

MEDICAL MANSLAUGHTER

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On 20 April 2009, Dr Jayant Patel was committed to stand trial in the Brisbane Supreme Court on three counts of manslaughter in relation to the deaths of patients under his care during his time as director of surgery at Bundaberg Base Hospital from 2003 to 2005. 'Dr Death', as he has become known in Australia's media, faces a further 10 charges including several counts of grievous bodily harm arising from his treatment of patients.

If Dr Patel is convicted of any of the manslaughter charges, he will be the first doctor in Australia since Dr William Valentine in 1843 to be found liable for the manslaughter of a patient. This, perhaps astonishing fact, must be further considered against the extremely small number of doctors who have actually been charged with the manslaughter of their patients. This is also despite regular damning reports in the media concerning the number of deaths attributed to sub-standard medical treatment.¹

In 2002, the Medical Error Action Group reported that each year more than 18,000 people die in Australia from 'avoidable medical adverse events'.² In January 2009, it was reported that:

A four-year study of NSW hospitals has revealed staff and senior health bureaucrats blame each other for shocking errors, including deaths of patients. The statewide 'safety check' found patients were at significant risk of death or injury from falls, medication errors, staffing levels, lax infection control and mistakes in diagnosis and treatment.³

While a number of deaths have and will continue to give rise to damages claims for negligence by doctors, other health professionals or hospitals, as well as to professional disciplinary action such as suspension, the number of criminal prosecutions has been miniscule. This article assesses two interrelated explanations for this. These are i) a lack of willingness to prosecute doctors and ii) the significant legal difficulties in obtaining a conviction. To assess fully i) is beyond the scope of this article, though some explanations are postulated. As for ii), it is argued that there are indeed significant legal obstacles to obtaining a conviction and these are a major reason for the low prosecution rate.

The term medical manslaughter is used here to cover all incidents where a victim has been killed by apparent gross negligent medical treatment. Such treatment, however, is not restricted to treatment only by qualified doctors, and while the article focuses on the liability of doctors, cases involving other health care providers are considered. It is also acknowledged that liability for medical manslaughter in Australia differs between those states and territories adopting the common law

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¹ It is acknowledged that not all of these deaths were due to medical negligence.

² Tracy Bowden, *The Danger in Australian Hospitals* (2002) ABC 7:30 Report <<http://www.abc.net.au/7.30/content/2002/s496140.htm>> at 23 May 2009.

³ Louise Hall, 'Hospital Management and Staff Pass the Buck', *Sydney Morning Herald* (Sydney), January 25 2009.

offence of negligent manslaughter⁴ and the Code states and territories that hold that manslaughter is proven where there is a negligent breach of a 'duty relating to the preservation of human life'. Under the Queensland Criminal Code, for example, s 303 defines manslaughter as:

A person who unlawfully kills another under such circumstances as not to constitute murder is guilty of manslaughter.⁵

In Chapter 27 – Duties relating to the preservation of human life – s 288 states:

It is the duty of every person who, except in a case of necessity, undertakes to administer surgical or medical treatment to any other person, or to do any other lawful act which is or may be dangerous to human life or health, to have reasonable skill and to use reasonable care in doing such act, and the person is held to have caused any consequences which result to the life or health of any person by reason of any omission to observe or perform that duty.⁶

Since 1990,⁷ only three doctors (including Dr Patel) and a dentist have been charged with the manslaughter of their patients. While Dr Patel's case is ongoing, one of the doctors and the dentist were acquitted at trial, with the other doctor's charges being dropped. Dr Gerrit Reimers, who was acquitted in 2001, was the first doctor in NSW history to be charged with the manslaughter of a patient.⁸ In 2007, a Queensland doctor, Dr Bruce Ward was charged with the manslaughter of a patient in his care and while media coverage does not state this, it is likely that he was the first doctor in Queensland history to be so charged.⁹ Dr Ward's charges were subsequently dropped and as such Dr Patel is the first Queensland doctor to face trial for medical manslaughter. As noted, no doctor has been convicted for the manslaughter of a patient anywhere in Australia since Dr Valentine in 1843. It is very difficult to be certain but there is a strong likelihood that only three doctors and a dentist have even been charged since Dr Valentine.¹⁰

Comparative figures from England are still low in terms of charges and convictions, but not as low as in Australia. English figures referred to later indicate a greater propensity for English doctors to be charged with medical manslaughter and for the courts there to convict compared to Australia. This is of legal significance

⁴ New South Wales, Victoria, South Australia and the Australian Capital Territory (ACT).

⁵ *Criminal Code 1899* (Qld).

⁶ *Criminal Code 1899* (Qld). This is identical to *Criminal Code 1913* (WA) s 265 and *Criminal Code 1983* (NT) s 150. It is different but very similar to *Criminal Code 1924* (Tas) s 149, which must also be read in conjunction with s 156(2)(b) which states: '(2) Homicide is culpable when it is caused – (b) by an omission amounting to culpable negligence to perform a duty tending to the preservation of human life, although there may be no intention to cause death or bodily harm.'

⁷ This start date is chosen because no cases of medical manslaughter can be identified prior to this date, the exception being Dr Valentine. It is also chosen so as to allow for certain comparisons to be made between Australia and England.

⁸ *Drug Addicted Anaesthetist Struck off Register* (2003) ABC News <<http://www.abc.net.au/news/stories/2003/11/04/981905.htm>> at 29 March 2009.

⁹ Sean Parnell, *Surgeon Charged with Manslaughter*, (2007) News.com.au <<http://www.news.com.au/story/0,23599,22669131-2,00.html>> at 29 March 2009.

¹⁰ This is based on a media search but it is accepted that this may not be conclusive and charges against doctors may have been laid in the past but subsequently dropped.

because the current Australian legal position on medical manslaughter is largely based on that in England. This is assessed as part of the legal analysis that follows but other literature is also considered which indicates other differences, not the least being an apparent greater preparedness of England's Crown Prosecution Service to lay such charges.

Before beginning, however, it is of interest briefly to consider the case of Dr Valentine. The accused was charged with manslaughter by medical negligence, the trial taking place in the Supreme Court of Van Dieman's Land on 7 January 1842. The facts and legal basis for the charge are best summed up in a quote from the report outlining the case presented by the Attorney-General who acted as the public prosecutor.

The facts of the case had been detailed before a coroner's inquisition. From them it appeared, that on the morning of the 20th November Mr. Swifte felt himself indisposed before breakfast, and sent for some medicine to Dr. Valentine, who kept a dispensary at Campbell Town. The prisoner intended to have sent a black draught, (*but instead sent back a bottle containing laudanum*¹¹) – and here he wished 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, although it was necessary for the law to allege that it was done feloniously; and if they were of opinion that the negligence evinced was of a culpable nature, that was sufficient to sustain the charge which it had become his distressing duty to prosecute.¹²

After hearing the evidence and the testimony of a number of character witnesses for the accused, 'the jury did not retire long and brought in a verdict of guilty with a strong recommendation to mercy.' The judge 'addressed the prisoner, and said he should be sorry to aggravate the sufferings he must have endured in consequence of the melancholy occurrence which placed him there, nor would he do more than express his entire concurrence with the verdict of the jury. Taking into consideration their recommendation to mercy as also the palliating circumstances of the case, the sentence he should pass would be a fine of twenty-five pounds to the crown'.¹³

I MEDICAL MANSLAUGHTER IN AUSTRALIA

As noted in the introduction, the approach taken by Australian states and territories to medical manslaughter is generally divided between those jurisdictions that have adopted the common law offence of negligent manslaughter (for example New South Wales) and those, like Queensland, which statutorily state that a person who 'undertakes to administer surgical or medical treatment to any other person, or to do any other lawful act which is or may be dangerous to human life or health ... is held to have caused any consequences which result to the life or health of any person by reason of any omission to observe or perform that duty'. Liability for manslaughter follows where the failure to observe or perform the duty is negligent. While these different approaches are legally significant, the approach to negligence is largely the same. In *Callaghan*,¹⁴ the High Court, in dealing with provisions of the Western Australian Criminal Code noted that:

¹¹ Author's addition

¹² *R v Valentine* [1842] TASSupC 4, 1.

¹³ *Ibid* 5.

¹⁴ *Callaghan v R* [1952] HCA 55.

It would be wrong to suppose that it was intended by the Code to make the degree of negligence punishable as manslaughter as low as the standard of fault sufficient to give rise to civil liability. The standard set both by s 266 and by s 291A should, in our opinion, be regarded as that set by the common law in cases where negligence amounts to manslaughter.¹⁵

The High Court also referred to House of Lords decision in *Andrews* where Lord Aitkin noted that:

Simple lack of care such as will constitute civil liability is not enough: for purposes of the criminal law there are degrees of negligence: and a very high degree of negligence is required to be proved before the felony is established.¹⁶

Callaghan was subsequently applied by the Victorian Supreme Court in *Nydam*, this judgment containing what is now the most definitive judicial statement on the requirements of negligent manslaughter.

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.¹⁷

As in *Callaghan*, the court in *Nydam* was also significantly influenced by the decision in *Andrews*, the Victorian Supreme Court further noting Lord Aitkin's following of the earlier case of *Bateman*.¹⁸ The authority of *Nydam* has been subsequently confirmed by the High Court in *Wilson*¹⁹ and *Lavender*.²⁰

While *Nydam* was a case of a negligent act, its test for negligence also applies to negligent omissions. It is this area of negligent manslaughter which is most relevant to cases of medical manslaughter. This is based on death arising from a doctor's breach of his/her duty of care. A leading New South Wales authority is *Taktak*. While not a case of medical manslaughter, Carruthers J stated that:

It was incumbent upon the Crown to prove beyond reasonable doubt:
(1) That the appellant owed a duty of care in law...

¹⁵ Ibid [17].

¹⁶ *Andrews v DPP* (1937) AC 576, 583

¹⁷ *Nydam v R* [1977] VR 430, 445. It is significant to note the legislative adoption of the *Nydam* test for negligence in both the Northern Territory and ACT Criminal Codes. Section 43AL of the Northern Territory Code provides that: A person is negligent in relation to a physical element of an offence if the person's 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. This is nearly identical to s21 of the ACT Code.

¹⁸ *R v Bateman* (1925) 19 Cr App R 8. *Bateman* is also significant as it is one of the earliest reported English manslaughter cases involving a medical practitioner.

¹⁹ *Wilson v R* (1992) 107 ALR 257.

²⁰ *R v Lavender* (2005) 218 ALR 521.

(2) That it was the omission of the appellant to obtain medical treatment which was the proximate cause of ... death.

(3) That such omission by the appellant was conscious and voluntary, without any intention of causing death 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 would follow that the omission merited criminal punishment.²¹

With regard to (3), it is clear that this is an adaptation of *Nydam*. Carruthers went on to note that the main problems with the Crown's case in *Taktak* related to (2) and (3). Leaving aside the issue of causation, which could well be an issue in medical manslaughter cases, a significant obstacle to conviction lies in the degree of negligence required. In this regard, Carruthers referred to the judgement of Yeldham J. While Yeldham considered numerous authorities, including *Andrews* and *Bateman*, he focussed on the 1874 case of *Nicholls*.²² In allowing *Taktak's* appeal, Yeldham ruled:

I am of the view that any conclusion that the appellant was guilty of manslaughter, having regard to the high degree of negligence required, should be set aside as being unsafe and unsatisfactory. I mention but few of the authorities. In *R v Nicholls* Brett J (at 76) told the jury that a grown up person who chooses to undertake the charge of a human creature who is helpless is bound to execute that charge 'without (at all events) wicked negligence ... Mere negligence will not do, there must be wicked negligence, that is, negligence so great, that you must be of the opinion that the prisoner had a wicked mind, in the sense that she was reckless and careless whether the creature died or not'. In *R v Bonnyman*²³ the Lord Chief Justice, after referring to *R v Bateman* [1925]²⁴ and to *Andrews* reiterated the need for 'a very high degree of negligence' to be proved before the felony of manslaughter is established.²⁵

In *Pace and Conduit*,²⁶ two Victorian Government carers were acquitted of manslaughter over the death of a disabled man who died after drinking liniment at a suburban football match.

In upholding a 'no case to answer' submission, Lasry J ruled that:

An appropriate starting point for a consideration of *manslaughter by criminal negligence* is *R v Nydam*. (emphasis added)

He then went on to note that:

It had been earlier determined by the House of Lords, in *Andrews v DPP*, that to establish manslaughter by a negligent act or omission it must be established that the negligent act or omission is so gross as to go beyond a mere matter of compensation between the wrong-doer and the victim. *Andrews* was confirmed by *R v Adomako*, meaning that in England proof of the offence of manslaughter requires a death resulting from the negligent breach of a duty of care owed by the defendant to the deceased and that in the negligent breach of that duty, the victim was exposed by the defendant to risk of death in circumstances so reprehensible as to amount to gross negligence.

²¹ *R v Taktak* (1988) 14 NSWLR 226, 250.

²² *R v Nicholls* (1874) 13 Cox CC 75.

²³ (1942) 86 Sol Jo 274; 28 Cr App R 131.

²⁴ *Bateman*, see above n 18.

²⁵ *Taktak*, above n 21, 247.

²⁶ *R v Pace and Conduit (Ruling No 2)* [2008] VSC 308.

On the basis of the evidence as it stands, as to the allegation of a failure to supervise in the period leading up to the consumption by Mr Chuter of the liniment, I am unable to identify any evidence the jury could rely upon to conclude that that conduct was criminally negligent – i.e. that there was such a significant departure from the applicable standard of care that it merits criminal punishment. Further, whatever might be the case in the application of the civil law of negligence, I agree that the manner of supervision is not capable of sustaining the allegation that its quality held a high risk of death or really serious injury.²⁷

In *Pegios*,²⁸ a dentist, was charged with the gross negligent manslaughter of a 67 year old male patient. The central issues before the court were i) whether the drugs had been negligently administered by the defendant, ii) whether the defendant's response was negligent and iii) the degree of negligence required. With regard to i) and ii), Murrell SC DCJ, sitting without a jury, noted that:

In order to establish negligence, more is required than medical error or misjudgement.²⁹

He then went on to conclude that he was not satisfied beyond reasonable doubt that the drugs had been negligently administered. He was satisfied, however, that Dr Pegios had been negligent in his response.

Given the recurring low readings, lack of sustained recovery, and the serious risks associated with oxygen deprivation, a reasonable dentist in the accused's situation would have terminated the procedure well before 9.45 am. I am satisfied beyond reasonable doubt that, in this respect, the accused was negligent.³⁰

As to the final issue, iii), the degree of negligence required:

The offence of manslaughter requires gross negligence in circumstances where what is at risk is the life of the individual to whom the accused owes a duty of care: *R v Misra* [2004] EWCA Crim 2375, applying *R v Adomako* [1995] 1 AC 171.

As to the degree of negligence needed to establish manslaughter, in *R v Bateman* (1925) 19 Cr App R 8 at 11, the Lord Chief Justice said: '*judges have used many epithets, such as 'culpable,' 'criminal,' 'gross,' 'wicked,' 'clear,' 'complete.'* But, whatever epithet be used and whether an epithet be used or not, in order to establish criminal liability the facts must be such that, in the opinion of the jury, the negligence of the accused went beyond a mere matter of compensation between subjects and showed such disregard for the life and safety of others as to amount to a crime against the State and conduct deserving of punishment.' (emphasis added)³¹

This legal position has been very recently confirmed by the NSW Court of Criminal Appeal in *Cittadini*.³²

²⁷ Ibid.

²⁸ *R v Pegios* [2008] NSWDC 105

²⁹ Ibid.

³⁰ Ibid [64].

³¹ Ibid [65] and [66].

³² *R v Cittadini* [2008] NSWCCA 256. This was not a case of medical manslaughter. The charges arose from the drowning deaths of four crew members of a yacht.

Manslaughter by criminal negligence is committed where an accused causes the death of a person by an act or omission which so far falls short of the standard of care required by a reasonable person, that it goes beyond a matter of civil wrong and amounts to a crime: *Nydam v R* [1977] VR 430 (apparently approved by the High Court in *The Queen v Lavender* [2005] HCA 37; 222 CLR 67 at 87). To prove the offence a very high degree of negligence is necessary: *Andrews v DDPP* [1937] AC 576; *R v Adomako* [1995] 1 AC 171.

Where it is alleged that the accused is guilty of manslaughter by reason of an omission, the Crown must prove that the accused owed a personal legal duty of care to the victim and failed to carry out that duty to such a high degree that it could be viewed as 'wicked' negligence: *R v Taktak* (1988) 14 NSWLR 226.³³

II MEDICAL MANSLAUGHTER IN ENGLAND

The leading authority is the House of Lords decision in *Adomako*. This case arose from the death of a patient during a routine eye operation. During the operation, the victim was connected to a mechanical breathing tube. This tube became disconnected and although an alarm sounded, the defendant, the anaesthetist at the time and the doctor responsible for this aspect of the operation, failed to notice or remedy the disconnection. Two expert witnesses for the prosecution described the defendant's standard of care as 'abysmal' and a 'gross dereliction of care'.³⁴

Lord Mackay, Lord Chancellor, who gave the judgment of the court, reviewed the authorities, notably the cases of *Bateman* and *Andrews*, noting in particular the decision in *Andrews* as a previous decision of the House of Lords. As to the elements of the offence he stated:

On this basis in my opinion the ordinary principles of the law of negligence apply to ascertain whether or not the defendant has been in breach of a duty of care towards the victim who has died. If such breach of duty is established the next question is whether that breach of duty caused the death of the victim. If so, the jury must go on to consider whether that breach of duty should be characterised as gross negligence and therefore as a crime. This will depend on the seriousness of the breach of duty committed by the defendant in all the circumstances in which the defendant was placed when it occurred. The jury will have to consider whether the extent to which the defendant's conduct departed from the proper standard of care incumbent upon him, involving as it must have done a risk of death to the patient, was such that it should be judged criminal.³⁵

His Lordship then went on to consider the use of the term reckless by Lord Aitkin in *Andrews*, agreeing with Lord Aitkin that it should be given its ordinary meaning. As such, 'it is perfectly open to a trial judge to use the word 'reckless' if it appears appropriate in the circumstances of a particular case as indicating the extent to which a defendant's conduct must deviate from that of a proper standard of care'.³⁶ In this regard, however, his Lordship accepted that the test was somewhat circular but 'in this

³³ Ibid [4] and [5].

³⁴ *R v Adomako* [1995] 1 AC 171, 182.

³⁵ Ibid 187.

³⁶ Ibid 189. This is significant because of the confusion arising from the notion of the concept of objective recklessness for the purposes of negligent manslaughter as compared to the subjective notion of conscious risk taking.

branch of the law that is not fatal to its being correct as a test of how far conduct must depart from accepted standards to be characterized as criminal'.³⁷

Adomako was most recently considered in *Misra*.³⁸ Here the Court of Appeal stated:

In our judgment the law is clear. The ingredients of the offence have been clearly defined, and the principles decided in the House of Lords in *Adomako*. They involve no uncertainty. The hypothetical citizen, seeking to know his position, would be advised that, assuming he owed a duty of care to the deceased which he had negligently broken, and that death resulted, he would be liable to conviction for manslaughter if, on the available evidence, the jury was satisfied that his negligence was gross. A doctor would be told that grossly negligent treatment of a patient which exposed him or her to the risk of death, and caused it, would constitute manslaughter.³⁹

In commenting on *Misra*, Barsby and Omerod criticized the judgment for not meeting the criticisms of circularity; as well the test required a jury to determine the scope of the criminal law. They did note, however, that the judgment 'provided welcome clarification that only the risk of death (not serious injury) will be sufficient for gross negligent manslaughter'.⁴⁰ This clarification has not yet occurred in Australia, *Nydam* referring to a risk of death or really serious injury.⁴¹

Whatever the legal criticisms of *Adomako*, the case serves as a focal point for a major shift in the prosecution of medical manslaughter in the United Kingdom. In 2000, Ferner found that there were two medical manslaughter cases in the period from 1970-89 compared to 13 cases (involving 17 doctors) from 1990-9.⁴² This figure, however, does not include incidents where there was an investigation but no charges laid. In this regard, and in a more recent study, Quick identified 40 incidents that were investigated from 1996-2005. This resulted in 19 convictions for manslaughter although six defendants subsequently had their convictions quashed on appeal.⁴³

As such both investigations and charges, while still small in number, can no longer be said to be rare. Quick states that it is of some interest that this apparent increase coincided with the establishment of the Crown Prosecution Service in 1986. This in itself does not explain the increase but Quick suggests a number of interrelated factors that assist in understanding why this has occurred. At a general level, he notes a decline in community trust of professions, including the medical profession. This in turn has led to a significant increase in complaints and government enquiries. Much of this has also been played out in the media with significant attention being given to the costs of such medical mistakes. Where such mistakes result in fatalities, then considerable public pressure for action of one kind

³⁷ Ibid 187.

³⁸ *R v Misra* [2004] EWCA Crim 2375.

³⁹ Ibid [64].

⁴⁰ Clare Barsby and David Omerod, 'Manslaughter: Manslaughter through Gross Negligence – Whether Sufficient Certainty as to Ingredients of Offence' (2005) *Criminal Law Review* 234, 238

⁴¹ There is confusion here with cases such as *Pace* and *Pegios*, for example, appearing to limit the risk to the death of the victim.

⁴² RE Ferner, 'Medication errors that have led to manslaughter charges' (2000) *British Medical Journal* 1.

⁴³ Oliver Quick, 'Prosecuting 'Gross' Medical Negligence: Manslaughter, Discretion, and the Crown Prosecution Service' (2006) 33(3) *Journal of Law and Society* 421, 427

or another arises. The increase in prosecutions is a response to such pressure and Quick notes that 'the very definition of this offence depends on the use of discretion by prosecutors'.⁴⁴

III CONCLUSION

In terms of Quick's explanations for the increase in prosecutions in England, it is difficult to identify any differences in these factors between Australia and England. As noted in the Introduction, there has been considerable concern in Australia with the state of medical services combined with numerous incidents of apparent medical negligence. Many of these incidents have also led to patient deaths. What then is the explanation for the lack of prosecution of medical manslaughter in Australia?

As noted from the legal analysis above, the prosecution faces a number of difficulties in obtaining a conviction for medical manslaughter. These difficulties include: i) proof of causation, where the victim was already suffering from a serious illness; ii) that the mistreatment was negligent in terms of it being a breach of a duty of care; and iii) that the degree of negligence was so gross or culpable as to warrant criminal conviction and punishment.

Pegios is perhaps the best and most recent example of these difficulties. As noted in Murrell's judgment, Dr *Pegios* had not been negligent in his administration of certain drugs. According to the evidence, the dosage may have been high 'but not excessive'. This was despite 'an inappropriate loss of consciousness that was associated with a serious risk of injury'. In this regard, Murrell J also placed importance on the accused's completion of a University of Sydney Diploma during which he had been taught that the dosage levels he administered were acceptable.⁴⁵ There was a contrary finding, however, regarding his failure to appropriately respond once the victim's oxygen desaturation levels had fallen to 90%. There being no argument as to causation, it could therefore be said that causation and breach of his duty of care to respond appropriately had been established in the judge's opinion. The prosecution ultimately failed, however, on the basis that there was simply insufficient evidence to prove that such negligence was gross and criminal.

One could not expect that a reasonable general dentist practising sedation would have been better informed than the accused. The deficiency was largely a deficiency in training and accreditation. The accused's negligent conduct fell well short of that which would 'amount to a crime against the State and conduct deserving of punishment'.⁴⁶

In terms of authority it is significant again to note Murrell's reliance on the English decisions in *Misra*, *Adomako* and *Bateman*.⁴⁷

While there are legal differences between the common law approach to negligent manslaughter as demonstrated by *Taktak* and liability for medical manslaughter in the Code states and territories, *Callaghan* noted that the degree of negligence required for breaches of the relevant duty provisions in the Western Australian Criminal Code 'be regarded as that set by the common law in cases where

⁴⁴ Ibid 429.

⁴⁵ *Pegios*, n 28 above, [45]-[49].

⁴⁶ Ibid.

⁴⁷ It is somewhat surprising, however, that there is no reference to the NSW Court of Criminal Appeal decision in *Taktak*. This would appear to be an oversight but is of little importance given *Taktak's* confirmation in *Cittadini*.

negligence amounts to manslaughter'.⁴⁸ In this regard, it is especially important to note the decision in *Nydam* regarding the degree of negligence required; that is, conduct which involved such a high risk of death or grievous bodily harm that the doing of which merited criminal punishment. Decisions such as *Nydam* have in turn adopted the judicial reasoning in the English cases of *Nicholls*, *Bateman*, *Andrews* and *Adomako*. *Bateman* is of considerable historical significance as one of the first English cases of negligent manslaughter involving a doctor. In allowing Dr Bateman's appeal and quashing his conviction, the Court of Criminal Appeal stated that:

(i)n order to establish criminal liability the facts must be such that, in the opinion of the jury, the negligence of the accused went beyond a mere matter of compensation between subjects and showed such disregard for the life and safety of others as to amount to a crime against the State and conduct deserving of punishment.⁴⁹

Recent Australian case law⁵⁰ has been quite specific in its confirmation of the legal position taken in England, notably that taken by the House of Lords in *Adomako*, and while this judgment continues to receive academic criticism there is no questioning its current legal authority.⁵¹ It is also of interest to note that the circumstances involving Dr Adomako are not dissimilar to those of Dr Gerrit Reimers. In 2001 Dr Reimers was found not guilty by a New South Wales District Court jury of the manslaughter of 74 year old Shirley Byrne. Mrs Byrne died of severe brain damage after Dr Reimers, the anesthetist in her operation, failed to notice that she had stopped breathing. This is a controversial case because Dr Reimers was later suspended for 10 years by the NSW Medical Tribunal 'for taking patients' drugs and failing to properly monitor people under his care, contributing to at least one death'.⁵² In the Tribunal hearing, Dr Reimers admitted that he may have been under the influence of drugs during Mrs Byrne's operation. Evidence of Dr Reimers' drug use, however, was not allowed at his trial for manslaughter.

What then is the explanation for the apparent difference between England and Australia in terms of the charging of medical practitioners with the manslaughter of their patients? One answer is that the difference is pure chance and that cases similar to those in England have simply not arisen in Australia. In addition to this we could also note the obvious differences in population size. As noted in the introduction, however, the level of growing concern over the number of patient deaths in Australia due to sub-standard medical treatment makes this explanation unlikely. If the figures of the Medical Error Action Group are to be believed, 18,000 people die in Australia annually from 'avoidable medical adverse events'.⁵³

Despite this figure, only three doctors and a dentist appear to have been charged with manslaughter since 1990. In fact these may be the only four charges laid since Dr Valentine in 1843. With the exception of Dr Valentine no doctor has yet been convicted. In his article Quick suggests that the explanation for the increase in charges in England since 1990 has been a response by the Crown Prosecution

⁴⁸ *Callaghan*, see above n 14.

⁴⁹ *Bateman*, see above n 18, 11.

⁵⁰ See *Pace and Conduit*, see above n 26, *Pegios*, see above n 28 and *Cittadini*, see above n 32.

⁵¹ Note *Misra*, see above n 38.

⁵² *Addict Doctor's 10-year Ban* (2003) Fairfax Digital <<http://www.smh.com.au/articles/2003/11/04/1067708212677.html>> at 23 March 2009.

⁵³ Bowden, see above n 2.

Service to growing public pressure for such action. Certainly the case of Dr Patel, including his very expensive extradition from the United States, is an example of an Australian (in this case Queensland) justice system's response to such public pressure.

In England, however, this increase in prosecution has been met with considerable opposition from the medical profession. While there will be the obvious criticisms of professional bias and protecting one's own, Dyer believes charging doctors with manslaughter and the subsequent involvement of the criminal process may inhibit a full and proper inquiry into such deaths. He does acknowledge, however, that:

(t)he relatives of those killed will often feel that without a criminal sanction grossly negligent doctors will have got away with it.⁵⁴

Writing in the same journal as Dyer, Elias-Jones contends that 'an over-zealous crown prosecution service and judiciary convicting for simple and careless mistakes will have serious consequences ... The eventual result will be a deficient health service of detriment to future patients'.⁵⁵

Properly assessing the views of Australia's state and territory prosecution agencies as to their views and approaches to charging doctors with negligent manslaughter is a major research project and beyond the scope of this article. As Quick noted above, however, 'the very definition of this offence depends on the use of discretion by prosecutors'.⁵⁶ Therefore it is certainly debatable whether the Australian prosecution agencies have got the balance right in terms of when and when not to charge and proceed to trial. The statistics previously referred to raise questions about this. As noted above, there is little reason to believe that there is any difference between England and Australia in terms of a declining trust of the medical profession.

While medical manslaughter case numbers in Australia are small, it may be relevant to note the number of cases in Queensland and NSW since 1990 which involve health care providers generally, including doctors. In Queensland, there has been the conviction of two alternative health care providers,⁵⁷ the charging but subsequent dropping of manslaughter charges against two nurses,⁵⁸ the charging but again discontinuation of the prosecution of a doctor⁵⁹ and finally the committal of Dr Patel. NSW has seen the conviction of a naturopath,⁶⁰ the acquittal of a naturopath⁶¹,

⁵⁴ Simon Dyer, 'Gross negligence manslaughter: The facts of *R v Mulhem*' (2004) 10 *Clinical Risk* 28.

⁵⁵ Alun Elias-Jones, 'Medical manslaughter or systems failure?' (2004) 10 *Clinical Risk* 29.

⁵⁶ *Ibid* 429.

⁵⁷ See the sentencing appeal in *R v Pesnak & Anor* [2000] QCA 245 for a more detailed outline of the facts.

⁵⁸ Christine Kellet, *Nurses Plead Not Guilty to Manslaughter* (2008) Brisbane Times <<http://www.brisbanetimes.com.au/news/queensland/nurses-plead-not-guilty-to-manslaughter/2008/04/08/1207420364590.html>> at 29 March 2009.

⁵⁹ Parnell, see above n 9.

⁶⁰ *Naturopath gets five years for Baby's Deadly Treatment* (2004) Fairfax Digital <<http://www.smh.com.au/articles/2004/02/13/1076548205730.html>> at 29 March 2009.

⁶¹ *A Sydney Naturopath has been cleared of the manslaughter of a patient 'desperate for a cure' for his chronic kidney condition* (2007) Medical Search Australia and New Zealand from AAP New Wire <http://www.medicalsearch.com.au/News/Sydney_naturopath_is_cleared_of_kidney_patients_death-28269> at 23 March 2009.

the acquittal of a doctor⁶² and the acquittal of a dentist.⁶³ The extent to which these increased numbers in these two states are indicative of any trend is difficult to assess.

What is evident is that there are significant legal obstacles to conviction for medical manslaughter. In this regard, if Dr Valentine was to be charged today, it is most unlikely that a conviction would be obtained. While doctors may well be negligent in their treatment of patients, the degree of negligence required for a manslaughter conviction is high and may not be provable on the facts. Proceeding to prosecute doctors in any event would be wrong, with the damage to both the doctor and the profession being considerable.

Finally, while it is foolish and ethically wrong to make any predictions about the outcome in the Dr Patel case, certain comparisons can be drawn between the prosecution's case against Dr Patel and those cases mentioned above where the defendants have either been acquitted at trial⁶⁴ or the charges have been dropped.⁶⁵ Dr Patel's manslaughter charges involve:

- i) the incorrect diagnosis of bleeding and unnecessary removal of part of the patient's colon;
- ii) post operative bleeding following an operation which should not have been performed, and;
- iii) a failure to stop bleeding during an operation that Dr Patel was not qualified to perform.⁶⁶

Whatever the outcome of Dr Patel's trial, though, it may prove to be of profound legal significance to an Australian approach to medical manslaughter.

⁶² See above n 8.

⁶³ *Pegios*, see above n 28.

⁶⁴ Note here Dr Reimers and Dr Pegios.

⁶⁵ Note Dr Ward.

⁶⁶ *Patel Committed to Stand Trial* (2009) AAP, Sydney Morning Herald <<http://www.smh.com.au/national/patel-committed-to-stand-trial-20090420-ac58.html>> at 29 March 2009.