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Doctors and the criminal law

The essential difference between a civil and a criminal offence is that one reflects conflict between two or more individuals and is aimed at securing recompense, whereas the other is conflict between an individual and society with a view to punishment. Minor criminal offences are dealt with in the ***Magistrates Court*** but matters of greater importance are heard in the ***Crown Court*** by a Judge sitting with a jury whose members are the representatives of society. Doctors are not immune from criminality but prosecutions brought against individual practitioners are considered here only in the context of criminal charges arising from deaths associated with clinical practice.

Conviction for a criminal offence requires proof beyond reasonable doubt that

- the person charged has carried out an unlawful act (*'actus reus'*) and
- in doing so had the necessary guilty state of mind (*'mens rea'*).

Specific 'elements' for each offence define the unlawful act and the necessary guilty state of mind. Both must be made out if the prosecution is to succeed (cf the civil claimant's need to establish both breach of duty and causation), but a finding of guilt can still be diminished or even avoided if the defendant can advance a valid defence (for example, provocation in the context of murder).

The standard of proof required in a criminal case – beyond reasonable doubt – is higher than the balance of probabilities which suffices for civil actions. Another practical distinction is that the legal rules of evidence are observed more stringently in criminal matters. The phrase 'beyond reasonable doubt' does not mean 'beyond a shadow of doubt'. A remote possibility, which is not in the least probable, does not create 'reasonable doubt'. The Judge directs the jury on the standard required, often telling them 'they must be satisfied so that they are sure'.

Homicide

Homicide is the unlawful killing of a human being, identified in the context of infants as a life independent from the mother. Murder and manslaughter are both homicide, distinguished by the the state of mind of the defendant and the perceived culpability so determined.

The cause of death must be attributable to the unlawful act, as a matter of fact and of law. Causation in fact is determined by the 'but for' test – but for the act in question, would the victim have died? Causation in law requires exploration of the closeness of the link between the act and the death. Was the act a substantial and operating factor? An example helps to explain this concept – a victim is knocked unconscious and left on the shore where he drowns when the tide comes in. The factual cause of death is drowning: the cause in law is the act of the defendant. Undue vulnerability of the victim (the 'eggshell skull' rule) does not exonerate the perpetrator.

The importance of the distinction between causation in fact and in law is apparent when considering the role of medical interventions. Thus two assailants, each convicted of murder, appealed on the grounds that a subsequent medical decision to withdraw mechanical ventilation caused the deaths[1]. Both appeals failed. Even clinical negligence as an intervening event will not *necessarily* displace responsibility for an unlawful death (eg murder)[2]. Similarly, when considering an application for a declaration that withdrawal of mechanical ventilation from a patient with exceptionally severe Guillain-Barre syndrome would not be unlawful[3], a New Zealand court accepted that the cause of death would be the disease and not the act of withdrawal, *provided* the decision to withdraw ventilation had been made in accordance with good medical practice. Thus the *propriety* of the medical act which intervenes between initiating event or illness and the fatal outcome is to be taken into consideration when considering the legal cause of death, as well as the *magnitude* of the contribution of each element to the death.

Intention to kill *or to cause serious injury* is a prerequisite for a conviction of murder. Primary or specific purpose intent exists when a person sets out to secure an objective by whatever means lie within his power. Secondary intent (also known as indirect or foresight intent) is a presumption: a man is presumed to intend the consequences of his act if the outcome is a virtual certainty and he is aware, when acting, that this is so. Evidence must be adduced in each case to satisfy the jury to the requisite standard that these conditions were, in fact, fulfilled. An important distinction must be drawn between intention and motive. Intention refers to what

the actor seeks to achieve; motive is the reason for acting. A benevolent motive does not displace a criminal conviction for murder if the intention to kill is made out at trial[4].

Voluntary manslaughter is the likely verdict if a defendant is found guilty of causing death and of having the intention to kill but has successfully pleaded one of a number of defences, usually provocation or diminished responsibility. The significance lies in the sentence. Murder carries a mandatory life sentence whereas sentencing for manslaughter is at the discretion of the judge.

Involuntary manslaughter is a verdict which follows a finding that the defendant caused the death, but without any intention to kill or cause serious injury. It includes death occurring as the result of an unlawful act or, most common in the context of medical manslaughter, as a consequence of what has variously been described as 'recklessness' or 'gross negligence'. The discussion here is restricted to gross negligence in the discharge of professional responsibilities.

Manslaughter by gross negligence

It is arguable that deaths arising as a result of medical treatment can be distinguished from the usual case of homicide because it is the defendant's professional obligations which require him to deal with a pre-existing danger which is not of his own making. This philosophy lay behind the original definition of gross (ie criminal) negligence[5] which required

- the existence of a duty of care
- breach of the duty
- death occurring as a consequence of the breach of duty
- negligence which went beyond a mere matter of compensation between the parties.

The first three elements of this test are identical to those set out in chapter 2 as the basis for a *civil* claim in negligence. The fourth is the dimension which adds criminality – showing such disregard for the safety of others amounted to a crime against the State and was deserving of punishment.

After some years when 'gross negligence' was regarded by the courts as synonymous with recklessness, the importance of specific criteria for a finding of gross negligence in the discharge of professional responsibilities was re-emphasised by the Court of Appeal in the course of three appeals, heard simultaneously, against convictions for manslaughter by an

electrician, two junior doctors, and a locum anaesthetist[6]. Two of the appeals succeeded but the third did not. The third appellant appealed, unsuccessfully, to the House of Lords[7] when the criteria for a finding of involuntary manslaughter by breach of duty suggested by the Court of Appeal were confirmed as

- the existence of a duty
- breach of the duty causing death
- gross negligence which the jury considered justified a criminal conviction.

The third of these is the only one which differs in terminology, if not in meaning, from the original definition of 'gross negligence'. A jury is entitled to make a finding of gross negligence if evidence is adduced to show that the defendant

- was indifferent to an obvious risk of injury to health
- had actual foresight of the risk but determined nevertheless to run it
- appreciated the risk and intended to avoid it but displayed such a high degree of negligence in the attempted avoidance as the jury considered justified conviction
- displayed inattention or failure to advert to a serious risk which went beyond 'mere inadvertence' in respect of an obvious and important matter which the defendant's duty demanded he should address.

Given these directions, it is the *jury* which decides whether the evidence suffices to fulfil one or more of the criteria and, if so, whether the charge of gross negligence has been made out.

Criminal liability for end-of-life decisions

The conviction of a caring doctor for attempted murder[4], followed shortly by a House of Lords decision that it would not be unlawful to withdraw artificial nutrition and hydration from a patient in persistent vegetative state[8], led to the setting up of a House of Lords Committee[9] to consider the ethical, legal and clinical implications of end-of life decision-making. The recommendations of the Committee were conservative:

- the law should not be changed to permit active euthanasia
- the right of competent patients to refuse medical treatment was strongly endorsed

- the law on suicide[10] should not be changed
- there should be no new offence of 'mercy-killing'
- the mandatory life-sentence for murder should be dropped.

All but the last of the recommendations were accepted by government. The Committee also acknowledged that it is lawful – indeed proper – to administer drugs to relieve pain notwithstanding an awareness of the probability that they will hasten death, a view confirmed in caselaw both before and after the report was published[11,12]. The essential legal element is the intention of the practitioner – if the primary intention is to relieve suffering, the *mens rea* for a finding of murder is absent. The practitioner may foresee that death is virtually certain after, and perhaps as a consequence of the treatment, but the presumption that he therefore intends the death is refuted by evidence that his primary intent is to benefit the patient. Some regard this argument as specious – and perhaps in practice it is.

Termination of life-support is followed by death in stark, temporal proximity. The practitioner is protected from a charge of murder if the decision accords with good medical practice. There is no obligation to continue treatment deemed to be futile or not in the patient's best interests, but evidence must be available to support this contention[13]. Particular difficulty is associated with the chronic stable condition of persistent vegetative state. The House of Lords has accepted that 'treatment' can include nutrition and hydration when provided by artificial means[8]. In that case, the severity of the neurological damage was deemed such that either the patient had no best interests or they were not served by continued treatment. However, the decision was not to be used as a precedent – parliament, not the courts, should be responsible for formulating principle. Thus a declaration by the court should be obtained if the withdrawal of nutrition and hydration is contemplated from a profoundly damaged but physiologically stable patient[14]. Perceived conflict over the status of nutrition and hydration as 'treatment' or 'basic humanitarian care' means that particular care is necessary before taking such a step in any circumstances[15]. The present position is unsatisfactory because the limits of legality are not clearly defined. A private member's bill – Medical Treatment (Prevention of Euthanasia) – which sought to prohibit the withholding or withdrawing of medical treatment, including hydration and nutrition, when this would bring about the death of the patient, was rejected.

Withholding treatment is acceptable practice *provided* the treating practitioner genuinely and for good reason believes it to be in the best interests of the patient to do so[16]. The court will not dictate what is appropriate treatment[17]. The apparent discrepancy between the court's power to

over-rule parental decisions to withhold consent and its reluctance to order treatment requested by parents but resisted by the practitioner, reflects the principle that what is done should be in the best interests of the patient and that is primarily a matter of expert opinion.

The law as a vehicle for social change

In 1939 an eminent gynaecologist announced that he intended to terminate the pregnancy of a 14-year old victim of gang rape. He duly did so at a prestigious London hospital. He was prosecuted and acquitted on a technicality of interpretation of the then-relevant statute[18]. The case focussed attention on the fact that abortion, although unlawful, was widely practised, albeit in circumstances which were often unhygienic and dangerous. Subsequent caselaw reflected this liberal statutory interpretation and was followed ultimately in 1967 by the first Abortion Act. A number of controversial social and ethical issues have since prompted responsive legislation, often without a legal test case. Some examples include The Human Organ Transplantation Act 1989, The Human Fertilisation and Embryology Act 1990 and the Surrogacy Arrangements Act 1985. The law – whether it is defined in the courts or established by legislation – sets the limits of what is deemed to be acceptable practice. It is not immutable but can and does change in response to new developments or social pressures. There is no reason why medical practitioners, parliamentarians or judges should be the sole arbiters of ethical dilemmas, but rules need to be set and the law is empowered to fulfil that role. It is the duty of all citizens – including medical practitioners – to abide by the law and, if the law assists in defining the boundaries of acceptable medical practice, its intervention is to be welcomed, not feared.

References

1. R v Malcherek; R v Steel [1981] 2 All ER 422.
   Discontinuing mechanical ventilation did not suffice to interrupt the chain of causation between initial assault upon each of two victims and their subsequent death. Appeals against convictions for murder failed.
2. R v Cheshire [1991] 1 WLR 844
   Failure to recognise tracheal stricture the proximate cause of death of a victim who had been shot 5 weeks earlier. Defendant's appeal against conviction of murder was unsuccessful.
3. Auckland Area Health Board v Attorney-General [1993] 4 Med LR 239.
   New Zealand declaration that it would be lawful to withdraw mechanical ventilation from a patient severely affected by Guillain Barre syndrome. Questions explored were whether death was caused by the disease (yes) or the withdrawal of ventilation, and whether mechanical ventilation was a necessity of life (not in these circumstances).

4. R v Cox (1992) 12 BMLR 38; (and see legal commentary in BMJ 1992 305:731).
Conviction for attempted murder (cause of death unproven because body had been cremated before charges were brought). Consultant Rheumatologist administered intravenous potassium chloride to a woman terminally ill from chronic rheumatoid arthritis, in 'uncontrollable' pain, who begged to die and whose family supported her decision.
5. R v Bateman (1925) LJKB 791
Gross, fatal, pelvic visceral injury during attempted home delivery. Criteria for gross negligence defined.
6. R v Holloway; R v Adomako; R v Prentice & Sullman [1993] 4 Med LR 304.
This report does not include the facts of R v Holloway – an electrician whose faulty wiring of a central heating system caused death by electrocution – but the Court of Appeal set out principles applying to all three cases. The anaesthetic death involved failure to recognise disconnection of the ventilator; the third case arose from a fatal injection of vincristine into the theca of a patient receiving regular intrathecal methotrexate and intravenous vincristine. The appeals of Holloway, Prentice and Sullman were allowed, their convictions being quashed. Adomako's appeal failed.
7. R v Adomako [1994] 5 Med LR 277.
Appeal to the House of Lords by the unsuccessful appellant (an anaesthetist) from (6) above also failed. It is sufficient to direct the jury to adopt the criteria for gross negligence set out by the Court of Appeal in this case.
8. Airedale NHS Trust v Bland [1993] 4 Med LR 39.
House of Lords decision that withdrawal of artificial nutrition and hydration from a patient in persistent vegetative state would not be unlawful. Their Lordships specifically stated the decision should *not* be regarded as a precedent.
9. Select Committee on Medical Ethics, House of Lords Report. HMSO 1994.
Legal and ethical analysis of end of life decisions. Law should not be changed to permit active euthanasia. Offence of 'mercy-killing' not recommended; suggestion to drop mandatory life sentence for murder rejected by government.
10. Suicide Act 1961
Suicide is no longer a criminal offence but section 2 preserves aiding and abetting suicide as an offence.
11. R v Bodkin Adams [1957] Crim LR 365.
GP acquitted of murder by administration of increasing doses of opiates to elderly patients with a view to personal gain. See also *R v Arthur (1981) 12 BMLR 1*; acquittal of consultant paediatrician charged with attempted murder by prescribing 'dihydrocodeine and nursing care only' for a neonate with Down's syndrome, rejected by her mother.
12. Dyer C. BMJ 1999 318:1306.
Unwise public declaration by a GP that he had helped a number of patients to have pain-free deaths led to prosecution for murder. Unanimous verdict of 'not guilty'. GP's considerate treatment was applauded by the judge. See *Gillon R, Doyal L BMJ 1999 318:1431* for discussion of ethical doctrine of 'double effect'.
13. South Buckinghamshire NHS Trust v R (A Patient) [1996] 7 Med LR 401.
23-year old existed in a 'low awareness state'. No obligation to treat if, in all the circumstances, life would be so afflicted as to be intolerable. See also (8) above where treatment withdrawal was justified on grounds of futility.
14. Wade DT, Johnston C. The permanent vegetative state. BMJ 1999 319:841.
Review of clinical features plus practical guide on steps required to obtain court's approval to discontinue treatment.
15. Bliss MR. BMJ 2000 320:67
Critical analysis by a consultant geriatrician of the reprimand and suspension of a GP for ordering withdrawal of nutritional supplements from a demented elderly patient. Reported to police by nurses; police referred to GMC.
16. Re J (A Minor) [1993] 4 Med LR 21.
Infant with profound neurological disability and frequent convulsions compromising respiration. Court of Appeal reversed a decision requiring that child be given life-prolonging treatment, including mechanical ventilation. There was no obligation to provide treatment which, in *bona fide* opinion of practitioner, is not in patient's best interests. 'Wholly inconsistent with the law' to order treatment contrary to doctor's clinical judgment.

17. R v Portsmouth Hospital NHS Trust [1999] Lloyd's Rep Med 367.
    Seriously disabled 12-year old given morphine against wishes of mother and a non-consensual DNR order was written. Violence followed between staff and family. Application for Judicial Review of the Trust's decision failed. Court of Appeal held it was inappropriate for court to declare what a hospital should or should not do as a matter of law. Individual cases of conflict should be resolved at the time by referral to Family Division of the High Court for declaration of child's best interests, or application under s8 Children's Act 1989, or make child a ward of court.
18. R v Bourne [1939] 1 KB 687.
    Criminal prosecution for procuring a miscarriage. Not unlawful if done in good faith for sole purpose of preserving the life of the mother – interpreted to include adverse consequences to physical health short of death.