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978-1-107-02153-2 - Bioethics, Medicine and the Criminal Law Volume II: Medicine, Crime and Society

Edited by Danielle Griffiths and Andrew Sanders

Excerpt

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# 1 Introduction

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*Danielle Griffiths and Andrew Sanders*

This book focuses on the engagement of the criminal justice system in the regulation of healthcare practice and in the development of health-care law in the UK and elsewhere. In one of the few earlier books dedicated to this subject, Ost and Erin<sup>1</sup> highlight how in the past criminal justice agencies and the judiciary generally left the regulation of the medical profession to Parliament and the General Medical Council (GMC). In this era of deference, the medical profession enjoyed a relatively privileged position with little to fear from the criminal law. Likewise, medical deaths referred to coroners before the 1990s rarely led to extensive investigation, with the result that many of these deaths were closed at the post-mortem stage with a finding of natural causes.<sup>2</sup>

However, over the past twenty years, healthcare professionals have become much more vulnerable to criminal charges for behaviour relating to their professional practice. Their professions certainly make them susceptible to a whole array of possible criminal liability.<sup>3</sup> In making a momentary error or in seeking to assist in alleviating the suffering of a patient, a doctor can be cast into the criminal process and charged with gross negligence manslaughter (GNM) or murder far more easily than, for example, would a solicitor. The Human Fertilisation and Embryology Act 1990 (as amended by the Human Fertilisation and Embryology Act 2008) and the Human Tissue Act 2004 both contain criminal sanctions for doctors who fall foul of its provisions.<sup>4</sup> There is evidence that criminal

<sup>1</sup> S. Ost and C. A. Erin, 'An Ill-Suited and Inappropriate Union: Exploring the Relationship between the Criminal Justice System and Health Care', in C. A. Erin and S. Ost (eds), *The Criminal Justice System and Health Care* (Oxford University Press, 2007), pp. 15–27.

<sup>2</sup> D. Griffiths, 'Medical Manslaughter and the Decision-making Process: Discretion and Attrition' (unpublished).

<sup>3</sup> D. Griffiths and A. Alghrani, '"Criminal" Healthcare Professionals: Medical Malpractices and Public Perceptions' (unpublished).

<sup>4</sup> A. Alghrani and S. Chan, '"Scientists in the Dock": Regulating Science', in A. Alghrani, R. Bennett and S. Ost (eds), *Bioethics, Medicine and the Criminal Law*, vol. 1, *The Criminal Law and Bioethical Conflict: Walking the Tightrope* (Cambridge University Press, 2012).

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justice agencies and judges are not as deferential as they once were. There are more investigations of possible medical manslaughter and a greater scrutiny of cases where it is suspected that a doctor may have hastened the death of a patient.<sup>5</sup> Public demands for the medical profession to be made accountable have also increased markedly and perhaps contributed to this trend to use the criminal law. In the context of wider social and political changes, traditional levels of deference and trust towards doctors have changed radically.<sup>6</sup> In addition, high-profile patient-safety scandals, often played out in the media, have revealed that ‘bad apples’, incompetence and fallibility populate even the medical profession.<sup>7</sup> There has also been an emphasis on making healthcare management accountable for mistakes, as in scandals such as at Mid Staffordshire Hospital.<sup>8</sup>

The intervention of the criminal law into healthcare can be shocking. We want to trust healthcare professionals because there is a lot at stake, including our bodily integrity, health and privacy. When things go wrong it puts all of that at risk. Brazier noted, ‘Praised to the skies for their triumphs, few individuals attract greater public odium than the doctor or nurse who falls from her pedestal’,<sup>9</sup> while for the healthcare professional involved a criminal charge can be devastating. As Ashworth notes, ‘Criminal liability is the strongest formal condemnation that society can inflict, and it may also result in a sentence which amounts to a severe deprivation of the ordinary liberties of the offender.’<sup>10</sup>

With few exceptions,<sup>11</sup> analysis of the relationship of the criminal law to healthcare has been neglected. Whilst within criminal law, criminal justice and criminology there has been much debate about a punitive turn and the encroachment of the criminal law into many areas of society,<sup>12</sup> these debates have not been extended to look at criminalisation

<sup>5</sup> See Griffiths and Sanders, this volume. See also Mullock, this volume.

<sup>6</sup> O. O'Neill, *A Question of Trust* (Cambridge University Press, 2002).

<sup>7</sup> J. Feinmann, ‘Blunder that Killed my Wife’, *Daily Mail*, 12 December 2006. [www.dailymail.co.uk/health/article-421989/Blunder-killed-wife.html](http://www.dailymail.co.uk/health/article-421989/Blunder-killed-wife.html) (accessed 2 March 2012); ‘Dirty Doctor Jailed for Assaults’, BBC News, 20 December 2000. <http://news.bbc.co.uk/1/hi/health/1079820.stm> (accessed 2 March 2012).

<sup>8</sup> Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust, January 2005–March 2009 (2009/10 HC 375–1).

<sup>9</sup> M. Brazier and E. Cave, *Medicine, Patients and the Law*, 4th edn (London: Penguin, 2007), p. 4.

<sup>10</sup> A. Ashworth, *Principles of Criminal Law* (Oxford University Press, 2009), p. 1.

<sup>11</sup> See M. Brazier and N. Allen, ‘Criminalising Medical Practice’, in Erin and Ost, *The Criminal Justice System and Health Care*; O. Quick, ‘Prosecuting “Gross” Negligence: Manslaughter, Discretion and the Crown Prosecution Service’, *Journal of Law and Society* 33 (2006): 421–50.

<sup>12</sup> See D. Garland, *The Culture of Control* (Oxford University Press, 2001); J. Pratt et al. (eds), *The New Punitiveness: Trends, Theories, Perspectives* (Cullompton and Portland, OR: Willan, 2005); D. Downes and R. Morgan, ‘No Turning Back: The Politics of Law

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within medical practice. Similarly, within medical law there has been much debate surrounding the use and impact of the civil law in regulating medical practice, yet there has been little engagement with the use and impact of the criminal law. Within medical law, and also in other disciplines such as sociology, medicine and political science, there is a great deal of work exploring wider factors influencing modern healthcare such as the changing models of regulation in healthcare, improving patient safety, changing forms of 'professionalism' within medicine and declining levels of public trust and deference to medical professionals. Yet, again, there is scant attention devoted to the role that the criminal law may play in these areas: for example, in regulating aberrant medical practice or in public demands for medical accountability.

Such a lacuna in the literature needs to be addressed for several reasons. Should the healthcare profession fear the criminal law more now than twenty years ago and if so why? Data from the National Patient Safety Agency (NPSA) found there were 547,879 patient safety incidents<sup>13</sup> between 1 April and 30 September 2010.<sup>14</sup> Would more extensive criminalisation within medicine deter bad practice and result in safer healthcare or would it result in defensive medicine and more reticence to admit mistakes? Will senior management who do not ensure the safety of their patients be prosecuted under the Corporate Manslaughter and Corporate Homicide Act 2007? What behaviours should be criminalised; does the momentary error of an otherwise competent nurse warrant criminal liability and when should easing death cross the boundary into becoming a crime? How is the vagueness surrounding gross negligence manslaughter interpreted and applied by prosecutors in medical cases and is there still a degree of deference towards the medical profession? Finally, what can we learn from other jurisdictions such as in New Zealand and the Netherlands where the relationship between the criminal law and healthcare has evolved differently?

This book aims to fill these gaps. All of the chapters examine the engagement of the criminal process with healthcare, particularly in relation to medical error and assisted suicide but also in areas such as drug prescription and medical confidentiality. The focus is on the UK, but comparisons are drawn with other jurisdictions, including the USA,

and Order into the Millennium', in M. Maguire et al. (eds), *Oxford Handbook of Criminology* (Oxford University Press, 2007).

<sup>13</sup> A patient safety incident is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care.

<sup>14</sup> Of these, 1,304 resulted in death while 3,054 caused serious and permanent harm. See [www.nrls.npsa.nhs.uk/resources/collections/quarterly-data-summaries/?entryid45=132910](http://www.nrls.npsa.nhs.uk/resources/collections/quarterly-data-summaries/?entryid45=132910).

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Australia, New Zealand, France and the Netherlands. One major chapter in the book draws on empirical work conducted as part of an AHRC project, which included file analysis within the Crown Prosecution Service, coronial system and police forces, as well as interviews with many of these, and other, professionals. A number of these chapters have also been presented at and discussed in seminars and conferences that were held as part of the AHRC project.<sup>15</sup>

The chapters cover four themes that highlight the main issues at stake. The first part outlines historical perspectives. Brian Hurwitz explores the phenomenon of clinicide through the crimes of Harold Shipman. While such crimes involving intentional harm or wrongdoing are not the concern of the collection, Shipman's killings, and clinicide in general, have had great significance for wider symbolic configurations of 'the doctor' and 'doctoring' in modern society. In stark contrast to the common cultural belief of doctors being 'heroes in white coats', Hurwitz demonstrates that Shipman determinedly worked against patients' interests and the central principles of medicine. By attacking the traditional image of 'the doctor', Shipman's crimes shifted public levels of trust and deference and altered public attitudes to criminalising medicine. His actions impacted on public perceptions of doctors and perhaps influenced the current engagement of the criminal justice system in healthcare, including the increase in investigations of medical manslaughter.

Shipman's crimes and high-profile patient-safety scandals have collectively highlighted the fallibility of doctors to coroners, criminal justice agencies and the wider public. Barry Lyons charts how media coverage of medical mistakes and public distrust of professionals have created the conditions for the criminalisation of medical error. Lyons tracks the rise in criminal proceedings taken against anaesthetists for fatal medical error, tracing the first reported ether-related fatality in the mid-nineteenth century to the landmark *Adomako* case in the 1990s. Lyons shows how *Adomako*'s prosecution and perhaps the subsequent prosecutions of other healthcare professionals have been the result of a culmination of various social and political forces, including a rise in patient power and the undermining of medical power. Lyons concludes by questioning whether the *Adomako* case has acted as a deterrent against future fatal medical errors and is needed as a retributive tool: themes which will be discussed in the second section of the collection.

<sup>15</sup> This AHRC-funded project was based at the Universities of Manchester, Lancaster and Birmingham. The support of the AHRC is gratefully acknowledged. For further details, see [www.law.manchester.ac.uk/research/hccriminalprocess/](http://www.law.manchester.ac.uk/research/hccriminalprocess/).

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The relationship between healthcare and the criminal law is not just limited to medical mistakes. Even if a doctor is not directly facing criminal liability herself, the criminal law may have a negative impact on her medical practice. This has long been recognised in the civil context in relation to defensive medicine and ‘blame cultures’.<sup>16</sup> James Chalmers illustrates how, historically, doctors can ‘get mixed up in crime’ through their obligation of confidentiality. Chalmers highlights how the recent criminalisation of HIV transmission has added new impetus to this and affects the duty of confidentiality in a number of ways, including preventing the onward transmission of HIV, in the investigation of recklessly transmitting HIV and through the relevance of medical advice to criminal culpability. For example, in a prosecution for the reckless transmission of HIV, the police and prosecution would often want to access confidential medical records. Chalmers argues it is important that medical practice is not simply adapted to fit the needs (or not) of the criminal law whereby, for example, doctors do not record relevant information in a patient’s records because of the potential for investigative disclosure. Chalmers concludes that the dangers posed by a *perception* of interference from the criminal law are probably greater than the reality.

Dispelling fears surrounding the use of the criminal law in healthcare is the theme of the second part of the collection. The chapters mainly focus on cases of serious medical error. There has been great concern that increasing use of the criminal law in these cases will lead to defensive medicine and less willingness to admit mistakes and guilt. In exploring decision-making processes in cases of medical malpractice as well as the offences that a healthcare professional can be charged with, the chapters illustrate the complexity of criminal intervention. In different ways all the chapters recognise that while the intervention of the criminal law into healthcare is still very rare, decision-making processes in these cases need to be made more consistent and fairer for victims and defendants, and offences need to be reformed or expanded in order to address the different levels of culpability in the cases.

Andrew Sanders shows how victims’ voices have increased their influence in cases of medical deaths and assisted suicide, exploring how the interests and preferences of victims affect police and prosecution decisions. However, previous discussions have tended to treat this issue as dichotomous: prosecution or no prosecution. Sanders asserts that we need to eschew such limited debate. Instead of considering

<sup>16</sup> The Report of the Public Inquiry into Children’s Heart Surgery at the Bristol Royal Infirmary, 1984–1995: Learning from Bristol (2001/02 Cm 5207).

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*whether* to invoke criminal justice, we should consider *what type* of criminal justice to invoke. For him, the use of restorative justice (RJ) instead of traditional punitive sanctions for medical deaths and near-deaths as well as assisted suicide would be much more effective. It is argued that RJ gives victims and offenders a better understanding of each other and of the context of the offence. Victims become less punitive and achieve more closure, and offenders become more contrite and more willing to learn lessons. This is particularly relevant in medical deaths where research has shown that families often want explanations and apologies more than retribution and punishment.<sup>17</sup>

Continuing the theme of analysing how decisions are actually made in criminal cases involving healthcare professionals, Oliver Quick focuses on the role of experts in medical manslaughter cases. Quick's previous work has highlighted how the law surrounding GNM is often vague and unfair, particularly in relation to medical cases. Quick draws on empirical research conducted with experts and explores how they interpret and apply the test of gross negligence. This research shows that context and character assume significance in expert decisions and that while assessing both has a place in the evaluation of gross negligence, both pose risks and are potentially unfair to the defendants in these cases. For example, different experts can interpret context and character in different ways. For Quick, producing clearer prosecutorial guidance and/or replacing the test of gross negligence with subjective recklessness would offer more consistency and thus fairness. For him, less use of the criminal law in this area – reserving it for only the worst (reckless) cases – would be preferable.

Danielle Griffiths and Andrew Sanders draw on the main body of empirical research conducted as part of the AHRC project. After analysing the nature and forms of culpability in medical manslaughter cases sent to the Crown Prosecution Service (CPS), Griffiths and Sanders assess whether tests for GNM are workable in a healthcare context. As mentioned earlier, many previous debates in this area have focused on the concern that prosecutions against healthcare professionals for GNM are increasing. Griffiths and Sanders argue that while there is no reliable evidence for such an increase there are many cases of gross neglect and recklessness that are not prosecuted because of the inherent difficulties of the law surrounding GNM and reluctance on the part of prosecutors to prosecute. In contrast to Quick, they advocate more use of the criminal law in this area. However, recognising that punitive processes are often

<sup>17</sup> J. Allsop, 'Regaining Trust in Medicine: Professional and State Strategies', *Current Sociology* 54 (2006): 621.

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ineffective in healthcare cases, they endorse Sanders' earlier call for RJ to be considered as the initial strategy.

The lack of care displayed at Mid Staffordshire Hospital would certainly support Griffiths' and Sanders' arguments. The Report of the Mid Staffordshire Inquiry revealed evidence of horrific neglect.<sup>18</sup> Some reports suggest that almost 400 patients might have died prematurely as a result of individual and systemic failings.<sup>19</sup> But most of the patients would have been poorly before admission to hospital, and so proving that lack of care caused premature death would have been difficult. Only one case was referred to the CPS, which decided that there was insufficient evidence to prosecute.<sup>20</sup> Referring to the Mid Staffordshire cases, Neil Allen also recognises the limits of the criminal law in this area. He highlights how unless a patient dies it is not generally a crime for healthcare professionals to ill-treat or wilfully to neglect their patients unless the patient has a mental disorder or lacks mental capacity. Section 127(1) and (2) of the Mental Health Act 1983 and section 44 of the Mental Capacity Act 2005 make such ill-treatment and neglect an offence. However, he suggests these psychiatric offences need reconsideration. As well as profound technical difficulties with the offences, Allen asserts that all healthcare patients are in a vulnerable position and should be protected against neglect through the criminal law regardless of whether they are mentally disordered or incapacitated. He proposes a new welfare offence, which, on similar lines to suggestions made by Griffiths and Sanders, would address these difficulties and would target reckless behaviour that causes or is likely to cause patients to suffer unnecessarily.

The offences that Griffiths and Sanders and Allen propose, aim to encompass some of the failings of management in medical error cases. The third part of the book specifically addresses such corporate liability for medical error. In their contribution to the collection, Peter Gooderham and Brian Toft analyse the importance of thinking about psychological factors when investigating medical error. They describe the phenomenon of 'involuntary automaticity', which occurs when people develop the ability to carry out skilled tasks without devoting full conscious attention to them. While desirable in some ways, it also leads to errors being made and is particularly relevant to those errors made in a healthcare context.

<sup>18</sup> Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust.

<sup>19</sup> Denis Campbell, 'Andrew Lansley Announces Inquiry into Mid Staffs Hospital Scandal', *Guardian*, 9 June 2010. [www.guardian.co.uk/society/2010/jun/09/andrew-lansley-inquiry-mid-staffs-hospital](http://www.guardian.co.uk/society/2010/jun/09/andrew-lansley-inquiry-mid-staffs-hospital).

<sup>20</sup> J. Bingham, 'Diabetic Patient Died after Nurses Failed to Give Insulin Injections', *Daily Telegraph*, 7 Sept 2010.



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Gooderham and Toft argue that front-line clinicians who work in unsafe systems, including those that give rise to involuntary automaticity, should be protected from liability where warnings about the problems have been issued to managers. They argue that while gross negligence is an ill-defined concept, it allows prosecutors and juries to take into account the culpability of both individual healthcare professionals and managers, which is particularly important if managerial staff have not acted upon legitimate concerns.

The next two chapters focus on the Corporate Manslaughter and Corporate Homicide Act (CMCH Act) 2007. Celia Wells recognises that before the 2007 Act came into place it was notoriously difficult to secure a conviction for manslaughter against large corporations, including hospitals and NHS Trusts. For Wells, the new Act still has major problems, including being vague in defining causation and 'senior management'. Thus it is unlikely to be any easier to secure prosecutions under the new offence in healthcare contexts than it used to be. Similar to Chalmers, Wells concludes by arguing that rhetoric may have more of an impact than the actual application of the law. For Wells, fear of the criminal law in this context may have a positive effect and prompt healthcare organisations to make risk assessments in order to reduce the incidence of deaths caused by medical error. Alternatively, the Act may be counterproductive to patient safety in that the NHS may face even higher legal costs in defending cases. Whatever the result, Wells argues that the new Act is unlikely to have a dramatic impact. Penny Brearey-Horne explores whether the CMCH Act can address systemic deficiencies in maternity services. She outlines how substandard care continues to be a contributory factor in many maternal deaths. She asserts that the CMCH Act has the potential to effect change and achieve greater managerial accountability. However, similar to Wells, the chapter recognises the limits to using the Act, particularly in a health-care context.

The final section in the collection looks at medicine and crime in a range of other countries. The concern in England and Wales about rising prosecutions for medical manslaughter<sup>21</sup> similarly arose in New Zealand during the 1990s. Ron Paterson charts how, until 1997, New Zealand had a simple test for GNM. Following a number of cases for GNM in the 1980s and 1990s there was a revolt against the civil standard test used and the focus has shifted to other forms of accountability. A theme that runs through all of the chapters in the collection is whether the criminal

<sup>21</sup> R. E. Ferner and S. E. McDowell, 'Doctors Charged with Manslaughter in the Course of Medical Practice, 1795–2005: A Literature Review', *Journal of the Royal Society of Medicine* 99 (2006): 309. Griffiths and Sanders challenge these findings.



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law is constructive or destructive to good medical practice. Paterson's chapter convincingly shows how mechanisms that are now in place in New Zealand, such as the Health and Disability Commissioner, are far more effective means for dealing with medical error than traditional criminal prosecutions. The New Zealand experience could be instructive; in England and Wales, satisfactory forms of non-criminal means of accountability for medical error appear to be disappearing. Cuts to the funding of legal aid in clinical negligence cases currently threaten this form of redress, and confidence in professional regulators is low. Then Ian Dobinson looks at prosecutions of doctors in Australia. Dobinson asserts that in Australia prosecutions are very selective and focused on the worst and most sensational cases. Dobinson details the recent case of Dr Jayant Patel who in 2010 was convicted on three counts of manslaughter and one count of grievous bodily harm.

Despite the recent concern about a possible increase in cases of medical manslaughter in England and Wales, these cases are still relatively rare. In contrast, the criminal process plays a much broader role in holding doctors to account for medical error in France.<sup>22</sup> Anne-Maree Farrell and Melinee Kazarian explore the use of the criminal law in relation to the HIV blood contamination episode in France. They outline how both substantial and procedural aspects of the criminal law in France allowed those who were responsible for the scandal to be held to account. Despite some difficulties, Farrell and Kazarian argue that the use of the criminal law in this incident has had a positive lasting legacy and led to significant improvements in managing the blood system in France. In contrast to Paterson, and concurring with Griffiths and Sanders, Farrell and Kazarian state that the English system should draw lessons from the French experience in order to use the criminal law more widely in cases of medical error when patients have suffered serious injury or death.

The final two chapters in this part move away from cases of medical error to explore other potential offences a healthcare practitioner may face as part of their professional activity. Similar to previous chapters, the authors recognise that the use of the criminal law does not just affect a practitioner who may face criminal charges but has a much wider impact on the actual practice of medicine and the treatment of patients. Examining the regulation of medical practice and the prescription of pain medication, Stephen Ziegler discusses the use and impact of the criminal process on physicians in the USA. Ziegler identifies two related public health crises in the USA: the under-treatment of pain and the

<sup>22</sup> M. Kazarian, D. Griffiths and M. Brazier, 'Criminal Responsibility for Medical Malpractice in France', *Professional Negligence* (2011).

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abuse of prescription drugs. For Ziegler, the punitive, criminal justice approach taken in the USA in order to address the abuse of prescription drugs has resulted in a fear among physicians about the amount of drugs they prescribe and has acted as a barrier to the effective treatment of pain. For Ziegler, the use of the criminal law in this area is having negative and unintended consequences and harming patients more than preventing unnecessary deaths.

Noting that healthcare professionals are more at risk of prosecution under the Suicide Act 1961 than lay people, Alexandra Mullock asserts that medics are likely to feel constrained in any discussion with patients on how best to facilitate a 'good' death. The line between assisting an easeful death through palliation and through physician-assisted dying (PAD) is flimsy. Such caution and fear of prosecution have a negative effect on attempts to enhance end-of-life care. Mullock goes on to explore the situation in the Netherlands where palliative care does offer interventions which provides a compromise for people seeking PAD. In particular, the use of continuous deep sedation (CDS) is used in the Netherlands as a clear alternative to PAD. For Mullock, the legalisation of PAD in the Netherlands has allowed such a compromise and enhanced end-of-life care.

The book as a whole shows that the extent of criminal intervention in healthcare varies over both time and place. All of the chapters differ in their view of what role the criminal law should play in regulating healthcare practice, and show that this question is not as clear-cut as was previously thought. Nonetheless, some general conclusions can be tentatively offered. First, we should not expect to achieve much by changes to substantive law alone – whether extending individual liability (Allen, Griffiths and Sanders) or corporate liability (Wells, Brearey-Horne). Second, having appropriate substantive criminal law is a necessary but not sufficient condition. What is also needed is an appropriate legal culture (Farrell and Kazarian) and a problem-solving, as distinct from punitive, approach: whether for medical error or end-of-life (Mullock, Sanders) and whether via the criminal law or other forms of regulation (as in Paterson's example of New Zealand). Finally, while Ziegler's chapter vividly illustrates the misuse of traditional criminal processes, this should not blind us to the constructive possibilities offered by RJ, which are widely used elsewhere in the criminal justice system.