Errors, Equity and the Law

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In 2008, in Queenstown, I presented a talk entitled "*Mistakes, Misguided Moments and Manslaughter*".[1] This talk was motivated by a series of ten cases (eight in the 1990s) in which health professionals in Aotearoa/New Zealand faced criminal charges for manslaughter arising from simple errors in the clinical care of patients that tragically turned out to be fatal.[2] The impact on the patients and their families was clearly the greatest cause of concern, and one of the key messages of my talk was that too many patients are harmed by the healthcare intended to help them, and that this harm often represents substandard care.[3,4] At the same time, I argued that criminal prosecution of human error is neither just nor effective.[5] It is also illogical to resort the criminal law only when patients die, and not in those cases involving lesser harm through negligence. At that time there had been an increasing tendency for the police to descend upon the hospital in full force when a patient died in association with anaesthesia or surgery. Their manifest lack of contextual insight was captured by a certain sergeant who informed me that "*We take death very seriously*." The prosecuted health professionals included four anaesthetists and two cardiac surgeons, which is not surprising because patients who are at high risk often require treatment in these specialities, and some do end up dying. This inconsistency in the application of logic was one of the arguments that informed the advocacy of the New Zealand Medical Law Reform Group (NZMLRG) in seeking a change in the law.[6,7] Another, more important, argument was that New Zealand was out of kilter with comparable jurisdictions, notably those of England, Scotland, Australia and Canada, both in its law and in its prosecution policy. The contrast was made between ten such prosecutions, eight of which occurred in one decade (the 1990s), in a country of (then) three million people and some 14 or so in the entire last century in the UK, which at the time had a population of approximately 60 million people. Similarly, we believed that only three doctors and one dentist had ever faced such prosecutions in Australia and that the prosecution of a Dr Valentine in Tasmania in 1843 had been the only one to succeed in obtaining a conviction.[8]

In New Zealand, the crimes amendment act of 1997 established a requirement for a "*major departure*" from the standard of "*reasonable knowledge, skill and care*" for the criminal prosecution of negligence. Such prosecutions continue to be possible, but they have become much less frequent. In fact, there have only been three early prosecutions since this amendment of the law. One of these was actually brought under the provisions of the previous law, on the grounds that that was the law pertaining when the death in question occurred. A fourth case, involving rather different circumstances resulted in a finding of criminal nuisance.

The NZMLRG was very generously assisted by several people on a pro-bono basis in its submissions to Parliament and to a retired Judge of the High Court appointed by the Minister of Justice to consider the matter. One of these was the Professor of Medical and International Law at Edinburgh, Alexander McCall Smith. After the law change had been passed by Parliament, Professor McCall Smith suggested to me that we should write a book to capture the underlying principles that had informed the recommendations to change the law (the book is entitled "*Errors, Medicine and the Law*"[9]). These principles will be revisited briefly in my presentation, but readers are referred to the publication arising from my previous talk for an outline of them.[1] Professor McCall Smith and I

decided, however, that the question of interest was the general one of blame and negligence. We believed that this series of criminal prosecutions in New Zealand had been an aberration in the context of international law, and that the question of the role of the criminal law in healthcare was settled – i.e. that it was now agreed there was very little place for the criminal law in healthcare other than in clearly egregious circumstances such as those illustrated by the English General Practitioner Harold Shipman who murdered over 250 of his patients.[10,11] Therefore, we omitted an explicit discussion of this topic from the book.

Unfortunately, since the turn of the century, there has been an increasing and very disquieting sense that we were wrong. In Australia, several criminal prosecutions of doctors have received attention during this time frame, notably that of the so called "*Dr Death*", Jayant Patel, who was charged with manslaughter in relation to several the deaths associated with his time as Director of Surgery at Bundaberg Base Hospital. After a protracted and expensive series of proceedings the Director of Public Prosecutions finally (in 2013) and controversially decided to cease pursuing Patel, but it did seem from this and other cases that there was now an increased willingness to resort to the criminal law in Australia. It also turns out that there have been rather more prosecutions of doctors for manslaughter in Australia than had previously been believed. This illustrates an interesting point – it is difficult to identify previous law cases in a reliable manner. There is no readily searchable database or search engine equivalent to Medline or PubMed, and the commonest method involves searching for reports in the media. Using this method, Carter uncovered an additional 33 Australian cases, of which only four are known to have resulted in a conviction.[12] Dr Leona Wilson has similarly uncovered two early New Zealand prosecutions that were not known about at the time of the work of the NZMLRG.

This uncertainty about numbers does limit the confidence with which one can make comparisons between countries or between periods, but I and others are convinced that a genuine and marked increase in prosecutions for manslaughter against health professionals has occurred since the end of the last century in England and Wales, but not in Scotland (which has its own legal system). [13,14] Whether or not this is true, it is clear that there is a widespread perception amongst medical practitioners in England (at least) that the risk of being unjustly prosecuted in this way has increased substantially. There would be no concern about prosecutions for egregious behaviour that no reasonable doctor would condone (Shipman being a case in point). The concern arises from the sense that criminal proceedings might arise simply because of mistakes made while trying to do one's job, often under difficult circumstances. It is for exactly this reason that the case of Dr Bawa-Gaba has become a rallying call for reform, both of prosecution policy and of the subsequent processes of the General Medical Council and its independent Medical Practitioners Tribunal Service.[14] Two reviews have been published in the last few months, each of which makes numerous and potentially far-reaching recommendations for change.[15,16]

Dr Hadiza Bawa-Gaba was asked, as a paediatric registrar, to cover an acute paediatric service shortly after returning to work after some 13 months of maternity leave. During this day a six-year-old child, Jack Adcock, who had Down's syndrome and had previously undergone surgery for congenital heart disease, was admitted, investigated and treated, and died. The details of this case and its aftermath have been extensively discussed elsewhere,[14] but many aspects of the clinical challenges of caring for a very unwell child (Jack was diagnosed at post-mortem as having had sepsis) could apply in the context of cardiac surgery and cardiology as well as in paediatrics, including the question of an acceptable level of supervision of junior staff. It is very relevant to any evaluation of the role of the criminal law in healthcare that the only doctor prosecuted for these events was this registrar.[14]

Perhaps the most sticking thing about this case, however, is to be found in the many photographs of Dr Bawa-Gaba that can readily be located online. Suffice to say that although she received her medical training in England she was born in Nigeria and is typically seen wearing a hijab. If one turns to the four other doctors recently convicted of manslaughter in England, it turns out that they are also notable for their ethnicity – none of them appears to have come from a long line of "*blue-blooded*" English families.

Dr Bawa-Gaba received a prison sentence of two years which was suspended, in part because she was a mother with young children. Others have been less fortunate. In particular, Mr David Sellu, an experienced consultant colorectal surgeon, was sent not only to prison, but to a high-security prison where he found himself sharing a cell with two fellow convicts. He described this experience as "*like being locked in a toilet with strangers*". Whereas his "*crime*" was at worst an error in judgement (his conviction was subsequently overturned at appeal), one can but guess that the crimes that had been committed by his cellmates were less nuanced in nature. The case against Dr Sellu hinged on a delay in bringing a patient with a bowel obstruction to surgery in a private setting where his attempts to do so were delayed by several barriers, notably difficulty in obtaining an anaesthetist. Dr Sellu's life story should have been an inspiration to his children. Having been born in rural Sierra Leone to parents who could neither read nor write, he won a scholarship to study Medicine at Manchester University and had had an impressively successful career until the events which led to his prosecution. Dr Sellu's youngest child, James, had been accepted to study medicine at Manchester, but after seeing his father's experiences, he has decided not to pursue this option. His comments quoted in the Guardian newspaper are telling.

"*When something goes wrong, people look for a scapegoat," he says. "And if you're a black doctor, you're first in line. I loved the idea of being a doctor and impacting positively on other people's lives, but almost all doctors work in the private sector as well as the NHS, and the NHS needs the private sector to survive. And being a black doctor is just too risky. Also, if you end up in court, as my father did, you find yourself being tried by people who, with all due respect, haven't got a clue what they're listening to. At one point during my father's trial I noticed one of the jurors looking at a piece of evidence upside down."* [17]

The suggestion that racism has played a part in at least some English prosecutions of doctors, and perhaps also in their convictions and sentencing, has of course been denied. In fact, bias on this account is very likely (whether unconscious or conscious) and so is outcome bias, whereby judgement about the culpability of an act is influenced by knowledge of the consequences of that act.[14,18]

Could it be that unconscious bias played a part in at least some of the New Zealand Prosecutions? Without a doubt, outcome bias would have played a role, but what about more invidious prejudices, and perhaps even racism?

Last year the Professor Merry Lecture "*Surgery, Statistics, and Public Policy*" addressed aspects of inequity and institutional racism in Aoteroa/New Zealand. This year, Dr Wil Harrison is continuing this theme, with the authority of lived experience. Since last year the terrorist attack on two mosques in Christchurch has been a wake-up call for the country in many different ways. The conversation has indeed confronted the point that for all that we would like to believe that "*This is not us,*" perhaps it actually is. Also, since last year, the Waitangi Tribunal Report WAI2575 has been released as a pre-publication document.[19] Its review of the failure of the primary healthcare framework in New Zealand to address the health needs of Māori is sobering. Numerous breaches of the Treaty of Waitangi are identified. On the very day this paper was being written the New Zealand

Herald ran a story on an initiative at Auckland City Hospital to address institutional racism.[20] Māori are massively over-represented in New Zealand prisons. An "*exploratory report*" in 2007 stated that at that time, when Māori formed 12.5% of the general population aged 15 and over, 42% of all criminal apprehensions and 50% of all persons in prison identified as Māori. The situation was even worse for women, with 60% of women in prison identifying as Māori. The report found that "*bias and amplification*" in the justice system interact with "*early life environmental influences*" to produce this "*catastrophe*."[21]

Thus, there can be no doubt that racism is present in New Zealand at multiple levels.

However, as is so often the case, it is not possible to draw a firm conclusion on the role of bias in relation to the health professionals charged with manslaughter in New Zealand. Some of those charged were Pakeha, born in New Zealand. Of these, one who was convicted actually pleaded guilty almost immediately, to reduce stress on the family and protect other health professionals associated with the event. However, most were not convicted. The practitioners who were convicted included one had just arrived from Australia, one who was Sri Lankan trained in the UK, and one was an immigrant from England. The doctor pursued by the prosecution service, notwithstanding the change in the law was of German origin, although she had worked in New Zealand for many years. One difficulty in interpreting all of this is that international medical graduates make up a large proportion of New Zealand's health workforce. In the end, one can do no more than speculate on this matter, but given greater numbers, one might also extend the enquiry to cases of disciplinary proceedings.

An analysis of cases between 2003 and 2014 before New Zealand's Health Practitioner's Disciplinary Tribunal noted that "*characteristics, such as practitioner gender, age, or ethnicity… ..are not consistently reported in the published decisions, although they have been found to be associated with the risk of facing disciplinary procedures*." [22] This would seem to be a serious limitation of the system. Surely this information should be collected and analysed? Note also that bias could manifest in relation to characteristics not only of practitioners but also of patients. This broader question of the potential influence of bias in disciplinary processes within New Zealand would be worthy of further research.

A request for a second edition of "*Errors Medicine and the Law"* [23] provided an opportunity to address the omission of an analysis of role of the criminal law in regulating healthcare and responding to things that go wrong in the care of patients. These issues have been summarised in relation to the case of Dr Bawa-Gaba.[23]

A prosecution will obviously be devastating for the practitioners concerned, but this might be seen as reasonable if even some of three conditions were met:

- That there was sufficient cause to justify severe punishment of the practitioner
- That punishing the practitioner in this way served the victims or their families
- That punishing the practitioner would act as an effective deterrent to other practitioners in similar situations

The case of the NZMLRG rested largely on refutations of two of these conditions: human error is inevitable, so it is not possible to deter error, and it is unjust to punish error. Furthermore, although failures that involve some element of deliberate violation rather than error (which by definition is unintentional) [23] may warrant punishment, this punishment does need to be proportionate to the blameworthiness of the behaviour, rather than the consequences of that behaviour.

It is the failure to satisfy the third condition that leads us to perhaps the most compelling reason to discard the criminal law in this context. The fact is that the process seldom seems to work out well for anyone and in particular, often fails to satisfy the needs of the victims or their families. Amongst other reasons, this is because the proceedings are very protracted and stressful for all concerned, the majority of cases fail to secure a conviction, and even when a conviction is secured the sentence is usually light (this has certainly been the case in New Zealand). Thus, families of patients often feel that their expectations of justice have not been met.

There is an argument for the declaratory value of a criminal conviction, but there are better ways to achieve this. In fact, if one accepts the premise that most of the things that go wrong in healthcare involve practitioners who are well motivated and trying to do the right thing with limited resources within a flawed complex adaptive system, there is little point in such a declaratory function. On the contrary, it becomes evident that an excessively harsh legal response to iatrogenic harm often serves simply to make a bad situation worse. Litigation is less problematic than prosecution in this regard, but even then, the money spent on litigation (and on prosecution and other legal processes) represent an opportunity cost for proactive investment in safety. In short, the law as it currently functions in many parts of the world seems to provide a poor value proposition from the central perspective of trying to deliver safe healthcare, and often fails to serve its presumed objectives, such as justice and deterrence.

In addressing the role of the criminal law in healthcare, it thus became apparent that a completely different legal paradigm is called for. Professor Warren Brookbanks and I drew from the concept of "*therapeutic jurisprudence*" which has its origins in mental health law in the late 1980s.[23-25] In a somewhat parallel line of reasoning it was realised that mental health patients appearing before a judge were more in need of help than punishment, yet the justice system was designed primarily to punish culpable behaviour and again often served simply to make a bad situation worse. It was argued that the legal system itself had a responsibility to be therapeutic. Similar expectations would seem reasonable for all concerned when health practitioners are trying to do their best for patients, but things inadvertently go wrong.

New Zealand is uniquely placed to pursue this concept because it already has many of the required elements in place. These include:

- Universal access to healthcare
- No fault compensation
- The fact that lawsuits against doctors or hospitals are already almost impossible
- An established "*major departure*" requirement for criminal prosecutions
- The Health and Disability Commissioner and Code of Patient Rights which provide good access for patients to have their concerns heard and dealt with, ideally in a systems-oriented way
- The Health Quality and Safety Commission which is responsible for reporting on harm and recommending and implementing ways to reduce the likelihood of recurrence.

The question now is whether we could go further.

The best response to iatrogenic harm is to prevent it from occurring in the first place. It is reasonable to expect that all concerned will invest and actively engage in initiatives to this end. If this is done, and something still goes wrong, compensation, an explanation and redoubled efforts to improve safety may be justified but punishment will not be. However, it is not realistic to expect the public to trust practitioners and hospital managers in this matter. Some sort of proactive independent verification is needed. Thus, there seems to be a proactive role for independently employed

regulators within quality assurance and improvement teams to assure that the public interest is indeed being adequately served in this regard.

These independent "*monitors*" would need a reasonable foundation in the relevant aspects of the law. Like all those who work to improve the safety and quality of healthcare, they would need also need expertise in the big picture issues of healthcare and in the fundamentals of improvement science. In this rather utopian world, the regulators would work in a model of partnership and co-design with those who manage health services, those who deliver them as practitioners and those who receive them as patients or consumers. However, their primary responsibility would not be to drive improvement, but rather to represent the public interest in assuring that an appropriate commitment to safety was in place and embedded in the culture of the institution or service concerned. The intent is to put regulation at the top of the metaphorical cliff rather than the bottom, where (in many countries) ambulances wait for the next disaster with a posse of lawyers ready to pounce when things go wrong.

This brings us back to the insidious influence of bias in all its forms. It is hard not to share James Sellu's conclusion – the risks of prosecution seem to be increased by membership of an ethnic minority. This is clearly true in general (as evidenced by New Zealand's goal population), and possibly true in relation to the risks of prosecution in healthcare, at least in England in recent years. There is an increasing realization that that, amongst the elements of quality, equity (or the lack of it) is the priority for advancing the quality of healthcare in Aotearoa/New Zealand and probably in most countries, and also that cultural safety is integral to patient safety. It seems that these same priorities may apply to the system by which healthcare is regulated, and by which the law responds to things that go wrong, inadvertently, during normal patient care.

It is to be hoped that the two reports that have emerged from the widespread concern over the Bawa-Gaba case will lead to constructive reform in England. In my view, the changes that are required go further than any that have been called for. The adversarial division between the provision of healthcare and the regulation of the errors and failures which inevitably occur when humans engage with complex systems is not satisfactory. Further advances in the safety and quality of the health system in all our countries will require everyone to work together in broadly-based partnerships. This partnership will include those whose profession is in law or regulation and those whose profession is in healthcare. Furthermore, these partnerships should include those whom the law and healthcare are expected to serve, and they should reflect the populations and obligations of the countries in question.

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