

# The Medical Professional as Special before the Criminal Law

Suzanne Ost

## A. Introduction

In this chapter, the relationship of unequal power that is a primary focus of labour law shifts from the relationship between employer and employee to that between the professional and the ‘client’: the doctor and the patient. The doctor–patient relationship is arguably unique. After all, how many other professional relationships, even those that may be similarly intimate and confidential,<sup>1</sup> involve the weaker party laying themselves bare (sometimes literally), placing their trust, confidential information, and health in the hands of someone whom they may only have met minutes before?<sup>2</sup> This trust is given because of the esteem that society continues to hold the medical profession in, and is reflected in the fact that the profession is permitted to self-regulate through the General Medical Council (GMC).<sup>3</sup> Thus, in cases where a medical professional is deemed unfit to practise, having failed to abide by the strict standards and regulatory ethics set by the GMC,<sup>4</sup> a range of sanctions can be imposed.<sup>5</sup>

In some cases, however, when a doctor behaves in a way that violates the ethos of the doctor–patient relationship, professional regulation and even civil law remedies for private wrongs, are not enough. The private wrong committed against the patient because, for example, the doctor removes her kidney without her consent, is also considered to constitute a public wrong that demands the attention of the criminal law.<sup>6</sup> There has been increasing

<sup>1</sup> Such as that between lawyers and their clients. See further Hazel Biggs and Suzanne Ost, *Exploitation in the Doctor-Patient Relationship: Ethics and Law* (Routledge, forthcoming 2020) ch 3.

<sup>2</sup> See also Henri Colt, Silvia Quadrelli, and Friedman Lester, *The Picture of Health: Medical Ethics and the Movies* (OUP 2011) 298.

<sup>3</sup> On the continued existence of trust in the medical profession, see Biggs and Ost, *Exploitation* (n 1) ch 3, s 3. Note also that a primary reason for reforms of the GMC’s regulatory procedures was to maintain trust in the profession following, inter alia, the Shipman Inquiry’s conclusion that GP Harold Shipman was able to perpetrate murder on such a mass scale, in part, because of ‘systems failures’ and weaknesses in the (then) professional regulation: Janet Smith, *Disguising Death* (HMSO 2002) 200–01; Janet Smith, *Safeguarding Patients: Lessons from the Past-Proposals for the Future, the Shipman Inquiry* (HMSO 2004). On damaged public trust in the GMC’s regulatory procedures and the steps taken to address this, see John Martyn Chamberlain, ‘Malpractice, Criminality and Medical Regulation: Reforming the Role of the GMC in Fitness to Practise Panels’ (2017) 25 *Medical Law Review* 1, 12–13. On reform of the procedures, see, eg, Department of Health, *Trust, Assurance and Safety—the Regulation of Health Professionals in the 21st Century* (Cm 7013, 2007); GMC, *Reform of the Fitness to Practise Procedures at the GMC* (GMC 2011).

<sup>4</sup> The GMC is given the power to advise medical professionals on standards of professional conduct and performance and medical ethics under the Medical Act 1983, s 35.

<sup>5</sup> By one of the Medical Practitioners Tribunal Service Panels that adjudicate through public hearings following the investigation of complaints by the GMC.

<sup>6</sup> On public wrongs and the criminal law, see Sandra Marshall and Antony Duff, ‘Criminalization and Shared Wrongs’ (1998) XI *Canadian Journal of Law & Jurisprudence* 7.

academic interest in what has been described as the criminal law's extending intervention into health care matters, its policing of professional norms.<sup>7</sup> This chapter takes the existing literature forward and contributes to this volume by addressing two central questions. First, can we view the criminal law's treatment of doctors as special because their professional role *exempts* them from criminal culpability (ie a defence to certain offences is required in order to enable doctors to perform their professional responsibilities)? Or do doctors receive special treatment under the criminal law because their profession *enables* them to commit certain crimes (ie their professional role offers an opportunity for doctors to perpetrate serious wrongs related to a breach of trust), and/or medical practice *attracts* criminalization because of concerns related to protecting public health and safety, or morality? In other words, are doctors treated as special by the criminal law either because their professional role exculpates them, or attracts criminal liability, or is it actually both? The answer to this question may reveal that the medical profession is an example of a relatively autonomous category of personal work relations that, in some significant respects, is dealt with in a unique way by the criminal law. On this matter, the significance of the public interest cannot be underestimated. And secondly, is any such special attention appropriate? In particular, what is it about the doctor–patient relationship that justifies special treatment by the criminal law?

## B. The Criminal Law and the Doctor's Exculpatory and Influential Professional Role

...courts have striven to exculpate doctors for decisions taken in medical contexts which would probably, in almost all other situations, lead to the imposition of criminal liability.<sup>8</sup>

There are numerous judicial and other authoritative references to medical professionals being exempt from criminal responsibility for an offence under the Offences Against the Person Act 1861 (OAPA 1861),<sup>9</sup> a 'medical exception' that has existed since the late nineteenth century.<sup>10</sup> The exception functions and is justified on the grounds of public policy<sup>11</sup> in instances such as an emergency situation, where a doctor operates upon a patient knowing that there is a grave risk of death, but it is considered reasonable for her to do so,<sup>12</sup> or where the patient consents to a medical procedure that constitutes 'good medical practice' or 'proper medical treatment'.<sup>13</sup> As Lewis has observed, such references to professional

<sup>7</sup> Charles Erin and Suzanne Ost (eds), *The Criminal Justice System and Health Care* (OUP 2007); Amel Alghrani, Rebecca Bennett, and Suzanne Ost (eds), *The Criminal Law and Bioethical Conflict—Walking the Tightrope* (CUP 2012); Margaret Brazier and Suzanne Ost, *Medicine and Bioethics in the 'Theatre' of the Criminal Process* (CUP 2013); Danielle Griffiths and Andrew Sanders, *Medicine, Crime and Society* (CUP 2013).

<sup>8</sup> Andrew Ashworth, 'Criminal Liability in a Medical Context: The Treatment of Good Intentions' in Andrew Simester and Anthony Smith (eds), *Harm and Culpability* (Clarendon 1996) 173, 192.

<sup>9</sup> Such as wounding with intent to do grievous bodily harm (GBH) (s 18); inflicting GBH (s 20); and causing actual bodily harm (ABH) (s 47).

<sup>10</sup> Penney Lewis, 'The Medical Exception' (2012) 65 *Current Legal Problems* 355, 356.

<sup>11</sup> *Attorney General's Reference (No 6 of 1980)* [1981] QB 715, 719 (HL); *ibid* 357.

<sup>12</sup> See, for instance, Criminal Law Revision Committee, *14th Report: Offences Against the Person* (Cmnd 7844, 1980) 8 (cited in Ashworth (n 8) 176).

<sup>13</sup> *R v Brown* [1994] AC 212, 258 (HL); *Airedale Trust v Bland* [1993] AC 789, 891 (HL); *Attorney General's Reference (No 6 of 1980)* (n 11). On what constitutes 'proper medical treatment', see also Margaret Brazier and

practice are indicative of a professionally focused justification for a medical exception to criminal liability.<sup>14</sup> The recent case of *R v BM*<sup>15</sup> testifies to the restricted availability of this exception to the performance of medical procedures, by those in possession of medical qualifications, for a medical reason.

Alongside this medical exception to an offence against the person, certain defences to criminal offences are only available to doctors. Consider, for example, the statutory defence to the crimes of procuring a miscarriage and child destruction.<sup>16</sup> The Abortion Act 1967 (AA 1967) offers a defence to a registered medical practitioner who performs an abortion provided that two medical professionals are of the opinion, formed in good faith, that one of the lawful grounds for an abortion is met.<sup>17</sup> Notably, in order to secure the liberalization of abortion laws in the 1960s, abortion had to be medicalized to justify its occurrence in certain defined circumstances.<sup>18</sup> With this medicalization came the need to give doctors the reassurance of non-prosecution, provided they followed the procedural requirements and acted in good faith.<sup>19</sup>

As a further example of an exclusive defence, a more ‘concealed’<sup>20</sup> defence is seemingly available to medical professionals under the common law when they administer certain pain-alleviating drugs that can hasten death at the end of life. Perhaps loosely based on the philosophical doctrine of double effect,<sup>21</sup> the development of this defence can be traced back to Devlin J’s direction to the jury in *Adams*:<sup>22</sup>

If the first purpose of medicine—the restoration of health—can no longer be achieved, there is still much for a doctor to do, and he is entitled to do all that is proper and necessary to relieve pain and suffering, even if measures he takes may incidentally shorten life . . .<sup>23</sup>

[P]roper medical treatment that is administered and that has an incidental effect of determining the exact moment of death, or may have, is not the cause of death in any sensible use of the term.<sup>24</sup>

Sara Fovargue, ‘Transforming Wrong into Right: What is “Proper Medical Treatment?”’ in Sara Fovargue and Alexandra Mullock (eds), *The Legitimacy of Medical Treatment: What Role for the Medical Exception?* (Routledge 2015) 12, 16–30; and see Lewis (n 10).

<sup>14</sup> Lewis (n 10) 362. See also Lord Mustill in *R v Brown* (n 13) 266: ‘. . . proper medical treatment, for which actual or deemed consent is a prerequisite, is in a category of its own. Albeit beyond the scope of this chapter, there is an interesting question as to whether the medical exception might be more appropriately conceived of as a defence of justification or excuse. Persuasive arguments for it being the former are provided in Glenys Williams, *Intention and Causation in Medical Non-Killing: the Impact of Criminal Law Concepts on Euthanasia and Assisted Suicide* (Routledge 2007) 186–87. See also Peter Skegg, ‘Medical Procedures and the Crime of Battery’ [1974] *Criminal Law Review* 693, 696.

<sup>15</sup> [2018] EWCA Crim 560, [2018] 3 WLR 883 [45].

<sup>16</sup> Under the OAPA 1861, s 59 and the Infant Life Preservation Act 1929, s 1.

<sup>17</sup> Under the AA 1967, s 1(1). On other health care professionals’ involvement in abortions, see *RCN v DHSS* [1981] 1 All ER 545 (HL): the doctor should take ultimate responsibility for all stages of the abortion, even if some stages are carried out by other health care professionals. See also the later discussion in the concluding section.

<sup>18</sup> Sally Sheldon, ‘The Law of Abortion and the Politics of Medicalization’ in Jo Bridgeman and Susan Millns (eds), *Law and Body Politics: Regulating the Female Body* (Aldershot 1995) 105.

<sup>19</sup> Sheelagh McGuinness and Michael Thomson, ‘Medicine and Abortion: Complicating the Reforming Profession’ (2015) 23 *Medical Law Review* 177, 182, 188.

<sup>20</sup> Ashworth (n 8) 183.

<sup>21</sup> See Brazier and Ost, *Medicine and Bioethics* (n 7) 138.

<sup>22</sup> *R v Adams* [1957] Crim LR 365.

<sup>23</sup> *ibid* 375.

<sup>24</sup> As quoted in Glanville Williams, *The Sanctity of Life and the Criminal Law* (Faber and Faber 1957) 289.

Similar statements of legal principle have appeared in subsequent directions to juries,<sup>25</sup> and the existence of this ‘established rule’ was recognized by the House of Lords in *Airedale NHS Trust v Bland*.<sup>26</sup> The application of the label of ‘proper medical treatment’ to a situation where a doctor acts to relieve suffering by administering an analgesic drug that can also have a death-hastening effect offers a means of avoiding criminal liability that flies in the face of the criminal law’s ‘standard approaches to either causation or intention.’<sup>27</sup> And it appears to be the doctor’s acting in accordance with good medical practice which allows this marked step outside the usual strictures of the criminal law,<sup>28</sup> although the defence’s ambiguity leaves the exact nature of the reason for exoneration to judicial discretion.<sup>29</sup>

Looking next to the interpretation of the criminal law, medicalization 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. In the aforementioned *BM* case, the defendant was a tattooist who, with his customers’ consent, performed surgical body modification procedures (the removal of an ear, a nipple, and tongue splitting). The facts of the case presented the courts with a novel situation which was not a stated exception to the general rule that consent is no defence to a charge of assault occasioning actual bodily harm (ABH).<sup>30</sup> If the procedures were akin to body adornment, such as ear piercing or tattooing, then they could have fallen under an accepted non-medical procedure for which consent is recognized to negate criminal activity. Alternatively, the medical exception would apply if:

- they amounted to medical procedures carried out by a suitably qualified doctor; or
- they were carried out by a suitably qualified doctor, even if they are not recognized as procedures carried out on the grounds of health (such as cosmetic surgery).<sup>31</sup>

The appellant had no medical qualifications; thus, he could not be considered to be a qualified doctor. His counsel contended that the procedures were akin to body adornment, ‘a natural extension of tattooing and piercing, the last of which involves wounding by breaking the skin . . .’<sup>32</sup> However, the Court of Appeal judges turned to doctors to assess the nature of the procedures and the expert medical opinion was influential in shaping the judicial conclusion that the procedures were surgical with risk and, therefore, outside of the exceptions to the general rule that consent cannot offer a defence. According to the Court, it would have been a step too far to allow body modification to be an exception to the general rule.<sup>33</sup> There are reasons to be critical of this conclusion. As the Court observed, male circumcision is a recognized exception,<sup>34</sup> and parallels can be drawn between this and body modification

<sup>25</sup> For example, Ognall J in *R v Cox* (1992) 12 BMLR 38, and Hooper J in *R v Moor* [2000] Crim LR 31.

<sup>26</sup> *Airedale NHS Trust v Bland* (n 13) 867 (Lord Goff).

<sup>27</sup> Ashworth (n 8) 174.

<sup>28</sup> See also Patrick Devlin, *Samples of Lawmaking* (OUP 1962) 95.

<sup>29</sup> Ashworth (n 8) 183. Proper medical treatment, causation, and primary intent have each appeared to be the focal point(s) in various cases. See Brazier and Ost, *Medicine and Bioethics* (n 7) 137–44.

<sup>30</sup> OAPA 1861, s 47.

<sup>31</sup> See Danielle Griffiths and Alexandra Mullock, ‘The Medical Exception and Cosmetic Surgery: Culpable Doctors and Harmful Enhancement?’ in Fovargue and Mullock, *Legitimacy of Medical Treatment* (n 13) 105.

<sup>32</sup> *R v BM* (n 15) [34].

<sup>33</sup> *ibid* [45].

<sup>34</sup> *ibid* [39]: ‘. . . there is a need to reflect the general values of society which have long accepted tattooing and piercing (not just of ears) as acceptable, along with things such as ritual circumcision [and] sports . . .’

procedures. It tends to be traditional practitioners rather than medical qualified professionals who carry out circumcisions on older boys and infants, many circumcisions are not carried out on health grounds but on religious and cultural grounds, they involve risks such as haemorrhaging and ulceration of the penis, and it is certainly arguable that this procedure also causes ABH.<sup>35</sup> Since circumcision falls outside the medical exception but it is lawful on the grounds of social benefit, why should body modification be treated differently, and on the basis of medical opinion?

The judicial reliance on doctors' opinions in *BM* would seem to fly in the face of statements made in various arenas that, more broadly, medical practice and the profession should not be the final arbiter regarding the lawfulness of a (doctor's) course of conduct.<sup>36</sup> This statement may also be subject to challenge by Quick's findings in the context of 'medical manslaughter' that medical experts are given 'considerable freedom when evaluating the conduct of the accused and developed their own working rules or guidelines for assessing gross negligence'.<sup>37</sup> As an additional example here, certain aspects of the statutory criteria that form the necessary elements of the defence available to doctors under the AA 1967 are elucidated by professional guidance. Take the ground that permits abortion when 'there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped'.<sup>38</sup> Whilst the statute is silent on what constitutes a 'substantial risk' or a 'serious handicap', guidance from the Royal College of Obstetricians and Gynaecologists' (RCOG) advises doctors on the factors that should be considered on both matters.<sup>39</sup> Arguably, then, the medical profession shapes the scope of these crucial aspects of the defence offered under the 'foetal abnormality' ground; indeed, it would be difficult to claim that doctors who have complied with this guidance and have sought advice from 'appropriate specialists' have not acted in good faith.<sup>40</sup> Thus whilst remaining a criminal offence on the one hand, on the other, abortion is perceived to amount to 'proper medical treatment' when carried out by a doctor in defined circumstances,<sup>41</sup> albeit that its construction as both continues to court controversy.<sup>42</sup>

<sup>35</sup> Marie Fox and Michael Thomson, 'Short Changed? The Law and Ethics of Male Circumcision' (2005) 13 *International Journal of Children's Rights* 161; Brazier and Ost, *Medicine and Bioethics* (n 7) 51–52.

<sup>36</sup> Such as *R v Arthur* (1981) 12 BMLR 1, 17; Law Commission, *Involuntary Manslaughter* (Law Com CP No 135, 1994) [5.61].

<sup>37</sup> Oliver Quick, 'Medical Manslaughter and Expert Evidence: The Roles of Context and Character' in Griffiths and Sanders, *Medicine Crime and Society* (n 7) 101, 103.

<sup>38</sup> AA 1967, s 1(1)(d).

<sup>39</sup> On substantial risk: '[w]hether a risk is substantial depends upon factors such as the nature and severity of the condition and the timing of diagnosis, as well as the likelihood of the event occurring, and on what constitutes a serious handicap: 'the potential for effective treatment, either in utero or after birth; on the part of the child, the probable degree of self-awareness and of ability to communicate with others; the suffering that would be experienced; the probability of being able to live alone and to be self-supportive as an adult; on the part of society, the extent to which actions performed by individuals without disability that are essential for health would have to be provided by others'. RCOG, *Termination of Pregnancy for Fetal Abnormality in England, Scotland and Wales: Report of a Working Party* (RCOG 2010) 8, 9.

<sup>40</sup> *ibid* 9.

<sup>41</sup> On which, see Mary Neal, 'Locating Abortion on the Spectrum of "Proper Medical Treatment" in Fovargue and Mullock, *Legitimacy of Medical Treatment* (n 13) 124, 133–41.

<sup>42</sup> For critique of the continuing criminalization of abortion, see Sally Sheldon, 'The Decriminalization of Abortion: an Argument for Modernization' (2015) 36 *Oxford Journal of Legal Studies* 334. A more specific example regarding abortion as 'proper medical treatment' centres on the question of whether abortion can be conceived as such in order to terminate a pregnancy under the foetal abnormality ground. This question has been the subject of much debate, as has medical professionals' interpretation of what constitutes a 'serious handicap'. See *Jepson v Chief Constable of West Mercia Police Constabulary* [2003] EWHC 3318, [2003] 12 WLJK 12; Sheelagh McGuinness, 'Law, Reproduction, and Disability: Fatally "Handicapped"?' (2013) 21 *Medical Law Review* 213.

Thus, mirroring earlier observations within this book, the way in which the criminal law is applied and judicial interpretation play crucial roles in shaping its effect on those working within the medical profession. Particularly, this takes the form of judicial recognition of the medical exception to offences against the person for public policy reasons, the judicial construct of ‘proper medical treatment’, and exclusive defences available in the context of abortion and treatment at the end of life. What is also notable, however, is that the medical profession itself plays a central role in defining the contours of criminal liability that doctors (and sometimes others) are subject to, due to a certain willingness to allow the applicability of certain aspects of the criminal law to be influenced by medical opinion and elucidated by professional medical practice. In sum, it appears that doctors have little to fear from the criminal law provided they comply with responsible medical practice and act in ‘good faith.’<sup>43</sup>

### C. The Particular Criminal Liability that the Doctor’s Professional Role Attracts

The preceding analysis suggests that the doctor is in a privileged position when the criminal law looms over her medical practice. But this is to see only one part of the picture. A different light is cast on the doctor’s position when we explore the fact that numerous crimes are targeted specifically at medical practice, including both *mala in se* and *mala prohibita* crimes.

*Mala in se* crime is considered to be wrong in and of itself, outwith its criminal label. An obvious example in medical practice would be that given earlier: the removal of a patient’s organ without consent.<sup>44</sup> A further example could be the more recent criminalization of the ill-treatment or wilful neglect of a person by a health *care worker*.<sup>45</sup> In contrast, the wrongfulness of a *mala prohibita* crime, often a regulatory offence designed to protect public health and safety, is derived from its criminalization.<sup>46</sup> On the face of it, there are numerous *mala prohibita* crimes seemingly designed to protect public safety that can be committed through medical practice. One example could be the crimes of creating and using an embryo without a licence granted by the Human Fertilisation and Embryology Authority as an aspect of the statutory regulation of assisted reproduction and embryonic research.<sup>47</sup>

<sup>43</sup> There is much more that could be said here on whether a distinctive relational interaction exists between judges and doctors because of the real likelihood that many doctors and judges are drawn from the same social and economic circles. It is worth noting that the traditional scepticism of working people who encounter the courts does not translate easily into this context (a scepticism acknowledged in the classic labour law statement of Scrutton LJ, in which he expressed the working person’s view that ‘[Judges] all move in the same circle as the employers, and they are all educated and nursed in the same idea as the employers. How can [a working person] get impartial justice?’ (Thomas E Scrutton, ‘The Work of the Commercial Courts’ (1921) 1 Cambridge Law Journal 6, 8, as referenced by Lord Wedderburn, *The Worker and the Law* (3rd edn, Penguin 1986) 33). See also the chapter in this volume by Lydia Hayes on the parallel treatment of care workers in the criminal law.

<sup>44</sup> Constituting an assault under common law and an offence under Human Tissue Act 2004 (HTA 2004), s 5 when removed from a deceased person without (appropriate) consent. Note the addition of ‘deemed consent’ under the law in England by virtue of the Organ Donation (Deemed Consent) Act 2019, s 1, from spring 2020.

<sup>45</sup> Criminal Justice and Courts Act 2015, s 20. This offence also applies to individuals providing social care. I note that this *mala in se* conceptualization might be contested by authors who construe this offence as a form of criminal labour discipline for poorly paid and overworked workers in the contemporary context of austerity and the underinvestment in social care. Thanks to Alan Bogg for this observation.

<sup>46</sup> Antony Duff, *Answering for Crime* (Hart 2007) 90–92, 173 (hereafter Duff, *Answering for Crime*).

<sup>47</sup> Human Fertilisation and Embryology Act 1990 (hereafter HFEAct 1990), s 41.

There are health concerns posed to women seeking IVF, for instance, such as ovarian hyperstimulation and the increased likelihood of multiple births, which criminalization of non-licensed treatment could address.

A more critical appraisal of the grounds for criminalization, however, may peel away apparently regulatory and utilitarian-based concerns to uncover concerns founded in morality, and the appeasement of slippery slope fears that a less strict regulatory approach could lead to the availability of fertility treatment 'on demand' and scientists 'playing God'.<sup>48</sup> As will now be discussed, for each of the examples given above, there was a public interest beyond that of public safety which demanded criminalization.

Duff reminds us that in order for wrongful behaviour to be criminalized, there must be a sufficient public interest to criminalize the wrong in question<sup>49</sup> and the required seriousness of that wrong must be high, given the grave repercussions for the accused upon a guilty plea or conviction. Considering his first requirement, the particular statutory offence of removing, retaining, or using 'relevant material' from a deceased person's body came in the wake of great public concern and moral outrage surrounding the retained organs scandals in the late 1990s and early 2000s.<sup>50</sup> Similarly, the offence regarding the ill-treatment and wilful neglect of another by a care worker was created following highly publicized scandals such as that involving the callous indifference shown to patients' welfare by health care professionals at the Mid Staffordshire NHS Trust.<sup>51</sup> The genesis of the HFEAct 1990 lay in the report of the Warnock Committee, which itself was established to consider the legal, social, and ethical implications of medical and scientific developments regarding human fertilization and embryology.<sup>52</sup> The rapid progression of the research and treatment in this area in the late 1970s and early 1980s without regulation gave rise to public unease, to fears of doctors and scientists 'playing God', and to concerns that certain barriers should not be crossed.<sup>53</sup> Under the legislation subsequently enacted, the underscoring of moral lines by criminalization is illustrated by other offences that the crime regarding unlicensed treatment sits alongside, offences that prohibit the keeping or use of an embryo beyond fourteen days after its creation, the placing in a woman of a non-human embryo, and (subsequently) reproductive cloning.<sup>54</sup> And it was a public interest concern in the potential exploitation of women prepared to act as surrogate mothers that was provided for the Warnock Committee's recommendation that commercial surrogacy be criminalized, and that

<sup>48</sup> Mary Warnock (Chair), *Report of the Committee of Inquiry into Human Fertilisation and Embryology* (Cmnd 9314, 1984) [11.27].

<sup>49</sup> See generally Duff, *Answering for Crime* (n 46).

<sup>50</sup> At the Bristol Royal Infirmary and the Alder Hey Children's Hospital in Liverpool. See Retained Organs Commission, *Remembering the Past: Looking to the Future: The Final Report of the Retained Organs Commission* (Department of Health 2004).

<sup>51</sup> Mid Staffordshire NHS Foundation Trust Inquiry, *Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust January 2005–March 2009* (HMSO 2010).

<sup>52</sup> Warnock, *Report* (n 48).

<sup>53</sup> 'What is common (and this too we have discovered from the evidence) is that people generally want some principles or other to govern the development and use of the new techniques. There must be some barriers that are not to be crossed, some limits fixed, beyond which people must not be allowed to go.' Warnock, *Report* (n 48) 2[5].

<sup>54</sup> HFEAct 1990, s 41. Reproductive cloning is prohibited since an embryo created by cloning is not a 'permitted embryo', and the Act prohibits the placing in any woman of any embryo other than a permitted embryo. It was concerns that reproductive cloning was unregulated due to a gap in the original legislation (see *R (on the application of Quintavalle) v Secretary of State for Health* [2001] 4 All ER 1013) that led to the enactment of the Human Reproductive Cloning Act 2001, which criminalized reproductive cloning and was then superseded by the amendments to the HFEAct 1990 brought about by the Human Fertilisation and Embryology Act 2008.

... the legislation be sufficiently wide to render criminally liable the actions of professionals ... who knowingly assist in the establishment of a surrogate pregnancy [on a commercial basis].<sup>55</sup>

Each of these examples thus illustrates a public interest in favour of regulating certain aspects of medical practice via the criminal law embedded in something more than (just) public health and safety.

Although not an offence targeted specifically at the medical profession, the application of the offence of gross negligence manslaughter (GNM) to doctors ('medical manslaughter') raises important public interest issues both *for* and *against* invoking the criminal law which are worthy of note here. The offence applies to anyone who causes death through a grossly negligent act, with the seminal case of *Adomako* involving an anaesthetist who failed to notice for over four minutes that the tube carrying oxygen to the patient during an operation had become disconnected.<sup>56</sup> The first public interest argument in favour of prosecuting doctors for GNM rests upon a rule-of-law-based rationale: that in a society in which causing another's death through grossly negligent conduct is deemed grave enough to constitute a criminal wrong, the law should apply to all and all should be equal before the law. It was the general view that Dr Adomako's standard of care was abysmal and his breach of duty was grossly negligent,<sup>57</sup> and thus it was surely right that he faced the same penal consequences as anyone else who causes death through acting in a way that amounted to a grossly negligent breach of duty.<sup>58</sup> The second public interest ground in support of prosecuting doctors for GNM relates to trust, that is, the public's trust in the medical profession. Grievous mistakes can seriously erode this trust and doctors who cause or significantly contribute to a patient's death through gross negligence should face the consequences of criminal prosecution.

The prosecution of other doctors for GNM, however, has attracted concerns that doctors are being targeted unfairly,<sup>59</sup> that we are failing to take account of the nature of a medical professional's job and the risks she takes for socially beneficial reasons,<sup>60</sup> and that causing doctors to fear the criminal law endangers patient safety.<sup>61</sup> Notably, for instance, the convictions of junior doctors Prentice and Sullman who injected the drug vincristine into a

<sup>55</sup> Warnock, *Report* (n 48) 46–47, [8.18]. This is an offence under the Surrogacy Arrangements Act 1985, s 2. The legislature can hardly be accused of hasty reactionism in its response to assisted reproduction: following the establishment of the Warnock Committee in 1982 and the publication of the Committee's Report in 1984, the government's response was the publication of a white paper in 1987 (*Human Fertilisation and Embryology: a Framework for Legislation* (Cm 259, 1987), with the HFEAct 1990 being enacted after a further three years. In contrast, the HTA 2004 may be an example of the ill-thought-out reactionary criminal regulation of medical practice in response to a high-profile scandal on which emotions ran high (see Brazier and Ost, *Medicine and Bioethics* (n 7) 57).

<sup>56</sup> *R v Adomako* [1995] 1 AC 171 (HL).

<sup>57</sup> Although cf Peter Gooderham and Brian Toft, 'Involuntary Automacity and Medical Manslaughter' in Griffiths and Sanders, *Medicine Crime and Society* (n 7) 177, 185.

<sup>58</sup> 'The law is that anybody who causes the death of anyone else—it does not only apply to a doctor, it applies to motor drivers, railway men, or signalmen, to a number of people—is criminally responsible.' (*R v Bateman* [1925] All ER 45 (Shearman J's direction to the jury); Michael Devlin, 'Medical Manslaughter: When an Error Becomes a Crime' (2010) 26 *Medical Defence Union Journal* 7, 7.

<sup>59</sup> Robin Ferner and Sarah McDowell, 'Doctors Charged with Manslaughter in the Course of Medical Practice, 1795–2005: a Literature Review' (2006) 99 *Journal of the Royal Society of Medicine* 309.

<sup>60</sup> David Archard, 'Criminalizing Medical Negligence' in Alghrani, Bennett, and Ost, *Criminal Law and Bioethical Conflict* (n 7) 236, 245. I return to these matters in the following section.

<sup>61</sup> Brazier and Ost, *Medicine and Bioethics* (n 7) 73; Oliver Quick, *Regulating Patient Safety: The End of Professional Dominance* (CUP 2017) 108.



patient's spine with fatal results, were quashed by the Court of Appeal. The Court held that the judge's failure to direct the jury to consider systemic failings (such as the absence of: consultant supervision over an inexperienced doctor's provision of treatment; a data chart for cytotoxic drugs; and a senior nurse) and miscommunication between the two doctors, went to the issue of Prentice and Sullman's personal culpability.<sup>62</sup> Public interest concerns have been epitomized most recently in Dr Bawa-Garba's prosecution for GNM. A junior paediatrician, in 2015, she was convicted of the GNM of a six-year-old boy who died eleven hours after being admitted to hospital, having developed sepsis due to pneumonia and then suffered a cardiac arrest. Bawa-Garba had misdiagnosed the boy's condition as being caused by gastro-enteritis rather than septic shock, had failed to properly reassess him, and did not seek advice from a consultant.<sup>63</sup> On the day in question, she had been deployed to the Children's Assessment Unit unexpectedly, having just returned from maternity leave. Not only was she responsible for the CAU, but also the emergency department *and* a ward.<sup>64</sup> She had been working a double shift of twelve to thirteen hours and the hospital's IT system was down, meaning that she only received Jack's blood test results five and a half hours after ordering the tests.<sup>65</sup> Alongside a series of failings by medical staff, including Bawa-Garba,<sup>66</sup> there were numerous system failures at the hospital. The Trust's investigation into the incident found various root causes for Jack's death, including:

- the failure of 'medical staff to understand and communicate the significance of abnormal blood results' related to IT system failures;
- the failure of 'nursing staff to recognize the significance of abnormal observations and record and monitor according to clinical need';
- 'ambiguity of the observation and escalation tools in use' in the hospital; and
- 'poor communication of clinical condition between staff because of an absence of effective systems for handover'.<sup>67</sup>

Although her application for permission to appeal against her conviction for GNM was refused,<sup>68</sup> subsequent crowdfunding for Dr Bawa-Garba enabled a successful application to challenge a High Court ruling to erase her name from the Medical Register,<sup>69</sup> which has recently resulted in a successful appeal to the Court of Appeal and her reinstatement on the Register.<sup>70</sup>

<sup>62</sup> *R v Prentice* [1993] 4 All ER 935 CA. cf *R v Misra* [2004] EWCA Crim 2375, [2004] 10 WLUK 232, in which two junior doctors were unsuccessful in their appeals against conviction for GNM. Their employing Trust was later successfully prosecuted for a health and safety offence related to the way in which junior doctors were supervised.

<sup>63</sup> *R v Bawa-Garba* [2016] EWCA Crim 1841. She had also mistaken the boy for another patient for whom there was a 'do-not resuscitate' order in place and had thus halted the administration of life-saving treatment for about a minute until the error was realized and treatment recommenced. This error was accepted to have had no causative impact.

<sup>64</sup> *General Medical Council v Bawa-Garba* [2018] EWHC 76 (Admin), [2018] 4 WLR 44.

<sup>65</sup> *R v Bawa-Garba* (n 63) [4]–[18].

<sup>66</sup> Two nurses were also prosecuted for GNM. One was acquitted, the other convicted.

<sup>67</sup> University Hospitals of Leicester NHS Trust, Investigation Report, Incident Report Form ref no W65737, STEIS log no 2011/3518 <[www.whatdotheyknow.com/request/460255/response/1128108/attach/2/FOI.SUI%20REPORT%20FOI%20Redacted.pdf?cookie\\_passthrough=1](http://www.whatdotheyknow.com/request/460255/response/1128108/attach/2/FOI.SUI%20REPORT%20FOI%20Redacted.pdf?cookie_passthrough=1)> accessed 15 November 2018.

<sup>68</sup> *R v Bawa-Garba* (n 63).

<sup>69</sup> Deborah Cohen, 'Bawa-Garba Granted Court of Appeal Challenge against Erasure Ruling' *British Medical Journal* (29 March 2018) <[www.bmj.com/content/360/bmj.k1455.full](http://www.bmj.com/content/360/bmj.k1455.full)> accessed 15 November 2018.

<sup>70</sup> *Bawa-Garba v GMC* [2018] EWCA Civ 1879, [2019] 1 WLR 1929.

The rationale for this crowdfunding<sup>71</sup> and a primary public interest argument against her prosecution is reflected in the statement in the motion passed unanimously by the Royal College of Paediatrics and Child Health's annual general meeting in 2018 that: '... the criminal prosecution of dedicated doctors for gross negligence manslaughter, following systemic errors, impairs the advancement of safe healthcare for patients.'<sup>72</sup> The GNM example illustrates that, in weighing up whether criminalization of doctors is in the public interest, contextualization and awareness of the environment in which doctors perform their duties is key.<sup>73</sup>

Returning to Duff's second requirement—that the seriousness of the wrong must be high—the wrong of particular crimes can be exacerbated when the perpetrator has acted in their capacity as a medical professional.<sup>74</sup> Undoubtedly, this is because of the breach of trust (both concerning the patient who is the victim, and the public). The most obvious example is that of GP Harold Shipman's killing of vulnerable, elderly patients. Although convicted for murdering fifteen of his patients, reports estimate that the actual number of patients whom he murdered was between 215 and 260.<sup>75</sup> Dame Janet Smith, Chairperson of the Shipman Inquiry, commented that '... Shipman was trusted implicitly by his patients and their families. He betrayed their trust in a way and to an extent that I believe is unparalleled in history.'<sup>76</sup> Cases involving the sexual exploitation of patients are also pertinent here; given their relationship of unequal power, when the doctor's exploitation of his patient is of a sexual nature, this serves to render the abuse of trust especially serious.<sup>77</sup> According to the official Kerr/Haslam Inquiry into two psychiatrists' sexual exploitation of numerous patients in the UK, '[i]n most if not all cases, the effect upon the women of the breach of trust that occurred has been devastating.'<sup>78</sup> A final example here is that of Dr Bramhall, a surgeon who recently pled guilty to the offence of common assault by beating<sup>79</sup> having branded his initials on the livers of two patients during transplantation surgery with an argon gas coagulator.<sup>80</sup> The prosecutor in Bramhall's case presented the surgeon's behaviour as especially wrongful because it was an abuse of trust carried out with disregard for the feelings of unconscious patients.<sup>81</sup> I return to this case, and its implications for the question of whether the regulation of medical professionals' conduct via the criminal law is appropriate, below.

<sup>71</sup> Moosa Qureshi, James Haddock, and Chris Day, 'Independent Legal Opinion on Dr Bawa-Garba Case' *Crowd Justice* <[www.crowdjustice.com/case/help-dr-bawa-garba/](http://www.crowdjustice.com/case/help-dr-bawa-garba/)> accessed 15 November 2018.

<sup>72</sup> Ingrid Torjesen, 'Paediatricians Condemn Treatment of Bawa-Garba' *British Medical Journal* (16 March 2018) <[www.bmj.com/content/360/bmj.k1255](http://www.bmj.com/content/360/bmj.k1255)> accessed 15 November 2018. I return to the implications of this case in the concluding section. On the use of professional disciplinary processes as one alternative to criminal prosecution, see Oliver Quick, *Regulating Patient Safety: the End of Professional Dominance?* (CUP 2017) ch 4.

<sup>73</sup> See also Ash Samanta and Jo Samanta, 'Gross Negligence Manslaughter and Doctors: Ethical Concerns Following the Case of Dr Bawa-Garba' (2019) 45 *Journal of Medical Ethics* 10.

<sup>74</sup> On criminal wrongs being defined as such because of their institutional setting and meaning, see Antony Duff and others (eds), *Criminalization: the Political Morality of the Criminal Law* (OUP 2015) 21.

<sup>75</sup> Smith, *Disguising Death* (n 3) 179.

<sup>76</sup> *ibid* 201.

<sup>77</sup> David Archard, 'Exploited Consent' (1994) 25 *Journal of Social Philosophy* 92, 99.

<sup>78</sup> Department of Health, *The Kerr/Haslam Inquiry: Full Report* (Cm 6640, 2005) 4.

<sup>79</sup> Under the Criminal Justice Act 1988, s 39; *DPP v Little* (1992) 1 All ER 299.

<sup>80</sup> See Matthew Cooper, 'Simon Bramhall: Surgeon who Marked his Initials on Two Patients' Livers Admits Assault by Beating' *The Independent* (London, 13 December 2017) <[www.independent.co.uk/news/uk/crime/simon-bramhall-surgeon-initials-liver-marked-two-patients-livers-assault-guilty-admit-beating-a8108076.html](http://www.independent.co.uk/news/uk/crime/simon-bramhall-surgeon-initials-liver-marked-two-patients-livers-assault-guilty-admit-beating-a8108076.html)> accessed 5 August 2019; Suzanne Ost, 'Drs Bramhall and Bawa-Garba and the Rightful Domain of the Criminal Law' (2018) 45 *Journal of Medical Ethics* 151.

<sup>81</sup> *R v Bramhall* Trial Transcript, 13 December 2017.

Medical practice therefore demands the special attention of the criminal law, and the public interest to this end is wedded to:

- public health and safety (such as the offence regarding unlicensed treatment under the HFEAct 1990);
- morality and the need to counteract the power bestowed upon the medical professional with appropriate accountability (as with the other HFEAct 1990 offences);
- the need to address serious wrongs exacerbated by the doctor's breach of trust, especially in the wake of scandals where the public demands that there be *criminal* accountability for what are deemed to be serious wrongs (as reflected in the HTA and wilful neglect offences, and cases involving doctors who have committed crimes that violate the ethos of the doctor–patient relationship, such as Shipman, Kerr, Haslam, and Bramhall)

At the same time, the current controversy surrounding the application of GNM to doctors suggests that the public interest in invoking the criminal law is shaped by contemporary culture, and a desire to lay the blame at a particular person's feet that runs the risk of neglecting the larger environmental context in which doctors work. Indeed, this controversy may also evidence the way in which the criminal law can be used as a politically convenient tool that *obscures* these structural economic factors by framing the narrative around individual blameworthiness.<sup>82</sup>

#### D. Arguments Supporting the Criminal Law's Special Treatment

Having made the case that medical professionals are treated in a 'special' way by the criminal law and highlighting the significance of the public interest, in this section, I set out three justifications for special treatment.

##### 1. Providing Doctors with Special Protection from the Criminal Law is Appropriate Because of the Nature of their Professional Role

The beneficial role that medical professionals serve to society demands that a 'judgment of social value' be made, through which the point for criminal responsibility is set by assessing the nature of the act and the risk involved.<sup>83</sup> doctors require a medical exemption for what would, outside of the medical context, amount to battery or assault. Moreover, especially in specialities such as accident and emergency and cardiology, doctors face the risk of causing harm and death to others on a daily basis, a frequency of risk that those in other professions do not encounter.<sup>84</sup> Without this protection from prosecution for doing what is a necessary and fundamental part of their role in these specialities, there is a real danger that medical students and trainees would be discouraged from entering into such high-risk specialities.

<sup>82</sup> Thanks to Alan Bogg for this observation.

<sup>83</sup> Ashworth (n 8) 176.

<sup>84</sup> Archard, 'Criminalizing Medical Negligence' (n 60) 245, 247.

## 2. The Special Attention of the Criminal Law is Required to Protect Patients Because of the Nature of the Doctor–Patient Relationship

The scope of the medical exception and defences available exclusively to the medical profession must be carefully controlled. Otherwise, because the medical exception is a professionally focused justification, its existence and accepted legitimacy could engender a position whereby, effectively, the medical profession itself decides what medical behaviour should fall within and outwith the criminal law.<sup>85</sup> What is more, the significance attached to medical opinion in the case of *BM* should alert us to the potential power that doctors can exert over the question of whether procedures and treatment are ‘medical’ for criminal law purposes.

Within the context of the doctor–patient relationship, patients require the criminal law’s protection because of their less powerful position in the doctor–patient relationship. In some respects, this mirrors the situation faced by workers in the employer–employee labour context: patients are the weaker party in a relationship of unequal power; they are vulnerable because of this weaker position, but also because of their ill-health; and their reliance upon the doctor means that their trust can be abused.<sup>86</sup>

## 3. The Special Attention of the Criminal Law is Required to Address What are Perceived to be Both Private and Public Wrongs

Special responsibilities are assigned to doctors. As a society and as individual patients, we trust that doctors act for the good of their patients—and under the contemporary model of health care this involves respecting their autonomy and values—and that they will perform that role professionally.<sup>87</sup> Moreover, the ethics of relationships between doctors and patients

... are intrinsically on a deontological footing—they are about how one person should treat another ... In [the deontological] ethic the patient is an end in themselves, and not a means towards anything else.<sup>88</sup>

This is reflected in the preamble to the GMC’s *Good Medical Practice*: ‘[y]ou must make care of the patient your first concern.’<sup>89</sup> The guidance goes on to state that ‘[g]ood doctors work in partnership with patients and respect their rights to privacy and dignity. They treat each patient as an individual.’<sup>90</sup> It is a private wrong to the patient when the doctor fails to respect this deontological ethic.

<sup>85</sup> And ‘[i]f (to put it crudely) the medical profession can resolve that a medical procedure is lawful, why not simply accept that the criminal law should not apply to medical procedures ...?’ Lewis (n 10) 370.

<sup>86</sup> As an aside, it is also worth highlighting the power asymmetries within medical employment, between senior and junior doctors. See, eg, Sophie Crowe, Nicholas Clarke, and Ruairi Brugha, “‘You Do Not Cross Them’: Hierarchy and Emotion in Doctors’ Narratives of Power Relations in Specialist Training’ (2017) 186 *Social Science & Medicine* 70.

<sup>87</sup> Biggs and Ost, *Exploitation* (n 1) ch 3, s 3.

<sup>88</sup> Gerard Garbutt and Peter Davies, ‘Should the Practice of Medicine be a Deontological or Utilitarian Enterprise?’ (2011) 37 *Journal of Medical Ethics* 267, 267–68.

<sup>89</sup> GMC, *Good Medical Practice* (GMC 2013).

<sup>90</sup> *ibid* 4(2).

According to Duff, a private wrong also amounts to a *public* wrong that warrants the criminal law's intervention when it contravenes defining societal values that the state endeavours to safeguard to ensure the good of its citizens, thereby causing it to be a wrong that should concern all in society.<sup>91</sup> There are stark examples where using the censure of criminal law to send out a message that behaviour will not be tolerated because it constitutes both a private wrong to the patient *and* a public wrong is surely appropriate, such as the afore-discussed examples of taking organs without consent and the ill-treatment of patients. Doctors who behave in such a way perpetrate a harm upon the patient that we should all rightly feel aggrieved by. They may also cause harm to society if patients do not see an appropriate penal response being taken. For patients may consequently fear that there is insufficient deterrent to prevent other doctors from acting in the same way and thus be reluctant to be an organ donor, for example, or to go into hospital. At the same time, there are greyer areas. To return to the example of Dr Bramhall, who branded his initials on patients' organs, a fellow surgeon raised the question whether the law is not 'making an ass of itself in judging his actions to be criminal'?<sup>92</sup> In this surgeon's view, what Bramhall did was 'very silly' and bringing public attention to his actions by criminalizing his behaviour was likely to do more harm than good regarding public trust in the profession and the profession's trust in society. This clearly contrasts with the prosecutor's view, noted above, that Bramhall committed an abuse of trust carried out with disregard for unconscious patients' feelings. And it was a violation of dignity that was emphasized in a comment from a spokesperson for Patient Concern, a patients' rights advocacy group: '[t]his is a patient we are talking about, not an autograph book.'<sup>93</sup>

It is because of the nature of the doctor–patient relationship, and the fundamental duty that lies at the heart of this relationship, that I agree with these latter views and contend that criminalization was indeed appropriate in this case. Although Bramhall caused only temporary, trivial damage to the surface of both patients' livers, his actions led to one patient suffering psychological harm. Whilst not because of any negligence, her liver transplant failed, and she could not shake the belief that this was because of Bramhall's actions. She was receiving counselling, had been unable to return to work, and her victim impact statement revealed that her trust in doctors had been 'destroyed'.<sup>94</sup> In contrast, there was 'no evidence of any adverse emotional impact' in the case of the second patient.<sup>95</sup> But even if the more serious harm had not been caused to the first patient, Bramhall committed wrongs against his patients' interests in dignity and autonomy. Some actions can be so contrary to a doctor's fundamental negative role-based obligations neither to breach the patient's trust, nor to act out of self-interest,<sup>96</sup> that there *is* a public interest in criminalization even where there is no lasting, serious harm. The censure of the criminal law is used rightly to send out the message that such behaviour will not be tolerated because it is both a private wrong to the patient and

<sup>91</sup> Duff, *Answering for Crime* (n 46) 140–46.

<sup>92</sup> Henry Marsh, 'The Surgeon who Signed his Patients' Livers Was Silly, not Criminal. The Law is an Ass' *The Guardian* (London, 15 December 2017) <[www.theguardian.com/commentisfree/2017/dec/15/doctor-signed-patients-livers-law-courts](http://www.theguardian.com/commentisfree/2017/dec/15/doctor-signed-patients-livers-law-courts)> accessed 5 August 2019.

<sup>93</sup> Frances Perraudin, 'Surgeon Admits Marking his Initials on the Livers of Two Patients' *The Guardian* (London, 13 December 2017) <[www.theguardian.com/uk-news/2017/dec/13/surgeon-admits-marking-his-initials-on-the-livers-of-two-patients](http://www.theguardian.com/uk-news/2017/dec/13/surgeon-admits-marking-his-initials-on-the-livers-of-two-patients)> accessed 5 August 2019.

<sup>94</sup> *R v Bramhall* Trial Transcript, Sentencing Remarks, 12 January 2018.

<sup>95</sup> *ibid.*

<sup>96</sup> See Suzanne Ost, 'Breaching the Sexual Boundaries: Should English Law Recognise Fiduciary Duties in the Doctor-Patient Relationship?' (2016) 24 *Medical Law Review* 206, 224.

a public wrong, in that it threatens trust in the profession and brings the medical profession into disrepute. In this sense, the criminal law and its sanctions serve an important symbolic purpose that the professional disciplinary processes of the GMC and professional sanctions cannot.<sup>97</sup>

### E. Concluding Thoughts

Returning to the first of the two central questions posed at the start of this chapter, it is indeed the case that the medical profession is dealt with in a unique way by the criminal law. In certain contexts, the medical professional role seemingly both exculpates doctors and allows medical opinion to have a significant influence on the interpretation of the criminal law. Yet this same role can also attract criminal liability in other circumstances. Looking to the second question, the strongest arguments in favour of this special treatment by the criminal law relate to the public interest in recognizing the beneficial and necessary role that doctors play in society and the public interest in protecting the patient, the weaker party, from serious wrongs that can be perpetrated through the doctor's position of power. More controversially, in some respects, the criminal law acts as the protector of morality under the guise of public safety.

It is striking that, whilst the patient's consent keeps organ transplantation away from the criminal law's grasp<sup>98</sup> and is one of the elements that can legitimate other medical interventions which would otherwise constitute offences against the person, patient choice/consent has not shaped the criminal law's response to doctors' involvement in abortion or medical intervention at the end of life that hastens death. Rather, the primary justification for the criminal law's special treatment lies in the professional standards of 'good medical practice' and 'proper medical treatment'. This is out of sync with the contemporary doctor–patient model that prioritizes patient autonomy and seeks to reduce the doctor's influence,<sup>99</sup> and it is notable that the case of *BM* furthers this discord by ignoring the autonomy of individuals who sought body modification through judicial reliance on medical opinion. Whilst aspects of the civil law have been modified to better reflect the contemporary doctor–patient model, such as the common law on the disclosure of risks of a particular medical procedure to the patient,<sup>100</sup> the criminal law has been left behind. But any call to change the ground of exculpation under criminal law to patient consent would undoubtedly be met with concerns that this could put the vulnerable at risk,<sup>101</sup> and would lead to a liberalization of the criminal law in highly morally contentious areas that would simply be too controversial.

<sup>97</sup> And the significance of the serious repercussions for a doctor who is found culpable under the criminal law is recognized by the provision of procedural protections under additional parts of art 6 of the European Convention on Human Rights that relate to criminal proceedings (the privilege against self-incrimination; not being forced to testify; the required presumption of innocence; the high standard of proof).

<sup>98</sup> Albeit that this is *deemed* consent under the law in England from spring 2020 (HTA 2004, s 3(6)(ba)).

<sup>99</sup> See also Sally Sheldon, 'British Abortion Law: Speaking from the Past to Govern the Future' (2016) 79 *Modern Law Review* 283, 294–96.

<sup>100</sup> In the move away from the application of the *Bolam* test to the prudent patient test in recent cases such as *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, [2015] AC 1430.

<sup>101</sup> As often voiced by members of the judiciary in cases where the criminal law's prohibition of assisted suicide is challenged. See, eg, *Pretty v UK* (2002) 35 EHRR 1 [74]; *R (on the application of Nicklinson) v Ministry of Justice* [2014] UKSC 38, [2015] AC 657 [86]; *R (on the application of Conway) v Secretary of State for Justice* [2017] EWHC 2447 (Admin), [2018] 2 WLR 322 [96], [116]. See also Biggs and Ost, *Exploitation* (n 1) ch 7.

Also noteworthy is the fact that whilst doctors receive special treatment from the criminal law by way of both protection and targeted criminalization, the criminal law acts only as a shield for patients; that is, there are no criminal offences that are directed specifically at patients. As such, there is a contrast with the criminalization of workers, the weaker party in the employer–employee relationship, for certain types of conduct in labour law. Although this criminalization of workers is critiqued persuasively elsewhere in this volume, we should be mindful of assuming that as the weaker party, the patient is unable or prevented from committing a crime against the doctor.<sup>102</sup> Indeed, there is no exemption from criminal liability for patients by virtue of their less powerful role in the doctor–patient relationship; a patient who makes unwelcome sexual advances to a doctor, including physical touching, commits the offence of common assault and, depending on whether the touching is sexual, sexual assault.<sup>103</sup>

Turning back to doctors' criminality, there are dangers in being too quick to lay the blame at the feet of individual doctors and being over-eager to bring them to account under the criminal law. If the doctor is always seen as the party most likely to violate the criminal law and wrong patients, as the party taking unjustified risks with patients' health and safety, then we may be less sensitive to systemic failures such as those which occurred in the cases involving Drs Prentice and Sullman and Bawa-Garba.<sup>104</sup> Whilst there is a clear public interest in prosecuting serious wrongdoing that leads to a patient's death, prosecuting an individual doctor for GNM because of their failings which have occurred in the context of systemic failings is unfair.<sup>105</sup> This is especially so in cases such as Bawa-Garba's, where 'systemic safety nets' which should have detected and removed the failings the day before the event were not working, with the result that serious failings had consequences that equally serious failings at another time simply would not have had.<sup>106</sup> What is more, prosecutions for GNM discourage doctors from following their duty of candour,<sup>107</sup> from being open about their mistakes, and learning from these mistakes. Bawa-Garba's prosecution and conviction may

<sup>102</sup> On the occurrence of sexual exploitation and harassment of health care professionals by patients, see Hazel Biggs and Suzanne Ost, '(I love you!) I do, I do, I do, I do, I do: Breaches of the Sexual Boundaries by Patients in Their Relationships with Health Care Professionals' in Catherine Stanton and others (eds), *Pioneering Healthcare Law: Essays in Honour of the Work of Margaret Brazier* (Routledge 2016) 91.

<sup>103</sup> Sexual Offences Act 2003, s 3; *ibid* 100–01.

<sup>104</sup> While space precludes discussion, the issue of the employing Trust's duties to doctors (as employees), especially under health and safety law, is of relevance here.

<sup>105</sup> A prosecution for GNM is focused primarily on *individual* culpability, and this explains why systemic failings 'were only of peripheral relevance to the guilt or absence of Dr Bawa-Garba's guilt' (*Bawa-Garba v GMC* (n 70) [74]). That said, it was stated by Lord Mackay in *R v Adomako* (n 56) 187 that whether a breach of duty amounts to gross negligence '... will depend on the seriousness of the breach of duty committed by the defendant *in all the circumstances* in which the defendant was placed when it occurred'. (emphasis added). Bawa-Garba's appeal can be contrasted with that in *R v Prentice* (n 62) because her case for appeal was based on the judge's direction to the jury on causation, with no focus on any systemic failings as excuse or mitigation regarding whether she was grossly negligent. In passing sentence, the judge alluded briefly to failings other than Bawa-Garba's, noting that '[t]here was a limit to how far these issues could be explored in the trial, but there may be some force in the comment that yours was a responsibility that was shared with others' (*General Medical Council v Bawa-Garba* (n 64) [3]). It has since been a positive development that the new definitive guideline on sentencing manslaughter requires judges to take account of environmental factors such as 'circumstances where there was reduced scope for exercising usual care and competence' and the offender being 'subject to stress or pressure (including from competing or complex demands) which related to and contributed to the negligent conduct' in mitigation (Sentencing Council, *Manslaughter Definitive Guidance* (Crown 2018)). However, this does not address the concerns of prosecuting doctors for GNM in such cases in the first place.

<sup>106</sup> *General Medical Council v Bawa-Garba* (n 64) [46].

<sup>107</sup> GMC, *Good Medical Practice* (n 89) 55; Oliver Quick, 'Regulating and Legislating Safety: The Case for Candour' (2014) 23 *British Medical Journal Quality & Safety* 614.

have made the achievement of 'a just and learning culture'<sup>108</sup> more difficult, especially given that there is already a 'culture of fear' within the medical profession regarding the perceived increasing risk of being prosecuted for GNM.<sup>109</sup> In particular, Bawa-Garba's case has given rise to a fear that doctors' written reflections for appraisals concerning incidents involving mistakes could be used against them in court, causing some doctors to disengage from this practice notwithstanding it being a professional requirement.<sup>110</sup> This is one of the reasons why the case was the catalyst for the GMC's review into the way in which the GNM offence is applied to doctors.<sup>111</sup>

In cases like Bawa-Garba's, the utilization of a criminal offence that captures the wider, systemic wrongs rather than targets one individual is surely more appropriate. The obvious candidate crime might seem to be corporate manslaughter, for which an NHS Trust could be prosecuted where a patient dies because of a gross breach of a duty of care, and 'the way in which its activities are managed or organized by its senior management is a substantial element in the breach'.<sup>112</sup> Indeed, a request has been made to the Leicestershire Police that the hospital trust involved in the Bawa-Garba case be investigated for alleged corporate manslaughter.<sup>113</sup> In the broader context, early in 2018, doctors working in sixty-eight A&E departments across the UK advised the Prime Minister that 'conditions in many A&E units are so appalling that they could kill patients'.<sup>114</sup> If systemic failings as grave as those which occurred in the Bawa-Garba case are present more widely across NHS hospitals and lead to other patients' deaths, this could constitute a public criminal wrong at the corporate level. However, there are cogent arguments that this offence is far from the best means to achieve this because of its complexities, especially when applied to NHS Trusts.<sup>115</sup> An alternative means of bringing a Trust to account under the criminal law is through health and safety offences.<sup>116</sup> It has been opined that directing accountability at the organizational level might reduce the likelihood of doctors making mistakes provided it leads to the modification of

<sup>108</sup> A key concern for the government's recent rapid policy review into issues regarding GNM in healthcare: Norman Williams, *Gross Negligence Manslaughter in Healthcare* (Crown 2018) 9, [3.4].

<sup>109</sup> Margaret Brazier, Sarah Devaney, Danielle Griffiths, Alex Mullock, and Hannah Quirk, 'Improving Healthcare through the Use of Medical Manslaughter?' (2017) 22 *Clinical Risk* 88.

<sup>110</sup> Nick Bostock, 'GMC warning over calls for GPs to stop written reflection' *GP* (4 March 2018) <[www.gponline.com/gmc-warning-calls-gps-stop-written-reflection/article/1459415](http://www.gponline.com/gmc-warning-calls-gps-stop-written-reflection/article/1459415)> accessed 15 November 2018; Jenny Vaughan, Oliver Quick, and Danielle Griffiths, 'Medical Manslaughter: Where Next?' (2018) 100(6) *Royal College of Surgeons Bulletin* 17.

<sup>111</sup> GMC, 'Marx Medical Manslaughter Review Invites Written Evidence' *GMC* (4 June 2018), <[www.gmc-uk.org/news/media-centre/media-centre-archive/marx-medical-manslaughter-review-invites-written-evidence](http://www.gmc-uk.org/news/media-centre/media-centre-archive/marx-medical-manslaughter-review-invites-written-evidence)> accessed 15 November 2018.

<sup>112</sup> Under the Corporate Manslaughter and Homicide Act 2007 (CMHA 2007), s 1.

<sup>113</sup> Tim Pieters, 'Police "to Discuss" Calls to Prosecute Hospital over Bawa-Garba Case' *Pulse* (London, 2 February 2018) <[www.pulsetoday.co.uk/your-practice/practice-topics/legal/police-to-discuss-calls-to-prosecute-hospital-over-bawa-garba-case/20036103.article](http://www.pulsetoday.co.uk/your-practice/practice-topics/legal/police-to-discuss-calls-to-prosecute-hospital-over-bawa-garba-case/20036103.article)> accessed 15 November 2018; Anon, 'Jack Adcock Death: Call to Charge Leicester Royal Infirmary' *BBC News* (31 January 2018) <[www.bbc.co.uk/news/uk-england-leicestershire-42892862](http://www.bbc.co.uk/news/uk-england-leicestershire-42892862)> accessed 5 August 2019.

<sup>114</sup> Denis Campbell, Pamela Duncan, and Sarah Marsh, 'NHS Patients Dying in Hospital Corridors, A&E Doctors Tell Theresa May' *The Guardian* (London, 11 January 2018) <[www.theguardian.com/society/2018/jan/11/nhs-patients-dying-in-hospital-corridors-doctors-tell-theresa-may](http://www.theguardian.com/society/2018/jan/11/nhs-patients-dying-in-hospital-corridors-doctors-tell-theresa-may)> accessed 5 August 2019.

<sup>115</sup> There are wider implications of assigning criminal responsibility at the corporate level when hospital conditions and the systems in place are unavoidably affected by a lack of resources. And note that if the patient's death is attributable to a decision concerning a matter of public policy, such as the allocation of public resources, then a Trust could not be liable under the legislation (see CMHA 2007, s 3(1); Celia Wells, 'Medical Manslaughter—Organisational Liability' in Griffiths and Sanders, *Medicine Crime and Society* (n 7) 192, 202).

<sup>116</sup> Under the Health and Safety at Work Act 1974, s 33. See, eg, *R v Southampton University Hospital NHS Trust* [2006] EWCA Crim 2971, [2006] 11 WLUK 278.



working conditions.<sup>117</sup> But the punishments imposed on NHS bodies in the health and safety prosecutions that have come before the courts have led to arguments that ‘individuals are punished disproportionately as compared to their employing NHS bodies,’<sup>118</sup> and ‘a health and safety conviction seems to be an unfair label to ascribe to ... cases where a patient’s death results from gross systemic negligence.’<sup>119</sup>

Related to the concern of placing the blame for the consequences of broader failings upon individual doctors, we should not forget that doctors are workers; they are employees capable of being exploited and over-worked by their employers<sup>120</sup> and for some, their professional role gives rise to challenging dual duties towards their patients and their employers, such as doctors who work in prisons.<sup>121</sup>

As a final point for consideration, does the analysis in this chapter indicate that there is something distinctive about the *medical* profession that means it is a unique category of the professions requiring special attention from the criminal law, or is this also the case for other professionals whose role also involves intimate and confidential relationships of trust and on whom society bestows privileged status? I have in mind here solicitors and their professional relationships with clients, and clerics and their professional relationships with members of their congregations, for example. Just as the seriousness of the wrong of a sexual offence can be exacerbated further when committed by a doctor who breaches his patient’s trust, for instance, so too can this be the case if the offence occurs through a breach of trust perpetrated by a clergyman.<sup>122</sup>

If medical practice and the provision of health care is unique, then should the special treatment explored in this chapter be restricted to those who possess medical qualifications,<sup>123</sup> or should it be extended to other health care professionals? There are aspects of criminal law’s special exculpatory treatment of doctors (primarily the ‘medical exception’) that are connected integrally to the medical nature of the role.<sup>124</sup> That said, even with regard to the provision of some procedures that are generally construed to be medical, there is reason to challenge the position that the criminal law’s special treatment by way of a defence should only be offered to doctors. Take abortion, for instance: especially in cases of early abortion, the doctor’s role is largely reduced to prescribing drugs and providing instruction, the drugs that cause abortion are often self-administered by the woman, and abortion through vacuum aspiration (a commonly used method in England and Wales) could be carried out by an appropriately trained nurse or midwife.<sup>125</sup> What is more, if we consider special treatment by way of targeted criminalization, there are examples of criminalization in the medical context that are less connected to medical procedures or treatment and can

<sup>117</sup> Neil Allen, ‘Medical or Managerial Manslaughter?’ in Erin and Ost, *Criminal Justice System* (n 7) 51, 54.

<sup>118</sup> Gooderham and Toft (n 57) 185.

<sup>119</sup> Allen (n 117) 53.

<sup>120</sup> Antonia Rich and others, ‘“You Can’t be a Person and a Doctor”: The Work–Life Balance of Doctors in Training—A Qualitative Study’ (2016) *British Medical Journal* <<https://bmjopen.bmj.com/content/6/12/e013897>> accessed 15 November 2018.

<sup>121</sup> See British Medical Association Ethics Department, *Medical Ethics Today: The BMA’s Handbook of Ethics and Law* (Wiley 2012) 27–28.

<sup>122</sup> The case for a new abuse of trust offence that would be committed when, whilst in a position of trust, a person intentionally causes a sexual act to occur by exercising undue control or influence, is made in Biggs and Ost, *Exploitation* (n 1) ch 5, s 4.

<sup>123</sup> See, eg, Brazier and Fovargue, ‘Transforming Wrong’ (n 13) 16. Cf Ashworth, (n 8) 186 and 190.

<sup>124</sup> See also Lewis (n 10) 372.

<sup>125</sup> Sheldon, ‘British Abortion Law’ (n 99) 303–07.

clearly apply to other professionals, such as the offence of wilful neglect which can be committed by any health or social care worker. Thus, we return to the significance of context; whilst the medical profession continues to be a relatively autonomous category of personal work relations that is dealt with in a unique way by the criminal law, whether there is a public interest in treating doctors in this special way depends upon the duties being performed, the environment in which the doctor is working, and whether a serious wrong has been committed through the abuse of a position of power and trust.