

LAW AND MEDICINE IN PAPUA NEW GUINEA: LICENSING AND LIABILITY OF PRACTITIONERS.

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I. *Licensing - The Medical Services Act.*

The law with respect to the registration and discipline of medical practitioners and other health workers in Papua New Guinea is contained in the *Medical Services Act* 1965¹ and the regulations promulgated in accordance with s.74 of the Act. The Act creates a Medical Board² and a Nursing Council,³ and charges these bodies with the responsibility for controlling the registration of persons in the medical professions, and for disciplining those persons for certain breaches.

A. Registration

The Medical Board has the authority to register doctors,⁴ dentists,⁵ and allied health service workers⁶ in Papua New Guinea, such registration being a pre-requisite for practice within the country.⁷ With regard to medical practitioners, the Board may grant either full⁸ or provisional registration,⁹ and may register a practitioner as a

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1. No. 1 of 1966, as amended to date. Section 3 of the Act repeals the *Medical Ordinance* 1952-63.
2. Section 15. The Secretary for Law is a member of the Board, under s.15(1)(b).
3. Section 46. A solicitor from the Justice Department sits on the Council, under s.46(1)(b).
4. Sections 18-21.
5. Sections 23-26.
6. Sections 28-42.
7. Section 72.
8. Section 19.
9. Section 20.

specialist in a particular field.10

Applicants may receive provisional registration under s.20 if they have: (a) received a medical degree from an approved University; or (b) successfully completed a medical course of not less than five years duration which has been approved by the Board.11 Provisional registrants with a University degree receive full registration after one year's training as a resident at a hospital, while those with a diploma from a five year course must spend at least two years in full-time employment, engaged in the practice of medicine, at an approved hospital.12 During the period of provisional registration a person is prohibited from charging or accepting any fee for his services.13

For persons qualified outside Papua New Guinea who are here in some capacity connected with specialist care or disease prevention, or are engaged in teaching or research, the Board may issue a "certificate of temporary registration".14 Such a certificate may be issued for up to two years in the first instance, and may be renewed from time to time, although the certificate may not be in force in excess of three years total for any individual. Holders of such certificates are deemed to be legally qualified practitioners, subject to any limitations or restrictions imposed by the Medical Board.

Nurses may apply to the Nursing Council for registration or enrolment as general nurses, psychiatric nurses, maternal and child health nurses, or in any other nursing category approved by the Council.15 Enrollees must be graduates of a training school for nurses approved by the Council.16 Full registration as general nurses

10. Section 22.

11. This latter provision was designed to accommodate institutions like the Central Medical School at Suva in Fiji, as well as the Papuan Medical College, which at the time the Act entered into law did not have University status. The College has since become the Faculty of Medicine of the University of Papua New Guinea.

12. Section 19.

13. Section 21.

14. Section 44.

15. Section 50. Detailed requirements for enrolment, registration, post-basic and post-graduate qualifications may be found in the *Medical Services (Categories and Qualifications of Nurses) By-Laws* 1975 (NO. 9 of 1975), made pursuant to s.66 of the principal Act, by the Director of Public Health on the recommendation of the Nursing Council.

16. Section 52. For enrolment as a psychiatric nurse, an additional one year specialist course at an approved hospital is required. Section 52(3).

may be obtained by enrollees who are employed full-time in an approved hospital for at least two years and perform their duties satisfactorily.¹⁷ Enrollees seeking registration as maternal and child health nurses or psychiatric nurses are further required to obtain a certificate in their specialty from an approved training school.¹⁸

Dentists may receive provisional registration from the Medical Board if they have: (a) received from a University degree in dental studies in Australia, or at a University or institution approved by the Board; or (b) graduated in dentistry from the Central Medical School in Fiji or from another course of at least four year's duration which has been approved by the Board.¹⁹ Full registration may be obtained after one year's satisfactory experience in the case of provisional registrants with University degrees, and two year's satisfactory experience in the case of provisional registrants holding diplomas from approved dental courses.²⁰

Pharmacists,²¹ clinical psychologists,²² physiotherapists,²³ occupational therapists,²⁴ medical technologists,²⁵ radiographers,²⁶ dental mechanics,²⁷ dental nurses,²⁸ health inspectors,²⁹ opticians,³⁰ medical assistants,³¹ and medical aids³² are all classed as members of

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17. Section 51.
 18. Section 51(3) and (4).
 19. Section 25.
 20. Section 24, as amended by the *Medical Services Act* 1967 (No. 79 of 1967), s.3.
 21. Section 31.
 22. Section 32.
 23. Section 33.
 24. Section 34.
 25. Section 35.
 26. Section 36.
 27. Section 37.
 28. Section 38.
 29. Section 39.
 30. Section 40.
 31. Section 41. See also s.80(3).
 32. Section 42, as amended by the *Medical Services (Medical Aids) Act* 1969 (No. 89 of 1969), s.3.

of associated health services,³³ and are subject to registration by the Board in accordance with the minimum qualifications laid down by Act for each class of health workers.

A question arose recently in Parliament whether traditional "witchdoctors" could be registered.³⁴ While no specific provision covers witchdoctors or other practitioners of traditional medicine, such persons might be registered as medical aids, under s.42 of the Act.³⁵ A medical aid must show that he has undertaken a formal training course at an approved institution, or "has had other training or experience appropriate, in the opinion of the Board, for a medical aid, and that a legally qualified practitioner authorised by the Board certifies him as competent to give first aid and to diagnose and treat under supervision the common diseases of the [country]."³⁶

B. Discipline

Sections 60-62 of the Act provide for disciplinary actions to be taken against registered persons in certain cases. There are six situations where the controlling authority - the Medical Board in the case of practitioners, dentists and allied health service workers; the Nursing Council in the case of nurses - may take action: (a) where the person has been convicted in Papua New Guinea of an indictable offence, or elsewhere of an offence which if committed in Papua New Guinea would be an indictable offence, or (b) where the person's qualifications

33. Section 27.

34. "Witchdoctors Can Register", *Post-Courier*, 9 June 1976, at p.3.

35. *Ibid*, the then Minister for Health, Sir Paul Lapun also speculated that witchdoctors could be registered as "medical attendants", but no such category of health workers is recognised under existing legislation.

36. Section 42(2), as amended. See fn. 32, *supra*. No witchdoctors have applied to the Board for registration as medical aids to date, and one Board member has indicated privately that such applications would not likely be viewed as being in the public interest and would not be favourably received. The National Health Plan encourages continued reliance on the "useful content" of traditional medicine, particular in the treatment of people who live far from aid posts, without commenting on the role that traditional practitioners, or witchdoctors, are to play. See Department of Public Health, *National Health Plan 1974-1978, Summary*, points No. 13 and No. 18. The same problem is currently being faced in Africa as well. See *The IDRC Reports*, Vol. 6, No. 2, pp. 6-7 (1977).

for registration have been withdrawn or cancelled by the institution which initially awarded the qualifications; or (c) where the person is found to be of unsound mind; or (d) where the person obtained his registration through fraud or mistake or (e) where the person is found to be addicted to alcohol or another deleterious drug; or (f) where the person is found to be guilty of such professional misconduct as renders him unfit to be allowed to continue to practice.' 37

Where the controlling authority determines that one of the above situations exists, it may: (a) strike the person's name from the register; (b) suspend the person's registration for a specified period of time; (c) merely reprimand the person; and/or (d) impose a fine not exceeding K100.38 A person involved in a disciplinary action must be notified in writing of the complaint against him and the date on which the hearing will be held.39 A full inquiry must be made into the complaint and the person must be given an opportunity to present a defence, either in person or by legal counsel.40 Such hearings are open to the public only when the Board so allows or the complainant or registrant so requests.41 A person who is either refused registration or disciplined under the Act may appeal to a Judge of the National Court, whose decision is final.42

II. *Civil Liability.*

In addition to the "professional" regulation of medical profession under the *Medical Services Act*, a practitioner also faces situations in which sanctions may be imposed upon him under the civil law, or the criminal law, or both. The most common areas of civil liability are negligence, or medical malpractice, and trespass. While the following deals mainly with medical practitioners, the principles involved apply with equal force to other health care workers and professionals. As this area of the law is governed mainly by case law rather than by statute, and as malpractice cases have thus far been rare in Papua New Guinea, the following consists largely of the common law points and authorities with selected reference to Papua New Guinea.

37. Section 60(1)(a)-(e). The definition of "professional misconduct" accepted by the Medical Society of Papua New Guinea, as embodied in the preamble to the Society's *Code of Ethics*, is: "If a medical man in the pursuit of his profession has done something which will be reasonably regarded as disgraceful or dishonourable by his professional brethren of good repute and competency, then it shall be regarded as misconduct in a professional respect".

38. Section 60(1)(f)-(i).

39. Section 60(5)(a).

40. Section 60(5)(b).

41. Section 60(6).

42. Section 62(1) and (3).

A. Negligence

A person is guilty of civil negligence:

[W]hen he does not desire the consequences and does not act in order to produce them but is nevertheless indifferent or careless as to whether they happen or not, and therefore does not refrain from the act notwithstanding the risk that they may happen.⁴³

Not every unintentional act which causes injury to another person is the result of negligence. In order for a person to be held liable at law, it must be shown that: (a) the person who caused the injury owed the person injured a "duty of care" not to injure him; (b) there was a breach of this duty; (c) there was ascertainable damage, and (d) the breach of the duty was the cause of the person's damage.

The first element of negligence is that there must be a 'duty of care.' This duty of care is not owed in the abstract nor is it owed to the world at large.⁴⁴ It arises out of particular relationships between people. The first general statement of the relationship necessary to establish a duty of care was the "neighbour" principle set out in *Donoghue v. Stevenson*.⁴⁵

The rule that you are to love your neighbour becomes in law you must not injure your neighbour; and the lawyer's question who is my neighbour? receives a restricted reply. You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour. Who, then, in law is my neighbour? The answer seems to be .. persons who are so closely and directly affected by my acts that I ought reasonably to have them in contemplation as being so affected when I am directing my mind to the acts or omissions which are called in question.⁴⁶

Among the relationships to which the "neighbour" principle has been held to apply is the relationship between medical practitioners and their patients. The basis of the relationship creating the duty of care was discussed in *R. v. Bateman*.⁴⁷

43. *Salmond on the Law of Torts* (15th ed.) p.249.

44. *Palsgraf v. Long Island Railroad* 248 NY 839 (1928).

45. [1932] AC 562.

46. *Ibid*, at p. 580.

47. [1925] All ER 45.

If a person holds himself out as possessing special skill and knowledge and he is consulted, as possessing such skill and knowledge, by or on behalf of a patient, he owes a duty to the patient to use due caution in undertaking the treatment. If he accepts the responsibility and undertakes the treatment and the patient submits to his direction and treatment accordingly, he owes a duty to the patient to use diligence, care, knowledge, skill and caution in administering the treatment. No contractual relationship is necessary, nor is it necessary that the service be rendered for reward.⁴⁸

Although the standard of care required to meet this duty is a high one, it is not absolute.

A medical man who practices for profit .. the medical profession .. professes skill. He does not come and say "I am an unskilled person" ... he is engaged and professes skill. Of course you will understand it is not for every humble man of the profession to have all the great skill of the great men of Harley Street, but, on the other hand, they are not allowed to practice medicine in this country unless they have acquired a certain amount of skill. They are bound to show a reasonable amount of skill according to the circumstances of the case... but not necessarily so skilled as more skillful men in the profession.⁴⁹

In *Roe v. Minister of Health*,⁵⁰ Denning L.J. recognised the limitations of placing too high a standard on the medical profession.

Medical science has conferred great benefits on mankind but these benefits are attended by considerable risks. Every surgical operation is attended by risks. We cannot take the benefits without taking the risks. Every advance in technique is also attended by risks. Doctors, like the rest of us, have to learn by experience; and experience often teaches in a hard way ... We should be doing

48. *Ibid.* at p. 48. If a practitioner holds himself out as having greater skill than the ordinary doctor, as in the case of a specialist, the standard is modified accordingly. See Prosser, *Law of Torts* (48 ed. 1971), p.163.

49. *Ibid.*, at p. 49.

50. [1954] 2 all ER 131.

a disservice to the community at large if we were to impose liability on hospitals and doctors for everything that happens to go wrong. Doctors would be led to think more of their own safety than of the good of their patients. Initiative would be stifled and confidence shaken. A proper sense of proportion requires us to have regard to the conditions in which hospitals and doctors have to work. We must insist on due care for the patient at every point, but we must not condemn as negligence that which is only misadventure.⁵¹

A number of cases may be used to illustrate the duty of care and the standard required to meet it.⁵²

(1) Acting in Accordance with General and Approved Practice.

In *Marshall v. Lindsey* C.C.⁵³ a woman entered a maternity hospital for her confinement. Some days before, a case of puerperal fever had occurred at the hospital. Disinfecting precautions were taken but the doctors decided that it was not necessary to close the hospital to new patients. The woman did not know of the case of puerperal fever when she entered the hospital. She contracted the disease and suffered a long illness.

The Court of Appeal found that the doctors were not negligent in failing to close the hospital since the precautions taken were in accordance with the general practice used in maternity hospitals:

The whole technique of disinfection and sterilisation adopted and followed in the Home was one approved by Dr. Scott and Dr. Campbell, whose competence is not attacked. The issue of negligence ... will depend on whether it was negligent of the defendants to follow and rely on the [approved] technique. In my opinion, there was no evidence upon which the jury could so hold ... The practice of the home in not refusing fresh patients after a single case of puerperal sepsis has occurred, taking, however, the recognised sterilisation precautions, is in accordance with the universal practice of maternity homes and hospitals throughout England ... I am of the opinion that the defendant ... acted in accordance with the recognised practice and is therefore free from liability on the grounds of negligence.⁵⁴

51. *Ibid*, at p. 137.

52. For an excellent article on this topic, see McCoid, "The Care Required of Medical Practitioners", 12 *Vanderbilt L Rev.* 549 (1959).

53. [1935] 1 KB 516.

54. *Ibid*, at pp. 539-540.

The Court did find, however, that the matron was negligent in failing to warn the woman of the case of puerperal fever before she entered the hospital.

The courts have held that it is sufficient that the "general and approved practice" was the practice at the time the negligence is alleged to have occurred and not a practice adopted at a later time. In *Roe v. Minister of Health*⁵⁵ a patient was injected with nupercaine, a spinal anaesthetic, by a specialist anaesthetist in preparation for an operation. The nupercaine was contained in glass ampoules which were kept in a jar of phenol to sterilise them before use. Unknown to anyone at that time, there were cracks in the ampoules which were not visible under ordinary examination. As a result, some of the phenol percolated through the cracks in the ampoules and contaminated the nupercaine. The patient became permanently paralysed below the waist.

During the trial a number of specialists gave evidence as to the cause of the injury. The Court found that the anaesthetist, in attempting to avoid a known risk that the ampoules might become infected before use, had, unknown to him, subjected the patient to another risk by placing the ampoules in the jar of phenol. However at the time he took the precaution, the anaesthetist was acting in accordance with accepted practice and thus was not liable for negligence.

(2) Warning the Patient of the Risks of Treatment.

An area of increasing litigation in the medical malpractice field is the suit which alleges negligence not in the performance of the treatment or surgery, but rather in failing to advise the patient of the hazards involved.

In *Smith v. Auckland Hospital Board*,⁵⁶ the patient was suspected of suffering from an aortic aneurism. In the course of the medical investigation he was subjected to a procedure known as aortography, in which a catheter was inserted into the femoral artery and guided upwards through the arterial passage towards the aorta, into which an opaque dye is injected, enabling the aorta to be outlined for the purpose of an x-ray. During the procedure the catheter dislodged a plaque of atheromatous material from the interior wall of the artery. Clotting resulted degenerating into gangrene, and eventually requiring amputation of the patient's right leg.

From the evidence it was clear that the doctors were not negligent in the performance of the operation, and that the complication was a recognised, though small, risk of the procedure. Prior to the operation, however, the patient had asked members of the surgical unit about the risks attendant in such a procedure, and was assured that the procedure was a very safe and simple one. The patient argued that since a risk of mishap was a reasonably foreseeable consequence of the procedure, albeit a small one, he should have been warned prior to the treatment, and that failure to warn amounted to actionable negligence.

55. *Supra*.

56. [1965] NZLR 191; discussed (1966) 39 ALJ 372.

In formulating its judgement, the Court of Appeal relied on the leading English case of *Hedley Byrne & Co. Ltd. v. Heller and Partners, Ltd.*,⁵⁷ which held that a banker is liable for negligent (though honest) misstatements which are relied on by a client to his detriment.

In a business or professional transaction where the gravity of an inquiry and the importance which will be attached to the answer is apparent then when one person seeking information from another person possessed of a special skill trusts that other to exercise due care and the other knows or ought to know that reliance is being placed on his skill and judgement the law will require of him that if he does answer the question he must take care in doing so, and if he fails to take care and has not excluded liability on his part, as was done in the *Hedley Byrne* case, he will be negligent.⁵⁸

The particular relationship of doctor and patient which is proved in the case before us is sufficient to impose upon the doctor a duty to use due care in answering a question put to him by a patient where the patient, to the knowledge of the doctor, intends to place reliance on the answer in making a decision as to a treatment or procedure to which he is asked to consent.⁵⁹

While finding the defendants liable in this case, the Court stressed that:

On no account must it be thought that we are laying down any general rule as to what a doctor should tell his patient before performing an operation or carrying out an exploratory procedure. Still less are we saying what information should be volunteered by the doctor if he is merely explaining the nature and purpose of what is proposed and no question is asked of him as to the risks involved. We are considering a case in which there was an express inquiry as to the risks involved.⁶⁰

57. [1963] 2 All ER 575, [1964] AC 465. This case changed the law regarding negligent misstatements as laid down in *LeLievre v. Gould* [1893] 1 QB 491 and *Candler v. Crane Christmas & Co.* [1951] 2 KB 164, [1951] 1 All ER 426.

58. [1965] NZLR at pp. 197-198, *per* Barrowclough CJ.

59. *Ibid*, at p. 205, *per* Turner J.

60. *Ibid*, at p. 197, *per* Barrowclough CJ.

Absent such an express inquiry, the standard of care for judging whether a doctor has discharged his duty to inform a patient as to the nature and consequences of an operation is "measured by what other competent and experienced medical men would conceive as their duty in like circumstances."⁶¹ The Courts have often stressed that doctors must be allowed discretion in deciding exactly what a patient should be told, having in mind the dangers of distressing him or frightening him away from necessary treatment, and the importance of encouraging or reassuring him.⁶²

The standard of care in most American jurisdictions is the same as that laid down by Turner J. in *Smith v. Auckland Hospital*.⁶³ The modern trend, however, seems to be in favour of requiring a greater degree of disclosure. In *Canterbury v. Spence*,⁶⁴ the new standard laid down by the Court of Appeals for the District of Columbia requires that a doctor disclose to a patient every item of information with respect to the need for the proposed procedure, the risks involved, alternative methods available, etc., that a reasonably prudent physician would deem "material knowledge" in order for the patient to be able to make an enlightened consent. Thus the doctor would likely be required to

61. *Ibid.*, at p. 205, *per* Turner J. See also *Hunter v. Hanley* [1955] SC 200, 227, [1955] SLT 213, 240, *per* Gresson J.

62. (1966) 39 ALJ 372, 373; see also Prosser, *supra*, at pp. 165-166.

63. See *Natanson v. Kline* 350 P2d 1093, 1106 (Kans. 1960); *DiFilippo v. Preston* 173 A2d 333 (Del. 1961); *Watson v. Clutts* 136 SE2d 617 (N.C. 1964); Curran and Shapiro, *Law Medicine and Forensic Science* (2d ed. 1970) p. 574, notes 2-3; for a criticism of this standard, see Note, 75 Harvard LR 1445, 1447 (1962):

The duty to warn should not be based on the doctor's practice but on the patient's needs; that is, the inquiry should be whether a reasonable man in the doctor's position and with his knowledge of the patient would have been justified in concluding with substantial certainty that the patient, if informed of this risk, would not have withdrawn his consent.

64. 464 F2d 772 (D.C. Circuit Ct. App, 1972). See also *Salgo v. Leland Stanford Jr. University Board of Trustees* 154 Cal. App.2d 560, 317 P 2d 170: "A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent." Cf. Note, 40 Minn. L.R. 876 (1956).

disclose that there exists a small chance of a serious complication, or a large change of a minor complication, and would most certainly be required to advise the patient of a large risk of a serious complication.⁶⁵

This new standard, as well as the old, recognises the 'therapeutic exception' - that is where

disclosure may be undesirable or even dangerous for success of the treatment or the patient's own welfare,⁶⁶

particularly in the case of an apprehensive or neurotic patient. Even in these cases, however, it is better practice to secure an informed consent from a close kin of the patient, and to seek concurrence from other practitioners.⁶⁷ The Code of Ethics of the Medical Society of Papua New Guinea states that:

A patient has the right to know the facts and opinion about his case. In serious illness, especially where likelihood of recovery is slight or absent, the doctor should use great discretion in what he tells the patient and how he tells him, bearing in mind that he must act in the patient's best interests. It should be perfectly ethical to inform a near and responsible relative of the true state of affairs in such a case and to discuss how far he, the doctor, should go in giving his opinion when the patient demands it.⁶⁸

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65. A.R. Moritz and R.C. Morris, *Handbook of Legal Medicine* (4th ed. 1975), at pp. 139-141. An alternative standard, suggested in Note, 75 Harv L Rev 1445, 1448 (1962), tries to find a middle ground:

[S]ince the patient of average sophistication is aware of certain dangers inherent in any surgical treatment, he may be presumed to have considered these in giving his consent, even though he has not been specifically reminded of them. The duty narrows then, in the average case, to disclosure of dangers peculiar to the treatment proposed and of which it is likely that the patient is unaware.

66. Moritz and Morris, *supra*, at p.141.

67. Prosser, *supra*, at p.165. See also Lund, "The Doctor, the Patient and the Truth," 19 Tenn L Rev 344 (1946), and Smith, "Therapeutic Privilege to Withhold Specific Diagnosis from Patient Sick with Serious or Fatal Illness," 19 Tenn L Rev 349 (1946).

68. Section 2.7.

In the case of operations, treatments or experiments by medical researchers, a greater degree of disclosure to the volunteer is required of the researcher. In *Halushka v. University of Saskatchewan*,⁶⁹ the plaintiff was a university student who volunteered to test a new anaesthetic, at a teaching hospital, in return for a fee. The plaintiff was told by one of the doctors conducting the test that there was no danger. In fact, application of the anaesthetic left the plaintiff unconscious for four days, hospitalised for ten, and left him, according to his testimony, with impaired mental ability and an inability to concentrate, which precluded further University studies. The Court ruled that:

There can be no exceptions to the ordinary requirements of disclosure in the case of research as there may well be in ordinary medical practice. The researcher doesn't have to balance the probable effect of lack of treatment against the risk involved in the treatment itself. The example of risks being properly hidden from a patient when it is important that he should not worry can have no application in the field of research. The subject of medical experimentation is entitled to a full and frank disclosure of all the facts, probabilities and opinions which a reasonable man might be expected to consider before giving his consent.⁷⁰

The Code of Ethics of the Medical Society of PNG also counsels that doctors engaging in non-therapeutic clinical research explain fully to the subject "the nature, the purpose and the risk" involved,⁷¹ and that the subject's consent "should as a rule be obtained in writing."⁷²

There is strong authority that in order for a plaintiff to recover damages for negligence owing to a failure to warn of risks, the plaintiff must show not only that the failure was negligent, but also that if he had been properly warned, he would *not* have consented to the procedure.⁷³

69. (1966) 53 DLR2d 436; discussed (1966) 40 ALJ 206.

70. *Ibid.*

71. Section 9.4(b).

72. Section 9.4(c)(iii).

73. *Bolam v. Friern Hospital Management Committee* [1957] 2 All ER 118, 122 and 124; *McNair J* in his instructions to the jury. Here the plaintiff was not warned of a one in ten thousand risk of injury, which eventuated. The American view is the same - see *Natanson v. Kline* 354 P2d 670, 673 (1960).

(3) Conflicting Schools of Thought as to Proper Treatment.

Where there are different schools of medical thought, the conflict is not one for the courts to resolve, and a doctor is entitled to be judged according to the principles and practices of the school to which he belongs, provided that he fulfills the minimum requirements of skill and knowledge, and exhibits reasonable care, as to both diagnosis and treatment.⁷⁴

In *Hunter v. Hanley*,⁷⁵ Clyde LP summed up this principle well:

[A] deviation from ordinary professional practice ... is not necessarily evidence of negligence. Indeed it would be disastrous if this were so, for all inducements to progress in medical science would then be destroyed ... A doctor isn't negligent, if he's acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view. At the same time, that doesn't mean that a medical man can obstinately and pigheadedly carry on with some old technique if it has been proved to be contrary to what is really substantially the whole of informed medical opinion. Otherwise you might get men saying: "I don't believe in anaesthetics. I don't believe in antiseptics. I am going to continue to do my surgery in the way it was done in the 18th Century." That would clearly be wrong.

To establish liability by a doctor where deviation from normal practice is alleged, three facts require to be established. First of all it must be proved that there is a usual and normal practice secondly, it must be proved that the doctor has not adopted that practice; and thirdly (and this of crucial importance) it must be established that the course the doctor adopted is one which no professional man of ordinary skill would have taken if he had been acting with ordinary care.⁷⁶

74. Prosser, *supra*, at p. 163.

75. [1955] SC 200.

76. *Ibid*, at p. 206.

In *Bolam v. Friern Hospital Management Committee*,⁷⁷ the above instruction by Clyde LP was cited with approval by McNair J as the common law rule.⁷⁸ In *Bolam*, the plaintiff was suffering from mental illness, and was advised by a doctor at the defendant hospital to submit to electro-convulsive therapy. No relaxant drugs or manual controls were used during the treatment, and the plaintiff suffered severe dislocation of both hips and a multiple fracture of the pelvis.

The evidence revealed that there were two schools of thought on the use of relaxant drugs, which exclude the risk of fracture: one school favoured use of relaxant drugs as a general practice, the other viewed such drugs as dangerous in themselves, and prescribed their use only in special circumstances, which were not present in this case. There were, likewise, two schools of thought on whether manual controls should be used in the absence of relaxant drugs, and whether the plaintiff should have been warned of the risks, however unlikely, involved in electro-convulsive therapy.

After hearing the evidence, and being directed in accordance with the instruction of Clyde LP in *Hunter v. Hanley*, the jury found for the defendant hospital.

(4) Careless Treatment.

In *Mahon v. Osborne*,⁷⁹ a patient underwent an operation for a duodenal ulcer. During the operation swabs were used to pack off the adjacent organs in the patient's abdomen from the area of the operation. At the end of the operation the doctor removed all of the swabs of which he was aware from the patient's body and inquired of the nursing sister whether all of the swabs used during the operation had been accounted for. He was told incorrectly, that all of them had been accounted for. Three months later the patient became seriously ill. An operation was performed and it was discovered that a swab had been left in his abdomen from the first operation. The patient died the next day, and there was no question that the cause of death was the left-over swab. The patient's mother brought an action against the doctor alleging negligence in leaving the swab in her son's body.

The Court of Appeal reiterated the well-established standard of care owed by a doctor to his patient - that is, reasonable skill and due care - and also re-asserted that the law does not import negligence to every accidental slip or mistake:

[In] applying the duty of care to the case of a surgeon, it is peculiarly necessary to have regard to the different kinds of circumstances that may present themselves for urgent attention ...

77. [1957] 2 All ER 118.

78. *Ibid*, at pp. 121-122.

79. [1939] 1 All ER 535.

a few, applicable to a major abdominal operation [are] (1) the multifarious difficulties presented by the particular circumstances of the operation, (2) the condition of the patient, and the whole set of problems arising out of the risks to which he is being exposed, (3) the difficulty of the surgeon's choice between risks, (4) the paramount need of his discretion being unfettered if he thinks it right to take one risk to avoid a greater, (5) at the penultimate stage (swab removal) he may, particularly where the patient has been taking the anaesthetic badly and is suffering from shock, be so anxious on surgical grounds to bring the operation to an end as rapidly as possible that, in the exercise of his discretion, perhaps unconsciously exercised, as soon as he has completed the removal of all swabs of which he is at that moment aware he asks the sister for the count and forthwith starts to close the wound.⁸⁰

The Court of Appeal noted that the doctrine of *res ipsa loquitur* had been raised during the trial by the plaintiff, and had created a strong presumption against the defendant surgeon. The Court ruled that the doctrine of *res ipsa loquitur* was inapplicable in the case of a complicated surgical procedure, since the ordinary reasonable man could not make a determination as to whether adequate precautions had been taken, and due care exercised, without the benefit of expert evidence.⁸¹ The Court also found that the trial judge had misled the jury in reading to it abstracts of cases which seemed to place the surgeon under a positive obligation to make sure he had removed all the swabs. A proper instruction would have directed the jury to take into account all the circumstances surrounding the operation, as described above.⁸² Accordingly, the jury verdict in favour of the plaintiff was vacated and the case remanded for retrial.

(5) Failure to Treat.

In *Barnett v. Chelsea & Kensington Hospital Management Committee*,⁸³ a number of night watchmen fell ill after drinking tea, and proceeded to defendant hospital for treatment. The doctor in charge of the casualty ward was ill himself on the night in question, and he instructed the night watchmen to return to their homes and call in their own doctors. One of

80. *Ibid*, at p. 548, *per* Scott LJ.

81. *Ibid*, at pp. 542-543. For the opposite view, see *Ybarra v. Spangard* 154 P2d 687 (Cal. 1944); for criticism of *Ybarra*, see Seavey, "Res Ipsa Loquitur : Tabula in Naufragio," 63 Harv. L Rev 643 (1950); and Adamson, "Medical Malpractice : Misuse of Res Ipsa Loquitur," 46 Minn. L Rev 1043 (1962).

82. *Ibid*, at pp. 549-552. In most American cases with similar facts however, doctors have been held negligent even though it is customary for a nurse to keep track of the swabs. See *Leonard v. Watsonville Community Hospital* 305 P2d 36 (Cal. 1957). See also Prosser, *supra*, at p. 165 for additional citations.

83. [1968] 1 All ER 1068; [1969] 1 QB 428.

the men died shortly thereafter, from what was diagnosed as arsenic poisoning. The deceased's representative brought an action for damages against the hospital, alleging that the hospital was, through its employees, negligent in not diagnosing nor treating the deceased's condition.

The Court held that, under the doctrine of *Donoghue v. Stevenson*,⁸⁴ there was a "close and direct" relationship between the deceased and the defendant to warrant the exercise of due care. The fact that the defendant provided and ran a casualty department open to the general public imposed a duty of care to treat a person who presented himself complaining of illness or injury.⁸⁵ In this case, however, the plaintiff did not succeed in carrying the onus of proving that the deceased's death was *caused* by the defendant's negligence, the defendant having presented evidence that the deceased's condition was one that was extremely difficult to diagnose, and that even if he had been duly admitted there was no reasonable chance that the arsenic poisoning would have diagnosed and treated in time to save his life.

Thus, the key questions in establishing negligence on basis of a failure to treat are: (1) whether there exists a relationship between the defendant medical practitioner and the plaintiff which imposes a duty of care on the defendant; (2) whether the defendant failed to discharge this duty; and (3) whether such failure was the cause of the damages.⁸⁶

The Code of Ethics of the Medical Society of PNG places an affirmative duty on doctors to "give the necessary treatment in *emergency* [situations],"⁸⁷ (emphasis supplied) broadening those instances in which a legal relationship exists between doctor and patient which imposes a duty of care on the doctor.

84. [1932] AC 562, discussed above.

85. [1968] 1 All ER 1068, at p. 1072. Where failure to act on the part of a doctor was considered "outrageous," a number of courts in the United States in recent years have found the doctor liable for the tort of outrage. (Defined *Second Restatement of Torts*, s.46.) See *Gramsky v. Samson* 530 P2d 291 (Wash. 1975); Hirsch, "The Medical Malpractice Tort of Outrage," *Case and Comment*, Vol 81, No. 4 (1976).

86. *Ibid.* at p. 1074.

87. Section 2.8. An earlier draft of the Code qualified this duty: "A doctor must give the necessary treatment in emergency, *unless he is assured that it can and will be given by others. A doctor is not bound to respond to every request to attend cases of sickness apart from any contract he may have entered into (including his terms of service).* (Italics supplied.) The italicised portion of the section was omitted from the final version of the Code.

B. Trespass.

"Trespass to the person" is a broad term used to cover a number of acts, including assault and battery. Under the common law, *battery* is the intentional, unlawful touching of another person without that person's consent, and *assault* is the attempt or threat to apply such force without consent. In popular usage, and in the Papua New Guinea Criminal Code,⁸⁸ the term *assault* is used to describe either or both of these acts. Although assault may be both a criminal⁸⁹ and a civil wrong, for the medical practitioner, criminal responsibility is rare for acts arising out of a professional relationship with a patient;⁹⁰ the most common action would be a civil suit for damages, alleging the intentional tort of trespass to the person, arising out of an examination or treatment or surgical procedure without the valid consent of the patient.^{90A}

88. No. 78 of 1974.

89. Section 248 reads. "A person who strikes, touches, or moves, or otherwise applies force of any kind to, the person of another, either directly or indirectly, without his consent or with his consent if the consent is obtained by fraud, or who by any bodily act or gesture attempts or threatens to apply force of any kind to the person of another without his consent, under such circumstances that the person making the attempt or threat has actually or apparently a present ability to effect his purpose, is said to assault that other person, and the act is called an assault." Section 249 makes assault an offence "unless it is authorised or justified or excused by law." Section 285 offers one such justification in the case of medical practitioners: "A person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon any person for his benefit ... if the performance of the operation is reasonable, having regard to the patient's state at the time and to all the circumstances of the case." Unlawful assaults are punished by s.344.

90. See *Akerele v. The King* [1943] AC 255; discussed *infra*.

90A. Whereas failure to disclose mere risks of a medical procedure may be actionable as negligent malpractice, failure to disclose the known consequences of an operation is battery. See Prosser, *supra*, at pp. 105-106. A classic case of failure to disclose known consequences is *Bang v. Charles T. Miller Hospital*, 88 NW2d 186 (Minn. 1958), where the patient was not told that the inevitable consequences of the operation was sterility, and that an alternative method, without this consequence, was available.

In *Latter v. Braddell*,⁹¹ a young girl who worked as a domestic servant was taken by her employers to a doctor for an examination to determine whether or not she was pregnant. "Although the plaintiff submitted to the examination she strongly expressed her dislike to take her clothes off and cried most of the time." The girl brought an action against the doctor for damages for assault. The Court of Appeal held that the doctor was not liable.

If the doctor had done more than was necessary for the purpose of the examination, although the plaintiff submitted to the examination, she would not have submitted to what was done in excess of what was necessary. But there is no controversy here as to the facts. It is admitted by the plaintiff that no threats or violence were used by the doctor, nor did he act in such a way as that she could suppose that force would be used against her. She must have reasonable cause for supposing it; if she supposed it without reason, that does not help her case.⁹²

Although this case is still cited as authority,⁹³ it is doubtful whether, if such a case came before the courts today, the same decision would be reached. This case was decided at a time when an employer was considered to stand "in loco parentis" with regard to young employees. Thus just as a young child could not complain of his parent requiring him to undergo a medical examination, such an employee could not complain. However it is doubtful whether the courts would still be willing to look upon an employee of child-bearing age as a "child" of her employer.

A more difficult situation arises where the doctor is unable to secure the consent of his patient before the treatment or surgical procedure. In *Murray v. McMurchy*,⁹⁴ a woman underwent a Caesarian section operation for the delivery of her child. During the course of the operation the surgeon discovered the presence of a number of fibrous tumors in the uterus wall. After consultation with another surgeon who was assisting him, the defendant surgeon decided to tie off the Fallopian tubes of the patient, to prevent her from undergoing the hazards of another pregnancy. The woman later brought an action for damages against the surgeon for battery.

Although the husband had signed a consent form during the delivery for a Caesarian operation, the question for the court was whether the additional treatment was also authorised. Was the procedure necessary at that time or should the doctor have consulted the patient?:

91. (1881) 44 LT 369.

92. *Ibid*, at p. 370.

93. See, eg., 46 *English and Empire Digest* 418, 420, 422.

94. [1949] 2 DLR 442.

If it were necessary in the sense that it would be, in the circumstances, unreasonable to postpone the operation until a later date, I would say ... the surgeon would have that authority. There are times under circumstances of emergency when doctors must exercise their professional skill and ability without the consent which is required in the ordinary case.⁹⁵

The Court went on to quote from an earlier case, *Parmley v. Parmley*;⁹⁶

The conclusion appears unavoidable that both of the parties, particularly in the operating room, failed to recognise the right of the patient when consulting a professional man in the practice of his profession to have an examination, a diagnosis, advice and consultations, and that thereafter it is for the patient to determine what, if any operation or treatment shall be proceeded with.⁹⁷

The surgeon produced evidence at trial showing that 97 per cent of all patients in such a situation would have welcomed the additional procedure, and, indeed, would have been annoyed if the tubal ligation had *not* been performed during the Caesarian and required a second operation. The Supreme Court of British Columbia nevertheless ruled in favour of the plaintiff, stating that while the additional procedure may have been more convenient and desirable, only *necessity* - that is, an emergent threat to the woman's life or health - could justify taking such a drastic step without the consent of the patient.⁹⁸ The consent given to the original procedure - the Caesarian section - may not be extended to cover the additional procedure. As stated by Prosser:

If the defendant goes beyond the consent given, and does a substantially different act, he is liable. The rule frequently is applied to surgical operations ... With the patient unconscious under an anaesthetic, and unable to be consulted, the mere desirability of the operation does not protect the surgeon, who becomes liable for battery which ... renders quite immaterial any question of whether he has complied with good professional practice.⁹⁹

95. *Ibid*, at p. 445.

96. [1945] 4 DLR 81.

97. *Ibid*, at p. 89.

98. See, generally, Foley, "Consent as a Prerequisite to a Surgical Operation," 14 U Cin L Rev 161 (1940).

99. Prosser, *supra*, at p. 104.

Where there are no actual damages the award may be nominal, but pain and suffering are elements of damages and may serve to inflate the award.¹⁰⁰ Additionally, punitive damages may be awarded in appropriate cases.¹⁰¹ It is good practice for surgeons, or doctors engaged in hazardous procedures, to secure written consent from the patient which is sufficiently broad to cover such contingencies as are likely to arise, but not so broad as to render such consent meaningless.¹⁰²

As noted in *Murray*, above, it is well established that consent is required except in cases of necessity, where consent is implied under the circumstances.¹⁰³ A number of cases follow which illustrate this principle.¹⁰⁴

In *Bennan v. Parsonnet*,¹⁰⁵ the patient authorised the defendant doctor to operate on a left side groin rupture. During the operation the doctor discovered a rupture on the right side of the groin as well, which seriously endangered the life and health of the patient. The doctor operated to remedy this condition, and was subsequently sued in tort for trespass. At trial the jury found for the plaintiff, but this verdict was reversed by the Supreme Court of New Jersey, which held that:

when a person has selected a surgeon to operate upon him and has appointed no other person to represent him during his period of unconsciousness ... the law will by implication constitute such surgeon the representative *pro hac vice*.

100. Moritz and Morris, *supra*, at p. 138.

101. Prosser, *supra*, at p. 104.

102. Morris and Morris, *supra*, at p. 138.

103. Prosser, *supra*, at pp. 102-103; *Second Restatement of Torts*, s.62. See Bates, "Consenting to the Necessary", (1972) 46 ALJ 73, 78, in which the author adds two minor provisos to this general rule: (1) where the new treatment is of conceptually the same character as that consented to; and (2) where a doctor has obtained a general consent, he need not get specific consent to each new step if it is related to the rest of the treatment. See also 26 Harv L Rev 91 (1912).

104. See Bates, *supra*, for a fuller discussion of these cases.

105. 83 A. 948 (NJ 1912); discussed 26 Harv L Rev 91 (1912).

In *Tabor v. Scobee*,¹⁰⁶ a young woman underwent an appendicitis operation, during which time the surgeon found that her Fallopian tubes were badly infected. The surgeon was of the opinion that the infected tubes constituted a potential threat of peritonitis and would require removal in the near future anyway. The surgeon proceeded to remove the tubes during the course of the operation. The patient sued in tort for trespass, and at trial the jury found for the defendant. The Kentucky Supreme Court took a very narrow view of the doctrine of necessity, however, and reversed the decision of the jury and remanded the case for a re-hearing, with the new jury to be instructed that to escape liability, the defendant must have been acting in an emergency situation.

In *Marshall v. Curry*,¹⁰⁷ the plaintiff was operated on for a hernia condition. During the operation the defendant surgeon removed the patient's left testicle, which, in his professional judgement, was a necessary part of the cure. In finding the defendant not liable for damages for negligence or assault, the Supreme Court of Nova Scotia considered the judgement in *Bennan v. Parsonnet*, *supra*, and found that it would be better:

instead of resorting to a fiction, to put consent altogether out of the case where a great emergency which could not be anticipated arises, and to rule that it is the surgeon's duty to act in order to save the life or preserve the health of the patient, and that in the honest execution of that duty he should not be exposed to liability.

A difficult situation arises where a person actually refuses to consent to a medical procedure which may be necessary to preserve his life or health. In *Njareketa v. Director of Medical Services*,¹⁰⁸ a young man entered a hospital suffering from a tumor on his leg. His condition deteriorated and the doctor informed him that it would be necessary to amputate the leg. The patient initially gave his consent to the operation. However before the operation was performed the young man's father advised him not to have it and the patient said he would not go against his father's advice. On "humanitarian considerations" the doctor decided that the patient was not in a fit state of mind to make such a decision and decided to go ahead with the operation which was then performed. The young man brought an action against the doctor for damages.

The East African Court of Appeal found that, while there had been a technical trespass against the patient, had the operation not been performed the patient would not have lived. Therefore the patient

106. 254 SW2d 474 (Ky. 1952). See, similarly, *Perry v. Hodgson* 148 SE 659 (Ga. 1929); *Franklyn v. Peabody* 228 NW 681 (Mich. 1930).

107. [1933] 3 DLR 260 (Nova Scotia).

108. (1950) 17 EACA 60.

suffered no damage and the Court averred that the action should never have been brought.

In *Leigh v. Gladstone*,¹⁰⁹ the plaintiff was convicted of resisting arrest and sentenced to four months imprisonment. She claimed that the sentence was an infringement of her rights and that she was a political prisoner. She subsequently went on a hunger strike. The prison doctor eventually subjected her to force feeding for about a fortnight and she brought an action against him for assault.

The doctor argued that as a medical man he considered it his duty to resort to any means to save a patient's life and that at the time the woman was first force-fed it had become dangerous to allow her to abstain from food any longer. He produced evidence that in insane asylums such refusals and force-feeding were common.

The Court stated that it was the duty of the prison doctor to preserve the health and lives of the prisoners. If they were forcibly fed when it was not necessary, that would be assault. But here there was evidence as to the necessity of the feeding and the woman did not allege that the methods used constituted undue violence against her. Therefore the doctor was found not liable.

The situation becomes even more complicated when the patient who refuses medical treatment bases his non-consent on religious grounds. In what situations should the doctor be able to override such refusals? According to one view:

Doctors should have the power to override a patient's religious beliefs where they consider a blood transfusion could save his life. Professor E.K. Braybrooke, professor of jurisprudence at the University of Western Australia said yesterday. He said there was a limit to the extent to which a person could allow his convictions to impinge on the welfare of the rest of the community. The parent who chose to die rather than accept a transfusion could create a social problem by escaping his responsibilities and forcing society to contribute towards the welfare and upkeep of his survivors. He has no more right to do this than to deny his child a life-saving transfusion.¹¹⁰

109. (1909) 26 TLR 139.

110. *The Age*, (Melbourne), 16 June 1965.

The legislatures¹¹¹ and the courts¹¹² have consistently offered legal protection to medical practitioners who give blood transfusions as a life-saving measure where consent cannot be obtained or has been refused. In Papua New Guinea in the case of a parent who refuses to allow a blood transfusion to his minor child, the law permits a doctor to override that refusal under the *Health Act (Papua)*¹¹³ and the *Public Health Act (New Guinea)*.¹¹⁴ Both of those Acts provide that:

(1) A legally qualified medical practitioner may perform the operation of transfusion of human blood upon a minor without the consent of a parent or guardian or any other person if -

- (a) the parent guardian or other person -
 - (i) when requested to give consent has failed or refused to do so; or
 - (ii) cannot after reasonable inquiry be found, or it is impracticable in the circumstances to obtain the consent;
- (b) the medical practitioner and, where practicable, at least one other legally qualified medical practitioner considers -
 - (i) that the operation is a reasonable and proper one to be performed for the condition from which the minor is suffering; and
 - (ii) that the operation is essential in order to save the life of the minor ...

(2) Where an operation of transfusion of human blood has been performed upon a minor under and in accordance with last preceding subsection, it shall be deemed to have been performed with all consents otherwise required by law.¹¹⁵

111. See, e.g., Victoria's *Medical (Blood Transfusion) Act*, 1960, (No.6689).

112. See *Application of Georgetown College* 331 F2d 1000 (1964) (DC Cir.), where Skelly Wright J. issued an order authorising the petitioning hospital to administer blood transfusion to a patient who had refused them on religious grounds. In *St. v. Perricone* 37 NJ 463 (1962), the Supreme Court of New Jersey ordered a blood transfusion on a pregnant woman, to protect the unborn child, where the woman had refused to consent to the procedure on religious grounds.

113. No. 48 of 1960, s.3, which adds s.125A to the principal ordinance, 1912-1960.

114. No. 37 of 1960, s.3, which adds s.18A to the principal ordinance, 1932-1960.

115. Both sections are identical to Victoria's provision; see *supra* p. 106. See also Code of Ethics of the Medical Society of PNG, s.2.6 (h) para.2.

In the case of an adult who refuses to consent to a needed blood transfusion on the grounds of religious conviction, the Code of Ethics of the Medical Society of PNG advises that;

[E]ven if his life would be imperilled if transfusion were withheld, such an adult should have his beliefs respected and it is up to the surgeon to decide whether or not he will perform an operation on such a person ... he should insist that the patient sign a statement protecting the surgeon and his team from subsequent legal action should there be untoward results due to the withholding of blood transfusion.116

Only one case of trespass by a medical practitioner has reached the Courts in Papua New Guinea to date. In *Baupupu Arinuma v. R. Likeman and the Government of Papua New Guinea*,¹¹⁷ the plaintiff was admitted to Goroka General Hospital, where she gave birth to her seventh female child. Two days later the plaintiff underwent a salpingectomy, or ligation of the Fallopian tubes, rendering her sterile. The plaintiff subsequently sued for damages for negligence, or alternatively for assault, alleging that she had not consented to the operation.

According to the evidence, the Department of Public Health has, for the past decade, recommended that mothers with seven or more children submit to a tubal ligation, for the greater the number of pregnancies undergone by a woman, the greater the risk to the woman's life and health in subsequent confinements. The practice at the Goroka hospital was to obtain the written consent of both the woman and her husband before proceeding with the operation.¹¹⁸

In the present case no written consent was obtained from either the plaintiff or her husband. The evidence was contradictory as to whether the plaintiff had consented orally - the nursing sister on duty at the time testified that the woman had said that she would like to have the sterilisation operation; the plaintiff testified that she said that although she had seven female children, she wanted a male child, and thus refused to consent to the operation. The plaintiff protested to ward attendants as they readied her for the operation, but she made no protest once inside the operating theatre.

116. Section 2.6 (h) para. 1.

117. Unreported Judgement No. N40, 17 May 1976, Williams J. This case is digested in [1976] PNG Law No. 6. The case was covered extensively by the mass media as well. See *Papua New Guinea Post-Courier*, 24 March 1976 at p.3, and 18 May 1976, at p.3.

118. The Code of Ethics also provide that "sterilisation should normally be performed only if consent is provided by both the patient and the spouse." Section 2.6(j).

After considering all the evidence, the Court was "not satisfied that the plaintiff in fact consented to the operation."¹¹⁹ No written consent was ever obtained, the evidence was in conflict regarding the oral consent, and the husband was never consulted. The Court refused to consider the plaintiff's failure to protest in the operating theatre as an implied consent, in that it appeared that the woman was relatively unsophisticated and was likely frightened or awed by the presence of the doctors and the atmosphere of the theatre.¹²⁰

The Court held that the action for the unauthorised operation was properly framed in trespass to the person rather than in negligence, citing from the American case of *Hershey v. Peake*:

The distinction ordinarily between an unauthorised amounting to assault and battery on the one hand, and negligence such as would constitute malpractice, on the other, is that the former is intentional, while the latter is unintentional ... ¹²¹

and the English case of *Letang v. Cooper*.¹²² Although the defendant doctor honestly believed that the necessary consent had been obtained, the Court ruled that it was clear, as a matter of law, that such mistake affords no defence in an action for trespass to the person.¹²³

In assessing the damages the Court expressed difficulty in making the calculation, owing to a lack of authority which could serve as a guide in the "unusual circumstances" of the case. Taking into consideration the sense of disappointment and grievance suffered by the plaintiff at being unable to produce a son, and the possibility that she would not have been able to produce a son even if the sterilisation had not been performed, the Court awarded damages in the sum of K400.00.¹²⁴

119. *Arinumu v. Likeman*, *supra*, at p.8.

120. *Ibid.*, at pp. 9-10.

121. 115 Kan 562 (1924), as cited in *Marshall v. Curry* (1933).

122. [1965] 1 KB 232; per Denning LJ.

123. At p.10, citations to *Clerk & Lindsell on Torts* (13th ed), para. 122 and Fleming, *The Law of Torts* (4th ed), at p.74. In *Bravery v. Bravery* [1954] 3 All ER 59, 67, Denning LJ, in his *obiter dicta* suggested that a sterilisation operation where consent was obtained may be unlawful unless it was performed for a "just cause" on the principle that one cannot consent to an unlawful act. Denning LJ averred that sterilisation solely to enable a person to have the pleasure of sexual intercourse without shouldering the responsibilities attaching to it ... the operation is plainly injurious to the public interest. It is degrading to the man himself. It is injurious to his wife or to any woman he may marry, to say nothing of the way it opens to licentiousness; and unlike contraceptives it allows no room for a change of mind on either side. It is illegal, even though the man consents to it.

124. At pp. 10-12.

The Code of Ethics of the Medical Society of PNG recognise that on most occasions the consent of the patient is implied, but it requires that express consent be obtained "when loss of the patient's consciousness is to be induced", and recommends express consent "when any investigation or operation which is not in the normal everyday run of examination or treatment is proposed".¹²⁵

Such express consent may be either verbal or written, although the Code suggests that written consent is preferable as it "carries more authority and permanence".¹²⁶ The consent should cover not only the intended procedure, but also "any further or alternative measures which may be found necessary during the operation",¹²⁷ in order to avoid action for tort based on an unauthorised operation or procedure, as in *Murray v. McMurchy*, *supra*.

C. Liability of Hospitals.

The injury of a patient in a hospital raises the question of who is to bear the responsibility: the medical practitioner or the hospital? Although this question was once the focus of numerous cases and considerable academic debate¹²⁸ the scope of the hospital's responsibility is no longer in question.

... hospital authorities are responsible for the whole of their staff, not only for the nurses and doctors, but also for the anaesthetists, and surgeons. It does not matter whether they are permanent or temporary, resident or visiting, whole-time or part-time. The hospital authorities are responsible for all of them. The reason is because, even if they are not servants, they are the agents of the hospital to give treatment. The only exception is the case of consultants or anaesthetists selected and employed by the patient himself.¹²⁹

In Papua New Guinea, a patient injured in a government-run hospital would bring his action against the Government of Papua New Guinea. Under the *Law Reform (Miscellaneous Provisions) Act*,¹³⁰ the Government is responsible for all of the torts of its employees, servants and agents. Thus medical practitioners employed as part of the staff of such hospitals would be considered agents of the government to give medical treatment. A person injured in a private hospital would bring his action against the hospital board.¹³¹

125. Section 2.6(c).

126. *Ibid*.

127. Section 2.6(d).

128. See "Recent Developments in the Hospital Cases", 17 MLR 547 (1954).

129. *Roe v. Minister of Health*, [1954] 2 All ER 131, 137.

130. No. 58 of 1962; s.5.

131. Section 71 of the *Medical Services Act* 1965 authorises the establishment of private hospitals.

In *Arinuma v. Likeman and Government*, *supra*:

it was not contended on behalf of the second defendant that it would not be vicariously responsible in law for the actions of the first defendant or of other members of the hospital staff.¹³²

If the Government or a hospital board is sued by an injured patient who recovers compensation, the Government or board may seek contribution from the medical practitioner responsible. A doctor in such a case can protect himself from such a suit through medical malpractice insurance. At present it is common in Papua New Guinea for expatriate doctors to carry such insurance but rare for Papua New Guinean doctors to do so.

D. Liability for Acts of Assistants.

The liability of a medical practitioner for the negligence of other persons depends upon the relationship between them. The doctrine of "vicarious liability" holds that an employer will be liable for the negligence of his employees committed "in the course of his employment."¹³³ The determination of when a person is an employee depends upon a number of considerations including who has the power to engage the person, to pay him, to prescribe the jobs he is to undertake and to dismiss him. Thus while a medical practitioner will be liable for the negligence of an assistant employed by him, he is not, as a general rule, liable for the negligence of an assistant or nurse in a hospital.¹³⁴

In addition to the common law rules for determining an employee, and thus the liability of the employer, the Medical Services Act specifically states that certain types of associated health services may only be performed under the direction of a medical practitioner and that such assistants are not entitled to accept any fee for their services except by way of a salary of employment.¹³⁵ Such persons then are always under the employment of either a doctor, dentist or hospital.

Once it is established that a person is an employee of another, the employer will only be liable for negligence or acts done "in the course of employment."¹³⁶ However the courts have been strict in holding employers responsible. Once a person consults a medical practitioner and treatment is undertaken, the medical practitioner cannot relieve himself of his duty of care by delegating the work to an assistant. He remains answerable for the way in which the work is performed even if it is outside the prescribed range of treatment.

132. At p.10.

133. Prosser, *supra*, at pp. 458-459.

134. See *Perionowsky v. Freeman and Another* (1866) 176 ER 873, 875, where it was held that doctors are not liable for the negligence of nurses unless they were personally present and supervising the treatment or procedure.

135. Section 43.

136. Prosser, *supra*, at pp. 460-464.

III. *Criminal Liability.*

In addition to a medical practitioner's civil liability for certain acts, there are cases which may raise the possibility of criminal responsibility. The most common grounds for such criminal liability are for criminal negligence and abortion.

A. Negligence

The elements of negligence have been discussed above. If a medical practitioner is alleged to be negligent, it may give rise to a civil or criminal action. Although most cases result only in a claim for damages by the injured person, the common law has recognised that gross negligence or incompetence by the person, which results in death, may amount to the crime of manslaughter.¹³⁷

The "duty of care" imposed by the criminal law on medical practitioners is found in s.291 of the Criminal Code:¹³⁸

It is the duty of every person who, except in a case of necessity, undertakes to administer surgical or medical treatment to any other person or to do any other lawful act which is or may be dangerous to human life or health, *to have reasonable skill and to use reasonable care* in doing such act; and he is said to have caused any consequences which may result to the life or health of any person by reason of any omission to observe or perform that duty. (Emphasis supplied).

This duty is qualified by s.285 of the Code which provides that:

A person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon any person for his benefit ... if the performance of the operation is reasonable, having regard to the patient's state at the time and to all of the circumstances of the case.

This duty and the standard of care required to meet the duty is illustrated by *R. v. Bateman*.¹³⁹ The defendant, a qualified medical practitioner, was called in by a midwife to assist in the delivery of a child. He found the delivery unusual and difficult. He administered

137. Section 307 of the Papua New Guinea *Criminal Code Act* 1974 (No. 78 of 1974) states that "A person who kills another under such circumstances as not to constitute wilful murder, murder or infanticide is guilty of manslaughter." Section 314 provides that "Any person who commits the crime of manslaughter is liable to imprisonment with hard labour for life."

138. *Criminal Code Act* 1974 (No. 78 of 1974).

139. *R. v. Bateman* (1925) 94 LJ (KB) 791.

chloroform and attempted unsuccessfully to deliver the child with instruments. When this failed, he used his hands to perform an operation known as "version" which required considerable force. He worked at this operation for an hour and then delivered the child, which was dead. In removing the placenta, he mistakenly removed along with it a portion of the uterus. The doctor did not expect the woman to live. For the next five days, the husband and the midwife requested the doctor to transfer the woman to the infirmary. Finally the doctor agreed to this but the woman died two days later. A post mortem examination showed the bladder to be ruptured, the colon crushed against the sacral promontory, a small rupture of the rectum, and the uterus almost entirely gone.

The doctor was charged with criminal negligence on three grounds: (1) causing the internal ruptures in performing the operation of "version"; (2) removing part of the uterus along with the placenta; and (3) delay in sending the patient to the infirmary for treatment.

The defendant doctor replied, in his defense, that the operation was performed under difficult circumstances, was not inconsistent with a reasonable degree of care and competence, and that if he had moved the patient earlier this might have caused further complications which would have accelerated her death.

The Court ruled that as a matter of law, where the degree of negligence or incompetence of the person:

[W]ent beyond a mere matter of compensation between subjects and showed such disregard for the life and safety as others as to amount to a crime against the state and conduct deserving punishment ...140

then the person will be liable for criminal negligence. The issue in such cases is not merely whether there was negligence - for a mistake or error in judgement which may give rise to civil liability may not amount to criminal carelessness - but whether if there was negligence, was it so great as to be criminal. In the words of Lord Hewart, C.J.:

It is ... most desirable that in trials for manslaughter by negligence it should be impressed on the jury that the issue is not negligence or no negligence, but felony or no felony ... It is, in a sense, a question of degree, and it is for the jury to draw the line, but there is a difference in kind between the negligence which gives a right to compensation and the negligence which is a crime.141

In this case the Court of Appeal found no evidence to support a conviction for criminal negligence amounting to manslaughter.

140. *Ibid*, at p. 794. See also *R. v. Lowe* [1973] 1 All ER 805.

141. *Ibid*, at p. 796.

This common law approach to criminal negligence has been found to apply, likewise, to those jurisdictions (like Papua New Guinea) which have adopted the Queensland Criminal Code. In *Callaghan v. The Queen*¹⁴² and *R. v. Scarth*,¹⁴³ the High Court of Australia and the Court of Criminal Appeal of Queensland, respectively, established that negligence giving rise to criminal liability must be of a much higher degree than negligence sufficient to give rise to civil liability. In *Eugeniou v. Reginam*,¹⁴⁴ the High Court of Australia on appeal from the Supreme Court of the Territory of Papua New Guinea, applied the decisions in *Callaghan* and *Scarth*, holding that;

negligence sufficient to meet the standard of civil liability is not enough to constitute a breach of s.289; there must be negligence according to the standard of the criminal law, which may be described shortly as recklessness involving grave moral guilt.¹⁴⁵

In general, the courts have been most reluctant to convict doctors of manslaughter of patients under their care.¹⁴⁶ In *Akerele v. The King*,¹⁴⁷ the Privy Council made sure to:

stress the care which should be taken before imputing criminal negligence to a professional man acting in the course of his profession.¹⁴⁸

To date, no licensed medical practitioner has been charged with criminally negligent manslaughter in Papua New Guinea. Cases have been heard, however, with respect to others who administered "surgical or medical treatment."

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142. (1952) 87 CLR 115. The defendant in this case was charged with manslaughter for criminal negligence in the operation of a motor vehicle, under s.289 of the Queensland Criminal Code; "Duty of Persons In Charge of Dangerous Things".
143. (1945) Q.S.R. 38; (1945) 39 QJPR 73.
144. [1964] PNGLR 45.
145. *Ibid*, at p.47. This decision is cited with approval in *Prosecutor's Request No. 2 of 1974* [1974] PNGLR 317, at p. 328 per Prentice J.
146. Howard, *Criminal Law* (3rd ed. 1970), at p. 104.
147. [1943] AC 255.
148. *Ibid*, at p. 263.

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146. Howard, *Criminal Law* (3rd ed. 1970), at p. 104.
147. [1943] AC 255.
148. *Ibid*, at p. 263.

In *R. v. Wabia Yasi*,¹⁴⁹ the accused was charged with unlawful killing, under s.288 of the *Criminal Code* (Queensland, adopted) (In Its Application to the Territory of Papua),¹⁵⁰ which is identical to the present s.291 of the *Criminal Code Act* 1974.

The accused was a nineteen year old Aid Post Orderly, who received fifteen months of training after completing Grade 6. During the course of his training, he was taught about how to give injections, and about determining dosages, but he did not in fact ever give any injections.

For approximately six months the defendant served as an Aid Post Orderley at Mendi Hospital and administered injections on a number of occasions, without incident. On the day in question Yagari, himself an Aid Post Orderly (at an out-station post) of twelve years' standing, brought in his son, aged about five, whom he believed to be suffering from malaria. The defendant suggested a treatment dose of "infant camoquin", but Yagari insisted on an injection of 2 cc. of chloroquin. The defendant went to the dispensary to get an ampule of the anti-malarial, but returned instead with an ampule of "suxamethonium chloride", having glanced only at the letters "chlor...". The defendant administered the injection of the drug, which is a muscle relaxant, and the child died shortly thereafter.

The Court found that the case was not one of necessity, and thus came within the provisions of s.288, requiring a determination as to whether the accused was criminally negligent. The Court then went on to state that the accused, after making allowances for his limited training and experience, did fail to take reasonable care, for: (1) not making certain he was administering the correct drug, and (2) not checking with a doctor before giving the injection, as was common, although not required, practice.

Despite this finding of negligence, however, the Court acquitted the accused. Citing *R. v. Bateman*, *supra*, the Court ruled that in order to convict the accused, the prosecution would have to demonstrate, beyond a reasonable doubt, that the accused "showed such disregard for the life and safety of others as to amount to a crime against the State and conduct deserving punishment ...". The Court took into consideration the "whole of the circumstances" - the youth of the accused; his limited education, training and experience, and the fact that he was overborne by Yagari, who he regarded as a man of great knowledge - and concluded that while "the case is somewhat close to the line", the degree of negligence was not such that criminal liability would be imposed.

149. Supreme Court Judgement No. 577, 9 June 1970, Kelly J. (Unreported). The pre-Independence "Supreme Court" (one Judge) is now known as the "National Court", and the pre-Independence "Full Court" (at least three Judges) is now known as the "Supreme Court". See ss. 160-161, 163-4 and 166 of the *Constitution of the Independent State of Papua New Guinea*, and the *Supreme Court Act* 1975.

150. 2 Laws of the Territory of Papua 1888-1945 (Annotated) 1031.

In *The Queen v. Tumbipai Laki and Diru Talipuan*,¹⁵¹ the defendants were also charged with unlawful killing, under s.288 of the old *Criminal Code* (Queensland, adopted). The deceased, an Engan villager, had been suffering from an illness for about a year prior to his death, the cause for which he attributed to a blow from a stick received during a fight. Evidence was presented by the deceased's family that he had sought medical attention from qualified non-national doctors at neighbouring hospitals on several occasions, but that the condition persisted nevertheless. Immediately prior to his death, the deceased's condition worsened, and he called upon the defendants, "village surgeons", to operate upon him.

The defendants made an incision in the deceased's chest with a bamboo scalpel, and without concern for antisepsis. The defendants testified that upon opening up the deceased, they found a large amount of pus, and concluded that their patient was likely to die soon. The defendants bound up the incision, and moved the deceased to a rest house, where he died three days later. An expatriate doctor, who examined the deceased thirty-six hours after death, gave evidence through deposition attributing the death of the deceased to a massive infection resulting from the "operation" by the defendants.

The Court stated that under s.288, the prosecution must establish that: (1) the operation did not take place under circumstances of necessity; (2) the surgical treatment was or could be dangerous to human life; (3) that the accused did not act with reasonable skill and did not employ reasonable care, and (4) that death was a consequence of the failure in the duty to have reasonable skill and use reasonable care.¹⁵²

With regard to the third element, above, the Court ruled that the applicable standard of reasonable skill and reasonable care required of 'unqualified medical men' under s.288 is the common law test set out by Lord Ellenborough C.J. in *Rex v. Williamson*:

To substantiate that charge [of manslaughter], the prisoner must have been guilty of criminal misconduct, arising either from the grossest ignorance or the most criminal inattention.¹⁵³ (Emphasis supplied).

Further, the Court ruled that in applying this standard, it must ask itself "whether a jury of Enga villagers would find that the Crown had proven beyond reasonable doubt that the accused had acted with the grossest ignorance."¹⁵⁴ The Court answered this question in the negative,

151. Supreme Court Judgement No. 782, 22 April 1974, Lalor J. (Unreported). Digested in [1974] PNG Law 23.

152. Ibid, at pp. 4-5.

153. (1807) 3 Car. & P. 635.

154. *R. v. Tumbipai Laki and Diru Talipuan*, *supra*, at p.7. In making this ruling the Court relied on *Kwaku Mensah v. The King* [1946] A.C. 83, 93, which held that 'it is on just such questions as these that the knowledge and common sense of a local jury are invaluable.'

citing evidence that the defendants were accepted by the villagers of their area as skillful "surgeons". Applying the same jury test with respect to the question of a lack of reasonable care, the Court found that use of a bamboo scalpel together with a lack of antiseptic were not in themselves proof of criminal inattention. Nor could the fact of the death of the patient from a massive infection, standing by itself, be considered sufficient proof of negligence; for if that were the case:

... then only total success could save thoracic surgeons from prosecution. The evidence as to the source of the massive infection was not wholly satisfactory, in that whilst the doctor was certain that it had been introduced as a result of the operation, the evidence of the accused was there was a pre-existing infection. Assuming, however, that the infection was caused [by] or was secondary to the operation, is this then evidence of lack of reasonable care? The Crown argument suffers from the very defect which the Board rejected in *Akerele's Case*, *supra*. In other words, they argued from an actual consequence to an assumed but undefined criminally negligent act, rather than from a defined act bearing probable consequences. As a matter of logic, the Crown proposition could only be supported if there was a valid major premise to the effect that "all infections are caused by criminally negligent acts". Of course, such a premise is factually untenable.¹⁵⁵

Accordingly, the Court found the accused not guilty of manslaughter, and reinforced the verdict by quoting at length from the dicta by Hulloock B. in *Rex v. Van Butchell*,¹⁵⁶ which reads, in relevant part;

... it makes no difference whether the party be a regular or an irregular surgeon, indeed, in remote parts of the country, many persons would be left to die if irregular surgeons were not allowed to practise ... It is quite clear, you may recover damages against a medical man for a want of skill, but, as my Lord Hale says, "God forbid that any mischance of this kind should make a person guilty of murder or manslaughter". ... It would be most dangerous for it to get abroad, that, if an operation performed either by a licensed or an unlicensed surgeon should fail, that surgeon would be liable to be prosecuted for manslaughter.¹⁵⁷

155. *Ibid*, at p.8. /

156. (1829) 3 Car. & P. 629.

157. *R. v. Tumbipai Laki and Diru Talipuni*, *supra*, at pp. 8-9.

The Court concluded its opinion by chastising the prosecution for pursuing the action and causing the pre-trial imprisonment of "two reputable citizens", where there was not a reasonable prospect of securing a conviction on the evidence available.¹⁵⁸

The opinion of the Court in *The Queen v. Tumbipai Laki and Diru Talipuan* was referred to the Full Court by the Secretary for Law¹⁵⁹ under s.30 of the *Supreme Court (Full Court) Act 1968*,¹⁶⁰ in *Prosecutor's Request No. 2 of 1974*.¹⁶¹ The Full Court considered in particular two questions: (1) whether the standard of criminal negligence used by the trial court - either the "grossest ignorance or the most criminal inattention" - was the proper one; and (2) whether it was proper to introduce the hypothetical concept of "a jury of Enga villagers" in assessing liability. On both questions, the Full Court found that the trial court erred.

As to the first question, the Court disapproved of the dicta of Ellenborough CJ in *Rex v. Williamson*, *supra*:

[E]ven at common law today to apply Lord Ellenborough's words literally would be to ignore the change in English usage since the year 1807. To adopt them as the basis of a judgement was to set too high a standard and was, in my opinion, wrong.¹⁶²

The Court ruled that s.288 of the Code provided its own standards - "reasonable skill" and "reasonable care", and that it was unnecessary to resort to the common law. Where elaboration is required to construe the degree of negligence required under s.288, "the most useful expression of the common law standard" is the opinion in *R. v. Bateman*, *supra*.¹⁶³

158. *Ibid*, at pp. 9-10.

159. Now called the Secretary for Justice.

160. No. 87 of 1968. The same procedure is available under s.41 of the new *Supreme Court Act 1975* (No. 104 of 1975), which enables the prosecution to challenge a ruling or interpretation of the Court without disturbing an acquittal. For more on this, see Griffin, *Criminal Procedure in Papua New Guinea* (1977), at pp. 163-4.

161. [1974] PNGLR 317; digested in [1974] PNG Law 125. The Full Court was comprised of Frost, ACJ., Prentice J., and Raine J.

162. *Ibid*, at p. 322, *per* Frost A.C.J.

163. *Ibid*, at pp. 323-4.

With regard to the second question, the Full Court found it "more than misleading"¹⁶⁴ to substitute for the "reasonable man" or "man of ordinary prudence" test, the concept of "a jury of Enga villagers":

[T]he standard applicable is better expressed simply as that of the reasonable man. For the purposes of this case a reasonable man was to be presumed one whose state of knowledge and prudence was such that he appreciated the difference in training and skill between a qualified medical practitioner and a "village surgeon" without any medical qualifications.¹⁶⁵

While *R. v. Wabia Yasi*, *The Queen v. Tumbipai Laki and Diru Talipuan*, and *Prosecutor's Request No. 2 of 1974* all deal with non-qualified medical practitioners, the principles involved apply equally to fully-qualified practitioners.¹⁶⁶ In the latter case, Chief Justice Frost quotes from Archbold's summary of the common law:

In *R. v. Webb*, 1 M. & Rob. 405, Lord Lyndhurst laid down the following rule: "In these cases there is no difference between a licensed physician or surgeon and a person acting as physician or surgeon without licence ..."¹⁶⁷

and states that:

It is apparent that the law as stated in *R. v. Webb* cited by Archbold, a case which was tried in 1834, was drawn on in the drafting of s.288 of the Queensland *Criminal Code*.¹⁶⁸

A problem which may arise in relation to criminal negligence, but which was not present in the above-mentioned cases, is where a person has been injured by the acts of one person, is given medical treatment, and subsequently dies. Who bears the responsibility for the death in such a case? Section 301 of the Criminal Code provides that:

164. *Ibid*, at p. 329, per Prentice J. See also pp. 329-330, per Raine J.

165. *Ibid*, at p. 326, per Frost ACJ.

166. *R. v. Spiller* (1832) 5 C. & P. 333, 172 ER 999.

167. At p. 322.

168. At p. 323.

When a person does grievous bodily harm to another, and such other person has recourse to surgical or medical treatment, and death results either from injury or treatment, he is deemed to have killed that other person, although the immediate cause of death was the surgical or medical treatment, provided that the treatment was reasonably proper under the circumstances, and was applied in good faith.

In *R. v. Smith*,¹⁶⁹ a soldier was stabbed by the defendant during a fight. A fellow soldier carried him to the medical reception station. However along the way the soldier tripped twice over a piece of wire and dropped the man. The medical station was busy and the man was not thought to be seriously injured. In fact, one of the stab wounds had pierced his lung and caused haemorrhaging. He was treated by a transfusion of saline solution and later oxygen and artificial respiration. However, the soldier died about an hour later.

The defendant argued that the treatment given the deceased was abnormal. There was evidence that there is a tendency for a wound of this type to heal and the haemorrhage to stop. The dropping of the man and the artificial respiration impeded this. In addition, there were no facilities for a blood transfusion at the medical station. There was evidence that if the deceased had received immediate and different treatment, his chances for survival were as high as 75%.

The Court of Appeal held that the trial court was correct in finding that the medical treatment was not the cause of the death.

... if at the time of death the original wound is still an operating cause and a substantial cause, then the death can properly be said to be the result of the wound, albeit that some other cause of death is also operating. Only if it can be said that the original wound is merely the setting in which another cause operates can it be said that the death does not result from the wound.¹⁷⁰

Such a situation is illustrated by *R. v. Jordan*,¹⁷¹ in which a man was admitted to hospital with stab wounds. While in hospital he was treated with terramycin after he had shown that he was intolerant to it. He was also given an abnormal amount of the drug intravenously. The man subsequently died. The Court of Criminal Appeal accepted as the law that death resulting from any normal treatment employed to deal with a felonious injury may be regarded as caused by the felonious injury, but the same principle does not apply where the treatment employed was abnormal.¹⁷²

169. [1959] 2 All ER 193.

170. *Ibid*, at p. 198.

171 (1956) 40 Cr. App. R. 152.

172. *Ibid*, at p. 157.

The Court of Appeal held that the mistreatment "broke" the chain of causation so as to exempt the man who stabbed the deceased from liability for his death.

B. Abortion

Despite popular misconceptions to the contrary, abortion has been treated as possible grounds for criminal liability only in relatively recent years. The offense did not arise at common law, but rather entered into the English legal system by statute in the Nineteenth Century.¹⁷³ A review of common law precedents shows that abortion before "quickening", i.e. before the first perceptible movements of the fetus during gestation (usually between the sixteenth and eighteenth week), was never considered an offense. Abortion after quickening was in some cases considered a minor offense, but was never fully established as a common law crime. Thus, Blackstone, writing in 1765, stated that while some cases held that abortion after quickening was a misdemeanor, "modern law" took an even less serious view of the act.¹⁷⁴

The first criminal abortion statute, *Lord Ellenborough's Act*,¹⁷⁵ was promulgated in 1803. It retained the quickening distinction, making abortion of a quick fetus a capital offense, while abortion before quickening was a felony which carried with it relatively minor penalties. In the major criminal law revisions of 1837, which, *inter alia*, eliminated the death penalty for capital offenses, the Act was repealed, and with it the crime of abortion.¹⁷⁶

The offense was restored in 1861, with the passage of the *Offences Against the Person Act*, which made it an offense punishable by life imprisonment for a person, including the pregnant woman herself, to administer drugs or use instruments with the intent to induce a miscarriage.¹⁷⁸ Knowingly supplying or procuring drugs or instruments

173. *Roe v Wade* 410 US 113 (1973); 41 US LW 4213, 4218

174. *Ibid*, at p. 4220. Quickening was apparently settled on as a compromise, to resolve the long-standing debate as to when a fetus became a person - that is, infused with a "soul". *Id*, at 4219.

175. 43 Geo. III c. 58. (Also known as the *Miscarriage of Women Act*).

176. *Ibid*.

177. 24 and 25 Vict., c.100, ss. 58-9. Minor amendments to these sections were made by the *Statute Law Revision Act 1892* (55 & 56 Vict. c.19) and the *Statute Law Revision (No. 2) Act 1893* (56 & 57 Vict. c.54).

178. Section 58. The wording of this section is such that when a woman is charged with intending to procure her own miscarriage, it is necessary to show that she was actually pregnant, whereas such a showing is not necessary where another person is charged with the offense.

for the purpose of an unlawful abortion is a misdemeanor under the Act.¹⁷⁹ The Act was supplemented in 1929 by the *Infant Life (Preservation) Act*, 1929,¹⁸⁰ which makes it a felony to abort the life of a child "capable of being born alive",¹⁸¹ unless for the preservation of the life of the mother.

The provisions of the Papua New Guinea Criminal Code relating to abortion are virtually identical to those in the English *Offences Against the Person Act*, 1861 save for lesser penalties. Section 228 provides that:

Any person who, with intent to procure the miscarriage of a woman, whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses force of any kind, or uses any other means whatever,¹⁸² is guilty of a crime, and is liable to imprisonment with hard labour for fourteen years.

Section 230 states that:

Any person who unlawfully supplies to or procures for any person any thing whatever, knowing that it is intended to be unlawfully used to procure the miscarriage of a woman, whether she is or is not with child, is guilty of a misdemeanour, and is liable to imprisonment with hard labour for three years.

Section 229 makes it an offence for a woman to procure her own miscarriage.¹⁸³ A concise version of the *Infant Life (Preservation) Act*, 1929 also appears in the Code, at section 319;

179. Section 59. It is not necessary for the prosecution to show that the woman involved was actually pregnant.

180. 19 and 20 Geo. 5 c.34.

181. Section 1(2) establishes the presumption that a fetus of twenty-eight weeks or more is a child capable of being born alive.

182. In *R. v. Linder* [1938] SASR 412, 415, prayer and witchcraft were considered examples of instrumentalities *outside* the meaning of "or uses any other means whatsoever".

183. Unlike s.58 of the English Act, fn.28, *supra*, however, s.229 makes it possible for the woman to be convicted for attempting to procure her own miscarriage even when she is not, in fact, pregnant.

Any person who, when a woman is about to be delivered of a child, prevents the child from being born alive by any act or omission of such a nature that, if the child had been born alive and had then died, he would be deemed to have unlawfully killed the child, is guilty of a crime ...

Section 285 of the Criminal Code makes the performance of an abortion lawful under certain circumstances:

A person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation ... upon an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable, having regard to the patient's state at the time and to all the circumstances of the case.

The situations which will justify an abortion "for the preservation of the mother's life" have been the subject of considerable discussion by the courts in common law jurisdictions.¹⁸⁴

In the leading case of *R. v. Bourne*,¹⁸⁵ a respected obstetric surgeon was charged under s.58 of the *Offences Against the Person Act* with having used an instrument with the intent to procure a miscarriage in a young girl. The doctor intentionally drew attention to the act, to test and clarify the law in the area. His defence was that the continuation of the pregnancy would probably result in serious injury to the girl's physical and mental well-being. Although there was no evidence to suggest that the girl's life was in danger at the time of the operation, the defendant justified his considerations of health on a number of grounds: the girl was only fourteen years of age; she had not reached full physical maturity; and her mental health would almost certainly have suffered from a continued pregnancy, as the pregnancy resulted from a violent rape.

The Court of Appeal was thus called upon to construe the phrase "for the preservation of the mother's life" and to determine whether this phrase comprehended dangers to a woman's health short of death. First the Court considered the broad meaning of these words:

I do not think that it is contended that those words mean merely for the preservation of the life of the mother from instant death. There are cases ... where it is reasonably certain that a woman will not be able to deliver the child with which she is pregnant ... The law is not that the doctor has got to wait until the unfortunate woman is in peril of immediate death and then at the last moment snatch her from the jaws of death. He is not

184. No such case has arisen to date in Papua New Guinea, however.

185. [1939] 1 KB 687; [1938] 3 All ER 615; Macnaghten, J. The two reports contain substantial differences in phraseology.

only entitled, but it is his duty, to perform the operation with a view to saving her life.

[I]f the doctor is of opinion, on reasonable grounds and with adequate knowledge, that the probable consequence of *the continuance of the pregnancy will be to make the woman a physical or mental wreck*, the jury are quite entitled to take the view that the doctor, who, in those circumstances, and in that honest belief, operates, is operating for the purpose of preserving the life of the woman.¹⁸⁶ (Emphasis supplied).

The Court in *Bourne* also ruled that the *Infant Life Preservation Act 1929* had no application to the question of abortion, but rather relates to the destruction of a child at the time of delivery,¹⁸⁷ and not *in utero*.

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186. *Ibid*, at pp. 618-619. In *R. v. Bergmann and Ferguson*, an unreported 1948 case, cited in Havard, "Therapeutic Abortion; *R. v. Newton and Stungo*" [1958] Crim. LR 600, 605, Morris J. (as he was then) stated that the Court will not look too narrowly into the question of danger to life, where danger to health is anticipated. In *Newton v. Stungo*, Ashworth also applies a liberal interpretation of *Bourne*: "When I say health I mean not only her physical health but also her mental health." [1958] Crim. LR 469.
187. *Ibid*, at pp. 616-617. As noted above, s.319 of the Papua New Guinea Criminal Code makes it a separate offence, unrelated to abortion, to kill a child at the time of delivery. The Canadian equivalent to the *Infant Life (Preservation) Act* and s.319, which in fact predated the British enactment, has been amended to also make this clear. Section 221 of the Criminal Code (Can. Rev. Stat. c.34, 1970) now reads: "Everyone who causes the death, *in the act of birth*, of any child ..." (Emphasis supplied). The unlawful killing of a fully born child would, of course, amount to wilful murder, murder or manslaughter depending on the intent of the accused. In Papua New Guinea, however, the *Infanticide Act 1953* (No. 96 of 1953, as amended), reduced to manslaughter a wilful act or omission by a woman which causes the death of her child under the age of one year, if at the time "the balance of her mind was disturbed by reason of her not having fully recovered from the effect of giving birth to the child or by reason of the effect of lactation consequent upon birth of the child ...". Two infanticide cases have been reported to date: *R. v. Yigwai and Aku* [1963] PNGLR 40; and *R. v. Asamakan* [1964] PNGLR 193. The contents of the Act are now embodied in s.306 of the Criminal Code.

In *R. v. Davidson*,¹⁸⁸ the Supreme Court of Victoria was called upon to determine under which circumstances an abortion would be "lawful" under s.65 of the *Crimes Act* 1958,¹⁸⁹ which parallels s.228 of the Papua New Guinea Criminal Code. In the words of Menhennit, J:

[F]or therapeutic abortion to be lawful I think that the accused must have honestly believed on reasonable grounds that the act done by him was *necessary* to preserve the woman from some serious danger. As to this element of danger, it appears to me in principle that it should not be confined to danger to life but should apply equally to danger to physical or mental health *provided it is a serious danger not being merely the normal dangers of pregnancy and childbirth*. In *R. v. Bourne* MacNaghten, J., extends the principle to cover the case where the woman would be a physical or mental wreck.¹⁹⁰ (Emphasis supplied).

Thus, *Davidson* may appear at first blush to be somewhat more restrictive than *Bourne*, in that it explicitly¹⁹¹ introduces the tests of *necessity* and *proportionality* (as measured against the dangers to the mother) in determining whether a given abortion is lawful. Commentary on the decision, however, suggests that the requirement of proportionality was meant only to emphasise the danger of abortions performed at a late stage in the term of pregnancy, and that the element of necessity provides a basis for further liberalisation of the law.¹⁹²

As noted above, abortion is lawful in Papua New Guinea only "for the preservation of the mother's life".¹⁹³ The phrase has not been judicially construed in Papua New Guinea,¹⁹⁴ nor have the identical

188. [1969] VR 667.

189. No. 6321.

190. [1969] VR 667, at p. 671.

191. Menhennit J. asserts that the element of proportionality was *implicit* in *Bourne*; see [1969] VR 667, 672.

192. Elliott, "Australian Letter", (1969) 11 Crim. LR 511, 524-5.

193. *Criminal Code Act* 1974, s.285.

194. Nor does the Code of Ethics of the Medical Society of PNG shed any light on the scope of this phrase. The Code, at s. 2.6(k), states that "termination of pregnancy is performed only if justified on *medical grounds* ...", and at s.3.3, that "procuring or attempting to procure an abortion for *non-therapeutic* reasons is unethical and illegal". (Emphasis supplied). The Code does, however, remind doctors of the "importance of preserving human life *from the time of conception until death*" (Emphasis supplied), which might reflect a strong anti-abortion bias.

provisions of the Criminal Codes of Queensland¹⁹⁵ and Western Australia,¹⁹⁶ nor the similar provision in the Tasmanian Code.¹⁹⁷ It may be reasonable, but by no means certain, to assume that the logic of the common law *Bourne* and *Davidson* decisions would be found to apply, in view of the pronounced trend in favour of the liberal construction of abortion laws. At least one commentator, however, holds the contrary view, stating that under the Code provisions:

the prescribed criterion is directed to the continuance of life. It is absolute. The construction placed upon the words by MacNaghten J. [in *Bourne*] substitutes for the absolute a relative criterion which does not go to the continuance of life but to its quality.¹⁹⁸

Apart from the provisions of s.228, an unlawful abortion may result in further criminal liability, for murder or manslaughter, where the act results in the death of the woman. A murder is committed, under s.305(b) of the Code, where:

death is caused by means of an act done in the prosecution of an unlawful purpose, which act is of such a nature as to be likely to endanger human life . . . it is immaterial that the offender did not intend to hurt the particular person who is killed.

This section of the Code is a legacy of the old common law "felony-murder" or "constructive malice" doctrine, which has since been repealed

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195. Section 282. In *R. v. Ross, McCarthy and McCarthy* [1955] QSR 48, the Court, in a lengthy discussion, placed the burden of proof squarely on the prosecution to prove that an abortion was *not* performed for the lawful purpose of preserving the life of the mother. The Court did not, however, tackle the issue as to whether the phrase "preserving the life" should be given the broad meaning attributed to it by MacNaghten J. The Court merely noted, at p.81, that:

the words "preservation" and "life" do not bear any technical meaning, and although in *R. v. Bourne* ... the meaning of similar words was explained to the jury, it is my opinion that no such explanation is necessary in this case.

196. Section 259.

197. Criminal Code, s.51(1). See Howard, *Criminal Law*, 146-147.

198. (1966) 1 Med. J. of Aust. (Supp.) 16, at p.17.

in England,¹⁹⁹ but lives on in Queensland,²⁰⁰ Western Australia²⁰¹ and Papua New Guinea in its harshest form, and is extant in most common law jurisdictions despite moves to limit its scope, and criticism from the bench and bar.²⁰²

Prior to its abolition in England, the doctrine was limited in the first instance to killings during the execution of a felony (rather than any unlawful purpose), and later to killings during the execution of *felonies of violence*, or inherently dangerous felonies,²⁰³ such as rape, robbery, assault, arson, mayhem, et. al. Further, deaths resulting from unlawful abortions were considered as a separate category, and subject to a different and more lenient jury instruction regarding the application of the felony-murder rule.²⁰⁴ In such cases the accused would be found guilty of murder only if he contemplated, or as a reasonable man should have contemplated, that the act would cause death or grievous bodily harm.²⁰⁵ If the accused as a reasonable man could not have expected the consequences, then the proper verdict would be manslaughter.²⁰⁶

199. *Homicide Act*, 1957 (5 and 6 Eliz. 2 c.11) s.1(1).

200. Criminal Code s.302(2).

201. Criminal Code s.279(2).

202. See, e.g. Howard, *op.cit.*, at p.62; "The felony-murder rule is a barbarous relic and should be abolished"; and the jury instruction of Gavan Duffy J. in *R. v. Carlos* [1946] VLR 15, 20: "Nobody nowadays likes this principle of constructive murder". Most criticism centers on the anomaly that extreme negligence is required for manslaughter, whereas a wholly accidental killing may be elevated to murder, despite the lack of the necessary intent, through the operation of the felony murder rule. Glanville Williams has written that "in some ways the least defensible extension of the doctrine in modern time was in connection with abortion". [1957] Crim. LR 296.

203. *D.P.P. v. Beard* [1920] AC 479, 493; *R.v. Vickers* [1957] 2 QB 664, [1957] 2 All ER 741. For the similar American view, see *People v. Phillips* 64 Cal. 2d 574 (1966) (Cal. Sup. Ct.). The similar common-law Australian view is found in *Ryan v. The Queen* (1967) 121 CLR 205, 230 and 241.

204. See *R. v. Lumley* (1911) 22 Cox C.C. 635, 636, and *R. v. Stone* [1937] 3 All ER 920, 921-922. In practice, the DPP did not bring indictments for murder in cases of deaths resulting from abortion except in "extreme circumstances which suggested that the accused must have contemplated that death or grievous bodily harm might result from the operation". Testimony before the Royal Commission on Capital Punishment, Cmd. 8932, para. 80, cited in 8 Halbury's Laws of England 459. For an excellent concise discussion of the development of the felony-murder rule in Australia, see Howard, *op. cit.*, at pp. 56-72.

205. *R. v. Lumley*, *supra*; see also *R. v. Carlos*, *supra*, at p.20; and *R. v. Brown v. Brian* [1949] VLR 177, 181.

206. *Ibid.*

Under the Code, the constructive murder rule is not limited to acts during the execution of a felony, but rather to acts "done in the prosecution of an unlawful purpose ... likely to endanger human life". It is for the Court²⁰⁷ to determine whether the act was likely to endanger human life, based on the circumstances of the case, *without* reference to whether the accused contemplated the dangers, that is, without a differentiation in the case of abortion.²⁰⁸

In *Hughes v. The King*,²⁰⁹ the High Court of Australia, in construing the analogous section of the Queensland Code, ruled that the constructive-murder rule is applicable only where the unlawful purpose is different from the act causing death. In this case the accused was convicted at trial of murder, under s.302(2), for his assault on a woman, which resulted in her death. The High Court overturned the verdict, finding that the assault "constituted at once the unlawful purpose and the dangerous act", whereas the law requires a dangerous act "done in the prosecution of a further purpose which is unlawful", and directed that the lower court substitute a verdict of manslaughter.²¹⁰

In the *Gould* case,²¹¹ the Court of Criminal Appeal of Queensland dealt with a case in which the defendants were convicted at trial of murder, under s.302(2), after their attempt to procure an abortion in a woman resulted in her death. On appeal the defendants raised a defence, based on *Hughes*, that the dangerous act and the unlawful purpose - procuring the abortion - were one and the same, and that therefore their criminal liability did not extend beyond manslaughter. The Court, however, held in a unanimous decision, that *Hughes* was distinguishable on the facts; in this case the *act* of administering the abortifacient and the unlawful *purpose* of procuring the abortion were separable.²¹²

While this distinction may be seen to be a bit too fine, the High Court of Australia, in *Stuart v. The Queen*,²¹³ used the same logic in affirming the conviction of a defendant of murder for a death that resulted after the commission of arson. In *Stuart*, the defendant

207. In Papua New Guinea, acting in the absence of a jury.

208. *R. v. Walker* [1915] St. R. Qd. 115, 133; *Vera Humphries v. The King* [1943] St. R. Qd. 156, 172; *R. v. Gould & Barnes* [1960] Qd. R. 283, 291-292.

209. (1951) 84 CLR 170.

210. *Ibid*, at pp. 174-175.

211. [1960] Qd. R. 283.

212. *Ibid*, at pp. 294-296, *per* Townley J.; at p. 292 *per* Philp J. The defendants' criminal liability was reduced to manslaughter, however, when the Court ruled that the trial judge had erred in summing up the evidence for the jury, and such error constituted a miscarriage of justice. *Id.*, at p. 293.

213. (1974) 48 ALJR 517. Cf. *R. v. Downey* [1971] NZLR 97, 102, where the dicta of Philp J. in *Gould* is approved.

through his confederates, set fire to a night club to convince other proprietors in the area of the necessity of paying protection money to avoid such criminal interference. The Court held that the act of arson was done in prosecution of the unlawful purpose of *extortion*, and thus the verdict of murder was open to the jury. In his dicta, Gibbs J. continued that the verdict would have been equally correct on the basis that the dangerous act was the setting of the fire, in the prosecution of the unlawful purpose of arson.²¹⁴

In so ruling, the Court compared the decisions in *Gould* and in *R. v. Nichols, Johnson and Aitcheson*²¹⁵ and found them incompatible. In *Nichols*, the defendant set fire to a hotel, and a young woman died in the conflagration. The trial judge, in his direction to the jury, stated that according to his interpretation of *Hughes*, he was bound to direct that a verdict of murder under s.302(2) (Qsld.) was not open on the evidence, as the act of arson was one and the same as the unlawful purpose. The High Court in *Stuart* expressly overruled the *Nichols* case, and consequently affirmed *Gould*, stating that the dangerous *act* of striking a match and applying it to kerosene, was in prosecution of the separate *unlawful purpose* of arson.²¹⁶

At the time of the adoption of the Independence Constitution an informal query was raised by the then Public Prosecutor as to the possible effect on abortion law of the "Right to Life" provision of the Constitution.²¹⁷ This provision, although bearing the same title used as a rallying cry by anti-abortion groups, states that "No person shall be deprived of his life intentionally except ..." (Emphasis supplied). There is nothing in the section or in the writings of the Constitutional Planning Committee²¹⁸ to indicate that "person" should be construed beyond the broad meaning of the word to include a fetus.

In interpreting this section of the Constitution, the Supreme Court would almost certainly look to s.295 of the Criminal Code for guidance:

A child becomes a person capable of being killed when it has *completely proceeded in a living state from the body of its mother*, whether it has breathed or not, and whether the navel string is severed or not. (Emphasis supplied).

214. *Ibid*, at p. 522.

215. [1958] QWN 29.

216. 48 ALJR at p. 522.

217. Section 35. This section is almost identical to s.10 of the *Human Rights Act 1971* (No. 4 of 1972).

218. See *Final Report of the Constitutional Planning Committee - Part I* (1974), at p. 5/1/0; and *Part 2*, at p. A/33.

Thus the Code specifically precludes considering a fetus as a "person", and makes abortion a separate offense from the homicide offenses.

This Code section has been interpreted once, in *R. v. Castles*,²¹⁹ a Queensland case, in which the Court ruled that the section would apply in the situation where the child proceeded in a living state from the body of its mother, but was not viable - that is, it was doomed to die very shortly. While the Crown Prosecutor entered a *nolle prosequi* because of insufficient evidence, Lucas J., in his dicta, stated that where an attempted abortion resulted in the early birth of the child, which decreased its capability of surviving, and the child subsequently died as a result of its premature birth, the defendant would be liable for manslaughter.²²⁰

In the past decade, many common law jurisdictions have moved, either through legislation or judicial decision, strongly in the direction of liberalising abortion laws.²²¹ In 1967 the British Parliament promulgated the *Abortion Act*,²²² which excepts from criminal responsibility an abortion performed by a registered medical practitioner, in a duly registered or approved hospital if two fellow practitioners concur that (1) continuance of the pregnancy would risk the life of the pregnant woman, or endanger the physical or mental health of the woman or any existing child of her family, greater than if the pregnancy were terminated; or that (2) there exists a substantial risk that the child, if delivered, would suffer from serious physical or mental abnormalities.²²³ In determining the risk of injury to the health of the woman, the medical practitioners are permitted to take into account the woman's "actual or reasonably foreseeable environment".²²⁴ The requirement of securing the opinions of two other doctors is dispensed with, however, where the doctor performing the operation believes, in good faith,²²⁵ that such an operation is "immediately necessary to save the life or prevent grave permanent injury to the physical or mental health of the pregnant woman".²²⁶

219. [1969] Qd. L Reporter 77; QWN 36. See also *R. v. West* (1848) 2 Cox CC 500.

220. *Ibid*, at pp. 78-79.

221. See generally, E. Veitch and RRS Tracey, "Abortion in the Common Law World", 22 Am J Comp. L 652 (1974).

222. 15 and 16 Eliz. 2, c.87. The Act is expressly inapplicable to Northern Ireland. For a scathing criticism of the Act, see G.E.F. Hughes, "England's Great Leap Backward - The Abortion Act 1967" 43 A.L.J. 12 (1969).

223. *Ibid*, ss. 1(1) and 1(3). This provision was anticipated by Lord Denning in a 1956 lecture. See [1956] Brit. Med. J. 821.

224. *Ibid*, s. 1(2).

225. The question of good faith is for the jury to decide (or the Court in PNG), based on the totality of the evidence. See *R. v. Smith (Joh)* [1974] 1 All ER 376, 381.

226. *Ibid*, s. 1(4).

In 1969, the state of South Australia implemented legislation identical to section 1 of the United Kingdom's Abortion Act, except for a provision imposing a two-month residency requirement for women seeking an abortion in the state.²²⁷

The most sweeping abortion law reform was accomplished by the United States Supreme Court in 1973 in the companion cases *Roe v. Wade*,²²⁸ and *Doe v. Bolton*.²²⁹ In *Roe*, the Court, by a 7-2 decision,²³⁰ struck down as unconstitutional the criminal abortion laws of Texas, which proscribed abortion except for the purposes of saving the mother's life. After surveying ancient attitudes towards abortion, the development of statute and case law relating to abortion in the United Kingdom, and the respective positions of the American Medical Association, the American Public Health Association, and the American Bar Association, the Court concluded that in balancing the interests of the woman as against the interests of the state in regulating abortion, consideration must be given to the stage of the woman's pregnancy. Statutes which do not make such distinctions are violative of the Fourteenth Amendment's guarantee of Due Process, which, *inter alia*, protects the individual from state action which impinges on the Constitutional right to privacy.²³¹

Accordingly, the Court divided the gestation period into three trimesters, for the purposes of deciding at which stages the state's interest in protecting health and the potentiality of human life becomes compelling, and outweighs the woman's right to personal liberty: (1) During the first three months of pregnancy, the rights of the woman are supreme, and decision to terminate the pregnancy rests solely with the woman and her doctor. (2) During the second three months, the state may regulate abortion procedures in ways that are reasonably related to the protection of maternal health. (3) During the final three months, the fetus is regarded as viable, that is, capable of existence independent of the mother, and the state's interest in the fetus has reached the compelling point. The state may then regulate, and even proscribe, abortion except when necessary for the preservation of the life or health of the mother.²³²

227. *Criminal Law Consolidation Act* s.82a, inserted by the *Criminal Law Consolidation Act Amendment Act*, 1969, s.3. See *The Queen v. Anderson* (1973) 5 SASR 256.

228. 410 US 113 (1973); 41 US LW 4213.

229. 410 US 179 (1973); 41 US LW 4233.

230. White and Rehnquist, JJ., dissenting.

231. 410 US 113, at p. 153. Cf. s.49 of Papua New Guinea's Constitution.

232. *Ibid*, at pp. 164-5. For a criticism of the Court's superimposition of "its own view of wise social policy on those of the legislatures", see J.H. Ely, "The Wages of Crying Wolf: A Comment on *Roe v. Wade*", 82 Yale LJ 920 (1973). The Court's reliance on viability has also been called into question, in view of developing medical technology. See Brodie, "The New Biology and the Pre-natal Child" 9 J. Family Law 391 (1970). A number of symposia on abortion have been held to discuss the religious, moral and ethical, as well as legal, aspects of the abortion issue. See, e.g. "Law, Morality and Abortion", 22 Rutgers L. Rev. 415 (1968).

In *Doe v. Bolton*, the Court struck down a Georgia statutory scheme which proscribed abortion except where necessary to preserve the life and health of the mother, or where the fetus is likely to be born with serious defects, or where the pregnancy resulted from rape. Where an abortion was indicated, the Georgia law required that (1) the operation be performed in a specially accredited hospital; (2) the operation be approved by the hospital's abortion committee; and (3) that the performing doctor's judgement be confirmed by the independent opinions of two other doctors. The Court found that all these procedures violated the Due Process Clause of the Fourteenth Amendment, for they took no account of the stage of pregnancy, as per *Roe v. Wade*, and they imposed restrictions which weren't *reasonably* related to protection of maternal health.²³³ It is interesting to note that the Court stated that the requirement that the performing doctor get confirmation from two other physicians not only had no rational connection with the woman's needs, but also unduly infringed upon her *doctor's right to practice*.²³⁴

Because the Supreme Court decisions mandated a less restrictive system than that imposed by the vast majority of states, they resulted in the reconsideration of abortion laws by most state legislatures. Some states have tried to limit, or even reverse, the effects of the decisions,²³⁵ but most of the legislation accepts the basic premises of *Roe* and *Doe*, and attempts to deal with the gray areas. For example, many states have adopted "conscience laws", which allow doctors and hospitals to refuse to perform abortions on religious or moral grounds.²³⁶

The reforms in the United States, England and Australia came about in large part because of growing public opinion on the side of the pro-abortionists.²³⁷ In the absence of any formal studies or opinion polls, speculation as to public attitudes towards abortion in Papua New Guinea would be impressionistic at best. It may, however, be safely stated that there exists at this time no organised movement of any description that is lobbying for abortion reform, and that the influence of missions is such that opposition to any such reform movement could be effectively mobilised.

233. 41 US. LW at 4236-7.

234. 41 US. LW at 4239.

235. See Veitch and Tracey, *op. cit.*, at pp. 667-671.

236. See Curran and Shapiro, *Law, Medicine and Forensic Science* (1974 Supp.) 172; Veitch and Tracey, *op. cit.*, at 687-690. The English and South Australian enactments afford a "qualified" right of conscientious objection - medical personnel may refuse to perform an abortion, except where the operation is *necessary* to save the life or health of a pregnant woman. *Id.*, at p. 689.

237. Veitch and Tracey, *op. cit.*, at p. 675, and fn. 151, at p. 676. See also Chappell and Wilson, "Public Attitudes to the Reform of the Law Relating to Abortion and Homosexuality", 42 Aust. LJ 120, 123-125 (1968).

Changes could indirectly come about in the law with respect to criminal liability for abortions during the current move to give customary law a greater role in the legal system of Papua New Guinea. Under the present law, custom may be taken into account in a criminal case only for the purposes of ascertaining state of mind, determining reasonableness, deciding whether to proceed to conviction in accordance with a written law, and determining sentence upon conviction.²³⁸ An amendment to the Criminal Code recently suggested by the Law Reform Commission would create a new defense at law, eliminating criminal responsibility for an act (or omission), other than an act causing grievous bodily harm or death, where the accused was acting "under the influence of a traditional custom, perception or belief" which is likewise "held by other members of the customary social group to which the person belongs", living in similar circumstances.²³⁹ Where such an act or omission, other than a "pay-back" killing, results in the unlawful killing of another person, the Commission proposes that the accused should be guilty of a "diminished responsibility killing", which would carry with it a lighter penalty than a conviction for wilful murder, murder or manslaughter.²⁴⁰

While no comprehensive survey has ever been conducted,²⁴¹ there is significant evidence that many Papua New Guinea societies have practiced, and still do practice, abortion by traditional methods, and that such practices are generally not considered wrong.²⁴² Thus the

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238. *Native Customs (Recognition) Act* 1963 (No. 28 of 1963), s.7. Custom may not be recognised, however, which is repugnant to the general principles of humanity; inconsistent with a written law; would result in an injustice or be against the public interest; or adversely affect the interests of a child under age sixteen. *Id.*, at s.6.
239. Law Reform Commission of Papua New Guinea, "Criminal Responsibility: Taking Customs, Perceptions and Beliefs Into Account", Working Paper No. 6, Feb. 1977, cl.22A, at p.22. The original proposal excepted from this defense only acts (or omissions) causing death; more recent proposals have also excepted acts causing grievous bodily harm.
240. *Ibid.*, cl. 307A and 314A, at pp. 22-23.
241. Unfortunately, Marilyn Strathern's *Report on questionnaire relating to sexual offenses as defined in the Criminal Code*, prepared for Department of Law, Feb. 1975, did not deal with the issue of abortion.
242. See, for example, Nilles, "The Kuman of the Chimbu Region, Central Highlands, New Guinea", 21 *Oceania* 25, 30-1 (1950), who observed that:

As children are a social and economical asset to the father's group, he wishes to beget as many as possible. The mother, however, realises more the physical discomfort of bearing and rearing children and considers this sufficient reason to put these sentiments aside and prevents conception or procures abortions ... I don't think that [they] realise the difference between birth prevention and abortion.

Law Reform Commission proposal would, if enacted, eliminate criminal responsibility where an individual procured an abortion under the influence of a traditional belief in the propriety of abortions. Of course, this would not likely affect most licensed medical practitioners, whose professional actions would not be coloured by customary beliefs.

IV. Conclusion.

Civil litigation involving medical practitioners has been very rare in Papua New Guinea, only one case having reached the level of the National Court. This is likely due to a number of factors: (1) few Papua New Guineans are aware of their legal rights and the remedies available to them; (2) few Papua New Guineans have access to legal services - the legal practitioners who have been available at little or no cost through the Public Solicitor's Office have, in the past, been forced to concentrate their attention primarily on serious criminal matters;²⁴³ (3) there are numerous difficulties in preparing such a case in Papua New Guinea: doctors are frequently transferred from one part of the country to another, or leave the country altogether after finishing a short-term contract, and (4) many Papua New Guineans are unfamiliar with the nature and practice of Western-style medicine and thus are not in a position to make a complaint even if they have been the victims of negligent treatment. It is indicative that the sole civil case (*Arimama v. Likeman*) was an action for battery based on an unauthorised surgical procedure, rather than an action arising out of negligence.

Negligence which is very extreme in nature may amount to criminal negligence, and where death occurs, to criminally negligent manslaughter, under s.291 of the Criminal Code. Two such manslaughter cases have been heard by the courts in Papua New Guinea; though neither involved a licensed physician nor resulted in a conviction, they have served to spell out the law in this area. No such judicial clarification has yet been given to the law regarding unlawful abortions, as no prosecutions have been brought under the relevant Code section.

242. continued:

See also P. Lawrence, *Road Belong Cargo* (1964), at pp. 11, 143, 160-161, regarding traditional abortion practices in Southern Madang. M. Potter's bibliography *Traditional Law in Papua New Guinea* (1973) contains a short listing of articles that refer to traditional abortion practices, at p.68. Cf. A.H. Sarei, *Traditional Marriage and the Impact of Christianity on the Solos of Buka Island* (New Guinea Research Bulletin No. 57, 1974). Sarei asserts that abortion was virtually unknown to traditional Solo society, but that the coming of Christianity led to a breakdown of the extended family and changes in the cultural values and attitudes of women towards childbearing, such that abortion today is "rather frequent". *Id.*, at pp. 42-43, 54. See also R.N.H. Bulmer, "Traditional Forms of Family Limitation in New Guinea" in *Population Growth and Socio-Economic Change*, New Guinea Research Bulletin No. 42 (1971) pp. 152-154, for a general survey of fertility control measures in traditional societies in Papua New Guinea.

243. See Weisbrot and Paliwala, "Lawyers for the People: Reviewing Legal Services in an Independent Papua New Guinea", 4 MLJ 184, 190 (1976). The plaintiff in the *Arimama* case was, however, represented by the Public Solicitor's Officer.