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## 12 From prosecution to rehabilitation: New Zealand's response to health practitioner negligence

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In common with other countries with modern health systems, New Zealand has for many years searched for an appropriate legal response to cases where a health practitioner's lack of care results in the death of a patient. The past two decades have seen an increasing emphasis on accountability for harm to patients, fuelled by greater public awareness of the inadvertent harm caused by healthcare, and a growing tendency for injured persons and family members to demand official action, and if dissatisfied with the response to publicise their concerns via the traditional media and the Internet. It might therefore have been expected that more health practitioners would face prosecution, if only because more cases have been brought to external authorities for investigation, sometimes in the media spotlight.

Surprisingly, this expectation has not materialised. The continuing increase in complaints, incident reviews and media publicity about adverse events in healthcare has not translated into more prosecutions. Instead, the prosecution of health practitioners has markedly abated, both in the criminal courts and before disciplinary tribunals. Other forms of accountability have come to the fore. In New Zealand, the emphasis has shifted from prosecution to rehabilitation of doctors and other health practitioners whose careless conduct results in patient harm.

Having spoken out publicly against some of the claims of the New Zealand Medical Law Reform Group that lobbied successfully for reform of culpable homicide laws (because of the perceived injustice of 'medical manslaughter' prosecutions); advised the government on reforms of the medical disciplinary system and on the drafting of New Zealand's Code of Patients' Rights;<sup>1</sup> and served from 2000 to 2010 in the key role of

<sup>\*\*</sup> I am grateful to Peter Skegg, Joanna Manning and Marie Bismark for helpful comments on an earlier draft of this chapter.

<sup>1</sup> The full title is the Code of Health and Disability Services Consumers' Rights. The Code is a schedule to the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996.

Health and Disability Commissioner, I can offer an informed perspective on the shift from prosecution to rehabilitation. The following account is presented through the lens of these experiences. Wherever possible I have cited data or examples in support of my claims.

In this chapter, I seek to do four things: establish the shift from prosecution to rehabilitation; suggest some reasons for the shift; explain why, having investigated many cases where a health practitioner could have been prosecuted for manslaughter (or a lesser criminal offence), I now support only a very limited role for the criminal law in response to adverse events in healthcare; and argue that the pendulum may have swung too far in New Zealand, at the expense of proper accountability for injured patients and their families.

### **Background**

Although the equivalent law had been on the statute book since 1893,<sup>2</sup> no health practitioner was prosecuted under the so-called ‘medical manslaughter’ provisions of New Zealand’s Crimes Act until 1981. Over the years 1981 to 1998, eight health practitioners faced such a prosecution: four anaesthetists (two found guilty, one discharged before trial, one found not guilty), one surgeon (found guilty),<sup>3</sup> one radiologist (guilty plea), one nurse (guilty plea) and one dentist (discharged during trial).<sup>4</sup> At the time of these prosecutions, it was sufficient for purposes of conviction to show that death had been caused by a health practitioner’s failure ‘to use reasonable knowledge, skill, and care’ in administering medical or surgical treatment (s. 155) or ‘to take reasonable precautions’ and ‘use reasonable care’ to avoid endangering human life when in charge of dangerous things (s. 156). New Zealand courts read the Crimes Act literally and applied the ‘ordinary negligence’ standard, without any requirement of gross or reckless failure.<sup>5</sup> Thus, if it could be proved beyond reasonable doubt that a clinician had failed to provide reasonable care (breach of duty of care) and that the patient died as a result (causation) – difficult hurdles to overcome when applying the law to complex clinical situations – the offence of manslaughter was established.

<sup>2</sup> The Criminal Code Act 1893.

<sup>3</sup> The conviction was quashed on appeal in the Privy Council: *Ramstead v. R.* [1999] 2 AC 92.

<sup>4</sup> The cases are fully discussed in P. D. G. Skegg, ‘Criminal Prosecutions of Negligent Health Professionals: The New Zealand Experience’, *Medical Law Review* 6 (1998): 220–46 and usefully tabulated in A. Merry, ‘When Are Errors a Crime? – Lessons from New Zealand’, in C. Erin and S. Ost (eds.), *The Criminal Justice System and Health Care* (Oxford University Press, 2007), pp. 75–7.

<sup>5</sup> *R. v. Yogasakaran* [1990] 1 NZLR 399 at 402.

In the leading *Yogasakaran* case, the Court of Appeal denied being aware of any case in which ‘the long-standing rule in New Zealand has produced an unjust result’.<sup>6</sup>

The spate of prosecutions in the early 1990s led to a remarkably successful campaign by the New Zealand Medical Law Reform Group (NZMLRG), headed by anaesthetist Alan Merry and surgeon Ross Blair, to change the law. Many factors contributed to the effectiveness of the efforts of the NZMLRG, including the cultivation of a strong base of grassroots support within the medical profession, intense lobbying of politicians and skilful use of the news media. Sensationalist headlines raised the spectre of patients being denied surgery by risk-averse doctors fearful of prosecution: ‘Labour services halted for fear of litigation’;<sup>7</sup> ‘Elderly patients refused surgery’.<sup>8</sup> Doctors were portrayed as victims of an unfair law: “‘Hell” over for doctor’;<sup>9</sup> ‘Ruined life shows need for law change – doctor’.<sup>10</sup> Pressure mounted for change.

Comments of the trial judge, Hammond J, in the *Long* case (who noted that ‘the social stigma of a manslaughter conviction is very heavy indeed’ and that it was ‘a very harsh penalty’ for ‘harm inadvertently caused’ to a patient)<sup>11</sup> provided weighty support for the case for reform. When retired Court of Appeal judge Sir Duncan McMullin, who had been asked by the Minister of Justice to review the operation of the current law, was persuaded of the merits of the NZMLRG case and recommended reform,<sup>12</sup> the die was cast. The resulting law change occurred alongside other developments that reshaped healthcare law in New Zealand.

### July 1996 – a turning point

The month of July 1996 can be seen, in retrospect, to mark a turning point in New Zealand’s medico-legal system. First, in July 1996, the Crimes Amendment Bill (No. 5) was introduced into Parliament, paving the way for the reduction in the threshold to establish manslaughter by omission from ordinary negligence to a ‘major departure from the standard of care expected of a reasonable person . . . in those circumstances’. In essence, this introduced a requirement of ‘gross’ rather than ‘ordinary’ negligence. The reform was subsequently enacted by the Crimes Amendment Act 1997, which came into force in November 1997. This

<sup>6</sup> *Ibid.*, p. 404.      <sup>7</sup> *New Zealand Doctor*, 9 December 1993, p. 12.

<sup>8</sup> *Sunday Times*, 21 November 1993, p. 1.      <sup>9</sup> *New Zealand Herald*, 8 June 1995, p. 15.

<sup>10</sup> *Dominion*, 27 June 1995, p. 5.      <sup>11</sup> *Long v. R.* [1995] 2 NZLR 691 at 700.

<sup>12</sup> D. McMullin, ‘Report of Sir Duncan McMullin to Hon Douglas Graham, Minister of Justice, on Sections 155 and 156 of the Crimes Act 1961’ (1995).

law change, although not limited to deaths in healthcare settings, effectively removed the threat of a careless health practitioner facing a 'medical manslaughter' prosecution in the absence of other circumstances indicating a woeful lack of care. In a statement to the media at the time of tabling the amending legislation, the Minister of Justice asserted that 'manslaughter is an inappropriate crime for acts of mere carelessness as distinct from gross negligence or recklessness' and explicitly referred to the Health and Disability Commissioner Act 1994 and the Medical Practitioners Act 1995 (discussed below) as providing 'more appropriate mechanisms for dealing with persons who are careless'.<sup>13</sup>

New Zealand's Code of Patients' Rights, made under the Health and Disability Commissioner Act, came into force on 1 July 1996. The Code gave patients (and other healthcare consumers) legally enforceable rights and subjected all health practitioners (and healthcare providers more generally, whether individuals or organisations) to a new set of legal duties when providing health services. The Code rights became enforceable via the independent Health and Disability Commissioner (HDC) statutory complaints regime, removing complaint handling from registration boards. As will be seen, the Code and its application by the HDC has been a major factor in the shift from prosecution to rehabilitation since 1996. Notably, unlike the culpable harm provisions of the Crimes Act, and the no-fault compensation available for 'treatment injury' under New Zealand's accident compensation law, a finding of a breach of the Code does not require harm to a patient. Thus the Code separates liability for inadequate care from patient harm. The focus is on whether the patient received the standard of care and communication to which he or she was entitled, irrespective of whether any harm ensued, although in practice the fact that a patient suffered serious harm influences the Commissioner's decision to investigate.

The month of July 1996 also marked the commencement of a new regulatory system for medical practitioners, with the coming into force of the Medical Practitioners Act 1995. Key features of the statute were new powers for the Medical Council to undertake a confidential 'competence review', rather than disciplinary proceedings, when alerted to concerns about an alleged poorly performing practitioner, and the separation of the Council's registration and standard-setting functions from medical discipline, with the creation of a separate Medical Practitioners Disciplinary Tribunal independent of the Council. The Medical Practitioners Act was the model for the overhaul of

<sup>13</sup> Press release, 'Legislation Codifies Standard of Criminal Responsibility', Office of the Minister of Justice, Wellington, 18 July 1996.

health practitioner regulation in New Zealand that followed in the Health Practitioners Competence Assurance Act 2003.

### **Impact of law changes**

The impact of this triad of legislative changes – the amendments to the Crimes Act, the new Code of Patients’ Rights and the reform of medical regulation – is obvious in retrospect. By 1996, the zenith had been reached in prosecutions of health practitioners, and of doctors in particular. The fifth (and final, to date) conviction in New Zealand of a health practitioner for ‘medical manslaughter’ occurred in 1996.<sup>14</sup> The convictions dated from 1982 to 1996; no health practitioner has been convicted of ‘medical manslaughter’ since 1996. Medical disciplinary hearings peaked at over ninety a year in 1994 and 1995.<sup>15</sup> In 1996, the number of hearings dropped to under thirty-five.<sup>16</sup> By the year ended 30 June 2012, annual medical disciplinary hearings had dropped to three.<sup>17</sup>

The natural corollary of a reduction in criminal and disciplinary proceedings against doctors would be expected to be an increase in Medical Council competence reviews and HDC investigations of medical practitioners. These less draconian interventions became possible only when the new laws took effect in July 1996. In the year ended 30 June 2000, twenty-three doctors were subject to a competence review by the Medical Council,<sup>18</sup> and 128 doctors were found in breach of the Code of Patients’ Rights following an HDC investigation; thirty-nine of these doctors were referred to the Director of Proceedings for potential disciplinary or civil proceedings.<sup>19</sup> However, in relation to HDC investigations, the picture has changed dramatically over the past decade. In the year ended 30 June 2012, fifteen doctors were found in breach of the Code following an HDC investigation; and five doctors were referred to the Director of Proceedings for potential disciplinary or civil proceedings.<sup>20</sup> The trend towards alternative

<sup>14</sup> *R. v. Ramstead*, CA 428/96, 12 May 1997.

<sup>15</sup> D. Collins and C. Brown, ‘The Impact of the Cartwright Report upon the Regulation, Discipline and Accountability of Medical Practitioners in New Zealand’, *Journal of Law and Medicine* 16 (2009): 597.

<sup>16</sup> *Ibid.*

<sup>17</sup> Information provided by the Health Practitioners Disciplinary Tribunal, September 2012.

<sup>18</sup> Medical Council of New Zealand, ‘Annual Report 2000’ (Wellington, 2000), p. 19.

<sup>19</sup> Health and Disability Commissioner, ‘Report of the Health and Disability Commissioner for the Year Ended 30 June 2000’ (Auckland, 2000), pp. 22, 23 and 27.

<sup>20</sup> Information provided by the Office of the Health and Disability Commissioner, September 2012.

dispute resolution, sanctioned by Parliament in law reforms in 2003<sup>21</sup> and vigorously applied in my own time as Commissioner (with an emphasis on resolution at the lowest appropriate level) is now well embedded. The torrent of investigations has reduced to a mere trickle.

The upshot is that accountability via HDC investigations has, like criminal and disciplinary proceedings, reached a very low ebb. Whether that is considered a good thing depends on one's view of the appropriate legal response to health practitioner negligence. However, from the vantage point of 2012 it is intriguing to read public comments of the chairman of the New Zealand Medical Association in 1998, in the aftermath of the manslaughter law reform:

I am sure they [families of patients who die from negligent healthcare] would feel a lot more vindicated in their grief and their desire to blame someone if a medical practitioners tribunal said a doctor was at fault, was guilty of professional misconduct or something of that nature and the thing was taken down that avenue rather than the manslaughter one.<sup>22</sup>

The envisaged accountability via the imposition of official findings of professional misconduct and breach of the Code of Patients' Rights has been short-lived.

The only figure for medico-legal interventions that has remained fairly constant over the past decade is the number of doctors required to undergo a performance assessment or 'competence review', the focus of which is rehabilitation rather than accountability. In the year ended 30 June 2012, thirty-seven medical practitioners were subject to a competence review by the Medical Council.<sup>23</sup> At current levels of fewer than three competence reviews annually per 1,000 registered doctors in New Zealand, this is a modest regulatory intervention in medical practice.

The goalposts have thus shifted dramatically. In the early 1990s, a voluble minority of doctors (especially anaesthetists) were alarmed at the possibility of facing a manslaughter prosecution if a patient died due to their careless acts or omissions. The reform of the Crimes Act in 1997 greatly reduced that prospect, but doctors found a new bogeyman. By the mid-1990s some doctors had become fearful of a disciplinary prosecution in the event of a patient complaint about substandard care, with charges and hearings reaching an all-time high. By 2000, the number of disciplinary proceedings had begun to decline, so the fear of discipline ought to have eased. However, a new target of concern loomed: the risk

<sup>21</sup> Under the Health and Disability Commissioner Amendment Act 2003, discussed in text accompanying nn. 43 and 44, below.

<sup>22</sup> 'Can the Public Feel Protected?', *Evening Post*, 16 March 1998, p. 6.

<sup>23</sup> Information provided by the Medical Council of New Zealand, September 2012.

of investigation by the Health and Disability Commissioner, with the potential for a breach finding to open the way to disciplinary and/or civil proceedings. Yet, by 2012, even that risk has become insignificant, with only a tiny number of doctors facing an HDC investigation, rendering the risk of a breach finding and referral to the Director of Proceedings almost negligible.

The changing landscape is all the more remarkable given the absence of civil liability for negligence in New Zealand, on account of the accident compensation scheme that provides cover for ‘treatment injury’ but effectively bars damages claims. Is New Zealand an example of ‘a world-leading focus on addressing aspects of the system, which contribute to patient harm rather than only seeking to identify individual scapegoats when things go wrong’, as patient safety experts Merry and Seddon claim?<sup>24</sup> Has New Zealand found an appropriate balance between accountability and healthcare quality improvement? Answering these questions requires consideration of the reasons for the changed response to health practitioner negligence.

### **New forms of accountability**

It is reasonable to conclude that the temporary surge in criminal and disciplinary medico-legal proceedings in late-twentieth-century New Zealand was a response to a gap in the system for accountability of negligent health professionals, at a time of heightened public concern about problem doctors and inadequacies in the complaints and medical disciplinary system. Judge Cartwright’s Report of the Cervical Cancer Inquiry<sup>25</sup> in 1988 highlighted the underdevelopment of patients’ rights in New Zealand. The Cartwright Report was championed by the patients’ rights movement, in particular the leading consumer advocacy organisation, Women’s Health Action, whose spokesperson Sandra Coney was an articulate and widely quoted commentator on the need for better protection for patients in New Zealand. Other outspoken women’s health advocates such as Phillida Bunkle, Lynda Williams and Judi Strid helped keep patients’ rights issues on the public and political agendas.<sup>26</sup>

<sup>24</sup> A. Merry and M. Seddon, ‘Quality Improvement in Healthcare in New Zealand. Part 2: Are our Patients Safe – And What are We Doing About It?’, *New Zealand Medical Journal* 119 (2006). Available online at [www.nzma.org.nz/journal/119-1238/2086/](http://www.nzma.org.nz/journal/119-1238/2086/).

<sup>25</sup> S. Cartwright, ‘The Report of the Committee of Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women’s Hospital and into Other Related Matters’ (Auckland: Government Printing Office, 1988).

<sup>26</sup> See, for example, the essays published in S. Coney (ed.), *Unfinished Business: What Happened to the Cartwright Report?* (Auckland: Women’s Health Action, 1993).



The legislative framework in the 1980s and early 1990s was also a key factor. Since 1974, a by-product of New Zealand's accident compensation scheme (with its bar on negligence claims for compensatory damages for 'medical misadventure') had been that negligent health practitioners were effectively immune from civil liability for their lack of care. Yet a statutory compensation scheme does not meet an injured patient's needs for explanation, apology, sanction or correction.<sup>27</sup> Lacking the ability to sue,<sup>28</sup> injured patients and families could only turn to the complaints system to voice their concerns. On that front, the public encountered outdated professional regulation, which left complaints and discipline in the hands of registration bodies, with private hearings where guilty practitioners were often given name suppression and dealt only the meagre penalties available under the statutory scheme at the time.<sup>29</sup>

Public concern about self-regulation by the medical profession escalated in the early 1990s. The lack of independence of medical disciplinary committees made the complaints and discipline system vulnerable to claims of 'doctors looking after doctors'. Although the medical profession was itself lobbying for an overhaul of medical regulation, prior to the long-awaited reforms there was undoubtedly pressure on medical disciplinary committees to be seen to take complaints seriously. Certainly, in the early to mid-1990s increasing numbers of complaints about doctors led to a formal prosecution and disciplinary hearing rather than to informal resolution in ways that had previously been common (and are once again becoming routine).

The lacunae created by the civil law and the complaints and disciplinary system may have resulted in pressure on the police to hold careless health practitioners to account via the criminal law. One law change undoubtedly played a part. The enactment of the Coroners Act 1988 introduced new requirements for every death as a result of surgery or anaesthesia to be reported to the police. This inevitably brought more hospital deaths to police attention and in turn led to more investigations.

Yet, even in the mid-1990s, no public commentator seriously suggested that the solution to a perceived lack of accountability of doctors

<sup>27</sup> M. Bismark and E. Dauer, 'Motivations for Medico-Legal Action', *Journal of Legal Medicine* 27 (2006): 55.

<sup>28</sup> Save for the exceptional circumstances in which a claim for exemplary damages may be available. See *A v. Bottrill* [2003] 1 AC 449 (PC) and *Couch v. Attorney-General* [2010] NZSC 27.

<sup>29</sup> Under the Medical Practitioners Act 1968, s. 43(2)(a), a maximum fine of \$1,000 could be imposed on a doctor found guilty of a disciplinary offence.

was more frequent resort to the criminal law. Professional leaders, patient advocates, policymakers and politicians looked to the new Code of Patients' Rights, the HDC complaints system, and the reformed medical regulatory system to ensure better protection of patients and proper accountability of errant doctors. However, the interplay between no-fault compensation for medical accidents and accountability for practitioner injury has proved to be complex.

Before the establishment of the Health and Disability Commissioner, the only explicit legislative link between negligent harm to patients and professional discipline was in the legislation underpinning the accident compensation scheme between 1992 and 1998. At that time, one of the two bases of cover for 'medical misadventure' was 'medical error', defined as 'the failure of a registered health professional to observe a standard of care and skill reasonably to be expected in the circumstances'.<sup>30</sup> In the event that a patient injury was covered as 'medical misadventure' that 'may have been attributable to negligence or inappropriate action on the part of a registered health professional' (i.e., all cases of 'medical error'), the Accident Compensation Corporation (ACC) was required to 'report the circumstances to the appropriate body *with a view to the institution of disciplinary proceedings*'.<sup>31</sup>

The explicit link between health practitioner negligence causing harm to a patient and professional discipline was severed with removal of the mandatory reporting requirement in 1998.<sup>32</sup> However, in 2001, a modified duty to report (in relation to any incident accepted as 'medical error', to the 'relevant professional body and the Health and Disability Commissioner')<sup>33</sup> was reinserted in the legislation,<sup>34</sup> but without any mention of the potential for disciplinary proceedings. The shift to a focus on competence assurance, rather than discipline, was evident in the requirement that ACC 'report to the relevant professional body any concerns it has about a registered health professional's professional competence'.<sup>35</sup>

<sup>30</sup> The Accident Rehabilitation and Compensation Insurance Act 1992, s. 5(1).

<sup>31</sup> The Accident Rehabilitation and Compensation Insurance Act 1992, s. 5(10); emphasis added.

<sup>32</sup> The Act was repealed by section 417(1) of the Accident Insurance Act 1998 and the relevant definitions replaced by sections 34–7.

<sup>33</sup> The Injury Prevention, Rehabilitation, and Compensation Act 2001, s. 284(2).

<sup>34</sup> The modified duty was intended to address concerns about 'silos of information' relating to incompetent practitioners, an issue that featured prominently in the Cull Report. H. Cull, *Report of Processes Concerning Adverse Medical Events* (Wellington: Ministry of Health, 2001).

<sup>35</sup> The Injury Prevention, Rehabilitation, and Compensation Act 2001, s. 284(8).

### The patient safety movement

As the new complaints and medical regulatory systems bedded in, other factors began to influence thinking about the appropriate response to health practitioner negligence. The most influential factor was the patient safety movement that emerged in the late twentieth century. There were two key elements to this. First, the New Zealand Quality of Healthcare Study reported in 2001 that 12.9 per cent of public hospital admissions were associated with an adverse event.<sup>36</sup> Of these, approximately 10 per cent were associated with serious harm, and 4 per cent resulted in death; approximately 35 per cent were judged to be preventable.<sup>37</sup> Against this backdrop of the high prevalence of preventable harm to patients, the idea that a tiny subset of negligent harm should result in criminal or disciplinary proceedings began to look haphazard and antiquated.

A second significant factor was the influence of ‘systems thinking’. Proponents of this approach argued that focusing on individual error was short-sighted and would fail to address the underlying systems factors that cause most preventable harm to patients.

In the early 2000s, a common mantra repeated by medical professional leaders and medical defence lawyers in New Zealand was the need to move away from a ‘name, blame and shame’ medico-legal environment<sup>38</sup> – even though there was scant evidence that it existed. As a judge noted in 2001, on a medical disciplinary appeal, a rehabilitative focus was ‘in the interests of the public primarily for reasons of safety but also because of the extensive investment New Zealand has in the education of medical practitioners, and the need to provide a proper quality service for all New Zealanders’.<sup>39</sup> Writing the same year, I described New Zealand as having ‘a regulatory system that is rehabilitative, rather than punitive; one that seeks to protect patients yet support doctors. It includes a number of features consistent with modern approaches to reducing error and improving safety’.<sup>40</sup>

Nonetheless, problems remained. Injured patients reported finding the process for making a healthcare complaint ‘confusing, cumbersome, difficult to access and costly, both financially and emotionally’,<sup>41</sup> and the Health

<sup>36</sup> P. Davis, R. Lay-Yee, R. Briant et al., ‘Adverse Events in New Zealand Public Hospitals: Principal Findings from a National Survey’ (Wellington: Ministry of Health, 2001), p. xv.

<sup>37</sup> *Ibid.*, pp. 23 and xv.

<sup>38</sup> See, for example, G. Phipps, ‘Public Airing Leads to Culture of Shame’, *New Zealand Doctor*, 28 January 2004, p. 19.

<sup>39</sup> *Parry v. Medical Practitioners Disciplinary Tribunal* [2001] DCR 769 [85].

<sup>40</sup> R. Paterson, ‘The Public’s Hue and Cry: Medical Complaints in New Zealand’, *Journal of Health Services Research and Policy* 6 (2001): 193.

<sup>41</sup> H. Cull, ‘Report of Processes Concerning Adverse Medical Events’ (Wellington: Ministry of Health, 2001), p. 14.

and Disability Commissioner struggled with a backlog of complaints.<sup>42</sup> Cases of apparently incompetent doctors and weak regulatory responses continued to be publicly reported. The retention of ‘medical error’ as a statutory basis of compensation for injured patients was seen as hindering the necessary cooperation from doctors to enable claims to be pursued.

Another triad of important legislative reforms in the mid-2000s sought to address these problems. The Health and Disability Commissioner Act was amended to give the Commissioner much greater flexibility in handling complaints, beyond the original options of referral for investigation, referral to a consumer advocate, or taking ‘no action’ on very limited grounds. The Commissioner became empowered to take ‘no further action on the complaint if [he] considers that, having regard to all the circumstances of the case, any action or further action is unnecessary or inappropriate’.<sup>43</sup> New resolution options included referring the matter to a healthcare provider for resolution (if the complaint did not raise public safety concerns) and referring a complaint to a registration body ‘if it appears from the complaint that the competence of a health practitioner or his or her fitness to practise or the appropriateness of his or her conduct may be in doubt’.<sup>44</sup> I publicly endorsed the reforms, claiming that ‘[t]he new legislation strikes a sensible balance between early resolution for individuals, and protection of the public in cases where notification to relevant authorities or full investigation is necessary’.<sup>45</sup>

The HDC legislative reforms did not point only in the direction of low-level resolution. One change was intended to enhance accountability: the extension of the right to bring proceedings before the Human Rights Review Tribunal (HRRT), following a breach finding in an HDC investigation, to the ‘aggrieved person’.<sup>46</sup> Potentially, this opened the way for damages claims by injured patients, if they could circumvent the accident compensation bar. In the event, few HRRT proceedings have been brought by injured patients, and none has led to a substantive hearing, in part because so few complainants obtain the prerequisite HDC investigation and breach finding.<sup>47</sup> The prospect of a civil claim is an illusory form of accountability for injured patients.

<sup>42</sup> Health and Disability Commissioner, ‘Annual Report for the Year Ended 30 June 2002’ (Auckland, 2002), p. 6.

<sup>43</sup> The Health and Disability Commissioner Act, s. 38(1).

<sup>44</sup> The Health and Disability Commissioner Act, s. 34(1)(a).

<sup>45</sup> ‘Annual Report for the Year Ended 30 June 2005’ (Auckland: Health and Disability Commissioner, 2005), p. 1.

<sup>46</sup> The Health and Disability Commissioner Act, s. 51.

<sup>47</sup> Other relevant factors are discussed by P. D. G. Skegg, ‘A Fortunate Experiment? New Zealand’s Experience with a Legislated Code of Patients’ Rights’, *Medical Law Review* 19 (2011): 249–53.

The companion reform to the changes to the HDC legislation was the enactment of the Health Practitioners Competence Assurance Act 2003, with its principal purpose ‘to protect the health and safety of members of the public by providing mechanisms to ensure that health practitioners are competent and fit to practise their professions’, and a subsidiary purpose of providing for ‘a consistent accountability regime for all health professions’.<sup>48</sup> The new law put all health practitioners on an equal footing in relation to registration, competence assurance and professional discipline. In the lead-up to its enactment, medical professional leaders expressed concern about excessive accountability being imposed by external regulation,<sup>49</sup> but there is no evidence that has come to pass.

The third law change, and the one most clearly influenced by patient safety thinking, was the reform of the coverage of medical accidents under the accident compensation legislation. Section 47 of the Injury Prevention, Rehabilitation, and Compensation Amendment Act (No. 2) 2005 extended cover to all ‘treatment injury’, on a no-fault basis, but required the Accident Compensation Corporation to report any ‘risk of harm to the public’ (perceived from claims information) to the appropriate ‘authority responsible for patient safety’. In theory, as Marie Bismark and I noted at the time, the new law harmonised ‘injury compensation, provider accountability, and patient safety’.<sup>50</sup> Yet here too the gains appear doubtful: the claim that the Health and Disability Commissioner ‘provides accountability where care has not been provided with reasonable care and skill’<sup>51</sup> is contestable on current data; and the patient safety gains from use of ACC data have not been fully realised. After a strong reaction from the medical profession in the first year of reporting, when ACC made thirty reports about individual doctors to the Medical Council under the ‘risk of harm’ provisions, the average number of reports has dropped to six per year in the past four years.<sup>52</sup> An ‘information gap’ has opened up in the legislation,<sup>53</sup> since it may be difficult for ACC to conclude that a risk of harm exists, or to make a meaningful report about it, on the basis of the limited claims information.

<sup>48</sup> The Health Practitioners Competence Assurance Act 2003, ss. 3(1) and 3(2)(a).

<sup>49</sup> Ross Blair, quoted in ‘More Controls, Slower Delivery Warns Health Expert’, *Marlborough Express*, 9 May 2003.

<sup>50</sup> M. Bismark and R. Paterson, ‘No-Fault Compensation in New Zealand: Harmonizing Injury Compensation, Provider Accountability, and Patient Safety’, *Health Affairs* 25 (2006): 278.

<sup>51</sup> *Ibid.*, p. 281. <sup>52</sup> Information supplied by ACC, July 2011.

<sup>53</sup> Letter from Chief Executive of ACC to Health and Disability Commissioner, 30 May 2007.

### Other developments

The law changes occurred in a context of other developments relevant to discussion of New Zealand's response to health practitioner negligence causing harm to a patient. One was the recognition of the professional responsibility of health practitioners 'openly to disclose' unintentional harm to patients<sup>54</sup> – reinforced by official guidance from the Health and Disability Commissioner and the Medical Council.<sup>55</sup> It is now widely acknowledged that an affected patient or family has the right to an explanation in the aftermath of an adverse event. Voluntary disclosure has become a primary means by which health practitioners *account* to patients and families for unintended harm, but this is obviously different from the external accountability involved when a Commissioner, coroner or disciplinary tribunal holds an individual to account for substandard care.

Accountability at a systems level has been evident in other ways. Initially prompted by media requests for release of hospital data under freedom of information laws,<sup>56</sup> it has become standard practice for the publicly funded health system to reveal, on an annual basis, the number and nature of 'serious and sentinel events', identifying the name of the district health board where the adverse event occurred.<sup>57</sup> This is a form of voluntary public disclosure rather than a formal means of accountability.

During my time as Health and Disability Commissioner (2000–10), the Office explicitly pursued an approach of 'Learning, not Lynching; Resolution, not Retribution', with an emphasis on early resolution of complaints at the lowest appropriate level (frequently without recourse to a formal investigation). This was counterbalanced in two ways: by a pronounced emphasis on holding healthcare organisations (district health boards, public and private hospitals, rest homes and medical centres) to account for individual and systemic failings<sup>58</sup> and by a

<sup>54</sup> M. Bismark and R. Paterson, "“Doing the Right Thing” after an Adverse Event", *New Zealand Medical Journal* 1219 (2005): 55.

<sup>55</sup> Health and Disability Commissioner, 'Guidance on Open Disclosure Policies' (Auckland: 2009) and Medical Council of New Zealand, 'Disclosure of Harm Following an Adverse Event' (Wellington, 2010).

<sup>56</sup> The Official Information Act 1982.

<sup>57</sup> Since February 2008, the Quality Improvement Committee, and its successor the Health Quality and Safety Commission, has released aggregate 'serious and sentinel event' information reported from all district health boards. The latest report is Health Quality and Safety Commission, 'Making our Hospitals Safer: Serious and Sentinel Events Reported by District Health Boards in 2010/11' (Wellington, 2012).

<sup>58</sup> See, for example, Health and Disability Commissioner, Case 03HDC14692, 14 October 2005, available at [www.hdc.org.nz/decisions-case-notes/commissioner's-decisions/2005/03hdc14692](http://www.hdc.org.nz/decisions-case-notes/commissioner's-decisions/2005/03hdc14692).

concerted effort to lift the veil of medico-legal secrecy<sup>59</sup> by implementation of a policy of naming substandard providers (in practice, almost invariably healthcare organisations) in certain circumstances.

Under the HDC naming policy, individual practitioners found in breach of the Code can be publicly named if their conduct showed a flagrant disregard for the rights of the consumer or a severe departure from an acceptable standard of care, such that the practitioner poses a risk of harm to the public; or if the practitioner is a 'frequent flier'.<sup>60</sup> To date, only a single health practitioner has been publicly named under this policy,<sup>61</sup> reflecting the safety net of registration boards (which can be alerted if public protection appears necessary) and the paucity of breach reports. However, the policy that healthcare organisations found in breach of the Code can be named so as to be 'publicly accountable for the quality of care they fund or provide'<sup>62</sup> has led to numerous district health boards and hospitals being identified, and the circumstances of their substandard care being publicly exposed.

The Medical Council of New Zealand undertakes its statutory function of ensuring the competence and fitness to practise of doctors with a strong focus on rehabilitation. An independent review of the Medical Council in 2010 endorsed its rehabilitative approach, but noted the need for greater transparency to ensure 'accountability and maintaining public confidence in the system of regulation of doctors in New Zealand'.<sup>63</sup> At a time of medical workforce shortages, it may be tempting for the Medical Council to pursue rehabilitation at the expense of public protection and accountability.

One form of accountability has endured: coroners' inquests into unexpected patient deaths. Although very few preventable patient deaths proceed to a formal inquest hearing, with findings and recommendations, such cases do constitute an important form of accountability to

<sup>59</sup> S. Holt and R. Paterson, 'Medico-legal Secrecy in New Zealand', *Journal of Law and Medicine* 15 (2008): 602.

<sup>60</sup> Defined as a practitioner found in breach of the Code in relation to three episodes of care within the past five years, where each breach involved a (at least) moderate departure from appropriate standards.

<sup>61</sup> Surgeon Richard Stubbs was publicly named after a trio of cases leading to breach findings (within an eighteen-month period) resulting from his inadequate information disclosure: Health and Disability Commissioner, Case 09HDC01870, 4 March 2010. Available at [www.hdc.org.nz/decisions-case-notes/commissioner's-decisions/2010/09hdc01870](http://www.hdc.org.nz/decisions-case-notes/commissioner's-decisions/2010/09hdc01870).

<sup>62</sup> Health and Disability Commissioner, 'Naming Providers in Public HDC Reports' (Auckland, 2008), p. 1.

<sup>63</sup> Council for Healthcare Regulatory Excellence, 'Performance Review of the Medical Council of New Zealand: Promoting Improvement in Regulation through International Collaboration' (London, 2010), para. 7.31.

families and the public. The reforms introduced by the Coroners Act 2006 have resulted in a smaller, full-time corpus of expert coroners. The public spotlight of a coronial inquest into the causes and circumstances of a patient's death – with involved practitioners being called to give evidence in open court and be cross-examined – remains a daunting prospect for clinicians. In theory, no individuals are 'blamed' for shortcomings in care, but their exposure during the coronial process and any criticism in inquest findings can be a chastening experience that risks harm to their reputation (which explains why lawyers are invariably engaged as defence counsel and any proposed criticisms in draft findings are vigorously contested).

In summary, the response to health practitioner negligence that has evolved in New Zealand since 2006 can be characterised as generally mild and relatively non-interventionist. It seeks to compensate and rehabilitate injured patients (under the 'treatment injury' cover provisions of the accident compensation legislation); attempts to resolve complainants' concerns (most often by referral to an advocate, the provider or another agency, or by gathering information and sending letters to the providers with improvement recommendations, but usually without formal investigation);<sup>64</sup> and encourages practitioners 'openly to disclose' their mistakes and healthcare organisations to review incidents so as to improve healthcare quality (with legal protection for approved 'quality assurance activities').<sup>65</sup> Combined with the generally benign approach of health sector employers (often risk-averse in the face of procedural requirements of New Zealand employment law) and regulatory authorities, the net effect is that careless practitioners are rarely prosecuted or punished, and seldom 'held to account' in any meaningful way for mistakes that harm patients.

### **Gross negligence manslaughter**

Against this backdrop, there was significant interest in the prosecution in 2006 of a Dunedin midwife, charged with manslaughter for her involvement as lead maternity carer in the death of a baby following a vaginal breech delivery. The trial attracted extensive media coverage, highlighted conflicts of expert opinion and resulted in a 'not guilty' verdict after lengthy jury deliberations. As I wrote at the time, the prosecution was a

<sup>64</sup> These resolution methods account for 85 per cent (1,175 of 1,380) of closed complaint files: information provided by the Office of the Health and Disability Commissioner, September 2012.

<sup>65</sup> Under the Health Practitioners Competence Assurance Act 2003, ss. 54–63.



significant step backwards for three important reasons: it suggested an inconsistent and uneven application of the law; it frustrated the regular mechanisms for health professional accountability; and it cast a chilling shadow over the health sector.<sup>66</sup>

The first concern relates to inconsistency. As I can testify from the many files I reviewed as Health and Disability Commissioner, numerous other health practitioners who *are* 'guilty' of major shortcomings in their care, causing a patient's death, escape prosecution. Some cases are dealt with in the workplace; a few lead to an HDC investigation and the censure of a breach finding; others result in a competence review and, occasionally, practice conditions. A coroner may hold an inquest and make recommendations. On rare occasions a practitioner is disciplined, fined and named. Yet, apart from the death of the Dunedin baby, no other patient death since 1996 has resulted in a manslaughter prosecution.<sup>67</sup>

A second problem with invoking the criminal law in cases of health practitioner negligence is that it frustrates the normal channels of accountability via the Health and Disability Commissioner and registration boards. It is impracticable for these agencies to undertake a formal investigation or a competence review while a practitioner is facing a manslaughter charge, so files are usually put on hold. When the lengthy criminal process is over – in the Dunedin case the charge was laid fourteen months after the baby's death, and the trial and acquittal followed ten months later – it is very difficult to turn back the clock and commence normal inquiry processes.

A third problem is the 'ripple effect' of manslaughter prosecutions. They risk driving mistakes underground. Police investigation of anaesthetic deaths in the late 1980s led to the demise of the Anaesthetic Mortality Assessment Committee.<sup>68</sup> Renewed police interest in prosecuting 'clinical crime' would jeopardise morbidity and mortality reviews and quality assurance activities. Health practitioners are unlikely to share their mistakes in a peer review setting if a police search and seizure is a possibility. The real causes of patient deaths will remain hidden, and the potential to learn from mistakes will be lost.

In the HDC ruling on the complaint brought by the local district health board following the death of the baby in Dunedin, I commented: 'There is a place for the criminal law in the clinical setting

<sup>66</sup> R. Paterson, 'Doctors in the Dock', *Medical Council News*, June 2006, p. 4.

<sup>67</sup> The backdrop to the Dunedin prosecution involved tensions surrounding maternity service provision in New Zealand, with lead maternity carers (usually 'independent' midwives) accessing public hospital delivery wards under access agreements with district health boards.

<sup>68</sup> Skegg, 'Criminal Prosecutions', pp. 242–3.

where a health practitioner kills a patient by reckless acts or omissions. But in cases of unexpected patient death, even where gross negligence may be proved, a manslaughter prosecution is likely to do more harm than good.<sup>69</sup> I repeated my concerns in a second case concerning the treatment by two psychiatrists of a young man in the three years prior to his death by suicide in a secure inpatient mental health facility. After a lengthy investigation lasting three and a half years, the police ultimately decided not to prosecute the psychiatrists for manslaughter. In my investigation of a complaint made by the patient's father, I noted that the delays had 'significantly frustrated the normal accountability processes for the health professionals and organisations' involved in the case.<sup>70</sup> Quite apart from the usual difficulties of proving a major departure from the expected standard of care, a moment's reflection shows the improbability of being able to prove beyond reasonable doubt that a psychiatrist's acts or omissions (short of providing the means of suicide) caused a patient to take his own life.

### A changed perspective

Why do I now believe that in clinical settings the criminal law should be invoked only where a health practitioner kills a patient by reckless acts or omissions? After all, this is a higher threshold than the current gross negligence standard for 'medical manslaughter' in New Zealand, yet seventeen years ago I queried the need for Parliament even to reduce the threshold from ordinary negligence. Back in 1995, I thought that the case for law reform was 'overstated and that the fears of doctors, though clearly real, [were] misconceived'.<sup>71</sup> I was struck by the views of local anaesthetist Dave Chamley: '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.'<sup>72</sup> As Peter Skegg reflected in the aftermath of the law change, the prosecutions had been 'so few' and 'so difficult', and the penalties 'so lenient'.<sup>73</sup>

<sup>69</sup> Health and Disability Commissioner, Case 04HDC05503, 28 November 2006, 12. Available at [www.hdc.org.nz/decisions-case-notes/commissioner's-decisions/2006/04hdc05503](http://www.hdc.org.nz/decisions-case-notes/commissioner's-decisions/2006/04hdc05503).

<sup>70</sup> Health and Disability Commissioner, Case 07HDC06607, 8 January 2009, 2. Available at [www.hdc.org.nz/decisions-case-notes/commissioner's-decisions/2009/07hdc16607](http://www.hdc.org.nz/decisions-case-notes/commissioner's-decisions/2009/07hdc16607).

<sup>71</sup> R. Paterson, 'Medical Manslaughter Law Reform: The Wrong Diagnosis?', *LawTalk*, 24 July 1995, p. 8.

<sup>72</sup> D. Chamley, 'The Furore Over Medical Manslaughter: A Mistaken Diagnosis', *Newsletter, New Zealand Society of Anaesthesia* 42 (1994): 12.

<sup>73</sup> Skegg, 'Criminal Prosecutions', pp. 220–46.

I now accept that a manslaughter conviction is an unhelpful form of accountability for a careless health practitioner whose acts or omissions cause a patient's death. If the rationale is to punish a wrongdoer, professional disciplinary processes seem better designed to that end. If the purpose is to recognise the value of a human life, and the tragedy of preventable death, that is better achieved through coronial mechanisms designed for that very purpose. If the aim is deterrence (to prevent the deaths of other patients in similar situations), manslaughter prosecutions are an ill-conceived intervention, as shown by the continuing deaths from administration of the anti-cancer drug vincristine, notwithstanding highly publicised English prosecutions of doctors who mistakenly administered it.<sup>74</sup> If the goal is to provide answers for grieving families, mediations or investigations by independent public officials such as a Commissioner or coroner are more effective to that end.

### **Accountability in 2012**

Writing in 1996, prominent advocates of the reform of New Zealand's criminal law, Alexander McCall Smith and Alan Merry, observed that '[i]t will be interesting to look back in ten years time', predicting 'a promising future for accountability in medicine in New Zealand'.<sup>75</sup> In the intervening period, much has been achieved as a result of patient safety law reforms, the development of the Health and Disability Commissioner complaint system and the overhaul of health practitioner regulation. Peter Skegg writes that 'New Zealand's experience with a legislated Code of Rights warrants its characterisation as a fortunate experiment'.<sup>76</sup>

Yet it must be asked whether the pendulum has swung too far in New Zealand. Has the 'promising future for accountability' been realised when so many families struggle to see individual practitioners or their employing organisation held to account for a lack of care with fatal consequences? Joanna Manning underscores the importance to a family of an HDC investigation and report in the event of the death of a patient/family member, and notes

the significance of the Commissioner's opinion *to complainants and consumers* in addressing their remedial interests. It is ... the fact that it is an official adjudication by the Commissioner, who holds this statutory, government-appointed,

<sup>74</sup> A. Merry, 'When Are Errors a Crime?', pp. 80–2.

<sup>75</sup> A. McCall Smith and A. Merry, 'Medical Accountability and the Criminal Law: New Zealand vs The World', *Health Care Analysis* 4.1 (1996): 53.

<sup>76</sup> Skegg, 'A Fortunate Experiment?', p. 266.

independent, consumer protection office, that imbues the decision with special legitimacy and significance, in addressing the remedial interests of patients, particularly that of accountability.<sup>77</sup>

As Manning points out, there are also significant access to justice considerations given the current low level of HDC investigations,<sup>78</sup> since a finding of breach of the Code is a prerequisite to any claim for breach of a patient's rights before the Human Rights Review Tribunal.

### Conclusion

There is a place for the criminal law in clinical settings. The doctor who deliberately harms patients is a criminal. Where a health practitioner kills a patient by reckless acts or omissions, a manslaughter prosecution may be warranted. But in the vast majority of cases of unexpected patient death, a manslaughter prosecution is likely to do more harm than good. Accountability mechanisms specifically designed for health practitioners, such as those in place in New Zealand, offer a better way forward, but they must ensure that individuals and systems are appropriately held to account when careless conduct kills a patient.

The unexpected death of a patient through a lack of care from health practitioners or the health system is a tragedy that warrants investigation and follow-up. As I stated in a public lecture in 2008, 'there will always be a place for HDC to undertake inquiries where external scrutiny is necessary'.<sup>79</sup> Prosecution has a limited part to play in accountability for unintended patient harm, and rehabilitation is an important goal in addressing the shortcomings of individual practitioners. However, external investigations and inquiries into the causes and circumstances of unexpected patient deaths, and remedial recommendations, remain a vital aspect of accountability in a modern health system.

<sup>77</sup> J. Manning, 'Access to Justice for New Zealand Health Consumers', *Journal of Law and Medicine* 18 (2010): 188.

<sup>78</sup> I recognise that this criticism could be levelled at my own time as Commissioner. In my last full year (to 30 June 2009), HDC completed 109 investigations (8 per cent of file closures): Health and Disability Commissioner, 'Annual Report for the Year Ended 30 June 2009' (Auckland, 2009), p. 3. The number of investigations dropped to forty-four in the year to 30 June 2012 (3 per cent of file closures): information provided by the Office of the Health and Disability Commissioner, September 2012.

<sup>79</sup> R. Paterson, 'Inquiries into Health Care: Learning or Lynching?', *New Zealand Medical Journal* 121 (2008): 1286. 28 November 2008. Available at <http://journal.nzma.org.nz/journal/archive.php>.