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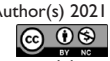
MEDICAL LAW INTERNATIONAL

Medical Law International
2021, Vol. 21(4) 343–368



DOI: 10.1177/09685332211057004
journals.sagepub.com/home/mli


# Surgical harm, consent, and English criminal law: When should 'bad-apple' surgeons be prosecuted?

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## Abstract

This article examines the legal principles determining when surgical harm becomes a criminal matter. In England and Wales, and other common law jurisdictions, the criminal law has predominantly concerned itself with fatal medical misconduct via the offence of gross negligence manslaughter. The convictions of two surgeons in 2017 (Ian Paterson and Simon Bramhall), for offences against the person, suggests that police and prosecutors have, for the first time, become willing to prosecute surgeons for non-fatal surgical harm. Understanding when non-fatal surgical harm should be treated as a criminal matter is, however, a complex issue. The medical exception to the criminal law legitimizes consensual and reasonable surgical harm. Thus, the question of what is reasonable and what constitutes valid consent is key to determining the parameters of lawful surgery; however, the principles are perplexing and insofar as they may be agreed and understood, they are arguably unsatisfactory. After examining the cases involving serious surgical harm and analysing the doctrines applied, this article argues for a more patient-centred approach. The focus should be on the nature of the harm to the victim, the behaviour of the dangerous surgeon and whether a violation has occurred, rather than on traditional professional assessments, which are unduly deferential to the medical profession.

## Keywords

Surgical harm, non-fatal offences, Ian Paterson, consent, reasonable surgery, the medical exception, criminal law

Received 6 November 2020; Revised 19 August 2021; Accepted 15 October 2021

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## Introduction

This article examines the uncertain principles concerning non-fatal surgical harm and the criminal law. In England and Wales, and other common law jurisdictions, the criminal law has predominantly concerned itself with *fatal* medical misconduct via the offence of gross negligence manslaughter (GNM).[1] The 'medical exception' within criminal law creates a legitimate but uncertain space, allowing doctors to consensually harm patients for 'reasonable' surgical purposes.[2] Thus, lawful surgery must be both consensual and reasonable. Without the medical exception, because surgery necessarily involves intentional wounding, it inevitably satisfies the requirements of section 20 of the Offences Against the Person Act 1861 (OAPA) and, if the wound is sufficiently serious to constitute grievous bodily harm (GBH), section 18 OAPA is potentially applicable.[3] The convictions of two surgeons *Paterson*[4] and *Bramhall*,[5] in 2017, for offences against the person, suggests that police and prosecutors have become more willing to question the presumption that surgical harm is not a criminal matter. This article examines *Paterson, Bramhall*, other cases involving surgical malpractice and the legal principles determining when surgical harm might be regarded as a non-fatal offence.

This research contributes to the debate about the appropriate domain of the criminal law in medicine. While doctors have been convicted of sexual offences,[6] the criminal law has not traditionally been used to capture other non-fatal medical harm-doing.[7] The seminal work of Glanville Williams urged us to trust in the medical profession's ability to self-regulate and not look to the criminal law when things go wrong, unless serious problems demand the concern of Parliament:

1. See *Adomako* [1993] 4 All ER 935 CA; [1995] 1 AC 171, HL; *Rose v R* [2017] EWCA Crim 1168.
2. *R v Brown* [1994] 1 AC 212 HL (at 17 and 33). See P Lewis, 'The Medical Exception', *Current Legal Problems* 65 (2012), pp. 355–376.
3. Section 20 (unlawful wounding/inflicting GBH) is satisfied when a wound is inflicted 'maliciously', which means it is only necessary to intend or be reckless as to the infliction of 'some harm', not necessarily a serious wound or GBH. See *R v Savage, R v Parmenter* [1992] 1 AC 699 (HL). Section 18 is appropriate for intentionally causing GBH.
4. Ian Paterson was convicted of wounding and grievous bodily harm (GBH) (sections 20 and 18 OAPA 1861) in April 2017 by a jury in Nottingham Crown Court (unreported). The Court of Appeal accepted an appeal against sentence by the Attorney general: See https://www.gov.uk/government/news/butchering-breast-surgeon-has-sentence-increased-by-5-years.
5. *R v Bramhall* Trial Transcript, 13 December 2017 (Unreported). And see C Dyer, 'Arrogant Surgeon Fined for Writing his Initials on Patients' livers', *BMJ* 30 (2018), pp. K200.
6. For example, paediatric haematologist, Dr Myles Bradbury, was convicted of sexually assaulting many children. See 'Children's Cancer Doctor Pleads Guilty to Sexually Abusing Patients as Young as 11', *The Telegraph*, 15 September 2014. Also, GP Jaswant Rathore, was convicted of sexual assault and jailed for 12 years in 2018, see 'Midlands GP Jailed for 12 Years for Sexual Assaults on Four Patients', *The Guardian*, 18 January 2018, https://www.theguardian.com/world/2018/jan/18/midlands-gp-jailed-12-years-for-sex-attacks-on-four-female-patients.
7. This has prompted criticism of the significance of moral luck (whether the patient dies or survives) in medical gross negligence manslaughter (GNM). See J C Smith, 'The Element of Chance in Criminal Liability', *Criminal Law Review* 63 (1971).

> It may be questioned whether the criminal law has any place in controlling operations performed by qualified practitioners upon adults of sound mind with their consent, whether for reasons of therapy, charity or experiment. Controls exercised by the medical profession itself should be accepted as sufficient.[8]

*Paterson* and *Bramhall* suggest that the criminal law does have a role to play when surgeons abuse trust and harm patients, but understanding when non-fatal surgical harm should be treated as a criminal matter is a complex issue. The question of what is *reasonable* and what constitutes consent are key to determining the parameters of lawful surgery; however, the principles are perplexing and insofar as they may be agreed and understood, they are arguably unsatisfactory. By examining these principles, I consider the challenges of determining whether and when harmful surgical injuries should be treated as a criminal rather than a civil matter. Ian Paterson's crimes – mutilating many patients over more than a decade – provides an extreme example of criminal conduct, usually however, 'bad-apple' surgeons who recklessly inflict serious harm are subjected only to the scrutiny and accountability available via civil law and regulatory, disciplinary measures.

In the first section, I examine the problem of harmful surgery perpetrated by 'bad-apple' surgeons (Paterson, Bramhall, and others) and how contextual challenges when applying the criminal law to a medical setting make it difficult to capture surgical crime. The second section explores the principles of consent and the uncertainty over what constitutes reasonable – and thus unlawful – surgery. My analysis reveals that while we can be sure that lying to patients about a procedure is a criminal wrong, the threshold for sufficient information for valid consent is uncertain and seemingly inadequate to protect patient interests. Similarly, it is far from clear what the threshold for 'reasonable' and thus lawful surgery is. The next section draws from Feinberg's work on consent and the relationship between being *harmed* and being *wronged* in order to present an argument for requiring more than minimal honesty for lawful consent. Finally, I argue that a clearer, less professionally driven concept of 'reasonable surgery' within the criminal law should be established. These arguments point towards the need for a more patient-centred approach, which recognizes the serious harm that can be inflicted under the guise of legitimate surgery as a criminal wrong. The focus should be on the nature of the harm to the victim, the behaviour of the bad-apple surgeon and whether a violation has occurred, rather than on traditional professional standards, which are unduly deferential to the medical profession.

## Harmful surgery and 'bad-apple' surgeons

'To err is human'[9]; even highly competent, well-intentioned surgeons make mistakes. Moreover, sometimes in the absence of mistake, the hoped-for beneficial outcomes of risky surgery do not transpire, leaving patients in a state no better, or sometimes even

8. G Williams, *Textbook of Criminal Law* (London: Stevens & Sons, 1978), pp. 544–545.
9. From the poem, *An Essay on Criticism*, by Alexander Pope, first published in London, 1711.

worse, than before the surgery. This article is not concerned with mistakes, well-intentioned errors of judgement or poor surgical results. Rather, the focus is on surgical abuse that demonstrates criminally culpable behaviour beyond civil negligence and the question of when such misconduct is – and should be – regarded as a potential crime.

Notwithstanding very rare criminal prosecutions, generally, when harmful medical behaviour comes to light, it will (often) be captured by the civil law on negligence[10] and/or disciplinary scrutiny by employers and perhaps also the General Medical Council (GMC). The Medical Act 1858 permits the GMC to determine the terms of professional regulation. The historical regulatory ethos – characterized by Glanville Williams, above – is that the medical profession is best placed to determine the appropriate limits of medical practice, with limited opportunity for external scrutiny.

Dixon-Woods, Yeung, and Bosk have discussed how the collegial model of self-regulation is vulnerable and arguably inadequate when 'bad-apple' doctors pollute the system.[11] They characterize a 'bad-apple' as one failing to deliver on their professional commitment and betraying the trust of both patients and peers, a description that perfectly fits the surgeons discussed here. Regulatory vulnerability arises because self-regulation relies on doctors being inherently altruistic, trustworthy, and motivated only by a desire to act in patients' best interests. When bad-apples flout this expectation, it will not always come to light immediately. Whistle-blowing and patient activism are the main routes to alert the GMC to errant professionals. However, whistle-blowers are likely to experience fear of reprisals,[12] making them reluctant to speak up, and patient complaints are often too readily ignored, as my subsequent discussion illustrates. This can result in dangerous, highly unethical behaviour going unchallenged for long periods.

In the mid-1990s, a series of scandals began to erode the self-regulatory model. Harold Shipman's multiple murders[13] and other scandals led to legal changes addressing abusive medical malpractice. For example, as a result of the organ retention scandal it became an offence to take (store, use, etc.) organs and human tissue without consent, and a criminal offence was created to capture 'ill-treatment or wilful neglect' of patients following the Stafford Hospital scandal.[14] In cases of surgical abuse, as the convictions of Paterson and Bramhall demonstrate, non-fatal offences can be utilized, however, determining when the harm done is a criminal matter is challenging for a number of reasons, which will be examined here. The main reason, articulated by Lord Mustill in *Brown*, is because there is a presumption that no crime has been committed due to the medical exception:

10. *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 and *Bolitho v City & Hackney Health Authority* [1958] AC 232 HL.
11. M Dixon-Woods, K Yeung, C L Bosk, 'Why is UK Medicine No Longer a Self-regulating Profession? The Role of Scandals Involving "bad apple" Doctors', *Social Science and Medicine* 73(10) (2011), pp. 1452–1459.
12. J Lennane, 'What Happens to Whistle-blowers, and Why', *Social Medicine* 6(4) (2012), pp. 249–258.
13. See Dame Janet Smith, *Safeguarding Patients: Lessons from the Past – Proposals for the Future, the Shipman Enquiry* (London: HMSO, 2004).
14. See, respectively, the Human Tissue Act 2004 and sections 20–25 Criminal Justice and Courts Act 2015.

> [M]any of the acts done by surgeons would be very serious crimes if done by anyone else, and yet the surgeons incur no liability . . . proper medical treatment, for which actual or deemed consent is a pre-requisite, is in a category of its own.[15]

As a result of this special 'category', the question of when surgical malpractice crosses the uncertain line between civil and criminal liability is a question rarely considered. When suspicion does arise, because the context in which the harm is done is medical, rather than being obviously hostile or dubious, there can be significant confusion over responsibility and causation; whether the alleged harm was attributable to the patient's condition or was an unfortunate risk or side-effect of the surgery or other supposedly legitimate treatment. Two now infamous doctors, Harold Shipman and Ian Paterson, demonstrated criminal conduct with a clear causal connection between their actions and the harm done, yet before they were prosecuted both men had, for many years, successfully concealed their crimes behind the façade of being a good doctor. Shipman was treating his (usually elderly) patients for their ailments and pain by giving them pain-relieving injections,[16] Paterson was performing breast surgery. With both doctors, it was only when the volume of victims and weight of evidence became impossible to ignore that police and prosecutors took action.

Post *Shipman*, changes to the law on death certification[17] have made it less likely that a murderous doctor would accumulate so many victims before being stopped. Moreover, a patient death following any medical intervention (or failure to intervene) that might have negligently contributed to that death is likely to provoke scrutiny. Rarely, this might lead to a prosecution for GNM. In contrast, there may be limited attention paid to non-fatal surgical harm. All surgery involves some harm – a wound that will need to heal – as an expected consequence. Thus, determining the difference between anticipated and reasonable harm, inflicted for seemingly therapeutic purposes, and surgical violation, is extremely challenging, as the following analysis shows.

Ian Paterson's conviction,[18] for mutilating many patients over a period of at least 13 years, represented a unique application of the criminal law to a case of non-fatal surgical harm. Similarly, although with far less serious consequences, transplant surgeon Simon Bramhall's conviction,[19] for branding the livers of two patients with his initials using an argon gas coagulator, was also a novel prosecution because, ordinarily, consent to surgery within the medical (surgical) exception to the criminal law legitimizes surgical harm.[20] In order to examine these issues and assess how the criminal law has been applied

15. *Brown*, n.2, at 41.
16. While there were multiple reasons why Shipman was not stopped sooner, the doctrine of double effect (see *R v Adams* [1957] Crim LR 365) provides some explanation of how he was able to evade suspicion over so many deaths. And see the *Shipman Enquiry*, Note 11.
17. Part I of The Coroners and Justices Act 2009.
18. *Paterson*, Note 4.
19. *Bramhall*, Note 5.
20. In addition to Brown (n.2), see *Airedale Trust v Bland* [1993] AC 789, 891 HL, *Attorney General's Reference (No 6 of 1980)* [1981] QB 715. For a discussion, see S Fovargue and A Mullock (eds), *The Legitimacy of Medical Treatment: What role for the Medical Exception?* (London: Routledge, 2016).

(or not), I will explore cases involving surgeons who have harmed patients in situations that have either invited criminal liability or were, in my view, suitable candidates for a criminal investigation. The main focus is on *Paterson*, and second on *Bramhall*, with analysis of evidence from court documents and reports from inquiries (into Paterson's malpractice).

## *Ian Paterson*

In April 2017, a jury in Nottingham Crown Court convicted Ian Paterson of 17 counts of wounding with intent to cause GBH and three counts of unlawful wounding.[21] Ultimately Paterson was given a 20-year prison sentence.[22] Alarmingly, Paterson's 10 victims; nine women and one man, have been reported to represent a tiny proportion of all Paterson's alleged victims, a group that might amount to several hundred or more from his many years of practice in the National Health Service (NHS) and private sector.[23] The facts that emerged during Paterson's trial revealed that for many years he performed unnecessary or discredited procedures, such as his so-called 'cleavage sparing' (partial) mastectomies, mutilating patients under the pretence of providing appropriate treatment for breast cancer. Paterson told many patients that they had breast cancer when in fact they were cancer free. Other patients, who did have cancer, were given ineffective partial mastectomies when full mastectomies were needed to remove the cancerous tissue. Consequently, in addition to the many patients harmed by unnecessary and inappropriate surgery, it seems that some patients, who could have been saved, died (or will die) of cancer because of Paterson's inadequate treatment.[24]

Paterson's prosecution only involved victims harmed in his private practice at two Spire hospitals. The prosecution suggested that financial gain was Paterson's primary motive. As a private practitioner, he was *selling* his surgical services and so presumably, in order to sell more, he fabricated information to compel people to undergo the surgeries that he was offering. Having said that, Paterson took a similar approach within his NHS work,[25] which suggests that his motives were complex and perhaps not only fiscal.

In a typical criminal scenario involving, for example, a violent wounding with a knife, the act itself will inevitably satisfy the requirement that the wound was inflicted *maliciously*. Note that 'maliciously'[26] simply means that the accused foresaw that the victim

21. Respectively, under sections 18 and 20, Offences Against the Person Act 1861.
22. Paterson was initially given a 15-year sentence, but on appeal by the AG his sentence was increased to 20 years (see Note 4).
23. A report by think tank, The Centre for Health and the Public Interest; *No safety without liability: reforming private hospitals in England and Wales* (2017) estimates that Paterson's victims from his private practice run to approximately 500. See: https://chpi.org.uk/wp-content/uploads/2017/10/CHPI-PatientSafetyPaterson-Nov29.pdf.
24. See *The Report of the Independent Inquiry into the issues raised by Paterson*, chaired by the Right Reverend Graham James (February 2020), which includes evidence of deceased patients given inadequate treatment (e.g. Patient 53, p.15 and Patient 99, p.28) and patients with a terminal diagnosis (e.g. Patient 148, p.35).
25. Ibid., (e.g. Patient 248, p.43).
26. The *mens rea* for section 20 of the OAPA 1861 is intention or foresight of some harm.

might suffer some harm.[27] In surgery, the *mens rea* for a section 20 offence is always satisfied in a technical sense, for the surgeon intentionally wounds the patient and thus foresees the wound, which is intended (ordinarily) to benefit the patient. Consequently, the usual approach to establishing liability for wounding and/or GBH is obviated by the core principle of the medical exception, which legitimizes consensual 'reasonable surgery'.[28] In order to establish criminal liability in a situation where a surgeon appears to have harmed a patient in way that might be criminal, the surgery must sit outwith the medical exception, because there was no consent and/or because the surgery was not 'reasonable surgery'.[29] In *Paterson*, the prosecution concentrated on consent and whether the information supplied to patients was responsible, rather than considering the question of whether the surgery itself was reasonable.

Consent to medical treatment – after being informed about the risks and benefits in reasonably accurate and honest terms – is a necessary, but not sufficient (because the procedure must also be 'reasonable'[30]) legal requirement. Treatment without consent may be a criminal assault,[31] a civil battery,[32] and a violation of one's bodily integrity.[33] The main principles were established in *Chatterton v Gerson*,[34] which indicated that *information in broad terms about the nature and purpose of the procedure* suffices for valid consent, thus avoiding a civil battery or criminal assault. With only limited authority as to the clear threshold for lawful consent, common law principles suggest that only a complete failure to tell the patient what is proposed, or active deception – lying to the patient, rather than neglecting to impart important information – will place the doctor at risk of criminal prosecution.

Paterson's victims all signed consent forms but the consent was based on false information, either regarding the nature of the procedure or the diagnosis. The prosecution's case was that the false information patients were given meant that they had not given valid consent. Paterson's defence was that he believed the information to be reasonably accurate and appropriate and so the consent supplied was sufficient to avoid criminal consequences, or indeed a civil action for battery. In the closing direction, the judge sought to navigate the jury through the maze of legal issues by providing them with a 'route to verdict', asking them to consider three questions in order to determine whether Paterson was guilty:

27. See *R v Savage, R v Parmenter* [1992] 1 AC 699 (HL).
28. *Brown*, Note 2.
29. Ibid.
30. *R v Brown*, Note 2.
31. *R v Tabassum* [2000] Lloyd's Rep Med 404, CA.
32. *Chatterton v Gerson* [1981] 1 All ER 457. For a helpful discussion of the principles, see E Cave, 'Valid Consent to Medical Treatment' *JME*. Epub ahead of print 23 June 2020. DOI: 10.1136/medethics-2020-106287.
33. Article 8 European Convention on Human Rights also offers protection against non-consensual treatment, for example, see *Glass v UK* [2004] 1 FLR 1019, ECtHR.
34. *Chatterton*, (Note 32). There are very few cases from which to derive clear principles, *R v Clarence* ((1888) 22 QBD23), however, suggests that the patient must be deceived as to the very nature of what was to be done.

1. For each allegation, was the patient's consent based on advice which no responsible body of duly qualified and experienced breast surgeons would have given?[35]
2. If the answer to question 1 is 'no', they must return a not guilty verdict, but if it is 'yes', the second question is *whether the accused knew* that no responsible body of duly qualified and experienced breast surgeons would have given that advice?
3. If the answer to that question is 'no', they must return a not guilty verdict, but if it is 'yes', the final question is whether the accused intended to cause GBH? (And, because it was clear that the accused did *intend* to perform the surgery, whether the harm caused did amount to really serious harm/GBH?).[36]

Returning their verdict, the jury answered yes to the first two questions for all charges. For the third question, they answered yes for 17 charges and for three they answered no. In these three instances Paterson was convicted of the less serious offence of unlawful wounding,[37] rather than inflicting GBH.

Reflecting on *Paterson*, the first question in the route to verdict uses language usually deployed in civil negligence,[38] with the second question asking whether the defendant was aware his conduct fell outside the parameters of responsible professional practice. With no criminal precedent involving a surgical non-fatal offence to guide the court, drawing from civil principles seems appropriate. However, the lack of relevant criminal precedent means that it is debatable whether this is indeed the best way to fill the legal lacuna. I return to this issue later when examining the meaning of 'reasonable surgery'.

Ultimately, the jury rejected Paterson's account that he believed he was acting in the patient's best interests. Often the parameters of what is responsible, and thus reasonable according to the *Bolam* principle,[39] may be fluid, and before the verdict, it is important to note that Paterson's evidence, together with several favourable accounts of his work as a surgeon put forward in his defence,[40] had cast doubt over his liability. The extent to which any doctor has kept up to date with the prevailing professional consensus over what is *good* or, as a minimum threshold *reasonable*, medical practice has traditionally been a matter of individual conscience, guided by the GMC[41] and scrutinized only when things go wrong.[42] Paterson's abuse predates the revalidation scheme,[43] which was

35. This question uses civil law negligence principles from *Bolam*, Note 10.
36. On file with the author.
37. Section 20 OAPA 1861.
38. *Bolam*, n.10.
39. *Bolam*, n.10.
40. Paterson was described as charismatic and popular with patients, and some patients were very grateful and satisfied with his surgery. See also *The Paterson Inquiry* (above Note 25) which includes evidence of happy patients (e.g. Patient 341, p.13 and Patient 299, p.25) and evidence that Paterson was well-regarded by some peers (e.g., see GP evidence N377, p.214 and Clinical Manager evidence N430, P100).
41. The GMC provides guidance on 'Good medical Practice', see: https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice.
42. For example, scrutiny by the civil courts; see *Bolam, Bolitho* (Note 10), and in relation to disclosure; *Montgomery v Lanarkshire Health Board* [2015] UKSC 11.
43. Revalidation, introduced in 2012, requires doctors to demonstrate that they are fit to practice at least every 5 years in order to retain a medical licence. See GMC Guidance on Revalidation,

introduced in 2012 in response to *Shipman*, although since Paterson was able to evade disciplinary attempts to curtail his abuse of patients over the period in question (1998 to 2011), it seems unlikely that revalidation would have prevented him.[44]

The Kennedy Report, which examined Paterson's NHS practice, revealed a dangerous culture in which hierarchical attitudes, bullying, and professional arrogance were permitted to flourish.[45] Within his private practice, those responsible at Spire failed to scrutinize Paterson's activities on the basis that as a self-employed surgeon, he was merely 'renting a room' and so was personally responsible.[46] Moreover, his employment as an NHS consultant was taken as sufficient evidence that he was a safe surgeon.

*Paterson* is an exceptionally serious example of surgical crime, yet according to the *Paterson Inquiry*, '[I]t is our opinion that it would be unwise to dismiss him as a one-off, given the evidence we have heard'.[47] Reports of serious surgical malpractice investigated by the GMC indicate that such malpractice is not as rare as we might hope, though other surgeons accused of harming patients in similar circumstances in the United Kingdom,[48] discussed later, have escaped criminal liability unless the harm proved fatal. Simon Bramhall,[49] however, also found himself in the criminal dock although for a much less serious offence.

## *Simon Bramhall*

No tangible *physical* harm or injury was caused to Bramhall's victims when he branded their livers during transplant surgery, but one victim has suffered serious emotional trauma and is convinced (wrongly, according to the medical view discussed by the court) that the branding caused her new liver to fail.[50] Colleagues within Bramhall's surgical team were aware that he liked to brand patients. It was reported to the court that when one of the surgical nurses noticed what he was doing during surgery, Bramhall said, 'I do this'.[51] Yet no one spoke up and it was not until later, after complications meant that one

available at: https://www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation/guidance-on-supporting-information-for-appraisal-and-revalidation.

44. According to the clinical panel in the *James Inquiry* (above Note 25), revalidation is a 'paper exercise' that adds little to professional appraisals, see p.123.
45. See *Solihull Hospital Kennedy Breast Care Review* (2013) by Professor Sir Ian Kennedy. Available at: https://hgs.uhb.nhs.uk/wp-content/uploads/Kennedy-Report-Final.pdf.
46. See the *James Report* (Note 25). Also, Spire commissioned an independent review by Veritas into Paterson's abuse. See Verita, *Independent Review of the governance arrangements at Spire Parkway and little Aston hospitals in light of concerns raised about the surgical practice of Mr Ian Paterson*, (2014).
47. Above Note 23, p. 216.
48. Note that in Australia (*Reeves v The Queen* [2013] HCA 57), a surgeon was convicted of GBH. In the United States, the offence of maim has been used for surgical harm (see S Young, 'Dallas doctor gets life in prison for maiming patients', *Dallas Observer*, 21 February 2018).
49. Above, Note 5, and see Simon de Bruxelles, 'Surgeon Who Burnt Initials on Patients' Organs Admits Assault', *The Times*, 14 December 2017, https://www.thetimes.co.uk/article/simon-bramhall-surgeon-who-burnt-initials-on-patients-organs-admits-assault-vmr5n27rl.
50. See the Sentencing Remarks of Farrer J, Birmingham Crown Court, 12 January 2018 (on file with author).
51. Ibid.

of the marked livers had to be removed, that the initials 'SB' were discovered. In the investigation that followed, a second branding emerged when colleagues who had witnessed Bramhall's actions gave evidence. The fact that none of Bramhall's colleagues voiced a concern before the rejected liver revealed his crime, illustrates the reluctance within such surgical teams to challenge or speak out against surgeons who appear to be abusing their surgical privilege.

The discovery of Bramhall's liver branding led to a dubious legal first with his conviction (after a guilty plea) for two counts of 'assault by beating', to reflect the marking of the liver.[52] At the sentencing hearing in Birmingham crown court in January 2018, Judge Paul Farrer QC described Bramhall's crimes as examples of 'professional arrogance'.[53] Bramhall was fined £10,000 and ordered to undertake 120 hours of community service.

At his fitness to practise hearing, the Medical Practice Tribunal (MPT) held that while neither conviction raised any current issues regarding patient safety, the serious breach of 'Good Medical Practice' necessitated a 5-month suspension in order to maintain public confidence.[54] The GMC successfully appealed the MPT decision on the grounds that a 5-month suspension is insufficient to maintain public confidence in the profession and/or proper standards and conduct for the profession.[55] The High Court held that the MPT did not do enough to assess Bramhall's conduct and so did not do full justice to the case. It now falls upon a differently constituted MPT to reconsider the case with a clear signal from the court that a 5-month suspension is insufficient.

Bramhall's actions involved very deliberate action and a clear objective (to brand patients), whereas Paterson's conduct demonstrated a more complex pattern of behaviour with a less identifiable motive, which seemingly made it more challenging for the prosecution to establish his guilt. Both men, however, clearly disregarded the welfare and autonomy of vulnerable patients, and both surgeons demonstrated a high level of professional arrogance, which, as the following discussion illustrates, appears to be a feature of cases involving abusive surgeons.

## *Other surgeons accused of misconduct*

This section examines other examples of serious surgical malpractice. Walshe and Chambers have observed how Paterson's case follows a tragic theme of abuse and scandal within medicine:

> To anyone who is familiar with the litany of medical failures and scandals of the past two decades – Rodney Ledward, Richard Neale, Dick van Velzen, James Wisheart, Harold Shipman and several others – the Paterson case will seem depressingly familiar. Once again we see a

52. Section 39 Criminal Justice Act 1988; common assault with battery.
53. Ibid. See also, 'Surgeon Fined £10,000 for Branding Patients' Livers' (*The Times*, Saturday 13 January 2018).
54. MPTS Public Record, 2/12/20-4/12/20, 14/12/20, GMC no: 3358940.
55. *The GMC and Professional Standards Authority for Health and Social Care v Simon Bramhall* [2021] EWHC (2109) (Admin).

> charismatic, powerful doctor whose incompetence, misconduct and criminal behaviour went unchecked for years, in healthcare organisations where senior leaders know what was going on but did not act.[56]

Some of those mentioned involved surgical malpractice. Obstetrician and gynaecologist, Rodney Ledward (deceased), was struck off by the GMC after he botched 13 operations in the 1980s and 1990s in circumstances similar to Paterson.[57] A second gynaecologist, Richard Neale, was struck off in 2001 after seriously harming 12 women. Neale's misconduct was discussed in the House of Commons by William Hague (Member of Parliament (MP)), who called (unsuccessfully) for a public enquiry.[58] Previously, Neale had been struck off the Canadian medical register after the deaths of two of his patients. Despite this, after his return to the United Kingdom in 1985, the GMC allowed his registration. As with Rodney Ledward, no criminal charges were brought against Neale in the United Kingdom in spite of compelling evidence that he demonstrated reckless malpractice in seriously harming many patients.

A further UK case worth highlighting is that of Stephen Walker.[59] In 2004, after a series of botched operations, which seriously harmed and killed a number of patients between 1995 and 1998, Walker admitted the GNM of Dorothy McPhee (in 1995) and was given a 21-month suspended sentence. It took almost 20 years to bring Walker to trial and but for the death of Dorothy McPhee it seems very unlikely that Walker would have found himself in the criminal dock. Until *Paterson*, it appeared that GNM was the only offence applicable to dangerous surgeons. This highlights criticisms of scholars such as Smith[60] and Brazier and Ost,[61] regarding moral luck over consequences within the criminal law, which, prior to *Paterson* and *Bramhall*, has only been engaged when the unfortunate victim died.

My final example involves cosmetic surgery. Harm caused by botched surgery within the private cosmetic surgery industry has been identified as a serious public health problem.[62] The case of Denise Hendry, who eventually died as a result of abdominal liposuction carried out by a Swedish surgeon, Gustaf Aniansson,[63] illustrates the problem.

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56. K Walshe and N Chambers, 'Clinical Governance and the Role of NHS Boards: Learning Lessons from the Case of Ian Paterson', *BMJ* 357 (2017), p. 2138.
57. See J Hartley-Brewer, 'Downfall of Surgeon Who Ruined Lives', *The Guardian*, 2 June 2000, https://www.theguardian.com/uk/2000/jun/02/juliahartleybrewer. Note that Ledward was also accused of rape, but never prosecuted.
58. Hansard HC Deb 31 January 2002, vol 379 cc520-34.
59. See BBC 'Killer surgeon Stephen Walker withdraws bid to return as doctor', 12 November 2013: https://www.bbc.co.uk/news/uk-england-lancashire-24913970.
60. Smith, 'The Element of Chance in Criminal Liability'.
61. M Brazier and S Ost, *Medicine and Bioethics in the 'Theatre' of the Criminal Process* (Cambridge: Cambridge University Press, 2013), see chapter 3.
62. See the report of the Committee established by Sir Bruce Keogh on the *Review of Regulation of Cosmetic Interventions* (April 2013), commissioned by the Government in response to the Poly Implant Prothese (PIP) breast implant scandal. And see Nuffield Council on Bioethics, *Cosmetic Procedures: Ethical Issues*, (2017), available at: http://nuffieldbioethics.org/wp-content/uploads/Cosmetic-procedures-full-report.pdf.
63. See 'Denise Hendry's daughter calls for tighter cosmetic surgery regulation', *The Guardian*, 15 February 2012, https://www.theguardian.com/lifeandstyle/2012/feb/15/denise-hendry-cosmetic-surgery-regulation.

Botched liposuction perforated Mrs Hendry's bowel, causing an almost immediately fatal injury. She survived after life-saving NHS surgery, though she never fully recovered and after several years of poor health, Mrs Hendry died from a brain infection caused by her abdominal injuries. Aniansson fled the United Kingdom immediately after the surgery.[64] Within cosmetic surgery, the therapeutic justification for operating is often absent; the patient does not *need* the surgery, but rather *wants* it for aesthetic reasons, which has prompted concern over the risks.[65] A number of scholars have questioned the legal and ethical implications; Baker, for example, has examined the concept of reasonable surgery within cosmetic surgery.[66] He argues that certain very invasive procedures, such as non-therapeutic breast augmentation, are fundamentally unreasonable because they are risky, often harmful, and should not be accepted as lawful within the medical exception. While Baker's concerns are well-founded, his argument (that all such surgery should be regarded as unlawful) overlooks the potential benefits if carried out responsibly and ethically by a skilled surgeon. A second consideration is that prohibition might encourage people to seek treatment in a black market or in a more permissive jurisdiction.[67] It is, however, evident that (private) cosmetic surgery, which is a poorly regulated industry, results in preventable harm to a significant minority of clients.[68]

The dangerous surgeons I have identified appear to be part of a larger group. Medical scandals regularly come to public attention in reports that highlight the abuse of surgical privilege.[69] Such reports suggest that the problem is a significant public health concern which sits within wider concerns about patient safety and preventable harm. Uncertain principles cloud the picture, limiting the opportunity to scrutinize bad-apple surgeons. Brazier and Cave have observed that 'there remains a question of whether any maverick or extreme surgery may be beyond the privilege usually accorded to medicine and

64. Ibid.
65. See the *Keogh Review* and the *Nuffield Council on Bioethics Review*, Note 62.
66. D Baker, 'Should Unnecessary Harmful Nontherapeutic Cosmetic Surgery be Criminalized?' *The New Criminal Law Review* 17(4) (2014), pp. 587–630.
67. D Griffiths and A Mullock, 'Cosmetic Surgery: Regulatory Challenges in a Global Beauty Market', *Healthcare Analysis* 26(3) (2018), pp. 220–234.
68. See *Keogh* and the Nuffield Report, n.62.
69. For example, Cosmetic surgeon Arnaldo Paganelli was struck off by the GMC in 2020 for practicing without insurance after botched surgery left his victims with no redress (see *BMJ* 2020;370:m3231). Surgeon Michael Walsh has been investigated, see D Campbell, 'Doctor Who Worked at Same Firm as Ian Paterson Accused of Botched Operations', *The Guardian*, 16 February 2020; Roger Bainton has been struck off for harming patients; see C Dyer, 'Oral Surgeon Whose Misconduct Was "serious, persistent and shocking" is Struck Off', *BMJ* 356 (2017), p. j4255; Anthony Dixon has been investigated for harming many women, see H Devlin, 'Scores of Women Say Top Surgeon Left Them with Traumatic Complications', *The Guardian*, 24 November 2017; Lawal Haruna has been struck off, see C Dyer, 'Surgeon Struck Off After Three "never events," *BMJ* 357 (2017), p. j2359; finally, Sam Elijimel, former Head of Neurosurgery at Tayside NHS, was permitted to leave the medical register to avoid being struck off after harming many patients, see C Dyer, 'Surgeon Allowed to Leave the Register without Being Investigated', *BMJ* 351 (2017), p. h4663. Elijimel has since been investigated by the police and is now working abroad.

surgery'.[70] This alludes to novel or experimental surgery, but the central concern is that a high level of professional autonomy appears to be permitted, which can be detrimental to patient welfare when 'bad-apples' abuse their privilege. In the next section, the legal doctrines are examined in more depth in order to gain a better understanding of what constitutes unlawful surgery and the limits of 'reasonable surgery'.

## Consent to 'reasonable' surgery

The principle that consensual surgery carried out by qualified professionals is legitimate (proper medical treatment)[71] means that when surgery does lead to non-fatal harm, there might be grounds for a negligence claim but, until *Paterson*, it seemed that only death would invite a criminal investigation (for GNM). There are, however, exceptions to the presumption that consensual surgery is lawful. Regardless of consent, surgery that constitutes Female Genital Mutilation (FGM) is a crime.[72] Similarly, consensual *surgical* procedures carried out by a person without a medical licence in pursuit of 'body modification' are unlawful.[73] Both examples, however, place such activity outwith the realm of *surgery*, either because of the nature of the intervention (mutilation) or because only surgeons may perform *surgery*. Accordingly, what constitutes unlawful *surgery* is unclear. In order to examine how the ambiguous principles have evolved, this section examines the parameters of consent, and the principle of 'reasonable surgery' within the criminal law. I then consider the question of whether reasonable surgery should be therapeutic.

The case of *R v Brown*,[74] which involved the infliction of consensual sadomasochistic harm, set out the legal position on consent to non-fatal harm. Previously, as Lewis has discussed,[75] although there was no authority for the medical exception, the 'truth of the exception' was directly linked to professional status.[76] The House of Lords in *Brown* confirmed that as a general principle, consent does not provide a defence to those who consensually inflict actual or serious (grievous bodily)[77] harm on another. Certain consensual harms, however, may be regarded as legitimate if the harm occurs as a result of parental chastisement, reasonable surgery, reasonable body adornment such as tattooing or piercing,[78] properly conducted sport, or reasonable 'horseplay'.[79]

The *Brown* ruling has been criticized for introducing an inappropriately moralistic theme to the law.[80] The medical exemption of 'reasonable surgery', however, sits apart

70. M Brazier and E Cave, *Medicine, Patients and the Law*, 6th ed. (Manchester: Manchester University Press, 2016), at 124.
71. For discussions of relevant principles, see S Fovargue and A Mullock (eds), above Note 21.
72. The Female Genital Mutilation Act 2003.
73. *R v BM* [2018] EWCA 560.
74. *R v Brown* [1993] 2 All ER 75, HL.
75. Lewis, 'The Medical Exception', pp. 355–376.
76. Ibid., p. 355.
77. Amounting to ABH under section 47 or GBH under sections 20 and 18 Offences Against the Person Act 1861.
78. Following *Brown*, the case of *Wilson* [1997] Q.B. 47 confirms the body adornment exception.
79. For example, see *R v Jones* (1986) 83 Cr. App. R. 375.
80. For example, see L Bibbings and P Alldridge, 'Sexual Expression, Body Expression and the Defence of Consent', *Journal of Law and Society* 20(3) (1993), pp. 356–370.

from the other exceptions because it is socially vital. The social value of allowing doctors to lawfully perform surgery and other potentially harmful medical interventions is unquestionable.[81] Moreover, while the question of what constitutes reasonable horseplay or body adornment will be determined after judicial consideration of the context and nature of the harm perpetrated,[82] the question of what constitutes reasonable surgery has traditionally been a matter of professional surgical opinion and discretion.[83] As Ost observed, when legal questions arise, 'medicalisation has resulted in the medical profession having significant influence on the judicial interpretation of aspects of the criminal law when applied to procedures that are, or might be, medical'.[84] While this approach has a practical appeal that has no doubt benefitted many patients, it also carries the risk of placing too much power in the hands of those perpetrating the harm.

*Reasonableness*, in the context of surgical harm, has traditionally been a private matter of compensation and not a criminal matter. Most cases concerning consent involve only civil liability, a negligent failure to sufficiently inform the patient about the material risks of the treatment and any alternatives, as illustrated in *Montgomery v Lanarkshire*.[85] As the court asserted in *Montgomery*, 'patients are now widely regarded as persons holding rights rather than as the passive recipients of the care of the medical profession'.[86] Thus, patients should be fully informed of the nature, risks, and any alternatives to a particular intervention. Heywood and Miola have suggested that *Montgomery* has diminished the potential for paternalism and the abuse of professional power (within civil law).[87] Certainly, it is clear that *Bolam* no longer rules; *Montgomery* was a victory for patient autonomy in cases of negligent consent. Yet Cave and Milo have examined how *Bolam* unfortunately continues to pervade other legal questions about medical conduct.[88] This was clearly illustrated in *Paterson*, and although he was convicted, the principles applied perpetuated the theme of deference to the medical profession. The legal tradition of determining liability by reference to what is objectively acceptable according to the profession is well established in GNM,[89] but also in *Paterson*, recall that the jury were first asked to consider whether his advice was such that 'no responsible body of duly qualified and experienced breast surgeons would have given'.[90] The question of his

81. See A Ashworth, 'Criminal Liability in a Medical Context: The Treatment of Good Intentions', in A Simester and A Smith, eds., *Harm and Culpability* (Oxford: Clarendon Press, 1996), pp. 173–193.
82. See *Wilson* (Note 78) and *Jones* (Note 79).
83. *Bolam*, Note 10.
84. S Ost, 'The Medical Profession as Special before the Criminal Law', in A Bogg, J Collins, M Freedland and J Herring, eds, *Criminality at Work*, (Oxford: Oxford University Press, 2020), p. 298.
85. *Montgomery v Lanarkshire Health Board* [2015] UKSC 11.
86. Ibid., at 75.
87. See J Miola and R Heywood, 'The Changing Face of Pre-operative Medical Disclosure: Placing the Patient at the Heart of the Matter', *Law Quarterly Review* 133 (2017), pp. 296–321.
88. E Cave and C Milo, 'Informing Patients: The *Bolam* Legacy', *Medical Law International* 20(2) (2020), pp. 103–130.
89. See *Adomako* and *Rose*, Note 1.
90. Above 'route to verdict', Note 36.

criminal liability, however, rested upon whether Paterson had known that his advice was not responsible. Thus, according to the flimsy principles available,[91] while actively deceiving a patient will land a surgeon in the criminal dock, purposefully neglecting to inform a patient of even very important risks, will almost certainly be regarded a civil matter.[92] This suggests that surgeons are exercising too much power under paternalistic legal principles which prioritize professional power and interests over patient welfare and autonomy. The doctrines have not evolved in line with other legal changes that promote consent, or indeed the wider prioritization of individual autonomy in society.[93]

The Law Commission have investigated the principles of consent to medical treatment, suggesting that the exemption to the criminal law does not turn on consent, but rather the *purpose* for which the treatment is administered[94]; the implication being that the purpose must be therapeutic in order to be lawful regardless of whether consent was adequate.[95] The meaning of *therapeutic* in the traditional medical sense indicates a curative intervention to treat a disease or condition. There is, however, considerable professional discretion as to what constitutes an appropriate and reasonably therapeutic intervention, particularly in the private sector. Thus, the question of whether 'reasonable' means that there should be a *reasonably therapeutic* purpose to lawful surgery is crucial.

## *Does 'reasonable' mean reasonably therapeutic?*

From a practical perspective, public funding for surgery (within the NHS) is available only on therapeutic grounds,[96] which covers most surgery in the United Kingdom. With respect to the law, courts have inferred that legitimacy rests upon any harm being a consequence of a therapeutic intervention; for example, the case of *Bland*[97] confirmed that bodily invasion for *therapeutic* medical purpose is in a special category of legitimate harm, that is, 'proper medical treatment', which stands outside the criminal law. However, in practice, it is not clear that legitimacy is conferred only when surgery is therapeutic.

Penney Lewis's work, examining how the medical exception regulates medical and surgical practice,[98] addresses the question of what might be construed as a reasonable surgical intervention. Lewis identifies three public policy justifications. The first two of these relate to Williams' categorization ('therapy, charity . . . experiment'[99]) cited in my

91. *Tabassum* (Note 31) and *Chatterton* (Note 32).
92. *Montgomery*, Note 85.
93. For example, in human rights law (Article 8 European Convention Human Rights).
94. Law Commission, *Criminal Law; Consent and Offences Against the Person: A Consultation Paper*, No 134 (HMSO, 1994) para. 2.4, and; *Criminal Law; Consent and in the Criminal Law: A Consultation Paper*, No 139 (HMSO, 1995). For a critique, see P Alldridge, 'Consent to Medical and Surgical Treatment', *Medical Law Review* 4(2) (1996), pp. 129–143.
95. Ibid., para. 8.5.
96. For example, cosmetic surgery is only available on the NHS in order to treat 'health problems', such as breathing difficulties (i.e. rhinoplasty) or serious psychological distress. See: https://www.nhs.uk/conditions/cosmetic-procedures/cosmetic-procedures-on-the-nhs/.
97. *Airedale NHS Trust v Bland* [1993] AC 789, 891, HL.
98. P Lewis, Note 75.
99. G Williams, Note 8.

introduction. The first is a patient-focused justification; that the procedure is beneficial for the patient because it is therapeutic. The second may be broadly understood to serve a legitimate public interest, such as live kidney donation or medical research on healthy volunteers. Thus, even if the intervention is not therapeutic for the patient, it will serve other important personal interests or wider public interests, which render it reasonable. For example, live kidney donation is legally justified provided that consent is fully informed and freely given,[100] in order to save or improve the life of another.

The third and for present purposes, the most important justification identified by Lewis is a professionally focused validation, which engages with notions of *who* may perform medicine and what is *reasonable* or *necessary* according to professional opinion. This third justification is crucial because it suggests that professional opinion is a legitimizing condition irrespective of whether the surgery is therapeutic and (until *Paterson*) regardless of whether the patient is harmed. As my preceding analysis demonstrated, while status (as a qualified doctor) is clearly an essential requirement for surgical privilege, arguably it should not be a sufficient condition to impart legitimacy when the surgery is demonstrably objectively unreasonable and harmful.

The requirement that only medically qualified persons may perform 'surgical procedures' was recently tested.[101] Tattooist and body piercer, Brendan McCarthy, was prosecuted for GBH and/or wounding under the OAPA 1861 after he performed body modifications on three clients: removing an ear, removing a nipple and tongue splitting to achieve a reptilian effect.[102] McCarthy sought to persuade the court that his actions were a simple expansion of what ought to be considered a permissible 'body adornment'. The Crown, however, rejected that expansion and instead likened the modifications to cosmetic surgery, stating that the defendent had conducted 'a series of medical procedures for no medical reason'.[103] The Court of Appeal agreed and so dismissed the appeal, stating,

> The appellant's argument envisages consent to surgical treatment providing a defence to the person performing the surgery whether or not that person is suitably qualified as a doctor, and whether or not there is a medical (including psychological) justification for the surgery.[104]

The court highlighted the lack of 'medical (including psychological) justification' for the procedures, suggesting that therapeutic justification *and* professional status are essential for legitimacy. However, we know that not all surgery is performed for therapeutic purposes. Commercial cosmetic surgery might be regarded as a highly medicalized form of body modification, in which surgeons adapt/enhance physical features for purely aesthetic purposes. Clinically evident psychological distress is not an essential condition in order to legitimize surgical enhancement. Qualified doctors are free to sell cosmetic surgery within

100. Human Tissue Act 2004.
101. *R v BM* [2018] EWCA Crim 560.
102. The preparatory ruling, under section 31(3) Criminal Procedure and Investigations Act 1996, was made by Judge Nawaz following a hearing on 29 September 2017 at Wolverhampton Crown Court.
103. *BM*, above Note 101, at 42.
104. Ibid., at 45.

a relaxed regulatory environment, which, according to Latham, does not do enough to protect vulnerable people.[105] Pitts-Taylor describes this as, 'a purchase, characterised by the rhetoric of fashion, consumption and self-presentation rather than medical or psychological necessity'.[106] Numerous reports of mutilating surgery within the commercial sector, which is 'big business', suggest that some surgeons are abusing surgical privilege.[107] As Baker and others have argued,[108] much of the work carried out by cosmetic surgeons in the private sector could not be therapeutically justified. While GMC guidance urges cosmetic surgeons to carefully consider the risks to the patient,[109] recent research suggests that many in the commercial cosmetic surgery industry are flouting GMC guidance.[110] Moreover, the evidence that a significant amount of harm caused by botched cosmetic surgery must later be dealt with by the NHS is well documented,[111] and was tragically illustrated by the harm done to Denise Hendry, discussed earlier.

Brazier and Fovargue have also explored this issue within their examination of 'proper medical treatment'.[112] They argue that attempting to understand the principles, including whether medical treatments must be therapeutic to be lawful (*proper*), results in a circular exercise because 'all roads lead us to the medical profession . . . which may, on occasion, leave patients unprotected'.[113] Brazier and Fovargue considered whether the resurrection of maim[114] (also previously discussed by Elliot)[115] might offer a solution to

105. M Latham, '"If it Aint't Broke, Don't Fix It?": Scandals, "risk," and Cosmetic Surgery Regulation in the UK and France', *Medical Law Review* 22(3) (2014), pp. 384–408.
106. V Pitts-Taylor, 'Becoming a Cosmetic Surgery Patient: Semantic Instability and the Intersubjective Self', *Studies in Gender and Sexuality* 10(3) (2009), p. 122.
107. See the Keogh Report and the Nuffield Bioethics Council Report (n.63). In 2016, MP Kevan Jones unsuccessfully attempted to pass a private members bill restricting the commercial selling of cosmetic surgery (see Hansard, 19 October 2016, Vol 615, Column 819). Also, several TV shows examine evidence of 'botched' cosmetic surgery, such as 'Botched Up Bodies' and 'Celebrity Botched Up Bodies', Channel 5.
108. Baker (above Note 67), and see D Griffiths and A Mullock, 'The Medical Exception and Cosmetic Surgery' in Fovargue and Mullock (eds), (above Note 21).
109. GMC, *Guidance for Doctors Who Offer Cosmetic Interventions*, 2016, available at: https://www.gmc-uk.org/-/media/documents/Guidance_for_doctors_who_offer_cosmetic_interventions_210316.pdf_65254111.pdf. Guidance states that doctors should consider patients' psychological needs, consult the patient's GP if necessary, regarding risks and benefits, and allow patients time to reflect and change their minds before personally taking consent (rather than delegating consent-taking).
110. See Keogh and Nuffield Council Reports, (n.62).
111. Ibid.
112. M Brazier and S Fovargue, 'Transforming Wrong into Right: What is "proper medical treatment"?', in S Fovargue and A Mullock (eds), (Note 21).
113. Ibid., p. 3.
114. Maim is a serious, disabling injury that would prevent the victim from fighting for their country. Maim has recently been used in the US; see the case of Texan surgeon Christopher Duntsch (so-called 'Dr Death', see: https://nypost.com/2017/02/16/dr-death-surgeon-convicted-of-maiming-elderly-patient/).
115. T Elliot, 'Body Dysmorphic Disorder, Radical Surgery and the Limits of Consent', *Medical Law Review* 17(2) (2009), pp. 149–182,

the problems of the OAPA. Noting the uncertainty over the status of maim,[116] they suggest that it might serve to delineate the limits of the medical exception; 'for example, cosmetic surgery even of a highly invasive and risky nature might be lawful but limited from the point it risked permanent disabling injury'.[117] This suggestion has some merit and would avoid some of the problems with applying sections 18 and 20 OAPA. The problem, however, is that maim requires a serious, disabling injury, which would preclude less serious injury. This might invite similar criticisms to GNM and the element of chance – whether the victim survives or not – and moral luck regarding consequences,[118] rather than fully assessing what the accused has actually done and their moral culpability.

I have examined how the medical exception, coupled with appropriate consent (honest information in broad terms),[119] creates a shield of immunity between surgeons and criminal liability. *Paterson* demonstrates that there are ultimately limits to the immunity shield, but it seems to go too far in providing immunity to dangerous surgeons. Should the shield operate regardless of whether qualified doctors have provided sufficient information about the risks of treatment, or whether the harmful surgery is therapeutic? The influence of the medical profession may now be waning within the civil law, as seen in the approach to negligent consent, yet the power of the medical profession to direct questions of legitimacy according to a professional agenda may be leaving the door to abuse open. The next section considers how this problem could be addressed by shifting criminal consent principles to a more patient-centred approach.

## Questioning the parameters of consent

The requirement for only minimal information coupled with honesty for valid consent means that when patients are given honest yet inadequate information, or a surgeon purposefully omits to impart information, it appears to be merely a civil matter regardless of the harm inflicted. Arguably, however, inadequate or misleading consent should potentially, depending on the circumstances, lead to a criminal prosecution in the event that the patient suffers harm. With this in mind, Feinberg's work on the harm principle[120] and the role of consent provides a useful distinction between being harmed and being wronged.[121]

In *Harm to Others*, Feinberg identifies two types of harm: harm as a setback to (welfare) interests, which would not necessarily constitute a *wrong*, and harm as a wrong to another.[122] Applying this to (reasonable) surgery, while the patient is necessarily harmed

116. *Brown* (Note 2) indicated that maim is no longer a valid offence in English law.
117. Brazier and Fovargue, (Note 112) at 31.
118. J C Smith, 'The Element of Chance in Criminal Liability', p. 63.
119. *Chatterton v Gerson*, Note 32.
120. The Harm Principle derives from the work of J S Mill, (*On Liberty*, first published in 1859), in which Mill advocated that only acts which harm others ought to be criminalized.
121. See Joel Feinberg, *The moral limits of the criminal law, Volume 1, Harm to others, Volume 2, Offense to others, Volume 3, Harm to self*, (1986), *Volume* 4, Harmless wrongdoing (1988) Oxford University Press.
122. Ibid.

as a means to perform the procedure, they are not wronged, because they have consented and also because, ultimately, the surgery is intended to be, and usually will be, beneficial. Feinberg suggested that only harms that are also wrongs should be criminalized, that it is the 'overlap of harming and wronging' that invokes the harm principle.[123] In *Brown*, for instance, the sadomasochism participants were harmed, but they were not (morally) wronged because they sought and consented to their injuries. The same might be true of the body modification clients in *BM*.[124]

Thus, Feinberg advocates placing greater reliance on consent as a legitimizing principle; *volenti non fit injuria*, so that one who has genuinely consented to be harmed has not been wronged. On this basis, consent legitimizes surgery, but if we consider the low threshold for lawful consent in criminal law,[125] there is an argument that we ought to reflect more carefully on the nature of consent for surgery in order to respect, 'the absolute priority of personal autonomy'.[126] If the patient is in precarious health and needs the surgery, choice is constrained and patients may be reluctant to question a surgeon who seems to be offering a therapeutic intervention. The patient is unlikely to be informed of the details of the procedure and, if they were told, they might not understand. Assuming a general anaesthetic precedes surgery, the patient cannot stop or pause the procedure once it has begun. Consequently, unlike other consensual harmful activities, such as boxing or having a tattoo, consent cannot be withdrawn once surgery has commenced, it is necessarily a 'before the event' decision. Of course, it is implausible to suggest that patients must understand the precise details of a procedure in order to consent, or that the temporary loss of capacity during the general anaesthetic is avoidable. Nevertheless, both these aspects of the therapeutic interaction highlight how the patient is particularly vulnerable. Their ability to autonomously exercise control over what happens to their body, to consent in a truly autonomous fashion, is restricted.

An additional concern arises if the surgery is cosmetic rather than therapeutic. Factors such as depression associated with body dysmorphia[127] may affect the patient's ability to balance the risks and benefits of the surgery. In the private sector, there may be a reluctance to impart full information about risks and results because the truth might discourage the sale. Unless the surgeon (and others dealing with the client) is able to separate the primary commercial purpose of the enterprise from the ethical obligation to the potential patient, the temptation to *sell* the surgery might undermine the therapeutic obligation to warn of risks and poor results.

In addition to the implications for patient welfare and personal autonomy, a person's bodily integrity may be violated by harmful surgery. As Herring and Walle have examined,[128] there is a distinction between the right to autonomy and the right to bodily

123. Feinberg, *Harmless Wrongdoing*, Note 124. See pp. 211–220.
124. *R v BM* [2018] EWCA Crim 560.
125. *Chatterton*, Note 32.
126. Feinberg, *Harmless Wrongdoing*, Note 123, at 130.
127. See D Griffiths and A Mullock, 'The Medical Exception and Cosmetic Surgery' in Fovargue and Mullock (eds), (Note 21).
128. J Herring and J Walle, 'The Nature and Significance of the Right to Bodily Integrity', *Cambridge Law Journal* 76(3) (2017), pp. 566–588.

integrity, the latter being a more serious concern. Priaulx has argued that bodily integrity is the most basic psychological need.[129] For some people that might be overstating it–their most important psychological needs might prioritize other concerns–but for the vast majority of people, Priaulx's view is surely correct. Even when patients are informed as to the broad nature of the surgery, if serious harm subsequently occurs, they are unlikely to agree that they consented to being mutilated, or left with long-term health problems. Their consent was predicated on the understanding that the surgery was in their best interests. The harm inflicted was not in their contemplation when they consented to the surgery. Consequently, the patient's trust in that surgeon, and perhaps the medical profession more broadly, may be seriously damaged.

Fox and Thompson have offered a more nuanced conception of bodily integrity in their examination of claims of parental ownership of children's bodies.[130] In doing so, they point out that conceptualizing the body as a sacred space can have regressive implications, such as inviting over-regulation or placing too much power in parental hands. As my earlier discussion revealed, inadequate regulation opens the door to violations of bodily integrity and so appeals to improve protection of bodily integrity may involve more regulation. However, that does not necessarily involve over-regulation, although there is undoubtedly potential for that. Adopting a more patient-centred approach to valid consent would encourage surgeons to reflect more carefully on the risks and benefits of the procedure, enabling patients to consider what the proposed surgery involves and, if it is not essential or therapeutic, whether the benefits of that surgery are worth the risks. Considering the serious impact on victims who have experienced surgical harm[131] suggests that the current approach to consent to 'reasonable surgery' needs reappraising in order to properly consider the possible *criminal* responsibility for that harm.

While civil law now provides improved protection of autonomy and bodily integrity,[132] it might be argued that this area of criminal law should only be concerned with overtly violent conduct, rather than conduct that but for the unfortunate consequence would be lawful. That argument has not prevented individuals from being held criminally responsible under the OAPA for sexual contagion.[133] Consent to sex is no longer treated as consent to be infected with a sexually transmitted disease. This development provides greater protection against seemingly consensual yet abusive sexual encounters and consequently has clear parallels with the question of whether consent to surgery should infer consent to be seriously harmed by surgical malpractice. A further example that shifts the parameters of lawful consent can be seen in a recent rape conviction in Worcester, when a man was convicted after piercing holes in condoms used

129. N Priaulx, 'Rethinking Progenitive Conflict: Why Reproductive Autonomy Matters', *Medical Law Review* 16(2) (2008), pp. 169–200.
130. M Fox and M Thompson, 'Bodily Integrity, Embodiment, and the Regulation of Parental Choice', *Journal of Law and Society* 44(4) (2017), pp. 501–531.
131. For example, see the multiple reports from patients who were not included in Paterson's criminal prosecution, who gave evidence to the James Inquiry, Note 30.
132. *Montgomery*, above, Note 85.
133. *R v Dica* [2004] EWCA Crim 1103, *R v Konzani* [2005] EWCA Crim 706 (CA).

for (consensual) sex with his partner in an apparent attempt to impregnate her.[134] This follows a similar case in Canada, *Hutchinson*,[135] in which the defendant pierced a condom and was initially convicted of sexual assault, before his conviction was overturned by the Supreme Court.

This section has highlighted the case for requiring more than minimal honesty in consent to surgery in order to fully respect patient autonomy and bodily integrity, and avoid outcomes that are both harmful and a 'wrong' according to Feinberg's characterization. Shifting the threshold for valid consent would potentially criminalize more surgeons, inviting debate about whether that is desirable and worthwhile according to the aims of the criminal law.[136] That assessment is important but space constrains further discussion here, except to say that improving patient safety is an important public issue which may be served by establishing a stronger deterrent to bad-apple surgeons. Moreover, when a bad-apple surgeon inflicts serious harm, punishment (retribution) would also appear to be potentially appropriate.

It is also important to remember that the civil law and GMC requires consent to be informed and individualized,[137] so the obligation to take a patient-centred approach is already present. Thus, only surgeons who fail to provide sufficient information to enable patients to appreciate the risks *and* who then perform harmful surgery would need to fear the criminal law. Consent – being necessary but not sufficient – is only the first half of the story, because the surgery must also be 'reasonable'. The final section presents an argument in favour of challenging the traditional *Bolam* approach to the assessment of reasonableness, so that there is greater opportunity to examine the harm done and the impact on the victim, rather than simply accepting professional opinion over what sits within the realm of reasonable surgery.

## Reasonable surgery and surgical harm: error or violation?

In the section on 'Consent to "reasonable" surgery', I examined how the medical profession are essentially the arbiters of what constitutes *reasonable surgery*. This means that non-therapeutic surgery is deemed reasonable provided it is performed by a qualified doctor with the patient's consent, and even when significant harm is caused to the patient, the surgery seems likely to be deemed reasonable (in criminal law), provided that the surgeon causing the harm appeared to believe – however wrongly – that their conduct was professionally responsible. In this section, I consider what kind of surgical harm *should* be regarded as potentially unreasonable and the circumstances that ought to give

134. This is an unreported conviction from Worcester Crown Court, see: https://www.worcesternews.co.uk/news/18767987.worcester-man-raped-woman-puncturing-hole-condom-jailed/.

135. *R v Hutchinson* (2016) 35176.

136. These may be identified as retribution, deterrence, public protection, and rehabilitation, see HLA Hart, *Punishment and Responsibility: Essays in the Philosophy of Law*, 2nd ed (Oxford: OUP, 2008).

137. GMC, *Decision Making and Consent*, (2020), available: https://www.gmc-uk.org/-/media/documents/gmc-guidance-for-doctors—decision-making-and-consent-english_pdf-84191055.pdf?la=en&hash=BE327A1C584627D12BC51F66E790443F0E0651DA.

rise to a criminal investigation. My aim in so doing is to provide greater clarity about when surgical harm should not be automatically excused by the surgical exception to consensual harm.

All surgery carries risks and is inherently harmful, but the necessary harm is justified for the end result. When things do not go as hoped, a patient may suffer a bad side-effect or a poor result as a consequence of surgery that was performed appropriately and carefully. Essentially, the surgery was in the patient's best interests, but the results were disappointing. In other examples of surgical harm, however, the surgery in question is not appropriate and/or performed carefully and thus there might be grounds for either a civil claim or a criminal prosecution. With the latter, a surgeon may cause harm by (1) performing surgery that should not be done at all on that patient, (2) performing a procedure that is not safe, or (3) by making a catastrophic mistake, such as wrong-site surgery. The first two examples of harmful surgery were demonstrated by Iain Paterson. The third (wrong-site surgery) is described as a 'never event',[138] and has never been the subject of a criminal prosecution for a non-fatal offence, but surgeons have been erased from the register for such errors.[139] If, however, a patient died as result of a 'never event' or other fatal surgical error, it is possible that a charge of manslaughter (GNM) would be pursued. An example was discussed earlier, with the conviction for GNM of Stephen Walker,[140] who was also found by the GMC to be responsible for seriously harming other patients. This highlights the issue of moral luck,[141] whereby (until *Paterson*) only errant doctors who have killed have been subject to criminal censure while others, whose harm does not prove fatal although they might be morally culpable, do not attract the attention of the criminal law. Now that the convictions of Paterson and Bramall have seemingly opened the door to using the criminal law in non-fatal surgical harm cases, it highlights the question of what kind of surgical misconduct should be viewed as a criminal matter. This question, in relation to harmful surgery, is the final point considered here.

The starting point for a non-fatal surgical offence is that there must be an injury (GBH or wounding) that should not have occurred, either at all, because the surgery should not have been done, or the injury should not have resulted from that particular procedure. The next assessment should focus on the conduct of the surgeon, seeking to determine whether the harm done might be explained as an error that would constitute civil negligence, or whether it demonstrates criminally culpable conduct.

The work of Merry and McCall Smith,[142] in distinguishing between *error* and *violation* in gross negligence manslaughter, is also valuable here. They characterize human *error* as unavoidable and not morally culpable, in contrast to 'violation', which involves a choice to disregard patient welfare. This accords with the capacity-conception of

138. See NHS Improvement, *Never Events Policy and Framework*, revised January 2018.

139. For example, Lawal Haruna was struck off by the GMC, see C Dyer, 'Surgeon struck off after three "never events"', p. j2359

140. For the death of Dorothy McPhee, see n.60.

141. See J C Smith, Note 60.

142. See A Merry and A McCall Smith, *Errors, Medicine and the Law* (Cambridge: Cambridge University Press, 2001). See also A Merry, 'How Does the Law Recognise and Deal with Errors?', *Journal of the Royal Society of Medicine* 102 (2009), pp. 265–271.

criminal responsibility,[143] so that responsibility is present only when a person makes a choice in a situation in which there is fair opportunity to avoid committing the relevant *actus reus*. So misconduct that might be characterized as an error would be an example of a simple negligence; for example, harm resulting from either failing to tell a patient about an alternative treatment, or failing to perform the surgery with reasonable care. A violation in this context would involve more culpable conduct, such as was demonstrated by Paterson and Bramhall. Recall, however, that it was only when Paterson accumulated a high number of victims, harmed over more than a decade, that the police took action. If the police had acted much sooner, many victims would have been spared. However, it is hardly surprising that the police did not act until the volume of victims and weight of evidence was extremely compelling, because ordinarily the medical exception applies to surgical harm. Thus, developing a clearer principle about what constitutes criminal surgical misconduct, which falls outwith the medical exception, is important in order to protect the public by preventing and deterring bad-apple surgeons.

With that objective in mind, I suggest that when a patient suffers harm that exceeds the parameters of possible poor results and points towards a possible violation, criminal action should be considered in the following situations:

A. If the patient subsequently discovers that the surgery was entirely unnecessary and had no therapeutic value, for example, when Paterson told people they had cancer when they did not.
B. Surgery that is botched in a situation that goes beyond a negligent error and demonstrates recklessness. For example, where the risks, when weighed against the benefits of that particular procedure to that particular patient, could not have been justified as being in the patients' best interests. The injuries suffered by Denise Hendry (discussed earlier) as a result of abdominal liposuction show this type of violation.
C. Surgery that involves a very serious mistake that demonstrates a reckless disregard for patient welfare; for example, removing the wrong organ or tissue (wrong-site surgery) or operating when intoxicated.

(A) and (B) would strongly indicate a violation. Depending on the reasons for the conduct and any possible mitigation – such as an administrative error that affected the surgeon's actions or other factors that suggested the surgeon was negligent rather than reckless – (C) might also constitute a violation. Currently, based on the principles applied in *Paterson*, only the first scenario (A) would be an obvious case for a criminal prosecution, because there would be no consent. In the second two scenarios (B and C), consent may be present if the patient had been given honest information prior to the surgery. However, in all three scenarios, the surgery would not be 'reasonable' and thus, because consent to harm should be only possible for 'reasonable surgery', arguably all three scenarios might be considered as a potentially criminal violation.

143. Discussed by N Lacey; 'In Search of the Responsible Subject: History, Philosophy and Social Sciences in Criminal Law Theory', *Modern Law Review* 64(3) (2003), pp. 350–371.

Approaching the assessment in this way also fits well with the risk/benefit analysis that should be a precursor to all surgery and which requires the surgeon to consider whether the surgery is clinically justifiable and ethically sound. If a procedure is purely cosmetic, then the chances of being prosecuted if a patient is harmed via botched surgery would be higher than in a case involving clinically necessary surgery, because the risk/benefit analysis ought to require a more cautionary approach. As Latham has examined by comparing the French and British responses to the breast implant scandal,[144] a more risk-averse approach is justified because of the serious harm that can result from cosmetic surgery. In other words, when weighing the benefits of a procedure, the surgeon should be very sure that the risks to that particular patient are both minimal and proportionate to the benefits sought by the patient. Essentially, this means that necessary therapeutic surgery should be less likely to be deemed not reasonable because there is a strong justification for it. Approaching the issue with a clear link to assessing clinical best interests and the therapeutic justification should help to address the serious problem of botched surgery within the cosmetic surgery industry and private provision more broadly. As *Paterson* revealed, when surgeons are free to sell their services within an industry that prioritizes profit, bad-apples may go unchecked for many years.

Post *Paterson*, the 'regulators'[145] have stated that they have learnt lessons, and it is now less likely that an errant surgeon would be permitted to harm patients in this way.[146] The Paterson Inquiry have disputed this, stating, '[F]rom the evidence we have heard, it is our opinion that this is not the case.'[147] To reduce the dangers posed by such surgeons, the Paterson Inquiry recommended a number of improvements to

1. the organization and availability of information about surgeons (with a single repository providing data on consultant performance);
2. the information provided to patients, and between the public and private sectors;
3. consent procedures (with a period for reflection between consent and the procedure);
4. how complaints, investigations, and apologies are managed.[148]

If these improvements are effectively introduced it may reduce the dangers, particularly in private practice. Other recent evidence, however, suggests that the problems with consent and paternalistic approaches are endemic, indicating that more fundamental reforms are needed. The recent Cumberlege Report on safety concerns for certain interventions highlighted how patients with 'harrowing stories' of being harmed were not told about risks or alternatives.[149] When harm occurred, they felt violated and abandoned,

144. M Latham, above n.105.
145. The GMC, the Nursing and Midwifery Council, and the Care Quality Commission.
146. See the *James Inquiry*, Note 255, p. 192.
147. Ibid.
148. Ibid., p. 218.
149. *First Do No Harm: The Report of the Independent Medicines and Medical Devices Safety Review*, (2020), led by Baroness Cumberlege. This Government review examined evidence

often with devastating consequences. *Cumberlege* points to serious systemic failings, but the review also demonstrates how professional power dominates, which may leave patients in a vulnerable position. Addressing such deep rooted systemic and cultural problems is extremely complex. On the subject of harmful surgery, however, a small step to offer a more patient-centred approach may be taken by treating surgical violations as a more serious, potentially criminal, matter.

In order to better protect patients and deter bad-apple surgeons, criminal principles – currently mired in confusion regarding the medical exception and the thresholds for both consent and reasonable surgery – should be examined and modernized in line with other legal developments,[150] to show due respect to patient autonomy and welfare. The principles also need to be properly understood by police and prosecutors in order to stop dangerous surgeons sooner, before more patients are harmed. To achieve that, guidance is needed to address the scope for liability for non-fatal offences, explaining the principles of consent, reasonable surgery, and how the medical exception operates. This should establish a clearer distinction between negligence and criminal violation, determining when it is appropriate to investigate and subsequently prosecute. This suggestion also ties in with the central recommendation of the recent rapid policy review of GNM, led by Sir Norman Williams.[151] *Williams* concluded that establishing a clear understanding of the law is essential in order to encourage a fair, consistent, and transparent approach in cases of medical manslaughter. Greater transparency and clarity would also encourage greater learning from error in order to improve patient safety. While distinct issues arise with non-fatal surgical misconduct compared to GNM,[152] similar challenges arise concerning the need to scrutinize medical care that, at first glance, might appear beneficent, in order to assess possible criminal liability. Surgical education should also inform the profession of the legal principles, so that any bad-apples may pause and reflect more carefully before picking up their scalpel.

## Conclusion

The OAPA 1861 is ill-suited to capturing surgical harm because the usual approach to establishing liability for wounding and/or GBH is obviated by the core principle of the medical exception. As was shown in *Paterson*, until a surgeon has accumulated many victims and is therefore obviously dangerous, police and prosecutors are understandably reluctant to become involved in what is usually a civil matter of compensation. The same reluctance to scrutinize doctors enabled Shipman's murders to continue for far too long.

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about a number of treatments including treatments in pregnancy and pelvic mesh surgery. Several of the findings chime with this article and my findings: for example, patients were not told about risks, informed consent was absent, and when the harm transpired, they were not listened to.

150. For example, sexual offences discussed in section IV, and human rights law.

151. *Gross Negligence Manslaughter in Healthcare: The Report of a Rapid Policy Review* (June 2018), https://www.gov.uk/government/groups/professor-sir-norman-williams-review.

152. For example, with GNM doctors might suffer anxiety that they could be prosecuted for errors within systems beyond their control, for example, *Bawa-Garba*, [2016] EWCA Crim 1841.

Since then lessons have been learnt, with efforts made to close the window of opportunity for murderous doctors. With non-fatal surgical harm, similar lessons need to be learnt in order to enable police and prosecutors to identify and investigate bad-apple surgeons before more victims are harmed. With that aim in mind, understanding when harmful surgery might constitute an offence is essential.

Consent is necessary but not sufficient. Lawful surgery must also be deemed reasonable. My analysis of *Paterson* revealed that the flimsy criminal principles available, which essentially borrow from *Bolam*, do not create a sound approach to determining whether a bad-apple surgeon has departed from their professional obligation to *do no harm* in a way that is not reasonable and thus, might be criminal. Moreover, the threshold for lawful consent, which requires only minimal honesty, is failing patients. Individual autonomy and bodily integrity has now been given greater protection in other areas of criminal law,[153] civil law,[154] and human rights law,[155] and so it is time for the criminal law in relation to consent to surgical harm to enter the twenty-first century. While deference and paternalism once characterized the doctor/patient relationship, times have changed.[156] Reasonable surgery should not simply be a question of what the medical profession deems reasonable, followed by an assessment of the views and honesty of the accused. Whenever a patient suffers significant and unexpected harm at the hands of a surgeon whose conduct suggests patient welfare has been disregarded, there should be greater scrutiny of how and why that harm occurred.

## Acknowledgements

I am grateful to Sara Fovargue, Suzanne Ost and Elizabeth Chloe Romanis for their wise comments on earlier drafts.

## Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

## Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

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153. *Dica*, Note 133.
154. *Montgomery*, Note 86.
155. Article 8 ECHR.
156. See S Devaney and S Holm, 'The Transmutation of Deference in Medicine: A Medico-Legal Perspective', *Medical Law Review* 26(2) (2018), pp. 202–224.