THE CRIMINALISATION OF MEDICAL MISTAKES IN CANADA: A REVIEW

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1. Introduction
The issue of health professionals facing criminal charges of manslaughter or criminal negligence causing death or grievous bodily harm as a result of alleged negligence\(^1\) in their professional practice was thrown into stark relief by the recent acquittal of four physicians accused of mismanaging Canada’s blood system in the early 1980s.\(^2\) Stories like these, as well as international reports detailing an increase in the numbers of physicians being charged with (and in some cases convicted of) serious criminal offences as the result of alleged negligence in their professional practice,\(^3\) have resulted in some

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1 I predominantly use the terminology “negligent acts or omissions” or “negligence” in this paper, recognising that this is how the legal system characterises these types of occurrences. In other contexts, especially patient safety literature, other terminology such as “errors” or “preventable adverse events” may be used.


anxiety about the apparent increase in the incidence of such charges and their appropriateness in the healthcare context. Whilst research has focused on the incidence, nature and appropriateness of criminal charges against health professionals, particularly physicians, for alleged negligence in their professional practice in the United Kingdom, the United States, Japan, and New Zealand, the Canadian context has yet to be examined.

This article examines the Canadian context and how the criminal law is used to regulate the negligent acts or omissions of a health care professional in the course of their professional practice. It also assesses the appropriateness of such use. It is important at this point to state that the analysis in this article does not focus on those, fortunately few, cases where a health professional has intentionally killed his or her patients but rather when patients’ deaths or grievous injuries were allegedly a result of that health professional’s negligent acts or omissions when providing health services to that patient.

In the first section of this article, I review the use of the criminal law in the healthcare context, discuss its theoretical justifications, and review the problems associated with its application in health care. In the second section

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4 Ferner & McDowell, supra note 3.


7 Skegg, supra note 3.

8 Dr Harold Shipman, a physician from the U.K., being the most notorious in this respect. He was found guilty of murdering 15 of his patients and is suspected of murdering over 215 patients.

9 Of course in some circumstances a health professional will act when they know that death is the probable result of a procedure and thus will be considered reckless. However, their acts will be justifiably reckless if those actions are the only measure that may save the person from an otherwise certain death. An extreme example of this may be seen in the facts of Re A (children) (Conjoined Twins: Surgical Separation), [2001] 2 W.L.R. 480 (C.A.) where doctors undertook the surgical separation of conjoined twins knowing that the procedure would kill one twin but that absent such a procedure both twins would die.
of this article, I move from theory to practice and examine the circumstances in which the criminal law is being employed as mechanism to address allegedly negligent acts or omissions committed by Canadian physicians in their professional practice which result in the deaths or grievous injuries of their patients. More specifically, I quantify the numbers of physicians who have faced criminal charges in such circumstances and the outcomes of those cases. I do this to determine the incidence of such charges in Canada but also to determine whether charging patterns, conviction rates and acquittal rates map with broader concepts about the appropriateness of the application of the criminal law in this context. I then place these results in their broader context by comparing them, as much as it is possible to do so, with data from the United Kingdom. Although other health professionals have faced criminal charges as the result of alleged negligence in their professional practice, I focus the analysis in this article on physicians. I do this because the data is strongest for this group and also to enable comparison with the data from the United Kingdom which also focuses on physicians. However, the discussion and analysis in this article also applies to other health professionals.

2. Criminal Law and Negligent Acts

Criminal liability for negligence has long been contentious as it raises, to quote McCall Smith, “fundamental issues of criminal policy which go to the heart of our notions of when it is appropriate to punish those whose conduct demonstrates fault rather than an intention to inflict harm.” Some suggest that negligence should not be a basis for criminal liability as criminal sanctions should only be imposed upon people for the consequences of actions they intended or outcomes that they foresaw as a probable consequence of their actions. Others support the imposition of criminal sanctions for those who were negligent on the basis that a defendant could have complied with expected standards of conduct expected by reasonable persons but did not do so. In addition, supporters argue on utilitarian grounds that the threat

10 There are of course difficulties in making such comparisons and I discuss these difficulties in greater detail later in this article.
12 Jerome Hall, “Negligent Behaviour should be Excluded from Penal Liability” (1963) 63 Colum. L. Rev. 632; McCall Smith, “Merely Human”, supra note 3.
13 See notably, H.L.A. Hart, Punishment and Responsibility: Essays in the Philosophy of
of criminal sanction has a prospective effect in that it encourages improved standards of practice.\(^\text{14}\)

Despite this principled disagreement the latter view prevails and criminal liability can be found for grossly negligent conduct in the common-law and in the codified criminal law in Canada. Those whose negligent acts or omissions cause a death may face, in Canada, a charge of criminal negligence causing death or, in other common-law countries, a charge of manslaughter through gross negligence.

### Criminal Negligence and Health Professionals

Negligent acts or omissions by health professionals in the course of their professional practice are part of the human condition – after all, to quote Alexander Pope, “to err is human.” The law has long responded to these events in a variety of ways, most commonly through the provision of compensation to injured patients through the use of tort law and the imposition of sanctions against health professionals through professional regulatory mechanisms. But in the gravest of such circumstances, the criminal law has a long history as a tool through which to address alleged negligence in a health professional’s practice which results in the death or grievous injury of a patient. Indeed, as early as the 14\(^{th}\) century, a case exists in which a health professional was found criminally liable for negligence.\(^\text{15}\)

Use of the criminal law is the strongest mechanism through which the state holds an individual to account for actions that are contrary to the public interest. No person should be immune from the criminal law because of his or her professional status. However, there are specific circumstances associated with the provision of health services which make finding criminal liability for alleged negligence in professional practice especially challenging.

One of the most significant challenges associated with using the criminal law against health professionals for negligence in professional practice is that the criminal law is ill-equipped to address the complexities of the environment within which health professionals commonly operate – the modern

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\(^{14}\) Ibid.

healthcare system. The paradigm of the criminal law is based upon an acknowledgement of human agency – an autonomous individual makes a decision to act (or not to act) in a manner that contravenes the law and must accept the consequences of that action or omission. This theory envisions a simple world that recognises few relational factors. Criminal negligence is commonly employed in respect of deaths caused in motor vehicle accidents – a relatively uncomplicated context where an individual is clearly making decisions about when and how they intend to drive. When the criminal law was initially used to regulate health professionals in the 14th and subsequent centuries, services were provided very much in an individual context, there being no health system to speak of. The historical foundations of healthcare are based upon the autonomous professional who is either competent or incompetent in his or her professional practice and this conception still resonates as to how responsibility is assigned in this realm. However, in the present reality, most health professionals are embedded in the complexity of modern healthcare, which has multiple interacting health care providers and treatments, patients with multiple co-morbidities, advanced technology, and a high pressure environment.\textsuperscript{16} This context is not always acknowledged. Research into the psychology of error has suggested that often errors are not the outcome of individual incompetence but are created by factors inherent to the complex system within which that individual works.\textsuperscript{17} An acknowledgement of context in many circumstances may undermine an individual’s culpability and blameworthiness or, as Alicke puts it, “factors that establish personal control intensify blame, whereas constraints on personal control potentially mitigate blame.”\textsuperscript{18} Both the criminal law and our perceptions of responsibility in healthcare are still firmly individualistic in nature and may not enable recognition of the context within which these services emerge and are created. What this points to is the moral ambiguity inherent in assigning criminal responsibility to a health professional whose agency is limited by the environment in which he or she practices; an ambiguity that raises questions about justice.

\textsuperscript{17} See for example, James Reason, \textit{Human Error} (New York: Cambridge University Press, 1990) [Reason].
The Tests for Criminal Negligence

Whilst the concept of criminal responsibility for negligence has been accepted in law, it has remained challenging to elucidate a principled test for criminally negligent conduct that creates a bright line between conduct that is merely negligent and conduct that is sufficiently negligent to attract criminal sanctions. In jurisdictions like England the relevant criminal offence is termed manslaughter while in Canada the equivalent offence is called criminal negligence causing death. However, in both countries the standard for culpability is the same – gross or criminal negligence.19 Sopinka J., writing for the majority in R. v. Anderson,20 suggested (at para. 10) that criminal negligence “has proved to be one of the most difficult and uncertain [areas of the law] in the whole of the criminal field.” Generally, to constitute criminal negligence, the accused’s conduct must amount to a marked departure from the standard of care that a reasonable person would observe in the circumstances – thus the greater the risk of harm the more likely that a reasonable person and the person concerned should have foreseen consequences which are the natural result of the conduct which creates the risk.21 In R. v. Bate-
man22 the English Court of Criminal appeal stated (at 11)

In explaining ... 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’, ‘com-
plete’. 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

19 To convict someone of manslaughter in England the prosecution must prove beyond reasonable doubt that the defendant is under a duty of care, is in breach of this duty to the extent of being grossly negligent and the breach caused the victim’s death. (See: R. v. Adomako, [1994] 3 W.L.R. 288 (H.L.) [Adomako] per Lord MacKay; Jeremy Horder, “Gross Negligence and Criminal Culpability” (1997) 47 U.T.L.J. 495 [Horder].
21 Ibid.
showed such disregard for the life and safety of others as to amount to a crime against the state and conduct deserving punishment.

Lord MacKay in *R. v. Adomako* provided further: “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.” These types of definitions have attracted criticism for being circular. In practice what this means is that, in both England and Canada, there is a distinction, albeit one of degree, between mere negligence and gross negligence sufficient to attract criminal sanction. As Lord Atkin put it: “Simple lack of care such as will constitute civil liability is not enough; for the purposes of the criminal law there are degrees of negligence; and a very high degree of negligence is required to be proved before the felony is established.” This sentiment was phrased somewhat similarly in the Ontario Court of Appeal by Weiler J.A. who stated that “the offence of criminal negligence causing death is at the high end of a continuum of moral blameworthiness.”

In suggesting that there are, to use Lord Atkin’s term, “degrees of negligence” or Weiler J.A.’s term “a continuum of moral blameworthiness,” the courts are establishing a process where first the police and prosecutors and then the judge or the jury must assess the nature of the allegedly negligent act and make a judgement as to where it falls on a continuum. This is at all times a precarious judgement, but it is particularly fraught with difficulty when considering the consequences of the negligent actions of health professionals which may involve the death or grievous injury of a patient. The outcome, the death or grievous injury of the patient, should not be conflated into the equation that determines how morally blameworthy or how negligent an action or omission is, yet too often this can occur. Douglas, for

24 *Horder, supra* note 19.
25 *Andrews, supra* note 22 at 583.
example, would argue that we increasingly live in a blame society where “every death and most illnesses will give scope for defining blameworthiness.”

Research into the psychology of error may assist in making these types of determinations about where a negligent act sits on a continuum of negligence or moral blameworthiness. Reason’s typology of human error suggests that there are four forms of errors: (1) mistakes: errors in planning, (2) slips or lapses: errors in execution, (3) technical errors: failure to carry out action successfully even if the plan of action and technique were appropriate, and (4) violations: deliberate deviation from safe practice. Human errors falling into the first three categories are more likely to be less morally blameworthy and causatively influenced by systemic factors, especially in complex environments such as healthcare. The last category contains a heightened element of moral blameworthiness, albeit in the context of negligence, which can be ascribed solely to an individual. Thus Merry and McCall Smith suggest that only violations, deliberate deviations from safe practice, should attract criminal prosecutions, as only violations involve moral blameworthiness.

The difficulty with this type of categorisation exercise is what constitutes a violation? In hindsight it often appears, to quote Dekker, “as if people chose to err, despite available evidence indicating they were about to make the wrong choice and despite their knowledge and experience that would have allowed them to do otherwise.” In other words, people may know that the course of action they are taking gives rise to a risk of harm. The question then must be in what circumstances are they relationally constrained into the course of action by environmental factors and when do they volitionally choose to take the course of action? McCall Smith uses the example of a medication error to point to the difficulties in this area. Is it grossly negligent to fill a syringe with a drug and inject it into the patient without checking the label of the drug? Yes, because checking a label is an elementary precaution that everyone, even laypersons, accept as required. But what if the label is misread when health professionals are under pressure? Ensuring

29 Reason, supra note 17.
31 Dekker, supra note 16 at 467.
32 McCall Smith, “Incompetent Doctor”, supra note 11.
that sufficient time is taken to carefully and correctly read the label is another elementary precaution and a failure to so read could seem to be a deliberate deviation from safe practice. However, interpreted another way, a failure to carefully and correctly read a label could be construed as a slip or a lapse – an error in execution. Environmental factors can influence conduct, such as when a patient is dying, there is an influx of patients waiting for care, or a health professional is attending to 30 patients. Contextual factors specific to the individual such as fatigue, lapses in concentration, etc. can also influence conduct. Indeed, such lapses are all too human. Is such a lapse gross negligence sufficient to attract criminal sanction or human error amounting to mere negligence? Who is morally blameworthy – health professionals, who have legal duties and ethical obligations to their patients, the systems in which they work, where multiple patients, complex systems and overwhelmed health professionals, conspire to create an environment ripe for error, or both? Is there moral blameworthiness in these circumstances sufficient to require the imposition of criminal sanctions against an individual?

Reason’s typology provides an empirical basis upon which to assess where on the continuum a negligent act or omission may fall – whether it is civil or civil and criminal negligence. What the use of Reason’s typology in this context indicates is that clear violations, where an individual or an institution in respect of corporate manslaughter, deliberately chooses not to comply with basic standards of safe practice, should attract criminal sanctions and the health professional/health service provider should be held accountable by society for their grossly negligent conduct. Equally, it indicates that the criminal law should be used far more judiciously in respect of the other categories of error where the blameworthiness of an individual for an action or omission is more opaque. In these circumstances, retrospective accountability against an individual can be obtained through other measures, such as professional discipline or competency review, tort litigation, or privilege review. Prospective accountability in this venue may be best served by not raising the spectre of criminal convictions against health professionals but by implementing systemic changes to the culture of the health professions and the environments and systems in which health professionals


34 Ibid.
serve. It is important to remember at a policy level that the prosecution of an individual can protect an unsafe system from scrutiny and therefore prevent that institution from learning and improving the systems for treatment and care\(^{35}\) – an outcome that is not in the public interest.

### 3. The Criminal Law and Negligence in Professional Practice in Canada

It is clear that the threshold for criminal prosecution needs to be relatively high and thus criminal charges can be expected to be considerably rarer than actions for negligence. Despite an increase in litigation over the last several years, numbers of claims in tort for negligence remain low relative to the numbers of health services provided on a daily basis, the numbers of physicians and other health professionals that are employed in health systems, and the numbers of negligent acts or omissions within the sector\(^{36}\). But saying that criminal charges for alleged negligence in professional practice should be rare and are rare, albeit increasing, in other jurisdictions does not help establish the rates of such charges in Canada, nor the rates of convictions. Nor does it assist with an assessment of whether the criminal law is being employed appropriately in this area in accordance with the principles outlined above. In this section of the article, I quantify the numbers of physicians charged with criminal negligence in the course of their professional practice in Canada, examine the outcomes of such charges, place the charging and conviction rates within the broader international context, categorise the nature of the negligent acts or omissions where charges have been laid and analyse the factors deemed relevant to the courts when making determinations of guilt or innocence.

### Research Design and Methods

To establish the numbers of cases where physicians in Canada were charged with manslaughter/criminal negligence causing death or grievous bodily harm, I conducted a search of relevant databases between the years 1900 and 2007 to ascertain the numbers of such cases and whether there were

35 Dekker, supra note 16 at 467.
any significant historical trends associated with incidence. This review of the number of physicians charged with criminal negligence/manslaughter as a result of alleged negligence in professional practice was designed, allowing for differences in context, to mimic Ferner and McDowell’s study of physicians charged with manslaughter in the course of their professional practice in the United Kingdom. This similarity in methods was in part to provide a basis for cross-jurisdictional comparison. I examine a 107 year time period to indicate that such charges are not a new phenomenon and to place the incidence of such charges in context. That context appears to be that very few charges have been laid across a large expanse of years, especially when one considers the likely numbers of patient interactions during that time period.

I searched The Globe and Mail: Canada’s Heritage from 1844 (1900-2003), Lexis Nexis Quicklaw (1900 – 2007), and Westlaw eCarswell (1900 – 2007) databases to identify relevant newspaper articles and law reports. I also searched the titles and abstracts of the Canadian Medical Association Journal (1966-2007) electronically. I used the text words physician or surgeon or anaesthetist and criminal negligence or manslaughter to undertake the search. The search parameters were limited to cases where negligence in professional practice resulted in criminal charges being laid against a physician. I excluded from consideration physicians facing criminal charges associated with criminal abortion, assisted suicide or euthanasia, or where there was any allegation that the patient’s death was intentional.

To ascertain how Canadian courts are applying the criminal negligence standard and assessing culpability, I assessed the alleged negligent acts or omissions seen in the Canadian cases in light of Reason’s typology of human

37 One key difference between the U.K. and Canada is that in Canada, s. 219 of the Criminal Code R.S.C. 1985, c. C-46 contains specific offences relating to criminal negligence causing death or grievous bodily harm whereas in the United Kingdom the common-law offence of manslaughter is used to charge physicians whose alleged negligence in their professional practice results in the death of their patient. The search terms were adjusted accordingly.

38 Ferner & McDowell, supra note 3.

39 This database covers the years 1844 – 2003. Subsequent editions of this newspaper are searchable in the Lexis Nexis Quicklaw database.

40 The Canadian Medical Association Journal is electronically searchable from 1966 onwards.
error. I assessed the acts or omissions from the identified cases, where possible, as: (1) mistakes: errors in planning; (2) slips or lapses: errors in execution, (3) technical errors: failure to carry out action successfully even if the plan of action and technique were appropriate and (4) violations: deliberate deviation from safe practice.

The *Globe and Mail* is the closest Canada has to a truly national newspaper, but historically its focus was on Ontario and, to some extent, Québec and thus its coverage of events in other provinces and territories is historically incomplete. Databases of other newspapers, contained within *Lexis Nexis Quicklaw*, date back to the 1980s at the earliest. The legal databases primarily cover reported cases, with unreported cases only becoming available on these databases from the early 1980s. I was unable to find three of the cases identified through the *Globe and Mail* search in the case-law databases which meant that there was little available information about the facts of those cases, the legal reasoning associated with the outcomes, and, in one case, the outcome itself. Likewise, several of the cases identified in the case-law search were not identifiable in the *Globe and Mail* search. It is possible that some relevant early cases may not have been identified because data was unavailable; however, the reliability of the data increases from the 1980s because of improvements in database coverage.

**Results**

Using the search terms set out above, I identified 15 physicians charged with manslaughter or criminal negligence causing death or causing grievous bodily injury as a result of alleged negligence in their professional practice between the years 1900 and 2007 (figure 1). Only one physician was charged with manslaughter. All of the others were charged with criminal negligence causing death or grievous bodily harm. Only one physician has been convicted

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41 Reason, *supra* note 17.
42 *Ibid*.
43 Also charged with criminal negligence, and more rarely manslaughter, related to alleged errors in professional practice were 17 other health professionals: two former physicians (one in the capacity of a midwife/birth attendant and the other as a naturopath); three persons who provided medical services but who were not registered, or indeed trained, as physicians; one electro-therapist; one chiropractor; four nurses; one pharmacist; two naturopaths; and three midwives/birth attendants. As this research focuses on physicians, these other health professionals were excluded from this analysis.
(after a guilty plea) and that conviction was for criminal negligence causing bodily harm (table 1). Five physicians faced charges in respect of an alleged failure to diagnose and therefore to appropriately treat a condition, four due to alleged mismanagement of the Canadian blood system, two in relation to the prescription or administration of medications, two faced charges in the context of the provision of methadone to patients, one in relation to the management of a birth and one in relation to anaesthesia. The specialities of the physicians charged are set out in table 2.

**Table 1: Outcomes of charges against physicians**

<table>
<thead>
<tr>
<th>Years</th>
<th>Total Charged</th>
<th>Total Convicted / Guilty plea</th>
</tr>
</thead>
<tbody>
<tr>
<td>1889-1980</td>
<td>6</td>
<td>3 (but all overturned on appeal)</td>
</tr>
<tr>
<td>1980-2007</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>15</strong></td>
<td><strong>1 out of 15 (6.67 percent)</strong></td>
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</table>

Applying Reason’s typology of human error I classified two cases as violations: both resulted in convictions, although one was overturned on appeal. I classified one case as technical error; this too resulted in a conviction
that was overturned on appeal. One case was classified as a slip or lapse with a not guilty finding. Nine cases were classified as mistakes and in one of these cases the physician was convicted, although again the conviction was overturned on appeal. I was unable to classify two cases because of insufficient information. Examples are set out below.\textsuperscript{44}

\textbf{Mistakes}

\textit{Case 8: 1992}

A teenager died after drinking what he thought was white rum but which was subsequently determined to be methyl hydrate (anti-freeze). The physician who assessed the teenager when he and two others presented to the local emergency department sent them home with instructions to drink plenty of fluids. The court held that the conduct of the physician who assessed and treated him “did fall below the standard of a reasonable doctor in the circumstances” and was an error of judgement which “though tragic

\begin{table}[h]
\begin{center}
\begin{tabular}{|l|c|}
\hline
\textbf{Practice area} & \textbf{Total charged} \\
\hline
Obstetrics & 1 \\
Paediatrics & 1 \\
Anaesthesia & 1 \\
Addictions & 2 \\
Surgery & - \\
Physician in hospital setting & 3 \\
House surgeon/resident & 2 \\
Health system management & 4 \\
Unknown & 1 \\
\hline
\textbf{Total} & 15 \\
\hline
\end{tabular}
\end{center}
\caption{Number of physicians charged with criminal offences by practice area}
\end{table}

\textsuperscript{44} Cases are listed chronologically. For example, case 1 is the earliest case.
in its consequences, was made in light of all the facts as he perceived them at the time.”  

Accordingly, the physician’s conduct did not show a “wanton and reckless disregard” for the patient’s “life and safety” sufficient to meet the standard required for criminal negligence. In this case, although the patient died, the seriousness of the outcome was not sufficient in and of itself to constitute a criminal act. The physician’s exercise of professional judgement, although flawed, was made in the context of a busy emergency department amidst uncertainties about what substance was actually drunk and therefore was not sufficient to attract a criminal conviction.


A 29 year old woman with a history of drug addiction had been on a methadone program under the supervision of the physician. After she ceased taking methadone she became depressed, agitated and suicidal and on several occasions was admitted for psychiatric treatment. She was prescribed a variety of medication whilst in hospital and was discharged for follow-up by the physician. The physician became aware that she had started to take a mixture of other medications and required her to attend the clinic each day to access her medication. The patient’s condition worsened and she threatened to commit suicide if she did not get assistance. The physician could not get her admitted into hospital immediately and, as an interim measure, prescribed two 20mg doses of methadone; the patient consumed one dose immediately and was thought to have taken the other a few hours later. The patient died some hours later. The physician was acquitted because it could not be established beyond reasonable doubt that the methadone caused her death as she had consumed a variety of medications and therefore the cause of death was uncertain. In addition, there was doubt as to whether the physician’s actions constituted a “marked and substantial departure from the norm” with evidence being led that indicated that that norm for the prescription of methadone at that time was uncertain. In this case, unlike some of the others considered here, there were few external or systemic factors that influenced the physician’s exercise of professional

46 *Ibid*.
47 2006 BCSC 1766, 215 C.C.C. (3d) 120.
48 *Ibid* at para. 64.
judgement. However, setting aside issues associated with causation, the expert evidence presented indicated uncertainty within the profession about (1) the appropriate level of methadone to prescribe in these circumstances, (2) the timing of such a prescription and (3) what, if any, other diagnostic tests should be undertaken before prescribing methadone. Given these areas of disagreement, it was not clear that the physician’s actions were negligent, let alone criminally negligent.


Four physicians faced multiple charges of criminal negligence for allegedly permitting or causing the distribution of a blood product that was infected with HIV to four persons to whom the blood products were administered in the course of medical treatment. These persons subsequently contracted HIV and all but one has died as a consequence of the infection. One of the physicians was responsible for the distribution of blood products in Canada and two of the physicians were responsible for the regulation of blood products in Canada in the early to mid 1980s. The remaining physician worked for the pharmaceutical company that manufactured the blood products. Benotto J. concluded that “… the conduct examined in detail for over one and a half years confirms reasonable, responsible and professional actions and responses during a difficult time. The allegations of criminal conduct on the part of these men and this corporation were not only unsupported by the evidence, they were disproved.” Benotto J. also noted that it was important to ensure that “subsequently acquired knowledge is not imported into the analysis” – knowledge of the tragic outcome cannot affect the assessment of the decision-making processes at the time.

**Slips and Lapses**

**Case 2: R. v. Giardine (1939)**

A patient was prescribed mapharsen by a house surgeon. The house surgeon instructed a nurse to get the drug and prepare a tray so he could treat the patient, adding that if no mapharsen was available the nurse could sub-

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49 Supra note 2.
50 The pharmaceutical company that manufactured the blood products also faced charges of criminal negligence.
51 Armour, supra note 2 at para. 305.
52 Ibid. at para. 4.
53 71 C.C.C. 295 (Ont. Co. Ct.).
stitute novarsan. The nurse misheard because of an interruption and placed an ampoule of diarsenol on the tray (this was apparently the only ampoule of diarsenol within the hospital and the physicians and nurses who testified were surprised that it was in the medicine cabinet). Mapharsen, novarsan, and diarsenol were in small ampoules that were similar in size and shape and the drugs were the same colour. However, the labelling on the ampoule of diarsenol was in red on a light background, whereas the other drugs were labelled in white letters on a dark background. The house surgeon, without checking the label, injected the diarsenol into the patient, who died shortly afterwards. There were normally three supervising nurses on duty on that floor who would have usually double-checked the medication trays but on the day in question none were on duty and so no check was made. The house surgeon was very busy and his wife was very ill. Having regard to these circumstances, and to evidence from other physicians that there must be “team work between the nurse and the doctor” the judge determined that there was no evidence of gross negligence, wanton misconduct or intent and, absent this, convicting the accused would be carrying criminal liability too far. 54 There appeared to be some systems in place to prevent these types of errors, such as cross-checking of the drugs, a written prescription requirement, a practice of not storing drugs that are not in common use in the medicine cabinet, and differences in the labelling of the ampoules. However, these safeguards were defeated by a variety of latent defects, such as short-staffing and a busy and rushed environment with a consequential impact on actors functioning within that environment, and thus the negligence occurred.

**Technical Errors**

**Case 3: R. v. Simard (1962)** 55

A premature baby died a few days after his birth from a cerebral haemorrhage. The baby’s head got stuck during the delivery requiring, in the physician’s opinion, either the use of forceps or a caesarean section. The physician chose to use forceps and it was alleged that he used forceps wrongly during the delivery and caused the cerebral haemorrhage. Evidence was presented that alleged that the physician applied sustained traction for ten minutes, although other evidence was also led that suggested that intermit-

54 Ibid. at 299.
55 43 C.R. 70 (B.R. (A.) Que.).
tent traction was applied during a period of several minutes. The balance of the expert evidence was that the use of forceps was appropriate in the circumstances, given the condition of the baby, and that the forceps were employed appropriately. The judge held that on the evidence that the surgeon had proceeded in a “normal and reasonable manner” and therefore did not appear to be negligent, let alone reaching the standard required for criminal negligence.

Violations

Case 1: R. v. Watson (1935)

A man died nine days after being admitted into a hospital. It was alleged that the physician had failed to diagnose and treat the patient and was drunk whilst examining the patient on at least two occasions. The physician’s conviction was overturned on appeal after the court determined that too much weight was placed on the physician’s apparent drunken condition. Although it appeared that the physician may have been drunk on at least two occasions when he examined the patient, he appeared sober during other consultations. There was no evidence presented to the court that suggested an “omission or failure to supply proper treatment.” The conduct, apparent drunkenness, was reprehensible and a deliberate deviation by the physician from safe practice and the established norms of professional conduct, but this deviation did not seem to lead to any negligence in the diagnosis and treatment of the patient and accordingly the patient’s death could not be attributed to the act or omission of the physician.


The teenage patient underwent routine surgery to mend his broken leg when the anaesthetic equipment became disconnected and he was left with an irreversible brain injury in a persistent vegetative state. The anaesthetic equipment had four safety systems, two of which the anaesthetist did not use, despite a nurse’s suggestion to the contrary. The anaesthetist left the room to make a personal phone call without providing further instructions for the patient’s care. During his fairly lengthy absence (in the circumstanc-
The anaesthetic equipment became disconnected; one alarm failed to function and the other was not immediately noticed. The anaesthetist could not immediately be found once it was noticed. The anaesthetist subsequently made a false statement saying that he was present in the theatre during these events. The anaesthetist pled guilty and was sentenced to six months imprisonment. The appeal court concluded that “all of this places his conduct much beyond the range of pure mischance, or, as the trial judge expressed it, “as being explained away by a combination of unfortunate circumstances.” In other words, whilst there could have been systemic factors that contributed to the outcome, the defendant’s decisions to deliberately deviate from safe practices directly led to the harm to the patient.

**Results in Context**

**Outcomes**

I identified 15 physicians in Canada who faced serious criminal charges as a result of alleged negligence in professional practice between 1900 and 2007 (107 years). The conviction rate is a low 6.67 percent (one guilty plea). Given the numbers of physicians registered to practice over this period (The Canadian Institute for Health Information states that the number of registered physicians in Canada in 2006 was 62,307) and the number of patient consultations that will have occurred within this time period, it is apparent that in Canada very few physicians face serious criminal charges as a result of negligence in their practice and even fewer are convicted.

Placing the Canadian figures in an international context makes this conclusion even more strongly. The best comparative data comes from the U.K. where Ferner and McDowell undertook a longitudinal study of charging patterns and where there is significant concern about substantial increases in the numbers of charges laid since the 1990s. Such a comparison can only be made with caution; amongst other things it is important to note that the Canadian figures include criminal negligence causing death and crime.

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60 Ibid.
61 Ibid. at para 11.
63 Ferner & McDowell, *supra* note 3.
nal negligence causing grievous bodily harm, whereas the United Kingdom figures only include charges where the allegedly negligent act resulted in death and which resulted in manslaughter charges. In the United Kingdom during the period 1900 – 2005 approximately 54 physicians were charged with manslaughter in relation to errors in practice with an approximately 30 percent conviction rate$^{64}$ (see figure 2). That more physicians were charged in the U.K. is not altogether surprising given the differences in terms of population and in the number of physicians registered given those populations. However, even taking population changes into account it is clear that physicians in the United Kingdom are more likely to face serious criminal charges for errors in practice and are more likely to be convicted of those charges than their Canadian counterparts. There too, many of the charges related to events that Ferner and McDowell categorised as mistakes, slips and lapses and technical error, as well as violations. The conviction rates for violations were higher than for the other categories at 63 percent.$^{65}$

The rate at which charges are laid does not appear to have increased in Canada (see figure 2). The minor spike identifiable in 2005 relates to charges being laid against four physicians in relation to the management of the Canadian blood system in the 1980s and can be regarded as unusual. Contrast this with the United Kingdom where the rates of charges laid against physicians has substantially increased since the early 1990s.$^{66}$

**Explaining differences in outcomes**

What factors explain why charging rates in Canada remain low or, expressed another way, why rates in the U.K. are so high? As there are no significant differences in nature of the charges faced by physicians, we must look to cultural factors to provide an explanation. There is a great deal of speculation as to why there has been such a significant increase in the rates of physicians facing manslaughter charges in the U.K. for allegedly negligent professional practice. These speculations point to a different climate within which health services are provided in the U.K. and different systems, structures, and priorities within its justice system. Some, such as Holbrook, suggest that the increased incidence of criminal charges against health providers is associated with changing societal perceptions that require an attribution of

$^{64}$ Ibid.

$^{65}$ Ibid.

$^{66}$ Ibid.
blame against events that would have formerly been accepted as accidents. Quick also points to changing societal perceptions about the professions and the level of trust vested in them by the public. In addition to a general sense that we increasingly live in a “post-trust society,” the U.K. population’s trust in their medical profession and the health system more generally has been shaken by a number of high profile events in which patients have died as the result of negligent or intentional acts or omissions. The ‘fallout’, as Quick puts it, from these events may result in public and media pressure for accountability and to assign blame. This pressure may be felt most acutely by agencies like the police and the prosecutions services that are seen by the

Figure 2: Physicians facing serious criminal charges as a result of alleged negligence in professional practice: Comparison of UK and Canadian charging rates 1900-2005

68 Quick, supra note 15.
69 See for example, Ragnar Löfstedt, Risk Management in Post-Trust Societies (Basingstoke: Palgrave MacMillan, 2005).
public as being in a position to ensure that ‘justice’ must seen to be done.\textsuperscript{71} The lack of trust has been accompanied by empirical evidence of the levels of adverse events in health care\textsuperscript{72} as well as an increase in the numbers of complaints made against providers of health services.\textsuperscript{73} The apparent trust deficit in the U.K. towards the ability of the health professionals to effectively self-regulate may, at least in part, explain the sharp increase in the numbers of charges laid against physicians alleging medical manslaughter. Also, in a recent empirical study, Quick demonstrated that charging patterns for medical manslaughter in the U.K. are geographically mal-distributed in favour of one geographical region.\textsuperscript{74} He postulates that this may be a sign of increased prosecutorial confidence in a region that has brought successful prosecutions, particularly given the generally low conviction rate for medical manslaughter vis-à-vis manslaughter more generally.\textsuperscript{75}

It is unlikely that Canadian society has been immune amongst western countries in experiencing the types of cultural change associated with a generalised loss of trust and an increased desire for accountability and blame. However, this generalised mistrust does not yet appear to be associated as strongly with health systems and health professionals as it does in other countries. To some degree federalism can be held to be a contributing factor to explain these differences, as Canada has not one but many health

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\textsuperscript{71} Quick, \textit{supra} note 15.
\textsuperscript{73} Quick, \textit{supra} note 15.
\textsuperscript{74} Ibid.
\textsuperscript{75} Ibid.
\end{flushleft}
systems, each with its own separate regulatory environment, regulatory actors and policing agents. Events are thus localised in effect. Although there have been several inquiries into allegations of unsafe practices in healthcare in Canada, these inquiries have not, at least to date, resulted in a public loss of faith in self-regulation by hospitals and professional bodies, nor a fundamental reappraisal of the regulatory environment. Such inquiries in the Canadian context have also been few in number compared to the level of public scrutiny afforded in England of an astonishingly frequent litany of negligent acts involving significant numbers of patients. Lastly, the nature of the Canadian inquiries have differed. The Krever Inquiry looked at the management systems for blood and the Winnipeg Inquiry’s scrutiny focused on hospital management and did not examine in any detail other actors in the health system. In not looking more broadly, these investigations may have confirmed or at least may suggest to the public that these events were isolated and that the self-regulatory mechanisms in place remain effective to safeguard the public interest.

Prosecutions of physicians for alleged negligence in their professional practice have been even less successful in Canada than in the United Kingdom. The outcome of the most recent case, where four doctors were acquitted after facing charges of criminal negligence and public nuisance relating to the management of the Canadian blood system, may further discourage prosecutions for criminal negligence.

What is apparent from an examination of the Canadian case-law is that in a number of cases, judges have been somewhat scathing about the degree of negligent practice shown by the accused, but have concluded that in the specific circumstances of the case the mere fact of negligence with a dreadful outcome does not amount to criminal negligence. The Canadian courts,

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77 The Krever Report, ibid.

78 Winnipeg, supra note 71.

79 See especially, Abate, supra note 45.
unlike, it is suggested, the courts in some other jurisdictions\textsuperscript{80}, also do not appear to be conflating the seriousness of the consequences with the culpability of the actions.\textsuperscript{81} To quote Benotto J.: “The events here [the “tainted blood” disaster] were tragic. However, to assign blame where none exists is to compound the tragedy.”\textsuperscript{82} The Canadian courts seem to reserve criminal negligence in the context of the provision of health services for only the gravest cases, in contrast with U.K. courts whose decisions to convict some physicians for negligent acts that were mistakes, slips or lapses with a significant systemic component have attracted critical comment.\textsuperscript{83}

Broader considerations of policy have also been considered by at least one Canadian court in respect of negligence in professional practice. Although this article focuses on physicians, a relatively recent case involving a nurse against whom a criminal charge was laid in respect of admitted negligence in professional practice nicely illustrates this point.\textsuperscript{84} In that case a nurse was accused of criminal negligence after administering an incorrect drug to a patient. The judge noted that the nurse had a reasonable belief that it was the right drug. The judge concluded that there was no moral blameworthiness on the part of the nurse nor was there a marked departure from accepted standards. As to broader policy considerations, the judge particularly noted that the nurse had immediately and voluntarily reported the error to the hospital and her colleagues which enabled the patient to be treated, albeit unsuccessfully. Also, the nurse’s prompt disclosure facilitated a review by the hospital of its policies and practices to minimise the likelihood that the same or similar mistake could occur in the future and thus improved the safety and quality of the services offered to the public. Accordingly, the judge determined that a conviction in this case could deter self-reporting of negligent acts or omissions by health professionals – an outcome that the judge thought was not in the public interest.\textsuperscript{85}

\textsuperscript{80} Runciman \textit{et al.}, \textit{supra} note 27.
\textsuperscript{81} \textit{Ibid}.
\textsuperscript{82} Armour, \textit{supra} note 2 at para. 307.
\textsuperscript{83} Merry \& McCall Smith, \textit{supra} note 31; Ferner \& McDowell, \textit{supra} note 3; McCall Smith, “Merely Human”, \textit{supra} note 3.
\textsuperscript{85} \textit{Ibid}.
4. Conclusion
The criminal law is an important regulatory tool to employ against health professionals who grossly deviate from safe practice but not when a negligent act, however tragic its outcome, is one to which all humans, especially those working in complex systems are prone. The limited numbers of cases and the very small conviction rate indicate that, at present anyway, those responsible for administering the criminal system in Canada see that the criminal law should have limited application in this area.