renders invisible that a lot of care work is not for sale in the market but is actually done by patients themselves,⁷⁴ in the

⁶⁴ Abraham M Nussbaum, *The Finest Traditions of My Calling: One Physician's Search for the Renewal of Medicine* (Yale University Press, 2016).

⁶⁵ Mol, above n 2, 29.

⁶⁶ See Chapter Two in Mol, above n 2.

⁶⁷ Ibid 27.

⁶⁸ Mol, above n 2 this understanding of patient-consumer is key to the consumer movement within healthcare, which has worked explicitly to reposition patients and others as consumers of health services, drawing into the discourse of medicine, a marketised relationship which advocates within that movement see as empowering, see for example .

⁶⁹ Ibid 28.

⁷⁰ Ibid.

⁷¹ Ibid.

⁷² Ibid.

⁷³ Annemarie Mol, Ingunn Moser and Jeannette Pols (eds), *Care in Practice: On Tinkering in Clinics, Homes and Farms* (transcript Verlag, 2015) 9.

⁷⁴ Mol writes in another context, 'far from just "receiving" care, patients actively attend to their symptoms, swallow their pills, follow their diets, and so on. Even when they are being anaesthetised

civic variant good citizenship depends on the ability to choose, and thus control and rule, in ways that people lack when living with a disease.⁷⁵ This patient-as-citizen model then ‘skips over and denies what it is that makes people look for care in the first place: their bodies happen to not submit to their wishes, let alone their commands. They are unruly’.⁷⁶ Governed as citizens, and not patients, those seeking care ‘have to bracket a part of what they are’,⁷⁷ subjugating the body in order to be emancipated from medical paternalism.⁷⁸ The first variant of the logic of choice cannot understand disease, whilst the second needs us to control, tame or transcend our bodies so that we are able to choose.

Subject to either the market or civic variant of the logic of choice, the process of healthcare is enacted in largely the same way. Individual patients, after receiving the relevant facts and information regarding their situation from healthcare providers, should decide the course of action they want to pursue. By making choices, so the logic of choice claims, we become masters of our own lives.⁷⁹ The logic of choice ‘promulgates the idea that there are options and that we have the freedom to choose between them. It also emphasises the notion of the right to choose’.⁸⁰ In this way, both variants of the logic of choice are positioned as responses to medical paternalism. Imagined either as citizens or as consumers, ‘who would be so paternalistic...as to deny [the patient] their choice?’⁸¹ asks Mol. The imposition of a situation of choice is somehow an ‘end of discussion... as if it were a magic wand, the term ‘choice’ has ended the discussion’.⁸²

Yet, in ‘ending the discussion’ by constructing a situation of choice, the logic of choice transforms a formerly (and actually) open-ended process of care into a discrete activity of choosing. It twists and reshapes care practices in such a way that a situation of choice

they engage in the job of counting down. Patients also actively visit their doctor – usually not because they freely “choose” to shop for care, but rather because they “have no option””, *ibid.*

⁷⁵

⁷⁶ Asa Alftberg and Kristofer Hansson, ‘Introduction: Self-Care Translated into Practice’ (2012) 4(3) *Culture Unbound: Journal of Current Cultural Research* 415, 9.

⁷⁷

Mol, above n 2, 31.

⁷⁸

Many legal and regulatory interventions rely and support the patient-as-citizen model explicitly. This includes much of the patient right’s movement within healthcare regulation and service design, including the ubiquitous (but wholly unenforceable) patient charters of rights, such as the Australian Australian Commission on Safety and Quality in Health Care, ‘Australian Charter of Healthcare Rights’.

⁷⁹

Mol, above n 2, 80.

⁸⁰

Moira Kelly, ‘The Logic of Care: Health and the Problem of Patient Choice - by Mol, A.’ (2009) 31(4) *Sociology of Health & Illness* 618, 618.

⁸¹

Mol, above n 2, x.

⁸²

Ibid.

arises where ‘all the possible advantages and disadvantages of the treatment, all its goods and bads [sic], have been turned into private concerns’.⁸³ This is how the logic of choice reshapes the world in particular ways, misrepresenting and colonising the tradition and practices of good care in the process. This too, Mol suggests, is how the logic of care works to obscure neglect. The situation of choice is framed as giving people more power but tricks patients rather than frees them. For, in reality, choice comes with responsibilities that are often not made clear.

Mol illustrates this process plainly by reference to a case discussion surrounding involuntary psychiatric treatment, a context in which concerns about paternalistic medicine and patient control are foregrounded. In this discussion between Mol and a group of ethicists and psychiatrists, one morning a patient on an open ward does not wish to get up.⁸⁴ Should the patient be allowed to stay in bed, or somehow to be forced out of bed? Mol reports that most of the ethicists answer with ease: ‘a person who stays in bed does no harm to anyone else’, they argue, drawing upon central liberal principles. Only one considers whether the man in question is currently a subject capable of making choices, and whether this might be a problem with allowing him to stay in bed. The psychiatrists discuss other concerns: how, in a communal psychiatric setting, patients ‘often have to *learn* to make choices’, and have to adapt to shared rules, with such routines making for a better daily existence.⁸⁵ Finally, a retired professor of psychotherapy intervenes and says:

‘[I]t is all a question of money’. He reproaches the ethicist who has presented the case for leaving out the institutional context. A dilemma like this only arises when there are not enough staff: ‘On a ward with enough staff, I’d send a nurse to sit next to the patient’s bed and ask *why* he does not want to get up. Maybe his wife is not coming to visit... maybe he feels awful and fears he will never be released from hospital’. Someone who does not want to get up, says the psychotherapist, needs care. Offering him the choice of staying in bed is as much a way of neglecting him as is forcing him to get up.⁸⁶

Through the lens of the logic of choice, we see a patient attempting, or failing, to exercise their autonomy through choice. By reconstructing the patient’s behaviour as a question of choice, our attention is redirected from the material reality of neglectful care. We find it

⁸³ Ibid.

⁸⁴ Ibid.

⁸⁵ Ibid xi.

⁸⁶ Ibid.

difficult to ‘see’ the negligence at the heart of the case. The logic of choice has shifted responsibility to the patient. It has reduced our frame of reference and concern to a specific and definable moment or action of choosing. Divorced from context and evacuated of meaning, his predicament is now a discrete, transactional question of who is in charge of the body, rather than open-ended, relational, practical doctoring. The moral weight has shifted so that, enacted through practices of civic choice understood as contract, or consumer choice understood as purchasing, those around the patient (both near and far) are able to ‘wash their hands’ of the citizen/consumer by reference to either contractual or consumer principles: no injustice is done by enforcement of a contract voluntarily entered into under conditions of market equality. *Caveat emptor* indeed!

Whilst Mol develops her particular view from the lives of those engaging with diabetes care, her critique of choice mirrors the arguments mounted by that broader ethics of care tradition. In that literature, dominant theories of rights and justice imagine or construct moral subjects as autonomous, impartial and distanced from others, ‘[r]ationalist moral reasoning is said to act as an impersonal mediator between subjects’.⁸⁷ Liberal justice reasoning imagines that individuals as moral agents are guided by formal rules that rest upon principles generated by the application of reason; rather than through social-relational practices and encounters with concrete others. Certainly, it seems clear that a logic of choice, in both healthcare and broader theoretical positions, presents a world that might not be preferable – or as medically effective – as one shaped by the logic of care. Mol’s particular contribution to that tradition is her naming of the concealment or obscuring of neglect as a function of the logic of choice. The ‘unwelcome embrace’⁸⁸ of the single ideal of choice, like the dominance of liberal rationalist theories of rights and justice, leads to a denial of the alternative way of conceiving of our duty and obligation to care. ‘Choice’, Mol insists, ‘comes with many hierarchical dichotomies that are foreign to care: active versus passive; health versus disease; thinking versus action; will versus fate; mind versus body’.⁸⁹ The trouble with dichotomies is that some people will always end up on the ‘wrong side’.⁹⁰ In contrast, Mol tells us, care arises from responsiveness to the ongoing practical activities and constantly changing demands of living with disease and

⁸⁷ Ghandeharian, above n 48, 8.

⁸⁸ Mol, above n 2, 5.

⁸⁹ Ibid 84.

⁹⁰ Ibid.

caring for diseased bodies. Resistance to the logic of choice then calls for care, but so often the disciplining logic of choice works to (re)present such calls for care as failed attempts at successfully exercising choice.⁹¹ The practitioner might well ask “how can I be responsible? This was the result of a choice you made. My duty ends there”.

What might this mean for the particular question of iatrogenic harm, and criminal responsibility for it? It should be clear by this point that there are two main moves the logic of care makes. The first is not allowing us to capture the complexities of living with a medical condition, nor the work that is required to attend to it. In the logic of choice, ‘making normative judgments is the moral activity par excellence, and it is this activity that this logic endorses’.⁹² In actual care, in life as lived with a disease, it is practices that carry moral weight, and it is this activity that the logic of care endorses: ‘for care is not a (small or large) product that changes hands, but a matter of various hands working together (over time) to produce a result.’⁹³ The second move is that the logic of choice facilitates neglect. Awarding primacy to the logic of choice – and all that it brings with it – renders neglect invisible. It does so by its privatisation of the risks and benefits, the successes and failures of healthcare practices and by reshaping the world so that we only come to see what the logic of choice makes present to us. Choice pretends care is a discrete activity with a beginning and an end. Care, however, is an open-ended process. A choice is a transaction, whilst care is a relationship. Choice promises outcomes; care promises only work. Choice demands that we tame or transcend the body; care occurs only with the body. Choice asks who is in charge of the body; care asks how we live with the body. Choice assumes that scientific knowledge is becoming ever more certain; care attunes scientific knowledge to particular patients. Choice is about managing the body; care is about ‘tinkering’ (or doctoring) the body.⁹⁴

In all of this the moral act, subject to the logic of choice, becomes the making of a choice. The moral act in the logic of care, however, remains practical activity. Any discourse or practice that awards primacy to the logic of choice will participate in the reconstitution of

⁹¹ Flis Henwood, Roma Harris and Philippa Spoel, ‘Informing Health? Negotiating the Logics of Choice and Care in Everyday Practices of “Healthy Living”’ (2011) 72(12) *Social Science & Medicine* 2026.

⁹² Mol, above n 2, 74.

⁹³ Ibid 18.

⁹⁴ These are my adaptation of some of the contrasts which Mol uses to explain the logic of care and choice drawn from the work of Nussbaum. I expand and unpack most of these positions in Chapter Two, and then later, in Chapter Six, Nussbaum, above n 64.

the world into situations of choice and, in so doing, enact these two moves of failing to capture the complexities of living with a disease whilst rendering neglect invisible. These are the costs of the logic of choice. And what is purchased by it can only be the frustration of good care. The discipline of the quality and safety sciences participates in this process. Its disciplinary logic awards primacy to the logic of choice, and in so doing reads criminal law in a way that misrepresents how care is construed by criminal negligence; by denying care's legitimacy, the quality and safety discipline risks participating in the invisibility of neglect within the health setting. Yet whilst mobilising choice in this way, the discipline of quality and safety in its substantive work on quality improvement practices denies choice such a place. Instead, it denies that choice is a descriptor or way by which human action or agency functions in the contemporary healthcare setting. How it does this is a question I turn to in the following and final sections.

III. HOW THE LOGIC OF CHOICE IS ENACTED IN THE DISCOURSE OF QUALITY AND SAFETY SCIENCE?

If it is the case, as I contend, that the literature produced according to the disciplinary logic of quality and safety science adheres to the primacy of choice, what kind of world does this bring about? What 'mode of organising action and interaction; of understanding bodies, people and daily lives; of dealing with knowledge and technologies; of distinguishing between good and bad and so on'⁹⁵ does it enact? The literature I review here does not self-consciously refer to the tradition or logic of choice. Nor does it always say (directly) that it awards primacy to choice, or assents to all that must go along with such a decision. Yet it does, in fact, award primacy to the logic of choice.

Mol is helpful here not only in theorising of the logic of choice and of care; her work assists methodologically too. Her exploration of healthcare, like my exploration of this part of the literature of the quality and safety discipline, attempts to 'make words for, and out of, practices'.⁹⁶ It does so to explore how practices form some sense of coherence, making some practices appropriate or logical in some site or situation and others not. This coherence is not necessarily obvious to the practitioners and patients Mol studies. Nor is it necessarily obvious to those who write and think about criminal responsibility according

⁹⁵ Mol, above n 2, 7.

⁹⁶ Ibid 8.

the disciplinary logic of quality and safety science. For both groups, it might ‘not even be verbally available to them’,⁹⁷ but it is there, implicit, ‘embedded in practices, buildings, habits and machines’,⁹⁸ operating as an underlying rationale for what makes sense to do or not do or, as Mol puts it, ‘organising action and interaction; of understanding bodies, people and daily lives; of dealing with knowledge and technologies; of distinguishing between good and bad and so on’.⁹⁹ I adopt this approach by working over the following pages to read the rhetoric used by the leading writers on criminal blaming and iatrogenic harm as a practice of the quality and safety discipline. The mobilisation of particular languages and the shape and structure of leading arguments, what those writers conceive makes sense to do or not to do in relation to responsibility and criminal liability for iatrogenic harm is the practice I attempt to make words out of. In so doing, what the following pages make clear is that the quality and safety literature enacts the object of its concern in ways that depend and rely upon the primacy of the logic of choice.

In this section I make three sub-claims using this method. First, I argue that the logic of choice dominates the quality and safety discipline’s conception of responsibility for healthcare-related harm. In making sense of criminal negligence and its prosecution, these texts repeatedly use a rhetoric that depends for its meaning and legitimacy on choice. Secondly, I claim that the specific responsibility practices either condemned or proposed by the literature on healthcare-related harm receive that condemnation or support based on their alignment with the dictates of the logic of choice. Finally, I claim that adherence to the primacy of choice within the discipline of quality and safety science operates as the fundamental justification for rejection of criminal negligence. This is due to the doctrine’s strident opposition to the use of ‘choice’ as the definitive marker of criminal culpability. In its place, the doctrine proposes that it is a gross failure to ‘care’ (and not a culpable choice) that is a reasonable basis for criminal culpability and blame. This decentring of choice is identified by the quality and safety literature as cause for rejection of the doctrine’s legitimacy.

⁹⁷ Ibid.

⁹⁸ Ibid 10.

⁹⁹ Ibid 8.

D *The logic of choice dominates the literature's conception of responsibility for healthcare-related harm*

The logic of choice dominates the literature's conception of responsibility for healthcare-related harm. I demonstrate this through analysis of two of its principal expressions – first, how the literature's conception of error is oriented by the logic of choice and, second, how the human person and human action are subsequently constructed by the same logic of choice. Put differently, this is to enquire as to how the literature defines what harm is and whether it has occurred. I deal with both in turn.

Oliver Quick notes that 'much lies between the two extremes of blame-free accident and deliberate harm, and this is reflected by the myriad terms competing to describe the phenomenon of error in medicine: accidents, mishaps, mistakes, errors, negligence, failures, incompetence, misconduct, malpractice, deficient or substandard care, adverse or untoward events and iatrogenic harm'.¹⁰⁰ For this reason, one of the foundational contributions of the quality and safety discipline is to attempt clarification of what iatrogenic harm is and thus also of human action, causation and responsibility for it. One of the discipline's dominant expressions has been the production of taxonomies.¹⁰¹ These taxonomies of harm and its cause(s) depend for their meaning and legitimacy on the logic of choice and the specific ways of knowing (epistemology), of deciding (ethics) and of acting (praxis) that form part of the world this logic brings with it.

I focus on the work of Alan Merry and Alexander McCall Smith in my analysis.¹⁰² I do so because their extended work on law and iatrogenic harm, *Errors, Medicine and the Law*,¹⁰³ is the most developed statement opposing criminal blaming to emerge in recent years. It is also the most significant and focused treatment of the topic that is allied primarily to the quality and safety sciences, advancing its arguments against criminal law by drawing upon

¹⁰⁰ Oliver Quick, 'Medical Killing: Need for a Specific Offence?' in *Criminal Liability for Non-Aggressive Death* (Ashgate Publishing Ltd, 2013) 155, 172.

¹⁰¹ For two of the most influential such taxonomies in relation to harm and error, see James Reason, *Human Error* (Cambridge university press, 1990); Alan Merry and Alexander McCall Smith, *Errors, Medicine and the Law* (Cambridge University Press, 2001).

¹⁰² I draw on the original edition of the text for this analysis, Merry and McCall Smith, above n 101; whilst a new edition of the text - now authored by Merry and Brookbanks - has been recently released, it was released after research for this thesis was complete. There are updates to the text, and I have attempted to review material changes, integrating them into my analysis where relevant, see especially Chapter Five. Alan Merry and Warren Brookbanks, *Merry and McCall Smith's Errors, Medicine and the Law* (Cambridge University Press, Kindle Edition, 2017).

¹⁰³ Merry and McCall Smith, above n 101.

and applying the work of that discipline. Merry and McCall Smith advance one of the best-known and well-developed taxonomical frameworks in their *Errors, Medicine and the Law*.¹⁰⁴ They conceive of their taxonomy in the context of an overarching quest to understand and clarify the (proper) relationship between iatrogenic harm and blame.¹⁰⁵ The basis of their view in relation to harm and blame is their definitional schema both of harm, and thus human action, and of forms or situations of blame. In relation to harm and human action, they propose a principal division between ‘errors’ and ‘violations’. They write that ‘errors are seldom intentional whereas violations are deliberate deviations from accepted rules, norms or principles’.¹⁰⁶ Whilst Quick aptly interprets this as a difference between ‘doing wrong and wrongdoing’,¹⁰⁷ both concepts are united by their shared orientation to choice. This orientation is hard-wired into the very construction of the taxonomical categories themselves. Choice (or lack of choice) is what does the work of classification; choice is the very basis on which the two categories are formed. My own gloss on their definitional criteria shows how this is so: according to their taxonomy, errors are seldom ~~intentional~~ [the result of choice], whereas violations are ~~deliberate deviations~~ [choices to deviate] from accepted rules, norms or principles. In this foundational definitional schema, the entire axis of differentiation between categories of error and understanding of human action hinges on the role and place of choice; the taxonomical category of violation is applied to scenarios where a choice has occurred,¹⁰⁸ but its alternative – error – to those scenarios where choice has not.

This is not the only place where choice is granted primacy in this foundational work of Merry and McCall Smith. Not only is their taxonomical/definitional structure arranged or organised internally according to the binary of choice/no choice, but the apparatus of the taxonomy itself reproduces the primacy of choice more generally.¹⁰⁹ Its deployment

¹⁰⁴ Ibid.

¹⁰⁵ Clearly, much depends on the specific nomenclature used in this context. Quick’s comment above makes clear that there are many and varied (and competing) terms which circulate within this literature. Each brings with them their own advantages, disadvantages and moral overtones. Merry and McCall Smith, for instance, describe their inquiry as focused upon the question of ‘how mishaps occur and how people are blamed for them.’ I have no opposition to this term, however, have chosen to paraphrase it by use of ‘iatrogenic harm’ in the place of mishap, as this is the term I have chosen to use throughout this thesis. Ibid loc. 33.

¹⁰⁶ Quick, above n 100, 172.

¹⁰⁷ Ibid.

¹⁰⁸ ‘Violation involves choice’, Merry and McCall Smith, above n 101, loc. 44.

¹⁰⁹ In this I clearly draw on a Foucauldian understanding of both productive power and the classification of the error/violation classificatory system as an apparatus (‘dispositif’) in a similarly Foucauldian

produces a conversion or reshaping of human action associated with iatrogenic harm into a situation of choice, remaking the world in a way that misrepresents actual social practice and colonises alternative ways of conceiving of it. The taxonomy itself determines what does and should exist.¹¹⁰ It does this in two ways in relation to the practitioners themselves, but also to our understanding of ‘harm’.

As to practitioners first. The construction of situations of choice is something that Mol discusses, however primarily in relation to patients rather than practitioners: producing situations of choice involves an active re-organisation of the world so that situations arise where choice(s) are required of patients and are pivotal. Practices and relations of care require twisting to create these situations so that a choice is demanded of the patient. Her work, however, is still instructive in relation to practitioners. In this context, the taxonomical/definitional structure of Merry and McCall Smith achieves something quite similar for practitioners. The taxonomy’s effect is to produce the subject and agency of the practitioner in a particular manner. This is as (what I term) a ‘choosing-practitioner’. Applied to a specific instance of harm, or equally when utilised as an apparatus with which to theorise or conceive of harm at a more general level, the taxonomy’s utilisation of ‘choice’ as the axis of error or violation (between ‘doing wrong, and wrongdoing’¹¹¹) reframes and reproduces the practitioner’s action, subjectivity and context by reinterpreting/reshaping it into a situation of choice. Put differently, the taxonomy crafts a situation of choice, wherein the practitioner has/must/will choose. Armed with the taxonomy, we come seeking out choice or its absence as the pivotal question. No longer a

sense. See Giorgio Agamben, *What Is an Apparatus?: And Other Essays* (Stanford University Press, 2009).

¹¹⁰ The work of Gillian Rose has an abiding influence on this thesis, and in many ways undergirds much of my way of seeing this material, despite her not featuring greatly upon its surface in its final form. This concept of the tension between social practice/reality and what Rose understood to be a neo-Kantian way of appeal to a transcendental register is very much Mol’s, but is undeniably also influenced by Rose, see Gillian Rose, *Dialectic of Nihilism: Post-Structuralism and Law* (Wiley-Blackwell, 1st ed, 1991); Gillian Rose, *The Broken Middle: Out of Our Ancient Society* (Blackwell, 1992); Gillian Rose, *Mourning Becomes the Law: Philosophy and Representation* (Cambridge University Press, 1996); Gillian Rose, *Love’s Work* (NYRB Classics, Kindle Edition, 2011); in this, I have been influenced in particular by Vincent Lloyd’s detailed reading of Rose - and proposed completion of her unfinished work - most clearly put in his Vincent Lloyd, *Law and Transcendence: On the Unfinished Project of Gillian Rose* (Palgrave Macmillan, 2009); Also see the work of Brower-Latz who has recently added a valuable new voice to the reception of Gillian Rose’s work, Andrew Brower-Latz, *The Social Philosophy of Gillian Rose: Speculative Diremptions, Absolute Ethical Life* (PhD Thesis, Durham University, 2015) <<http://etheses.dur.ac.uk/11302/>>; Andrew Brower Latz, ‘Gillian Rose and Social Theory’ (2015) Winter 2015(173) *Telos* 37; Andrew Brower Latz, ‘Ideology Critique via Jurisprudence: Against Rose’s Critique of Roman Law in Kant’ (2016) 133(1) *Thesis Eleven* 80.

¹¹¹ Quick, above n 100, 172.

question of factors like adequate funding or staffing,¹¹² or of the complex socio-technical nature of healthcare, it is now down to the practitioners themselves and their choice as to whether we have an ‘error’ or ‘violation’ on our hands. Framed and re-shaped as a situation of choice, the choosing-practitioner’s internal, cognitive disposition is radically privileged over and above any other relevant concern, the taxonomy re-interprets, and thus produces, the practitioner, their agency, action and responsibility by reference to the presence or absence of (a) choice.

Merry and McCall Smith identify ‘rules, norms or principles’ as that which a practitioner may violate by virtue of their choice. Even the choice of this list of elements that might properly be violated by a choice is oriented by the logic of choice. These three elements are each cognitively knowable forms, which can be the subject of choice understood as a cognitively-located, internal willing of a subject to enact particular behaviours that violate knowable rules, norms or principles. Choosing to violate ‘adequate resourcing’ is not included, for example, as this element cannot be cognitively located; despite its absolute material impact on the outcome of healthcare it belongs to something of a different register. This structuring by exclusive use of cognitive aspects or understandings of human behaviour weds the analysis of human action and causation of harm entirely to a conception of human cognition and will – and thus to the logic of choice. So, too, does it inculcate a particular form of subjectivity. This is a fundamentally liberal conception of the willing, individual choosing-subject divided from its social context, imagined as standing alone in its moment of choice. It is the rational, sovereign subject who is autonomous, secure and free.

The logic of choice not only produces a choice-based taxonomy and choosing-practitioner. By extension, the taxonomy is productive of the very concept of ‘harm’, too. Choice, or its absence, produces our understanding of what, in fact, has occurred in the social world. In a fashion similar to that described above in relation to the choosing-practitioner, the application of the taxonomy produces this effect by actively controlling the frame through which its object of concern – ‘harm’ – is viewed/understood/constructed. It directs attention and concern towards a single ‘snapshot’ in time – the ‘moment’ of choice – producing ‘harm’ by forcing our understanding of a particular episode first through a limiting temporal frame, but similarly through a subsequent channelling of that episode

¹¹² As in the case of the psychiatric ward discussed above.

based on whether or not a choice (to violate a rule, norm or principle) has occurred. Merry and McCall Smith propose a form of tracing theory, where ‘antecedent activity’ must be taken into account.¹¹³ This is, however, limited in two ways. Firstly, they apply this process to distinguishing whether blame is appropriate (rather than whether a harm is an error or violation) and, secondly, the antecedent activity they identify as relevant prior acts or omissions, is no more than a form of tracing theory, proposing that blame be assessed by tracing it to relevant earlier choices (e.g. ‘consumption of alcohol before engaging in a dangerous activity’). This does not unseat the centrality of choice; it simply lengthens the chain of choices that might be relevant. Their work thus produces, in a direct way, what ‘harm’ itself actually means or ‘is’ in a particular situation. So too does it produce what ‘harm’ means in a general sense, by interposing choice as the filter through which any general concept of harm must pass.

In summary, the logic of choice is active and embedded in both the formation of the error/violation taxonomy and in the subsequent production of the choosing-practitioner and understanding ‘harm’ itself. The utilisation of choice earlier ‘down the line’ within the internal structure of the taxonomy of error or violation reproduces choice and its logic as primary in its subsequent effects. By selecting ‘choice’ to do the work of sorting and classifying at that early stage, the taxonomy embeds and later intensifies the primacy of the logic of choice. In so doing, it renders other matters or concerns secondary. Practically invisible are the substantive ethical, social and political contexts of action. In fact, so too is action itself. The action, the practices and behaviour of the practitioner (or any other person or system) are made quite irrelevant. Instead of action, we are directed to attend to the cognitive internal disposition or exercise of the will of a practitioner. Attending to the entire question and incidence of iatrogenic harm in that way reduces the complexity (and thus accuracy) of the inquiry and understanding of harm, human agency, action and responsibility. The effect is to cover-over the embeddedness of the choosing-practitioner, whilst radically privatising the locus of inquiry. This, perhaps surprisingly for a perspective that aims to radically limit the exposure of practitioners to liability for iatrogenic harm, forces responsibility onto the shoulders of the choosing-practitioner alone, for it is upon their choice that the entire enterprise pivots. Moreover, this renders invisible the harmed patient. It orientates the very practice of defining harm in a manner

¹¹³ Merry and McCall Smith, above n 101, Loc 1698.

that is radically practitioner-centric, rather than attending, for example, to the physical effect or lived experience of the harmed-patient in defining what harm is and whether it has occurred.¹¹⁴

The primacy awarded to the logic of choice is clear in the way in which harm and associated human actors, action and responsibility are understood by the literature produced within the quality and safety discipline. Merry and McCall Smith's conception is the most influential and developed of these perspectives. So, too, is their work influential on the question of responsibility practices such as blaming and criminal liability. The logic of choice is also embedded in that second area of focus. For Merry and McCall Smith responsibility practices are quite explicitly approved or rejected based on their alignment with the logic of choice. Showing how this is so is the task I take up in the next section.

E *The logic of choice is embedded in the responsibility practices proposed by the literature on healthcare-related harm*

The primacy of the logic of choice is embedded in the responsibility practices proposed by the literature on healthcare-related harm. So, too, is the primacy of the logic of care made clear in the responsibility practices they reject. This is so in the first instance because of the role that choice – and the related ways of being that it brings with it – plays in differentiating between responsibility practices that are approved or rejected. Responsibility practices that rely upon a free choice by defendant-practitioners are approved of, whilst those that do not are rejected.

Merry and McCall Smith's influential taxonomy or schema of harm was surveyed above. In that same text they also develop a similar schema for situations of blame. This schema expresses Merry and McCall Smith's own understanding of how to properly distinguish between good and bad. It relies upon the division made in their taxonomy of harm (error/violation) and, again, choice is directly embedded in the schema itself. The role of choice is again to act as a 'pivot' – in this instance, a pivot upon which the division between instances where blame might correctly or incorrectly be directed towards a particular practitioner or practitioners.

¹¹⁴ Similar arguments are made in relation to the focus on mens rea and its impact upon victims especially in relation to sexual assault. *DPP v Morgan* [1976] AC 182 is of note in this regard.

They develop this model, a system of five ‘levels of blame’, as a method of clarifying the ‘traditional bands’ within the spectrum of behaviour. They do this mindful of disciplinary, tortious and criminal systems. The traditional grouping of behaviour involves breaking the spectrum of correct/acceptable behaviour through intentional harm.¹¹⁵ Blameless behaviour, negligence, recklessness and internationally wrongful conduct are the broad categories they recognise in the traditional scheme. Their five levels schema aims to generate greater clarity in relation to negligence, recklessness and intentional conduct and to think through each in relation to the context of iatrogenic harm. In brief, level one of their schema is ‘pure causal responsibility’,¹¹⁶ similar to what is referred to in criminal law as ‘factual causation’,¹¹⁷ where the agent is ‘identified as the physical cause of the event’.¹¹⁸ Level two applies where action has unintentionally deviated from normative expectations of the actor.¹¹⁹ Level three applies to actions that deviate not simply from normative expectations, but from what can ‘*reasonably* be expected of the actor’, where intention was not present but where the actor failed to do things in the way they ‘*are*’ done by ‘people of reasonable competence in the field’. Moral culpability may exist at this level. The fourth level is a relatively straightforward match for (subjective) recklessness, where an actor knows of the existence of a risk and runs the risk regardless. Finally, level five is the ‘unambiguous intention to cause harm’.¹²⁰

The overarching principles that drive the scheme’s construction are that ‘people can only be morally accountable for acts they have chosen to perform’,¹²¹ and that legal liability follows moral culpability.¹²² The schema holds that choice, and only choice, may form the ground of blame. Only at ‘level three’ of Merry and McCall Smith’s schema does moral culpability, and thus (for them) potential legal culpability, enter the picture. It does so because it is at that level in their schema of blame that ‘prior awareness on the part of the

¹¹⁵ Merry and McCall Smith, above n 101, 148.

¹¹⁶ Ibid 5.

¹¹⁷ See the discussion of the Court on this question in *Royall v The Queen* [1991] CLR 378 (‘*Royall*’).

¹¹⁸ Alan Merry and Alexander McCall Smith, *Errors, Medicine and the Law* (Cambridge University Press, Kindle Edition, 2001) loc 1695.

¹¹⁹ Specifically, the ‘theoretical norm’, that is ‘the way of doing things prescribed in the textbook’, *ibid* loc 1696.

¹²⁰ *Ibid* loc 1704.

¹²¹ *Ibid* loc 1702.

¹²² I say overarching for two reasons. For one, there are, at times, a discussions of when negligence might be a suitable standard for responsibility.

actor’¹²³ that their action has fallen short of what could be expected exists; ‘in other words’, as they put it, ‘choice was possible’.¹²⁴

According to this perspective, without the possibility of choice, no moral or legal blame can properly be placed upon the head of the defendant-practitioner. To do so would both be unjust and undermine the legitimacy of the blaming enterprise that is civil and criminal law.

It is clear that the primacy of the logic of choice is embedded in the responsibility practices approved by the literature on healthcare-related harm. In contrast, the primacy of the logic of care is embedded in the responsibility practices that they reject, namely, manslaughter by criminal negligence. It is this conflicting primacy that operates as the fundamental justification for this rejection of criminal negligence. The quality and safety literature’s adherence to the primacy of choice so fundamentally conflicts with manslaughter by criminal negligence’s adherence to the logic of care that any engagement with iatrogenic harm by the quality and safety discipline will fail to understand the operation and legitimacy of manslaughter by criminal negligence. This is the matter I turn to next.

F *Adherence to the primacy of choice within the discipline of quality and safety science operates as the fundamental justification for rejection of criminal negligence*

As discussed above, the primacy of the logic of choice is embedded in the responsibility practices proposed by the literature on healthcare-related harm.¹²⁵ Yet the logic of choice also dictates the responsibility practices that they reject. The litmus test of that approval or rejection is whether or not a proposed practice adheres to the primacy of choice. Should it not do so, this is cause to reject the practice. The schema developed by Merry and McCall Smith discussed above is one of general application. That is, it applies to moral and legal responsibility of a variety of forms. How it applies to criminal law is confirmed later in their work. There it is the failure to locate choice as the primary basis for that practice operates as the fundamental justification for rejection of criminal negligence: ‘we accept

¹²³ Merry and McCall Smith, above n 118, loc 3181.

¹²⁴ Ibid.

¹²⁵ Ron Patterson outlines in his work both his move away from acceptance of criminal prosecution, but also what responsibility practices he finds acceptable and in what circumstances - such as professional disciplinary hearings. These are the practices which are preferred by the quality and safety literature in general. Ron Patterson, ‘From Prosecution to Rehabilitation: New Zealand’s Response to Health Practitioner Negligence’ in Danielle Griffiths and Andrew Sanders (eds), *Bioethics, Medicine and the Criminal Law: Medicine, Crime and Society* (Cambridge University Press, 2013) vol 2, 229.01

that there is a role for the criminal prosecution of a health professional whose wilful or egregiously reckless conduct causes the death of the patient, but such an approach should of course be a last approach'.¹²⁶ This adheres to a significant tradition within criminal law theory, and like much of that theorising assumes particular facets about the agent, including most notably free will, self-control, cognition and volition,¹²⁷ 'whilst highlighting, in one version at least, 'knowledge, intentions, and beliefs of the defendant are central'.¹²⁸ Because of this, the theory goes, we may be held responsible for actions we choose, and only for those we choose. As Ngaire Naffine puts it, this form of 'criminal law is morally obliged to address us as choice-makers'.¹²⁹

The 'problem' for the doctrine of manslaughter by criminal negligence should be quite clear by this point. The doctrine of criminal negligence not only fails to be orientated to choice, but it in fact stridently and actively opposes the use of 'choice' as the definitive marker of criminal culpability. In its place, the doctrine proposes that it is a gross failure to 'care' (and not a culpable choice) that is a reasonable basis for criminal culpability and blaming. This decentring of choice is identified by the literature as cause for rejection of the doctrine's legitimacy.¹³⁰

Merry and McCall Smith argue that the criminal punishment of negligence is a 'matter of particular concern'¹³¹ for them. This is so because criminal punishment carries 'substantial moral overtones',¹³² and that conviction for any substantial criminal offence must require that the defendant 'should have acted with a morally blameworthy state of mind'.¹³³ Their schema of blame makes clear that recklessness and intentional mens rea (levels four and five of their taxonomy respectively) are for the authors morally blameworthy. However, any episode falling into one of the lower levels does not carry with it the appropriately blameworthy state of mind to justify criminal punishment. Where does this leave

¹²⁶ Merry and Brookbanks, above n 102, loc 9299-9311. What they mean by 'egregiously reckless' is unclear, however, I take it to mean advertently reckless.

¹²⁷ See particularly Nicola Lacey on 'capacity responsibility', Nicola Lacey, *In Search of Criminal Responsibility: Ideas, Interests, and Institutions* (Oxford University Press, 2016) 27.

¹²⁸ Ibid 31.

¹²⁹ Ngaire Naffine, 'Criminal Conversations: Farmer, Lacey and the New Social Scholarship' (2016) 38 *Sydney Law Review* 505, 513.

¹³⁰ How the doctrine achieves this is the subject of Chapter 5. As to the rejection of the doctrine on these grounds, see both the Introduction to this thesis and Chapter 4.

¹³¹ Merry and McCall Smith, above n 118, loc 556.

¹³² Ibid loc 3219.

¹³³ Ibid.

manslaughter by criminal negligence? For Merry and McCall Smith, the common law's approach has been to provide a definition of criminal negligence that requires such significant negligence (negligence that is 'gross' or 'criminal' or 'total' etc.) that it 'is likely to be indistinguishable from recklessness, in that some degree of deliberate risk-taking or knowing disregard for the safety of others is involved'.¹³⁴ Yet, manslaughter by criminal negligence operates with a wholly objective form of mens rea, that is there is no requirement that there be a 'knowing' or 'deliberate' risk-taking or disregard of the safety of others. For Merry and McCall Smith, this form of objective negligence constitutes second-level blaming,¹³⁵ and is not worthy of criminal punishment. As Merry and Brookbanks put it in their most recent edition of the text, the offence of manslaughter by criminal negligence has 'outlived its usefulness and ought to be replaced by the subjective fault standard of advertent recklessness'.¹³⁶

IV. IMPLICATIONS

I have argued above that the world the disciplinary logic of quality and safety produces is a world dominated by the logic of choice. The discipline of quality and safety constructs this world through its commitment to a rhetoric about criminal negligence that depends upon choice for its legitimacy and meaning. It rejects criminal negligence on the basis that such an offence deviates from adherence to the primacy of choice. Negligence's objective form of mens rea is a prime target for this criticism, rejecting as it does the notion that choice plays a definitive role in delineating criminal from non-criminal conduct.

Simply understanding that the dual logics of care and of choice are at the heart of this conflict is a valuable and important contribution to knowledge in this area. However, knowing this points to a further, and potentially more productive, slippage or dissonance internal to the disciplinary literature itself. By this, I mean that what is potentially most interesting about the adherence to the primacy of choice by the quality and safety literature on criminal liability, is that it conflicts with the discipline's far more fundamental

¹³⁴ They note the anomalous situation which had existed in New Zealand, where a standard of ordinary negligence would suffice for a finding of a criminal offence, *ibid* loc 3223.

¹³⁵ They differentiate, as the quote immediately above shows, between negligence in its objective form, and something which seems to import aspects of recklessness, as had been in the case in Britain and Wales for some years – to which see Chapter Five for a discussion of so-called 'Caldwell Recklessness'.

¹³⁶ Merry and Brookbanks, above n 102, loc 9322. This position squares with conclusions reached in the first edition.

commitments and practices.¹³⁷ Taken as a whole, rather than just the portion of the literature that deals directly with criminal law and responsibility, the discipline's major contribution has been to theorise the emergent properties of iatrogenic harm in a novel way, one distinct from the accepted, perhaps 'common sense', view of harm and its causes. That distinctive contribution consists of a theorisation of human agency, action and harm itself that denies the health practitioner's ability to choose as an autonomous subject, subject as they are to control by external forces, their freedom severely attenuated. This central contribution of the discipline was described in some detail in the Introduction to this thesis. Recalling that description, healthcare (or its context at least) is understood by the quality and safety sciences to be a socio-technical system, not amenable to top-down decision making nor to control by individual agents, but characterised instead by functional interdependencies that self-regulate the system, the 'natural properties'¹³⁸ of which 'are formed by relationships among clinicians which rest on mutual (often implicit) agreements to participate'.¹³⁹ Yet, at the same time, the part of the discipline's scholarship that focuses on criminal responsibility supports forms of criminal responsibility practice that rely upon choice. They do so by means of a largely straightforward reliance upon familiar themes of intention, will and causation, which depend upon notions of control, choice and independent agency – which the discipline's substantive understanding of quality and safety improvement rejects. The quality and safety literature argues that healthcare is not a process or cluster of social practices amenable to top-down decision making or control by individual agents. Rather, the 'world' of healthcare is imagined to 'consist *a priori* of systems in which entities and their non-living environments are intrinsically connected by characteristic functional interdependencies, interdependencies that self-regulate the system as a functioning unit.'¹⁴⁰ In these terms, the healthcare system is understood as an objectively existing and functionally integrated unit. These are the 'complex systems' that dominate the work of quality and safety scholars, the 'natural properties'¹⁴¹ of which 'are formed by relationships among clinicians which rest on mutual

¹³⁷ This is a matter I take up in more detail in Chapter 4.

¹³⁸ J Braithwaite, WB Runciman and AF Merry, 'Towards Safer, Better Healthcare: Harnessing the Natural Properties of Complex Sociotechnical Systems' (2009) 18(1) *Quality and Safety in Health Care* 37, eg 37, 38 Table 1.

¹³⁹ Ibid 37.

¹⁴⁰ Marc Welsh, 'Resilience and Responsibility: Governing Uncertainty in a Complex World' (2014) 180(1) *The Geographical Journal* 15.

¹⁴¹ Braithwaite, Runciman and Merry, above n 138, eg 37, 38 Table 1.

(often implicit) agreements to participate’,¹⁴² that ‘respond poorly or not at all to conventional management or control measures... [and] emerge spontaneously and function with little or no externally imposed structure’.¹⁴³ Under such conditions, the dominant response has been to require a ‘shifting from individual blame to a systems perspective’.¹⁴⁴ Whilst it remains true that ‘[p]eople make errors... errors can cause accidents... in healthcare, errors and accidents result in morbidity and adverse outcomes and sometimes in mortality’,¹⁴⁵ from the systems perspective medical error is seen as emerging from an accretion of conditions rather than the more standard causal chain. Patient *harm*, rather than patient safety, is itself understood as the naturally emergent phenomena of healthcare-as-complex-system.¹⁴⁶ In such a domain, individual responsibility, and thus blame, cannot be ‘made out’. So embedded and ‘debased’¹⁴⁷ is such a subject/agent, so lacking in the ability to alter the emergent causation caused by the flow of events,¹⁴⁸ that the question of whether individual agency is something that healthcare organisations should even direct attention to has become a live question.¹⁴⁹ The literature, however, is clear. The criminal law’s focus on individual actors proximate to harm is an unintelligible and ‘prehistoric’¹⁵⁰ practice, the result of nothing more than the exercise of brute power in aid of satisfying the base desire for blame. On this basis, it is clear why the question of criminal culpability has become so controversial for those who support this view of healthcare and the limits of human agency within it.

¹⁴² Ibid 37.

¹⁴³ Ibid.

¹⁴⁴ Angus Corbett, Jo Travaglia and Jeffrey Braithwaite, ‘The Role of Individual Diligence in Improving Safety’ (2011) 25(3) *Journal of Health Organization and Management* 247, 248.

¹⁴⁵ Philip G Boysen, ‘Just Culture: A Foundation for Balanced Accountability and Patient Safety’ (2013) 13(3) *The Ochsner Journal* 400, 400.

¹⁴⁶ Corbett, Travaglia and Braithwaite, above n 144, 248; Corbett et al cites John Øvretveit, ‘Understanding and Improving Patient Safety: The Psychological, Social and Cultural Dimensions’ (2009) 23(6) *Journal of Health Organization and Management* 581.

¹⁴⁷ Julian Reid, ‘The Disastrous and Politically Debased Subject of Resilience’ [2012] (58) *Development Dialogue* 67.

¹⁴⁸ See generally on this conception emanating from regulatory studies, with which I largely agree, Judith Healy, *Improving Health Care Safety and Quality: Reluctant Regulators* (Ashgate Publishing, Ltd., 2013) xvii.; Judith Healy and John Braithwaite, ‘Designing Safer Health Care through Responsive Regulation’ (2006) 184 *Medical Journal of Australia* S56; see also Julia Black, ‘Critical Reflections on Regulation’ (2002) 27 *Australian Journal of Legal Philosophy* 1; see also in relation to iatrogenic harm and tort specifically Angus Corbett, ‘Regulating Compensation for Injuries Associated with Medical Error’ (2006) 28(2) *Sydney Law Review* 259.

¹⁴⁹ Corbett et al write ‘the problem of whether health care organisations should direct attention to creating the conditions for encouraging individual diligence’ Corbett, Travaglia and Braithwaite, above n 144, 248.

¹⁵⁰ Sidney Dekker, *Patient Safety: A Human Factors Approach* (CRC Press, 1st ed, 2011) 38.

Importantly, that substantive scholarship on quality and safety improvement does not describe choice as only being unavailable in particular circumstances, a temporary or particular ‘aberration’ of the usual way of things. Their claim is far stronger than this: they reject that these notions of control or choice are accurate or relevant elements of the practice of healthcare.¹⁵¹ The ‘reality’ of the practice of healthcare is not something that can ever be directed by liberal choosing-subjects/practitioners, who can direct and control the flow of events. Rather, even in ‘perfect’ circumstances, the very practice of healthcare or medicine is something that cannot involve, or be directed by, a choosing subject. Choice and control are simply not part of the equation. Healthcare, understood by the discipline, is much more like an autonomic function (such as breathing) to which the application of ‘choice’ is but a highly partial and not particularly relevant descriptor.

This being the case, by relying upon and supporting only subjective forms of criminal culpability the literature on criminal law, like that of Merry and McCall Smith, remains oriented by the familiar liberal themes of intention, will and causation. Being so oriented the specific part of the quality and safety science literature that deals with criminal responsibility betrays the far more fundamental insights and commitments of the discipline of quality and safety science as a whole. Being able to parse these two parts of the quality and safety literature means that not only is there a contradiction to be explored, but that something might be gained by setting aside – if only for a moment – the specific quality and safety literature that deals with criminal law. For, if the most important and novel contribution of the discipline as a whole is something that is radically questioning of the role of choice in the practice of (good) medicine, then there is an opening here for a re-evaluation of the relationship between the discipline and criminal negligence.

The discipline of quality and safety science’s substantive contribution to improvement practices (as opposed to its reflections on criminal negligence) and the doctrine of manslaughter by criminal negligence potentially share much in common, both sharing views of human agency, action and harm that do not rely upon subjective, choice-based agential control. If it is true, then, that the liberal, atomistic view of agency and action are,

¹⁵¹ The underlying psychological mechanisms which Merry and McCall Smith use to explain (and exculpate) errors (vs violations) draw from quality and safety science is a prime example of this form of argumentation. Merry and McCall Smith’s use of this scholarship to show how individual blame is both faulty and pointless, missing the systemic causes which really cause harm, and misunderstanding the levels of control which an individual can exert, Merry and McCall Smith, above n 118.

as Robert Pippin describes it in a different context, ‘false, or less credible and under increasing pressure’,¹⁵² what difference should it make to how we understand responsibility and culpability? Accepting that we are not ‘in charge’ or ‘in control’ in ways that the best learning in quality and safety studies seems to suggest must involve a different way of thinking about these issues of responsibility and culpability – one that, at a minimum, does not rely for its validity upon now-rejected forms of agency or action. I propose that the traditional jurisprudence of criminal negligence, which is deeply and unashamedly critical of liberal, atomistic conceptions of agency and individuality, holds at least part of the answer. Criminal negligence, like the best thinking and practice of quality and safety science, is concerned with the substantive ethical, social and political context of action. It is reliant upon a social theory of action that addresses questions of intention, action, cause, agent and culpability by reference to the communicative and evaluative practices in which these questions arise and are ultimately decided.

V CONCLUSION

In this chapter, I have shown that it is fruitful to view the conflict about manslaughter by criminal negligence as one driven and structured according to the primacy granted to either ‘choice’ or ‘care’. Applying the work of Annemarie Mol, it is clear that the quality and safety science literature on criminal negligence and the doctrine of manslaughter by criminal negligence express conflicting logics, one in the tradition of ‘care’ and the other in the tradition of ‘choice’. Infused with and motivated by the logic of choice, the healthcare quality and safety literature on criminal responsibility finds the doctrine of manslaughter by criminal negligence severely deficient in its failure to locate choice as the primary basis for its responsibility practices. This ‘failure’ operates as the fundamental justification for rejection of criminal negligence. Unfortunately, one of the most serious implications of this conflict is the potential for rejecting good care and what it offers. For what constitutes good medicine is good care, and adherence to the primacy of the logic of choice renders it almost impossible to capture the complexities of living with a disease and, in the process, creates the risk of rendering neglect invisible.

This chapter has been an explicit attempt to examine the fundamental and conceptual difficulties that underpin this debate. The motivation for doing so is the sense that the

¹⁵² Robert Pippin, *Participants and Spectators* (April 2010) On the Human [II] <https://nationalhumanitiescenter.org/on-the-human/2010/04/participants_and_spectators/>.

existing literature has not yet engaged with such fundamentals, and suffers for having not done so. Yet, this is completely understandable. A focus on *progress* and what is *practical* remains central to a field tasked with implementing relatively urgent and decisive action in the face of widespread, unnecessary and preventable harm and death. Given that context, the focus on the applied and practical – such as the operation and effect of criminal prosecution – rather than more fundamental questions – such as those posed here about the underlying jurisprudential or ethical orientation – seems a natural way of proceeding. In so doing, however, the pursuit of ‘practical’ answers has meant a too uncritical acceptance of the logic of choice and the world it enacts, not simply because it ‘works’ but because seeking out ‘what works’ in contemporary medical cultures – and perhaps culture more broadly – entails a commitment to what seems ‘natural’ and ‘orthodox’ in late modernity: a liberal rationalism marked by application of utilitarian calculus to judge what is right and wrong, practical and impractical. Developing a more critical stance in relation to the adherence to the logic of choice creates the potential for a new conversation about the role of criminal law in matters of iatrogenic harm; one that might give cause to re-evaluate the current denial of its suitability, which is near-universal in the scholarly and professional literature.

THE AFFINITY BETWEEN QUALITY AND SAFETY IMPROVEMENT PRACTICES AND THE LOGIC OF CARE

CHAPTER FOUR

I. INTRODUCTION

The consistent theme of quality and safety science literature that concerns itself with the criminal law is that the use of manslaughter by criminal negligence is wholly incompatible with the improvement practices of the quality and safety sciences.¹ This ‘incompatibility thesis’ drives the vast majority of scholarship and practice surrounding manslaughter by criminal negligence in this field. However, in this chapter I argue that there is in fact a misalignment between the stream of quality and safety literature that concerns itself with criminal negligence’s incompatibility with quality and safety improvement, and the discipline’s own substantive practices surrounding quality and safety improvement. This misalignment is founded on the markedly different relation and use of ‘choice’ between these two components of the quality and safety sciences. The substantive improvement practice of the discipline eschews the centrality of choice whilst the literature that rejects criminal negligence does so by holding fast to choice. On that basis, contrary to the incompatibility thesis, healthcare quality and safety improvement practices in fact share a marked affinity with fundamental aspects of the doctrine of manslaughter by criminal negligence: both regimes reject choice as the central or definitive marker of their ways of seeing and engaging with the world, and both seem to engage in practices that align with the logic of care.

To build this argument requires that I first differentiate the discipline of quality and safety science’s substantive work on quality and safety *improvement* from the discipline’s stream of work on *criminal responsibility*. This differentiation has not been made thus far by others, with the literature not yet having attended to the dissonance and slippage between the markedly different logic that motivates these two streams of quality and safety scholarship. To establish this differentiation, I present a synthesis of the discipline of quality and safety science’s substantive scholarship on improvement by reference to its understanding of human agency, action and the social world. This material establishes how

¹ See the extended discussion of this claim both in Chapter 2 and, particularly, Chapter 3.

the discipline has rethought the ‘reality’ of the practice of healthcare as something that can very rarely be directed by choosing-subjects/practitioners who, by exercise/force of their agential control or choice, can direct and control the flow of events. Rather, for the discipline of quality and safety science, the very practice of healthcare or medicine is something that cannot involve, or be directed by, a choosing subject. Choice and control are simply not part of the equation. Healthcare provision as understood by the discipline is much more like an autonomic function (such as breathing) to which the application of ‘choice’ is but a highly partial and not particularly relevant descriptor.

Having revealed the internal division between the quality and safety science literature that concerns itself with criminal negligence and that discipline’s substantive work on quality and safety improvement, I then turn to the affinity between the practices of healthcare quality and safety improvement and the core practices of care. In that section, I claim that the hallmarks of the discipline of quality and safety science, its substantive work on quality and safety improvement, are features commensurate with Annemarie’s Mol’s description of the ‘logic of care’.² In support of this overarching claim, I focus on how the substantive literature on quality and safety improvement and the logic of care both participate in a de-centring of the choosing subject and of the significance of choice. Having established a strong affinity and compatibility between quality and safety improvement practices and the logic of care, I conclude by drawing a connection between the doctrine of manslaughter by criminal negligence and the discipline of quality and safety science in its substantive work on quality and safety improvement. I conclude in this chapter that all three regimes – the logic of care, quality and safety improvement and criminal negligence – eschew the centrality of choice, and instead theorise human agency, action and healthcare-related harm in a manner deeply unconcerned with, if not in outright denial of, the relevance or availability of personal, subjective control or choice as definitive of their view of the world.

Revealing the internal dissonance between the quality and safety science literature that concerns itself with criminal and other practices of blame, and its substantive work on quality and safety improvement differs markedly from the existing policy and scholarly discourse that currently conceives of them in unified terms. In that context, to undermine

² See generally, Annemarie Mol, *The Logic of Care: Health and the Problem of Patient Choice* (Routledge, 2008).

the validity of the ‘incompatibility thesis’ – that criminal negligence and quality and safety are fundamentally incompatible – will help re-orientate scholarly and practice-oriented knowledge. This contribution lays the ground for a potential shift in predominant discourses and associated practices about criminal negligence and iatrogenic harm. For, if as I argue it is true that criminal negligence shares much in common with the discipline of quality and safety science, then there exists an opportunity to reconsider the place and operation of manslaughter by criminal negligence in this field. Moreover, demonstrating that the doctrine ‘fits’ in a coherent manner with the practices of healthcare delivery and quality and safety improvement, means that the doctrine itself, long rejected, may be recognised as a productive resource for healthcare quality and safety practice, forging better ways to conceive of our responsibility for the care of strangers, and to render visible those moments when a lack of care turns into neglect.

To begin, I turn to the task of differentiating the discipline of quality and safety science’s substantive work on quality and safety *improvement* from the discipline’s stream of work on *criminal responsibility* by offering a synthesis of the discipline of quality and safety science’s understanding of human agency, action and the social world it develops in its writing on quality improvement practices.

II. THE DISCIPLINE OF QUALITY AND SAFETY SCIENCE’S UNDERSTANDING OF HUMAN AGENCY, ACTION AND THE SOCIAL WORLD OF MEDICINE

As has been made clear already in this thesis, the mainstream of the literature does not reject the criminal prosecution of intentional harm. If a health practitioner chooses to kill, the criminal blaming that might follow is not seriously controversial.³ When it comes to manslaughter by criminal negligence, however, the literature is much more widely opposed to its imposition. This is rooted, I argued in Chapter 3, in a fundamental clash between the quality and safety literature on criminal negligence that grants primacy to the logic of ‘choice’ and the criminal negligence’s failure to be oriented in that same manner seen in its awarding of primacy to the logic of ‘care’.⁴ Infused with and motivated by the logic of choice, the healthcare quality and safety literature on criminal responsibility finds

³ But see Dekker, who argues for the most broad eradication of all forms of individual blaming, Sidney Dekker, *Just Culture: Balancing Safety and Accountability* (Ashgate, 2nd Edition, Kindle Version, 2012).

⁴ Mol, above n 2.

the doctrine of manslaughter by criminal negligence severely deficient in its failure to locate choice as the primary basis for its responsibility practices. This ‘failure’ operates as the fundamental justification for rejection of criminal negligence.

This orientation towards the paradigm of choice exists in a range of ways, the principal two being the two clusters of arguments that I termed ‘right and wrong’ and ‘practical and impractical’ in the Introduction. The first category of arguments – as to what is ‘right and wrong’ – focuses on what practitioners can be fairly held morally and/or criminally responsible for, and the relationship between those domains of responsibility. The second basis of opposition – what I termed the ‘practical and impractical’ – is the collection of arguments that focuses on the ‘good’ of reducing iatrogenic harm, and demands the decriminalisation or non-prosecution of the offence on the basis that it represents an unhelpful, ineffective, or even harmful practice in relation to reducing iatrogenic harm in ways aligned to the disciplinary logic of the quality and safety agenda. I review these arguments here, framed by an analysis of how they differ from the substantive contribution of the quality and safety discipline to which they belong.

A. *‘Right and Wrong’*

First, to ‘right and wrong’. A significant portion of the literature applies arguments based on classic views of valid and invalid bases of criminal blame, namely the subjectivist orthodoxy.⁵ The role of choice is definitive in these arguments, for without the presence of choice on the part of the defendant-practitioner, no criminal liability can be properly attributed to them. Applying this mode of argument, Merry and McCall Smith, for instance, accept that ‘certain forms of error may merit criminal punishment’,⁶ but that ‘the real task for the law is to distinguish between culpable errors and those which are non-culpable’.⁷ They claim ‘that provided that the mistake is one which does not point to moral culpability on the part of the person making it, then it is wrong in principle to subject such

⁵ The orthodox subjectivist approach is really the legal expression of ideas about human will and moral agency. It expresses in legal terms or is, perhaps, more correctly, the legal result of the idea that individual human person or subject is somehow in ‘control’ of their own actions. This is expressed by its adherence to subjective forms of mens rea. Alan Norrie presents the deeper difference between the subjectivists and those who do not fully adhere to that orthodoxy as one of tension between subjectivism and what he terms ‘morally substantive approaches to responsibility’, see Alan Norrie, *Law & the Beautiful Soul* (Routledge, 2013) 125.

⁶ Alexander McCall Smith and Alan Merry, ‘Medical Manslaughter: A Reply to Paterson’ (1996) 4(3) *Health Care Analysis* 229, 229.

⁷ Ibid.

a person to criminal punishment'.⁸ For them 'moral culpability' is strictly limited. It refers only to 'those who *deliberately* inflict harm on others or who are *reckless* in relation to the interests of others' (emphasis added),⁹ that is, to those who demonstrate, in the language of criminal law, subjective forms of fault or mens rea. To punish anyone by reference to an objective standard in the manner of manslaughter by criminal negligence, is to thus hold them culpable for 'ordinary human mistakes' and is for those authors 'harsh and morally unsophisticated'.¹⁰

Hindle et al express the same concern when reviewing the major quality and safety scandals of the past two decades, concluding that

[h]ardly anyone in these cases knowingly or deliberately tried to harm anyone. The actors in the cases were not like Dr Shipman, the British general practitioner who systematically killed at least 250 patients in a cold blooded, calculating manner...¹¹

Comparison between the notorious serial killer (and doctor) Harold Shipman and other health practitioners who might harm or kill patients in the conduct of their profession underscores the conceptual separation regarding criminal culpability built around and by reference to the logic of choice. In the mainstream of the literature, separation is enacted between instances where patients were harmed or died due to the 'knowing' or 'deliberate' actions/choices of the defendant-practitioner. Culpability in this instance adheres to the primacy of the logic of choice and very few oppose the validity of criminal or tortious negligence claims in those circumstances.¹²

B. 'Practical and Impractical'

The 'Shipman contrast' also points to the second basis upon which the literature remains oriented to the logic of choice; the collection of arguments that relate to the 'practical and impractical' in the realm of responding to iatrogenic harm. In this group of arguments about criminal negligence, it is the extent to which criminal culpability is applied outside

⁸ Ibid.

⁹ Ibid emphasis my own.

¹⁰ Ibid 230.

¹¹ Don Hindle et al, 'Patient Safety: A Comparative Analysis of Eight Inquiries in Six Countries.' (2006) 8–9.

¹² But see Dekker, who goes further than most in his critique of blaming practices in any circumstance. Sidney WA Dekker, 'Just Culture: Who Gets to Draw the Line?' (2008) 11(3) *Cognition, Technology & Work* 177.

of the subjectivist orthodoxy that produces adverse consequences, casting criminal liability as a hindrance to the prevention of iatrogenic harm. The undesirable consequences of most concern were the practical impacts of criminal prosecutorial activity is said to have upon a practitioner's willingness to engage in change initiatives and activities. Alan Merry makes this concern clear in his use of the same Shipman contrast to establish the binary between acceptable culpability and the consequences of culpability outside of that subjectivist orthodoxy:

Sending Shipman to jail achieved the objective of punishment, and did presumably save the lives of some patients who might otherwise have been murdered. This was essential, but how effective was it in addressing the overall problem of the harm caused by doctors, most of which is entirely unintentional? Not very.¹³

In this literature then, the criminal law is granted jurisdiction over intentional homicide like that committed by Shipman. However, where criminal negligence retains jurisdiction over what is often termed 'normal medical practice' – where death may arise outside of the intention or recklessness of the defendant-practitioner – the consequences are said to be a failure to affect the overall problem of the harm caused by doctors.

A major feature of this line of argumentation is the claim that such inappropriate criminal blaming pushes iatrogenic error and near-misses 'underground' – thus preventing effective action based on the learning gained from those episodes. Importantly, the reason given for this process is that practitioners fear the application of criminal blaming in circumstances outside of the subjectivist orthodoxy and which they feel are unjust. The literature considers the personal toll of prosecution as the basis of their explanation as to how criminal negligence prevents progress towards reducing iatrogenic harm and death by driving underground the necessary openness and behaviours needed to effectively tackle its correction. Doctors are described as the 'second victim'¹⁴ of iatrogenic harm. This

¹³ Alan Merry, 'When Are Errors a Crime?—Lessons from New Zealand' in Charles A Erin and Suzanne Ost (eds), *The Criminal Justice System and Health Care* (Oxford University Press, 2007) 94.

¹⁴ The term seems to have originated with Wu's influential article, Albert W Wu, 'Medical Error: The Second Victim - the Doctor Who Makes the Mistake Needs Help Too' (2000) 172(6) *Western Journal of Medicine* 358; see also Sidney Dekker, *Second Victim: Error, Guilt, Trauma, and Resilience* (CRC Press, 2013); Tom Delbanco and Sigall K Bell, 'Guilty, Afraid, and Alone — Struggling with Medical Error' (2007) 357(17) *New England Journal of Medicine* 1682; Charles R Denham, 'TRUST: The 5 Rights of the Second Victim' (2007) 3(2) *Journal of Patient Safety* 107; Massimiliano Orri, Anne Revah-Lévy and Olivier Farges, 'Surgeons' Emotional Experience of Their Everyday Practice - A Qualitative Study' (2015) 10(11) *PLoS ONE* e0143763; Susanne Ullström et al, 'Suffering in Silence: A Qualitative Study of Second Victims of Adverse Events' (2014) 23(4) *BMJ Quality & Safety* 325; Albert W Wu and Rachel C Steckelberg, 'Medical Error, Incident

victimisation includes the fear of (unjust) criminal prosecution after the emergence of an error that causes harm. It is this fear that is said to induce a ‘closed-shop’ in relation to harm and near-misses. That is, in response to the threat or activation of criminal prosecution for criminal negligence – even of distant colleagues – transparency and the open reporting of error closes down.¹⁵ As expressed in the vast majority of the literature critical of criminal law, this is not simply a fear of prosecution – although that is no doubt also a factor – but specifically a fear of *unjust* criminal prosecution, that is, prosecution outside of the subjectivist orthodoxy by offences like criminal negligence for actions that, the literature argues, are outside of the control of individual practitioner’s will or that cannot be prevented by the exercise of their individual faculties of choice.

Merry illustrates how the impact of such unjust criminal prosecution acts as a mechanism to shut down open reporting. It is in the form of a chilling effect. He writes that ‘[p]eople are less likely to report [error]’, which, it must be remembered, is defined by the literature as non-intentional deviations from planned practice, ‘fully, frankly, and promptly if they fear that the consequences of doing so might include criminal charges’.¹⁶ The seriousness, moral opprobrium and lived experience of the criminal blaming process comes together in these arguments about how criminal negligence prosecution comes to shut-off error wisdom. Criminal negligence prosecution is invariably unpleasant, but also wholly

Investigation and the Second Victim: Doing Better but Feeling Worse?’ (2012) 21(4) *BMJ Quality & Safety* 267.

¹⁵ Judith Healy, *Improving Health Care Safety and Quality: Reluctant Regulators* (Ashgate Publishing, Ltd., 2013) e.g. 247, 268-269; Alan Merry and Alexander McCall Smith, *Errors, Medicine and the Law* (Cambridge University Press, 2001) e.g. 216-217, 243; Danielle Griffiths and Andrew Sanders, *Bioethics, Medicine and the Criminal Law: Medicine, Crime and Society* (Cambridge University Press, 2013) vol 2, 5; the fear has been likened to that of being ‘in the closet’ by Quick, (‘Experts have preferred to closet errors, fearing loss of trust and status should they ‘come out’), Oliver Quick, ‘Outing Medical Errors: Questions of Trust and Responsibility’ (2006) 14(1) *Medical Law Review* 22, 27; This view formed a background assumption of much of the debate in relation to the introduction of the duty of candour in Australian jurisdictions and in the UK, see for instance, David M Studdert and Mark W Richardson, ‘Legal Aspects of Open Disclosure: A Review of Australian Law’ (2010) 193(5) *Medical Journal of Australia* <<https://www.mja.com.au/journal/2010/193/5/legal-aspects-open-disclosure-review-australian-law?inline=true>>; Julian L Rait and Elizabeth H Van Ekert, ‘Letters: Legal Aspects of Open Disclosure II: Attitudes of Health Professionals—findings from a National Survey.’ (2011) 194(1) *The Medical Journal of Australia* 48; Michael Faure, *Tort Law and Economics* (Edward Elgar Publishing, 2009) 354; Margaret Brazier, *Medicine, Patients and the Law: Revised and Updated Fifth Edition* (Penguin, 2011) [8.19]; as to the incidence of defensive medicine in response to legal threat, see Maurizio Catino, ‘Blame Culture and Defensive Medicine’ (2009) 11(4) *Cognition, Technology & Work* 245.

¹⁶ Merry, above n 13, 94.

objectionable when applied to medical practitioners.¹⁷ Being charged by the State with a serious criminal offence might be deserved in cases that are of an ‘obviously egregious nature’;¹⁸ however, for Merry and others, medical manslaughter does not deserve that label because of its failure to be oriented by the logic of choice, expressed by its use of an objective form of mens rea. In these circumstances, avoiding this serious, unpleasant and unjust process is only a rational response, and so open reporting and discussion of error is driven underground. That humans would attempt to avoid criminal prosecution – deserved or otherwise – is not particularly noteworthy. However, in relation to iatrogenic harm, the stakes are far higher and the reasons given are somewhat different to the simple avoidance of justifiable accountability. For ‘[i]f the healthcare system is to be improved, it is essential that workers report accidents, and also their insights into why the accidents occurred’.¹⁹ The problem of this chilling effect of criminal prosecution is that effective approaches to the reduction of iatrogenic harm rely upon open and free disclosure of near-misses and errors. Without this information, it is argued, we decrease – or even halt – the ability of quality and safety science to reduce harm.²⁰

Considerable significance had been attached to this issue of fear of blame, or the ‘culture of blame’. So widespread is the phrase, that it has ceased to be attributable or attributed to individuals, passing over, in the words of Joanne Travaglia, into ‘doxa’.²¹ Waring, too, notes that the concept was widespread, and its use based on arguments that practitioners would be disinclined to be open and honest about their experiences of error because of the deep-seated assumption that ‘they will be found at fault and held individually responsible

¹⁷ This includes criminal negligence liability predicated on the usual criminal standard, as opposed to the earlier civil standard of plain negligence that applied in New Zealand at the time of Merry’s earliest writing on this question.

¹⁸ Merry, above n 13.

¹⁹ Ibid 93.

²⁰ But see Quick, who correctly notes that the evidence of this mechanism being relieved by the introduction of no-fault system in New Zealand, the system most similar to our own in Australia (culturally, legally and medically), in relation to tortious negligence (where this concern is most pronounced in the literature), Oliver Quick, *Regulating Patient Safety* (Cambridge University Press, 2017) 99–100; but see in relation to civil liability and its effect, Simon Taylor, *Medical Accident Liability and Redress in English and French Law* (Cambridge University Press, 2015) 169 and generally.

²¹ Joanne Francis Travaglia, *Locating Vulnerability in the Field of Patient Safety* (PhD Thesis, University of New South Wales, 2009) 84; see also Hindle et al, above n 11; see also Joanne F Travaglia and Jeffrey Braithwaite, ‘Analysing the “Field” of Patient Safety Employing Bourdieusian Technologies’ (2009) 23(6) *Journal of Health Organization and Management* 597.

or punished for the event',²² which, to reiterate, is defined by the literature by reference to choice, as an adverse outcome caused by a non-intentional, non-knowing action on the part of the practitioner. It is, then, not simply that they might be 'found at fault' that is at issue. Rather, it is that they will be found at fault under circumstance where they deny that such fault is warranted or justified. Criminal blaming is not simply an unpleasant lived experience. For Merry and others, the fear and silence brought about by blame culture is intensified by the sense that such prosecution is unjustified and unjust in relation to medical practitioners because of its failure to be orientated to the logic of choice, utilising objective standards rather than subjective forms of mens rea.

The majority of the literature falls away at this point, having established the dominant claims that criminal negligence represents a morally non-blameworthy – or at least criminally non-labile – form of responsibility practice and that criminal negligence prosecution drives iatrogenic harm underground and, in so doing, prevents effective measures aimed at reducing iatrogenic harm. On the basis of these dual arguments, a distinct contrast between the two regimes of quality and safety and criminal law is established. Criminal negligence is constructed as incompatible with quality and safety science interventions in aid of preventing iatrogenic harm; nor are quality and safety science interventions compatible with a criminal law response, except in the most limited of circumstances.²³

There are elements of this literature, however, that either point out or utilise the underlying and substantive contribution of the quality and safety sciences to advance their position. Almost all of the literature critical of criminal blaming includes within its pages references to the insights of the quality and safety sciences. Merry and McCall Smith are key examples of this. As discussed in Chapter 3, for example, they draw extensively and repeatedly on contemporary work in psychological sciences and human factors to construct their taxonomy of blame.²⁴ Key parts of the literature also undertake deeper analysis, asking 'why' criminal negligence is so radically incompatible and even detrimental to the efforts of quality and safety improvement as such.

²² Justin J Waring, 'Beyond Blame: Cultural Barriers to Medical Incident Reporting' (2005) 60(9) *Social Science & Medicine* 1927, 6.

²³ Namely, intentionally caused harm or death, like the example of Dr Harold Shipman.

²⁴ See the discussion of this work in Chapter Three. See also generally, Merry and McCall Smith, above n 15.

The most promising form of such analysis rests on claims made by quality and safety science in its substantive work on quality improvement to the effect that the incompatible operation of criminal blaming and the quality and safety sciences occurs because criminal negligence labours under a false view of human action, agency and the emergence of error. In short, this is a claim that the nature of contemporary healthcare systems means that individual actors/practitioners cannot be said to be the source, nor definitive influences, on the flow of events such that attribution of criminal blame is appropriate; after all, how could anyone be praised or blamed, punished or rewarded, if what they do is in some ultimate sense not ‘up to them’?²⁵

Displacing this centrality of the choosing-practitioner, however, is part of the discipline of quality and safety’s more substantive contribution to the field, and key to its understanding of human action and iatrogenic harm. James Reason – one of the earliest and most influential theorists of quality improvement – directs attention in this manner, for instance, in his observation of the primacy accorded to individual autonomy in Western thinking and his argument that, for error management to work, this culture of autonomy needed to be overcome.²⁶

Recognising that there is a subtle, but important, difference between the quality and safety literature that still holds fast to the centrality of the choosing practitioner, and the character of the much larger stream of quality and safety literature that rejects such a focus, is advanced in the following section where I outline that stream of work within the quality and safety field that rejects the centrality of choice.

A *Systemic and Sociotechnical Understandings of Harm and Healthcare*

In this section, I describe the particular vision of human action and agency that the quality and safety sciences has developed over the past two decades of work on iatrogenic harm and improvement practices. Rather than focusing on the more technical aspects of the disciplinary project, I present that contribution by reference to the authors and discussion

²⁵ I adopt the phrasing from Stephen J. Morse, but also note that there is a fruitful avenue of investigation - beyond the scope of this thesis’ aims - drawing on the contemporary debate about compatibilism and the quality and safety science debate about criminal negligence and responsibility more generally, Stephen J Morse, ‘Common Criminal Law Compatibilism’ in Nicole A Vincent (ed), *Neuroscience and Legal Responsibility* (Oxford University Press, 2013) 27, 41–2.

²⁶ James Reason, *Managing the Risks of Organizational Accidents* (Routledge, 2016).

about blame and criminal responsibility where possible so as to maintain continuity with the discussion above and throughout the thesis.

Sidney Dekker, a leading scholar on questions of quality and safety improvement practices as they relate to blaming,²⁷ argues that criminal and tort law alike²⁸ fail to offer a way of providing satisfactory explanation of failure.²⁹ Why might this be the case? In part, Dekker echoes the concern of the literature described above as to the ‘chilling effect’ of criminal law upon open disclosure being related to the fear of the criminal prosecution.³⁰ However, he also concentrates on arguments to show that criminal negligence fails to offer a way of providing satisfactory explanation of failure, or an opportunity to make progress towards safer practice.³¹ Amongst other reasons, he argues that criminal prosecution is based upon a ‘pigeonholing [of] human acts’³² that reveals that law operates according to a flawed understanding of human action, agency and the social practices of medicine.³³ For Dekker, this failed grasp of reality means that criminal negligence liability is simply and solely an exercise in brute power, for ‘somebody still needs to decide what category to assign behaviour to, and that means that somebody will have got the power to do so... such assignments are nothing more than somebody’s attribution’.³⁴ That ‘nothing more’ of Dekker’s reveals his view of law’s injustice:

[the criminal law] constructs an account from its own pick of the evidence. It makes its own story. It is interesting that society may turn increasingly to their legal systems to hand out that story, to provide accountability after a terrible outcome. There must be something in

²⁷ Dekker, *Just Culture*, above n 3; see especially his application of those principles to the Mid-Staffordshire quality and safety disaster in healthcare where he writes with Hugh, that ‘To promote safety and quality, we encourage a sensitivity to the differences between understanding, satisfying demands for justice, and avoiding recurrence’, Sidney WA Dekker and Thomas B Hugh, ‘A Just Culture after Mid Staffordshire’ (2014) 23(5) *BMJ Quality & Safety* 356.

²⁸ For his clear summary see Dekker, *Just Culture*, above n 3, 111–112.

²⁹ Ibid 111 Dekker is, of course, not alone in this view.

³⁰ Dekker’s reflection on the prosecution of ‘Mara’ from the Swedish case of EH, known also as the ‘Kalmar case’ is a known as ‘Mara’ in Dekker’s writing, is a nurse who faces the criminal justice system, and in so doing is, according to Dekker, rendered ‘an outcast...a black sheep...perversely with her license to practice still in her pocket’, *ibid* location 152; *B2328-05* 2006 NJA 228 (‘Case of “EH”’); see also ‘Decision of the Swedish Supreme Court (Högsta Domstolens) in the Matter of EH (b 2328-05)’ <http://www.hogstodomstolen.se/Domstolar/hogstodomstolen/Avgoranden/2006/2006-04-19_B_2328-05_dom.pdf>.

³¹ Dekker, *Just Culture*, above n 3, 111.

³² Ibid location 69.

³³ Alan Merry, with Alexander McCall Smith, later engage in this same argument, developing the key text in the genre based in-part upon it, see Merry and McCall Smith, above n 15.

³⁴ Dekker, *Just Culture*, above n 3, location 77.

that account that we find terribly attractive; more enticing than what the people have to say who were actually there.³⁵

For Dekker, this turn towards the criminal law is utterly unintelligible. He writes that the law produces stories that are, in turn: ‘bizarre’; constructed so as to ‘present a rather believable truth’ from its ‘own pick’ of evidence’; providing a ‘certain conclusion’ to get at the ‘truth’; and used to ‘mete out supposedly appropriate consequences’.³⁶ The law tells false stories of human action and error. It ‘is not about truth. It’s about procedure and legal interpretation... the truth is secondary’.³⁷

This particular claim of Dekker’s about criminal law’s false and failed grasp of iatrogenic harm is based on his use of the quality and safety science’s substantive vision of human action and agency. His view, like that of Merry and McCall Smith, is that a fundamental and intractable incompatibility exists between the understanding of human action, agency and the social practice of medicine constructed by manslaughter by criminal negligence and the ‘firm scientific foundation’³⁸ (read: accurate view) of the same constructed by the quality and safety sciences. The most significant expression of this clash of paradigms is that law continues to blame, when the quality and safety science proves that blame cannot, and should not, be made out. It argues that the law’s view remains wedded to a historical understanding of errors as the result of erroneous and incompetent individual behaviour. Yet, within the discipline of the quality and safety sciences, it has become clear that this is no longer the most accurate description of error or its source. Rather, current thinking is profoundly at odds with person-centred views, focusing instead upon how human error is ‘often conditioned by wider contextual factors’.³⁹

This view of human action, agency and the social world of medicine where doctors are rendered as a second victim of iatrogenic harm, entangled in and subject to a system that produces iatrogenic harm,⁴⁰ is generally referred to as the ‘systems approach’.⁴¹ This ‘new

³⁵ Ibid location 367.

³⁶ Dekker, *Just Culture*, above n 3.

³⁷ Ibid location 177.

³⁸ Merry and McCall Smith develop their leading arguments in relation to responsibility for iatrogenic harm on the twin bases of the both law and the quality and safety sciences basis upon firm moral and scientific foundations Merry and McCall Smith, above n 15.

³⁹ Justin Waring, ‘Getting to the “Roots” of Patient Safety’ (2007) 19(5) *International Journal for Quality in Health Care* 257, 257.

⁴⁰ The systems approach is often expressed in a manner deeply, and perhaps surprisingly, in alignment with the language of original sin. According to the traditional expression of that doctrine we are

orthodoxy of error management’⁴² draws strategies into healthcare including cognitive and social psychology, ergonomics and ‘human factors’ research, thought to have been successful in other industries, particularly aviation.⁴³ Once framed by use of concepts and theories from medical science, ergonomics, human factors and resilience engineering, these paradigms mean that rather than seeing errors ‘as the result of individual mistake or failure, which tends towards blaming and encouraging secrecy’,⁴⁴ the correct view is that ‘individual or group performance is conditioned by a variety of upstream factors located in the wider system of care’.⁴⁵ These upstream sources of error include ‘quality of teamwork, communication, the allocation of tasks, workload scheduling, equipment and resource management, and broader service cultures’.⁴⁶

With regard to ‘control’ and ‘choice’, key writers contend that a complex, sociotechnical system is the context for, if not the very nature of, healthcare practice.⁴⁷ The quality and safety literature argues that healthcare is not a process or cluster of social practices amenable to influence by top-down decision making or control by individual agents. Rather, the ‘world’ of healthcare is imagined to consist *a priori* of systems in which entities and their non-living environments are intrinsically connected by characteristic functional interdependencies, interdependencies that self-regulate the system as a functioning unit.⁴⁸ In these terms, the

‘born’ into structures of sin having not actively chosen them. Yet, we are not only, as Couenhaven puts it so graphically, ‘overtaken by the power of sin, which perpetuates itself like a virus, vampirically living off and perverting the powers of its host’, but we re-perpetuate this sin ourselves. In this way, I have proposed elsewhere, that it may be fruitful to more fully explore the shared contours of original sin and systemic harm, see David J Carter, ‘A Legal Theology of Negligence: Negligence & Original Sin’ (on file with the author, 2015); Jesse Couenhoven, *Stricken by Sin, Cured by Christ: Agency, Necessity, and Culpability in Augustinian Theology* (Oxford University Press, 2013) 214.

⁴¹ See the memorable phrase that opens Shonjania and Dixon-Woods editorial: ‘[t]he patient safety movement of the early 21st century rode into town on the “systems” horse’, Kaveh G Shojania and Mary Dixon-Woods, “‘Bad Apples’: Time to Redefine as a Type of Systems Problem?” (2013) 22(7) *BMJ Quality & Safety* 528, 528; as to ‘systems’ and ‘system approaches’ see generally Barbara J Youngberg, *Patient Safety Handbook* (Jones & Bartlett Publishers, 2012); Dr Patrick Waterson, *Patient Safety Culture: Theory, Methods and Application* (Ashgate Publishing, Ltd., 2014); see also the emerging focus on resilience, and the Safety II agenda, Jeffrey Braithwaite, Robert L Wears and Erik Hollnagel, *Resilient Health Care* (Ashgate Publishing Group, 2013).

⁴² Waring, ‘Beyond Blame’, above n 22.

⁴³ Ibid.

⁴⁴ Justin Waring et al, ‘Healthcare Quality and Safety: A Review of Policy, Practice and Research’ (2016) 38(2) *Sociology of Health & Illness* 198, 202.

⁴⁵ Ibid.

⁴⁶ Ibid.

⁴⁷ J Braithwaite, WB Runciman and AF Merry, ‘Towards Safer, Better Healthcare: Harnessing the Natural Properties of Complex Sociotechnical Systems’ (2009) 18(1) *Quality and Safety in Health Care* 37.

⁴⁸ Marc Welsh, ‘Resilience and Responsibility: Governing Uncertainty in a Complex World’ (2014) 180(1) *The Geographical Journal* 15.

healthcare system is understood as an objectively existing and functionally integrated unit. These are the ‘complex systems’ that dominate the work of quality and safety scholars, the ‘natural properties’⁴⁹ of which ‘are formed by relationships among clinicians that rest on mutual (often implicit) agreements to participate’,⁵⁰ that ‘respond poorly or not at all to conventional management or control measures... [and] emerge spontaneously and function with little or no externally imposed structure’.⁵¹

Under such conditions, the dominant response has been to require a ‘shifting from individual blame to a systems perspective’.⁵² Whilst it remains true that ‘[p]eople make errors... errors can cause accidents... in healthcare, errors and accidents result in morbidity and adverse outcomes and sometimes in mortality’,⁵³ from the systems perspective medical error is seen as emerging from an accretion of conditions rather than the standard causal chain with an actor or actors at its source. Patient *harm*, rather than patient safety, is itself understood as the naturally emergent phenomena of healthcare-as-complex-system.⁵⁴ In such a domain, individual responsibility,⁵⁵ and thus blame, cannot be ‘made out’. So embedded and ‘debased’⁵⁶ is such a subject/agent, so lacking in the ability to alter the emergent causation caused by the flow of events,⁵⁷ that the question of whether individual agency is something that healthcare organisations should even direct attention to has become a live question.⁵⁸

Justin Waring, a leading critical sociologist of patient safety, provides an important review of the nature of the discipline of healthcare quality and safety science and the dominance

⁴⁹ Braithwaite, Runciman and Merry, above n 47, eg 37, 38 Table 1.

⁵⁰ Ibid 37.

⁵¹ Ibid.

⁵² Angus Corbett, Jo Travaglia and Jeffrey Braithwaite, ‘The Role of Individual Diligence in Improving Safety’ (2011) 25(3) *Journal of Health Organization and Management* 247, 248.

⁵³ Philip G Boysen, ‘Just Culture: A Foundation for Balanced Accountability and Patient Safety’ (2013) 13(3) *The Ochsner Journal* 400, 400.

⁵⁴ Corbett, Travaglia and Braithwaite, above n 52, 248; Corbett et al cites John Øvretveit, ‘Understanding and Improving Patient Safety: The Psychological, Social and Cultural Dimensions’ (2009) 23(6) *Journal of Health Organization and Management* 581.

⁵⁵ Which as will be seen still relies upon a liberal conception of the choosing and isolated subject, despite the radical rejection of that form of subjectivity by the same writers, see the Introduction to this thesis.

⁵⁶ Julian Reid, ‘The Disastrous and Politically Debased Subject of Resilience’ [2012] (58) *Development Dialogue* 67.

⁵⁷ See generally on this conception emanating from regulatory studies, with which I largely agree, Healy, above n 15, xvii.; Judith Healy and John Braithwaite, ‘Designing Safer Health Care through Responsive Regulation’ (2006) 184 *Medical Journal of Australia* S56; see also Julia Black, ‘Critical Reflections on Regulation’ (2002) 27 *Australian Journal of Legal Philosophy* 1; see also in relation to iatrogenic harm and tort specifically Angus Corbett, ‘Regulating Compensation for Injuries Associated with Medical Error’ (2006) 28(2) *Sydney Law Review* 259.

⁵⁸ Corbett et al write ‘the problem of whether health care organisations should direct attention to creating the conditions for encouraging individual diligence’ Corbett, Travaglia and Braithwaite, above n 52, 248.

of the ‘no blame culture’,⁵⁹ which has become a form of doxa within it.⁶⁰ Waring astutely reads this new orthodoxy as constructing our understanding of error along the two dimensions of ‘active errors’ and ‘latent factors’.⁶¹ The first dimension constructs error by marshalling the resources of human factors and psychology to describe cognitive lapses that lead to ‘active errors’. The second dimension emphasises the structural over the individual, with latent factors understood here by the discipline to ‘enable or exacerbate human error within organisational systems’.⁶² Once constructed by this regime of active errors and latent factors, ‘[h]uman behaviour is regarded as inherently error-prone but importantly these errors are facilitated or amplified by actions, decisions, and plans made elsewhere, or ‘upstream’ within the system’.⁶³ In this way, the figure of the practitioner is altered. No longer the central ‘mover’ or agent, the systemic, extra-personal factors have come to take centre stage in understanding action and error formation in healthcare.

The implications of this view are understood to necessitate a profound shift on a range of fronts. For quality and safety science research and analysis, for example, this means examination of the relationship between these ‘active errors’ by use of psychological and other disciplines to construct new ways of speaking and conceiving of human action. Now terms like ‘cognitive errors’, ‘slips’, ‘lapses’, ‘trips’, ‘violations’ or ‘behavioural mistakes’ are produced, each with a highly specific and, importantly, non-individual orientation. Latent factor research also calls for a new set of terms and techniques, with ‘system stress’, ‘sociotechnical’, ‘emergent’, ‘design’, and ‘team dynamics’, all phrases developed by the quality and safety sciences to understand clinical risk in terms of extra-personal and collective forces. Their effect is to de-centre and render problematic the notion that error is caused by personal choice, personal control, will or volition, or a failure to exercise any of these. Subject to these insights, ‘control’ is not fully possible, subject as the practitioner is to a complex of supra-personal systemic factors, through to the uncontrollable cognitive

⁵⁹ Waring is weary of the use and veracity of the no blame culture, particularly questioning whether, in fact, a no blame culture succeeds in really looking beyond the individual to tackle root causes, see especially Waring, ‘Beyond Blame’, above n 22.

⁶⁰ As to its status as ‘doxa’ see, Travaglia, above n 21.

⁶¹ Waring, ‘Beyond Blame’, above n 22; he utilises the same construction in his editorial, Waring, ‘Getting to the “Roots” of Patient Safety’, above n 39.

⁶² Waring is here drawing on the work of James Reason 1997 Waring, ‘Beyond Blame’, above n 22.

⁶³ Ibid.

systems that psychological insights tell us are both the cause of our contribution to error, but are, importantly, unable to be brought securely within our control.⁶⁴

With these new ways of conceiving human action, agency, risk and error become, perhaps most importantly for this context, new ways of re-conceiving causation. A series of highly influential models emerged in the discipline. Most notable, perhaps, is the ‘Swiss Cheese Model’, a model or metaphor that depicts the trajectory of errors through a series of gaps or weaknesses in the healthcare system, like holes in Swiss cheese. Constructed by James Reason,⁶⁵ this model/metaphor has been called the dominant paradigm in the analysis of errors in healthcare.⁶⁶ The metaphor’s use constructs error as occurring due to hazards being allowed to ‘travel’ through the system, via ‘holes’ formed by active failures or latent conditions. In this, and similar models, the convergence of human factors and medical science is at its most intense, causing scholarship and practice to develop along a ‘very particular trajectory’.⁶⁷ In short, the cause-and-effect modelling of human action and agency ‘parallels a similar operating logic within clinical care, which says first, secure a diagnosis, and then treat the patient in line with assembled evidence or derived consensus’.⁶⁸ This is the cause of three important effects. Firstly, it supports the construction of the field as a ‘science’, affording it legitimacy both within and outside the medical and healthcare professions. It also may reflect the work of the medical profession (in particular) to maintain control both of self-regulation, and of the otherwise embarrassing and professionally damaging revelations of the extent of iatrogenic harm.⁶⁹ Finally, it is also where the scholarship comes to most differentiate itself from what it understands to be the nature of criminal negligence’s understanding of causation. Even if personal control or choice remained possible within the practice of medicine, the application of this causal model to iatrogenic harm renders the exercise of it deeply irrelevant in terms of its ability to re-direct the flow of events within the complex

⁶⁴ Merry and McCall Smith’s account of these facts in particular is both very well advanced, and highly influential. Their taxonomy of harm rests significantly upon the insights of cognitive and other forms of psychology, see Merry and McCall Smith, above n 15.

⁶⁵ Reason, above n 26 (first published in 1997).

⁶⁶ Thomas V Perneger, ‘The Swiss Cheese Model of Safety Incidents: Are There Holes in the Metaphor?’ (2005) 5(1) *BMC Health Services Research* 71.

⁶⁷ Waring et al, above n 44, 203.

⁶⁸ Ibid.

⁶⁹ See Waring’s argument in relation to this in particular, Justin Waring, ‘Adaptive Regulation or Governmentality: Patient Safety and the Changing Regulation of Medicine’ (2007) 29(2) *Sociology of Health & Illness* 163; Travaglia and Braithwaite mount similar arguments, particularly in relation to the flow of capital within the ‘field’ of patient safety, see Travaglia, above n 21.

sociotechnical system. In short, choice, will and freedom are deeply attenuated, but more importantly, they are not the dominant experiences of practitioners in the practice of contemporary healthcare, nor are they particularly material to the cause of error and associated iatrogenic harm.

With the re-imagination of the dominant paradigm of action, control and causation in ways that are radically extra-personal, suspicious of the ability and usefulness of personal control of action or of the flow of events within healthcare, analytic attention is drawn distinctly away from the potentially negligent individual clinician, towards systemic factors such as ‘task design, communication patterns, teamwork, the availability of resources, time pressures and work stresses, and the broader configuration of work’⁷⁰ as they impact upon the quality and safety of care through conditioning and shaping individual and group performance. Intervention comes to look like a series of safety improvements that centre upon the immediate clinical environment.⁷¹ This involves interventions like ‘introducing safety checks and warning alarms, standardising tasks and introducing guidelines or automating activities’.⁷² What seems unnecessary are interventions that focus on blame, because, in a very real sense, error rather than safety is the emergent property of the healthcare system. Error is understood to be inevitable as is the human contribution to it. As Corbett et al conclude, ‘the uncomfortable conclusion for organisations and healthcare workers is that, to date, improvements in the quality and safety of care are not naturally emergent phenomena. Rather, the persistence of errors would seem to indicate that medical errors are best viewed as “‘emergent phenomena’ in complex systems” that occur “as the result of an aggregation of conditions rather than the inevitable effect of a chain of causes”’.⁷³

B *Application of the Systemic Understanding of Harm to Cases of Iatrogenic Harm*

I will present three short extracts from the Camden and Campbelltown Hospital Inquiry to illustrate how these views of human agency, error and responsibility come to shape and re-order the influential responses to iatrogenic harm.⁷⁴ This series of inquiries came about

⁷⁰ Waring et al, above n 44, 203.

⁷¹ Waring, ‘Getting to the “Roots” of Patient Safety’, above n 39, 257.

⁷² Waring, ‘Beyond Blame’, above n 22, 257.

⁷³ Corbett, Travaglia and Braithwaite, above n 52, 248; Corbett et al quote Øvretveit, above n 54.

⁷⁴ New South Wales Government, Health Care Complaints Commission, *Investigation Report Campbelltown and Camden Hospitals Macarthur Health Service* (Health Care Complaints

after four nurses made allegations about management and clinical practices at the hospitals to the then-Minister for Health, the Honourable Craig Knowles, on 5 November 2002.⁷⁵ The subsequent inquiry led by the NSW Health Care Complaints Commission represents, perhaps, the moment at which the discipline of healthcare quality and safety science was first able to engage with a widespread and major public instance of iatrogenic harm in Australia. Whilst short, the extracts demonstrate how the dominant disciplinary discourse of quality and safety science has come to so thoroughly shape the mentalities of governing iatrogenic harm.⁷⁶

The first is an extract from the opening paragraph of the Commission's report. It speaks to the Commission's predominant view of the field and practice of contemporary healthcare:

Health care in 2003 is provided in a highly complex and pressured environment often involving the care of vulnerable seriously ill people. Community expectations are that competent and ethical professional clinicians will deliver safe and appropriate care and that they will be protected from poor care that harms. Unlike other industries where risks occur, health care is heavily reliant on people to make decisions, exercise judgement and take the action that determines the outcome for the sick or injured person.⁷⁷

The Commission's view mirrors that of the quality and safety sciences. Healthcare is 'highly complex' and at its heart is a tension regarding the delivery of safe care. Community expectations of competent and ethical clinicians are held in tension with the claim of a unique relationship of those clinicians to risk and harm. The second vignette builds upon the first. It expresses how the concepts of quality, systems, safety and performance are constructed by the Commission:

The Commission's experience and the research show that many adverse events and problems that arise in the provision of health care are not merely attributable to one individual who was on the spot at the time the event occurred. They are often the result of a chain of errors or failures in the system of care that, unless identified and fixed, will lie latent until the circumstances occur again. Given what the health system now knows, there is no defence if

Commission, 2003) <<http://pandora.nla.gov.au/tep/40205>>; thank you to Joanne Travaglia for drawing these to my attention, see Travaglia, above n 21.

⁷⁵ New South Wales Government, Health Care Complaints Commission, above n 74, 2.

⁷⁶ In this I am referring to the 'governmentality' literature, see Nikolas Rose and Peter Miller, 'Political Power Beyond the State: Problematics of Government' [1992] *British Journal of Sociology* 173; Waring draws on the same literature in his work on regulation of medicine, 'Adaptive Regulation or Governmentality', above n 69.

⁷⁷ New South Wales Government, Health Care Complaints Commission, above n 74, i.

effective quality and safety systems are not in place to identify risks and minimise the possibility of a reoccurrence of a known risk.⁷⁸

Here, the systems approach is predominant. The chain of errors latent ‘in the system’ are foregrounded explicitly, de-emphasising the potential for ‘one individual’ to be the source of harm. In response to iatrogenic harm, the discourse of quality and safety science is wholly dominant. And it is this discourse that highlights the systemic level and degrades the individual agent, that elaborates what it is that is so unique in the relationship of clinicians to risk and harm. They are not the source, nor can they fix iatrogenic harm, for practitioners are so subjugated to the systemic forces, in a state of severely attenuated freedom, that their choices, even where important, are merely a final step in the complex emergence of harm, lacking the sufficient control to alter the flow of events away from harmful ends. That being the case, where safety is concerned, blaming individual clinicians does nothing to promote patient care. Drawing upon and expanding Joanne Travaglia’s commentary on this theme, the concept of ‘support’ of staff through establishment of a blame-free culture is that which is used to link ‘safety’ and ‘care’:

We found that the approach adopted by the [Macarthur Health Service, the meso-level health organisation within which hospitals in question were located,] in dealing with the four nurses did not reflect a patient care focus because it did not promote a culture of learning or a willingness to share information about error and system failure. The likely consequence of management's actions, which in the case of the operating theatre nurses became widely known at the hospital, was to discourage other staff from openly and actively raising concerns about clinical care...⁷⁹

In this, the Commission echoed – by quotation – Reason’s argument that ‘[t]rust is a key element of a reporting culture and this, in turn, requires the existence of a just culture – one possessing a collective understanding of where the line would be drawn between blameless and blameworthy actions. Engineering a just culture is an essential early step in creating a safe culture’.⁸⁰

Taken as a whole, the distinctive contribution of quality and safety science consists of a theorisation of human agency, action and of harm itself that denies the health practitioner’s ability to choose as an autonomous subject, subject as they are to control by external

⁷⁸ Ibid.

⁷⁹ Ibid 5.

⁸⁰ James Reason, ‘Human Error’ (2000) 172(6) *Western Journal of Medicine* 393, 394.

forces. According to this view, healthcare is understood to be a sociotechnical system, not amenable to top-down decision making nor to control by individual agents, but characterised instead by functional interdependencies that self-regulate the system, the ‘natural properties’⁸¹ that ‘are formed by relationships among clinicians that rest on mutual (often implicit) agreements to participate’.⁸² What is of principal importance for the quality and safety science intervention literature are (a) the practices and behaviour of the practitioner (or any other person or system) rather than their internal states of mind; (b) the importance of contexts within which action is embedded; and (c) the complex nature of healthcare and action as the basis of an accurate inquiry and understanding of harm, human agency, action and responsibility.

Importantly, however, is also what is of *very little importance* to the substantive literature on quality and safety science intervention and improvement: ‘choice’. Subject to its discourse about reality, it appears particularly problematic to speak of personal power, will and choice as independent and transcendent of the concrete situatedness and relatedness of practitioners to complex sociotechnical systems, within which they work. Choice is simply not mobilised as a central, definitive or accurate description of the social world or lens through which to understand human action for the discipline’s substantive work on iatrogenic harm. Nor does it play a role in relation to its intervention practices. This lack of a role for choice for the broader quality and safety sciences is in quite stark contrast to the central and definitive role that choice plays for the stream of work on criminal responsibility. For this reason, we should work to differentiate the literature on healthcare quality and safety that focuses on criminal liability, and the larger body of work and more fundamental contribution of the quality and safety sciences to understanding human action and agency within the context of the contemporary healthcare system.

Without such a differentiation between these streams of work, the usual interpretation that the doctrine of manslaughter by criminal negligence is incompatible with improvement practices will otherwise remain. Based as it is upon an orientation towards choice as the primary and definitive marker of right and wrong and of practical and impractical, this continued hegemony of ‘choice’ within the stream of literature on criminal negligence betrays the far more substantial contribution and perspective made by the discipline as a

⁸¹ Braithwaite, Runciman and Merry, above n 47, eg 37, 38 Table 1.

⁸² Ibid 37.

whole. Insofar as this continues, it remains a serious – and potentially productive – slippage or dissonance within the broader contribution and orientation of the discipline. To continue to do so will see the literature that is critical of criminal negligence fail fully to align with the more distinctive view generated by the past two decades of quality and safety science. The result may be that criminal law is still rejected; and my task here is not to take up a direct point-for-point rebuttal of that view. However, at a minimum the dissonance and slippage internal to the quality and safety science aligned literature should be explored for what it might add to our understanding of the basis of claims that criminal negligence is incompatible with the quality and safety sciences because of its rejection the centrality of choice.

To begin that further conversation about the implications of this slippage, in the next section I explore what seems to be a remarkable affinity between the language of human action, agency and the social practice of healthcare that is used to describe the insights of the quality and safety science improvement practices, and the hallmarks of the logic of care as described by Annemarie Mol. Both the language used by quality and safety science improvement practice and Mol's work seem to speak about action in ways that do not make strong references to or rely upon particular states of mind, but instead de-centre the choosing subject, and the act or significance of choosing. On this basis, I believe that each echoes a similar view of human agency and responsibility; the resistance to both of which chafes against the ascendant view of responsibility in wider culture, that of the primacy of choice.

III. THE SHARED CONTOURS OF THE IMPROVEMENT PRACTICES OF THE QUALITY AND SAFETY SCIENCES AND THE LOGIC OF CARE

I have already claimed that one of the distinctive features of the literature on quality and safety science intervention is its interrelated claims about the practice of medicine. These distinctive features include (a) a focus on the practices and behaviour of the practitioner (or any other person or system) rather than their internal states of mind; (b) a prioritising of the importance of contexts within which action is embedded; and (c) a commitment to the complex nature of healthcare and action as the basis of an accurate inquiry and understanding of harm, human agency, action and responsibility. Building on that work, the general claim I make in this section is that these hallmarks of the discipline of quality

and safety science in its substantive work on quality and safety improvement are features consummate with Annemarie's Mol's description of the 'logic of care'.⁸³ In support of this overarching claim, I focus on how both the substantive literature on quality and safety improvement and the logic of care both participate in a de-centring of the choosing subject and of the importance of choice and the significance of choice.

C Both Quality and Safety Improvement Practices & The Logic of Care De-Centre the Choosing-Subject & Prioritise the Practices of Care

One distinctive feature of the quality and safety science literature on improvement is the principal importance it places upon the practices and behaviour of the practitioner (or any other person or system). In coming to understand iatrogenic harm and human action associated with it, the quality and safety discipline does not enquire as to the state of mind of the practitioner. Rather, on the basis of its theorisation of the 'systemic nature' of iatrogenic harm, quality and safety science eschews the centrality of the choosing-subject. It instead operates with a view of human agency, action and healthcare-related harm that is suspicious, if not in outright denial, of the relevance of personal subjective control or choice. This is primarily expressed by its prioritisation of the extra-personal and structural sources of harm and activity – the systemic and sociotechnical makeup of the health system – rather than the agency of individual human actors. This leads to a quite serious de-centring of the importance and centrality of the subject as a choice-maker.

As I have made clear above, this way in which the quality and safety intervention literature de-centres the importance of the choosing subject conflicts with the stream of quality and safety literature on criminal liability and its granting of primacy to the logic of choice in understanding the world. That stream of literature on criminal negligence makes constant reference to particular internal states of mind of the defendant-practitioner and prioritises those states when it justifies critique of criminal negligence (and other practices of blaming). In so focusing on the internal states of mind, that literature actively supports forms of criminal offence based on those internal states of mind – namely intention and advertent recklessness – rather than forms of criminal offence that are primarily interested in action and behaviour.

⁸³ See generally, Mol, above n 2.

By focusing upon the choosing-subject in this way, this stream of literature awards primacy to the logic of choice, allowing choice to shape its ways of seeing the world, whilst justifying the mobilisation of choice and the choosing-subject – rather than action – as central to demarcating right and wrong, practical and impractical in the field of iatrogenic harm. Recall the description in Chapter 3, for example, how the logic of choice is active and embedded in the formation of the error/violation taxonomy of Merry and McCall Smith.⁸⁴ By selecting ‘choice’ to do the work of sorting and classifying, the taxonomy embeds and later intensifies the primacy of the logic of choice, influencing the subsequent production of both the idea of the choosing-practitioner and the understanding ‘harm’ itself. In so doing, this move renders other matters or concerns secondary. Practically invisible, for example, are the substantive ethical, social and political contexts of action. In fact, so too is action itself rendered invisible. The action, the practices and behaviour of the practitioner (or any other person or system) are made quite secondary. Instead of action, we are directed to attend to the cognitive internal disposition or exercise of the will of a practitioner. As I argued in Chapter 3, attending to the entire question and incidence of iatrogenic harm in that way reduces the complexity (and thus accuracy) of the inquiry and understanding of harm, human agency, action and responsibility. The effect is to cover over the embeddedness of the choosing-practitioner, whilst radically privatising the locus of inquiry. This, perhaps surprisingly for a perspective that aims to radically limit the exposure of practitioners to liability for iatrogenic harm, forces responsibility onto the shoulders of the choosing-practitioner alone, for it is upon their choice that the entire enterprise pivots. Moreover, this renders invisible the harmed patient. It orientates the very practice of defining harm in a manner that is radically practitioner-centric, rather than attending, for example, to the physical effect or lived experience of the harmed-patient in defining what harm is and whether it has occurred.

By contrast, the substantive literature on quality and safety intervention participates in a de-centring of the choosing subject. It does so in two ways – firstly, by understanding that the practice of care in medicine is a practical activity and, secondly, by understanding that care consists of work, and re-work and struggle. Both these characteristics of quality and safety improvement bear a strong resemblance with the practices that Annemarie Mol describes as good care. As will become clear, for both the quality and safety intervention

⁸⁴ See my discussion in Chapter Three.

literature and medicine as practiced according to the logic of care, it is practices and activity that carry moral weight rather than the internal cognitive states of practitioners. I expand each of these characteristics, their implications and how they reflect a similar de-centring of the choosing-subject in the paragraphs that follow.

The first characteristic shared by Mol's logic of care and the quality and safety science intervention literature is that both regimes underscore the centrality of practice, and practical activity. Annemarie Mol describes her understanding of care-as-practice as a 'practical task, one that is experimental'.⁸⁵ As something experimental, it cannot be worked out ahead of time, 'for care is not a (small or large) product that changes hands, but a matter of various hands working together (over time) to produce a result'.⁸⁶ According to this vision, good care is a matter of practice and activity, and that practice is marked by a spirit of constant work and re-work, re-adjustment and mutual re-negotiation over time. Good care is not that which is undertaken in association with a particular cognitive state. Rather, it is something that is marked by activity.

The quality and safety improvement literature similarly underscores the centrality of practices and activity as central to its understanding of the world and of successful healthcare quality and safety improvement. In manner similar to Mol's understanding of good medicine/good care, it also rejects a focus on the cognitive state of practitioners. The discipline of quality and safety improvement expresses this through its development and allegiance to their systems perspective on medical error.⁸⁷ This systems perspective is grounded in an understanding of patient safety, iatrogenic harm, and the social practices of medicine as wedded to practice and activity. The systems view is marked by a stringent rejection of emphasis upon the internal states of the practitioner. According to that systemic view of healthcare and harm, healthcare is not amenable to top-down decision making nor control by individual agents through the exercise of their will. Rather, the 'world' of healthcare is imagined to consist *a priori* of systems in which entities and their non-living environments are intrinsically connected by characteristic functional

⁸⁵ Mol, above n 2, 87.

⁸⁶ Ibid 21 emphasis my own.

⁸⁷ Beautifully put by Shojania and Dixon-Woods when they wrote that '[t]he patient safety movement of the early 21st century rode into town on the "systems" horse.' Shojania and Dixon-Woods, above n 41, 528.

interdependencies, interdependencies that self-regulate the system as a functioning unit.⁸⁸ It is the complex interaction of a series of different practices and activities, unable to be directed or characterised by the various internal states of practitioners. Within that context, iatrogenic harm is seen as emerging from an accretion of conditions rather than the more standard causal chain. In this way, safety or harm is truly, as Mol describes, ‘a matter of various hands working together (over time) to produce’⁸⁹ that safety or harm. So much so that Mary Dixon-Woods and Peter Pronovost have described patient safety as plagued by the ‘problem of many hands’, where ‘multiple actors—organisations, individuals, groups—contribute to the performance seen at the system level,’⁹⁰ and that such a ‘profusion of agents obscures the location of agency’.⁹¹

The second characteristic shared by quality and safety science improvement practice that expresses a link to the logic of care flows from the first. It is that in actual care and in quality and safety improvement, it is practices that carry moral weight, and it is activity that the logic of care endorses. In the logic of care, the crucial moral act is not making value judgments, but engaging in practical activities. And these activities of care are emergent, self-organising and dynamic. They are made in the moment and in relationship between doctor, patient, technology and other elements through processes of ‘doctoring’ and ‘tinkering’.

Mol’s description of the practices associated with living with diabetes highlights how this is the case:

Practices like testing and monitoring blood sugar levels, and either injecting the appropriate amount of insulin or ingesting high-sugar food, begin in the clinic, however patients who live with diabetes must learn to carry out these practices on their own, finding ways of working them into the fabric of their daily lives. Patients’ lives are not all the same, however, and they will encounter different types of problems as they face the task of caring for themselves. When different tasks such as monitoring blood sugar and injecting insulin conflict with other practices of daily living (like work, for example), good care involves attuning these variables to one another. It is in these moments, that patients and healthcare

⁸⁸ Welsh, above n 48.

⁸⁹ Mol, above n 2, 18 emphasis my own.

⁹⁰ Mary Dixon-Woods and Peter J Pronovost, ‘Patient Safety and the Problem of Many Hands’ [2016] *BMJ Quality & Safety* 485, 485.

⁹¹ *Ibid.*

providers must decide together what is most important. Some things must give way to others.⁹²

Because of these characteristics, to alter approach, to renegotiate goals – to have to ‘attune’⁹³ through slow or halting progress – is not a failure. According to the logic of care, failure is found only in ceasing to engage in the process of work or struggle, to fail to continue to attend to the patient, to resign from the process of care. Instead, as Mol et al put it, ‘try again, try something a bit different, be attentive’.⁹⁴ This sense of the need to tinker and a different attitude to ‘failure’ is a hallmark of many practices advocated by the quality and safety sciences. The ‘error wisdom’ that is generated by a failure or near-miss is highly prized by improvement practice as a significant source for improvement, where that data calls for analysis, change to be tested and implemented in the clinical setting. Moreover, the disciplinary attitude to failure is one that calls for action. It is a future-oriented, problem-solving discipline, rather than a backwards-looking analytic practice. Action is what is called for by the quality and safety sciences.

So pronounced is this orientation towards action, that some elements of the quality and safety improvement approach risk a drift into an unforgiving utilitarianism at times. Take, for example, some of the stronger arguments against blaming. As described elsewhere in this thesis, the threat of blame is said to drive open disclosure ‘underground’, and thus is in the final analysis unhelpful for the prevention of iatrogenic harm.⁹⁵ This is argued by some, such as Dekker, to apply even when blame is justified on legal grounds. In one sense, this calls for a prioritising of the multitude who might benefit from the error wisdom that blame is said to stifle, rather than the singular (or multiple) harmed or killed patients at the centre of the error itself. On this basis, the calls to prioritise open disclosure by removing the threat of blame are in part justification for an unforgiveable pragmatism of means–ends thinking, motivated and justified by what I would see as a cruel utilitarian calculus that is not the proper concern of criminal law nor, I would argue, of good healthcare. It is an invitation we must resist, for it invites us to live in a world where the preventable death of another should be evaluated solely by weighing the costs and benefits

⁹² Mol, above n 2, 63.

⁹³ See for example *ibid* 58.

⁹⁴ Annemarie Mol, Ingunn Moser and Jeannette Pols (eds), ‘Care: Putting Practice into Theory’ (2010) 8 *Care in Practice: On Tinkering in Clinics, Homes and Farms* 7, 14.

⁹⁵ See the Introduction to this thesis for a more developed reading of this issue.

of the widespread, systemic practice of non-disclosure. This represents nothing more than a choice to render invisible the preventable death of a person who had sought out care and assistance, in return for the promise of (as-yet unrealised) reductions in iatrogenic harm.

Why this focus on care and improvement as a practical and experimental task is so important is because, in understanding care or improvement in terms that de-centre the act of choice for a focus on action itself, a ‘crucial difference’⁹⁶ is exposed. Mol argues that a focus on action means that clear boundaries are not erected; care, for Mol, is in this way ‘open-ended’,⁹⁷ an ‘ongoing process’⁹⁸ in which care work goes ‘back and forth’⁹⁹ between patient, doctor, family, technology, device and the collective. So, too, it seems, is quality improvement when it is practiced with a focus upon action, rather than the choice or cognitive state of the actor. The implications of this orientation towards process are quite important. For if care or improvement is a process that unfolds within time, then that process cannot be calculated ahead of time, or at all; care, like improvement practices, is a practice that is ‘attuned’¹⁰⁰ along the way, rather than a discrete activity with a beginning and an end. In contrast, the reshaping of healthcare according to the dictates of the logic of choice by focusing upon the choosing practitioner and their internal cognitive state directly sets us up to engage in just this cessation of struggle and work. According to the logic of choice is it not activity that carries moral weight. Instead, it is ‘making normative judgments [that] is the moral activity *par excellence*, and it is this activity that this logic [of choice] endorses’.¹⁰¹ The effects of this are devastating for good care or quality improvement. In reshaping practices of healthcare into situations of choice, where choice becomes the focus, this transforms a formerly (and actually) open-ended process of care or improvement into a discrete activity of choosing. A discrete choice – choose to lose weight or choose not to, or did they chose to harm someone or not – becomes a limit to our attending,¹⁰² forging an ‘end of discussion... as if it were a magic wand, the term ‘choice’

⁹⁶ Mol, above n 2, 20.

⁹⁷ Ibid.

⁹⁸ Ibid 21.

⁹⁹ Ibid.

¹⁰⁰ Ibid 58.

¹⁰¹ Ibid 85.

¹⁰² Ibid 20 (‘So the point is not that the market leads to cold and distanced relations...what it does, however, is draw a limit. The market requires that some product [device, plus skills training, plus kindness and attention] is delineated as the product on offer. A lot may be included in this product, but what is on offer and what it is not has to be specified. Then, or so the logic of choice has it, you may choose it, or not.’).

has ended the discussion'.¹⁰³ We have erected 'appropriate' and 'acceptable' end-points to the tinkering, re-work and trial that the process of care calls for and endorses:

The logic of choice comes with guilt. Everything that follows after a choice has to be accepted as following from it... In the logic of choice, having a choice implies that one is responsible for what follows. In the logic of care this is different. It is wise to face up to what went wrong, but not so as to find fault with yourself or with others.... Wonder what to do next and do not give up. This is the difficult part of care: to not give up... Here, morality is linked up with morale. The logic of care does not impose guilt, but calls for tenacity. For a sticky combination of adaptability and perseverance.¹⁰⁴

The quality and safety science literature that is critical of manslaughter by criminal negligence creates the opposite effect to an understanding of care and good medicine as shifting and requiring constant tinkering. Rather, thinking about harm through the lens of choice, as that stream of the literature does, works to centre attention on the choosing-practitioner, whilst covering over their embeddedness within complex systems and contexts. Practices and activity carry moral weight in the logic of care because the logic of care demands that actors 'do things'. In the logic of choice, actors are those who make decisions. And what follows from that choice, for better or for worse, is your responsibility. In the logic of care, the demand upon is no less burdensome; however, it is not an internal decision-making process that lies at its centre. Rather, it is activity; often a very wide range of activities.

IV. IMPLICATIONS

I have argued above that the discipline of quality and safety science, in its substantive work on quality and safety improvement, shares a great deal in common with the logic of care. I have earlier argued that the doctrine of manslaughter by criminal negligence is an expression of that same logic of care. On this basis, it seems that all three regimes – the logic of care, quality and safety improvement and criminal negligence – eschew the centrality of choice, and instead theorise human agency, action and healthcare-related harm in a manner deeply unconcerned with, if not in outright denial, of the relevance or availability of personal, subjective control or choice as definitive of their view of the world.

¹⁰³ Ibid x.

¹⁰⁴ Ibid 90–91.

Both regimes of criminal negligence and of the quality and safety science de-centre the choosing-agent or the importance of choice, imagining a world where choice, or being in charge or in control, are not dominant experiences, where individual agential control might not be fully possible, or where the things we choose are not the only source of serious obligation and where action is not best understood by reference to particular states of mind. For this reason, it seems possible their expression of key aspects of the logic of care might mean that, rather than being wholly incompatible, these two regimes might lay the ground for a potential shift in predominant discourses and associated practices about criminal negligence and iatrogenic harm. If it is true that criminal negligence shares much in common with the discipline of quality and safety science, then there exists an opportunity to reconsider the place and operation of manslaughter by criminal negligence in this field. Moreover, demonstrating that the doctrine ‘fits’ in a coherent manner with the practices of healthcare delivery and quality and safety improvement, means that the doctrine itself, long rejected, may be recognised as a productive resource for healthcare quality and safety practice, forging better ways to conceive of our responsibility for the care of strangers, and to render visible those moments when a lack of care turns into neglect.

The most original and important contribution of the discipline is made in its substantive work on improvement, rather than upon criminal responsibility. Given that, the discipline’s substantive contribution on improvement should be taken as normative when thinking about questions of compatibility between criminal negligence and the discipline. For this reason, when assessing the differences and similarities between how, on the one hand, the doctrine constructs the social world, human agency and action and how, on the other, the quality in safety science work on improvement should take precedence.

Simply testing and rethinking the validity of the ‘incompatibility thesis’ is a unique and significant contribution to scholarly and practice-oriented knowledge in this area. However, having done so a series of theoretical and practical implications do follow. For one, it seems that the veracity of the incompatibility thesis should be questioned. No longer should it be so firmly put that criminal negligence is itself wholly incompatible with the improvement practices of quality and safety science. It is at least an open question as to whether, empirically as it were, the threat of blame inhibits candour or whether – and this is a different question – the decriminalisation of medical manslaughter increases the flow

of open and forthright reporting of error or near-misses. However, it seems that outside of this question, there is in fact much held in common between the two regimes of practice I have been engaging with throughout this chapter. These areas of commonality are deeply held, and foundational to their practices of blaming, or improvement.

There are other theoretical implications that flow from this finding. As João Biehl writes about Mol's work, the logic of care is precisely a consequence of the deconstruction of the fact/value distinction, the governing binary between the so-called impartial or rational and moral sphere: 'The logic of care has no separate moral sphere. Because "values" intertwine with "facts", and caring itself is a moral activity, there is no such thing as an (argumentative) ethics that can be disentangled from (practical) doctoring'.¹⁰⁵ The logic of choice, on the other hand, 'comes with guilt. Everything that follows after a choice has to be accepted as following from it... In the logic of choice, having a choice implies that one is responsible for what follows'.¹⁰⁶ So, too, with the literature that critiques criminal negligence. In their adherence to the logic of choice, they themselves construct a fact/value distinction, and a separate moral sphere. 'In other words, it is a logic of choice [and the literature that follows its edicts] which, precisely by attempting to distil the moral from the neutral, rational and technological, permanently blocks us from approaching moral dilemmas that are fundamentally linked to those apparently value-neutral objects'.¹⁰⁷

This contribution lays the ground for a potential shift in predominant discourses and associated practices about criminal negligence and iatrogenic harm. If it is true that criminal negligence shares much in common with the discipline of quality and safety science, then there exists an opportunity to reconsider the place and operation of manslaughter by criminal negligence in this field. Demonstrating that the doctrine 'fits' in a coherent manner with the practices of healthcare delivery and quality and safety improvement, means that the doctrine itself, long rejected, may be recognised as a productive resource for healthcare quality and safety practice, forging better ways to conceive of our responsibility for the care of strangers, and to render visible those moments when a lack of care turns into neglect.

¹⁰⁵ Ibid.

¹⁰⁶ Ibid.

¹⁰⁷ João Biehl, 'Care and Disregard' in Didier Fassin (ed), *A Companion to Moral Anthropology* (John Wiley & Sons, 2014) 251.

I take on this task in the next chapter. There I engage directly with the doctrinal material and its operation in the setting of the Australian courtroom. Perhaps surprisingly, I come to accept the claims of critics that the doctrine is devoid of content and circular in construction. Yet, by carefully analysing these distinctive formal features of the doctrine of criminal negligence, I come to regard them as far from fatal flaws. Instead, by reviewing the operation of the doctrine's circularity and lack of positive content in recent Australian case law,¹⁰⁸ I maintain that these 'weaknesses' of the doctrine are in fact one of its greatest strengths.

¹⁰⁸ Namely, *R v Pegios* [2008] NSWDC 105 (2008) ('*Pegios*'); *R v Gary Gow* [2006] NSWDC 78 (27 October 2006) ('*Gow*'); *R v Pearce* [2000] Queensland Supreme Court Indictment No 96 of 2000 (15 November 2000) ('*Pearce*'); *R v Patel* [2010] QSC 233.

THE DOCTRINAL OPENNESS AND FLEXIBILITY OF THE DOCTRINE OF MANSLAUGHTER BY CRIMINAL NEGLIGENCE

CHAPTER FIVE

I INTRODUCTION

This thesis has worked to advance our thinking about manslaughter by criminal negligence as it applies to iatrogenic harm. My strategy has been to engage with various ‘foundational’ aspects of the debate, many of which have been left undeveloped or incomplete, particularly from an Australian point of view. This has led to, amongst other things, archival work to formulate a new account of the doctrine’s use in Australia, alongside analysis of the various ways that the availability and use of manslaughter is harmful to the functioning of the healthcare system came to be established as orthodoxy. Following this, I presented a sustained theoretical analysis of both the logics of care and choice that function as underlying jurisprudential or ethical orientations to so much practice and debate in this field. The construction and legal operation of the doctrinal material itself is no less foundational a question than these, and so it is to the doctrine I turn in this chapter.

Scholars and those concerned with iatrogenic harm who have directly engaged with the doctrinal material itself universally criticise its construction and operation as fundamentally flawed. Central to their arguments are two intimately related claims. First, that the doctrinal material upon which the offence relies is too unclear, circular in construction, and lacking sufficient positive content to provide firm, workable guidance to practitioner action. Second, that this unstable and unclear state of the doctrine inspires an imposition of standards dangerously alien to those of medical practice. These claims are, of course, only one particular part of opposition to the offence itself.¹ Moreover, these particularly doctrinally-oriented heads of opposition occupy a small part of the writing on the offence and its effects. However, these are deeply important critiques, directed as they

¹ For instance, Alan Merry and Alexander McCall Smith have pushed back against the offence’s availability on the grounds proposed here, but also on the grounds that, for them at least, *only* subjective/choice-based forms of mens rea represent a valid foundation of moral and thus criminal culpability.

are at the primary doctrinal material itself; the ‘building blocks’ upon which the offence’s availability, any legal proceedings, and by extension the lived effect of prosecution (or non-prosecution) are built.

In this chapter, I engage with these critiques of the doctrine. Perhaps surprisingly, I come to accept the claims of critics that the doctrine is devoid of content and circular in construction. Yet, by carefully analysing these distinctive formal features of the doctrine of criminal negligence, I come to regard them as far from fatal flaws. Instead, by reviewing the operation of the doctrine’s circularity and lack of positive content in recent Australian case law,² I maintain that these ‘weaknesses’ of the doctrine are in fact one of its greatest strengths. In my reading, they are essential features of the doctrine’s simultaneously open and closed form, features that construct a uniquely relative, rather than absolute, conception of duty, of harm, of care and of failure that, only when ‘activated’ through its application to a particular setting, purposively causes the law to radically reshape its very self according to the local and specific context to which it is applied. In the context of iatrogenic harm, this means the doctrine is able to take up into itself the values and standards of medical practice generated and expressed by medicine itself. By borrowing in this way, the doctrine reflects and thus reinforces what is particular to this field of practice, rather than imposing standards dangerously alien to good (medical) care. In short, rather than being in straightforward opposition, the criminal law borrows and dynamically transforms the ethical values, principles and practices of medicine and healthcare to construct the very substantive law that medicine and healthcare writers oftentimes regards as illegitimate, unhelpful and irrational.

Consistent with the overarching aim of the thesis, there is still significant business to be transacted at the very foundational levels of this field of debate. By pursuing answers to criticism of the fundamental doctrinal formulation and material itself, significant impacts can be had downstream. Furthermore, manslaughter by criminal negligence remains ‘on the books’ in Australia, and in many other countries besides. It continues to be used, albeit judiciously, in the Australian context and its presence exerts an influence on the regulation and conduct of medical and healthcare practice. In light of such persistence of the doctrine

² Namely, *R v Pegios* [2008] NSWDC 105 (2008) (*‘Pegios’*); *R v Gary Gow* [2006] NSWDC 78 (27 October 2006) (*‘Gow’*); *R v Pearce* [2000] Queensland Supreme Court Indictment No 96 of 2000 (15 November 2000) (*‘Pearce’*); *R v Patel* [2010] QSC 233.

in our legal system, an adequate account of its doctrine and its use should be advanced that makes better sense both of its basic requirements, and of its doctrinal operation.³ By constructing this theory of manslaughter by criminal negligence and negligent culpability, I advance a significant and original contribution to our understanding of the doctrinal structure and operation of this much-maligned and, I argue, misunderstood criminal doctrine. I make a significant advance on the first of these challenges in the following section of this chapter. So too does the treatment I present here bring together, in the unique context of iatrogenic harm, a new way of integrating law's demand that we exercise a duty of care towards the sick and those requiring treatment, with the particular demands and realities that form the context of that care.

II BACKGROUND

Direct engagement with the doctrinal material and form of manslaughter by criminal negligence has occupied a number of scholars who are concerned with the quality and safety of healthcare. Scholars like Oliver Quick,⁴ Alan Merry and Alexander McCall Smith,⁵ Karen Yeung and Jeremy Horder,⁶ and Sidney Dekker,⁷ amongst others,⁸ have each produced doctrinally-oriented engagements that locate themselves within the context

³ In this I follow the lead of Guyora Binder, who writes about another no-less misunderstood and unpopular criminal offence in his work on Felony Murder, or Constructive Murder as it is referred to in the Australian jurisdiction, see Guyora Binder, *Felony Murder* (Stanford University Press, Kindle Book, 2012).

⁴ Oliver Quick, 'Prosecuting "Gross" Medical Negligence: Manslaughter, Discretion, and the Crown Prosecution Service' (2006) 33(3) *Journal of Law and Society* 421; O Quick, 'Medicine, Mistakes and Manslaughter: A Criminal Combination?' (2010) 69(1) *Cambridge Law Journal* 186; Oliver Quick, 'Medical Manslaughter: The Rise (and Replacement) of a Contested Crime' in Charles A Erin and Suzanne Ost (eds), *The Criminal Justice System and Health Care* (Oxford University Press, 2007); Oliver Quick, 'Expert Evidence and Medical Manslaughter: Vagueness in Action' (2011) 38(4) *Journal of Law and Society* 496; Oliver Quick, 'Patient Safety and the Problem and Potential of Law' (2012) 28(2) *Professional Negligence* 78; Oliver Quick, 'Medical Killing: Need for a Specific Offence?' in *Criminal Liability for Non-Aggressive Death* (Ashgate Publishing Ltd, 2013) 155; Oliver Quick, *Regulating Patient Safety* (Cambridge University Press, 2017) Chapter Six.

⁵ Alan Merry and Alexander McCall Smith, *Errors, Medicine and the Law* (Cambridge University Press, 2001); Alexander McCall Smith, 'Criminal or Merely Human: The Prosecution of Negligent Doctors' (1995–1996) 12 *Journal of Contemporary Health Law and Policy* 131.

⁶ Karen Yeung and Jeremy Horder, 'How Can the Criminal Law Support the Provision of Quality in Healthcare?' [2014] *BMJ Quality & Safety* 002688.

⁷ See principally his work on Just Culture and the 'second victim', Sidney Dekker, *Just Culture: Balancing Safety and Accountability* (Ashgate, 2nd Edition, Kindle Version, 2012); Sidney Dekker, *Second Victim: Error, Guilt, Trauma, and Resilience* (CRC Press, 2013); see also Sidney WA Dekker, 'Criminalization of Medical Error: Who Draws the Line?' (2007) 77(10) *ANZ Journal of Surgery* 831; and see Sidney Dekker, 'The Criminalization of Human Error in Aviation and Healthcare: A Review' (2011) 49(2) *Safety Science* 121.

⁸ Including Filkins in the US, see James A Filkins, "'With No Evil Intent": The Criminal Prosecution of Physicians for Medical Negligence' (2001) 22(4) *Journal of Legal Medicine* 467.

of iatrogenic harm or of healthcare quality and safety more broadly. This scholarly literature has been uniformly critical of the doctrine, oftentimes calling for its reform or abolition.

Merry and McCall Smith, and later Merry and Brookbanks,⁹ for example, note that manslaughter covers a ‘notoriously broad range of moral culpability’.¹⁰ They express a strong opposition to the doctrinal reliance upon an objective standard,¹¹ and claim that the core doctrinal concept or language of ‘gross’ or ‘major departure’¹² is ‘notoriously vague, to a degree that it leaves prosecutors struggling to apply the test to medical cases’.¹³ For them, the current doctrinal form represents a ‘crude’¹⁴ legal notion of negligence of which injustice is the result; concluding that in its current form the doctrine ‘allows for the real possibility of innocent men and women suffering punishment for medical outcomes *that do not reflect serious moral culpability*’[emphasis in original].¹⁵ Whilst their analysis of the criminal law’s use extends much further than this,¹⁶ it is the doctrinal material and form that they find ‘poorly constructed to deal with the majority of things that go wrong in healthcare’.¹⁷ The doctrine is ‘harsh and morally unsophisticated’,¹⁸ it fails to understand the relationship between patient and doctor ‘is fundamentally different from the relationship which normally exists between, for example, the victim and perpetrator of a violent crime’.¹⁹

Sidney Dekker holds an even more wide-ranging opposition to criminal negligence doctrine. An academic concerned with applying the best learning from human factors

⁹ Merry and McCall Smith’s original work has now been released in a second edition, updated by Merry and Brookbanks, see Alan Merry and Warren Brookbanks, *Merry and McCall Smith’s Errors, Medicine and the Law* (Cambridge University Press, Kindle Edition, 2017).

¹⁰ Ibid 310.

¹¹ Merry and McCall Smith, above n 5; Merry and Brookbanks, above n 9, see for example loc 9733.

¹² In the case of New Zealand criminal law.

¹³ Merry and Brookbanks, above n 9, 9758 (claiming support for this view from the work of Oliver Quick).

¹⁴ Ibid loc 11693.

¹⁵ In England and Wales at least, ibid 313, loc. 9339.

¹⁶ Spending particular time developing and applying a taxonomy of harm developed with the insights of the quality and safety sciences to legal constructions of harm, finding that criminal negligence describes a morally and practically problematic form of liability. See Chapter Three for a more detailed overview of this material.

¹⁷ Merry and Brookbanks, above n 9, loc 9980 (in the context of concluding that the issues/failures of corporate manslaughter offences are further evidence of the unsuitability of criminal law in the healthcare context).

¹⁸ Alexander McCall Smith and Alan Merry, ‘Medical Manslaughter: A Reply to Paterson’ (1996) 4(3) *Health Care Analysis* 229, 230.

¹⁹ Ibid.

research, he argues that doctrinal formulae that utilise gross negligence – and, in fact, all forms of doctrine or systems of guidance that attempt to differentiate between legitimate and illegitimate behaviour – not only fail, but represent merely brute and illegitimate workings of power. As to the doctrinal material’s failure, Dekker argues that doctrinal formulations of gross negligence assume that ‘cases of “gross negligence” jump out by themselves... [that] a prosecutor or other authority can recognise—objectively, unarguably—wilful violations, or negligence or destructive acts when they show up’.²⁰ Much of Dekker’s writing on ‘just culture’ repeatedly urges attention be paid to how such a line is drawn and particularly its productive effects.²¹ ‘Justice is an essentially contested category,’ Dekker claims, arguing in particular the legal assessment of gross negligence (‘the administration of retributive justice’²²) relies upon lay people²³ who ‘do not speak [the] language and have little idea of the messy social, technical, or clinical details of what it means to practice [medicine], of the time pressures and goal conflicts, and of the uncertainties and ambiguities of the work’.²⁴ Dekker delivers his most developed analysis of the doctrinal aspects of manslaughter by criminal negligence in his extended narrative case study of ‘Mara’,²⁵ a Swedish paediatric ICU nurse who was charged with a form of negligent manslaughter.²⁶ In it, Dekker illustrates how the law produces stories, stories that are for him, ‘bizarre’, constructed so as to ‘present a rather believable truth’ from its ‘own pick’ of evidence, providing a ‘certain conclusion’ to get at the “truth”, and to mete out supposedly appropriate consequences’,²⁷ instead of listening to those who were there. To understand, navigate and to engage in the process of applying the doctrine requires

²⁰ Dekker, *Just Culture*, above n 7, 14–15.

²¹ Ibid 24 (‘This is why a just culture should not give anybody the illusion that it is simply about drawing a line. Instead, it should give people clarity about who draws the line, and what rules, values, traditions, language and legitimacy this person uses’).

²² Dekker, *Second Victim*, above n 7, 63.

²³ Here, he refers primarily to juries, Dekker, *Just Culture*, above n 7, location 253, (Dekker’s critique draws into the frame the judges of the Högsta Domstolens, the most senior judicial officers of the Swedish legal system: ‘people with little idea of what it all meant.’).

²⁴ Dekker, *Second Victim*, above n 7, 63.

²⁵ Known to the Court as ‘EH’, in the case generally referred to as the ‘Kalmar case’, see B2328-05 2006 NJA 228 (‘Case of “EH”’); see also ‘Decision of the Swedish Supreme Court (Högsta Domstolens) in the Matter of EH (b 2328-05)’ <http://www.hogstadamstolen.se/Domstolar/hogstadamstolen/Avgoranden/2006/2006-04-19_B_2328-05_dom.pdf>.

²⁶ The narrative forms the prologue to his major work on accountability and safety, *Just Culture*. The entire narrative is well-worth reading, particularly for the tone developed by Dekker, which is difficult to reproduce, Dekker, *Just Culture*, above n 7.

²⁷ Ibid.

specialist assistance, expressed in Dekker's reading in archaic language.²⁸ All of this is cause for significant confusion for practitioner-defendants, even to the point of inducing a state of meaninglessness.²⁹ All of which causes Dekker to render Mara in language beyond even the most enthusiastic of critical-legal scholars, a 'mere piece of detritus mangled through the criminal justice system in its quest for new turf, disposed [of] once the flag had been planted'.³⁰

Less vehemently polemical is the work of British legal academic Oliver Quick. Quick has provided the most sustained and detailed engagement to date with the doctrine itself in the context of iatrogenic harm. Open-minded about the value of law for patient safety,³¹ Quick has concluded in relation to manslaughter specifically that the doctrine of gross negligence itself 'remains an unduly vague concept that is incapable of objective measurement and consistent interpretation and thus potentially unfair to those prosecuted'.³² Whilst earlier concluding that the offence should be abolished,³³ Quick seems to have modified his view of manslaughter and the use of criminal law somewhat, with his most recent work on the subject positioning the offence as a part of broader assemblage of criminal, civil and regulatory material, highlighting the relationships between these various elements, whilst absent his earlier direct calls for abolition.³⁴ Moreover, he now posits that the negative view of criminal law in the context of healthcare safety 'is simplistic',³⁵ overlooking how

²⁸ Ibid location 164-166 (EH's own defence counsel is said to have offices in an 'imposing building in stately surroundings, with spacious offices, high ceilings, the quiet reverence and smell of an old library', uses 'archaic dress [and] archaic language', who 'prattled on', interested the case out of self-interest: a 'big one' being heard in the Supreme Court.).

²⁹ Ibid location 169 (EH, is described as being out-of-place by Dekker. In his words she is a 'fish on the shore, gasping, trying to make sense of its surroundings by the burden of a final crawl for survival started sinking in.').

³⁰ Ibid location 207.

³¹ See general Chapter Six, Quick, above n 4; see also Quick, 'Patient Safety and the Problem and Potential of Law', above n 4.

³² See for example, Quick, above n 4, 112; see also Quick, 'Medicine, Mistakes and Manslaughter: A Criminal Combination?', above n 4, 186 ("criminal law adopts a one size fits all approach – which, to my mind, can be a bad fit.").

³³ Quick, 'Prosecuting "Gross" Medical Negligence', above n 4, 449; Quick, 'Medicine, Mistakes and Manslaughter: A Criminal Combination?', above n 4, 186 (abolished in favour of subjective reckless manslaughter as the proper limit for liability).

³⁴ Quick, above n 4, 112 (here concluding that '...this offence category has survived and is unlikely to be abolished'). The shift I perceive may, of course, simply be that his most recent work is driven by broader concerns, however, his newly critical note at p 108 that 'criticisms of the use of criminal laws in [the context of iatrogenic harm] have been based on a limited view that regards all such laws as the same...', and that it 'would be wrong to dismiss [criminal law] completely...better to explore which types of offences and enforcement methods are best suited to the task of improving safety' seem more open to the possibility of negligence's use (even if with a modified test).

³⁵ Ibid 110.

‘certain [criminal] offences may have... potential for helping improve patient safety’,³⁶ particularly where they reinforce existing regulatory interventions. That being said, his most recent work does not recant his earlier analysis of the doctrine itself.³⁷ For Quick, there are three main problems with the doctrinal material itself: the doctrine is ‘grossly vague’,³⁸ it invites assessments partly driven by assessments of character (including, troublingly, race),³⁹ and, finally it relies upon and potentiates expert control, risking jury usurpation by undue reliance upon expert authority.⁴⁰

As to the charge of vagueness, for Quick the doctrinal formulation for gross negligence (at least as it stands in his own jurisdiction) is ‘unclear, unprincipled [and] often unfair’.⁴¹ The test is circular – ‘it is a crime if the jury think it *ought* to be a crime’ [emphasis in original]⁴² – causing gross negligence to suffer ‘from a lack of intelligent (and clear) communication’.⁴³ This doctrinal form threatens the justice of the offence.⁴⁴ Quick’s analysis of doctrine through the lens of *R v Misra and Srivastava*⁴⁵ is particularly instructive. Misra and Srivastava were convicted of gross negligence manslaughter after the death of a patient under their care from toxic shock syndrome arising in the post-operative period. Arguing that the doctrinal definition violated the defendant-practitioner’s rights to a fair trial and against retrospective criminalisation found in Articles 6 and 7 of the European Convention on Human Rights respectively, their appeal was rejected by the Court of Appeal. Quick quips that ‘[v]agueness must have been in vogue’⁴⁶ when the

³⁶ Ibid 109.

³⁷ See for example, ibid 112 (‘...gross negligence remains an unduly vague concept that is incapable of objective measurement and consistent interpretation and thus potentially unfair to those prosecuted’).

³⁸ Quick, ‘Medicine, Mistakes and Manslaughter: A Criminal Combination?’, above n 4, 192; see generally Quick, ‘Expert Evidence and Medical Manslaughter’, above n 4.

³⁹ Quick, ‘Medicine, Mistakes and Manslaughter: A Criminal Combination?’, above n 4, 193–195.

⁴⁰ Ibid 195–197; Quick, above n 4, 122–127; see particularly, Quick, ‘Expert Evidence and Medical Manslaughter’, above n 4, 496, 517 (‘Little is known about how experts negotiate the legal process, empirically speaking: how they approach their task, how they view their role as expert witnesses, and the attitudes, biases, and beliefs that may underpin their testimony’, ‘Experts enjoy the freedom afforded by the vagueness of gross negligence and develop their own working rules of interpretation and analysis.’).

⁴¹ Quick, ‘Medicine, Mistakes and Manslaughter: A Criminal Combination?’, above n 4, 186.

⁴² Ibid 189 following similar criticism by Gardner and Virgo; Simon Gardner, ‘Manslaughter by Gross Negligence - *R v Adomako* [1995] 1 AC 171’ (1995) 111(22) *Law Quarterly Review*; Graham Virgo, ‘Basics to Basics—Reconstructing Manslaughter’ (1994) 53(01) *The Cambridge Law Journal* 44; Graham Virgo, ‘Reconstructing Manslaughter on Defective Foundations’ (1995) 54(1) *The Cambridge Law Journal* 14.

⁴³ Quick, ‘Medicine, Mistakes and Manslaughter: A Criminal Combination?’, above n 4, 190.

⁴⁴ Ibid 190 (‘Vagueness must have been in vogue as the Court of Appeal decided not to elaborate further.’).

⁴⁵ (2005) 1 Cr. App. R. 21 (‘*Misra*’); [2004] EWCA Crim 2375 (2004) (‘*Misra*’).

⁴⁶ Quick, ‘Medicine, Mistakes and Manslaughter: A Criminal Combination?’, above n 4, 190.

Court of Appeal dismissed these arguments on what for Quick are ‘unconvincing grounds’.⁴⁷ As the Court put it, whilst there existed an ‘element of uncertainty about the outcome of the decision making process,’⁴⁸ there was no ‘unacceptable certainty about the offence itself’.⁴⁹ The Court found that the relevant Articles demanded ‘*sufficient*, rather than *absolute*, certainty and that the degree of vaguest here was acceptable’ [emphasis in original].⁵⁰

As noted, Quick also argues that the doctrinal form itself facilitates assessments of character driven, amongst other things, ‘race’,⁵¹ whilst unduly concentrating the important and control of experts over the trial process.⁵² Whilst these effects are not wholly an effect of the doctrine, the doctrinal form is a substantial cause or facilitator of them, inviting these problematic processes. Quick argues that a troubling feature of the field is the disproportionate number of non-white practitioners who have been subject to medical manslaughter prosecutions in the UK.⁵³ It is unclear why this is the case, with Quick citing both the potential for training and language skills of predominantly overseas-trained practitioners, their location (and lack of supervision) in poorer-quality hospitals or the potential for racist attitudes to be motivating decisions about complaint, prosecution and liability.⁵⁴

As to the dominance of expert opinion, Quick argues that the doctrine demands in effect that expert opinion be presented, principally in order to establish what had actually occurred, what the standard of care at the time was, to assess and contextualise the nature and significance of any deviation from that standard, and to understand and contextualise

⁴⁷ Quick, above n 4, 112.

⁴⁸ *Misra* (2005) 1 Cr. App. R. 21, [63] (Lord Justice Judge).

⁴⁹ *Ibid.*

⁵⁰ Quick, ‘Medicine, Mistakes and Manslaughter: A Criminal Combination?’, above n 4, 190.

⁵¹ *Ibid* 193–195. I agree with Quick that the relevance of ‘race’ as he terms it, is troubling and should be subjected to stringent critique. However, I respectively differ in his characterisation of race as a subset of character. Quick utilises this language and framing, and thus I have retained it here. How applicable this is to the Australian setting is unknown. The lower number of prosecutions (in raw terms) would make analysis difficult in Australia. That being said, the reliance on overseas trained medical practitioners is a feature of the Australian medical system, especially in rural and remote areas.

⁵² *Ibid* 195–197; Quick, above n 4, 122–127; see particularly, Quick, ‘Expert Evidence and Medical Manslaughter’, above n 4, 496, 517 (‘Little is known about how experts negotiate the legal process, empirically speaking: how they approach their task, how they view their role as expert witnesses, and the attitudes, biases, and beliefs that may underpin their testimony’, ‘Experts enjoy the freedom afforded by the vagueness of gross negligence and develop their own working rules of interpretation and analysis.’).

⁵³ Quick, ‘Medical Manslaughter: The Rise (and Replacement) of a Contested Crime’, above n 4, 38.

⁵⁴ *Ibid*; Quick, above n 4.

the many subsidiary questions involved in assessing these questions. This extensive use is one thing, but Quick also argues that in fact there is a particularly strong *reliance* upon that expert evidence. The fruits of that opinion come to actually form the ‘facts’ of the case, and thus influence in direct ways central facets of the assessment of liability. Finally, given the vagueness that Quick finds characterises the offence, the abundant availability, the centrality, and seeming authority of expert witnesses, the jury are likely to place a great reliance upon that form of evidence.⁵⁵

Across those authors I have surveyed here, each lays significant criticism at the feet of the doctrine of manslaughter by criminal negligence. There is significant commonality and overlap between them all on this matter. Together, this critical literature concludes that the doctrine itself is fatally devoid of content,⁵⁶ ‘circular’ in logic and construction, meaning that it is problematically defined in ‘innumerable shadings of grey’.⁵⁷ For all those surveyed, this uncertain and incomplete construction of the doctrine is understood to have significant implications, both practical and justice-oriented. The doctrinal construction of the offence is said either to impose standards alien to those of medicine, standards unjustly and dangerously detached from the realities of contemporary medical practice, and/or to lack sufficient guidance such that its imposition represents an unjust level of a practitioner-defendant being unable to ascertain with sufficient firmness what constitutes criminal behaviour.

Those with an interest in iatrogenic harm or healthcare are not alone in expressing criticism of or opposition to the doctrine. They are joined by jurists and legal scholars who similarly express discomfort, confusion, exasperation and, for very many, outright rejection of the doctrine. From Hart to Horder, Simons to Simester, many have

⁵⁵ See Quick, ‘Expert Evidence and Medical Manslaughter’, above n 4, 496 (see particularly Quick’s finding in relation to the tendency for expert witnesses to ‘go beyond offering purely medical opinion’ in his study).

⁵⁶ This helpful phrase I adapt from *Gore v Board of Medical Quality Assurance* (1980) 110 Cal.App.3d 184, where the Court cites Prosser on Torts and its definition of gross negligence as follows: ‘Gross Negligence. This is very great negligence, or the want of even scant care. It has been described as a failure to exercise even that care which a careless person would use. Many courts, dissatisfied with a term so devoid of all real content, have interpreted it as requiring wilful misconduct, or recklessness, or such utter lack of all care as will be evidence of either—sometimes on the ground that this must have been the purpose of the legislature. But most courts have considered that “gross negligence” falls short of a reckless disregard of consequences, and differs from ordinary negligence only in degree, and not in kind. So far as it has any accepted meaning, it is merely an extreme departure from the ordinary standard of care.’; the Court cites Prosser as the source of this quote, see William Prosser, *Handbook of the Law of Torts* (West Publishing Co., 1941).

⁵⁷ *State v Randol* (1979) 597 P.2d 672, 677.

tackled the question of negligence in the criminal law on far broader grounds. Jerome Hall argued that negligence has ‘proved inordinately troublesome’,⁵⁸ memorably concluding that ‘[t]he ways in which an individual may compromise himself [sic] morally are many and diverse; but it is only when a man [sic] has brought upon himself the worst sort of blame, by freely choosing to do something he knows to be wrong, that the suffering and humiliation of punishment may in all conscience be applied’.⁵⁹ H.L.A. Hart, on the other hand, was supportive of the retention of negligence,⁶⁰ and Ashworth and Horder reach a similar conclusions to Hart, namely that ‘people who cause harm negligently may be culpable, in so far as they fail to take reasonable precautions when they have a duty and the capacity to do so... where (potential) harm is great... [and] the risk of it occurring is obvious’.⁶¹ Simons applies the phrase ‘culpable indifference’ to best describe negligence,⁶² where a defendant will be liable if they have ‘not avoided the risk even if [the defendant] would have appreciated it’.⁶³

Amidst this unfolding of this broader scholarly debate, courts, legislators and law reform bodies who must work with the doctrine have similarly struggled or resisted the doctrine both in Australia and elsewhere in the common law world. In English law, the history and nature of what was termed ‘Caldwell recklessness’ is significant in this regard. In *Caldwell* the court held that recklessness included cases where a defendant failed to recognise an obvious risk,⁶⁴ and its eventual effect was to break down the distinction between recklessness and negligence, such that recklessness included both advertence and in advertence to risk (the latter being the traditional domain of negligence). Through a

⁵⁸ Jerome Hall, ‘Negligence and the General Problem of Criminal Responsibility’ (1972) 81(5) *Yale Law Journal* 949, 952; also see Jerome Hall, ‘Negligent Behavior Should Be Excluded from Penal Liability’ (1963) 63(4) *Columbia Law Review* 632.

⁵⁹ Hall, ‘Negligence and the General Problem of Criminal Responsibility’, above n 58, 979.

⁶⁰ HLA Hart, ‘Negligence, Mens Rea and Criminal Responsibility’ in AG Guest (ed), *Oxford Essays in Jurisprudence* (Oxford University Press, 1961) 29 as to whether gross negligence is worthy of punishment, however, see p 157.

⁶¹ Jeremy Horder, *Ashworth’s Principles of Criminal Law* (Oxford University Press, 2016) 206 (an expression, in slightly different form, of Hart’s well-known formulation: [i] Did the accused fail to take those precautions which any reasonable man[sic] with normal capacities would in the circumstances have taken? [ii] Could the accused, given his mental and physical capacities, have taken those precautions?).

⁶² Kenneth W Simons, ‘Rethinking Mental States’ 72 *Boston University Law Review* 463; Kenneth W Simons, ‘Culpability and Retributive Theory: The Problem of Criminal Negligence’ (1994) 5 *Journal of Contemporary Legal Issues* 365, 377–378 (he constructs this phrase to describe in advertence as to risk generally, and thus applies it both to forms of inadvertent recklessness and to negligence).

⁶³ Simons, ‘Culpability and Retributive Theory’, above n 62, 381.

⁶⁴ *R v Caldwell* [1981] AC 394 (‘*Caldwell*’).

succession of cases,⁶⁵ ‘recklessness’ came to be regarded as the most suitable term to signify the culpability required for what had previously been termed gross negligence manslaughter.⁶⁶ This confusing and unsatisfactory situation stood until the trio of cases, heard together, of *R v Prentice and another*, *R v Adomako* and *R v Holloway* reinstated the traditional test of gross negligence.⁶⁷ Part of the puzzle of Caldwell recklessness in the UK had, in a very limited way,⁶⁸ found expression in the reasoning of a series of judgments in Australia.⁶⁹

Despite this scholarly, professional, policy and curial contestation of the doctrine, there remain quite significant levels of confusion as to the basic definition and requirements of the doctrine. This includes even the leading scholarly treatments in the context of iatrogenic harm. For example, in the definition provided in the most recent edition of Merry and McCall Smith’s *Errors, Medicine and the Law*, Merry and Brookbanks describe the doctrine in Australia as requiring ‘recklessness’,⁷⁰ citing *R v Gunter* as authority where it says:⁷¹

Negligence which is essential before a man [sic] can be criminally convicted must be culpable, exhibiting a degree of recklessness beyond anything required to make a man liable for damages and civil action. It must be such a degree of culpable negligence as to amount to an absence of that care for the lives and persons of others which every law abiding man is expected to exhibit.⁷²

⁶⁵ *R v Lawrence* [1982] AC 510; *Seymour* (1983) 2 AC 493; *Kong Cheuk Kwan v The Queen* (1985) 82 Cr App R 18; see generally Stanley Yeo, *Fault In Homicide* (Federation Press, 1997) 153–58.

⁶⁶ AP Simester and GR Sullivan, *Simester and Sullivan’s Criminal Law: Theory and Doctrine* (Hart, 2010) 410.

⁶⁷ This shift is significant not only for the development of the law of recklessness in UK criminal law but also as a leading case of iatrogenic death and criminal negligence.

⁶⁸ The Australian courts had in some small part accepted an interpretation of *Andrews* that imported the phrase, and at times actual subjective recklessness into the definition of criminal negligence, see for example *R v Holzer* [1968] VR 481; however, this was short-lived, with the purely objective form of criminal negligence was strongly affirmed in *Nydam* in 1977 followed by *Wilson Nydam v The Queen* [1977] VR 430 (*‘Nydam’*); *Wilson v R* (1992) 174 CLR 313; however, this was not final use of ‘recklessness’ in the Australian jurisdiction, with Hulme J of the NSW Court of Criminal Appeal in *Lavender* reviewing extensive authority in NSW for a continued reference to recklessness as part of a test of criminal negligence, see *R v Lavender* [2004] NSWCCA 120 (21 May 2004).

⁶⁹ Adam Webster, ‘Recklessness: Awareness, Indifference or Belief?’ 2007(31) *Criminal Law Journal* 272 Webster (‘Although Australian courts did not follow the objective definition of recklessness proposed in Caldwell, defining recklessness has nevertheless presented challenges for Australian courts.’); see especially Webster’s discussion of the High Court’s discussion in *Banditt v The Queen* *Banditt v The Queen* 224 CLR at 269-270, 275-276.

⁷⁰ Merry and Brookbanks, above n 9, loc 9443.

⁷¹ (1921) 21 SR (NSW) 282.

⁷² *Ibid* 282 (Cullen CJ, Street, Wade JJ).

This is, unfortunately, not an appropriate statement of gross or criminal negligence as it exists in Australian common law jurisdictions. The unfortunate, if still technically acceptable, use of the epithet ‘recklessness’ in that case has been now overcome by the Court’s definition in *Nydam v R* (‘*Nydam*’) as the now-accepted and authoritative definition.⁷³ Because of this confusion, especially in relation to the specific situation in Australian common law, I provide a detailed, if brief, account of manslaughter by criminal negligence as it exists in the Australian jurisdiction in the next section.

III MANSLAUGHTER BY CRIMINAL NEGLIGENCE IN AUSTRALIA

Manslaughter may be proven on the basis of criminal negligence in each State and Territory.⁷⁴ The leading statement of the law of criminal negligence in the Australian common law is that of the Victorian case of *Nydam v The Queen*⁷⁵ confirmed by the High Court of Australia in *R v Lavender*,⁷⁶ and *Burns v The Queen*.⁷⁷ In *Nydam*, the Court described the offence in the following terms:

In order to establish manslaughter by criminal negligence, it is sufficient if the prosecution shows that the act which caused the death was done by the accused consciously and voluntarily, without any intention of causing death or grievous bodily harm but in circumstances which involved such a great falling short of the standard of care which a reasonable man would have exercised and which involved such a high risk that death or grievous bodily harm would follow that the doing of the act merited criminal punishment.⁷⁸

Fairall synthesises the definition as involving ‘a failure by a person under a duty of care to another to foresee the possibility of causing serious harm or death or to avoid taking the risk of causing death or serious harm in circumstances where that failure is a gross departure from the standard of care expected of a reasonable person in the position of the person in question’.⁷⁹ This, however, is still a relatively complex and compound definition.

⁷³ *Nydam* [1977] VR 430, at 445; *R v Lavender* (2005) 222 CLR 67, at [17], [60], [72], [136]; *Burns v The Queen* (2012) 246 CLR 334, per French CJ at [19].

⁷⁴ *Criminal Code 2002* (ACT) pt 2.2; *Crimes Act 1900* (ACT) s 15; *Criminal Code Act* (NT) s 43AL, see also ss 149-153; *Criminal Law Consolidation Act 1935* (SA) s 13, although see also s 14; *Criminal Code Act 1899* (QLD) s 291, may also be based on a breach of duty as described in Chapter 27 or in relation to the ‘preservation of life’ see ss 285-290; *Criminal Code Act Compilation Act* (WA) 1913, s 268, see also ss 262-267; *Criminal Code Act 1924* (Tas) s 156(2)(b), see also ss 144-151.

⁷⁵ *Nydam* [1977] VR 430.

⁷⁶ (2005) 222 CLR 67, at [17], [60], [72], [136].

⁷⁷ *Burns v The Queen* (2012) 246 CLR 334, per French CJ at [19].

⁷⁸ *Nydam* [1977] VR 430, at [445].

⁷⁹ Paul Fairall, *The Laws of Australia: Homicide* (Thomson Reuters, Online, 2012).

The Model Criminal Code assists somewhat in clarifying the structure of the offence, providing an elemental presentation in terms very similar to that of *Nydam*:⁸⁰

A person is negligent with respect to a physical element of an offence [actus reus] if his [sic] other conduct involves:

(a) such a great falling short of the standard of care that a reasonable person would exercise in the circumstances, and

(b) such a high risk that the physical element exists or will exist, that the conduct merits criminal punishment for the offence.⁸¹

The complexity of the *Nydam* formulation, whilst it remains authoritative, can also be expressed elementally for analytic purposes. Presented in an elemental fashion, the offence involves the following four core elements that I focus on here:⁸² a legal duty of care;⁸³ a standard of care; a breach of that duty by a gross departure from the standard of care; and, finally, that in so breaching their duty, the defendant's act or omission involved such a high risk that death or grievous bodily harm would follow that the doing of the act merits criminal punishment.⁸⁴ This is true of all statements of the offence in Australia. I deal briefly with these fundamental elements in turn.

⁸⁰ Model Criminal Code Officers Committee of the Standing Committee of Attorneys-General, 'Discussion Paper: Model Criminal Code Chapter 5 - Fatal Offences Against the Person' 149, n 255 <[http://www.ema.gov.au/www/agd/rwpattach.nsf/VAP/\(03995EABC73F94816C2AF4AA2645824B\)~modelcode_ch5_non-Fatal_offences_report.pdf/\\$file/modelcode_ch5_non-Fatal_offences_report.pdf](http://www.ema.gov.au/www/agd/rwpattach.nsf/VAP/(03995EABC73F94816C2AF4AA2645824B)~modelcode_ch5_non-Fatal_offences_report.pdf/$file/modelcode_ch5_non-Fatal_offences_report.pdf)>.

⁸¹ Parliamentary Counsel's Committee (Cth), *Model Criminal Code* (Commonwealth of Australia, 1st Edition, 2009) s 2.2.10; compare *Criminal Code Act 1995* (Cth) s 5.5 ('*Commonwealth Criminal Code*').

⁸² Fairall synthesises the elements into three, here I expand his, wanting to highlight the importance of the fourth element I describe here. See Fairall, above n 79, Section 10.1.2130 elsewhere Fairall has pointed out that '[i]n Queensland and Western Australia, Courts have interpreted the Griffith Codes in such a way that negligence is the underlying fault standard', citing as authority Stephen Edward Taiters [1996] QCA 232; (1996) 87 A. Crim R 507, 512: 'The Crown is obliged to establish that the accused intended that the event in question should occur or foresaw it as a possible outcome, or that an ordinary person in the position of the accused would reasonably have foreseen the event as a possible outcome': Paul Fairall, Review of Aspects of the Criminal Code of the Northern Territory, Adelaide University, March 2004, 41.

⁸³ Fairall writes, 'In the Northern Territory, Queensland, Tasmania and Western Australia, there is no liability for manslaughter by criminal negligence unless the accused breached a specific duty provided for under the relevant Criminal Code, (For example, the duties specified under *Criminal Code* (NT), s 151; *Criminal Code* (Qld), s 289; *Criminal Code* (Tas), s 150; *Criminal Code* (WA), s 266 to exercise care to avoid danger from an object under one's control are very similar to the general duty of care at common law: see *Callaghan v The Queen* (1952) 87 CLR 115, the Court at 121–124. See related discussion at [10.1.2140]– [10.1.2150] on the statutory duties imposed in these jurisdictions with respect to the preservation of human life. Compare *Criminal Law Consolidation Act 1935* (SA), s 14, which addresses criminal liability for death resulting from an unlawful act, in terms of "criminal neglect" in breach of "a duty of care to the victim", but does not specify express duties'

⁸⁴ *R v Lavender* (2005) 222 CLR 67; *Wilson v R* (1992) 174 CLR 313; *Andrews v DPP* [1937] AC 576; *R v Bateman* (1925) 19 Cr App R 8.

The offence is available only where a defendant owes a particular duty to the deceased and has, by breach of that duty, caused the death of the victim. Importantly, the relevant duty must be a legal duty, a moral duty being insufficient on its own to ground criminal liability.⁸⁵ In the Northern Territory, Queensland, Tasmania and Western Australia, the defendant must have owed, and breached, a specific duty provided for under the relevant Criminal Code.⁸⁶ The common law recognises that where a death is caused by positive act, the duty of care is established by the universally applicable tortious duty to conduct oneself in a manner that will not cause injury to another person, where a reasonable person placed in the same position would have foreseen a risk of injury to another person from that positive conduct.⁸⁷ Where the death is caused by an omission to act, the defendant must have been under a legal duty to take positive action to avoid causing death or injury to the victim. The common law recognises such a duty of care is owed in a range of circumstances. It is understood to arise from particular status relationships,⁸⁸ statute, contract, wrongfully placing someone in danger,⁸⁹ or a voluntary assumption of a duty of care.⁹⁰ Once a duty has been established, it must be proven that the act or omission of the defendant is the act or omission that actually caused the death of the victim.⁹¹

The second element requires establishment of the relevant standard of care. It is by reference to this standard of care that the defendant's act or omission will be judged; where the defendant's act or omission falls below the standard of care a reasonable person would have exercised, they will have been found to have breached their duty.⁹² A key feature of manslaughter by criminal negligence in most Australian jurisdictions is that that the

⁸⁵ *Burns v The Queen* (2012) 246 CLR 334, [97], [107] (Gummow, Hayne, Crennan, Kiefel and Bell JJ) (Citing Stephens, Stone and Dobinson and TakTak, the court held '...such an obligation may be imposed by statute or contract or because of the relationship between individuals. The relationships of parent and child, and doctor and patient, are recognised as imposing a duty of this kind. A person may voluntarily assume an obligation to care for a helpless person and thereby become subject to such a duty. Outside limited exceptions, a person remains at liberty in law to refuse to hold out her hand to the person drowning in the shallow pool'); *Lane v The Queen* [2013] NSWCCA 317 (13 December 2013) [59]-[62].

⁸⁶ See commentary at n 83 above.

⁸⁷ Fairall notes that this is implicit in *Nydam* Fairall, above n 79; in support of this, Fairall cites the Full Court at 445, *Nydam* [1977] VR 430, 445.

⁸⁸ Notably for our context, doctor/patient.

⁸⁹ *R v Taktak* (1988) 14 NSWLR 226.

⁹⁰ *Ibid.*

⁹¹ *R v Sood (Ruling No 3)* [2006] NSWSC 762 (15 September 2006); *Lane v The Queen* [2013] NSWCCA 317 (13 December 2013) [61].

⁹² It is a second and subsidiary question as to how far below the standard a defendant will need to fall in order that their act or omission be judged a breach worthy of criminal punishment, and thus criminally negligent.

concept of criminal negligence is not context dependent. The law as applied to an iatrogenic death in the context of healthcare or medicine is no different to that applied in other settings;⁹³ the ‘law is no different where the death is caused by a gun, a hydrofoil, or a train’.⁹⁴ Yet, the standard of care element is modified depending on the context. The standard of care expected of the defendant is that expected of a reasonable person in the position of the defendant. In the context of healthcare, the particular skill or knowledge of the defendant-practitioner becomes important in assessing the content of the duty and standard expected of the reasonable person in the position of the defendant-practitioner. A health practitioner owes a duty to exercise the skill of a reasonably competent member of that profession; not the most skilled or appropriately skilled, but, simply a reasonably competent member of that profession.⁹⁵ Thus, at common law, the practitioner-defendant’s conduct will be assessed by reference to the risk of causing death by failing to perform at the standard of a reasonably competent member of their profession. The content of the particular duty owed to a victim is a fundamental matter, defined either within the relevant code, or by reference to the duty itself. For example, a person who places another in a situation of danger has a concomitant duty to take reasonable steps to remove the person from that danger,⁹⁶ whilst a parent might have a duty to protect and provide the necessities of life for a child in their care.⁹⁷ In the Northern Territory, Queensland, Tasmania and Western Australia, calculating the standard of care relates to the risk of failing to perform a relevant statutory duty. At common law, calculating the standard of care relates to the risk of causing death or grievous bodily harm,⁹⁸ in other words, there may be a range of material acts or omissions that might be expected of a defendant in the proper exercise of their duty, but in relation to a question of criminal negligence the focus is upon whether there was a failure by the defendant to foresee the risk of causing death or grievous bodily harm when a reasonable person in their position would have done so.

⁹³ *Moore v The King* [1926] SASR 52, 67 (Poole J); See Fairall for his more detailed overview Fairall, above n 79.

⁹⁴ Yeo, above n 65, 211; citing Smith JC and Hogan B, *Criminal Law* (6th ed, Butt (UK), 1988) p 354.

⁹⁵ This becomes an issue especially for more junior or less-experienced health practitioners.

⁹⁶ *R v Taktak* (1988) 14 NSWLR 226.

⁹⁷ See, for example, the recent case of Sam, which involves consideration of both parental duty and health practitioner (homeopath) duty in the context of manslaughter, *R v Thomas Sam; R v Manju Sam (No 18)* [2009] NSWSC 1003 (28 September 2009); *SAM, Thomas v R SAM, Manju v R* [2011] NSWCCA 36 (10 March 2011).

⁹⁸ *Nydam* [1977] VR 430; compare *R v Taylor* (1983) 9 A Crim R 358, 360 (Lush J) (Young CJ agreeing).

Having established an applicable standard of care, the third and fourth elements require that the trier of fact decide whether the relevant act or omission fell so far below the standard of care a reasonable person would have exercised, and involved such a high risk of death or grievous bodily harm, that the act or omission merits criminal punishment. A simple breach of the duty owed to the victim is not sufficient to attract criminal liability. Instead, there must be a ‘gross’ departure from the standard of care by the defendant. Regardless of jurisdictional differences, there is commonality in the Australian context that the standard of care is appraised on a wholly objective basis.⁹⁹ Should the defendant have had an intention to cause death, or subjective awareness that death would probably or likely follow their conduct, then murder rather than negligent manslaughter will be the appropriate offence. The courts have suggested various tests to define the degree of negligence required to constitute a gross departure from the standard of care. In *Nydam*, the Full Court of the Victorian Supreme Court described the test as ‘a great falling short of the standard of care’.¹⁰⁰ McClellan CJ at CL and Howie AJ in their joint judgement on appeal in *Burns* provided a comprehensive account of what might constitute a ‘gross’ breach of duty.¹⁰¹ They named ‘conduct deserving punishment’,¹⁰² ‘gross’, ‘culpable negligence’,¹⁰³ ‘wicked negligence’,¹⁰⁴ and, finally ‘a very high degree of negligence’¹⁰⁵ as constituting the variety of expressions used to explain the test.¹⁰⁶ Courts have also found it helpful to draw a comparison between tortious and criminal negligence,¹⁰⁷ often referring to the test proposed in the English case of *R v Bateman*:¹⁰⁸

⁹⁹ The ruling in *Nydam* itself arose in a sense as a response to the finding in *Holzer* by Smith J that the accused must foresee the risk of causing death or grievous bodily harm, that is be advertently reckless, see *R v Holzer* [1968] VR 481, 482 (Smith J); see also and compare the position held by Gleeson CJ, McHugh, Gummow and Hayne JJ on the question *R v Lavender* (2005) 222 CLR 67, at [60] (Gleeson CJ, McHugh, Gummow and Hayne JJ).

¹⁰⁰ *Nydam* [1977] VR 430, 445; approved by the High Court in *R v Lavender* (2005) 222 CLR 67, at [17], [60], [72], [136]; confirmed in *Burns v The Queen* (2012) 246 CLR 334, [19] (French CJ).

¹⁰¹ *Burns v The Queen* (2011) 205 A Crim R 240, 240 (McClellan CJ at CL at [1], Schmidt J at [167], Howie AJ at [1]).

¹⁰² *R v Bateman* (1925) 19 Cr App R 8, 12 (Hewart LCJ).

¹⁰³ *R v Gunter* (1921) 21 SR (NSW) 282, 286 (Cullen CJ); *R v Taktak* (1988) 14 NSWLR 226, 351, 353.

¹⁰⁴ *R v Nicholls* 13 Cox CC 75, 76 (Brett J); see generally Penny Crofts, *Wickedness and Crime: Laws of Homicide and Malice* (Routledge, 2013).

¹⁰⁵ *Andrews v DPP* [1937] AC 576, 556 (Lord Atkin).

¹⁰⁶ Influenced by the House of Lords who sought to refine the test and observed the use of adjectives such as “culpable”, “criminal”, “gross”, “wicked”, “clear” and “complete”, when referring to the degree of negligence required, *Andrews v DPP* [1937] AC 576.

¹⁰⁷ *R v Shields* [1981] VR 717; see for example Judicial College of Victoria, *Victorian Criminal Charge Book* (Judicial College of Victoria, Electronic Edition, 2016) [7.2.5.1] <<http://www.judicialcollege.vic.edu.au>>.

¹⁰⁸ (1925) 19 Cr App R 8.

To support an indictment for manslaughter the prosecution must prove the matters necessary to establish civil liability (except pecuniary loss), and, in addition, must satisfy the jury that the negligence or incompetence of the accused went beyond a mere matter of compensation and showed such disregard for the life and safety of others as to amount to a crime against the State and conduct deserving punishment.

These efforts to provide further clarification of the test by a strategy of comparison or use of interchangeable terms has been met with some resistance. In *R v Stephenson*,¹⁰⁹ for example, the Full Court of the Victorian Supreme Court held that use of words like “glaring”, “flagrant” and “monstrous” are, in most cases... unnecessary and, particularly in the case of the word “monstrous”, may be unwise’.¹¹⁰ Most unwise, however, has been the use of the epithet ‘reckless’.¹¹¹ Australian jurisprudence has been strongly opposed to the use of the term, in an attempt to reduce the risk of confusion arising between murder on the basis of recklessness (wholly subjective) and manslaughter charges on the basis of gross or criminal negligence (objectively assessed).¹¹²

The development and use of manslaughter by criminal negligence in Australia has not been marked by significant dispute, as has been the experience in England and Wales.¹¹³ The doctrine itself has been largely settled, stable in its current form since at least *Nydam*.¹¹⁴ Support for the general offence in Australia is demonstrated by inclusion of negligence as a fault element, and of manslaughter proven on that basis as an available offence in the Model Criminal Code.¹¹⁵ Currently stalled, the Model Criminal Code project reflected on the inclusion of the fault element of negligence and the potential for an

¹⁰⁹ [1976] VR 376.

¹¹⁰ Ibid; on this question see especially the work of Penny Crofts on Malice and the monstrous, Crofts, above n 104.

¹¹¹ Despite Lord Atkin’s contribution in *Andrews v Director of Public Prosecutions* (UK) that: “[p]robably of all the epithets that can be applied ‘reckless’ most nearly covers the case”, *Andrews v DPP* [1937] AC 576, (Lord Atkin); so too was the epithet listed by the Court in *Burns*, see *Burns v The Queen* (2012) 246 CLR 334.

¹¹² Gibbs J in *La Fontaine v The Queen* (1976) 136 CLR 62 advocated the strongest caution regarding the application of the word “reckless” in directions to the jury, to avoid potential confusion with negligent liability. The jury should not be directed by use of the term; Ian Leader-Elliott, ‘Elements of Liability in the Commonwealth Criminal Code’ in *AJA Magistrates Conference* (2001) <<http://www.ajja.org.au/>>; see also Ian Leader-Elliott, ‘Recklessness and Murder-The Facts of the Case’ (1986) 10 *Criminal Law Journal* 359.

¹¹³ See for example Kumaralingam Amirthalingam, ‘Caldwell Recklessness Is Dead, Long Live Mens Rea’s Fecklessness’ (2004) 67(3) *The Modern Law Review* 491.

¹¹⁴ See for example *Taktak* and the use of ‘reckless’.

¹¹⁵ Parliamentary Counsel’s Committee (Cth), above n 81.

offence of manslaughter by criminal negligence.¹¹⁶ The Model Criminal Code Officers Committee concluded in their discussion paper on fatal offences that the offence be folded into an offence of dangerous conduct causing death (which includes where death is caused by someone who is negligent about causing their death).¹¹⁷ This movement, however, was not a turning away from negligence, nor a denial of its legitimacy or importance. Rather, the Committee was of the opinion that were a number of reasons ‘which make it attractive to retain some form of unlawful homicide by gross negligence as an offence’.¹¹⁸ These reasons included the expressive nature of the offence, signalling to society ‘acceptable standards of behaviour’, whilst re-enforcing the ‘value of human life’. The offence’s overlap with unlawful and dangerous act manslaughter was also regarded as positive, with the two offences working to discourage people from engaging in dangerous unlawful conduct; a dynamic that the Committee felt would be protected by retention of negligent manslaughter, even in the face of their recommendation to abolish unlawful and dangerous act manslaughter.¹¹⁹ All of these conclusions were drawn against a backdrop of a comprehensive affirmation of the acceptability of objective forms of liability. These forms, the Committee noted, would perhaps seem ‘inconsistent with the principles’ that the Committee adopted in relation to fatal offences, namely, that blameworthiness be determined by ‘reference to the defendant’s state of mind’.¹²⁰ However, they argued, the defendant’s state of mind is

...no more than a means to an end; it is the best indicator available to jurors in determining the culpability of a defendant... [it is a critical factor] only because of the implications it entails regarding criminal culpability... it is by no means the only factor which conveys such implications about criminal culpability.¹²¹

The draft of the Model Criminal Code eventually retained criminal negligence, by introduction of cl 5.1.11, Causing Death by Criminal Negligence.¹²² Despite it being

¹¹⁶ Model Criminal Code Officers Committee of the Standing Committee of Attorneys-General, above n 80, 249.

¹¹⁷ Ibid 155.

¹¹⁸ Ibid 153.

¹¹⁹ Ibid 137,153.

¹²⁰ Ibid 149.

¹²¹ Ibid.

¹²² Parliamentary Counsel’s Committee (Cth), above n 81, cl 5.1.11.

differentiated from manslaughter proper,¹²³ the maximum penalty remained the same, imprisonment for 25 years.

A *The Doctrinal Failings of Criminal Negligence*

Even when understood correctly, the Australian doctrine remains marked by the features that critics of manslaughter by criminal negligence doctrine describe as failings: circularity in structure, setting of the limits of law by the jury, and being devoid of sufficient content to be helpful. For one, the doctrine necessitates engagement in a circular process. The authoritative test developed in *Nydam* is based in part upon the circular formula developed by the Court of Criminal Appeal in *Bateman*.¹²⁴ This shared circularity is clear; the negligence of the defendant is ‘gross’ if it is ‘criminal’. The jury is asked to decide if the defendant’s conduct was ‘gross’ negligence by reference to whether it warrants criminal punishment, that is, whether the conduct constitutes a crime. As Jonathan Herring puts it, ‘if the jury asked a judge: “How do we know if the defendant’s negligence was bad enough to be criminal?”, they would have to be told, “It is if you think it is”’.¹²⁵ As Oliver Quick put it, conduct is ‘a crime if the jury think it *ought* to be a crime’.¹²⁶

Secondly, the doctrine of manslaughter by criminal negligence seems to demand that the trier of fact set the very limits of the criminal law; a power not available in any other context. Justice Heydon has recently reflected on this state of affairs in an appeal to the High Court on matters relating to negligence. In obiter he wrote that ‘[t]o direct a jury that they should not convict unless the accused’s conduct is “deserving of punishment by the criminal law” is curious... in modern times it is the legislature which determines what conduct is deserving of punishment. It is not the judiciary. And it is certainly not the jury’.¹²⁷ Justice Heydon is not alone in his position on negligence and the curious state of affairs it represents. Like others, he grants that a direction to the jury to perform this function may certainly have merits when (and only when) the aim is to distinguish between the type of negligence sufficient for civil as opposed to criminal liability. This

¹²³ Which applied to those ‘whose conduct causes the death of another person, and...who intends to cause, or is reckless as to causing, serious harm to that or any other person by that conduct’, *ibid* cl 5.1.10.

¹²⁴ (1925) 19 Cr App R 8.

¹²⁵ Jonathan Herring, *Criminal Law: Text, Cases, and Materials* (OUP Oxford, 2012) 297.

¹²⁶ Quick, ‘Medicine, Mistakes and Manslaughter: A Criminal Combination?’, above n 4, 189 following similar criticism by Gardner and Virgo ; Gardner, above n 42; Virgo, ‘Basics to Basics—Reconstructing Manslaughter’, above n 42.

¹²⁷ *King v The Queen* (2012) 245 CLR 588, [68] (Heydon J, in obiter).

contrastive strategy is a well-accepted feature of deliberations regarding criminal negligence. However, for Heydon J it is

risky to adopt the course of leaving to a jury *as a criterion of guilt* the question of whether particular conduct is deserving of punishment by the criminal law. When this is done with a succession of different juries, there is a risk of like cases being treated differently, and different cases being treated alike. Although it is not always possible, it is desirable for the application of legal rules to depend on clear and comprehensible factual criteria. [emphasis added]¹²⁸

This instability in the doctrine gives rise to the third area of critique, where the doctrine, even in its most succinct, elemental presentation, is understood to be fundamentally devoid of content. To demand that the trier of fact decide ‘whether an act or omission involved such a high risk of death or grievous bodily harm, that the act or omission merits criminal punishment’ has been described, on the one hand, as importing a community standard by its demand that assessment of the breach is sufficient to warrant criminal punishment,¹²⁹ and on the other hand, as being an illegitimate and unjust process of the jury settling the offence after the fact by embedding a circular form of reasoning into the offence structure. It is not clear, as Fairall points out, whether the ‘high risk’ that the act or omission must present to the life or bodily integrity of the victim, is to be assessed at the same level of risk that must be foreseen for murder at common law (i.e. probability).¹³⁰ Moreover, it is not clear what, specifically, will constitute conduct sufficient to warrant criminal punishment. Juries do not give reasons for their decisions, so no development of discoverable standards, applicable over time and across different cases, is possible. This requirement that the jury decide whether conduct is deserving of punishment as a ‘criterion of guilt’¹³¹ has the potential to reduce the clarity of communication regarding expectations of potential wrong-doers. By use of this element as a criterion of guilt in and of itself, a radical instability is introduced into the law of criminal negligence, where knowing with relative certainty what criteria will be applied to adjudge culpability is lost.

Taken together, these areas of critique are destructive of support for the doctrine by writers concerned primarily with healthcare quality and safety. For those writers, the objective

¹²⁸ Ibid emphasis my own.

¹²⁹ See for example *R v Mitchell* [2005] VSCA 304 (15 December 2005).

¹³⁰ *R v Crabbe* (1985) 156 CLR 464; *Royall v The Queen* [1991] CLR 378 (‘*Royall*’); *R v Lavender* [2004] NSWCCA 120 (21 May 2004).

¹³¹ *King v The Queen* (2012) 245 CLR 588, [68] (Heydon J, in obiter).

nature of the offence, combined with the fact that the doctrine expresses no static content, no pre-defined standards or state of mind by which practitioners can preview potential liability or ‘triangulate’ what is expected of them, means that the doctrine imposes standards dangerously alien to those of medical practice.¹³²

It seems that the characterisation of the doctrine as circular, reliant upon the jury in unique ways, and devoid of content is correct. Moreover, it seems that the risk that these factors present to seeing justice done, and rule of law upheld in relation to criminal negligence cases, is potentially significant.¹³³ There is an option to simply abolish the offence. However, this seems very unlikely in Australia and elsewhere. In fact, it seems not just unlikely, but ill-advised. There seems to exist popular, democratic support for the offence’s retention, or at least no sufficiently significant demand that it be abolished. In fact, popular/democratic sentiment regarding negligent failures in relation to child sexual abuse, workplace safety, corporate manslaughter and other like scenarios point, I believe, to growing support for the expansion of negligent forms of liability in Australia.¹³⁴

Those who write in this area should accept the offence’s place in our legal system. They should, however work to provide a more adequate explanation and justification of its use. There are two options. The first is to work with the existing doctrine, to question, clarify and understand its operation more fully. An example of this work would be to interrogate how it is, exactly, that Australian courts are using and interpreting the controversial element of the test that the conduct ‘involved such a high risk that death or grievous bodily harm would follow that the doing of the act merited criminal punishment’.¹³⁵ How is this being interpreted ‘on the ground’? What alternative interpretations might be developed? The second option is to work to develop an understanding of what might be necessary about the operation of the offence in the manner it has developed. What might be actually

¹³² Merry and Brookbanks summarises the position in a most comprehensive way, see Merry and Brookbanks, above n 9, 190 (on the impossibility of meeting the standard of care, of what might reasonably be expected, or recommended, on every occasion over an entire working lifetime; the ‘legal assessment of behaviour is artificially detached from the behaviour’s context).

¹³³ *King v The Queen* (2012) 245 CLR 588, [68] (Heydon J, in obiter) Heydon J himself describes these issues as risks.

¹³⁴ This seems particularly important in an era where relationships seem more frequently mediated through corporate forms, or between individuals and corporate entities. This includes formerly individual-state relationships, where the well-established principles and practices that governed such relationships do not apply in the same manner to privatised, or outsourced state services. However, see recent debates regarding corporate manslaughter offences in Australia and in England and Wales.

¹³⁵ *Nydam* [1977] VR 430, at [445].

attractive about its shape? These two options are of course related, however, by pursuing one, or both, I believe significant clarity and better justification of the doctrine's use can be achieved.

In the remainder of this chapter I take up this challenge, and develop an initial contribution to the task that lies ahead of writers on criminal negligence. I do so by focusing on the second way of engaging with the doctrine, by examining what might be necessary or even attractive about the way in which the 'curious'¹³⁶ features of the doctrine operate. I do so with the explicit understanding that the characterisation of the doctrine as circular, reliant upon the jury in unique ways, and devoid of content is correct. However, I come to see that this is far from a fatal flaw. Rather, in accepting the circularity and lack of positive content as a defining feature of criminal negligence, I argue that this 'weakness' of the doctrine is in fact its greatest strength.

IV METHOD AND SCOPE

To understand how it is that those features of criminal negligence thought to be the source of its failure are, in fact, its greatest strength, I engage in a close reading of both the doctrine and its principal sources, as well as its expression in recent Australian case law, namely *Pegios*, *Gow*, *Pearce* and *Patel*.¹³⁷ Although I bring these recent cases into the frame, I do not attempt to provide a comprehensive survey of the recent jurisprudence and practice of criminal negligence in Australian courts.¹³⁸ Instead, I draw upon these cases in order to progress my aim of describing what might be necessary or even attractive about the way in which the doctrine is structured by highlighting the affordances of that structure for its application in the healthcare setting, and as a response to iatrogenic death in particular.

I make three sub-claims in support of my contention that the defining features of criminal negligence – its circular character and lack of content – are in fact its greatest strength. First, I argue that that the law of criminal negligence is able to borrow, reflect and thus

¹³⁶ *King v The Queen* (2012) 245 CLR 588, [68] (Heydon J, in obiter).

¹³⁷ *Pegios* [2008] NSWDC 105 (2008); *Gow* [2006] NSWDC 78 (27 October 2006); *Pearce* [2000] Queensland Supreme Court Indictment No 96 of 2000 (15 November 2000); *Patel v The Queen* (2012) 247 CLR 531 ('*Patel*').

¹³⁸ Having established what might be necessary or attractive about the doctrinal form, such a survey of recent engagements with criminal negligence by the Courts would be an excellent candidate for further research.

reinforce what is particular to the area of human activity with which it engages because of its very openness, an openness that arises purposefully and is enabled by its lack of definite content. Second, I argue that, in the midst of this radical borrowing, the law of criminal negligence is still able to maintain normative solidity and coherence by a type of closure, where it draws upon its own ‘internal normativity’. Finally, I argue that this simultaneously open and closed structure of the doctrine is particularly suited to the legal enforcement of a duty of care in medicine. This is so because whilst the practices of care are local, specific and responsive, subject always to change and revision, the fundamental demand of care is that of attending to the other.

A *The law of criminal negligence is able to borrow, reflect and thus reinforce what is particular to the area of human activity with which it engages because of its openness.*

The doctrine of manslaughter by criminal negligence has been described as so devoid of sufficient positive content that practitioners are unable to either to preview or to understand the boundaries of potential liability. Without positive ‘content’ against which a practitioner might measure and comport their behaviour, the doctrine is thought to be unjust. It is argued that there is nothing by which a potential defendant might understand the ‘ingredients’ for liability; a function served in other circumstances by a subjective head of mens rea, such as intention. In those circumstances, the intentional form of mens rea will ground liability where the defendant’s conduct caused the death of the victim accompanied by an intention to kill. It is thought by positioning such a form of mens rea as the ‘machinery’ of the doctrine’s assessment of liability, that this facilitates a clear ‘preview’ of the ingredients for liability, whilst providing a guide to action based upon something (their own state of mind) controllable and knowable/observable by the defendant themselves.

The doctrine of manslaughter by criminal negligence operates by use of a different form of doctrinal machinery, namely, the concept of ‘gross’ negligence. This term, unlike those that comport with subjectivist orthodoxy, demands an objective assessment be made of the defendant-practitioner’s conduct, and a radically ‘open’ one at that. The concept is capacious, almost a placeholder, for it not only requires reference to extrinsic material to ascertain whether the degree of negligence is sufficiently ‘gross’,¹³⁹ it also requires

¹³⁹ As is also necessary for the use of subjectivist forms of mens rea.

reference to such material to define the meaning of negligence in the first place. Whereas most writers treat ‘intention’ as holding a kind of plain meaning, immediately graspable by defendant and jury without need for reference to other material,¹⁴⁰ gross negligence lacks this character. Approaching gross negligence requires first that a standard of care be established, and that process means the term itself is essentially meaningless without first establishing that standard. Once the relevant standard of care is established, and a deviation from that standard is observed, this general vagueness extends to the question of what a ‘gross’ deviation might mean in this context. This has driven scholars and courts to provide alternative descriptions in an attempt to fill out or pin down the meaning of the term. From ‘wicked’, ‘total’, ‘criminal’ or ‘reckless’, various epithets have been adopted to assist. However, these epithets are plagued by the same difficulties. Many are circular and all are in some sense opaque.¹⁴¹ What *exactly* does it mean to say that the jury, as a question of fact, will be satisfied beyond a reasonable doubt that a practitioner’s negligence was gross? As Ashworth argues, it is a ‘distinction without a difference’.¹⁴²

The doctrine, however, cannot be correctly understood if examined apart from its application. In its application, this seemingly unsatisfactory vagueness of the doctrine comes instead to seem like a capaciousness that facilitates a quite remarkable and, I argue, necessary ‘filling out’ of the lack of detail within the doctrine by reference to the particular practices of the context to which the offence is applied. This sounds quite straightforward and, at one level, it is. However, if the doctrine was not structured in the radically open way that it is – where it lacks significant amounts of positive content – this would be impossible. Moreover, without this doctrinal structure and process, as ‘open’ (or vague) as it may be, the doctrine would rigid, static, ill-fitting, and thus ill-suited, to the wide variety of human endeavours it is called upon to adjudicate.¹⁴³ For medicine in particular, the affordances of the doctrine’s capacious openness for the authority and control of medicine over its own domain would be lost, and the claims that the doctrine imposes standards alien to medicine, and deaf to the realities of medical practice, would be true.

¹⁴⁰ Even if some question the veracity of this, it is widely accepted.

¹⁴¹ They operate as a part of the explicitly normative part of criminal law history and remain part of it today. See for example how these similar issues arise in relation to other parts of the criminal law, see for example the doctrine and normative features of substantial impairment of the mind.

¹⁴² Horder, above n 61, 293.

¹⁴³ Recalling here that regardless of whether the doctrine should apply to such a range of settings is, for current purposes, a somewhat secondary concern. The fact is that it is applied to a broad range of settings, and my primary task here is to provide a more adequate explanation and justification of its use.

To develop this claim, I show first how the doctrine demands and then practices its borrowing of what is particular to the field of healthcare. This borrowing is achieved in medicine by the use of codes and other authoritative standards developed by the profession(s) and expressed and interpreted by expert witnesses, all of which is facilitated by the doctrine's radically open shape. Secondly, I show how this borrowing is not simply (or only) used to 'fill out' the doctrine's lack of definite content, but instead *transforms the doctrine itself* into something new upon each application. Rather than imposing something alien or ill-fitting upon (medical) practice, something unaccountable to (the changing and changeable) social practices of medicine (i.e. unaccountable to reality), this transformative remaking of the doctrine's very self renders it a reflection of the standards and practices immanent within healthcare and medicine.

Having established how this process of transformation functions, the third task of this section is to reflect on some of its implications. In particular, I work to establish how this doctrinal process does not simply reflect, but actually *reinforces* the practices and standards particular to medicine and healthcare. Criminal law, in a very real sense, offers its imprimatur to those practices, a move that is productive of the authority of the professions themselves rather than subverting their independence, control or autonomy as those critical of the doctrine suggest. Finally, I conclude that this doctrinal process and its productive implications for the underlying discipline/practice/profession of healthcare are results of the radically open shape and capaciousness of the doctrine. This feature has been called out for severe criticism by the quality and safety literature opposed to the use of criminal negligence doctrine in their field, yet this same openness is highly productive for those same disciplines that are so critical of it.

1 *Borrowing of what is particular to the field of healthcare.*

Describing how the doctrine demands and then practices its borrowing of what is particular to the field of healthcare is where I begin. To do so I draw upon and develop the work of Jeremy Horder and his observations about gross negligence as a valid, if misunderstood, form of mens rea.¹⁴⁴ I follow this theoretical material with a demonstration

¹⁴⁴ Found principally in his Jeremy Horder, 'Gross Negligence and Criminal Culpability' (1997) 47(4) *The University of Toronto Law Journal* 495.

of doctrinal borrowing in practice, reviewing the cases of *Pegios* and *Patel*,¹⁴⁵ spending some time to show how the Court itself negotiates and narrates this borrowing.¹⁴⁶

Jeremy Horder is a supporter of gross negligence liability in healthcare settings.¹⁴⁷ The basis of his engagement with the area is his view that part of contemporary difficulties with gross negligence is the insistence upon distinguishing in a ‘sharp’¹⁴⁸ manner between objective and subjective forms of mens rea.¹⁴⁹ His overarching proposal is that gross negligence, applied to manslaughter or other suitable offences, is a state of mind of ‘indifference’,¹⁵⁰ a form of mens rea that is unable to be characterised into simplistic categories of advertence and inadvertence.¹⁵¹ Horder propose that gross negligence may also take on a second, and more specific, form beyond indifference. This conception is more likely to apply in cases of manslaughter by criminal negligence in the medical context, being a situation where a positive duty of care was owed by the defendant (practitioner) to the victim (patient) and that there existed ‘a great departure from an acceptable standard of conduct’.¹⁵²

Codes and other authoritative standards developed by the profession(s), expressed by expert evidence, are a chief component of Horder’s engagement with gross negligence as a form of mens rea.¹⁵³ He argues convincingly that professional standards or codes of conduct act as a suitable substitute for the lack of an absolute standard of mens rea in doctrinal formulae.¹⁵⁴ These sources form a body of ‘well-known and accepted standards governing... ethical and professional conduct’¹⁵⁵ for those who might be subject to prosecution for Horder’s second form of gross negligence, such as medical practitioners.

¹⁴⁵ *R v Pegios* [2008] NSWDC 104 (2008) (*‘Pegios 1’*); *Patel* (2012) 247 CLR 531.

¹⁴⁶ I briefly describe there too how this borrowing is facilitated by the expert interpretation of codes and other authoritative standards developed by dental and medical professions, all of which is facilitated by the doctrine’s radically open shape.

¹⁴⁷ Horder, above n 144, 516 (Horder concludes that ‘[t]here is, in principle, an important reason for regarding a departure from a standard as the right measure of negligence, where doctors and trustees are concerned, whether the liability in question is civil or criminal.’).

¹⁴⁸ Ibid 495.

¹⁴⁹ Ibid 495–496; 497.

¹⁵⁰ Ibid 496.

¹⁵¹ Ibid.

¹⁵² Ibid In this second form, we see the echoes of the language of *Nydam*, constructed as it is, with the general duty to avoid harm, and those more specific legal duties that attach to particular relationships, such as doctor and patient.

¹⁵³ See ibid 495 (‘a controversial proposal’).

¹⁵⁴ Ibid 519.

¹⁵⁵ Ibid 517, see also 519.

These professional standards and codes of conduct are, of course, introduced, presented or explained and interpreted with the aid of expert evidence.

For Horder, not only do these sources substitute for absolute standards of mens rea, but their existence prior to any charge or trial, and voluntarily acceptance by a defendant upon their joining their profession, acts as a bulwark against complaints of vagueness and fair warning:

‘[W]hen a doctor... accepts a duty to act in the best interests of another and identifies him or herself with responsibility for the other person in that sense, he or she does so against a background of well-known and accepted standards... in such a context, a doctor... can expect to be judged by no other yardstick than the extent of their conformity to or departure from the requirements of those standards’.¹⁵⁶

Horder’s framework supports my more limited claim that the doctrine relies upon application to a particular field of human action and duty. Consistent with Horder’s vision of negligence as a form of mens rea, some significant part of the doctrine must be in a real (and non-problematic sense) a placeholder. My view is that only when applied can negligence doctrine develop its content through the process of drawing into itself these codes, practices and standards indigenous to the area of human activity with which it engages. As I have claimed, the doctrine borrows what is particular to the field of practice, rather than imposing standards alien to it. This borrowing is achieved in medicine by the use of codes and other authoritative standards developed by the profession(s) and expressed and interpreted by expert witnesses, all of which is facilitated by the doctrine’s radically open shape. The cases of *Pegios* and *Patel* demonstrate how this occurs.

As one of the very few recent Australian iatrogenic death-related manslaughter cases, *Pegios* illustrates how the doctrine not only refers to extrinsic material, such as codes and professional standards, but in fact borrows them as a substitute for an absolute form of mens rea.¹⁵⁷ In *Pegios*,¹⁵⁸ the defendant was a general dentist who performed a dental implant procedure upon the victim whilst administering IV sedation for between one-and-

¹⁵⁶ Ibid 517.

¹⁵⁷ In fact, at the close of the Prosecution’s case, the defence made a no case submission on this point specifically. It claimed, inter alia, that ‘there is no evidence capable of satisfying a properly-instructed tribunal of fact: (1) as to the substance of the relevant duty of care (as to what a fair and reasonable standard of care and competence required)...’, *Pegios I* [2008] NSWDC 104 (2008) [5].

¹⁵⁸ *Pegios* [2008] NSWDC 105 (2008).

a-half and three hours in total.¹⁵⁹ During that time, the victim suffered hypoxia, dying some days later of hypoxic brain damage.¹⁶⁰ In her remarks on sentence, Murrell SC DCJ, as she then was, repeatedly noted the centrality of formal professional guidelines and standards adduced at trial.¹⁶¹ The Court's reasons were, in fact, wholly orientated by this evidence, in a manner that demonstrates clearly the borrowing demanded and practiced by the doctrine when applied to the medical field.

In *Pegios*, the substance of the relevant duty of care concerned what a 'fair and reasonable standard of care and competence required'¹⁶² as to the administration of sedation and the management of oxygen loss in the practice of general dentistry. The doctrine itself, of course, provides no such guidance. Nor, I claim, is it designed to. Thus, the Court is forced to turn its attention to other sources to fill out the meaning of gross negligence. In *Pegios*, the Court turned its attention to expert evidence, in particular a guideline for sedation in dental practice known at the time as the 'P 21 Guideline'.¹⁶³

The P 21 Guideline outlined evidence-based processes and standards for administering sedation. Murrell SC DCJ went so far as to excerpt the relevant sections of the Guideline

¹⁵⁹ See also media reports of *Pegios*' professional disciplinary process/hearings, Natasha Wallace, 'Tribunal Finds Dentist Lied at Trial over Patient's Death' *The Sydney Morning Herald*, 21 October 2009 <<http://www.smh.com.au/national/tribunal-finds-dentist-lied-at-trial-over-patients-death-20091020-h6ys.html>>.

¹⁶⁰ *Pegios* [2008] NSWDC 105 (2008); see also *HCCC v Pegios (No 1)* [2009] NSWDT 1 (16 October 2009); *HCCC v Pegios (No 2)* [2010] NSWDT 1 (18 June 2010); *HCCC v Pegios (No 3)* [2010] NSWDT 2 (15 September 2010).

¹⁶¹ *Pegios* [2008] NSWDC 105 (2008) [7] (for example, 'in making findings of fact, I must rely upon the evidence. Matters of medical/dental expertise must be determined solely on the basis of the expert evidence adduced in the trial. In deciding the facts, I must apply my common sense.') Murrell SC DCJ.

¹⁶² *Ibid* [13]; see also *Pegios I* [2008] NSWDC 104 (2008) [5].

¹⁶³ 'In Australia the combined Colleges ANZCA and RACDS developed guidelines on "Sedation for Dental Procedures" P21 1990. This caused quite a bit of consternation amongst some dentists, but the Dental Board's promoted these guidelines in the name of patient safety. P21 was further refined in 2003 and became "PS21". This document further defined staffing, equipment and training. In 2010, ANZCA published a joint guideline on sedation with the Faculty of Pain Medicine, the Gastroenterological Society, the Australasian College for Emergency Medicine, the College of Intensive Care Medicine, the College of Dental Surgeons and the College of Radiologists. This document is current and is referred to as PS9 ("Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures") The current edition of these guidelines as Australian and New Zealand College of Anaesthetists (ANZCA), 'Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures' <<http://www.anzca.edu.au/documents/ps09-2014-guidelines-on-sedation-and-or-analgesia>>; Australian and New Zealand College of Anaesthetists (ANZCA), 'Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures - Background Paper' <<http://www.anzca.edu.au/documents/ps09bp-2014-guidelines-on-sedation-and-or-analgesi.pdf>>.

directly into her honour's judgment, providing additional emphasis and occasional signals throughout:

P 21...provided:

“Sedation for dental procedures includes the administration by any route or technique of all forms of drugs which result in depression of the central nervous system. The objective of these techniques is to produce a degree of sedation whereby rational communication with the patient is continuously possible, so that uncomfortable and/or stressful procedures may be facilitated. The drugs and techniques used should provide a margin of safety which is wide enough to render unintended loss of consciousness unlikely.

... it is important to understand... that over sedation or airway obstruction may occur at any time...

... if at any time such rational communication is lost, then the operator must cease the procedure and devote his/her entire attention to monitoring and treating the patient until such time as the patient recovers consciousness...” ([her Honour's] emphasis)

In relation to oxygen loss, the P 21 guideline provided:

“3.7 If loss of consciousness, airway obstruction or cardiorespiratory insufficiency occur at any time, both the proceduralist and assistant must devote their entire attention to monitoring and treating the patient until recovery, or until such time as another medical practitioner becomes available to take responsibility for the patient's care”.¹⁶⁴

Pegios, the Court noted, had completed a diploma course on sedation at the University of Sydney in 1999, and had used intravenous sedation ‘during more than 680 procedures’¹⁶⁵ by November 2002. The Court was at pains to highlight not merely this formal training (and associated certification) in the use of sedation in general dentistry, but that Pegios's training was explicitly delivered by reference to the P 21 Guideline.¹⁶⁶ Most importantly, the Court noted – three times – that ‘the accused considered himself “bound” by the [P 21] guideline’,¹⁶⁷ quoting Pegios's own words given in evidence at trial (‘bound’) on each occasion.¹⁶⁸ Not only did Pegios describe himself as ‘bound’, but the Court highlighted

¹⁶⁴ *Pegios* [2008] NSWDC 105 (2008) [18]-[19] Emphasis in original. (Not only did the Court draw directly upon the language of the Guideline, it was also pains to ensure that the Guideline was the version as applied at the time of the alleged manslaughter. In 2002, the 1996 version of the Guidelines applied).

¹⁶⁵ *Ibid* [25]-[26].

¹⁶⁶ *Ibid* [26].

¹⁶⁷ *Ibid* [35], see also At [25]-[26]: ‘In 1999, he had completed the University of Sydney's diploma course. By November 2002, he had used intravenous sedation during more than 680 procedures. [26] Although he was not a member of either of the associations that had produced the guideline, the accused considered himself to be “bound” by P21 (1996). It had formed the basis of his training in sedation at the University of Sydney.’

¹⁶⁸ *Ibid* [26], [35], [37].

how it was that he was able to describe the strict contours of what being so bound meant in the clinical setting:

[Pegios] appreciated the importance of maintaining ‘rational communication’ with the patient throughout the procedure. He acknowledged that ‘rational communication was essential’ and said that, had the deceased become unconscious at any time, then ‘that was absolutely a breach of the guideline’.¹⁶⁹

Pegios’s practical reason was so thoroughly shaped by the P 21 Guideline that he considered himself not merely ‘bound’, but his understanding of the standard of care expected of him was decisively shaped by this ‘background of well-known and accepted standards’.¹⁷⁰

Pegios’s training, certification and assent to be bound by the P 21 Guideline was not the end of the Court’s consideration of it. Instead, the nature and authority of P 21 Guideline was further examined by reference formal regulatory professional links between Pegios (as a registered general dentist) and the Guideline. The Court described how Pegios was not ‘a member of either of the associations that had produced the guideline,’¹⁷¹ namely, the Australian and New Zealand College of Anaesthetists and the Royal Australian College of Dental Surgeons, which presumably would have bound him and his standard of practice to the Guideline in a direct manner. Moreover, in response to a no-case submission from the defence, the Court accepted that at the time of the death (2002), there ‘was no evidence’ that the P 21 Guideline *as such* was ‘used and/or accepted by general dentists as the standard to which they should conform’.¹⁷² As such, Pegios was not in a strong sense bound by membership of a relevant college, nor by peer professional practice to the Guideline, despite being trained, certified, and feeling himself ‘bound’ to it. Whilst this meant that the P 21 Guideline was not in a sense ‘legislative’ for Pegios, nor had it reached the status or weight of widely binding ‘custom’, to borrow the legal idiom.¹⁷³

¹⁶⁹ Ibid [35].

¹⁷⁰ Horder, above n 144, 517.

¹⁷¹ *Pegios* [2008] NSWDC 105 (2008) [26].

¹⁷² *Pegios* [2008] NSWDC 105 (2008).

¹⁷³ This is also, I submit, an accurate expression of the doctrine’s demands; namely that the defendant-dentist not be bound to his own standards, nor the standards that he might particularly be trained in, nor to ‘best practice’, but instead to the relevant standard of a reasonable general dentist performing IV sedation at the time. This standard seemed to be different, if not lower, than that described by the P21 Guideline. Moreover, that standard did not include direct reference to the P21 Guideline as a binding authority for such practice at the time.

The utility of the Guideline was not exhausted by its lack of formal connection to *Pegios*. The Court took significant time to ‘peer behind’ the Guideline to ascertain whether its description of sedation practice in general dentistry might fruitfully express something of the standard of care that did apply to *Pegios*. That is, whether the P 21 Guideline was an accurate or helpful synthesis of the actual practice of sedation as practiced at the time. Justice Murrell noted that all Crown witnesses ‘assumed that the spirit (if not the letter) of the P 21 guideline applied to proper dental practice in 2002’,¹⁷⁴ and concluded that the Guideline then provided ‘some evidence of appropriate practice’,¹⁷⁵ and was consistent ‘with the thrust of the expert evidence’¹⁷⁶ that ‘proper practice for intravenous sedation... required that the patient be maintained in a state of conscious sedation and that, as far as possible, deep sedation or unconsciousness be avoided’.¹⁷⁷ The P 21 Guideline was found to express a consensus view of evidence, to influence the actual practices of sedation and to be a suitable record of the key contours thereof.

Pegios is not the only example of this borrowing and reflection of what is particular to the field of healthcare in recent jurisprudence. Take the case of *Patel*.¹⁷⁸ In that case, so much turned on the difference between undertaking surgical treatment as opposed to the practices relating to a recommendation to undergo such surgery.¹⁷⁹ In *Patel*, the Crown had initially presented the case as relating to *Patel*’s recommendation to the deceased to undergo surgery,¹⁸⁰ the performance of that surgery with reasonable care and skill, and the post-operative treatment under his care.¹⁸¹ As the trial progressed, however, evidence as to

¹⁷⁴ *Pegios I* [2008] NSWDC 104 (2008) [20].

¹⁷⁵ *Ibid.*

¹⁷⁶ *Ibid.*

¹⁷⁷ *Ibid.*

¹⁷⁸ *Patel* (2012) 247 CLR 531.

¹⁷⁹ The case and its appeal centred on the interpretation and application of Queensland law on the question, see *Criminal Code Act 1899* (QLD) ss 288, 303, 320.

¹⁸⁰ In this, his first trial, *Patel* was charged with offences relating to the death of three patients and the grievous bodily harm of a fourth patient, see *R v Patel* [2010] QSC 233; see also the first appeal *R v Patel; ex parte A-G (Qld)* [2011] QCA 81 (21 April 2011) (*‘Patel 3’*).

¹⁸¹ *R v Patel* [2010] QSC 233; the High Court recounts the progress of the trial in his judgement in some detail, see especially the judgment of Heydon J, *Patel* (2012) 247 CLR 531; David J Carter, ‘Correcting the Record: Australian Prosecutions for Manslaughter in the Medical Context’ (2015) 22(3) *Journal of Law and Medicine* 588, 588–590 (where I recount the progress of the various inquests related to *Patel* and surrounding health services); as to the broader regulatory impacts of the entire episode, see particularly Bradfield Owen Bradfield, ‘Serving Two Masters? Recent Legal Developments Regarding the Professional Obligations of Medical Administrators in Australia’ (2011) 18(3) *Journal of Law and Medicine* 545; Hedley Thomas’ journalistic work is still the most important source for the details of the *Patel* saga, having broken key elements of the story, see especially Hedley Thomas, *Sick to Death: A Manipulative Surgeon and a Health System in Crisis-- a Disaster Waiting to Happen* (Allen & Unwin, 2007).

the applicable standard of surgical practice came to show that Patel's surgery itself had been undertaken competently enough to avoid prosecution for gross negligence. That evidence was presented in the form of both expert opinion and by reference to relevant standards. This led the prosecution to radically alter its approach, focusing at that point on the decision to undertake the surgical procedures at all. Thus by the forty-third day of his initial trial, the Crown decided to dramatically narrow its case to the question of whether the recommendation to undergo surgery was itself negligent, rather than the performance of the surgery itself or supervision of its after-care.¹⁸² This decision by the prosecution rendered largely irrelevant much of the evidence that had been presented to the jury thus far, the tenor of which was highly prejudicial to the defence's case. On that basis, a gross miscarriage of justice had occurred. The High Court ordered that the verdict be set aside, and ordered a new trial.

Whilst the multiple trials, inquiries and surrounding health services and medical politics of the Patel case presents a deeply complex picture, for current purposes Patel's criminal prosecution demonstrates that the doctrine when applied takes into its very heart the practices and standards particular to the area of human activity to which it is applied. Patel's case is helpful, as it demonstrates how this borrowing process allows the doctrine to become so particular in its attention to the underlying (surgical) practices, so sensitive to their nature and reality, that it is able to, and in fact successfully does, borrow in a manner that allows even for differentiation between various aspects of surgery. For the Court held that 'surgical... treatment', as found in s 288 of the Queensland Criminal Code, encompassed all that was provided in the course of such treatment, such as formation of a judgment and recommendation that surgery be undertaken at all. Yet, at the same time it held that the performance of each aspect of 'surgical treatment' had different, distinguishable and specific practices and standards. Surgical assessment, formulating a judgment, the making of a recommendation to undergo surgery, the undertaking of surgery and the surgical after-care, were, as matter of law, all functions of what the Queensland Criminal Code describes as a single unity, namely 'surgical care'. Yet, even in that

¹⁸² The process of this 'narrowing' began at the trial's inception, with Heydon J providing an account of the disorganised manner in which the Prosecution conducted their case at first instance. Heydon J recounts in detail the efforts to which the Trial Judge went in order to ascertain the true nature of the charges/particulars during the trial, noting at one point how on the fifth day of the trial 'draft particulars' had been produced by the Prosecution at which Heydon J writes, '[t]he transcript then attributes to his Honour [the Trial Judge] the expression: "Mmm".' *Patel* (2012) 247 CLR 531, [175].

interrelated state, the specificity with which the doctrine borrows material from the field of surgery allows the Court to distinguish between particular expectations, practices and definable, if debatable, standards. Without this ability to distinguish, with sufficient sensitivity, the different aspects of what was (at the same time) a single undertaking of ‘surgical treatment’, the Court could not have found the miscarriage of justice.

2 *The transformative remaking of the doctrine’s very self into a reflection of the practices imminent to healthcare and medicine.*

The ‘borrowing’ demonstrated in both *Pegios* and *Patel* does not simply (or only) ‘fill out’ the doctrine’s lack of definite content. Instead, this process *remakes* the doctrine upon each application, affecting a transformation of the doctrine itself into something new. Rather than imposing something alien or ill-fitting upon (medical) practice, something unaccountable to the changing social practices of medicine (i.e. unaccountable to reality), this transformative remaking of the doctrine’s very self, renders it a reflection of the standards and practices imminent to healthcare and medicine. I illustrate this by reference to *Pegios*.

Recalling the discussion of *Pegios* above, the Court triangulated *Pegios*’s relationship to the P 21 Guideline. It examined his own sense of being ‘bound’ to the guideline and his adoption of its claims as a description of the practice of sedation. So too did it question his formal professional relationship to it, finding that he was not subject to its requirements in the manner a member of one of the authoring Colleges would be. However, it was a useful and accurate statement of the practice of sedation in general dentistry at the time. Whilst the expert evidence conflicted on a range of matters, it was of one voice as to the place of the standard, and was ‘all to the same effect as the P 21 guideline’.¹⁸³ So central was this clinical guideline to the reasoning of the Court, that the trial judge was able to conclude, quite neatly and with pin-point reference and direct quotation of the Guideline, that

All experts and the accused agreed that oxygen desaturation carries a risk of serious injury or death and, consequently, requires an immediate and appropriate response. The terms of paragraph 3.7 of the P 21 guideline – by which the accused considered himself ‘bound’ – are to the same effect. I am satisfied beyond reasonable doubt that the standard of care expected of a reasonable general dentist in the accused’s position in 2002 required that, when a patient

¹⁸³ *Pegios* [2008] NSWDC 105 (2008) [34].

exhibited oxygen desaturation, the dentist stop the procedure and ‘devote their entire attention to monitoring and treating the patient until recovery’.¹⁸⁴

Notice here how the very language of the P 21 Guideline is drawn directly into the expression of *Pegios*’s legal duty. Its language is interpolated into the criminal law itself, coming to directly from the content of the doctrinal material. Without the language taken from the P 21 Guideline, the test would, at best, remain expressed as involving ‘such a great falling short of the standard of care that a reasonable man [sic] would have exercised and that involved such a high risk that death or grievous bodily harm would follow that the doing of the act merited criminal punishment.’¹⁸⁵ Instead, the Court is able to take the P 21 Guideline and interpose the language of this clinical document, folding it into the very test itself. The ‘high risk that death or grievous bodily harm would follow’ becomes instead ‘All experts and the accused agreed that oxygen desaturation carries a risk of serious injury [read: grievous bodily harm] or death’.¹⁸⁶ So too are words of ‘paragraph 3.7 of the P 21 guideline’ substituted for the doctrinal definition given by *Nydam* of ‘the standard of care which a reasonable man [sic] would have exercised’. No longer is the test an abstract, or empty placeholder. Nor is it a formulation of legal terms of art. Rather, it is a direct and uninterrupted reflection of the clinical guideline back onto the practice it guides and governs, namely sedation in general dentistry. In this process, the doctrine has been remade.

As demonstrated by *Pegios*, the doctrine of criminal negligence becomes a reflection of the practices imminent to healthcare and medicine, rather than an imposition of distinctly legal terms or standards alien to medical practice. The doctrine has developed its very form and content through a process of drawing up into itself the practices and standards indigenous to the area of human activity with which it is called upon to engage. Here, a specific document, an expression of practice authored, controlled and interpreted by healthcare practitioners through expert evidence is taken up into the heart of the doctrine, to the point of inserting, and even replacing the doctrinal language, only to be re-applied to

¹⁸⁴ Ibid [37].

¹⁸⁵ *Nydam* [1977] VR 430, at [445].

¹⁸⁶ There is a potential misstatement here of the level of seriousness required to establish grievous bodily harm in NSW law today, namely, *really* serious bodily harm.

the instance of practice from which it drew that very language, in order to assess the degree of deviation. The result for *Pegios* was acquittal.¹⁸⁷

This process is much stranger and unique than it may seem at first glance. The use of expert evidence, for instance, is a commonplace in many areas of criminal law. However, elsewhere, the expert evidence itself fails to play such a decisive role. For example, criminal offences that utilise subjectivist forms of mens rea, such as murder established on the basis of an intention to kill, use expert evidence in relation to the establishment of all manner of elements. Typically, experts are called to resolve the interpretation of facts, or to draw specialised inferences from the facts. Thus, that evidence is adduced in order to demonstrate the existence of a fact demanded by the doctrine – for example, that the defendant held a particular state of mind at the relevant time. In this case, even without particular pieces of evidence, the very doctrinal requirements of most offences are sufficient in themselves to define in reasonably clear terms what will, or will not, constitute an offence prior to its commission. Without application of that particular piece of evidence, it will be clear, for example, that an intention to kill is the relevant fact that needs to be found to make out the offence. The question before the jury is – generally – were they satisfied as a question of fact that the defendant held that intention. This requires very little, or no further deliberation to establish what an intention to kill is, before assessing its existence. The evidence merely affirms the existence of that fact. Compare this to the situation of negligence. In negligence, the evidence – such as the P 21 Guideline – is itself formative of the very demand of the law. An inquiry must first be made as to what the applicable standard of care was, and then having established that – by use of evidence drawn from ‘outside’ of law, as it was – the trier of fact may then make an assessment as to whether the defendant in fact grossly failed.

The doctrine expresses a relative, rather than absolute, conception of duty, of harm, of care and of failure. This relative conception is due to its reflection of actual social practice, for what is actually practiced, what is actually possible, and what standards apply to various practices at various times or in differing settings – be it sedation or surgery or otherwise. Criminal negligence is not a kind of code by reference to which activity is regulated: this behaviour is appropriate here, and that behaviour not; doing this satisfies your duty, while doing that does not. Rather, criminal negligence’s form forces it to remake itself into a

¹⁸⁷ *Pegios* [2008] NSWDC 105 (2008).

reflection of the practices and standards of a particular community and particular field of practice to which it is applied.

3 *Reinforcing the practices and standards that are particular to medicine and healthcare.*

There are a range of implications of this doctrinal structuring and practice. The third task of this section is to reflect on one of those implications. In particular, I am interested in establishing how this doctrinal process of reflecting the practices and standards of the underlying field of practice to which it is applied actually *reinforces* those practices and standards particular to the field. I argue that this is achieved in a variety of ways. However, the process I wish to highlight in the case of iatrogenic death, where criminal law is applied to medical practice, is how the criminal law's borrowing and reflection process offers an imprimatur to the practices and standards of medicine. This move is productive of the authority of the professions themselves, rather than undercutting of the independence, control or autonomy that those critical of the doctrine worry about.

To again take the case of *Pegios* as an exemplar, the criminal law's adoption and use of the P 21 Guideline provides that material, otherwise with a life and status 'internal' to the professions or fields of medicine and dentistry, with a new character. The P 21 Guideline was formally binding on Fellows of the relevant authoring colleges, namely Australian and New Zealand anaesthetists and Australian dental surgeons. It was clearly not formally binding on those in the practice of general dentistry, even those who had been trained, used and felt 'bound' by the guideline, as *Pegios* himself did. Yet, by being adopted the way that it was by the Court in this criminal proceeding, the Guideline comes to develop a new authority over the practice of sedation in general dentistry that, as even the Court admitted, it earlier lacked.

Criminal law is here dependent on fields of practice external to itself to provide definite content to its otherwise empty character and yet, at the same time, those fields – here medicine and dentistry – are buttressed by law's role as a limit against which they establish authority to declare standards, and from which they gain an imprimatur for those knowledge claims.¹⁸⁸ The authority of the criminal law and criminal courtroom provides

¹⁸⁸ I have examined this relationship and dynamic in other contexts, describing it as a dependency, co-determinacy and mutual reliance for identity and content. See, t David J Carter, 'HIV Transmission,

an obvious source of this process. However, the operation of that power can be described in a more detailed manner.

The doctrine of manslaughter by criminal negligence, once applied, becomes replete with the knowledge, language and concepts of the underlying field of practice to which it is applied. This occurs when the language, knowledge and techniques of the underlying field of practice are translated into the jurisdiction of the criminal law.¹⁸⁹ In *Pegios*, this was the field of sedation and of general dentistry, facilitated by the P 21 Guideline. In *Patel*, it was the evidence from a huge number of experts on the difference(s) between all manner of surgical practices.¹⁹⁰ In *Gow*, it was quality and safety science research on the frequency of serious iatrogenic harm caused by medication errors.¹⁹¹ The doctrine itself necessitates this process, for the criminal law is wholly dependent upon the fields of practice that it is asked to authoritatively engage with. It relies upon those fields for its very language, vocabulary, concepts, knowledge and schemas, all of which are drawn into the doctrinal formula itself.

In these cases, the trial judge adopts and relies upon the somewhat unique vocabulary, concepts, knowledge and schemas of the underlying healthcare practice, not simply in

Public Health Detention and the Recalcitrant Subject of Discipline: *Kuoth, Lam v R and the Constitution of Public Health and Criminal Law* (2016) 25(2) *Griffith Law Review* 172.

¹⁸⁹ See my earlier work on *Kuoth* for a detailed case study of this mechanism in relation to HIV transmission, *ibid*.

¹⁹⁰ The detail of that expert evidence is difficult to ascertain. Under current Queensland regulations relating to transcription of proceedings, and access to transcribed proceedings, the cost for obtaining transcripts of *Patel*'s first trial at first instance would run to approximately \$20,000- \$30,000. After outsourcing transcription services to a private company (Auscript), overly restrictive intellectual property agreements licence the transcripts for very limited use. Importantly, despite the fact that the original *Patel* trial was transcribed by the State-owned and operated service, the obtain the transcript of the proceedings (which have already been transcribed) a fee is payable equivalent to the cost of transcribing that material afresh, see Email from Jessica Laycock (Transcript Co-ordination Team, formerly the State Reporting Bureau) to David J Carter, 20 February 2014. At that time, '...transcripts that were owned by the State Reporting Bureau are currently charged at \$77.50 for the first 8 pages or less, and \$9.60 per additional page whilst Queensland Court Audio that were owned by the State Reporting Bureau are currently charged at \$32.10 each hour or part thereof.' The *Patel* trial ran for some fifty days in length, with the estimate for Day 1 of the trial (22/3/2010) running to 56 pages and \$538.30. In subsequent correspondence, it was confirmed that these costs were for 'the cost for the Transcript and NOT for the Transcription of them', and that access for research purposes in the public interest were not grounds for a waiver of these fees: 'Fee Waivers are only granted to the Parties of the matter, so regrettably you are not eligible for any exemption of fees', see Email from Jessica Laycock (Transcript Co-ordination Team, formerly the State Reporting Bureau) to David J Carter, 21 February 2014.

¹⁹¹ *Gow* [2006] NSWDC 78 (27 October 2006) [27] ('Dr Phillip Hoyle. He was formerly the general manager of Royal North Shore Hospital and referred to an audit of adverse events in that hospital that showed that in a single year there were 10 serious prescription errors resulting in significant patient harm.').

describing disease or healthcare practice themselves, but in understanding the impact and the moral weight those practices. This process implicitly relies on a connection between healthcare practitioners, in the form of expert witnesses, and the processes of the court and its constituents – judge and jury – and in bringing these communities together to enter into shared contemplation and critical examination of those practices, policy and protocols.

While performed in the ‘space of the court’, and often in a legal idiom, this process is highly productive for the underlying discipline, for whilst criminal law borrows this language and content, it is at the same time a confirmation of the central claim of those fields of practice to ‘construct normality and to judge deviations from it’.¹⁹² Through this process the laws around manslaughter by criminal negligence, confirm and approve the utility and veracity of the concepts it settles upon to describing the ‘truth’ of the situation. Criminal law reinforces the knowledge claims of those disciplinary regimes, and at the same time buttresses particular formations], groups’ or even whole professions’ ‘jurisdiction’ over ‘their’ field.¹⁹³ Not only does criminal law’s borrowing process here buttress the authority of those underlying fields of practice, it also confirms law’s own subordination to them at the same time.¹⁹⁴ By its very openness to the authority and knowledge of other disciplines, law is thus ‘both a law subordinated to those other powers... whilst at the same time, because of this very same openness to subordination, forever unstable and surpassing’.¹⁹⁵ The process of law in this setting is, in a sense, facilitative rather than dictatorial, flexible rather than rigid, and deferential rather than deprecatory.

Much of the criticism against the workings of the law focus upon what is perceived to be the ineffectual and difficult ‘openness’ of its forms and practices. Yet without that openness, the doctrine could not function to achieve the kind of critical reflection that is posited in this chapter as its greatest strength, nor be successfully applied to the full range of contexts that it is. By approaching the role of law in accordance with these understandings and views of its action, the criticisms levelled against it in the key

¹⁹² Carter, above n 188.

¹⁹³ Such as the various Colleges who authored the P21 Guideline in the case of *Pegios*.

¹⁹⁴ This particular movement I first observed in a similar way in relation to HIV transmission and its interaction with law, see Carter, above n 188; in that work I have been inspired and have built out from the work of Ben Golder and Peter Fitzpatrick on Foucault, Ben Golder and Peter Fitzpatrick, *Foucault’s Law* (Routledge Cavendish, 2009).

¹⁹⁵ Carter, above n 188, 186.

literature then seem to misapprehend the full extent that the law is reinforcing of their authority and crucial to both the regulation of health practices and their development.

B *The law of criminal negligence is able to maintain normative solidity and coherence by drawing upon its own 'internal normativity'.*

In addition to the benefits provided by the open capaciousness of the doctrine, as outlined above, there is a sense in which such a process of radical remaking lends the law a difficult and too-flexible shape. However, here I want to briefly point out that the doctrine draws upon its own internal normativity, which give it sufficient solidity and coherence.

As shown thus far, the formal features of the doctrine of criminal negligence combine to form a relative, rather than absolute,¹⁹⁶ conception of duty, of harm, of care and of failure. Criminal negligence is not a kind of code by reference to which activity is regulated. Rather, criminal negligence remakes itself to reflect the values and standards of the particular community and field of practice to which it is applied. This is in part because of its application to the full range of human actions and duties, including those as-yet unknown to us. It is, then, essential that its form retains its ability to make a progressive, immanent development of law, rather than being an unprincipled collection of rules that must be formed and reformed to overcome contradictions in application. That kind of prescriptive 'regulatory' approach is in the final analysis unworkable. Instead, criminal negligence works by taking into its very self and structure the values and definitions of right and wrong practice, and then reapplying them to the community of practice from which it has drawn this positive content.

These professional standards, codes and practices that criminal negligence doctrine takes up are not merely evidentiary in nature. Rather, they forge a law that actively reflects everything that is *already true* about the relationship between the holder and recipient of a duty of care. And this relationship of duty is the source of the doctrine's normative solidity. In relation to the healthcare context for instance, a doctor is not justified in balancing competing reasons for (or against) conduct that imposes a risk.¹⁹⁷ Instead, it is clear that the doctor must *always* act in the best interests of their patient, for to do

¹⁹⁶ See my discussion above in relation to the work and views of Horder in particular on this point.

¹⁹⁷ Horder, drawing on Williams develops this claim more deeply, Horder, above n 144, 514 ('...whether a risk can legitimately be posed is often almost entirely a question of the balance of reasons for and against posing it...For certain agents, however, there are a number of situations in which some kinds of risk-taking ought to be automatically ruled out').

otherwise would be to betray ‘her very role’ as a doctor.¹⁹⁸ The criminal law, in a very real sense, imposes nothing more than what is already true about the relationship between doctor and patient. By identifying themselves (voluntarily) with responsibility for their patient, ‘against a background of well-known and accepted standards’,¹⁹⁹ ‘the existence of the relationship not only provides a reason for the dominant party to act in the reliant party’s best interests; it provides a reason that excludes consideration of countervailing reasons not to act in the reliant party’s best interests’.²⁰⁰ As Horder puts it: ‘The existence of such a relationship provides an “exclusionary reason” for the “dominant” party (the doctor or trustee) to act in the best interests of the “reliant” party (the patient or beneficiary)’. In coming to reflect and reinforce what this means by drawing on those well-known and well-accepted standards, the criminal law simply reflects the standards and practices of doctoring and the meaning of the relationship of duty, which is established by social practice; ‘in such a context, a doctor... can expect to be judged by no other yardstick than the extent of their conformity to or departure from the requirements of those standards’.²⁰¹

Oliver Quick raises a point of opposition to the implications of this observation regarding the reinforcing effect of criminal law’s use of material such as the P 21 Guideline in its adjudication. Whilst acknowledging the importance and even centrality of expert evidence, he finds that the ‘inevitability of opposing expert opinions on those standards’²⁰² means that any welcome given to them ‘oversimplifies’²⁰³ things:

Negligence is, after all, a contested social construction undertaken with the benefit of hindsight. And even if we could accept that the ingredients of the offence are sufficiently clear, the prosecution recipe is still kept secret... My argument is that gross negligence manslaughter suffers from a lack of intelligent (and clear) communication that we might legitimately expect from criminal law.²⁰⁴

¹⁹⁸ Ibid 516.

¹⁹⁹ Ibid 517.

²⁰⁰ Ibid 515.

²⁰¹ Ibid 517.

²⁰² Quick, ‘Medicine, Mistakes and Manslaughter: A Criminal Combination?’, above n 4, 190.

²⁰³ Ibid.

²⁰⁴ Ibid 190–191.

Quick's assessment is however potentially too broad a claim. All criminal offences are contested social constructions,²⁰⁵ whilst all assessments of the guilt of a defendant rely upon the benefit of hindsight.²⁰⁶ All law is an attempt to capture complex and changing social practice, and for that reason, laws are 'debatable and revisable'.²⁰⁷ Laws should be unsettled, in a real sense, as they are accountable to the norms that constitute the world, accountable to actual social practice. The level of clarity Quick seems to expect of the doctrine and associated legal practices is, at least as described here, near impossible to achieve. This was, in relation to the contestable state of expert evidence, an issue to which the Court in *Pegios* was alive:

The experts expressed different – and, in some respects, conflicting – opinions about appropriate medication, about the course of medical events, and about if, when and how a reasonable general dentist would have responded to those events... In assessing the reliability of each expert's evidence, I must consider the accuracy and completeness of the facts and assumptions upon which the opinion was based. It is not a matter of choosing between the experts. Rather, if I decide that there is a reasonable possibility that an expert is correct about a critical matter and, if so, the Crown is unable to establish an element of the offence, then I must conclude that the Crown has failed to prove the element beyond reasonable doubt.²⁰⁸

The difficulties raised by scholars such as Quick around the ability of non-professionals, particularly the jury, to assess medical decisions, and thus the likelihood that they are 'heavily influenced by their perception and interpretation of experts and their evidence, albeit contextualised somewhat by the direction and summing up of the trial judge',²⁰⁹ is *exactly* what I am advocating as the way in which criminal negligence doctrine actually operates and how it in fact should continue to do so.

V IMPLICATIONS

There are two major implications that flow from the analysis of criminal negligence doctrine, one theoretical and another practical. Principal amongst these is the theoretical implication that our understanding of the doctrine and its legal application/mechanics needs to be revised, at least in relation to its application to iatrogenic harm in Australian

²⁰⁵ I think particularly of the intense debate and tension surrounding the application and reform of the law of provocation in my own state of New South Wales, and elsewhere in Australia.

²⁰⁶ Including reliance in the particular form Quick is here referencing.

²⁰⁷ Vincent Lloyd, *Law and Transcendence: On the Unfinished Project of Gillian Rose* (Palgrave Macmillan, 2009) 6; a significant influence underlying various elements of this thesis is the work of Gillian Rose, particularly as read by Vincent Lloyd, a leading interpreter of her difficult work.

²⁰⁸ *Pegios* [2008] NSWDC 105 (2008) [10].

²⁰⁹ Quick, 'Expert Evidence and Medical Manslaughter', above n 4, 516.

jurisdictions. Dekker's claim that the State's ability to conclude what constitutes gross negligence is objectionable,²¹⁰ turns out to be not quite this straightforward. It is true that the State, through generally independent criminal prosecutorial authorities, selects cases for prosecution; however, as I have shown here, the idea that the State concludes what in fact constitutes gross negligence is not the case. Rather, there is a more complex dialectic at work, where the law takes up into itself the practices and standards inherent to the practice of medicine (or any other context) to form the very content of 'gross negligence'.²¹¹ Arguing that the openness of the law in these circumstances functions as a key asset in the regulation of human action in healthcare overturns much of the established scholarship on criminal negligence. In an attempt to resolve this rupture, one can turn to the research of Annemarie Mol, whose work on healthcare shows that its best and most effective form is as a set of materially heterogeneous practices that are always local and specific. Mol argues that, as an ethic, care is not, and cannot be, based on universal principles, but must draw on the experiences of everyday life and the moral problems and practices of humans in their ordinary lives. Such a form of care is at the heart of manslaughter by criminal negligence. It bears the term in its doctrinal formulation as the 'duty of care', and its primary task is to hold practitioner-defendants to account for their gross failures to exercise that duty. Most importantly, the doctrine of manslaughter by criminal negligence reflects this true meaning of care in its doctrinal structure, wherein it borrows, reflects and thus reinforces the particular, local and everyday practices of humans in their ordinary practices of healthcare, and then asks of them, did they (grossly) fail to care according to those standards and practices?

The primary practical implication of these findings is that the disciplines and professions of medicine, nursing, allied health and others, whose members may one day face a criminal negligence charge, retain significant, even decisive, control over the doctrine of criminal negligence itself. Negligence is concerned with the substantive ethical, social and political context of action. It is reliant upon a social theory of action that addresses

²¹⁰ Dekker, *Just Culture*, above n 7, 16 ('But guess who decides what counts as "gross negligence?" The State, of course. Via its prosecutors or investigating magistrates.').

²¹¹ In many ways, this specific tension and relation as between the conduct of criminal law and of medicine is, I believe, an particular expression of what Peter Goodrich has described as broader 'relations of inclusion and exclusion - between (a discourse), other discourses, and the social whole'. The terrain is truly a site of strategic plays at persuasion, where both criminal law and quality and safety science attempt to exclude from the authority of the other 'the possibility of alternative meanings and other discourses'. Peter Goodrich, *Legal Discourse: Studies in Linguistics, Rhetoric and Legal Analysis* (Macmillan Publishers Limited, 1987) 183.

questions of intention, action, cause, agent and culpability by reference to the communicative and evaluative practices in which these questions arise and are ultimately decided. When asking what a gross lack of care looks like, it asks this question in a specific context – such as medical practice – and then takes up into itself the answers provided by that field of human practice developed by those communities of practice themselves. It does not impose its own concepts or standards upon social practice, but rather reflects social practice. For this reason, whilst communities of practice – both professional and academic – retain primary responsibility for ending the scourge of preventable iatrogenic harm, so too do they hold the key to the formation of doctrine through their communal formulation and practice of their disciplinary and professional fields. Being clear, and honest, about what is acceptable and unacceptable practice, what best practice might entail, and ever-advancing practice in continuance with those standards, will all work to prevent instances of gross negligence manslaughter, but also provide the doctrine with its very content; content by which it will assess the conduct of medicine or health care in the rare moments it is called upon to do so.

VI CONCLUSION

The law of manslaughter by criminal negligence has been much-maligned by writing emerging from the quality and safety sciences and with those concerned with its application to iatrogenic harm. Much of that complaint has been founded upon a dissatisfaction with the doctrinal material upon which the offence relies; too unclear, devoid of sufficient content to provide guidance to practitioner action, unstable and an unjust and unclear imposition of standards alien to those of medical practice. This criticism, however, needs serious revision. Critique of the doctrine as devoid of content and circular in its construction are correct. However, this is far from a fatal flaw. Rather, these ‘weaknesses’ of the doctrine are in fact its greatest strength. Because of what I term the doctrine’s ‘openness’ – an openness that relies upon its lack of definite content – the law of criminal negligence borrows, reflects and thus reinforces what is particular to the area of human activity with which it engages. Rather than being fatally devoid of content, the doctrine is instead radically open to the field of human practice to which it applies, temporarily taking into its very core, the values, standards and meaning of contemporary and changing medical practice turning only then to (re)apply this newly adopted content to an assessment of an instance of harm emerging from that very same field of practice. This

being the case, charges that the doctrine works to apply standards dangerously alien to those of medical practice are unfounded. Rather, the doctrine is driven by the standards produced and expressed by medical practice itself.

This simultaneously open and closed structure of the doctrine is particularly suited to this practice as it legally enforces a duty of care in medicine. This is so because the practices of good care (and good medical or health care) are local, specific and responsive, subject always to change and revision. Assessment by law of our practice of care in medicine cannot ever be pre-defined. Care cannot be worked out ahead of time. Thus, it is not a theoretical paradigm or conception that we impose upon the practices of healthcare or medicine, as if 'from outside'. Rather, care is healthcare as successfully practised: 'persistent tinkering in a world full of complex ambivalence and shifting tensions'.²¹²

The traditional doctrine of criminal negligence recognises this as a form of dialectic between the active contribution of the person and what she receives as a consequence of her situatedness within traditions of medicine and of their local expression. For this reason, the theorising of criminal negligence engaged with here answers, in large part, the critique levelled at it by writers in the quality and safety sciences; no longer can it be so dogmatically put that criminal negligence's doctrinal structuring imposes standards alien to the social practices and values underpinning health and medical care.

²¹² Annemarie Mol, Ingunn Moser and Jeannette Pols, 'Care: Putting Practice into Theory' in Annemarie Mol, Ingunn Moser and Jeannette Pols (eds), *Care in Practice: On Tinkering in Clinics, Homes and Farms* (Transcript Verlag, 2015) 7, 14.

CONCLUSION

This thesis has reinterpreted and reconstructed the conduct of criminal law (in the form of manslaughter by criminal negligence) in relation to iatrogenic harm in the contemporary healthcare setting. In this chapter, I synthesise the main arguments of my thesis. I then reflect on their implications, both theoretical and more practical. By way of conclusion, I position these findings within the context of broader questions about iatrogenic harm, manslaughter by criminal negligence and the questions that remain open for future research and debate.

I THE QUESTION OF IATROGENIC DEATH AND CRIMINAL LAW

I began this thesis by describing iatrogenic harm as a grave problem with serious consequences: At least ten per cent of admissions to acute care hospitals are associated with iatrogenic harm, including 1.7 per cent of admissions associated with a major iatrogenic disability, and 0.3 per cent admissions with death.¹ Each year in Australian hospitals this leaves approximately 152,000 people with major disabilities and kills approximately 27,000.²

¹ William Runciman and J Moller, *Iatrogenic Injury in Australia* (Australian Patient Safety Foundation, 2001) 17; these rates are now regarded as consistent across both advanced and developing healthcare systems, see Angus Corbett, Jo Travaglia and Jeffrey Braithwaite, 'The Role of Individual Diligence in Improving Safety' (2011) 25(3) *Journal of Health Organization and Management* 247, 248; John D Hamilton, Robert W Gibberd and Bernadette T Harrison, 'After the Quality in Australian Health Care Study, What Happened?' (2014) 201(1) *The Medical Journal of Australia* 23; RM Wilson et al, 'Patient Safety in Developing Countries: Retrospective Estimation of Scale and Nature of Harm to Patients in Hospital' (2012) 344 *BMJ* e832.

² Runciman and Moller report a figure of 10,000 deaths in Australia per annum on 1992 figures, however, it is unclear from this report the exact source of this figure Runciman and Moller, above n 1, xv; The earlier QAHCS findings in Australia found 230,000 preventable iatrogenic injuries in 1992, of which 13,000 were associated with death Eric J Thomas et al, 'A Comparison of Iatrogenic Injury Studies in Australia and the USA I: Context, Methods, Casemix, Population, Patient and Hospital Characteristics' (2000) 12(5) *International Journal for Quality in Health Care* 371, 372; although hospital activity reporting is almost uniformly reported as separations (which includes discharges, transfer or statistical type changes) it seems the analysis of the incidence of iatrogenic in the landmark studies during the 1990's was based upon 'discharge' (home). As such, the estimate of 27,000 iatrogenic deaths per annum is based on an extrapolation of the widely agreed 0.3% incidence of iatrogenic death applies to discharge (home or to place of usual residency including residential aged care) which in 2013-14 accounted for 8,969,032 of 9,702,304 total separations (26,907 per annum) Australian Institute of Health and Welfare, 'Admitted Patient Care 2013-14, Australian Hospital Statistics' (No 60 Cat. HSE 156, 2015) (Table 5.37) 134 <<http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129550480>>; this assumes, per

I remember the first time I witnessed what I took to be an iatrogenic death. I had, by then, been managing health services for many years, yet this death troubled me greatly. It seemed to be a needless foreshortening of the life of someone who had walked past me only moments before. No one in the team had sought to harm our patient. None of us had intended to kill. In fact, our purpose was to contribute to recovery from serious illness and to alleviate suffering. Despite this, the harm was noticed too late. A person had placed themselves in our care, and we had failed to properly attend to them.

This event raised for me the question of what a duty of care entailed, and what law might offer in answer to that question. Discerning the answer to these questions involves difficult work. Tackling what it means to properly attend to disease and suffering in the environment of contemporary healthcare systems is hugely complex. Doing so in dialogue with manslaughter by criminal negligence and what it expresses about caring for others is even more challenging, for doing so raises one of the ‘oldest questions of law itself: “Am I my brother’s keeper?” What does it mean to be responsible?’.³ This task, Desmond Manderson reminds us, ‘is not a question that is easier to answer for us than for Cain’,⁴ despite the law’s long experience of interpretation in fields of ‘pain and death’.⁵

Although urgent and significant, proposing that the tradition of reasoning, doctrine and practice that we call criminal negligence might offer something of value to these questions is a controversial position. At present, the mere availability of the offence in relation to even the most serious iatrogenic harm is so controversial and contested that any discussion of the doctrine finds a cold reception. In this context, to give an account of the doctrine and to propose that what it expresses might be valuable, even helpful, for understanding care and our duties in the face of human vulnerability seems out-of-step. Yet, law does not

Braithwaite et al, that these rates have not materially shifted since their accounting in the early 1990’s and 2000’s, see Jeffrey Braithwaite, Robert L Wears and Erik Hollnagel, ‘Resilient Health Care: Turning Patient Safety on Its Head’ (2015) 27(5) *International Journal for Quality in Health Care* 418, 419.

³ Desmond Manderson, “‘Current Legal Maxims in Which the Word Neighbour Occurs’: Levinas and the Law of Torts’ in *Essays on Levinas and Law* (Springer, 2009) 111, 111; Desmond Manderson, ‘Proximity: The Law of Ethics and the Ethics of Law’ (2005) 28 *University of New South Wales Law Journal* 696, 696; see especially Manderson’s masterful work on Levinas, proximity and the duty of care (largely in the context of tort), Desmond Manderson, *Proximity, Levinas, and the Soul of Law* (McGill-Queen’s Press, 2006).

⁴ Manderson, “‘Current Legal Maxims in Which the Word Neighbour Occurs’”, above n 3, 111; Manderson, ‘Proximity’, above n 3, 696.

⁵ As Robert Cover reminds us, see Robert M Cover, ‘Violence and the Word’ (1986) 95(8) *The Yale Law Journal* 1601, 1601.

merely offer an instrumental method of delimiting guilt from innocence. It is, particularly with offences like criminal negligence, an expression of something more. The law is the ‘bearer of paradigmatic memory’;⁶ its existence and particular features speak to foundational experiences like illness, disease, vulnerability, harm and the need for care, whilst transposing them from an interpersonal, individual and particular realm into the historical and political. In relation to matters of bodies, illness and care, we rely, in part, upon criminal law to facilitate this process. Nel Noddings writes about this as a mode of caring at a distance, ‘[w]hen we cannot care directly for others but wish that we could’.⁷ For Noddings, in that situation – ‘when, that is, we sincerely care about the well-being of others – we rely on principles of justice that approximate or enable others to understand the actions we would perform if we could be bodily present’.⁸ This is all to say that there is wisdom, both normative and instrumental, that criminal negligence doctrine expresses but that, which amidst competing claims, might be difficult to discern. The doctrine’s content endorses particular values and recognises certain kinds of goods and then, on that basis, works to shape social relations.⁹ Its continued availability and use might, then, be not simply an unfortunate anachronism but a statement of the continued relevance of the particular values and goods of criminal negligence as a response to the experiences of illness, disease, vulnerability and harm. For me, manslaughter by criminal negligence reminds us particularly, as Gillian Rose put it so well, that there is a ‘risk of relation... we are at the mercy of others and we have others in our mercy’.¹⁰

With that commitment to law beyond a reductionist instrumentalism in mind, seeking out what that law might say to iatrogenic harm and our duties surrounding it has meant engaging in the difficult preliminary work of intellectual ‘ground-clearing’. The motivation for this scope and strategy was the sense that the existing literature had not yet engaged sufficiently with the reality of manslaughter by criminal negligence’s history, particular motivating logic and mobilisation in the Australian courtroom. Without that

⁶ A concept applicable to contemporary criminal negligence doctrine as much to other forms of law, a feature well illustrated in the context of Jewish law by Michael Welker, Michael Welker, ‘The Power of Mercy in Biblical Law’ (2014) 29(2) *Journal of Law and Religion* 225, 232.

⁷ Nel Noddings, *Starting at Home: Caring and Social Policy* (University of California Press, 2002) 3.

⁸ Ibid.

⁹ This sentiment is expressed by Guyora Binder in his work on Felony Murder, which has been an influence in my tackling of this similarly unpopular criminal offence, Guyora Binder, *Felony Murder* (Stanford University Press, Kindle Book, 2012) 71, loc. 1646; Binder draws on the work of Elizabeth Anderson who develops this account of value and valuing as a practice of institutions, see Elizabeth Anderson, *Value in Ethics and Economics* (Harvard University Press, 1995) 6–7, 11–15.

¹⁰ Gillian Rose, *Love’s Work* (NYRB Classics, Kindle Edition, 2011) location 1117.

engagement, I argued, the current state of the field had suffered. I therefore set myself the connected tasks of (a) testing the validity of that sense that the literature had insufficiently engaged with the realities of the doctrine in its historical, theoretical and doctrinal aspects and (b) then performing the corrective work needed to allow for a grappling with the actual experience, use and practices of criminal law in this field.

This scope setting and strategy has proven fruitful, for, as this thesis has shown, the key arguments for the rejection of manslaughter by criminal negligence have been conditioned by views of the criminal law that are underdeveloped, faulty or entirely absent. Understandings of the history, character and application of the offence used by the scholarly and professional literatures as arguments for its rejection have been exposed as insufficiently attentive or responsive to the actual practices of criminal law in this field; to the history of its use, to its particular motivating logic, and to its mobilisation in the courtroom.

Now, with the benefit of the significant body of new historical, theoretical and doctrinal material I have reported on in this thesis, some of the dominant conceptions of criminal negligence under which we have laboured have been seriously destabilised. In so doing, my research has created the potential for a new conversation about the role of criminal law in matters of iatrogenic harm – one that might give cause to re-evaluate the current denial of its suitability whilst seeking to explore what the tradition of manslaughter by criminal negligence expresses that might be valuable or even helpful for understanding illness, disease, vulnerability, harm and the need for care.

II RESPONSIBILITY FOR IATROGENIC DEATH IN AUSTRALIAN CRIMINAL LAW

In the introduction to this thesis, I observed that the ‘discovery’ of iatrogenic harm precipitated a fraught legal and regulatory debate. Key to that debate was the availability and use of criminal negligence prosecutions, which have become a site of particular tension for the healthcare quality and safety sciences. Whilst this criminal offence has been subject to study by others, including criminal law theorists, here I restricted the scope of my research to deal primarily with the literature emerging from, or allied to, the patient safety and quality and safety sciences specifically. I did so because this discipline and its literature are at the heart of the debate about criminal legal responses to iatrogenic harm. This is so both because of the discipline’s role in producing so much of the literature, and

its position as the agenda-setting ‘orthodox paradigm’¹¹ for engaging with iatrogenic harm more generally.

The scholarly and professional literature that formed the focus of my research rejects criminal negligence by constructing a form of radical incompatibility between criminal negligence and the quality and safety sciences. In the process, it rejects criminal negligence on two grounds: that it is unhelpful and that it is unjust. This critique is so strong that the vast majority of scholarship on the topic concludes that both the safety of patients and justice itself would best be served by abolition or non-prosecution of the offence. In response to this near-universal rejection,¹² this thesis offers a re-reading and correction to the foundations upon which the literature rejects the prosecution of manslaughter by criminal negligence.

I structured this research and its argument in three stages, each providing a new account of the actual practices of criminal law in this field: firstly, as to the history of its use in Australia; secondly, as to its particular animating logic; and finally, as to its mobilisation in the Australian courtroom. As was made clear through successive stages, the arguments mounted for the rejection of manslaughter by criminal negligence are based in large part upon an insufficient understanding of the criminal law in this field. Taken collectively, the findings presented in the thesis unsettle the foundations of the literature rejecting the use of

¹¹ Justin Waring et al, ‘Healthcare Quality and Safety: A Review of Policy, Practice and Research’ (2016) 38(2) *Sociology of Health & Illness* 198, 202 (‘The contemporary wave of interest in quality and safety has been predominantly framed by concepts and theories found within medical science, social psychology, ergonomics, human factors and resilience engineering. Rather than seeing errors as the result of individual mistake or failure, which tends towards blaming and encouraging secrecy, the prevailing view is that individual or group performance is conditioned by a variety of upstream factors located in the wider system of care, such as the quality of teamwork or communication, the allocation of tasks, workload scheduling, equipment and resource management, and broader service cultures.’).

¹² Again, I note as I did in the Introduction to this thesis that I do not attempt in this thesis to provide a sustained argument for when or in what circumstances manslaughter by criminal negligence should apply to instances of iatrogenic harm. This is not the aim of this thesis, nor the focus of any of its contributions. Instead, its focus has been to develop a critical reading of various arguments made against its validity, availability or application. Arguments which construct or define more clearly when it might then be applied are outside the scope of the thesis and are better undertaken once these more foundational or fundamental matters of interpretation of criminal negligence are settled. What remains clear, however, is that not all instances of iatrogenic harm are suitable candidates for criminal prosecution of any sort, let alone as instances of manslaughter by criminal negligence. The Australian history of prosecution developed in Chapter One shows as much. As the doctrine makes clear, it is instances of iatrogenic harm which are understood to be a gross or criminal fallings short of the duty of care which might be suitable candidates for investigation and/or prosecution. These, thankfully, are few and far between in relation to the practice of healthcare in Australia and make up a small portion of adverse events and iatrogenic harm in the healthcare setting.

manslaughter by criminal negligence and paint a radically different picture of manslaughter by criminal negligence from that offered under the dominant view proposed by the orthodox paradigm. I synthesise how this occurred in each stage of the thesis in the pages that follow.

A *History*

In the historically oriented work of the first two chapters of this thesis, my central task was to address the perilously inadequate account of criminal law's actual use in Australian legal history. There existed no adequate historical account of medical manslaughter prosecutions in the Australian jurisdiction, nor of iatrogenic harm incidents more generally. Only four cases of prosecution had been reported in the scholarly literature from the past two centuries, and it was unclear how frequent prosecutions had actually been or how these incidents have been handled by the criminal law. We simply did not know how many prosecutions have taken place in Australian jurisdictions. Nor did we understand their facts, contexts or findings. Without a more developed account of actual manslaughter by criminal negligence prosecutions in the jurisdiction, debate about the place of criminal prosecution as a response to serious iatrogenic injury seemed misguided and premature.

My research addressed this issue by providing the first robust account of the prosecutorial experience of manslaughter by criminal negligence in the context of healthcare-related harm in Australia. From the four cases known to the literature, an additional thirty-three cases, newly discovered through my archival research, were uncovered. Not only did this greatly expand available knowledge of the use of criminal prosecution in Australia, these cases confirmed a relatively stable set of themes or characteristics of the prosecutorial experience, many of which are shared by the experience in other jurisdictions. This new historical account challenges claims or concerns of prosecutorial overreach in the Australian setting, speaking instead to criminal law's relatively low rates of use and its stable, judicious and consistent capacity to distinguish between culpable and non-culpable instances of harm.

Taken as a whole, this new history seriously destabilises any claim as to prosecutorial overreach, or the ability to draw conclusions from the experience of other jurisdictions or foreign medical contexts. In other jurisdictions, like the United Kingdom or New Zealand, the sense of a growing rate of prosecution, or of controversial single instances of it, had

been cited as a major justification for review and reform of the criminal law. Given that the actual use of manslaughter by criminal negligence in response to iatrogenic death in Australia has been rare, judicious and unaccompanied by significant criticism, the prosecutorial experience in Australia cannot account for the development and dominance of the prevailing view that criminal prosecution is unhelpful, unsuccessful and somehow inimical to advancing healthcare safety in Australia. This predominant view must, therefore, have its source elsewhere, and so I developed a second new historical account, this time in relation to the contemporary history of the discipline of healthcare quality and safety science and the discovery of iatrogenic harm in Australia during the 1990s, in order to better understand the emergence of opposition to criminal blaming.

That second new historical account aimed to consider how ‘law’, and specifically criminal law, had come to be framed by and within the quality and safety science as it became the agenda-setting ‘orthodox paradigm’¹³ for engaging with iatrogenic harm. No one has yet written a history of the emergence of iatrogenic harm in Australia in that period, and thus the accepted view of law’s interface with healthcare during that period is marked by the figure of the tort and indemnity crisis, with overzealous lawyers, overly generous damages awards and ungrateful patients depicted as the root cause of health system strain, failed insurance systems and reform of a failing civil liability regime. Constructed from official inquiry records, news and media reporting and academic and professional literatures of the time, what this original history of the discovery of iatrogenic harm and the role of law revealed was that, despite strong opposition to and differentiation from law and legal practices, the quality and safety sciences and even the figure of iatrogenic harm itself are replete with law. Instead of being separate and incompatible with the field of patient safety, the very discovery of iatrogenic harm is correctly understood as an unintended consequence of the working of the civil liability system and attempts by key medical stakeholders to avoid legal liability, rather than attempts to seek out and rectify healthcare-related harm. In the Australian context, the direct justification for the Professional Indemnity Review and its QAHCS research was tightly bound to the question

¹³ Waring et al, above n 11, 202 (‘The contemporary wave of interest in quality and safety has been predominantly framed by concepts and theories found within medical science, social psychology, ergonomics, human factors and resilience engineering. Rather than seeing errors as the result of individual mistake or failure, which tends towards blaming and encouraging secrecy, the prevailing view is that individual or group performance is conditioned by a variety of upstream factors located in the wider system of care, such as the quality of teamwork or communication, the allocation of tasks, workload scheduling, equipment and resource management, and broader service cultures.’).

of (escaping) legal liability, and the hugely embarrassing wave of data that exposed for the first time the serious threat iatrogenic harm represented to patients' life and limb – and thus the increased exposure to legal liability – arrived as a direct result of attempts to avoid that very thing.

The history shows how various medical stakeholders worked in successive waves to deflect blame to the legal system, first for the healthcare system's dysfunction and then for the failure of the indemnity system. However, the repeated re-apportionment of blame to the legal system (and the resulting law reform) was misguided, based as it was upon partial and faulty understandings of the legal terrain. Lost in the debates of the time was the unfortunate truth that the healthcare system was harming vast numbers of patients. And so, instead of treating the cause itself, management of its symptoms occupied attention and resources at the time. As I concluded, there was in fact no tort 'crisis' for medicine; the failures of the medical indemnity system had nothing to do with tort and everything to do with inadequate indemnity arrangements, mismanagement of medical defence organisations, and medical politics of the time. Despite its innocence, criminal law – like tort law before it – was positioned as a threat to the sustainability of the medical system and to effective action in aid of reducing iatrogenic harm. This period, I argued, contributed to the governing binary between criminal law and quality and safety science that continues to this day, profoundly shaping the reception of criminal law in the field.

Taken together, what these two new historical accounts demonstrate is that arguments for the rejection of manslaughter by criminal negligence that rely upon the historical use of prosecutions and the conduct of law in the field have not been sufficiently attentive or responsive to the history of the law's actual use in this field. In particular, the legal history demonstrates a relatively stable, if sporadic, use of the offence, with a notable absence of any widespread critique of particular cases or escalation in the frequency of its prosecution over time. In the same way, the history of the discovery of iatrogenic harm in Australia and the responses to it during the 1990s ignores law's productive nature for the discipline of the quality and safety sciences – indeed, for the very formation of the field – demonstrating how, and in a sense why, the reasoning for criminal law's expulsion from the field of iatrogenic harm was related less to the actual conduct of law itself and more to the politics of medicine of the time.

B Theory

Arguments against the use of manslaughter by criminal negligence do not only rely upon these now-faulty understandings of its use. Rather, many writers, scholars and practitioners believe that accountability is truly misplaced in relation to iatrogenic harm. Whilst this view is expressed in multiple, oftentimes competing, ways, the position and its conflict with criminal negligence is one I propose is fruitfully understood as driven by and structured according to the primacy granted to what anthropologist Annemarie Mol termed the logics of ‘choice’ or ‘care’.¹⁴ Developing that argument formed the heart of the next stage of my re-reading of the foundations of the debate about manslaughter by criminal negligence.

In the early part of that engagement, I demonstrated how the quality and safety literature on criminal responsibility for iatrogenic harm reads criminal law according to its own commitment to a ‘logic of choice’ and finds the criminal doctrine fundamentally wanting. The doctrine of manslaughter by criminal negligence, on the other hand, remains an expression of the logic of care, and insofar as it is an expression of that alternative orthodoxy, any engagement with iatrogenic harm that is motivated by a logic of choice risks failing to understand that doctrine’s operation and appreciate its legitimacy.¹⁵ I concluded that insofar as quality and safety science and the doctrine of manslaughter by criminal negligence continue to express a primacy of conflicting logics, one in the tradition of ‘care’ and the other in the tradition of ‘choice’, their conflict will continue to run deep.

The debate about criminal negligence and its role in the patient safety field has not yet been tackled at this deeper or more theoretical level. Instead, a focus on *progress* and what is *practical* has dominated the field, even in its more critical aspects.¹⁶ This instrumentalist approach is understandable. After all, this is a field and discipline tasked with implementing relatively urgent and decisive action in the face of widespread, unnecessary and preventable harm and death. However, as the engagement with the work of Mol on the logics of care and choice demonstrates, there is much to be transacted at the more fundamental level, and much to be gained by having done so. For one, reading the debate

¹⁴ In this, I have drawn on the work of Annemarie Mol. See Annemarie Mol, *The Logic of Care: Health and the Problem of Patient Choice* (Routledge, 2008).

¹⁵ How criminal negligence is an expression of the logic of care is a topic I developed more fully in Chapter Four where I examined the obligations demanded or expressed by the doctrine of criminal negligence, namely, that we must actively care, rather than simply not cause harm.

¹⁶ Such as the critical sociological work of Justin Waring.

from a common framework allows the various aspects of the literature to come into a more fulsome contact with each other. Modes of argument, understandings of evidence, the often-scientistic nature of the quality and safety sciences and the often-clumsy normative-focused criminal law seem too often to be speaking at cross-purposes. My novel application of the thought of Mol to the practices of healthcare quality and safety, however, provides a more integrated view of this field of debate and allows for a more satisfactory way of navigating and progressing a debate where so much of the literature seems to be at cross-purposes, never quite ‘touching’ one another in the process.

If it were simply that the two regimes of criminal law and the quality and safety sciences were ineluctably incompatible because of their adherence to fundamentally different – and incompatible – logics, attempts at rapprochement might well be futile. However, in the second part of my argument about the logic of care and choice I noted how an interesting and productive slippage had thus far been ignored by quality and safety literature. This was that there is a serious misalignment between the stream of quality and safety literature that concerns itself with criminal negligence, on the one hand, and with the same discipline’s stream of literature on substantive quality and safety improvement practices on the other. In short, whilst the literature on criminal negligence mobilises the logic of choice to reject the validity of criminal negligence, the discipline’s substantive understanding of quality and safety improvement rejects choice as a central or definitive feature of its praxis. I named this slippage a kind of ‘betrayal’ of the discipline’s fundamental commitments and practices. For, given that the most original and important contribution of the discipline is its substantive work on improvement, rather than on criminal responsibility, it seems reasonable that thinking about questions of compatibility between criminal negligence and the discipline should take the discipline’s substantive contribution on improvement as normative when assessing the differences and similarities between how the doctrine of medical manslaughter constructs the social world, human agency and action and how the quality and safety science work on improvement does so. On that basis, and in stark contrast to the ‘incompatibility thesis’, healthcare quality and safety improvement practices in fact share a marked affinity with fundamental aspects of the doctrine of manslaughter by criminal negligence: both regimes reject choice as the central or definitive marker of their ways of seeing and engaging with the world, and both seem to engage in practices that align with the logic of care. In light of this new theoretical work, it can no longer be uncritically asserted that the offence operates with an understanding of

human action and agency so alien to what constitutes good medicine or the insights of the quality and safety sciences.

C Doctrine

Having revealed a broad continuity between the quality and safety sciences and the doctrine of manslaughter by criminal negligence, this work paves the way for a quite radical shift in predominant discourses and associated practices about criminal negligence and iatrogenic harm. If it is true that criminal negligence has much in common with the discipline of quality and safety science, and that it has been highly productive for the field in the past, then there exists an opportunity to reconsider the place and operation of manslaughter by criminal negligence in this field into the future. Re-reading the doctrine's actual mobilisation in the Australian courtroom was the final foundational challenge I set for this thesis. This was in aid of demonstrating how, contrary to the broad rejection of the doctrine as incompatible with healthcare practice, the doctrine itself might 'fit' in a coherent manner with the practices of healthcare delivery and quality and safety improvement.

Scholars and those concerned with iatrogenic harm who have directly engaged with the doctrinal material of manslaughter by criminal negligence have universally criticised the offence's construction and operation as fundamentally flawed. Central to their arguments are two intimately related claims. The first is that the doctrinal material upon which the offence relies is too unclear, circular in construction, and lacking sufficient positive content to provide firm, workable guidance to practitioner action. Second, they argue that this unstable and unclear state of the doctrine inspires an imposition of standards dangerously alien to those of medical practice. Whilst these criticisms occupy a small part of the writing on the offence and its effects, they are profoundly important critiques, directed as they are at the primary doctrinal material itself, the 'building blocks' upon which the offence's availability, any legal proceedings and, by extension, the lived effect of prosecution (or non-prosecution) are built.

In line with my strategy of reviewing and then re-reading fundamental aspects of the field, I engaged in a close reading of the doctrine's mobilisation in the Australian courtroom in

recent Australian case law, namely the cases of *Pegios*, *Gow*, *Pearce* and *Patel*.¹⁷ Perhaps surprisingly, I quickly came to accept the claims of critics that the doctrine is devoid of content and circular in construction. A more negative description of a doctrine might be difficult to find, and yet, by carefully analysing these distinctive formal features of the doctrine of criminal negligence, I argued that rather than fatal flaws these ‘weaknesses’ of the doctrine are in fact one of its greatest strengths. In my reading of the operation of the doctrine in Australian case law, these features of the doctrine show how it operates with a simultaneously open and closed form, which facilitates the construction of a uniquely relative, rather than absolute, conception of duty, of harm, of care and of failure that when ‘activated’ through its application to a particular setting, purposively causes the law to radically reshape itself according to the local and specific context to which it is applied.

In the specific context of iatrogenic harm, this means the doctrine is able to take up into itself the values and standards of medical practice generated and expressed by medicine itself. By borrowing in this way, the doctrine reflects and thus reinforces what is particular to this field of practice, rather than imposing standards dangerously alien to good (medical) care. In short, rather than being in straightforward opposition, the criminal law borrows and dynamically transforms the ethical values, principles and practices of medicine and healthcare to construct the very substantive law that medicine and healthcare writers oftentimes regards as illegitimate, unhelpful and irrational.

III CONCLUSION

This thesis has argued that some of the main grounds upon which manslaughter by criminal negligence has been rejected by the contemporary quality and safety sciences do not sufficiently attend or respond to the actual practices of criminal law in this field; not to the history of its use, its fundamental animating logic or its mobilisation in the courtroom. As this thesis shows, when these foundational materials are more fully and critically engaged, they seriously destabilise the validity of claims that manslaughter by criminal negligence is unhelpful or unjust when applied to iatrogenic harm.

¹⁷ *R v Pegios* [2008] NSWDC 105 (2008) (*‘Pegios’*); *R v Gary Gow* [2006] NSWDC 78 (27 October 2006) (*‘Gow’*); *R v Pearce* [2000] Queensland Supreme Court Indictment No 96 of 2000 (15 November 2000) (*‘Pearce’*); *Patel v The Queen* (2012) 247 CLR 531 (*‘Patel’*).

As I have said elsewhere, given the influence that the doctrine of manslaughter by criminal negligence seems to exert upon the regulation and conduct of medical and healthcare practice, the objective seriousness of the offence and the urgency of eliminating avoidable iatrogenic harm, to fashion claims about manslaughter by criminal negligence and iatrogenic harm without sufficient attentiveness to foundational areas of knowledge is an imprudent, even reckless, move. To help circumvent this risk, this thesis has worked to fill in some of the most urgent and significant gaps in our knowledge by contributing new historical, theoretical and doctrinal accounts of manslaughter by criminal negligence as it applies to iatrogenic harm, largely in the Australian setting.

My reconstruction of the actual conduct of law in Australian legal history,¹⁸ and my analysis of its motivating logic and its mobilisation in the Australian courtroom, has two main advantages over existing work on criminal prosecution for iatrogenic harm. First, it presents the application of criminal law in a more extensive manner than has been the case to date. This is particularly true for accounts of the conduct of criminal law in the Australian setting, where we have very little scholarly work on the topic. Second, it corrects the record with regards to the conduct of law in the three domains of Australian legal history, theoretical understandings of the motivating ‘logic’ of criminal law and the quality and safety sciences and, finally, the doctrinal shape and possibilities of its use when applied in the courtroom. In all three areas, the research presented here reshapes accepted understandings of the doctrine and its use. For these two reasons, this thesis represents the most comprehensive interpretation of manslaughter by criminal negligence as it applies to iatrogenic harm in the Australian setting to date.

There are both theoretical and practical implications that flow from the work undertaken in this thesis. From a theoretical perspective, the ‘incompatibility thesis’ has separated the tradition of criminal law from consideration of iatrogenic harm and almost entirely from the field of patient safety. This thesis has shown that such a perspective is unaccountable to actual practices of law. Criminal law concepts and practices have been engaged with the field of patient safety, even playing a highly productive role in its formation. The quality

¹⁸ Whilst my intellectual formation owes a great debt to scholarship of law with a Foucauldian influence, the concept of a ‘conduct’ developed by Dorsett and McVeigh is helpful for thinking through the meeting of medical and legal jurisdictions, see Shaunnagh Dorsett and Shaun McVeigh, ‘Conduct of Laws: Native Title, Responsibility and Some Limits of Jurisdictional Thinking’(2012)’ 36 *Melbourne University Law Review* 470.

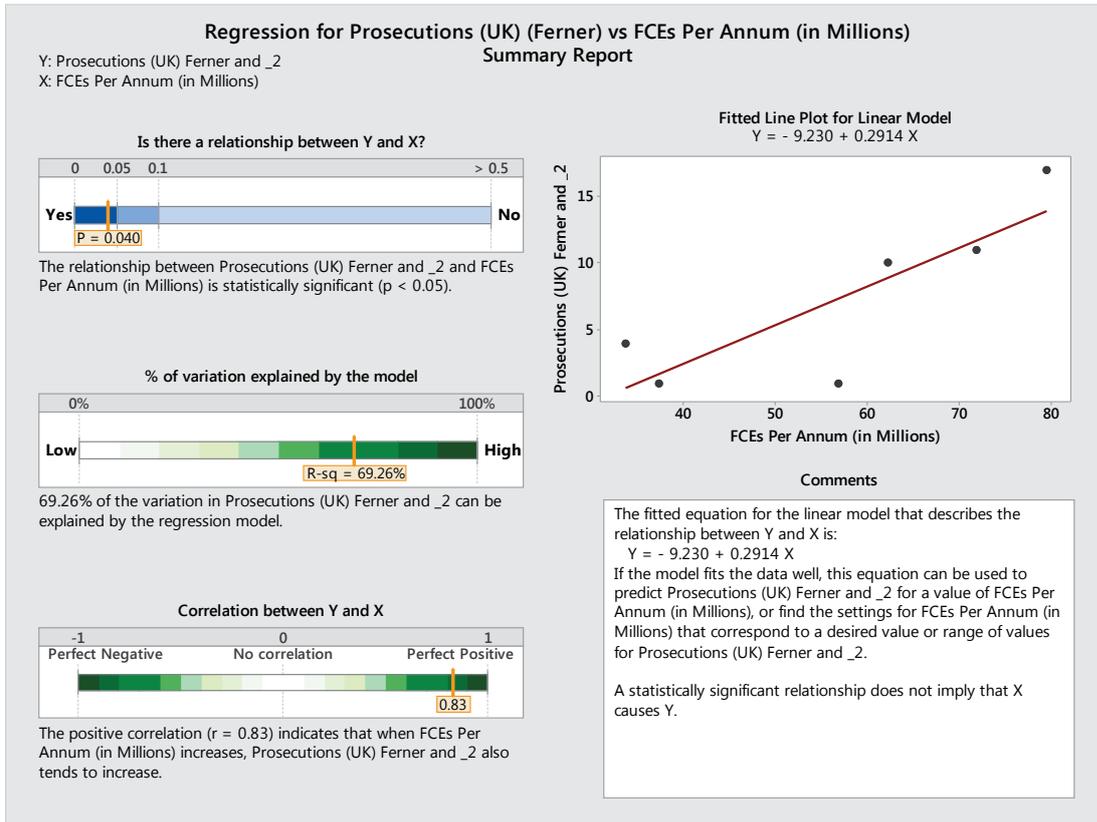
and safety sciences should no longer mobilise the concept of an incompatible criminal law as a form of common sense in this field. The practical implications of this research speak to a future of engagement with the criminal law on the basis of its actual use and practices, both where it might be unproductive or a stumbling block and where it might be productive for the project of reducing unnecessary harm and death in the healthcare system. It can no longer be sidelined in practical efforts at reducing harm and increasing patient safety.

In light of the new research presented here, it can be no longer said that the offence of manslaughter by criminal negligence is overused in Australia in response to iatrogenic harm. Nor can it be said that law, and specifically criminal law, has been wholly unhelpful for progressing the agenda of healthcare quality and safety science, or that manslaughter by criminal negligence operates with an understanding of human action and agency that is incompatible with the quality and safety project. Finally, it can no longer be said that manslaughter by criminal negligence represents an unjust imposition of liability by imposition of standards alien to those of medicine and healthcare.

The tensions between criminal negligence and the quality and safety sciences will likely not be easily resolved. Nor, perhaps, should they be; for the tensions inherent in any encounter between criminal negligence and the quality and safety sciences are a productive equivocation in the face of the enormous questions that iatrogenic harm and criminal law raise.

Even so, the ongoing task of retrieving the doctrine of manslaughter by criminal negligence and its particular vision of the human person, of human agency, of deep responsibility and even culpability in situations of compromised freedom and control will offer something of great value to the field: it will offer the tradition of law. Law brings with it a complex wisdom both normative and instrumental. It endorses particular values and recognises certain kinds of goods. Upon those foundations, law works to shape social relations, so that when faced with a person who has placed themselves in our mercy, when we attempt to heal serious illness or to alleviate suffering, we are called out of the seductive ease of the practices of neglect and instead into the difficult work of care.

APPENDIX A: REGRESSION ANALYSES



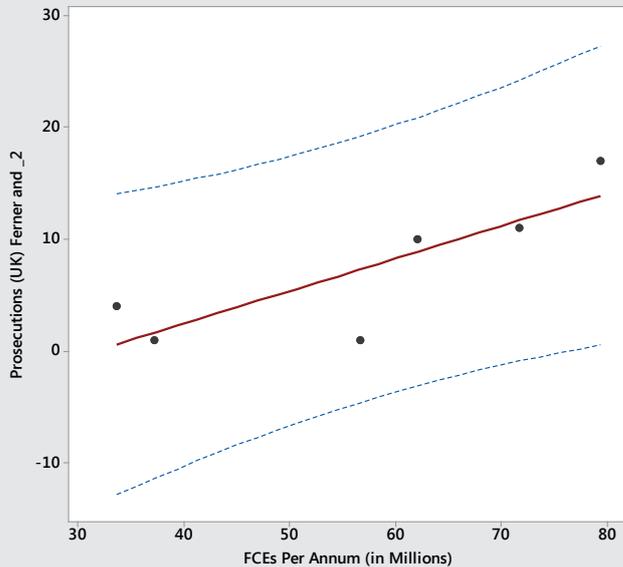
Regression for Prosecutions (UK, Ferner and McDowell) vs FCEs Per Annum (in Millions)

Y: Prosecutions (UK) Ferner and _2
X: FCEs Per Annum (in Millions)

Prediction Report

Prediction Plot

The red fitted line shows the predicted Y for any X value. The blue dashed lines show the 95% prediction interval.



X	Predicted Y	95% PI
33.694	0.58962	(-12.857, 14.036)
35.597	1.1442	(-12.072, 14.361)
37.500	1.6987	(-11.304, 14.701)
39.402	2.2533	(-10.553, 15.059)
41.305	2.8078	(-9.8188, 15.435)
43.208	3.3624	(-9.1037, 15.828)
45.111	3.9170	(-8.4078, 16.242)
47.014	4.4715	(-7.7318, 16.675)
48.916	5.0261	(-7.0764, 17.128)
50.819	5.5806	(-6.4420, 17.603)
52.722	6.1352	(-5.8291, 18.099)
54.625	6.6897	(-5.2379, 18.617)
56.528	7.2443	(-4.6688, 19.157)
58.430	7.7989	(-4.1217, 19.719)
60.333	8.3534	(-3.5967, 20.304)
62.236	8.9080	(-3.0935, 20.909)
64.139	9.4625	(-2.6119, 21.537)
66.041	10.017	(-2.1516, 22.186)
67.944	10.572	(-1.7119, 22.855)
69.847	11.126	(-1.2923, 23.545)
71.750	11.681	(-0.89229, 24.254)
73.653	12.235	(-0.51101, 24.982)
75.555	12.790	(-0.14776, 25.727)
77.458	13.344	(0.19826, 26.491)
79.361	13.899	(0.52785, 27.270)

Regression for Prosecutions (UK) (Ferner) vs Healthcare Expenditure (UK) (£ b)

Y: Prosecutions (UK) Ferner and _2
X: Healthcare Expenditure (UK) £ b

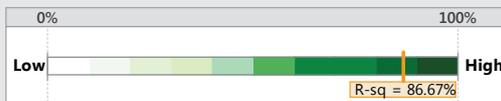
Summary Report

Is there a relationship between Y and X?



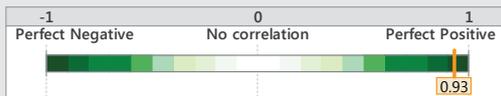
The relationship between Prosecutions (UK) Ferner and _2 and Healthcare Expenditure (UK) £ b is statistically significant ($p < 0.05$).

% of variation explained by the model



86.67% of the variation in Prosecutions (UK) Ferner and _2 can be explained by the regression model.

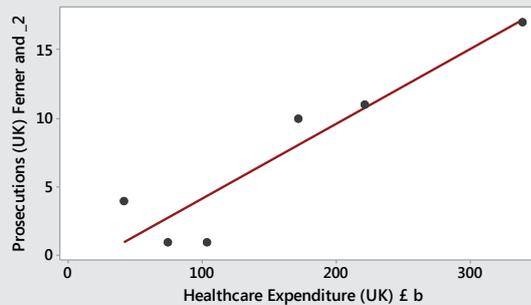
Correlation between Y and X



The positive correlation ($r = 0.93$) indicates that when Healthcare Expenditure (UK) £ b increases, Prosecutions (UK) Ferner and _2 also tends to increase.

Fitted Line Plot for Linear Model

$$Y = -1.287 + 0.05443 X$$



Comments

The fitted equation for the linear model that describes the relationship between Y and X is:

$$Y = -1.287 + 0.05443 X$$

If the model fits the data well, this equation can be used to predict Prosecutions (UK) Ferner and _2 for a value of Healthcare Expenditure (UK) £ b, or find the settings for Healthcare Expenditure (UK) £ b that correspond to a desired value or range of values for Prosecutions (UK) Ferner and _2.

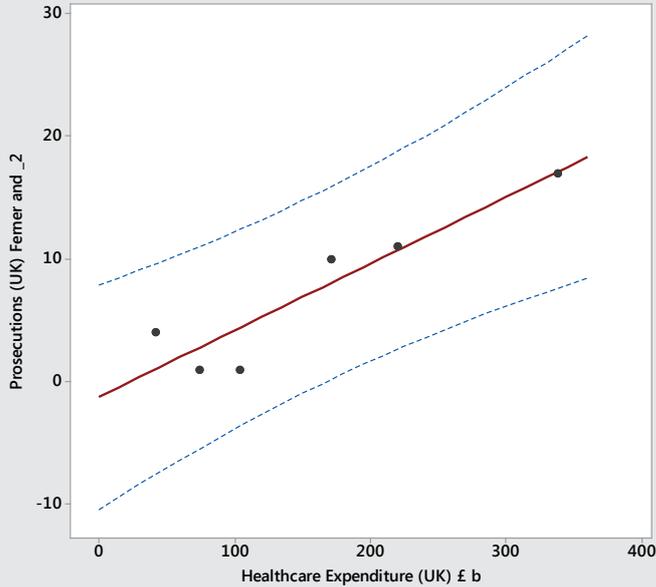
A statistically significant relationship does not imply that X causes Y.

Regression for Prosecutions (UK) Ferner and McDowell vs Healthcare Expenditure (UK) £ b Prediction Report

Y: Prosecutions (UK) Ferner and _2
X: Healthcare Expenditure (UK) £ b

Prediction Plot

The red fitted line shows the predicted Y for any X value. The blue dashed lines show the 95% prediction interval.

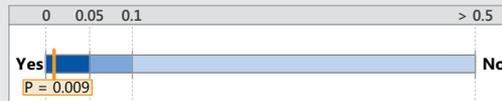


X	Predicted Y	95% PI
0	-1.2869	(-10.429, 7.8549)
15	-0.47039	(-9.3922, 8.4514)
30	0.34609	(-8.3727, 9.0649)
45	1.1626	(-7.3717, 9.6968)
60	1.9791	(-6.3901, 10.348)
75	2.7956	(-5.4294, 11.020)
90	3.6120	(-4.4905, 11.715)
105	4.4285	(-3.5744, 12.431)
120	5.2450	(-2.6820, 13.172)
135	6.0615	(-1.8141, 13.937)
150	6.8780	(-0.97101, 14.727)
165	7.6945	(-0.15307, 15.542)
180	8.5110	(0.63972, 16.382)
195	9.3275	(1.4076, 17.247)
210	10.144	(2.1510, 18.137)
225	10.960	(2.8706, 19.050)
240	11.777	(3.5673, 19.987)
255	12.593	(4.2419, 20.945)
270	13.410	(4.8957, 21.924)
285	14.226	(5.5298, 22.923)
300	15.043	(6.1454, 23.940)
315	15.859	(6.7438, 24.975)
330	16.676	(7.3260, 26.026)
345	17.492	(7.8934, 27.091)
360	18.309	(8.4471, 28.171)

Regression for Prosecutions (UK) (Ferner) vs Medical and Dental Staff in NHS Summary Report

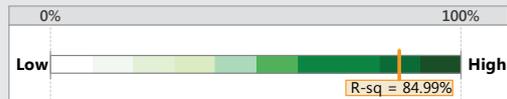
Y: Prosecutions (UK) Ferner and _2
X: Medical and Dental Staff in NHS

Is there a relationship between Y and X?



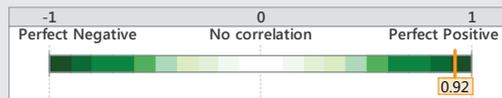
The relationship between Prosecutions (UK) Ferner and _2 and Medical and Dental Staff in NHS is statistically significant ($p < 0.05$).

% of variation explained by the model



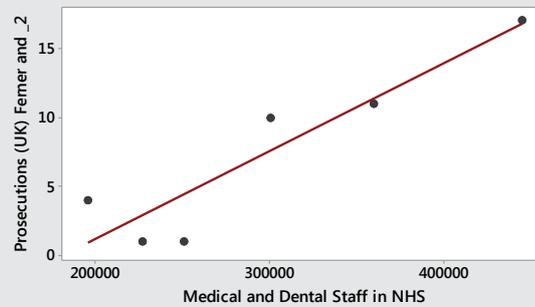
84.99% of the variation in Prosecutions (UK) Ferner and _2 can be explained by the regression model.

Correlation between Y and X



The positive correlation ($r = 0.92$) indicates that when Medical and Dental Staff in NHS increases, Prosecutions (UK) Ferner and _2 also tends to increase.

Fitted Line Plot for Linear Model $Y = -11.61 + 0.000064 X$



Comments

The fitted equation for the linear model that describes the relationship between Y and X is:
 $Y = -11.61 + 0.000064 X$
If the model fits the data well, this equation can be used to predict Prosecutions (UK) Ferner and _2 for a value of Medical and Dental Staff in NHS, or find the settings for Medical and Dental Staff in NHS that correspond to a desired value or range of values for Prosecutions (UK) Ferner and _2.

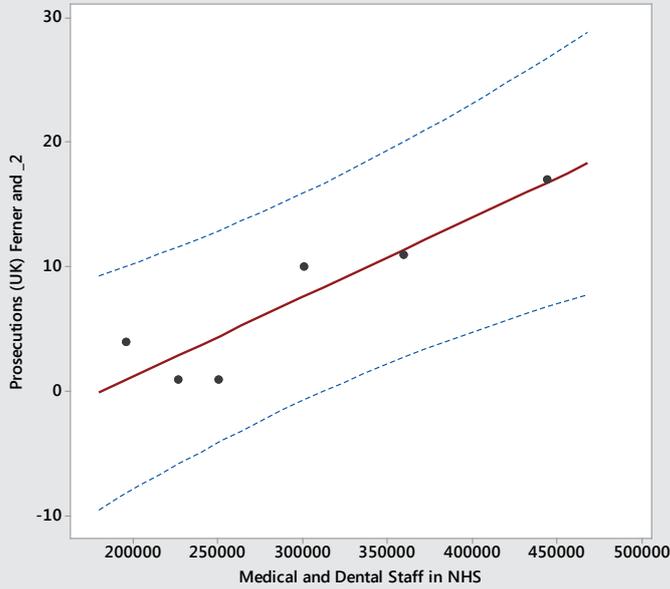
A statistically significant relationship does not imply that X causes Y.

Regression for Prosecutions (UK) (Ferner) vs Medical and Dental Staff in NHS
Prediction Report

Y: Prosecutions (UK) Ferner and _2
 X: Medical and Dental Staff in NHS

Prediction Plot

The red fitted line shows the predicted Y for any X value. The blue dashed lines show the 95% prediction interval.



X	Predicted Y	95% PI
180000	-0.10864	(-9.4981, 9.2808)
192000	0.65803	(-8.5331, 9.8492)
204000	1.4247	(-7.5860, 10.435)
216000	2.1914	(-6.6579, 11.041)
228000	2.9580	(-5.7497, 11.666)
240000	3.7247	(-4.8626, 12.312)
252000	4.4914	(-3.9973, 12.980)
264000	5.2580	(-3.1547, 13.671)
276000	6.0247	(-2.3354, 14.385)
288000	6.7914	(-1.5398, 15.123)
300000	7.5581	(-0.76813, 15.884)
312000	8.3247	(-0.02050, 16.670)
324000	9.0914	(0.70329, 17.479)
336000	9.8581	(1.4036, 18.313)
348000	10.625	(2.0810, 19.169)
360000	11.391	(2.7361, 20.047)
372000	12.158	(3.3699, 20.946)
384000	12.925	(3.9832, 21.866)
396000	13.691	(4.5771, 22.806)
408000	14.458	(5.1528, 23.763)
420000	15.225	(5.7112, 24.738)
432000	15.991	(6.2535, 25.729)
444000	16.758	(6.7808, 26.735)
456000	17.525	(7.2941, 27.755)
468000	18.291	(7.7944, 28.788)

To obtain additional predicted values, right-click the graph and use the crosshairs tool.

BIBLIOGRAPHY

A *Articles, Books & Reports*

'A Charge of Manslaughter. Melbourne, August 27.' *The Advertiser* (Adelaide, SA), 28 August 1897 7

'A New Trial Ordered Sydney, Saturday.' *Barrier Miner* (Broken Hill, NSW), 2 June 1928 2

AAP, 'Warnings of Dead Babies Slammed' *Sunday Tasmanian* (Hobart, Tas.), 4 August 2002 6

'A Suspicious Death. Melbourne, Monday Night.' *The Horsham Times* (Horsham, Victoria), 24 August 1897 3

'A Woman's Death.' *Scone Advocate* (Scone, NSW), 31 August 1915 4

"'Accident Every Surgeon Dreads" Cost Girl's Life' *Mirror* (Perth, WA), 13 July 1946 18

'Advertising: Cancer, Cancer, Cancer' *The Sydney Morning Herald* (Sydney, NSW), 27 March 1899 2

Agamben, Giorgio, *What Is an Apparatus?: And Other Essays* (Stanford University Press, 2009)

Alftberg, Asa and Kristofer Hansson, 'Introduction: Self-Care Translated into Practice' (2012) 4(3) *Culture Unbound: Journal of Current Cultural Research* 415

'Alleged Malpractice Charge Against Two City Doctors. (by Telegraph.) Sydney, Monday.' *Singleton Argus* (Singleton, NSW), 13 December 1921 2

'Alleged, Manslaughter. Doctor and Chemist Acquitted. Melbourne, Wednesday.' *Barrier Miner* (Broken Hill, NSW), 6 October 1915 2

Allen, Davina et al, 'Towards a Sociology of Healthcare Safety and Quality' (2016) 38(2) *Sociology of Health & Illness* 181

Allnutt, MF, 'Human Factors in Accidents' (1987) 59(7) *British Journal of Anaesthesia* 856

'AMA's Taxpayer-Funded No-Fault Plan 'ludicrous'' *The Cairns Post* (Cairns, Qld.), 29 July 2002 9

Amirthalingam, Kumaralingam, 'Caldwell Recklessness Is Dead, Long Live Mens Rea's Fecklessness' (2004) 67(3) *The Modern Law Review* 491

Anderson, Elizabeth, *Value in Ethics and Economics* (Harvard University Press, 1995)

Anleu, Sharyn L Roach and Wilfrid R Prest, 'Litigation: Historical and Contemporary Dimensions' in Wilfrid R Prest and Sharyn L Roach Anleu (eds), *Litigation: Past and Present* (UNSW Press, 2004) 1

Annas, George J, 'The Patient's Right to Safety-Improving the Quality of Care through Litigation against Hospitals' (2006) 354(19) *New England Journal of Medicine* 2063

'Another Health Burden for Taxpayers' *Advertiser, The (Adelaide, Australia)*, 1 May 2002 17

Anson, Fiona, 'Avoid Being Sued' *Daily Telegraph/Sunday Telegraph/Sunday Style Magazine (Sydney, Australia)*, 6 August 2002 34

Anson, Fiona, 'In a Limbo Lock' *Daily Telegraph/Sunday Telegraph/Sunday Style Magazine (Sydney, Australia)*, 12 November 2002 32

Archer, John, 'Doctors Cry Wolf Much Too Often - John Archer Finds That Looking Back Can Prove an Enlightening Experience When It Comes to the Medical Profession' *The Canberra Times* (Canberra, ACT.), 15 August 1994 13

Armstrong, Bruce Konrad, *The Final Report of the Taskforce on Quality in Australian Health Care* (Australian Health Ministers' Advisory Council, 1996)

Ashworth, Andrew, *Positive Obligations in Criminal Law* (A&C Black, 2014)

Aubusson, Kate, 'Fake Doctor Shyam Acharya Worked at Royal North Shore, Mona Vale Hospitals' *The Sydney Morning Herald* (Sydney, NSW), 23 March 2017 <<http://www.smh.com.au/national/health/fake-doctor-shyam-acharya-worked-at-royal-north-shore-mona-vale-hospitals-20170323-gv4ty5.html>>

Australian Associated Press Canberra Bureau, 'lives at Risk' Over Premiums' *Cairns Post, The (Australia)*, 3 August 2002 10

Australian Institute of Health and Welfare, 'Admitted Patient Care 2013–14, Australian Hospital Statistics' (No 60 Cat. HSE 156, Australian Institute of Health and Welfare, 2015) <<http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129550480>>

Australian Law Reform Commission, 'Managing Justice: A Review of the Federal Civil Justice System' (ALRC 89, Australian Law Reform Commission, 2000) <<http://www.alrc.gov.au/sites/default/files/pdfs/publications/ALRC89.pdf>>

Baker, R and B Hurwitz, 'Intentionally Harmful Violations and Patient Safety: The Example of Harold Shipman' in *Health Care Errors and Patient Safety* (Wiley-Blackwell, 2009) 33

Balen, Paul, 'Gross Negligence Manslaughter: Wayne Jowett (Deceased)' (2004) 10(1) *Clinical Risk* 25

Besley, Tim, 'Even Turtles Stick Their Necks out' *The Australian* (Sydney, NSW), 9 September 2002 11

Besley, Tim, 'Fear of Risk Is as Much a Risk as Risk Itself' *The Age* (Melbourne, Vic.), 24 December 2002 11

Biehl, João, 'Care and Disregard' in Didier Fassin (ed), *A Companion to Moral Anthropology* (John Wiley & Sons, 2014)

Bilimoria, Karl Y et al, 'Association Between State Medical Malpractice Environment and Surgical Quality and Cost in the United States': (2016) 263(6) *Annals of Surgery* 1126

Binder, Guyora, 'Making the Best of Felony Murder' (2011) 91 *Boston University Law Review* 403

Binder, Guyora, *Felony Murder* (Stanford University Press, Kindle Book, 2012)

Black, Bernard S, Wagner and Zenon Zabinski, 'The Association between Medical Malpractice Risk and Healthcare Quality: Evidence from Texas' [2011] (No. 11-20) *Northwestern Law and Economics Research Paper*

Black, Julia, 'Critical Reflections on Regulation' (2002) 27 *Australian Journal of Legal Philosophy* 1

Black, Julia, 'Constructing and Contesting Legitimacy and Accountability in Polycentric Regulatory Regimes' (2008) 2(2) *Regulation & Governance* 137

Boehm, Geoff, 'Debunking Medical Malpractice Myths: Unraveling the False Premises behind Tort Reform' (2005) 5 *Yale Journal of Health Policy, Law, and Ethics* 357

'Bogus Doctor Kills Woman London, Thursday.' *The Daily News* (Perth, WA), 12 July 1940 3

Boreham, Gareth, Joanne Painter and Steve Dow, 'Hospital Mistakes Kill 14,000 a Year - Report' *Age, The/The Sunday Age* (Melbourne, Australia), 2 June 1995 1

Boreham, Gareth, 'Doctors' Compo Fee Threat' *The Age*, 13 January 1996 5

Bovbjerg, Randall R and Laurence R Tancredi, 'Liability Reform Should Make Patients safer: "Avoidable Classes of Events" Are a Key Improvement' (2005) 33(3) *The Journal of Law, Medicine & Ethics*

Boysen, Philip G, 'Just Culture: A Foundation for Balanced Accountability and Patient Safety' (2013) 13(3) *The Ochsner Journal* 400

Bradfield, Owen, 'Serving Two Masters? Recent Legal Developments Regarding the Professional Obligations of Medical Administrators in Australia' (2011) 18(3) *Journal of Law and Medicine* 545

Braithwaite, J, WB Runciman and AF Merry, 'Towards Safer, Better Healthcare: Harnessing the Natural Properties of Complex Sociotechnical Systems' (2009) 18(1) *Quality and Safety in Health Care* 37

Braithwaite, Jeffrey, 'Hunter-Gatherer Human Nature and Health System Safety: An Evolutionary Cleft Stick?' (2005) 17(6) *International Journal for Quality in Health Care* 541

Braithwaite, Jeffrey, Robert L Wears and Erik Hollnagel, *Resilient Health Care* (Ashgate Publishing Group, 2013)

Braithwaite, Jeffrey, Robert L Wears and Erik Hollnagel, 'Resilient Health Care: Turning Patient Safety on Its Head' (2015) 27(5) *International Journal for Quality in Health Care* 418

Brazier, Margaret and Neil Allen, 'Criminalizing Medical Malpractice' in Charles A Erin and Suzanne Ost (eds), *The Criminal Justice System and Health Care* (Oxford University Press, 2007)

Brazier, Margaret, *Medicine, Patients and the Law: Revised and Updated Fifth Edition* (Penguin, 2011)

Brazier, Margaret and Suzanne Ost, *Bioethics, Medicine and the Criminal Law: Medicine and Bioethics in the Theatre of the Criminal Process* (Cambridge University Press, 2013)

Brennan, Gerard, 'Key Issues in Judicial Administration' in *AJJA Annual Conference, Wellington, NZ* (1996)

Brennan, Troyen A et al, 'Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study I' (1991) 324(6) *New England Journal of Medicine* 370

Brennan, Troyen A, 'The Institute of Medicine Report on Medical Errors—could It Do Harm?' (2000) 342(15) *New England Journal of Medicine* 1123

Brower Latz, Andrew, 'Ideology Critique via Jurisprudence: Against Rose's Critique of Roman Law in Kant' (2016) 133(1) *Thesis Eleven* 80

Brown, Bina, 'Ensure Thy Will Be Done on Earth' *The Australian*, 31 August 2002 33

Burdon, Dr Jonathan, 'Medical Indemnity Insurance in Australia' in Roy G Beran (ed), *Legal and Forensic Medicine* (Springer Berlin Heidelberg, 2013) 629

Callahan, Rebekah and Stanley Yeo, 'Negligence in Medical Manslaughter Cases' (1999) Volume 6 *Journal of Law and Medicine*

Calnan, Michael et al, 'Trust in the Context of Patient Safety Problems' (2006) 20(5) *Journal of Health Organization and Management* 397

Cane, Peter, *Responsibility in Law and Morality* (Hart Publishing, 2002)

Cane, Peter, 'Reforming Tort Law in Australia: A Personal Perspective' (2003) 27 *Melbourne University Law Review* 649

Carter, David J, 'A Legal Theology of Negligence: Negligence & Original Sin' (on file with the author, 2015)

Carter, David J, 'Correcting the Record: Australian Prosecutions for Manslaughter in the Medical Context' (2015) 22(3) *Journal of Law and Medicine* 588

Carter, David J, 'HIV Transmission, Public Health Detention and the Recalcitrant Subject of Discipline: Kuoth, Lam v R and the Co-Constitution of Public Health and Criminal Law' (2016) 25(2) *Griffith Law Review* 172

Carter, David J, James Brown and Adel Rahmani, 'Reading the High Court at a Distance: Topic Modelling the Legal Subject Matter and Judicial Activity of the High Court of Australia, 1903-2015' (2016) 39 *University of New South Wales Law Journal* 1300

'Case of Nurse Pears. Seven Years' Imprisonment. "An Abominable Trade." Perth, May 5.' *Kalgoorlie Miner* (Kalgoorlie, WA), 6 May 1908 5

Cashman, Peter, 'Tort Reform and the Medical Indemnity "Crisis"' (2002) 25 *University of New South Wales Law Journal* 888

Catino, Maurizio, 'Blame Culture and Defensive Medicine' (2009) 11(4) *Cognition, Technology & Work* 245

'Central Criminal Court. (before Mr. Justice Simpson and a Jury of 12.) the Solicitor-General (Mr. Hugh Pollock) Prosecuted for the Crown. Alleged Manslaughter. Dr. F. W. Marshall's Trial. Jury Disagree.' *The Sydney Morning Herald* (Sydney, NSW), 30 September 1904 7

Cetina, Karin Knorr, Theodore R Schatzki and Eike von Savigny, *The Practice Turn in Contemporary Theory* (Routledge, 2005)

Chandler, David, 'How the World Learned to Stop Worrying and Love Failure: Big Data, Resilience and Emergent Causality' (2016) 44(3) *Millennium-Journal of International Studies* 391

'Charge Against Doctor' *The Argus* (Melbourne, Vic.), 28 August 1941 5

'Charge of Man-Slaughter. Dr. F. Marshall on Trial. the Death of Amelia Lynch.' *Evening News* (Sydney, NSW), 20 March 1905 4

'Charge of Manslaughter. Making up a Prescription.' *Northern Star* (Lismore, NSW), 7 October 1915 4

'Charge of Murder.' *Clarence and Richmond Examiner* (Grafton, NSW), 9 December 1905 4

'Charged with Manslaughter. Committed for Trial. Melbourne, Thursday.' *Launceston Examiner* (Launceston, Tas.), 23 April 1897 6

Chessell, James, 'Greed' *The Age* (Melbourne, Vic.), 11 December 2002 16

'Chronicle of Events, 1871. January.' *The Sydney Morning Herald* (Sydney, NSW), 30 December 1871 5

Clancy, Carolyn, 'Improving Patient Safety-Five Years After the Iom Report' (2004) 351(20) *The New England Journal of Medicine* 2041

Coakley, Sarah, *The New Asceticism: Sexuality, Gender and the Quest for God* (Bloomsbury Publishing, 2015)

'Colonial. Medical Manslaughter. Melbourne, Friday.' *The Mildura Cultivator* (Mildura, Vic), 24 April 1897 5

Commission for Healthcare Audit and Inspection (the 'Healthcare Commission'), 'Investigation into Mid Staffordshire NHS Foundation Trust' (Investigation Report, Commission for Healthcare Audit and Inspection, March 2009) <www.healthcarecommission.org.uk>

Commonwealth of Australia, The Treasury, 'Review of Competitive Neutrality in the Medical Indemnity Insurance Industry' (March 2005) <https://archive.treasury.gov.au/documents/965/HTML/docshell.asp?URL=03_state.asp>

Commonwealth, Parliamentary Debates, House of Representatives, 1 June 1995, 911-915 (Hon. Dr Carmen Lawrence MP)

Cook, TM et al, 'Litigation Related to Anaesthesia: An Analysis of Claims against the NHS in England 1995–2007' (2009) 64(7) *Anaesthesia* 706

Corbett, Angus, '(Self)Regulation of Law: A Synergistic Model of Tort Law and Regulation, The' (2002) 25 *University of New South Wales Law Journal* 616

Corbett, Angus, 'Regulating Compensation for Injuries Associated with Medical Error' (2006) 28(2) *Sydney Law Review* 259

Corbett, Angus, Jo Travaglia and Jeffrey Braithwaite, 'The Role of Individual Diligence in Improving Safety' (2011) 25(3) *Journal of Health Organization and Management* 247

Corbett, Angus, 'Australia: An Integrated Scheme for Regulating Liability for Medical Malpractice and Indemnity Insurance Markets That Does Not Include the Goal of Improving the Safety and Quality of Health Care' (2011) 4 *Drexel Law Review* 199

'Coroner's Inquest.' *Launceston Advertiser* (Launceston, Tas.), 18 July 1839 3

Couenhoven, Jesse, *Stricken by Sin, Cured by Christ: Agency, Necessity, and Culpability in Augustinian Theology* (Oxford University Press, 2013)

'Council Blamed for Diving Mishap - \$5m Damages Bill a Sign of the Times' *The Gold Coast Bulletin* (Southport, Qld), 21 December 2002 6

Cover, Robert M, 'Violence and the Word' (1986) 95(8) *The Yale Law Journal* 1601

Crabb, Annabel, 'Council Tackles Hospital Deaths - Errors Include Surgeons Bungling Operations' *The Adelaide Advertiser* (Adelaide, SA), 22 January 2000 2

'Crisis Catches Government on the Hop' *The Courier Mail* (Brisbane, Qld.), 1 May 2002 12

Crofts, Penny, *Wickedness and Crime: Laws of Homicide and Malice* (Routledge, 2013)

Davidson, Jerome, Susan Dudley and Ann Palmer, 'Medical Indemnity (Competitive Advantage Payment) Bill 2005 Medical Indemnity Legislation Amendment (Competitive Neutrality) Bill' (Bills Digest No. 15–16, 2004–05, Parliamentary Library, Parliament of Australia, 2005)

Davies, Hon Geoffrey, 'Queensland Public Hospitals Commission of Inquiry ("The Davies Commission")' (30 November 2005)
<<http://www.parliament.qld.gov.au/documents/tableOffice/TabledPapers/2005/5105T5305.pdf>>

Davis, PB et al, 'Adverse Events in New Zealand Public Hospitals: Principal Findings from a National Survey' (Number 3, Ministry of Health, December 2001)
<<https://www.health.govt.nz/system/files/documents/publications/adverseevents.pdf>>

Davis, Peter et al, 'Adverse Events in New Zealand Public Hospitals I: Occurrence and Impact' (2002) 115(1167) *New Zealand Medical Journal*
<<http://www.nzma.org.nz/journal/115-1167/271/>>

Davis, Peter et al, 'Adverse Events in New Zealand Public Hospitals II: Preventability and Clinical Context' (2003) 116(1183) *New Zealand Medical Journal* U624

Davis, Ronald M and Barry Pless, 'BMJ Bans "Accidents"' (2001) 322(7298) *BMJ* 1320

Dean, Jodi, 'Politics without Politics' (2009) 15(3) *Parallax* 20

'Death by Poisoning', *The Sydney Morning Herald* (NSW), 13 July 1861 5

'Death of a Girl. Dr. Cassidy Discharged.' *The Argus* (Melbourne, Vic.), 10 February 1922 12

'Death of Isabel Dargaville [Sic] Sydney Doctor Remanded on Manslaughter Charge Sydney, Friday.' *Barrier Miner* (Broken Hill, NSW), 6 January 1922 1

'Death of Nurse Pears.' *The Daily News* (Perth, WA), 25 September 1909 13

Dekker, Sidney, *Drift into Failure: From Hunting Broken Components to Understanding Complex Systems* (Ashgate Publishing Company, 2011)

Dekker, Sidney, 'The Criminalization of Human Error in Aviation and Healthcare: A Review' (2011) 49(2) *Safety Science* 121

Dekker, Sidney, *Patient Safety: A Human Factors Approach* (CRC Press, 1st ed, 2011)

Dekker, Sidney, *Just Culture: Balancing Safety and Accountability* (Ashgate, 2nd Edition, Kindle Version, 2012)

Dekker, Sidney, *Second Victim: Error, Guilt, Trauma, and Resilience* (CRC Press, 2013)

Dekker, Sidney WA, 'Criminalization of Medical Error: Who Draws the Line?' (2007) 77(10) *ANZ Journal of Surgery* 831

Dekker, Sidney WA, 'Eve and the Serpent: A Rational Choice to Err' (2007) 46(4) *Journal of Religion & Health* 571

Dekker, Sidney WA, 'Just Culture: Who Gets to Draw the Line?' (2008) 11(3) *Cognition, Technology & Work* 177

Dekker, Sidney WA and Thomas B Hugh, 'A Just Culture after Mid Staffordshire' (2014) 23(5) *BMJ Quality & Safety* 356

Delbanco, Tom and Sigall K Bell, 'Guilty, Afraid, and Alone — Struggling with Medical Error' (2007) 357(17) *New England Journal of Medicine* 1682

Denham, Charles R, 'TRUST: The 5 Rights of the Second Victim' (2007) 3(2) *Journal of Patient Safety* 107

Devine, Miranda, 'Lawyers Delivered This Mess' *The Sydney Morning Herald* (Sydney, NSW), 2 May 2002 13

Dixon-Woods, Mary and Peter J Pronovost, 'Patient Safety and the Problem of Many Hands' [2016] *BMJ Quality & Safety* 485

Dobinson, Ian, 'Medical Manslaughter' (2009) 28 *University of Queensland Law Journal* 101

Dobinson, Ian, 'Doctors Who Kill or Harm Their Patients: The Australian Experience' in Danielle Griffiths and Andrew Sanders (eds), *Bioethics, Medicine and the Criminal Law: Medicine, Crime and Society* (Cambridge University Press, 2013)

'Doctor Acquitted of Manslaughter.' *The North Western Advocate and the Emu Bay Times* (Tas.), 7 October 1915 3

'Doctor Acquitted. Sequel to Young Woman's Death. Sydney, March 23.' *The Register* (Adelaide, SA), 24 March 1922 9

'Doctor and Chemist on Trial Both Get Off. Melbourne, Oct. 5.' *Kalgoorlie Western Argus* (Kalgoorlie, WA), 12 October 1915 8

'Doctor Asks Court to Drop Death Charge' *The Cairns Post* (Cairns, Qld.), 15 February 2003 27

'Doctor given Suspended Sentence over Death of Patient' *AAP News*, 27 October 2006

'Doctor Manslaughter Charges Rise' *BBC*, 1 June 2006
<<http://news.bbc.co.uk/2/hi/health/5033198.stm>>

'Doctor of Medicine Remanded. Charge of Forgery. Sydney. Tuesday.' *The Muswellbrook Chronicle* (Muswellbrook, NSW), 25 January 1938 2

'Doctor on Manslaughter Case.' *Townsville Daily Bulletin* (Qld.), 30 August 1941 8

'Doctor on Trial Error Alleged in Injection Used at Operation' *The Mercury* (Hobart, Tas.), 27 August 1941 6

“‘Doctor’ world Impostor?’ *The Courier-Mail* (Brisbane, Qld.), 26 May 1950 1

'Doctor's Death After Struggle in Surgery. Coroner's Finding of Manslaughter. Melbourne, Friday.' *The Sydney Morning Herald* (Sydney, NSW), 14 December 1935 18

'Doctor's Trial. Unexpected Ending. Crown Enters Nolle Prosequi.' *The West Australian* (Perth, WA), 30 August 1941 6

Donaldson, Liam J, 'Shadow of the Law in Cases of Avoidable Harm' (2016) 355 *BMJ*
<<http://dx.doi.org/10.1136%2Fbmj.i6268>>

Dorsett, Shaunnagh and Shaun McVeigh, 'Conduct of Laws: Native Title, Responsibility and Some Limits of Jurisdictional Thinking'(2012)' 36 *Melbourne University Law Review* 470

Douglas, Heather et al, *Australian Feminist Judgments: Righting and Rewriting Law* (Bloomsbury Publishing, 2014)

Dow, Steve, 'Taskforce to Tackle Hospital Deaths' *The Age* (Melbourne, Vic.), 3 June 1995 3

Dow, Steve, 'Bedside Manners' *The Sydney Morning Herald* (Sydney, NSW), 23 October 2003 1

'Down Scalpels - Doctors Warn Lives Could Be in Danger Surgeons Cancel Work as Crisis Deepens - Medical Indemnity Crisis' *Illawarra Mercury* (Wollongong, Australia), 1 May 2002 1

'Dr. Marshall Acquitted Dying Depositions Rejected. Sydney, March 27.' *The Advertiser* (Adelaide, SA), 28 March 1906 8

'Dr. Marshall Again. [by Telegraph.] Sydney, Wednesday.' *Barrier Miner* (Broken Hill, NSW), 2 June 1904 4

Dunbar, James, Prasuna Reddy and Stephen May, *Deadly Healthcare* (Australian Academic Press, 2011)

Duncanson, E et al, 'Medical Homicide and Extreme Negligence' (2009) 30(1) *American Journal of Forensic Medicine and Pathology* 18

Dyer, Clare, 'Junior Doctor Charged with Manslaughter after Medical Error' (2002) 325(7365) *BMJ* 616

Dyer, Simon, 'Gross Negligence Manslaughter: The Facts of R v Mulhem' (2004) 10(1) *Clinical Risk* 28

'Expert Forger. Sent to Gaol for Life. Johannesburg, October 19.' *The Advertiser* (Adelaide, SA), 20 October 1916 9

Fairall, Paul, *The Laws of Australia: Homicide* (Thomson Reuters, Online, 2012)

Farmer, Steven A, Bernard Black and Robert O Bonow, 'Tension Between Quality Measurement, Public Quality Reporting, and Pay for Performance' (2013) 309(4) *JAMA* 349

'Fatal Blow' *Sydney Morning Herald*, 4 May 2002
<<http://www.smh.com.au/articles/2002/05/03/1019441434022.html>>

Fauci, A, *Harrison's Principles of Internal Medicine* (McGraw-Hill, 13th ed, 1994)

Faunce, Thomas, 'Disclosure of Material Risk as Systems-Error Tragedy: Wallace v Kam (2013) 87 ALJR 648;[2013] HCA 19.' (2013) 21(1) *Journal of Law and Medicine* 53

Faure, Michael, *Tort Law and Economics* (Edward Elgar Publishing, 2009)

Ferner, RE, 'Medication Errors That Have Led to Manslaughter Charges' (2000) 321(7270) *BMJ* 1212

Ferner, RE, SE McDowell and AK Cotter, 'Fatal Medication Errors and Adverse Drug Reactions - Coroners' Inquests and Other Sources' in *Pharmacovigilance* (John Wiley & Sons, Ltd, 2nd ed, 2007) 635

Ferner, RE, 'The Epidemiology of Medication Errors: The Methodological Difficulties' (2009) 67(6) *British Journal of Clinical Pharmacology* 614

Ferner, Robin E and Sarah E McDowell, 'Doctors and Manslaughter—response from the Crown Prosecution Service Authors' Reply' (2006) 99(11) *Journal Of The Royal Society Of Medicine* 544

Ferner, Robin E and Sarah E McDowell, 'Doctors Charged with Manslaughter in the Course of Medical Practice, 1795-2005: A Literature Review' (2006) 99(6) *Journal Of The Royal Society Of Medicine* 309

Filkins, James A, "'With No Evil Intent": The Criminal Prosecution of Physicians for Medical Negligence' (2001) 22(4) *Journal of Legal Medicine* 467

Fisher OP, Anthony, 'Blame Is Not a Game You Win - The Moral Maze' *The Sun Herald* (Syd), 14 September 2003 64

Foucault, Michel, *Discipline and Punish: The Birth of the Prison* (Vintage Books, 1977)

Frakes, Michael, 'The Impact of Medical Liability Standards on Regional Variations in Physician Behavior: Evidence from the Adoption of National-Standard Rules' (2013) 103(1) *The American Economic Review* 257

Frakes, Michael and Anupam Jena, 'Does Medical Malpractice Law Improve Health Care Quality?' [2016] *Journal of Public Economics* <DOI: 10.1016/j.jpubeco.2016.09.002>

Frakes, Michael D, 'The Surprising Relevance of Medical Malpractice Law' [2015] *The University of Chicago Law Review* 317

Francis QC, Robert, *The Mid Staffordshire NHS Foundation Trust Public Inquiry. 2013* (2013) vol Executive Summary <www.midstaffspublicinquiry.com>

Gardner, Simon, 'Manslaughter by Gross Negligence - R v Adomako [1995] 1 AC 171' (1995) 111(22) *Law Quarterly Review*

'General News.' *The Maitland Mercury & Hunter River General Advertiser* (NSW), 21 December 1871 3

Gilby, Lisa, 'Litigious' Patients Under Fire' *Courier Mail, The/Sunday Mail, The/QWeekend Magazine* (Brisbane, Australia), 1 July 2002 2

Gillespie, James A, *The Price of Health: Australian Governments and Medical Politics 1910-1960* (Cambridge University Press, 2002)

Gilligan, Carol, *In a Different Voice* (Harvard University Press, 2009)

Golder, Ben and Peter Fitzpatrick, *Foucault's Law* (Routledge Cavendish, 2009)

Golder, Ben, 'The Distribution of Death: Notes towards a Bio-Political Theory of Criminal Law' in Matthew Stone, Illan rua Wall and Costas Douzinas (eds), *New Critical Legal Thinking: Law and the Political* (Taylor & Francis, 2012) 91

Goodman, NW, 'Book: Errors, Medicine and the Law' (2002) 324(7332) *BMJ* 304

Goodrich, Peter, *Legal Discourse: Studies in Linguistics, Rhetoric and Legal Analysis* (Macmillan Publishers Limited, 1987)

Gostin, Lawrence, 'A Public Health Approach to Reducing Error: Medical Malpractice as a Barrier' (2000) 283(13) *JAMA* 1742

'Goulburn. Wednesday.' *Empire* (Sydney, NSW), 28 April 1864 4

'GP Manslaughter Charges Increase since 1990s' *The Guardian*, 1 June 2006 <<https://www.theguardian.com/society/2006/jun/01/health.medicineandhealth1>>

Grattan, Michelle, 'A Tail Goes in Search of a Donkey' *The Sydney Morning Herald* (Sydney, NSW), 3 May 2002 11

Griffiths, Danielle and Andrew Sanders, 'The Road to the Dock: Prosecution Decision-Making in Medical Manslaughter Cases' in Danielle Griffiths and Andrew Sanders (eds),

Bioethics, Medicine and the Criminal Law: Medicine, Crime and Society (Cambridge University Press, 2013) vol 2, 117

Griffiths, Danielle and Andrew Sanders, *Bioethics, Medicine and the Criminal Law: Medicine, Crime and Society* (Cambridge University Press, 2013) vol 2

‘Gulgong. August 7.’ *Australian Town and Country Journal* (NSW), 16 August 1873 7

‘Had About 40 Aliases Sofala’s Bogus Medico’ *Townsville Daily Bulletin* (Townsville, Qld.), 27 May 1950 5

Hall, Jerome, ‘Negligent Behavior Should Be Excluded from Penal Liability’ (1963) 63(4) *Columbia Law Review* 632

Hall, Jerome, ‘Negligence and the General Problem of Criminal Responsibility’ (1972) 81(5) *Yale Law Journal* 949

Hamilton, John D, Robert W Gibberd and Bernadette T Harrison, ‘After the Quality in Australian Health Care Study, What Happened?’ (2014) 201(1) *The Medical Journal of Australia* 23

Hancock, Linda, ‘Addressing the “Problem Doctor”’ in Peter Lens and Gerrit van der Wal (eds), *Problem Doctors: A Conspiracy of Silence* (IOS Press, 1997)

Harpwood, VH, *Medicine, Malpractice and Misapprehensions* (Routledge-Cavendish Taylor & Francis Group, 2007) <<https://www.scopus.com/inward/record.uri?eid=2-s2.0-84917318400&doi=10.4324%2f9780203940457&partnerID=40&md5=1ae0a45bbf1a2c37263297819370d0cb>>

Hart, HLA, ‘Negligence, Mens Rea and Criminal Responsibility’ in AG Guest (ed), *Oxford Essays in Jurisprudence* (Oxford University Press, 1961) 29

Harvey, Anthony, ‘Doctors in the Dock: Criminal Liability for Negligent Treatment Resulting in the Death of a Patient’ (1994) 16(2) *Liverpool Law Review* 201

Hawe, Emma and Office of Health Economics (London England), *Compendium of Health Statistics 2009* (Radcliffe Publishing, 2008)

Healy, Judith and John Braithwaite, ‘Designing Safer Health Care through Responsive Regulation’ (2006) 184 *Medical Journal of Australia*

Healy, Judith, *Improving Health Care Safety and Quality: Reluctant Regulators* (Ashgate Publishing, Ltd., 2013)

“‘He Was brilliant” Married “bogus Doctor”” *The Courier-Mail* (Brisbane, Qld.), 29 May 1950 1

Held, Virginia, ‘Feminist Transformations of Moral Theory’ (1990) 50 *Philosophy and Phenomenological Research* 321

- Hemming, Andrew, 'Reasserting the Place of Objective Tests in Criminal Responsibility: Ending the Supremacy of Subjective Tests' (2011) 13 *University of Notre Dame Australia Law Review* 69
- Henderson, Paul, 'Why Barricades? - Doctors Are Not Under Legal Siege' *The Age/The Sunday Age (Melbourne, Australia)*, 10 July 1995 12
- Henry, Catherine, 'Bill Hits Victims Not the Lawyers' *Newcastle Herald (Australia)*, 29 October 2002 9
- Henwood, Flis, Roma Harris and Philippa Spoel, 'Informing Health? Negotiating the Logics of Choice and Care in Everyday Practices of "Healthy Living"' (2011) 72(12) *Social Science & Medicine* 2026
- Herring, Jonathan, *Criminal Law: Text, Cases, and Materials* (OUP Oxford, 2012)
- Herring, Jonathan, *Caring and the Law* (A&C Black, 2014)
- Hindle, Don et al, 'Patient Safety: A Comparative Analysis of Eight Inquiries in Six Countries.' (Centre for Clinical Governance Research, University of New South Wales, 2006)
- Hogarth, Murray, 'Killed in Error' *The Sydney Morning Herald* (Sydney, NSW), 11 May 1996 6
- Holbrook, Jon, 'The Criminalisation of Fatal Medical Mistakes' (2003) 327(7424) *BMJ* 1118
- Horder, Jeremy, 'Gross Negligence and Criminal Culpability' (1997) 47(4) *The University of Toronto Law Journal* 495
- Horder, Jeremy, *Ashworth's Principles of Criminal Law* (Oxford University Press, 2016)
- 'Hospitals Report Deserves Much Closer Analysis' *The Sydney Morning Herald* (Sydney, NSW), 7 June 1995 16
- Hubbeling, D, 'Medical Error and Moral Luck' (2016) 28(3) *HEC Forum* 229
- Hurwitz, B, 'Healthcare Serial Killings: Was the Case of Dr Harold Shipman Unthinkable?' in *Bioethics, Medicine and the Criminal Law Volume II: Medicine, Crime and Society* (Cambridge University Press, 2010) 13 <DOI: 10.1017/CBO9781139109376.004>
- Illich, Ivan, *Limits to Medicine: Medical Nemesis: The Expropriation of Health* (M. Boyars, 1995)
- Illich, Ivan, 'Medical Nemesis' (2003) 57(12) *Journal of Epidemiology and Community Health* 919
- 'In Trouble Again.' *The Raleigh Sun* (Bellingen, NSW), 25 March 1904 2

‘Incautious Use of Ammonia’ *The Sydney Morning Herald* (Sydney, NSW), 20 June 1871
4

‘Inquests.’ *The Cornwall Chronicle* (Launceston, Tas.), 20 July 1839 1

Institute of Medicine, Committee on Quality of Health Care in America, *To Err Is Human: Building a Safer Health System* (National Academy Press, 2000)
<www.nap.edu/readingroom>

Institute of Medicine (US) Committee on Quality of Health Care in America, *Crossing the Quality Chasm: A New Health System for the 21st Century* (National Academy Press, 2001)

‘Insurance Blow-Out’ *Newcastle Herald* (Newcastle, NSW), 26 September 2002 5

Ipp, D, ‘The Politics, Purpose and Reform of the Law of Negligence’ (2007) 81(7)
Australian Law Journal 456

Johnstone, Craig, ‘Ducking for Cover’ *Courier Mail, The/Sunday Mail, The/QWeekend Magazine* (Brisbane, Australia), 9 May 2002 19

Jones, Colin and Roy Porter, *Reassessing Foucault: Power, Medicine and the Body* (Routledge, 2002)

Judicial College of Victoria, *Victorian Criminal Charge Book* (Judicial College of Victoria, Electronic Edition, 2016) <<http://www.judicialcollege.vic.edu.au>>

Kachalia, Allen et al, ‘Legal and Policy Interventions to Improve Patient Safety’ (2016)
133(7) *Circulation* 661

Kay, Natasha et al, ‘Should Doctors Who Make Clinical Errors Be Charged with Manslaughter? A Survey of Medical Professionals and Members of the Public’ (2008)
48(4) *Medicine, Science, and the Law* 317

Kearney, Simon, ‘Doctors Take Cake, Then Want Icing’ *Sunday Times/Home Publication/Prestige Property/Sunday Style* (Perth, Australia), 12 October 2003 64

Keim, Tony, ‘Doctor Death Charges Dropped’ *Courier Mail* (Brisbane, Qld.), 18 August 2009 <<http://www.couriermail.com.au/news/dr-bruce-ward-walks-free-after-manslaughter-charges-dropped/news-story/75aec26bc50c366d8ad1f584ea10fc05>>

Kenney, Charles, *The Best Practice: How the New Quality Movement Is Transforming Medicine* (PublicAffairs, 2008)

Kercher, Bruce, ‘Recovering and Reporting Australia’s Early Colonial Case Law: The Macquarie Project’ (2000) 18(3) *Law and History Review* 659

Kessler, Daniel P, ‘Evaluating the Medical Malpractice System and Options for Reform’ (2011) 25(2) *The Journal of Economic Perspectives: A Journal of the American Economic Association* 93

- Koehn, Daryl, *Rethinking Feminist Ethics: Care, Trust and Empathy* (Routledge, 2012)
- 'Kugelmann Acquitted' *Evening News* (Sydney, NSW), 3 December 1908 5
- Lacey, Nicola, *In Search of Criminal Responsibility: Ideas, Interests, and Institutions* (Oxford University Press, 2016)
- Lanham, David et al, *Criminal Laws in Australia* (Federation Press, 2006)
- Lamont, Tara and Justin Waring, 'Safety Lessons: Shifting Paradigms and New Directions for Patient Safety Research' (2015) 20(1 suppl) *Journal of Health Services Research & Policy* 1
- Lapsley, I, 'Accountingization, Trust and Medical Dilemmas' (2007) 21(4-5) *Journal of Health, Organisation and Management* 368
- Larrabee, Mary Jeanne, *An Ethic of Care: Feminist and Interdisciplinary Perspectives* (Routledge, 2016)
- Larriera, Alecia, 'Hospital Errors Kill 14,000 a Year' *The Sydney Morning Herald* (Sydney, NSW), 2 June 1995 1
- Larriera, Alicia, 'Patients Get Right to See Medical Records' *The Sydney Morning Herald*, 3 June 1995 1
- Laster, Kathy, 'Arbitrary Chivalry: Women and Capital Punishment in Victoria, Australia 1842-1967' (1994) 6(1) *Women & Criminal Justice* 67
- 'Latest Intelligence. a Nolle Prosequi. Melbourne, Thursday Night.' *The Horsham Times* (Vic.), 1 October 1897 3
- 'Latest Telegrams. Melbourne, Thursday Night.' *The Horsham Times* (Vic.), 23 April 1897 2
- Latz, Andrew Brower, 'Gillian Rose and Social Theory' (2015) Winter 2015(173) *Telos* 37
- Law Council of Australia, 'Review of Chapter 2 Model Criminal Code' (2012 03 21 Sub re Review of Chapter 2 Criminal Code, Law Council of Australia, 23 March 2012) <<https://www.lawcouncil.asn.au/>>
- Leader-Elliott, Ian, 'Recklessness and Murder-The Facts of the Case' (1986) 10 *Criminal Law Journal* 359
- Leader-Elliott, Ian, 'Elements of Liability in the Commonwealth Criminal Code' in *AJJA Magistrates Conference* (2001) <<http://www.ajja.org.au/>>
- Leape, Lucian L et al, 'The Nature of Adverse Events in Hospitalized Patients: Results of the Harvard Medical Practice Study II' (1991) 324(6) *New England Journal of Medicine* 377

- Leape, Lucian L and Donald M Berwick, 'Safe Health Care: Are We up to It?' (2000) 320(7237) *BMJ: British Medical Journal* 725
- Leape, Lucian L and Donald M Berwick, 'Five Years after To Err Is Human: What Have We Learned?' (2005) 293(19) *Jama* 2384
- Leung, Chee Chee and Larissa Dubecki, 'End in Sight for Victoria's Insurance Nightmare - Public Liability' *The Age* (Melbourne, Vic.), 10 October 2002 6
- Levin, Joel, *Tort Wars* (Cambridge University Press, 2008)
- Lilleyman, J, 'The Trouble with Safety in the National Health Service: A Personal View' (2008) 14(3) *Clinical Risk* 101
- 'Little Surprise Among Those in the Front Line' *The Sydney Morning Herald* (Sydney, NSW), 2 June 1995 8
- Lloyd, Vincent, *Law and Transcendence: On the Unfinished Project of Gillian Rose* (Palgrave Macmillan, 2009)
- Loane, Sally, 'Hidden Agenda to Obstetrician "Shortage"' *The Sydney Morning Herald* (Sydney, NSW), 17 August 1993 12
- Localio, A Russell et al, 'Relation between Malpractice Claims and Adverse Events due to Negligence: Results of the Harvard Medical Practice Study III' (1991) 325(4) *New England Journal of Medicine* 245
- Luntz, Harold, 'Compensation Recovery and the National Disability Insurance Scheme' (2013) 20 *Torts Law Journal* 153
- Mace, Janine, 'Making Sense of the MDO Market' *Australian Doctor*, 23 February 2001 43
- 'Man Posed as Doctor for Six Weeks' *The Argus* (Melbourne, Vic.), 29 May 1950 3
- Manderson, Desmond, 'Proximity: The Law of Ethics and the Ethics of Law' (2005) 28 *University of New South Wales Law Journal* 696
- Manderson, Desmond, *Proximity, Levinas, and the Soul of Law* (McGill-Queen's Press, 2006)
- Manderson, Desmond, "'Current Legal Maxims in Which the Word Neighbour Occurs": Levinas and the Law of Torts' in *Essays on Levinas and Law* (Springer, 2009) 111
- 'Manslaughter by a Medical Practitioner.' *Empire* (Sydney, NSW), 8 March 1864 8
- 'Manslaughter Charge. Melbourne Doctor Acquitted. Melbourne, Friday.' *The Western Champion* (Barcaldine, Qld.), 21 March 1936 12
- McCall Smith, Alexander, 'Criminal or Merely Human: The Prosecution of Negligent Doctors' (1995) 12 *Journal of Contemporary Health Law and Policy* 131

McCall Smith, Alexander and Alan Merry, 'Medical Manslaughter: A Reply to Paterson' (1996) 4(3) *Health Care Analysis* 229

McCarthy, Kara M, 'Doing Time for Clinical Crime: The Prosecution of Incompetent Physicians as an Additional Mechanism to Assure Quality Health Care' (1997) 28 *Seton Hall Law Review* 569

McDonald, Barbara, 'Legislative Intervention in the Law of Negligence: The Common Law, Statutory Interpretation and Tort Reform in Australia' (2005) 27 *Sydney Law Review* 443

McDonald, Barbara, 'The Impact of the Civil Liability Legislation on Fundamental Policies and Principles of the Common Law of Negligence' (2006) 14(3) *Torts Law Journal* 268

McDowell, Sarah E and Robin E Ferner, 'Medical Manslaughter' (2013) 347(7926) *BMJ* f5609

McGuinness, Padraic P, 'Australia's Sickly Health System Cries out for a Remedy' *Age, The/The Sunday Age (Melbourne, Australia)*, 2 June 1995 12

McNeil, John J and Stephen R Leeder, 'How Safe Are Australian Hospitals?' (1995) 163(9) *The Medical Journal of Australia* 472

Medew, Julia, 'Hospital Errors Killing Hundreds of Thousands' *The Sydney Morning Herald*, 19 February 2015 <<http://www.smh.com.au/national/health/hospital-errors-killing-hundreds-of-thousands-20150218-13irpo.html>>

"'Medical Etiquette.' Strong Remarks by Coroner.' *Barrier Miner* (Broken Hill, NSW), 29 November 1911 2

'Medicos Fear Insurance Loss' *The Cairns Post* (Cairns, Qld.), 30 April 2002 2

Mehrpouya, Afshin and Marie-Laure Djelic, 'Transparency: From Enlightenment to Neoliberalism or When a Norm of Liberation Becomes a Tool of Governing' (SSRN Scholarly Paper ID 2499402, Social Science Research Network, 1 September 2014) <<http://papers.ssrn.com/abstract=2499402>>

Melo, Sara and Matthias Beck, *Quality Management and Managerialism in Healthcare: A Critical Historical Survey* (Springer, 2014)

Merry, AF, 'How Does the Law Recognise and Deal with Medical Errors?' in *Health Care Errors and Patient Safety* (Wiley-Blackwell, 2009) 75

Merry, AF, 'How Does the Law Recognize and Deal with Medical Errors?' (2009) 102(7) *Journal of the Royal Society of Medicine* 265

Merry, Alan and Alexander McCall Smith, *Errors, Medicine and the Law* (Cambridge University Press, 2001)

Merry, Alan and Alexander McCall Smith, *Errors, Medicine and the Law* (Cambridge University Press, Kindle Edition, 2001)

Merry, Alan, 'When Are Errors a Crime?—Lessons from New Zealand' in Charles A Erin and Suzanne Ost (eds), *The Criminal Justice System and Health Care* (Oxford University Press, 2007)

Merry, Alan and Warren Brookbanks, *Merry and McCall Smith's Errors, Medicine and the Law* (Cambridge University Press, Kindle Edition, 2017)

Mills, Don Harper, John S Boyden and David S Rubsamens, 'Report on the Medical Insurance Feasibility Study' (California Medical Association, California Hospital Association, 1977)

Mills, Don Harper, 'Medical Insurance Feasibility Study: A Technical Summary' (1978) 128(4) *Western Journal of Medicine* 360

Miola, J, 'The Impact of the Loss of Deference towards the Medical Profession' in *Bioethics, Medicine and the Criminal Law Volume I: The Criminal Law and Bioethical Conflict: Walking the Tightrope* (Cambridge University Press, 2010) 220

Mol, Annemarie, *The Body Multiple: Ontology in Medical Practice* (Duke University Press, 2002)

Mol, Annemarie, *The Logic of Care: Health and the Problem of Patient Choice* (Routledge, 2008)

Mol, Annemarie, Ingunn Moser and Jeannette Pols (eds), 'Care: Putting Practice into Theory' (2010) 8 *Care in Practice: On Tinkering in Clinics, Homes and Farms* 7

Mol, Annemarie, Ingunn Moser and Jeannette Pols, 'Care: Putting Practice into Theory' in Annemarie Mol, Ingunn Moser and Jeannette Pols (eds), *Care in Practice: On Tinkering in Clinics, Homes and Farms* (Transcript Verlag, 2015) 7

Mol, Annemarie, Ingunn Moser and Jeannette Pols (eds), *Care in Practice: On Tinkering in Clinics, Homes and Farms* (transcript Verlag, 2015)

Monrouxe, Lynn V and Charlotte E Rees, "'It's Just a Clash of Cultures": Emotional Talk within Medical Students' Narratives of Professionalism Dilemmas' (2012) 17(5) *Advances in Health Sciences Education* 671

Mooney, Graham, *Intrusive Interventions: Public Health, Domestic Space, and Infectious Disease Surveillance in England, 1840-1914* (Boydell & Brewer, 2015)

Morath, Julianne M and Joanne E Turnbull, *To Do No Harm: Ensuring Patient Safety in Health Care Organizations* (John Wiley & Sons, 2005)

Morse, Stephen J, 'Common Criminal Law Compatibilism' in Nicole A Vincent (ed), *Neuroscience and Legal Responsibility* (Oxford University Press, 2013) 27

Moss, Lyndsay, 'The Scotsman: More Doctors End up in the Dock as Bereaved Families Seek Retribution' *The Scotsman*, 1 June 2006 16

'Mr. H. E. Kugelmann' *The Register* (Adelaide, SA), 6 June 1912 6

Naffine, Ngaire, 'Criminal Conversations: Farmer, Lacey and the New Social Scholarship' (2016) 38 *Sydney Law Review* 505

Nagel, Thomas, *The View From Nowhere* (Oxford University Press, USA, 1989)

Nason, David, 'Crisis Can Be Traced to a Snail' *Weekend Australian* (Sydney, NSW), 1 March 2002 30

'New Magistrates.' *The Sydney Morning Herald* (Sydney, NSW), 6 October 1882 5

New South Wales, *Report of the Royal Commission into Deep Sleep Therapy* (1990)

'New South Wales. Another Victim. Sydney, Saturday.' *Morning Post* (Cairns, Qld.), 20 November 1905 3

'New South Wales. Break-down of a Murder Trial. Sydney, March 27.' *The Mercury* (Hobart, Tas.), 28 March 1906 3

'New South Wales. [from Our Own Correspondents.] Sydney, February 6.' *The South Australian Advertiser* (Adelaide, SA), 7 February 1883 5

New South Wales Government, Health Care Complaints Commission, *Investigation Report Campbelltown and Camden Hospitals Macarthur Health Service* (Health Care Complaints Commission, 2003) <<http://pandora.nla.gov.au/tep/40205>>

New South Wales. Special Commission of Inquiry into Campbelltown and Camden Hospitals and Bret Walker, 'Final Report of the Special Commission of Inquiry into Campbelltown and Camden Hospitals' (NSW Government, Special Commission of Inquiry) <<http://trove.nla.gov.au/version/45513599>>

Nicolini, Davide, *Practice Theory, Work, and Organization: An Introduction* (Oxford University Press, 2013)

'No Title (Albert Reginald McLeod (40) and Sarsfield Cassidy (55))' *Queanbeyan Age and Queanbeyan Observer* (NSW), 29 November 1921 3

Noddings, Nel, *Starting at Home: Caring and Social Policy* (University of California Press, 2002)

Norrie, Alan, *Crime, Reason and History: A Critical Introduction to Criminal Law* (Cambridge University Press, 2001)

Norrie, Alan, *Crime, Reason and History: A Critical Introduction to Criminal Law* (Cambridge University Press, 2014)

Norrie, Alan, *Law & the Beautiful Soul* (Routledge, 2013)

‘Nurse Pears Sentenced’ *Sunday Times* (Perth, WA), 10 May 1908 5 S

‘Nurse’s Death. An Open Verdict.’ *The Sydney Morning Herald* (Sydney, NSW), 7 January 1922 14

Nussbaum, Abraham M, *The Finest Traditions of My Calling: One Physician’s Search for the Renewal of Medicine* (Yale University Press, 2016)

Ocloo, Josephine E and Naomi J Fulop, ‘Developing a “critical” Approach to Patient and Public Involvement in Patient Safety in the NHS: Learning Lessons from Other Parts of the Public Sector?’ (2012) 15(4) *Health Expectations* 424

Ocloo, Josephine Enyonam, ‘Harmed Patients Gaining Voice: Challenging Dominant Perspectives in the Construction of Medical Harm and Patient Safety Reforms’ (2010) 71(3) *Social Science & Medicine* 510

O’Doherty, Stephen, ‘Doctors and Manslaughter—Response from the Crown Prosecution Service’ (2006) 99(11) *Journal Of The Royal Society Of Medicine* 544

Orri, Massimiliano, Anne Revah-Lévy and Olivier Farges, ‘Surgeons’ Emotional Experience of Their Everyday Practice - A Qualitative Study’ (2015) 10(11) *PLoS ONE* e0143763

Ost, Suzanne, *The Criminal Justice System and Health Care* (Oxford University Press, 2007)

Ostrow, Ruth, ‘Dissatisfaction Guaranteed’ *The Australian* (Sydney, NSW), 10 August 2002 R31

‘Our Melbourne Letter’ *The Mercury* (Hobart, Tas.), 6 May 1897 4

Øvretveit, John, ‘Understanding and Improving Patient Safety: The Psychological, Social and Cultural Dimensions’ (2009) 23(6) *Journal of Health Organization and Management* 581

Paik, Myungho, Bernard S Black and David A Hyman, ‘The Direct and Indirect Effects of Medical Malpractice Reforms: Evidence from the Third Reform Wave’ [2012] (No 13-20) *Northwestern Law and Economics Research Paper* <<http://www.ssrn.com/abstract=2110656>>

Paik, Myungho, Bernard Black and David A Hyman, ‘The Receding Tide of Medical Malpractice Litigation: Part 1-National Trends’ (2013) 10(4) *Journal of Empirical Legal Studies* 612

Paik, Myungho, Bernard Black and David Hyman, ‘The Receding Tide of Medical Malpractice Litigation: Part 2-Effect of Damage Caps’ (2013) 10(4) *Journal of Empirical Legal Studies* 639

Paik, Myungho, Bernard Black and David A Hyman, ‘Do Doctors Practice Defensive Medicine, Revisited’ <<https://www.scholars.northwestern.edu/en/publications/do-doctors-practice-defensive-medicine-revisited>>

Panel of Eminent Persons, 'Review of the Law of Negligence: Final Report' (Commonwealth of Australia, The Treasury, September 2002) <<https://www.treasury.gov.au/ConsultationsandReviews/Reviews/2002>>

Parliamentary Counsel's Committee (Cth), *Model Criminal Code* (Commonwealth of Australia, 1st Edition, 2009)

Parnell, Sean, 'Surgeon Charged with Manslaughter' *The Australian* (Online Edition), 29 October 2007 <<http://www.news.com.au/national/surgeon-charged-with-manslaughter/news-story/7bdf021c6cfa3ff9f52487df6d75cbcf>>

Patterson, Ron, 'From Prosecution to Rehabilitation: New Zealand's Response to Health Practitioner Negligence' in Danielle Griffiths and Andrew Sanders (eds), *Bioethics, Medicine and the Criminal Law: Medicine, Crime and Society* (Cambridge University Press, 2013) vol 2, 229

Perkin, Steve, 'Sink or Swim' *Herald Sun/Sunday Herald Sun/Home Magazine* (Melbourne, Australia), 21 December 2002 27

Perneger, Thomas V, 'The Swiss Cheese Model of Safety Incidents: Are There Holes in the Metaphor?' (2005) 5(1) *BMC Health Services Research* 71

'Perth Doctor Operates With Dive-Bombers Attacking Ship' *Mirror* (Perth, WA), 29 April 1944 18

Pincus, Richard, John Watts and Tony Sowden, 'Letters, Medical Negligence and the Law' *The Australian/Weekend Australian/Australian Magazine*, 9 November 1998 12

Pirani, Clara, 'Patients and Taxpayers Will Foot the Medical Bill' *The Australian*, 16 August 2003 C14

Place, Amanda, 'When Sorry Is the Hardest Word - Health' *Age, The/The Sunday Age* (Melbourne, Australia), 29 November 2003 26

'Prescriptions by 'Phone & Letter Did Not Agree' *The Courier-Mail* (Brisbane, Qld.), 28 August 1941 7

Prosser, William, *Handbook of the Law of Torts* (West Publishing Co., 1941)

Quick, O, 'Medicine, Mistakes and Manslaughter: A Criminal Combination?' (2010) 69(1) *Cambridge Law Journal* 186

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

Quick, Oliver, 'Outing Medical Errors: Questions of Trust and Responsibility' (2006) 14(1) *Medical Law Review* 22

Quick, Oliver, 'Medical Manslaughter: The Rise (and Replacement) of a Contested Crime' in Charles A Erin and Suzanne Ost (eds), *The Criminal Justice System and Health Care* (Oxford University Press, 2007)

- Quick, Oliver, 'Expert Evidence and Medical Manslaughter: Vagueness in Action' (2011) 38(4) *Journal of Law and Society* 496
- Quick, Oliver, 'Patient Safety and the Problem and Potential of Law' (2012) 28(2) *Professional Negligence* 78
- Quick, Oliver, 'Medical Killing: Need for a Specific Offence?' in *Criminal Liability for Non-Aggressive Death* (Ashgate Publishing Ltd, 2013) 155
- Quick, Oliver, *Regulating Patient Safety* (Cambridge University Press, 2017)
- Quirk, H, 'Sentencing White Coat Crime: The Need for Guidance in Medical Manslaughter Cases' (2013) 2013 *Criminal Law Review* 871
- Rahmati, Mohammad et al, 'Insurance Crisis or Liability Crisis? Medical Malpractice Claiming in Illinois, 1980-2010: Insurance Crisis or Liability Crisis?' (2016) 13(2) *Journal of Empirical Legal Studies* 183
- Rait, Julian L and Elizabeth H Van Ekert, 'Letters: Legal Aspects of Open Disclosure II: Attitudes of Health Professionals—findings from a National Survey.' (2011) 194(1) *The Medical journal of Australia* 48
- Reason, James, *Human Error* (Cambridge university press, 1990)
- Reason, James, 'Human Error' (2000) 172(6) *Western Journal of Medicine* 393
- Reason, James, 'Beyond the Organisational Accident: The Need for "Error Wisdom" on the Frontline' (2004) 13(suppl_2) *Quality and Safety in Health Care* ii28
- Reason, James, *Managing the Risks of Organizational Accidents* (Routledge, 2016)
- Reckwitz, Andreas, 'Toward a Theory of Social Practices: A Development in Culturalist Theorizing' (2002) 5(2) *European journal of social theory* 243
- Reid, Julian, 'The Disastrous and Politically Debased Subject of Resilience' [2012] (58) *Development Dialogue* 67
- 'Rights Gone Wrong' *Northside Chronicle (Brisbane, Australia)*, 4 December 2002 6
- Robinson, Peter, 'Red Herring Hospitals' *The Sun Herald* (Sydney, NSW), 4 June 1995 34
- Romano, Patrick S, 'Improving the Quality of Hospital Care in America' (2005) 2005(353) *New England Journal of Medicine* 302
- Rose, Gillian, *Dialectic of Nihilism: Post-Structuralism and Law* (Wiley-Blackwell, 1st ed, 1991)
- Rose, Gillian, *The Broken Middle: Out of Our Ancient Society* (Blackwell, 1992)
- Rose, Gillian, *Mourning Becomes the Law: Philosophy and Representation* (Cambridge University Press, 1996)

- Rose, Gillian, *Love's Work* (NYRB Classics, Kindle Edition, 2011)
- Rose, Nikolas and Peter Miller, 'Political Power Beyond the State: Problematics of Government' [1992] *British Journal of Sociology* 173
- Runciman, Bill, Alan Merry and Merrilyn Walton, *Safety and Ethics in Healthcare: A Guide to Getting It Right* (Ashgate Publishing, Ltd., 2007)
- Runciman, William and J Moller, *Iatrogenic Injury in Australia* (Australian Patient Safety Foundation, 2001)
- Runciman, William, MJ Edmonds and M Pradhan, 'Setting Priorities for Patient Safety' (2002) 11(3) *Quality and Safety in Health Care* 224
- Runciman, William B et al, 'A Comparison of Iatrogenic Injury Studies in Australia and the USA II: Reviewer Behaviour and Quality of Care' (2000) 12(5) *International Journal for Quality in Health Care* 379
- Runciman, William B, Alan F Merry and Fiona Tito, 'Error, Blame, and the Law in Health Care-an Antipodean Perspective' (2003) 138(12) *Annals of Internal Medicine* 974
- Runciman, William B, 'Shared Meanings: Preferred Terms and Definitions for Safety and Quality Concepts' (2006) 184 *Medical Journal of Australia*
- Runciman, William B et al, 'CareTrack: Assessing the Appropriateness of Health Care Delivery in Australia' (2012) 197(2) *Medical Journal of Australia*
- Sanders, A, 'Victims' Voices, Victims' Interests and Criminal Justice in the Healthcare Setting' in *Bioethics, Medicine and the Criminal Law Volume II: Medicine, Crime and Society* (Cambridge University Press, 2010) 81 <DOI: 10.1017/CBO9781139109376.008>
- 'She Went to the Clinic with a Burnt Hand - the Next Day She Was' *Adelaide Advertiser* (Adelaide, SA), 10 July 1999 28
- Shojania, Kaveh G and Mary Dixon-Woods, "'Bad Apples": Time to Redefine as a Type of Systems Problem?' (2013) 22(7) *BMJ Quality & Safety* 528
- Simester, AP and GR Sullivan, *Simester and Sullivan's Criminal Law: Theory and Doctrine* (Hart, 2010)
- Simons, Kenneth W, 'Culpability and Retributive Theory: The Problem of Criminal Negligence' (1994) 5 *Journal of Contemporary Legal Issues* 365
- Simons, Kenneth W, 'Rethinking Mental States' 72 *Boston University Law Review* 463
- Skegg, PDG, 'Criminal Prosecutions of Negligent Health Professionals: The New Zealand Experience' (1998) 6(2) *Medical Law Review* 220
- Slote, Michael, *The Ethics of Care and Empathy* (Routledge, 2007)
- 'Social Fabric in Danger' *Mosman Daily* (Sydney, Australia), 7 November 2002 9

Springer, Elise, *Communicating Moral Concern: An Ethics of Critical Responsiveness* (MIT Press, 2013)

Stark, Findlay, *Culpable Carelessness: Recklessness and Negligence in the Criminal Law* (Cambridge University Press, 2016)

Studdert, David M et al, 'Negligent Care and Malpractice Claiming Behavior in Utah and Colorado' [2000] *Medical Care* 250

Studdert, David M, Michelle M Mello and Troyen A Brennan, 'Medical Malpractice' (350) 283

Studdert, David M and Mark W Richardson, 'Legal Aspects of Open Disclosure: A Review of Australian Law' (2010) 193(5) *Medical Journal of Australia* <<https://www.mja.com.au/journal/2010/193/5/legal-aspects-open-disclosure-review-australian-law?inline=true>>

Studdert DM et al, 'Defensive Medicine among High-Risk Specialist Physicians in a Volatile Malpractice Environment' (2005) 293(21) *JAMA* 2609

'Surgeon Almost Faints When Found Not Guilty Of Manslaughter Of Young Girl Patient' *Mirror* (Perth, WA), 17 August 1946 11

'Suspicious Circumstances. the Inquest Adjourned. [by Telegraph.] Sydney, Friday.' *Singleton Argus* (NSW), 3 September 1904 5

Sweet, Melissa, 'Hospital Dangers: A Tale of Inaction - Health Care Safety: A Three Year Wait' *The Sydney Morning Herald* (Sydney, NSW), 27 February 1998 10

Taliadoros, Jason, 'Eligibility for Lifetime Care and Support under the NDIS Act: Lessons from Accident Compensation Schemes in Victoria' in *Australasian Compensation Health Research Forum, 10-11 October 2013, Sydney* (Deakin University, School of Law, 2013)

Taussig, Isabel, 'Sentencing Snapshot: Homicide and Related Offences' (Bureau Brief Issue Paper no. 76, NSW Bureau of Crime Statistics and Research, February 2012) <<http://www.bocsar.nsw.gov.au/agdbasev7wr/bocsar/documents/pdf/bb76.pdf>>

Taylor, Simon, *Medical Accident Liability and Redress in English and French Law* (Cambridge University Press, 2015)

The Bristol Royal Infirmary Inquiry, 'The Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984-1995: Learning from Bristol' (CM 5207(I), July 2001)

'The Circuit Courts. Bathurst.' *Australian Town and Country Journal* (Sydney, NSW), 27 April 1872 5

'The Committal of Mr. Zimmler for Manslaughter.' *The Maitland Mercury & Hunter River General Advertiser* (Newcastle, NSW), 22 June 1871 4

'The Empire: The Case of Dr. Hornbrook' *Empire* (Sydney, NSW), 2 September 1864 4

‘The Gory Detail Behind the UMP Disaster’ *Crikey* (Online Edition), 3 May 2002
<<https://www.crikey.com.au/2002/05/03/the-gory-detail-behind-the-ump-disaster/>>

‘The Kugelman Prosecution’ *The Newsletter: an Australian Paper for Australian People* (Sydney, NSW), 21 November 1908 9

The Mid Staffordshire NHS Foundation Trust Inquiry, ‘Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust January 2005 - March 2009’ (HC375-II, 24 February 2010)
<http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113018>

‘The New South Wales Parliament.’ *Argus* (Melbourne, Vic.), 17 February 1883 12

Thomas, Eric J et al, ‘A Comparison of Iatrogenic Injury Studies in Australia and the USA I: Context, Methods, Casemix, Population, Patient and Hospital Characteristics’ (2000) 12(5) *International Journal for Quality in Health Care* 371

Thomas, Eric J et al, ‘Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado’ [2000] *Medical Care* 261

Thomas, Hedley, *Sick to Death: A Manipulative Surgeon and a Health System in Crisis-- a Disaster Waiting to Happen* (Allen & Unwin, 2007)

‘Time to Rethink Insurance’ *Canberra Times, The (Australia)*, 2 October 2002 21

Tito, Fiona, ‘Compensation and Professional Indemnity in Health Care, Review of Professional Indemnity Arrangements for Health Care Professionals: Final Report’ (Commonwealth of Australia, Department of Health, November 1995)

‘To the Editor of the Herald and Chronicle.’ *The Goulburn Herald and Chronicle* (Goulburn, NSW), 30 April 1864 5

‘To the Editor of the Queanbeyan Age.’ *Queanbeyan Age and General Advertiser* (Queanbeyan, NSW), 1 September 1864 2

Toh, Win-Li, Linda Satchwell and Jonathan Cohen, ‘Medical Indemnity – Who’s Got the Perfect Cure?’ (Paper presented at the 12th Accident Compensation Seminar, The Institute of Actuaries of Australia 22-24 November 2009)
<https://www.actuaries.asn.au/Library/ACS09_Paper_Toh%20et%20al..pdf>

Trabsky, Marc, ‘The Custodian of Memories: Colonial Architecture in Nineteenth-Century Melbourne’ (2015) 24(2) *Griffith Law Review* 199

Travaglia, Joanne F and Jeffrey Braithwaite, ‘Analysing The “field” of Patient Safety Employing Bourdieusian Technologies’ (2009) 23(6) *Journal of Health Organization and Management* 597

‘Trial for Manslaughter. the Accused Acquitted. Melbourne, June 30.’ *The Advertiser* (Adelaide, SA), 1 July 1897 5

Tuckett, Nikita, 'Balancing Public Health and Practitioner Accountability in Cases of Medical Manslaughter: Reconsidering the Tests for Criminal Negligence-Related Offences in Australia after R v Patel' (2011) 19(2) *Journal of Law and Medicine* 377

Tuckett, Nikita, 'Balancing Public Health and Practitioner Accountability in Cases of Medical Manslaughter: Reconsidering the Tests for Criminal Negligence-Related Offences in Australia after R v Patel' (2011) 19(2) *Journal of law and medicine* 377

Ullström, Susanne et al, 'Suffering in Silence: A Qualitative Study of Second Victims of Adverse Events' (2014) 23(4) *BMJ Quality & Safety* 325

'Unregistered Medicoes in Trouble. Committed for Manslaughter. [by Telegraph] Melbourne, Thursday Afternoon.' *Barrier Miner* (Broken Hill, NSW), 23 April 1897 1

Vale, Byron, 'GP Known for Taking Painkillers, Court Told' *The Courier-Mail* (Brisbane, Qld.), 18 November 2000

'Verdict of Manslaughter. Doctor and Chemist Committed for Trial. Ballarat, Friday.' *The Ararat advertiser* (Vic.), 28 August 1915 2

Verrender, Ian, 'Chelmsford Victims Call for Action on Insurance' *The Sydney Morning Herald* (Sydney, NSW), 19 March 1996 4

'Victoria. Alleged Manslaughter. Melbourne, August 27.' *The Daily News* (Perth, WA), 28 August 1897 3

Vincent, Charles, *Patient Safety* (John Wiley & Sons, 2011)

Virgo, Graham, 'Basics to Basics—Reconstructing Manslaughter' (1994) 53(1) *The Cambridge Law Journal* 44

Virgo, Graham, 'Reconstructing Manslaughter on Defective Foundations' (1995) 54(1) *The Cambridge Law Journal* 14

Wachter, Robert M, 'The End of the Beginning: Patient Safety Five Years After "To Err Is Human"' (2004) 23 *Health Affairs* W4

Wallace, Natasha, 'Tribunal Finds Dentist Lied at Trial over Patient's Death' *The Sydney Morning Herald*, 21 October 2009 <<http://www.smh.com.au/national/tribunal-finds-dentist-lied-at-trial-over-patients-death-20091020-h6ys.html>>

Walters, James William, *Martin Buber and Feminist Ethics: The Priority of the Personal* (Syracuse University Press, 2003)

Waring, Justin, 'Getting to the "Roots" of Patient Safety' (2007) 19(5) *International Journal for Quality in Health Care* 257

Waring, Justin, 'Adaptive Regulation or Governmentality: Patient Safety and the Changing Regulation of Medicine' (2007) 29(2) *Sociology of Health & Illness* 163

- Waring, Justin et al, 'Healthcare Quality and Safety: A Review of Policy, Practice and Research' (2016) 38(2) *Sociology of Health & Illness* 198
- Waring, Justin J, 'Beyond Blame: Cultural Barriers to Medical Incident Reporting' (2005) 60(9) *Social Science & Medicine* 1927
- Waring, Justin J, 'Constructing and Re-Constructing Narratives of Patient Safety' (2009) 69(12) *Social Science & Medicine* 1722
- Waterson, Dr Patrick, *Patient Safety Culture: Theory, Methods and Application* (Ashgate Publishing, Ltd., 2014)
- Wears, Robert L, Kathleen M Sutcliffe and Eric Van Rite, 'Patient Safety: A Brief But Spirited History' in Lorri Zipperer (ed), *Patient Safety: Perspectives on Evidence, Information and Knowledge Transfer* (Ashgate Publishing, Ltd., 2014) 3
- Webster, Adam, 'Recklessness: Awareness, Indifference or Belief?' 2007(31) *Criminal Law Journal* 272
- 'Wednesday, Oct. 9.' *Launceston Advertiser* (Launceston, Tas.), 10 October 1839 3
- 'Wednesday, October 9.' *The Cornwall Chronicle* (Launceston, Tas.), 12 October 1839 3
- Welker, Michael, 'The Power of Mercy in Biblical Law' (2014) 29(2) *Journal of Law and Religion* 225
- Wells, Celia and Oliver Quick, *Lacey, Wells and Quick Reconstructing Criminal Law: Text and Materials* (Cambridge University Press, 2010)
- Welsh, Marc, 'Resilience and Responsibility: Governing Uncertainty in a Complex World' (2014) 180(1) *The Geographical Journal* 15
- West, Robin, *Caring for Justice* (NYU Press, 1999)
- Wheatland, Fiona Tito, 'Medical Indemnity Reform in Australia: First Do No Harm' (2005) 33 *Journal of Law, Medicine and Ethics* 429
- Wheeler, Robert, 'Medical Manslaughter: Why This Shift from Tort to Crime?' (2002) 152 *New Law Journal* 593
- White, Andrew, 'A Tale of Catastrophe Foretold' *The Australian* (Sydney, NSW), 4 May 2002 1
- White, Andrew, 'Early Diagnosis of a Medical Trauma - Inside Story' *The Australian* (Sydney, NSW), 4 May 2002 1
- White, James Boyd, *Heracles' Bow: Essays on the Rhetoric and Poetics of the Law* (University of Wisconsin Press, 1989)

White, SM, 'Confidentiality, "No Blame Culture" and Whistleblowing, Non-Physician Practice and Accountability' (2006) 20(4) *Best Practice and Research: Clinical Anaesthesiology* 525

White, Stuart M, Nicky Deacy and Sandeep Sudan, 'Trainee Anaesthetists' Attitudes to Error, Safety and the Law' (2009) 26(6) *European Journal of Anaesthesiology (EJA)* 463

Whitton, Evan, 'Practitioners Sick of Legal Medicine' *The Australian*, 5 November 1998 15

Wilson, RM et al, 'Patient Safety in Developing Countries: Retrospective Estimation of Scale and Nature of Harm to Patients in Hospital' (2012) 344 *BMJ* e832

Wilson, Ross M et al, 'The Quality in Australian Health Care Study' (1995) 163(9) *Medical Journal of Australia* 458

Wilson, Ross M and Bernadette T Harrison, 'Are We Committed to Improving the Safety of Health Care?' (1997) 166(9) *Medical Journal of Australia* 452

Wolff, Leon, 'Litigiousness in Australia: Lessons from Comparative Law' (2013) 18 *Deakin Law Review* 271

Woman Dies after Botched Breast Surgery at Sydney Beauty Salon (1 September 2017) ABC News <<http://www.abc.net.au/news/2017-09-01/woman-who-underwent-botched-procedure-dies/8864854>>

'Women Swear by Bogus Doctor of 80' *Sunday Mail* (Brisbane, Qld.), 28 May 1950 3

Wood, C, 'The Misplace of Litigation in Medical Practice' (1998) 38(4) *The Australian & New Zealand Journal of Obstetrics & Gynaecology* 365

World Health Organization, *Conceptual Framework for International Classification for Patient Safety* (World Health Organization, Final Technical Report, Version 1.1, 2009) <<http://www.who.int/patientsafety/taxonomy>>

Wright, EW, 'National Trends in Personal Injury Litigation: Before and After "Ipp"' (Law Council of Australia, 26 May 2006) <<http://www.nswbar.asn.au/circulars/Prof%20Wright%20report%20May%2006.pdf>>

Wright, EW, 'National Trends in Personal Injury Litigation: Before and After "Ipp"' (2006) 14 *Torts Law Journal* 233

Wright, Ted and Angela Melville, 'Hey, But Who's Counting? The Metrics and Politics of Trends in Civil Litigation' in Wilfrid R Prest and Sharyn L Roach Anleu (eds), *Litigation: Past and Present* (UNSW Press, 2004) 96

Wu, Albert W, 'Medical Error: The Second Victim - The Doctor Who Makes the Mistake Needs Help Too' (2000) 172(6) *Western Journal of Medicine* 358

Wu, Albert W and Rachel C Steckelberg, 'Medical Error, Incident Investigation and the Second Victim: Doing Better but Feeling Worse?' (2012) 21(4) *BMJ Quality & Safety* 267

Yeo, Stanley, *Fault In Homicide* (Federation Press, 1997)

Yeung, Karen, Jeremy Horder and Jeremy Horder, 'How Can the Criminal Law Support the Provision of Quality in Healthcare?' [2014] *BMJ Quality & Safety* 2688

'Young Woman's Death. a Doctor Committed. Sydney, Dec. 12.' *The West Australian* (Perth, WA), 13 December 1921 7

Youngberg, Barbara J, *Patient Safety Handbook* (Jones & Bartlett Publishers, 2012)

Zabinski, Zenon and Bernard S Black, 'The Deterrent Effect of Tort Law: Evidence from Medical Malpractice Reform' [2013] *SSRN Electronic Journal* <<http://www.ssrn.com/abstract=2161362>>

B Cases

Andrews v DPP [1937] AC 576

B2328-05 2006 NJA 228

Banditt v The Queen 224 CLR

Burns v The Queen (2011) 205 A Crim R 240

Burns v The Queen (2012) 246 CLR 334

Callaghan v R [1952] HCA 55 (1952)

DPP v Morgan [1976] AC 182

Gore v Board of Medical Quality Assurance (1980) 110 Cal.App.3d 184

HCCC v Pegios (No 1) [2009] NSWDT 1 (16 October 2009)

HCCC v Pegios (No 2) [2010] NSWDT 1 (18 June 2010)

HCCC v Pegios (No 3) [2010] NSWDT 2 (15 September 2010)

He Kaw Teh v The Queen (1985) 157 CLR 523

Health Care Complaints Commission v Arthur Garry Gow [2008] NSWMT No 40011

Inquest into the Death of Nardia Annette Cvitic [2007] Brisbane Coroner's Court COR/02 2727 (29 October 2007)

King v The Queen (2012) 245 CLR 588

Kong Cheuk Kwan v The Queen (1985) 82 Cr App R 18

La Fontaine v The Queen (1976) 136 CLR 62

Lane v The Queen [2013] NSWCCA 317 (13 December 2013)

Medical Board of Queensland v Pearce [2001] QHPT 4 (20 July 2001)

Moore v The King [1926] SASR 52

Nydam v The Queen [1977] VR 430

Patel v The Queen (2012) 247 CLR 531

R v Adomako [1995] AC 171 (1995)

R v Bateman (1925) 19 Cr App R 8

R v Caldwell [1981] AC 394

R v Crabbe (1985) 156 CLR 464

R v Gary Gow [2006] NSWDC 78 (27 October 2006)

R v Gunter (1921) 21 SR (NSW) 282

R v Holzer [1968] VR 481

R v Lavender [2004] NSWCCA 120 (21 May 2004)

R v Lavender (2005) 222 CLR 67

R v Lawrence [1982] AC 510

R v Lubienski [1893] NSWLawRp 11 (3 March 1893)

R v Misra and Srivastava [2004] EWCA Crim 2375 (2004)

R v Misra and Srivastava (2005) 1 Cr. App. R. 21

R v Mitchell [2005] VSCA 304 (15 December 2005)

R v Nicholls 13 Cox CC 75

R v Patel [2010] QSC 233

R v Patel [2013] District Court of Queensland Indictment No 1701 of 2013 (21 November 2013)

R v Patel; ex parte A-G (Qld) [2011] QCA 81 (21 April 2011)

R v Pearce [2000] Queensland Supreme Court Indictment No 96 of 2000 (15 November 2000)

R v Pegios [2008] NSWDC 105 (2008)

R v Pegios [2008] NSWDC 104 (2008)

R v Shields [1981] VR 717

R v Sood (Ruling No 3) [2006] NSWSC 762 (15 September 2006)

R v Stephenson [1976] VR 376

R v Taktak (1988) 14 NSWLR 226

R v Taylor (1983) 9 A Crim R 358

R v Thomas Sam; R v Manju Sam (No 18) [2009] NSWSC 1003 (28 September 2009)

R v Valentine [1842] TASSupC 4 (7 January 1842)

R v Yogasakaran [1990] NZLR 399

Reimers v Medical Council of NSW [2015] NSWCATOD 38 (2015)

Royall v The Queen [1991] CLR 378

SAM, Thomas v R SAM, Manju v R [2011] NSWCCA 36 (10 March 2011)

Seymour (1983) 2 AC 493

State v Randol (1979) 597 P.2d 672

The Matter of Dr Ailee Louis Clarke [2000] Medical Tribunal of New South Wales No. 40029\98 (15 June 2000)

Wilson v R (1992) 174 CLR 313

C *Legislation*

Civil Law Wrongs Act 2002 (ACT)

Civil Liability Act 2002 (NSW), (WA), (Tas), (Qld)

Crimes Act 1900 (ACT)

Criminal Code 2002 (ACT)

Criminal Code Act 1899 (QLD)

Criminal Code Act 1924 (Tas)

Criminal Code Act 1995 (Cth)

Criminal Code Act (NT)

Criminal Code Act Compilation Act (WA) 1913

Criminal Law Consolidation Act 1935 (SA)

Health Insurance Act 1973 (Cth)

Personal Injuries (Liability and Damages) Act 2003 (NT)

Wrongs Act 1958 (Vic), (SA)

D Other

ABC Radio National, 'Quality in Australian Health Care', *The Health Report*, 7 July 1997
<<http://www.abc.net.au/science/kelvin/files/s177.htm>>

ABC Television, 'Dead and Buried', *Four Corners*, 7 July 1998
<<http://www.abc.net.au/4corners/stories/s11793.htm>>

AustLII - *Australasian Legal History Libraries*
<<http://www.austlii.edu.au/au/special/legalhistory/>>

Australian and New Zealand College of Anaesthetists (ANZCA), 'Guidelines on Sedation And/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures' <<http://www.anzca.edu.au/documents/ps09-2014-guidelines-on-sedation-and-or-analgesia>>

Australian and New Zealand College of Anaesthetists (ANZCA), 'Guidelines on Sedation And/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures - Background Paper' <<http://www.anzca.edu.au/documents/ps09bp-2014-guidelines-on-sedation-and-or-analgesi.pdf>>

Australian Broadcasting Corporation, 'Dr Jayant Patel Case Leaves Legacy of Change in Health', *AM*, 16 November 2013 <<http://www.abc.net.au/am/content/2013/s3892392.htm>>

Australian Commission on Safety and Quality in Health Care, 'Australian Charter of Healthcare Rights'

Boland, Stuart, 'Retirement Dinner Speech given by Associate Professor Stuart Boland the Former Chairman of Avant Mutual' <<http://www.avant.org.au/news/20140828-stuart-bolland-farewell-speech-by-former-chairman-of-avant-mutual/>>

Brower-Latz, Andrew, *The Social Philosophy of Gillian Rose: Speculative Diremptions, Absolute Ethical Life* (PhD Thesis, Durham University, 2015)
<<http://etheses.dur.ac.uk/11302/>>

Cambridge Law Faculty, *Medicine, Mistakes and Manslaughter: A Criminal Combination: Oliver Quick* <<https://www.youtube.com/watch?v=SbbhwG4WEX8>>

'Decision of the Swedish Supreme Court (Högsta Domstolens) in the Matter of EH (B 2328-05)'
<http://www.hogstodomstolen.se/Domstolar/hogstodomstolen/Avgoranden/2006/2006-04-19_B_2328-05_dom.pdf>

Division, Australian Government Department of Health and Ageing Acute Care, 'The Australian Government Medical Indemnity Package'
<<http://www.health.gov.au/internet/main/publishing.nsf/Content/health-medicalindemnity-faq-package.htm>>

Doctors Fight Back on Soaring Indemnity Costs (3 December 2000) Australian Medical Association <<https://ama.com.au/media/doctors-fight-back-soaring-indemnity-costs>>

Fletcher, Debra A, *The Woman in the Dock Is a Monster: An Investigation of Female Criminality in the Hearings of the Perth Supreme Court, 1890-1914* (PhD Thesis, Edith Cowan University, 1995) <<http://ro.ecu.edu.au/theses/1194/>>

Ghandeharian, Sacha, *Moral Distanciation: Modernity, Distance, and the Ethics of Care* (MA Thesis, Carleton University Ottawa, 2014) <<https://curve.carleton.ca/system/files/theses/31771.pdf>>

Legg, Michael, *Tort Wars: Class Actions Set to Increase as Laws Wind Back The Conversation* <<http://theconversation.com/tort-wars-class-actions-set-to-increase-as-laws-wind-back-32707>>

Medical Indemnity Insurance Association of Australia, 'Medical Indemnity Insurance: An Introduction' <http://www.miaaa.com.au/_files/f/879/Medical%20Indemnity%20Insurance%20An%20Introduction.pdf>

Minitab, Inc, 'Minitab 17 Statistical Software' <www.minitab.com>

Model Criminal Code Officers Committee of the Standing Committee of Attorneys-General, 'Discussion Paper: Model Criminal Code Chapter 5 - Fatal Offences Against the Person' <[http://www.ema.gov.au/www/agd/rwpattach.nsf/VAP/\(03995EABC73F94816C2AF4AA2645824B\)~modelcode_ch5_non-Fatal_offences_report.pdf/\\$file/modelcode_ch5_non-Fatal_offences_report.pdf](http://www.ema.gov.au/www/agd/rwpattach.nsf/VAP/(03995EABC73F94816C2AF4AA2645824B)~modelcode_ch5_non-Fatal_offences_report.pdf/$file/modelcode_ch5_non-Fatal_offences_report.pdf)>

National Health Service, United Kingdom, Health and Social Care Information Centre, 'NHS Data Model and Dictionary - NHS Business Definitions - Supporting Information: Consultant Episode (Hospital Provider)' <[http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/c/consultant_episode_\(hospital_provider\)_de.asp?shownav=1](http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/c/consultant_episode_(hospital_provider)_de.asp?shownav=1)>

National Library of Australia, *Trove* National Library of Australia <www.trove.nla.gov.au>

Pippin, Robert, *Participants and Spectators* (April 2010) On the Human <https://nationalhumanitiescenter.org/on-the-human/2010/04/participants_and_spectators/>

Radio National, Australian Broadcasting Corporation, 'Bundaberg's Dr Death', *Radio National*, 7 June 2005 <<http://www.abc.net.au/radionational/programs/backgroundbriefing/bundabergs-dr-death/3451382>>

Richards, Noel David, *Sidney Walter Spark* (2 February 2014) Australian Medical Pioneers Index <<http://www.medicalpioneers.com/cgi-bin/index.cgi?detail=1&id=2080>>

Rowland, Paula, *Power/knowledge, Identity and Patient Safety: Intersections of Patient Safety and Professional Practice Discourses in a Canadian Acute Care Hospital* (PhD Thesis, Fielding Graduate University, 2013)

Tjong, Richard, 'Medical Indemnity Industry in Australia' <<http://www.richardtjong.com.au/medical-indemnity/dr-richard-tjong-medical-indemnity-industry-in-australia/>>

Travaglia, Joanne Francis, *Locating Vulnerability in the Field of Patient Safety* (PhD Thesis, University of New South Wales, 2009)

Wooldridge, Michael, 'Australia's Health Ministers Are Acting on Quality Issues. Press Release MW 40/97 5 May 1997'

'No Quick Fix for Medical Indemnity Insurance Crisis', *Insiders*, 28 April 2002 <<http://www.abc.net.au/insiders/content/2002/s541902.htm>>