When Clinical Becomes Criminal: Reforming Medical Manslaughter

The English law on medical manslaughter, manifested in the common law offence of gross negligence manslaughter, seeks to punish conduct in the process of healthcare which is so negligent that it causes death and hence warrants the gravity and stigma of a criminal conviction. In reality, however, the law lacks the certainty of any clear definition, and fails to make the critical distinction between flagrant negligence and fleeting mistake. Ultimately, very little is done for justice or patient safety, as the law comes down hard on some doctors who are guilty of nothing more than doing their best under overwhelming pressure. In this paper, it will be argued that the current law is not satisfactory and is unduly burdensome on some healthcare professionals. A reform will be proposed which is founded upon culpability, and sets recklessness as the standard for criminal liability in medical manslaughter. It is suggested that such a reform is desirable, practical and useful as it seeks to enforce legal certainty, by clarifying the circular and ambiguous *Adomako* test, as well as the arbitrary and vague approach of the CPS to cases of medical manslaughter.

The Issue of Uncertainty

Arguably the greatest issue with the existing law[1] is that both the legal test for gross negligence manslaughter and the approach towards prosecution adopted by the Crown lack clarity and certainty, which puts into question its compatibility with the rule of law. The case of *R v Adomako*[2] lays out the test which distinguishes between mere negligence and gross negligence capable of punishment under the criminal law. After establishing that there must be breach of duty which causes the death, Lord Mackay concludes that, *"the jury must go on to consider whether that breach of duty should be characterised as gross negligence and therefore as a crime"*, based upon the extent to which the

[1] Kazarian, Griffifths and Brazier conclude that the "elusive concept of grossness" is, along with causation, the main problem in the English law of gross negligence manslaughter. M. Kazarian, D. Griffiths and M. Brazier 'Criminal responsibility for medical malpractice in France' (2011) 27 Professional Negligence 185

[2] [1995] 1 AC 171

defendant's conduct departed from the standard of care[3]. This test, however, offers very little guidance as to what is meant by the elusive principle of 'grossness', aside from Lord Mackay's comment that conduct should be 'so bad' as to amount to a criminal act[4]. Given that this 'badness' is the fundamental element of the offence which transforms negligence into a criminal act, it certainly ought to be a distinct and comprehensible concept. Furthermore, the use of the criminality of the act as a part of the definition of the offence is a cause for massive concern, and Lord Mackay himself acknowledges the circularity of it.

Despite this, opportunities to change and clarify this test have been overlooked by the judiciary, lending much credence to Griffiths and Sanders' assertion that the law on medical manslaughter is "curiously indispensable"[5]. Indeed, the *Adomako* test for gross negligence was affirmed by the Court of Appeal in *R v Misra*[6], following an appeal by two senior house officers against their convictions for manslaughter on the grounds of contravention of Article 7 of the European Convention of Human Rights. Judge LJ concludes that the law as it stands provides 'sufficient' clarity, as certainty needn't be absolute[7]. Whilst he confirms that the test asks the jury to consider grossness and criminality as a single element, rather than two separate questions, the definition remains still ambiguous and leaves open to the jury too much interpretation. The application of the *Adomako* test therefore promotes inconsistencies and does little to invoke justice.

Yet the problem of uncertainty arises well before cases of medical manslaughter reach the courtroom. In Quick's 2006 study[8], issues with defining 'gross negligence' were identified even within the CPS. It was observed that prosecutors themselves had difficulty with articulating their interpretation

[3] *Ibid.* at 187
[4] *Ibid.* at 187
[5] Griffifths, D. and Sanders, A., 'The road to the dock: prosecution decision-making in medical manslaughter cases' in Griffifths and Sanders (eds) *Medicine, Crime and Society* (CUP 2013) 117, 123
[6] [2004] EWCA Crim 2375
[7] Reaffirming the principle outlined in *Sunday Times v United Kingdom [1979] 2 EHRR 245*
[8] Quick, O., 'Prosecuting 'Gross' Negligence: Manslaughter, Discretion and the Crown Prosecution Service (2006) 33 *Journal of Law and Society* 421. Statistical analysis was conducted of all known cases of medical manslaughter since 2000. Additionally, four senior prosecutors with experience in handling medical manslaughter cases were interviewed at the York office of the CPS Directorate in July 2004.

of 'gross negligence' without simply referring to badness and its synonyms[9]. Additionally, there seems to be little evidence of a solid prosecution policy in this morally charged area of law, as prosecutors emphasised the importance of experience and "gut feeling"[10]. Prosecutors were also seen to be somewhat reliant on their own personal "moral frames" to prosecute practitioners about whom there was a lack of stored comparative information regarding their conduct[11]. Although Hawkins perceives individual moral framework to be inherent in all prosecutorial discretion[12], it is here argued that a more defined offence would reduce arbitrary decision making at the prosecution stage to promote transparency and better achieve justice.

Bad practice or just bad luck?

Another prominent criticism in academic reviews of medical manslaughter is the focus of the law on harm rather than moral culpability. There is no distinction in law between those doctors who have made a catalogue of poor decisions and display incompetency, and those who make momentary errors under pressure or because of systematic failings. The case of Drs. Sullman and Prentice, whose appeals were heard in *Adomako*[13], provides a very clear example of good doctors who have been ensnared by the unrefined law in this area. The pair were junior doctors instructed to perform a young boy's chemotherapy regime, and, through inexperience and poor supervision, administered the wrong drug into the boy's spine rather than intravenously. The boy died and both doctors were convicted of manslaughter at trial – it mattered little in the eyes of the law that they were "far from being bad men", as their momentary error rendered them criminals[14]. Similarly, in 2009 Dr Ubani was convicted in his home country of accidentally killing a patient in England whilst working as an out of hours doctor. He had been flown to England under 'tremendous stress' and exhausted, and had not received adequate

[9] *Ibid.* at 442
[10] *Ibid.* at 440
[11] *Ibid.* 441
[12] K. Hawkins, *Law as a Last Resort: Prosecution Decision Making in a Regulatory Agency* (OUP 2002), 52
[13] Op cit., n. 2
[14] The trial judge, quoted in Brazier and Alghrani, "Fatal Medical Malpractice and Criminal Liability" (2009) 25 *Journal of Professional Negligence* 51, 56. The doctors' convictions were overturned upon appeal.

general training or information on the medication he incorrectly administered[15]. If these cases are contrasted to ones of blatant negligence, such as Dr Adomako, who failed to notice a dislodged oxygen tube in the course of surgery for almost five minutes, then the shortcomings of the current law are undeniable.

Again, even within the CPS there is a difficulty in contending with the framework of medical manslaughter, as Quick notes that there is some unease with bringing the full force of prosecution upon individuals whose errors have catastrophic consequences[16]. This scepticism even amongst prosecutors suggests that there are fundamental problems in the law which are excessively unfair on professionals who work in some of the most stressful and precarious environments. Quick's study also uncovered a greater interest on the part of the CPS to prosecute cases with repeated failures and decisions to ignore warnings, though there have been some cases of momentary blunders which have been prosecuted[17]. It is certainly the logical approach for the CPS to pursue prosecutions in this manner in line with the concept of culpability, however it is here suggested that a 'habit' or observable pattern in prosecutions is not enough and undermines transparency. Instead, a reform in the law to reflect our moral perceptions of culpability and punish only those doctors who are truly guilty of a crime would produce a far fairer outcome in the name of justice.

Recklessness: a solution

It is proposed that changing the level of culpability in the law of medical manslaughter from negligence to recklessness is a desirable, practical and useful solution to the problems posed by the current legal framework. Recklessness has always remained within the peripheral of the scope of gross negligence manslaughter, and so would be a logical and coherent move from the present law. Lord Mackay advised in *Adomako* that, *"it is perfectly open to the trial judge to use the word 'reckless' in*

[15] Despite the CPS' request for extradition, Dr Ubani has not been prosecuted in the UK. See Care Quality Commission, 'Investigation into the out of hours services provided by Take Care Now', July 2010: http://www.cqc.org.uk/sites/default/files/documents/20100714_tcn_summary.pdf (accessed 22nd September 2017)
[16] Op cit. n. 8 at 441
[17] *Ibid.*

its ordinary meaning as part of his exposition of the law if he deems it appropriate", which suggests that there are already some moves to interchanging negligence with recklessness. Furthermore, subjectivity was affirmed by the Court of Appeal in *Misra*, where it was concluded that the defendant's state of mind may be a "critical factor" in their guilt, despite the apparently objective test[18]. On a prosecutorial level, Quick has observed that prosecutors often search for subjective fault as a basis for their judgments of 'grossness', owing to their unease with the unfair and unclear objective test. It is certainly apparent that there is a desire within the legal system to "rediscover recklessness"[19].

In order to prevent law-making for law-making's sake and to uphold the concept of legal minimalism, recklessness should be worked into the existing law as seamlessly as possible. It is suggested that endorsing the concept of 'indifference' or 'ignorance', based upon Duff's definition of recklessness as "practical indifference"[20], would best convey subjective recklessness to the CPS and the jury. In *Misra*, the Court of Appeal upheld the trial judge's direction as to the grossness of the defendants' conduct – 'gross negligence' must be "*truly exceptionally bad, which showed…indifference to an obviously serious risk to the life"* of the patient[21]. This direction offers a solid foundation for reform. Moreover, the work of academics can be drawn upon to formulate a new test; Brazier and Alghrani have attempted to redefine gross negligence. However it is argued that their test would work better in practice not as a modified test for gross negligence, but as a reformulated test based upon culpable recklessness. The proposed reform of the test for medical manslaughter is an adapted version of Brazier and Alghrani's model[22]:

1. Did the doctor's conduct fall short of responsible professional practice so as to incur liability in tort? (i.e. was there a duty of care, breach of duty and causation?)

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[18] *"Evidence of his state of mind is not a prerequisite to a conviction for gross negligence"* – Rose LJ in *Attorney-General's Reference (No. 2 of 1999)* [2000] 3 All ER 182

[19] Quick, O. 'Medicine, mistakes and manslaughter: A criminal combination?' (2010) 69 *Cambridge Law Journal* 186, 188

[20] Duff, A. *Intention, Agency and Criminal Liability* (Oxford 1990), chapter 7

[21] Ob cit. n. 6 at 25

[22] Brazier, M. and Alghrani, A. 'Fatal Medical Error and Criminal Liability' (2009) 25 *Professional Negligence* 49

2. Did the doctor show indifference to an obvious risk of serious injury to his patient? If the answer is yes, he has acted recklessly and has failed altogether in his duty to his patient and is culpable for the harm caused absolutely.
3. Was the doctor aware of such a risk and nonetheless exposed the patient to that risk for no accepted medical benefit? If the answer is yes, he has acted recklessly unless there is overwhelming evidence of significant mitigating factors.

To avoid the excessive brutality which the current law imposes upon inexperienced and overworked doctors, mitigation should be allowed for in the context of incapacity and lack of experience. However, the doctor will still be culpably reckless if he was aware that his inexperience or lack of capacity was likely to cause harm, and went ahead regardless. The mitigation should be considered in light of all the surrounding circumstances and is not an absolute defence to overtly poor practice. This reflects the existing *Adomako* test which makes reference to "all the circumstances" and is important considering the contentious nature of the law and its vast implications for doctors.

Desirable, practical and useful?

The law of gross negligence manslaughter has been criticised for its "incoherent and unjust" punishment of doctors simply owing to the inherently risky work which they perform[23]. Even some prosecutors see it as "wrong" to "pillory" doctors because of the dangerous nature of their job[24]. There have been calls from some academics to abolish the offence altogether[25]. However, this would be a step too far, and would surely undermine the purpose of the criminal law as a device with which to maintain order if doctors could cause death without repercussion. Cases such as *Adomako* and that of Dr Sinha, who administered fatally an overdose of morphine to a patient with kidney failure[26], have made it clear that there is a need for some criminal sanction on poor doctoring. The Court of Appeal in *R v Garg*[27],

[23] Kazarian, M., Griffifths, D. and Brazier, M. 'Criminal responsibility for medical malpractice in France' (2011) 27 *Professional Negligence* 185,
[24] Ob cit. n. 8 at 440
[25] Ob cit. n. 8
[26] [2004] 328 *British Medical Journal* 726
[27] [2012] EWCA Crim 2520

in which a consultant failed to identify sepsis in his patient, has confirmed that the legal framework of medical manslaughter must still reflect "the fatal consequences of a criminal act"[28]. A revised offence based on reckless culpability offers a solution which will punish doctors who have truly fallen below the accepted standard of healthcare, yet provides some flexibility to those who do not deserve the blame of the criminal law. As this reform aims to improve justice and clarify an ambiguous legal framework, it should certainly be viewed as a desirable move.

The utility of the suggested reform within the healthcare context, as well as from a legal perspective, is also unquestionable. Evidence has been found that there is a rising demand for healthcare professionals to be made accountable for mistakes[29], yet the effects of the prosecution of doctors upon patient safety have been doubted. The consensus amongst academics seems to be that prosecutions of medical manslaughter may actually be detrimental to good medical practice and may hinder future accountability. For as Merry and McCall Smith have argued, the law is "based on a denial of the nature of human error"[30], and punishes error rigidly in cases of medical manslaughter. In fact, good medical practice is based upon openness and the ability to learn from errors, and it has been frequently argued that pointing the criminal finger of blame where harm is caused is fatally counterproductive to this[31]. Baron Pollock once stated that, *"it would be most fatal to the efficiency of the medical profession if no one could administer medicine without a halter round his neck"*[32], and it is argued that the current law on gross negligence manslaughter, with its uncertainty and unfairness borne in mind, certainly amounts to a halter around the neck of doctors.

This essay is also in agreement with Berwick that *"recourse to criminal sanctions should be extremely rare, and should function primarily as a deterrent to wilful or reckless neglect or*

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[28] *Ibid.* at 44, Lord Judge C.J. quoted Sweeney J. in *R v Holton* [2010] EWCA Crim 934

[29] Kazarian, M., Griffifths, D. and Brazier, M., 'Criminal responsibility for medical malpractice in France' (2011) 27 *Professional Negligence* 185, 186

[30] Merry, A. and McCall Smith, A., *Merry and McCall Smith's Errors, Medicine and the Law (*CUP 2001) 104

[31] See Quick, O., 'Patient safety and the problem and potential of law' (2012) 69 *Cambridge Law Journal* 186; Kazarian, M., Griffifths, D. and Brazier, M., 'Criminal responsibility for medical malpractice in France' (2011) 27 *Professional Negligence* 185; McDowell, S. and Ferner, R., 'Medical manslaughter: Editorial' (2013) BMJ 347

[32] Foster TC, Finlason WF, "Reports of cases decided at Nisi Prius and at the crown side on circuit; with select decisions at chambers. R v Crick (1860) 519-20.

mistreatment"[33]. The deterrent effect of the present law as a means to maximising patient safety is limited both by the vague and arbitrary interpretation of the law, and the fact that it applies to inherently undeliberate errors. The current framework arguably contravenes the rule of law as the test for 'gross negligence' does not make it clear to medical practitioners exactly what the law expects from them and what is considered criminal. The reform of the law which has been set forth will serve a far greater deterrent role in the aim of discouraging poor and reckless practice by ensuring that doctors must think about their actions before carrying them out, and weigh them in the balance with associated risks to the patient. To punish medical practice which is genuinely substandard and careless, rather than unfortunately fatal, will be much more effective in deterring irresponsible doctoring, and will promote diligent practice and the avoidance of acknowledged mistakes. Moreover, given the current strain on resources within the NHS, the proposed reform is particularly desirable, practical and useful as it aims to improve systems of work and promote patient safety without the need to alter the infrastructure of healthcare.

Conclusion

The application of the law in the courts and at the prosecution stage is unclear and inconsistent, regardless of affirmations of the certainty of the *Adomako* test by the Court of Appeal in *Misra*. There is also a widespread feeling of dissatisfaction from both prosecutors and academics with the failure of the law to distinguish between doctors who have shown blatant incompetence, and those who make momentary errors. This disregard for the moral culpability of defendants means that the law is excessively harsh on those defendants who have made fleeting errors under the pressure of a clinical environment whilst trying to do their best for the patient. While this essay has not sought to argue that

[33] National Advisory Group on the Safety of Patients in England. *'A Promise to learn – a commitment to act. Improving the safety of patients in England'* (2013) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf accessed 26th September 2017

the law should provide the medical profession with favourable treatment, it has laid out a framework which provides flexibility to allow for the demanding circumstances in which doctors work.

Glanville Williams has concluded that recklessness is "socially superior" to gross negligence[34] as a means of determining liability, and this is certainly defensible given the improvements that the proposed test will make to healthcare and justice. The reform set out in this essay is based on recklessness, which reflects pre-existing approaches taken by the judiciary and CPS under the current test. These approaches demonstrate the endorsement of recklessness as a test for liability in medical manslaughter, and support the logical move towards the adoption of a test based on culpability. The centrality of 'indifference' to the test ensures that the defendant's state of mind is considered and aims to promote diligent practice when making heathcare decisions. Furthermore, the suggested reform allows for mitigation in some situations, which again aims to reduce the severity of the law on those who are doing their best despite their circumstances. It is argued that enforcing the proposed reform will promote patient safety by deterring genuinely poor and careless healthcare, whilst allowing for human error. It is important that any reform in this area acknowledges the inevitability of error in healthcare and uses this as a mechanism for improvement rather than punishment.

Throughout this essay, it has been argued that the current legal framework of medical manslaughter is unsatisfactory and ineffectual in furthering either justice or patient safety. The move from gross negligence to recklessness which has been proposed is desirable, practical and useful in promoting safe and careful healthcare, as well as furthering the pursuit of justice through the clarification of the substantive law, and a greater focus upon culpability.

[34] Williams, G., *Textbook of Criminal Law*, 2nd ed. (London 1983), at 100