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# MEDICINE, MISTAKES AND MANSLAUGHTER: A CRIMINAL COMBINATION?

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Medical mistakes come in many shapes and sizes, but criminal law adopts a one size fits all approach – which, to my mind, can be a bad fit. For individuals at the sharp end, the stakes are high and stark: manslaughter prosecution or no action. Involuntary manslaughter is an amorphous category covering a wide range of unintentional (but culpable) killings, and medical cases are prosecuted with reference to the catch all concept of "gross negligence". This is not unique as an example of objective criminal liability; in fact, crimes of negligence are on the increase.[1] But its use in homicide, coupled with the absence of a lesser or inchoate crime, renders this an unsatisfactory "all or nothing" scenario, often hinging on moral luck[2] and prosecutorial (and expert witness) performance. Although relatively rare, such prosecutions have risen markedly over the past twenty years. To the best of my knowledge, since 1925, 65 health professionals have been charged with medical manslaughter – with over 50 of these since 1990.[3] Understandably, this has caused much anxiety for healthcare professionals and invited academic inquiry.[4]

This article considers how criminal law should deal with fatal medical error. I will attempt to defend the following thesis: that the current test for liability (gross negligence) is unclear, unprincipled, often unfair and ought to be abolished. I will argue that subjective reckless manslaughter is the proper place to set the bar for liability.

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[1] For example, supplying intoxicating substances to the under aged (Intoxicating Substance (Supply) Act 1985, s. 1(1)); causing death by dangerous driving (Road Traffic Act 1988, s. 1); insider trading (Criminal Justice Act 1993, s. 52(2)(a)); harassment (Protection from Harassment Act 1997, ss. 1(1) and 2(1)); providing money or property for the purposes of terrorism (Terrorism Act 2000, ss. 15–18); money laundering (Proceeds of Crime Act 2002, s. 330(2)(b)); and causing or allowing the death of a child or vulnerable adult (Domestic Violence, Crime and Victims Act 2004, s. 5).

[2] See J.C. Smith, "The Element of Chance in Criminal Liability" (1971) Crim. L.R. 63, and T. Nagel, *Mortal Questions* (London 1991).

[3] These statistics are based on searching newspaper archives. For further details see R. Ferner and S. McDowell "Doctors charged with manslaughter in the course of medical practice, 1795–2005: a literature review" (2006) 99 Journal of the Royal Society of Medicine 309. It is hoped that more detailed data about suspected cases will emerge from an ongoing AHRC funded project entitled "The Impact of the Criminal Process on Healthcare Ethics and Practice", see http://www.law.manchester.ac.U.K./research/hccriminalprocess (accessed 8 January 2010).

[4] O.L. Quick, "Prosecuting 'Gross' Medical Negligence: Manslaughter, Discretion and the Crown Prosecution Service" (2006) 33 Journal of Law and Society 421. This article draws on some of the findings from this paper.



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This approach is quite old fashioned. A more modern approach would see the creation of a specific offence for the health care context – perhaps "death by dangerous doctoring" – but I am against this option. We are living in an era of quite obscene over-criminalization. As Professor John Spencer has recently remarked, the U.K. government is (regrettably) big on "binge law making".[5] We should resist the temptation to gorge around gross negligence by creating new special offences here. We really do not need a Dangerous Docs Act! As Douglas Husak reminds us in his recent book, *Over-criminalization*,[6] prosecutorial discretion offers the only way of slimming down on criminal liability. He notes that statutes are in effect menus from which prosecutors choose. In these circumstances (and perhaps these alone) I would prefer a limited choice set menu as opposed to a lavish à la carte – more Little Chef than Heston Blumenthal perhaps!

We would be wise to focus on the few cases where juries agree with prosecutors and return a guilty verdict – which tells us something about what the powerful term "criminal" means here. This is somewhat limited – the numbers are small, and we do not know the detail of jury room deliberation – so it is hardly scientific or sophisticated. But to my mind, these are the sort of (reckless) cases where we should confine the criminal law's reach.

## I. Criminal Combination?

One preliminary question can be quickly dealt with – that is whether criminal law should be involved *at all* in dealing with medical error? Not even the staunchest sympathiser of the medical profession would call for a blanket ban on criminalisation. Some events will always be beyond the pale and warrant a criminal response. The tough task is to settle on a morally meaningful and fair framework for culpability. Given that this involves a wide range of conduct – from the blatantly reckless to the momentary slip – this is far from straightforward. In 1952 a Dr. Gray was convicted for causing the death of his patient after getting high by sniffing anaesthetic gases prior to an operation.[7] This is quite different from the case of another anaesthetist, a Dr. Falconer, prosecuted in 2006 for a momentary slip – he fatally injected oxygen into the wrong tube (going into the vein rather than the abdomen) – of the baby being operated on.[8] These are conceptually distinct: a clear violation versus a momentary slip. They are morally quite different. But legally speaking, both are swept up by the broad (and perhaps

[5] J.R. Spencer, "The Drafting of Criminal Justice Legislation – Need it be so Impenetrable?" [2008] C.L.J. 585.
[6] D. Husak, *Overcriminalization: The Limits of the Criminal Law* (Oxford 2008) at p. 26.
[7] See D. Brahams, "Death of a remand prisoner" (1992) 340 The Lancet 1462.
[8] "Doctor cleared" The Times, 19 May 2004, p. 4.

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brutal) brush of "gross negligence". I think this is wrong. But we don't need a new broom to sweep clean – there is no clear case for creating new offences. Rather, we need to rediscover recklessness, which should be the bottom line.

## II. Medical Manslaughter: Some History

Prosecutions of doctors for medical manslaughter is by no means a modern phenomena. The first known prosecution occurred in 1329 in Newcastle where a practitioner was "commended" to God.[9] "Gross" negligence emerged in the nineteenth century, when we find the first cluster of cases.[10] Although such cases are rare, their tendency to challenge the very basis of liability has often led them to the appeal courts and into law reports as our leading authorities on manslaughter.

The first of these concerned the conviction of a Dr. Bateman[11] for his treatment of his patient during the difficult delivery of her child. The baby was in the breech position, and in performing a manual "version" (to move the baby to the head down position), he mistakenly removed part of her uterus and caused other internal damage resulting in death. In allowing the appeal and quashing the conviction, the Court of Criminal Appeal formulated the following familiar test of liability:

> In explaining to juries the test which they should apply to determine whether the negligence, in the particular case, amounted or did not amount to a crime, judges have used many epithets, such as "culpable"', "criminal", "gross", "wicked", "clear", "complete". But, whatever epithet be used 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 punishment.*[12]

In 1994 this was endorsed by the House of Lords in *R v Adomako*.[13] Here, an anaesthetist lost his appeal against conviction after fatally failing to spot a disconnected oxygen tube during a routine eye operation. Lord Mackay of Clashfern refined the *Bateman* test:

> In my opinion the ordinary principles of the law of negligence apply to ascertain whether or not the defendant has been in breach

[9] Not, as one translation of this form of medieval legal French said: "condemned" to God! I am grateful to Mr Ian Barker for this information.
[10] For example, *R. v. Williamson* (1807) 3 C. & P. 635; *R. v. Spencer* (1867) 10 Cox C.C., 525; *R. v. Noakes* (1866) 4 F. & F. 921; *R. v. Crick* (1859) 1 F. & F. 519.
[11] *R. v. Bateman* (1925) 19 Cr. App. R. 8.
[12] *Ibid*., at p. 11 *per* Lord Justice Hewart (emphasis added).
[13] *R. v. Adomako* [1995] 1 A.C. 171.

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> 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*.[14]

This formulation has been criticised,[15] largely because it amounts to the following circular test: it is a crime if the jury think it *ought* to be a crime. Unsurprisingly, the next case to reach the Appeal Courts[16] saw gross negligence manslaughter assessed for its compatibility with two human rights (of the doctors): namely the right in Article 6 of the European Convention to a "fair trial" and the Article 7 prohibitions on "retrospective criminalisation". Amit Misra and Rajeev Srivastava were senior house officers at Southampton General Hospital. They mismanaged the care of a 31 year old man who developed toxic shock syndrome after a routine knee operation. This is quite a rare complication, with a fairly low mortality rate (about 5%). Specifically, they responded inadequately to obvious signs of infection, such as raised temperature and pulse rate, and failed to chase up blood test results that would have prompted the antibiotic care which would probably have prevented death. The jury convicted and their appeals were rejected.

Article 7 of the European Convention on Human Rights prohibits retrospective criminalisation:

> No-one shall be held guilty of any criminal offence on account of any act or omission which did not constitute a criminal offence under national or international law at the time when it was committed.

In essence, the doctors argued that the vagueness of "gross negligence" offends the principles of legality and transparency. This was contrary to the prohibition on retrospectivity in Article 7 as the jury ultimately decides on gross negligence, and applies its evaluation *after* the event.

[14] *Ibid*., pp. 86–87 (emphasis added).
[15] For example, see S. Gardner, "Manslaughter by Gross Negligence" (1995) 111 L.Q.R. 22, G. Virgo, "Reconstructing Manslaughter on Defective Foundations" [1995] C.L.J. 14.
[16] *R. v. Misra and Srivastava* [2005] 1 Cr. App. R. 21.

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The Court of Appeal acknowledged the force of this argument and recalled Francis Bacon's famous linkage of justice and legal certainty from the seventeenth Century:

> For if the trumpet give an uncertain sound, who shall prepare himself to the battle? So if the law give an uncertain sound, who shall prepare to obey it? It ought therefore to warn before it strikes … Let there be no authority to shed blood; nor let sentence be pronounced in any court upon cases, except according to a known and certain law.[17]

But this argument was dismissed on the basis that Art 7 demanded *sufficient*, rather than *absolute*, certainty and that the degree of vagueness here was acceptable.[18] Vagueness must have been in vogue as the Court of Appeal decided not to elaborate further, which they could have, as Jeremy Horder has argued, by noting that professional standards or codes of conduct act as a suitable substitute for the lack of defined *mens rea* here.[19] But of course, this oversimplifies things given the inevitability of opposing expert opinions on those standards. Negligence is, after all, a contested social construction undertaken with the benefit of hindsight.[20] And even if we could accept that the ingredients of the offence are sufficiently clear, the prosecution recipe is still kept secret. But maybe not for much longer; after all, if Debbie Purdy can demand the publication of prosecution policy in relation to assisted suicide,[21] then why deny doctors the same service for gross negligence? Returning to Bacon's trumpet metaphor, we are still left with a tune with notes which are difficult to read. Now we might not expect (or want) the sort of complex, detailed and intricate music of the great jazz trumpeter Wynton Marsalis, but surely we deserve a bit more clarity from the criminal law? Marsalis has stated that "the jazz band, like our democracy, works best when participation is shaped by intelligent communication".[22] My argument is that gross negligence manslaughter suffers from a lack of intelligent (and clear) communication that we might legitimately expect from criminal law.

The certainty argument was connected to the argument under Article 6, which requires a "fair and public hearing within a reasonable time by an independent and impartial tribunal established by law". A fair trial under Article 6 requires a reasoned decision, and it was argued that juries are deciding a question of law here (that is, the

[17] *Ibid*., at para. 32.
[18] Of course vagueness has been defended as a necessary feature of law, for example see T. Endicott, *Vagueness in Law* (Oxford 2001).
[19] See J. Horder, "Gross Negligence and Criminal Culpability" (1997) 47 U. Toronto L.J. 495.
[20] See S.W.A. Dekker, *Just Culture: Balancing Safety and Accountability* (Ashgate 2007), ch. 7.
[21] *R. (on the application of Purdy) v. D.P.P.* [2009] 3 W.L.R. 403.
[22] Quoted in F.A. Salamone, *The Culture of Jazz: Jazz as Critical Culture* (Lanham, Maryland 2009), at p. 92.

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*meaning* of the offence – the meaning of gross negligence) and because they do not give reasons for their decisions, this contravened Article 6. Judge LJ did not agree:[23]

> On proper analysis, therefore, the jury is not deciding whether the particular defendant ought to be convicted on some unprincipled basis. The question for the jury is not whether the defendant's negligence was gross, and whether, *additionally*, it was a crime, but whether his behaviour was grossly negligent and *consequently* criminal. This is not a question of law, but one of fact, for decision in the individual case.

With respect, this attempt to separate the question of law from that of fact is unconvincing; it is, as Ashworth points out, a "distinction without a difference".[24] Juries have little option but to debate the meaning of gross negligence and thus decide the legal question.[25] For example, it is surely plausible that juries *do* on occasion accept that conduct *was* grossly negligent but decide *against* convicting the defendant of manslaughter. The relatively low conviction rate of around 35% of cases proceeding to trial lends some support to this. The Court of Appeal's conclusion is more than a little optimistic:[26]

> In our judgment the law is clear … 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.*

Again, to my mind, this is not particularly clear communication from the law.

Regrettably, an application for leave to appeal to the House of Lords was rejected. This represents a missed opportunity for a possible (and rare) declaration of incompatibility which would prompt a rethink about this offence. Prosecutors, experts, judges and juries are thus left to grapple with a difficult and circular concept. But just why is this concept is so troubling both philosophically and in its practical application?

[23] *Ibid*., note 16 above, at para. 62.
[24] A. Ashworth, *Principles of Criminal Law* (Oxford 2009), p. 279.
[25] Leading commentators are agreed on this: see Ashworth *ibid.*, D. Ormerod, *Smith and Hogan, Criminal Law* 12th ed. (Oxford 2008), p. 531, and M. Allen, *Textbook on Criminal Law*, 10th ed. (Oxford 2009), p. 350.
[26] *Ibid*., note 16 above, at para. 64 (emphasis added).

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## III. Gross Negligence – A Criminal Charge?

Negligent criminal liability has long exercised legal philosophers. Jerome Hall was not exaggerating when he called it an "inordinately troublesome" area.[27] Hall was responding (and rejecting) Hart's celebrated general theory of guilt in which Hart defended criminal negligence as part of a wider capacity theory of responsibility. Hart used the example of the man mending the roof and (without thinking) throws a slate down onto the street below, causing death – what he termed "culpable inadvertence".[28] Glanville Williams had subjectivist misgivings: for him, the search for the mental deficiency (for example, forgetfulness) amounted to "an unrewarding exercise in moralism".[29] But it retains contemporary support – notably by Andrew Ashworth[30] – and despite its general commitment to subjectivism in criminal law, the Law Commission has given its stamp of approval to gross negligence. I'll return to the commission's proposals in this area below.

For Jerome Hall, negligent liability loses sight of the notion of blame which is the proper foundation of criminal law. In other words, there is not enough *mens rea* – or perhaps none at all.[31] Such arguments are based on a principled objection to its unfairness – particularly as it applies to professionals working in high risk and unsafe systems. As Alan Norrie notes: "grossness depends on the way the conduct is socially and morally perceived, rather than its inherent quality".[32] However, there has been little *empirical* examination into the relevant perceptions here. Partly prompted by this, I reviewed all known prosecutions since the start of the Twentieth Century. This involved a statistical analysis of these cases and the conducting of interviews with Crown Prosecution Service (CPS) lawyers at an office of what was then called the Special Casework Directorate. The main findings, which are summarised below,[33] point to the conclusion that gross negligence is incapable of clear and objective measurement, and that it ought to be abolished. Analysis of the data presents at least three problems, which I'll now consider in turn.

### *A. Gross Negligence is Grossly Vague*

Despite the best efforts of the Court of Appeal in *Misra* to shield it from attack, the current law of gross negligence, manslaughter lacks

[27] J. Hall, "Negligence and the General Problem of Criminal Responsibility" (1972) 81 Yale L.J. 912 at p. 952.
[28] H.L.A. Hart, "Negligence, Mens Rea and Criminal Responsibility" in *Punishment and Responsibility: Essays in the Philosophy of Law* (Oxford 1968), pp. 136–157.
[29] G. Williams, *Textbook of Criminal Law*, 2nd ed. (London 1983), p. 91.
[30] A. Ashworth, note 24 above, at p. 187–188.
[31] See also, H. Morris, "The Decline of Guilt" (1988) 99 Ethics 62.
[32] A. Norrie, *Crime, Reason and History* (London 2001), p. 238.
[33] For a fuller analysis see O.L. Quick, note 4 above.

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sufficient certainty. This vagueness clearly plagues prosecutors struggling to apply the "test" to medical cases. In practice, prosecutors often rely on gut instinct because, as one prosecutor revealingly explained: "there's no overt criminality there". The notion of gross negligence was understood with reference to synonyms such as "absolutely disgraceful", "extra bad", "totally unacceptable" "pretty abysmal" and "beyond the pale". In short, there was no obvious or objective system for classifying episodes as "gross" or "not gross". This response reflects the definitional difficulty.

> Well I think it's difficult to quantify but you know you are looking at something which needs to be punished by the criminal law. So it's got to be something that really stands out as being something that ordinary people wouldn't say "Well we all make mistakes". Ordinary people would say that's shocking. You know it's got to be gross.

The following response from another prosecutor captures the difficulty of cases on the cusp of gross negligence:

> you could have made the decision not to prosecute and it would have been a proper decision, and you could have made the decision to prosecute … we thought it probably was gross negligence but we thought it was close to the borderline … and there were some in our office who said prosecute and some who said don't … I wouldn't say it was clear cut and we agonised over the decision to prosecute.

Interestingly, some prosecutors were more comfortable working with reference to subjective recklessness:

> I mean, the law says it's an objective test, but in reality I can't see how we would bring a prosecution without an element of subjective recklessness. I mean even if it's really a case where we say it's so blindingly obvious that the person must have realised and therefore are subjectively … even if there's no direct evidence of subjective recklessness … but it may be so blindingly obvious that anyone must have realised, it's simply not believable.

This is symbolically important as indicating prosecutorial unease with gross negligence. It is also of practical significance given the sense that some prosecutors are working to the higher standard of recklessness. Why persist with the wider term gross negligence when nobody really knows what it means or whether it constitutes sufficient moral blame for the serious crime of manslaughter.

### *B. The Character of Defendants*

Can aspects of the defendant's character contribute to constructing a case of medical manslaughter? Of course, the honest answer is that we

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just don't know. But we do know that references to conduct suggesting a general characteristic of indifference are apparent in medical manslaughter convictions. For example, it was reported that Dr. Adomako left the operating theatre for a cup of coffee[34] and that Dr. Ramnath fled the country days after the incident which led to her prosecution.[35] It is difficult to underestimate the powerful prejudicial force of adverse assessments about character. This attention to attitude and personality traits is resonant with a character theory of criminal liability. Antony Duff has defended this focus on the character-traits that conduct reveals and for which agents are authors and properly held accountable.[36] Similarly, Victor Tadros adopts a character based theory of criminal responsibility in asking whether conduct displays a vice worthy of criminal condemnation.[37] And as Nicola Lacey reminds us, character-based principles have a well established history within formal criminal law and are currently experiencing a renaissance both at the level of doctrine and criminal process.[38]

This reflection on virtues and vices is particularly pertinent in the context of generally well motivated health professionals who make mistakes. And this is likely to play out in practice with knowledge and assessment of general character informing the construction of cases in the first place. Families, colleagues, investigators, prosecutors and experts are likely to be swayed by evidence of what they perceive as good or bad character traits of the individual as a criminal case is considered. However, whilst character theory undoubtedly has appeal, as Duff acknowledges, it is potentially too rich an account of criminal responsibility and may be beyond the design and capabilities of the criminal process.[39] Character is complex and an attempt to try and fully understand someone's character within the confines of the criminal process is arguably overly ambitious. This could operate unfairly in practice in that the same error could be regarded as reflecting culpable recklessness or suggest some mental defect (such as forgetfulness or

[34] Although this was denied by Dr. Adomako, see D. Brahams, "Two Locum Anaesthetists Convicted of Manslaughter" (1990) 45 Anaesthesia 981.

[35] Dr. Ramnath claimed that this was a planned career move as opposed to running from the scene of a crime, see "Doctor Killed Patient with Injection" The Independent 13 January 2009.

[36] R. A. Duff, "Choice, Character and Criminal Liability" (1993) 12 Law and Philosophy pp. 345–383, at p. 380. Duff has further developed this virtue theory of criminal liability elsewhere: "Virtue, Vice and Criminal Liability: Do we want an Aristotelian Criminal Law?" (2002) 6 Buffalo Criminal Law Review 147 and "The Virtues and Vices of Virtue Jurisprudence" in T.D.J. Chappell (ed.) *Values and Virtues: Aristotelianism in Contemporary Ethics* (Oxford 2006), pp. 90–104.

[37] V. Tadros, *Criminal Responsibility* (Oxford 2005).

[38] N. Lacey, "Space, time and Function: Intersecting Principles of Responsibility across the Terrain of Criminal Justice" (2007) 1 Criminal Law and Philosophy 233 at p. 247, and see also "The Resurgence of 'Character'? Responsibility in the Context of Criminalisation" in A. Duff and S. Green (eds.), *Philosophical Foundations of Criminal Law* (Oxford forthcoming). In terms of evidence law, the rules of admissibility regarding bad character have been broadened by the Criminal Justice Act 2003, ss. 98–101.

[39] Duff (1993), note 36 above, at p. 368.

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stupidity) not worthy of criminal punishment, partly driven by assessments of character.

Disconcertingly, the most notable aspect of character evident in such cases is that of race. The statistics (albeit small) reveal that a disproportionate number of non-white practitioners feature in prosecutions – over 50%. This is high given that the number of non-white N.H.S. hospital doctors is estimated to be around 25%.[40] This may be understood with reference to a number of sociological explanations, such as the training and language skills of doctors trained overseas, as well as their ability to gain employment and superior supervision in better performing hospitals. This involves some speculation, but it may be that a higher proportion of foreign trained doctors are working in poorly performing hospitals, have received inferior training, possess inadequate language skills, are exercising responsibilities beyond their levels of skill, and are inadequately supervised. The high number may also be related to racist attitudes that creep in to the decisions to complain about and consider investigating individuals in the first place. Sadly, given what we know about the role of race, education, and social background as powerful determinants of individual success, it would be surprising if this was not reflected in the breakdown of such statistics. Of course, in order to speak with more certainty here we really need more complete information about the character of individuals in all cases of possible negligently caused death, those which lead to investigation and those which proceed to trial. But what we already know hardly instils confidence in a fair system of law and justice. Coupled with the vagueness of the offence, it is possible that the consequences may be particularly unfair for some because of reactions to their character.

### *C. Expert Control?*

Although gross negligence is a *legal* term of art, in this context, it is one which lawyers have devolved to medical experts, and to their subjective evaluation of whether conduct has crossed the vaguely drawn line of criminal fault. This resembles the (over) reliance on experts for defining the content of the partial defence of diminished responsibility,[41] and is part of a broader unease with the under regulation of experts and the need for reforming rules of the admissibility of expert evidence.[42] Fifteen years ago, Jones observed that the question of how much

[40] See L. Cooke, S. Halford and P. Leonard, *Racism in the Medical Profession: the Experience of U.K. Graduates* (B.M.A. 2003).

[41] For which the Law Commission has expressed its criticism: see Law Commission "A New Homicide Act for England and Wales" (Consultation Paper 177; 2005), paras 6.37 and 6.47.

[42] Law Commission, "The Admissibility of Expert Evidence in Criminal Proceedings in England and Wales: A New Approach to the Determination of Evidentiary Reliability" (Consultation Paper 190; 2009).

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influence experts should be allowed to exert has not been fully resolved[43] and this remains true today. Putting it bluntly, does the reality of expert evidence breach the prohibition against it going to the ultimate issue?[44] Ultimately, gross negligence is a matter for the jury, based on their objective and common sense consideration of all the evidence.[45] However, this is likely to be heavily influenced by their perception and interpretation of experts and their evidence. Ward helpfully draws a distinction between what juries might regard as factual, persuasive and authoritative expert evidence.[46] In theory, the expert evidence in medical manslaughter cases falls within the persuasive category: experts are neither witnesses of fact nor are they offering an authoritative account. Juries are free to independently evaluate the competing expert evidence in arriving at their decision. However, it is likely that factors such as their title, qualifications, demeanour and performance influence any weighting that the jury might accord particular experts and their evidence.[47] Ward is right that the current position underplays the risk of jury usurpation by investing too much epistemic authority in the expert.[48]

There appear to be numerous tensions between the theory and reality of the rules of expert evidence in these cases. Strictly speaking, experts are allowed to testify to the standard of care that would be exercised by the hypothetical *reasonable doctor*, but the question whether the *particular* departure from that standard is gross is left for the jury, with experts not permitted to speak to that. In reality, and perhaps inevitably, experts clearly address the particular person and conduct in question. Experts are not supposed to give their interpretation of the relevant law, yet when prosecutors engage their services to seek their opinion, are they not being asked for their interpretation of the law, that is, the meaning of gross negligence? Experts are not generally meant to testify in relation to witness credibility, but expert assessment here often hinges on which account (and which character) appears more credible. There is also a need to question what we regard as appropriate expertise in such cases. For example, was it appropriate that in *Misra*, the evidence of microbiologists and toxicologists assessed the conduct of junior orthopaedic surgeons? Clearly, the role

[43] C.A.G. Jones, *Expert Witnesses: Science, Medicine and the Practice of Law* (Oxford 1994) at p. 119.
[44] Albeit a rule which is "honoured most often in the breach" see M. Redmayne, *Expert Evidence and Criminal Justice* (Oxford 2001), p. 168.
[45] The so-called "common knowledge" rule from the leading case of *R. v. Turner* [1975] 1 All E.R. 70.
[46] T. Ward, "English Law's Epistemology of Expert Testimony" (2006) 33 Journal of Law and Society 572.
[47] The risk of the character and charisma of experts unduly influencing criminal trials was noted in "Forensic Science on Trial", House of Commons Science and Technology Committee, Seventh Report of Session 2004–05, (HC 96-I; 2005), p. 64.
[48] T. Ward, "Usurping the Role of the Jury? Expert Evidence and Witness Credibility in English Criminal Trials" (2009) 13 Int. J. Evidence & Proof 83.

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of medical experts here raises a number of important questions which are ripe for research.[49]

These problems about vagueness, character and expertise are arguably inevitable given the breadth of the term gross negligence. Now there *may* be sufficient cause to call for the *complete* abolition of gross negligence manslaughter. However, the arguments presented here rest on research into its application to medical cases. Further research would need to analyse its operation in other settings in terms of considering a complete abolition, although its harshness is likely to be felt by the other professional defendants it mainly applies to. The option of exempting healthcare professionals from gross negligence liability is open to the criticism that it offers unfair protection. Whilst perhaps a special case can be made for health care, any exemption would ultimately be unacceptable in terms of equality before the law. In reality then there are two choices: downgrade and prosecute more with a special homicide offence for those who kill whilst performing socially vital functions, or upgrade and narrow the focus on "reckless killing" as the business of criminal law. Before making the case for recklessness, might there be good grounds for introducing a special homicide offence for healthcare professionals?

## IV. Rejecting Specificity

There are two obvious objections to creating context specific crimes: (i) it offends against the principle of minimalism (i.e. there's too much law on the prosecutor's menu) and (ii) it marginalizes the offence, reduces its stigma and dilutes its deterrent effect. Yet, appreciation of different context has led to specific forms of liability in other settings. If, for example, we accept that vehicular[50] and familial[51] homicide warrant separation from the emotive term "manslaughter", why not do the same for deaths caused by careless medical treatment? One option is to create an offence for those who kill by virtue of (mis)performing their work duties. Some argue that a sophisticated, nuanced and fair approach to designing criminal law calls for a context specific approach to responsibility.

So what is the context in healthcare? We know that medical errors are predictable and routine. The statistics are striking: U.K. studies suggest there are around 850,000 adverse events in N.H.S. hospitals each year, and that 70,000 deaths are partly caused by such error. In the United States, this has been converted into what this would mean in

[49] I will discuss the role of experts in medical manslaughter cases in a forthcoming article.
[50] Road Safety Act 2006, s. 20 (causing death by careless driving).
[51] Domestic Violence, Crime and Victims Act 2004, s. 5 (causing or allowing the death of a child or vulnerable adult).

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terms of jumbo jet crashes: three every two days.[52] Now, this is not a call for airlines to run our hospitals: though the political third way of the public/private partnership might well permit the prospect of a so-called "easyhospital". But of course healthcare is far from easy. The systematic study of medical error is relatively new and lacks an agreed taxonomy of terms. Merry and McCall Smith have addressed the relationship between medical error and blame in conceptualizing these events as errors or violations.[53] Errors are seldom intentional whereas violations are deliberate deviations from accepted rules, norms, or principles. This could also be classified as the difference between doing wrong and wrongdoing; or, in *mens rea* terms, between negligence and recklessness. Administering the wrong drug or injection are errors as they are contrary to the intention to give the correct drug or injection, whereas a decision to continue with surgery contrary to common practice and colleague concern is a violation. Errors are further divided into skill based and technical errors. Skill based errors are slips or lapses, such as the momentary loss of concentration or distraction which are not necessarily manifestations of carelessness. Technical errors are connected with variability in competency and performance.

Whilst this is a useful taxonomy of error, there is no evidence that this has gained general acceptance within health care,[54] let alone filtered through to prosecutors. Designing a new criminal offence here must depend on a well understood typology of error, and its relationship with individual blame. Arguably, the study of medical error is at this time insufficiently well developed to support the significant step of creating a new criminal offence. It is for those who argue in favour of liability beneath recklessness to establish that medical cases merit such criminalization, yet persuasive arguments have not been forthcoming.

Calls for new legislative offences should also be based on clear evidence that existing criminal law is failing to deliver on its aims. Unlike, for example, domestic and sexual violence or corporate killing, there is no such consensus upon which to build a new specific offence or offences for the healthcare setting.[55] As Sanford Kadish would say,

[52] L.L. Leape, "Error in Medicine" (1994) 272 Journal of the American Medical Association 1851.
[53] A. Merry and A. McCall Smith, *Errors, Medicine and the Law* (Cambridge 2001).
[54] Editorial, "A Research Agenda for Patient Safety" (2006) 18 International Journal for Quality in Health Care 1. Though note the recent publication of personal accounts by doctors confronting their own errors and discussing ways to improve safety: see, F. Huyler, *The Blood of Strangers: True Stories from the Emergency Room* (London 1999); J. Groopman, *How Doctors Think* (London 2007); and the prolific A. Gawande, *Complications: A Surgeon's Notes on an Imperfect Science* (London 2003), *Better: A Surgeon's Notes on Performance* (London 2007) and *The Checklist Manifesto: How to Get Things Right* (London 2009).
[55] For fuller consideration of the case for a specific offence in the medical context, as well as many others, see C.M.V. Clarkson and S. Cunningham (eds.), *Criminal Liability for Non-Aggressive Death* (Ashgate 2008).

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we should first consider the *consequences* of criminalisation.[56] Would it contribute to the goals of improving patient safety? Although available evidence is not forthcoming,[57] this remains unlikely given that creating a safety culture depends to a large extent about making people feel safe to talk about and report error – something which is inhibited by the prospect of criminal prosecution – even a morally diluted form of homicide.

## V. Reviving Recklessness?

The easiest existing alternative would be to prosecute such cases under subjective reckless manslaughter, which despite a lack of recent common law authority, is uncontentious and well understood.[58] It is true that we are talking about very closely connected concepts; the legal line drawing between subjective recklessness and gross negligence has always been blurry at best. Jeremy Horder traces this back to the nineteenth Century, when judges were less concerned about carefully separating recklessness and gross negligence.[59] Of course, in the most part, using these terms interchangeably will not present problems: the conduct in question can properly be classed as both grossly negligent *and* reckless. But this will not be true of all cases – particularly those on the cusp. It is here that the wider term gross negligence risks the prosecution of weak cases. Having recklessness as the bottom line would offer some protection against this.

Whilst the higher courts have given their blessing to gross negligence, the word "reckless" is never far from view. For example in *Adomako*,[60] Lord Mackay stated that: "it is perfectly open to the trial judge to use the word "reckless" in its ordinary meaning as part of his exposition of the law if he deems it appropriate". This was endorsed in *Misra*[61] where the Court of Appeal stated that evidence of the defendant's state of mind is "not irrelevant" to the issue of gross negligence, in fact, adding that it will often be a "critical factor in the decision". It is probably no accident that recklessness lurks in the background. Arguably, this reflects judicial reluctance with leaving liability at the lower level of gross negligence. The law commission has

[56] S. Kadish, "The Crisis of Overcriminalization" (1967) 374 The Annals of the American Academy of Political and Social Science 157.
[57] See M. Brazier and A. Alghrani, "Fatal Medical Malpractice and Criminal Liability" (2009) 25 Professional Negligence 51.
[58] And which has not, as Ormerod correctly notes, been subsumed within gross negligence, see note 25 above, at p. 533.
[59] J. Horder, note 19 above.
[60] See note 13 above at p. 188.
[61] Note 16 above at para. 56.

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also endorsed this "recklessness as gross negligence" position in saying that:[62]

> recklessness falling short of reckless indifference can really be regarded as a kind of gross negligence … The fact that…the defendant saw a risk and wrongly discounted it or stupidly thought it insignificant is simply compelling evidence of the grossness of his or her negligence.

The Law Commission has for some time been working on reforming involuntary manslaughter, and more recently, with the harder task of re-structuring homicide. They deserve congratulations on a difficult job well done. Overall, the proposed three tier structure: first degree murder, second degree murder and manslaughter (by criminal act or by gross negligence) is an improvement on the current position.[63] In terms of involuntary manslaughter, the commission plumps for gross negligence. In fact they go further by proposing to abandon the reckless killing manslaughter category,[64] signaling a change from their previous position in 1996.[65] To my mind, the reasoning for this change of heart fails to convince. The Commission seems swayed by the belief that, in many cases (but of course not all), recklessness and gross negligence are indistinguishable and that retaining the two categories would only serve to confuse.

There is no denying that these are, if not indistinguishable,[66] then closely connected concepts, but is this reason enough to collapse both into the broader category of gross negligence? True, recklessness *has* been a troublesome term for courts, although things should be easier after the abolition of objective recklessness in the case of *G*,[67] but this rather glosses over the less than happy history of gross negligence. According to the Commission, although these are "reckless killings" this troublesome evaluative term is best avoided in favour of the cloudier concept gross negligence. It's the same as saying that "intention" is a problem word in criminal law, so let's just process all "intentional killings" as "reckless killings". With respect, whilst an element of pragmatism is necessary here, and compromises are inevitable, this is hardly compliant with fair labeling, and does not adequately address the problems in this area.

[62] Law Commission, "A New Homicide Act for England and Wales" (Consultation Paper 177; 2005), p. 90, para 3.182.
[63] See Law Commission, "Murder, Manslaughter and Infanticide" (Law. Com. No. 304; 2006). Its recommendations in relation to partial defences have culminated in Coroners and Justice Act 2009, ss. 52–56.
[64] *Ibid*., at para. 2.165 and paras. 3.54–3.57.
[65] Law Commission, "Legislating the Criminal Code: Involuntary Manslaughter" (Law. Com. No. 237; 1996).
[66] The best explanation of the difference between the two is still that of Glanville Williams, note 29 above, at pp. 98–100.
[67] *R. v G. and Another* [2004] 1 A.C. 1034.

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In their 1996 proposals the commission proposed to replace subjective reckless manslaughter with "reckless killing".[68] This would be committed on proof of subjective awareness that the conduct risked death or serious injury. The Commission's recent decision to ditch reckless manslaughter, part of its proposed restructuring of homicide, is likely to be explained by the fear of being unable to prove the defendant's subjective awareness *at the time* of the conduct in question. Of course, as Glanville Williams put it, "subjective theory is an ideal imperfectly achievable".[69] And the fear is misplaced. It's a red herring: famously (and controversially) introduced by Lord Diplock in *Caldwell*.[70] After all, if it is such a problem, where is the evidence? How do we explain the high number of convictions on the basis of subjective reckless criminal damage? Or convictions for subjective reckless assault? Granted, these comparisons may not be exact (the threshold will be lower for violent offences, for example), but the general point remains valid: without a confession as to state of mind, juries and magistrates will always draw inferences from behaviour. It happens all the time. It's their job! If it was reasonable to foresee a risk, they will conclude that the defendant did foresee the risk. Now this may not wash with dyed in the wool subjectivists, but it may be the best we can do.

How does this apply to the medical cases? In short, recklessness works. The (very few) cases which lead to conviction are classic subjective recklessness. Dr. Walker, who continued to remove a (larger than expected) liver tumour despite warnings that it was too dangerous.[71] Unusually, and tellingly, he pleaded guilty. Dr. Sinha, who gave a large morphine overdose to relieve the pain of severe arthritis in a patient with kidney failure.[72] He refused to read her medical chart which was offered by her husband. He closed his mind to the risk. He was given a custodial sentence. And more recently, Dr. Ramnath, who gave a fatal dose of adrenalin against the advice of three colleagues – which was regarded as a professional violation.[73] The worry that prosecutors couldn't prove subjective awareness of risk is an exaggerated one. And as we have seen, in reality some prosecutors are actually searching for evidence of subjective fault, perhaps agreeing with Glanville Williams that it is "socially superior" to gross negligence.[74]

But the problem of recklessness remains. Of course, it's not straightforward. Much ink (academic and judicial) has been spilt trying to define it. Despite the best attempts of, amongst others, Glanville

[68] See clause 1 of the Commission's Involuntary Homicide Bill, in Appendix A of note 64 above.
[69] G. Williams, note 29 above, at p. 98.
[70] *R. v. Caldwell* [1982] A.C. 341.
[71] "Doctor who killed patient on operating table escapes jail", The Independent, 24 June 2004, p. 19.
[72] (2004) 328 British Medical Journal 726.
[73] (2009) 338 British Medical Journal 545.
[74] See note 29 above at p. 100.

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Williams and Antony Duff, the courts have not settled on a coherent doctrine. The speeches of the Law Lords in *G* testify to this.[75] Williams famously redefined recklessness to require that the risk *would* have been obvious to the defendant had he paused to think.[76] Duff offers the test of "practical indifference",[77] that is, "I couldn't care less". Building on this, Victor Tadros defines it as where the individual has "failed to fulfil his duty of investigating the risks … or has willfully blinded himself to the existence of the risks."[78] To summarise, we could say the following: where a doctor has special knowledge that certain procedures carry with them certain risks, and fails to investigate those risks without justification, criminal responsibility can be properly attributed on the basis of recklessness. This strikes the right balance in terms of its breadth, and it should satisfy those unwilling to trust strict subjectivism.

But what about the standard *lacuna* case? A doctor is aware of the risk, aims to avoid it, but gets that wrong. And in getting it wrong, in making a mistake, we return to gross negligence: leaving the jury with a vague term and a difficult *legal* question to answer. I've tried to demonstrate the significant problems with this concept. To my mind, these are the cases that should fall below the line. And the two obvious arguments against do not appear that strong. First, no one has persuasively argued that more prosecutions in the health setting would be a good thing – that is, it would improve patient safety. Secondly, a sceptic might question whether the shift from gross negligence to recklessness would make any difference in practice. Well, surely it would be surprising if this did not result in less cases proceeding to trial given that recklessness represents a more onerous task for the prosecution.

## Conclusion

Medical errors (including fatal errors) are an inevitable feature of the delivery of health care. In terms of criminal law, it's not a question of "to have or not to have" but rather, where is the appropriate place to set the bar for liability? Gross negligence is too vague. Despite surviving a challenge in *Misra*, the issue of its human rights compatibility is not settled. There is no clarion call from the law's trumpet. It can (and has) been questioned on a philosophical level in that there is insufficient moral blame for criminal liability (especially for homicide). Its breadth leads to unfairness: lumping together cases of slips and lapses with

[75] Note 66 above.
[76] G. Williams, "Recklessness Redefined" [1981] C.L.J. 252.
[77] A. Duff, *Intention, Agency and Criminal Liability* (Oxford 1990), ch. 7.
[78] V. Tadros, "Recklessness and the Duty to Take Care" in S. Shute and A.P. Simester (eds.), *Criminal Law Theory: Doctrines of the General Part* (Oxford 2002), 227 at p. 258.

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those of clear recklessness. It fails the test of fair labelling. And empirical examination reveals further reservations. Prosecutorial and expert evaluations show that the term is too broad and vulnerable to the vagaries of subjective opinions. This translates into particular harshness for those exposed to prosecution by virtue of their risky yet socially vital work, often at the mercy of moral luck. Why continue to struggle with the trouble of interpreting gross negligence when there is no consensus about what it actually means and whether it should be a crime? In laying *Caldwell* to rest in the case of *G*, Lord Steyn said that "[T]he surest test of a new legal rule is not whether it satisfies a team of logicians but how it performs in the real world".[79] With a conviction rate of around 35% – quite low for homicide – gross negligence performs badly in the jury room. To my mind, the argument for abolition is clear and compelling. The bottom line should be recklessness. This concept is not without its difficulties, and I wouldn't claim to have cracked the code in this article. But reformist energies should be channelled towards its revision. Criminal law should be a last (and rare) resort. We should limit the set menu of prosecutors to one course: recklessness.

[79] Note 66 above at p. 1063.

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