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EDITORIALS



Shadow of the law in cases of avoidable harm

The law's intervention in patient safety can be haphazard and inconsistent

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“Jail time for a medical error.” This was the headline of Bob Wachter’s patient safety blog about the Ohio pharmacist Eric Cropp.¹ When Cropp’s professional colleagues saw him clad in an orange jumpsuit in a prison visiting room, they knew it could have been them. A pharmacy technician mistakenly mixed chemotherapy drugs with 23% saline, not 0.9%. A child died. It was a rushed, understaffed day, with computer failures. Cropp’s supervisory check failed to spot the error. He was convicted of manslaughter in 2009.

A junior doctor in Nottingham, England, was jailed in 2003 for killing a cancer patient who was given vincristine through the wrong route. The investigator had identified some 40 systems failures,² yet individual accountability won the day in court. It had happened before in the UK in similar circumstances, but other doctors had been quietly counselled.

A look back from 2005 at the doctors charged with manslaughter in the UK found 85 since records began, and 38 between 1990 and 2005³; there were a further 15 during 2006 to 2015.⁴

One of those was NHS surgeon David Sellu. On parole, part way through a two and a half year prison sentence for manslaughter of a patient in a private hospital, Sellu learnt on 15 November that the Court of Appeal had quashed his conviction.⁵ This was because of an aspect of the legal process in the lower court.

The chronology of events, set out in the Appeal Court’s judgment,⁶ has the chilling momentum and sense of inevitability characteristic of most patient safety narratives. It is a complex mixture of system and human factors with elements of poor clinical decision making. As such, there were questions of individual accountability. These could have been properly dealt with by local clinical governance procedures or by serious medical regulatory scrutiny. Awful though the case was, few doctors would say that it reached the threshold for a prosecution. This is especially so given no apparent pattern of past poor practice.

Should a doctor, or other health professional for that matter, ever be charged with manslaughter? If there is no suggestion of reckless behaviour or wilful misconduct, then treating the failure as a crime creates a negative and punitive climate in which the instinct for self preservation becomes stronger than

the motivation to make a report that could save lives. Good practice in safety in healthcare and other high risk industries points consistently to the necessity of an approach free of blame and retribution if learning to protect future patients is to be successful.⁷ Understandably, many patients and families affected by a serious incident can find this difficult to accept.

The initial legal processes that come into play in patient safety incidents are often problematic. I once asked a group of senior police officers why some doctors are prosecuted and others not, in similar situations. They said that it depended whether someone made a complaint. If they did the police were obliged to set up an inquiry team. This police work can last years. Healthcare organisations and the General Medical Council cannot proceed because of the risk of contaminating evidence. The victims get angry, suspecting a cover up. The staff member concerned suffers enormous stress. All progress is paralysed. Sometimes the investigation is dropped, and words such as “exoneration” are then used, despite ongoing concerns about safety.

In the courts, an adversarial approach is taken to establish causation. The focus is on the accused. From the word go, the wider systemic context hardly gets a look in. Juries have to cope with the emotion, perhaps relating the events to their own experience of care.

Like many past controversies involving doctors, the Sellu case raises important questions of policy. For example: why do so many acutely ill deteriorating patients have to die? The patient here slid into sepsis because delayed decision making, failure to escalate, and poor communication meant that he could not be rescued. A third of all deaths related to patient safety in England were found to result from mismanagement of the deteriorating patient.⁸ This clear systemic vulnerability causes major harm. The NHS shows a lamentable failure to tackle it. Also, what can be done about private hospitals that do not have adequate skilled cover for acutely ill patients?

The law’s interventions in the complex and subtle territory of avoidable harm in healthcare are too often haphazard and inconsistent. Its perspective and processes make more difficult the task of creating a system to make care safer and inspire health professionals to lead the way.

Competing interests: I have read and understood BMJ policy on declaration of interests and declare I was chief medical officer for England between 1998 and 2010 and led reforms to medical regulation. I am currently the World Health Organization's envoy for patient safety.

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