Medical manslaughter in New Zealand

The conviction of a 28-year-old female health professional on a charge of manslaughter has once again highlighted a medicolegal area troubling New Zealand doctors. In this latest case, an elderly man, recuperating after an operation, was given intravenous analgesic at 100 mL an hour instead of 5 to 10 mL. He suffered a cardiac arrest and died a week later.

Doctors, especially anaesthetists, have been lobbying the Minister of Justice to water down the criminal law or to exempt doctors from the law altogether. The New Zealand Medical Association, the Royal College of Surgeons, the Royal College of Physicians, the Anaesthetists Society, and the Medical Council have all called for revision of the law. The Anaesthetists Society president, Hugh Clarkson, claims that patients have died because scared doctors have refused to administer anaesthetics to patients whom they consider to be high risk. His society backs doctors in Christchurch and Whangarei who have refused to give epidurals to women during labour.

The section of the Crimes Act at issue states that everyone who undertakes "to administer surgical or medical treatment, or to do any lawful thing which may be dangerous to life" has a duty to exercise "reasonable knowledge, skill, and care" and is "criminally responsible" if they omit to do so. These provisions have been included in the criminal law since the last century, yet there have been only four convictions of doctors this century. The consternation is caused by the fact that all four have occurred since 1982, with three since 1989. In addition, the police are investigating patient deaths at Waikato Hospital and considering whether to lay charges against a cardiothoracic surgeon over five patient deaths at Christchurch Hospital. The three previous convictions involved an anaesthetist who administered carbon dioxide instead of oxygen; another who, without checking the labelling, administered the wrong drug during an emergency; and a radiologist who injected the wrong substance during myelography.

Ron Paterson, a senior lecturer in law at Auckland University, puts the increase in cases down to the growing awareness of patients' rights following the Cervical Cancer Inquiry in 1988 ("with families more aggressively seeking to learn the true cause of death"). The other factor is the Coroners Act, passed in 1988, which requires deaths during or after medical treatment to be reported to the police. But Paterson says that doctors have not been specifically "singled out". Like other medicolegal experts Paterson believes that doctors have overreacted. In recent years similar charges have been laid against non-medical people carrying out potentially dangerous tasks, including a bungee-jump operator who failed to ensure bands were properly connected, and an aero club instructor who piloted a plane involved in a mid-air collision.

Central to the doctors' protest is the equivalent situation in countries such as England, Canada, and Australia, where doctors must commit "gross negligence" to be convicted, rather than simple negligence. Paterson dismisses this argument as "semantic". Courts in these countries, he says, have struggled to come up with a meaningful definition of gross.

Peter Skegg, professor of law at Otago University, says that in view of the thousands of cases where harm has probably occurred, the risk of prosecution for doctors is "very slight" and so far the penalties have been a fine or a discharge. He points out that because New Zealand's accident compensation legislation blocks most civil actions, local doctors are "fortunate", compared with their counterparts overseas. Skegg warns that doctors who refuse to operate may be risking manslaughter charges if the patient then dies, and that avoiding "high-risk" patients is misguided since most of the cases have resulted from the deaths of low-risk patients.

It is not yet clear whether the Minister of Justice will respond favourably to arguments for a law change. The Department of Justice has advised him that there is not a strong case for amendment. Any change to the legislation would affect people other than doctors. Added to that, members of the public have yet to be consulted, and it seems probable that they might not tolerate a lesser standard for doctors than for the rest of the community.

Sandra Coney

NZ mammographic screening policy

A new government policy on mammographic screening—that it is not recommended for under-50-year-olds—is proving contentious with some breast surgeons. The policy was developed jointly with the Cancer Society of New Zealand, and to press the point home the government subsidy on screening mammograms has been removed for women in this age group, except for those in specific high-risk groups.

Apart from two pilot screening programmes for women aged between 50 and 64, the government does not currently provide mammographic screening. Nevertheless there is a great deal of entrepreneurial activity. Private radiology clinics actively recruit women under 50 through general practitioners and, more recently, by directly marketing mammography to women.

News of the impending release of the policy and removal of the subsidy caused agitation in some medical circles. The Ministry of Health appeared to waver, but ultimately the policy emerged intact, if some weeks later than planned.

Now twelve breast surgeons, some private and others working in both public and private sectors, have jointly written to the *New Zealand Medical Journal* stating that, despite the lack of definitive evidence, women themselves should make "an informed choice". "Individual risk factors and anxieties" should play a role in this choice, they say. They argue that because mammography does pick up cancers in young women, "it is likely" a benefit will be proved in time.

Sandra Coney

Breast cancer funding in Australia

After months of sustained political pressure, the federal government is planning a substantial boost in funding for breast cancer research in this month's federal budget. The pressure started with the Hancock Foundation in Perth, a charitable institution established by Gina Rinehart, daughter of the late mining magnate Lang Hancock. Rinehart exhorted women throughout the country to politicise breast cancer and make it a women's issue. She found support from Prof John Forbes, a surgical oncologist from the University of Newcastle, and Mrs Annita Keating, wife of the prime minister. All decried the lack of funding for research into such a common disease. More recently the leader of the opposition, Dr John Hewson, said the government was deliberately underfunding breast cancer research. According to information leaked to medical researchers, the government will respond to the pressure by substantially boosting funding for breast cancer research.

But the researchers who would benefit from the decision are unimpressed. The Australian Society for Medical Research (ASMR), the Royal Australasian College of Physicians (RACP), and the Australian Medical Association (AMA) all believe that such a decision is detrimental to medical research. They believe it will either bypass or distort the mechanisms by which the National Health and Medical Research Council (NHMRC) distributes research funds on the basis of the quality of the application.

Dr Christine Clarke, ASMR president and NHMRC research fellow who works in breast cancer, says there is no doubt breast cancer funding must be increased,

as must funding for all medical research. "But there is absolutely no support from medical researchers, including those who work in breast cancer, for specifically earmarking funds. This is not a response from disgruntled people who will miss out on the extra funding. None of us wants special interest groups and the political process to decide where money should go in research. We've got extraordinarily broad support from everyone we've spoken to for that view", says Clark. Prof Peter Brooks, RACP honorary secretary, says: "Providing medical research funds to those groups who can make the most noise or have more political clout than others is not in the best long-term interests of the community". Dr Brendan Nelson, AMA president, says: "Although more money is needed, it would be a dangerous move to direct it to breast cancer research for political purposes. It would mean research in Australia was governed by politicians, rather than by the needs and merits".

However, it is not clear whether their warnings will be acted upon. Breast cancer has become, as Rinehart suggested it should, a women's issue. In the context of Australian politics, that means it is sure to merit special attention.

Mark Ragg

MEDICINE AND THE LAW

Lindane exposure and aplastic anaemia

In a reserved (and first-ever) judgment[1] on whether the chemicals in a wood preservative, particularly lindane, could and did cause aplastic anaemia (AA), Mr Justice Otton found the plaintiff's case not proved and that, even if causation had been established, the injury had not been foreseeable at the time of exposure.

The plaintiff was born on July 27, 1967. Rentokil Ltd treated wood in his home in 1969 and in 1971 (particularly in and close to his bedroom). The preservative contained lindane (gamma HCH). In May, 1973, the plaintiff was diagnosed as having AA which was alleged to have been caused by exposure to the substances in Rentokil's treatment, particularly lindane, and that the defendants had been negligent. Damages were provisionally agreed, with liberty to apply for a further award of £25 000—subject to proof of liability.

In his judgment, Otton J said the principal issues were causation and negligence. Can lindane cause AA in human beings? Was the plaintiff exposed to lindane and to what extent? Did lindane cause the plaintiff's AA? If so, were the defendants negligent?

Prof Edward Gordon-Smith (St George's Hospital, London) was called on behalf of the plaintiff and Prof Yves Najean (St Louis Hospital, Paris) gave evidence for the defendants.

The judge noted that in cross-examination Gordon-Smith conceded that he had written of a possible (and not probable) connection in past academic publications. Nevertheless Gordon-Smith would not move towards Najean's denial of the possibility.

Otton J said that Gordon-Smith's assertion that there was cumulative evidence to support the lindane/AA connection was of little substance, since only 6 of the initial 19 cases were without confounders and were of typical cases.

The judge contrasted the evidence of the 6 cases with the widespread use of lindane.

The judge also noted the February, 1993, report of an advisory committee of the Ministry of Agriculture, Fisheries and Food. Its overall conclusion was: if a causal association does exist it is probably not dose related and is a very rare idiosyncratic response. This conclusion was in line with that of the WHO task group on environmental health on criteria for lindane in 1991.

The judge concluded that there is manifestly insufficient epidemiological, aetiological, pathogenetic, and statistical evidence to prove as a medical certainty that exposure to lindane causes AA in man. But he decided there is limited evidence for a possible link. In such cases there would be exposure to a high dosage over a long period with the onset of symptoms within 6 months (with an even more remote possibility of up to 12 months), and other agents could not be identified.

Although Otton J was not persuaded, on the balance of probabilities, that exposure to lindane caused the AA in any of Gordon-Smith's 6 index cases, he considered that there was enough substance in the evidence to leave open the possibility. Thus he could not find as a matter of medical or scientific certainty that such a link does not exist.

The plaintiff contended that atmospheric exposure to lindane had caused AA. The house had an unusually large amount of timber in the internal structure and woodworm treatment was done by spraying. No specific advice was given to the family about airing the house or leaving it unoccupied for any minimum time. The plaintiff developed symptoms of AA 2 years after the second exposure, which included treatment of wood in his bedroom.

The judge said inter alia that the temporal element was such that the plaintiff had failed to prove on the balance of probabilities that the exposure in 1969 and 1971 caused the AA that was diagnosed in 1973.

What types of injury were foreseeable in 1971? AA did not fall within the foreseeable risk of injury and was therefore not a recognised or identified consequence of exposure to lindane. The "eggshell skull principle" did not apply here. That establishes that defendants are liable in respect of an unforeseen amount or extent of damage, which arises from an otherwise foreseeable injury. This contrasts with an unforeseeable type of injury, such as was claimed here. AA was wholly different in kind from all the dangers in 1971—ie, transient damage to the central nervous system.

It followed that the issue of negligence was merely theoretical. The defendants had not failed to keep informed and were entitled to rely on the state of knowledge in the industry that lindane was not injurious to health, particularly in the concentration at which it was used. There was thus no duty to warn. The fact that there was a subsequent warning system did not mean there was a duty to warn in 1969 and 1971. It was not proved that it was dangerous to allow the plaintiff to be present when the spraying took place. The plaintiff's claim accordingly failed.

Diana Brahams

William Justin Gaskill v Rentokil Ltd. Otton J, March 29, 1994.