Manslaughter and preventable harm

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The criminal prosecution and subsequent imprisonment of surgeon David Sellu for manslaughter following the death of a patient under his care provided the impetus for a meeting on 'Doctors, manslaughter and avoidable harm', which took place in London in April.

No doctor goes into work intending to harm patients. However, in this world of increasingly complex and interdependent medicine, mistakes can, do and will always happen.1,2 The criminal prosecution and subsequent imprisonment of surgeon David Sellu for manslaughter following the death of a patient under his care has sent shock waves through the medical profession3 and provided the impetus for this meeting on 'Doctors, manslaughter and avoidable harm'. Ian Franklin, vascular surgeon, opened the meeting. Ian, together with Dr Jenny Vaughan, consultant neurologist, jointly organised an excellent event.

DAVID SELLU’S STORY

Mr Franklin described how David Sellu, a general surgeon with a previously blameless clinical record, had been referred a patient who had developed abdominal pain a few days after a total knee replacement in the Clementine Churchill, a private hospital in Harrow, North London.

The patient was seen that evening and a CT scan arranged for the following morning. This revealed free gas in the abdomen; a diagnosis of a perforated viscus and peritonitis was established. There was an unfortunate delay in getting to the operating theatre, mainly because of the difficulty in finding an anaesthetist, since there was no on-call anaesthetic rota for that hospital. Sadly, the patient subsequently died and this fatal outcome set in train the eventual criminal prosecution and imprisonment of Mr Sellu for gross negligence and manslaughter.

MEDICAL CRIME

Michael Powers QC, a qualified doctor and a barrister, then provided a historical review of medical crime, pointing out that to obtain a successful prosecution the jury had to be convinced that the medical practitioner was not merely negligent, but criminally negligent, in his or her 'disregard of life'. He exemplified this with the cases of Richie Williams and Wayne Jowett, two teenagers with leukaemia, who both died as a direct result of vincristine being administered intrathecally as opposed to intravenously, in Great Ormond Street and Nottingham Hospitals, respectively. In both cases the doctors were prosecuted, but only in the latter was the prosecution upheld, despite the clear similarities between the two scenarios. Neil Dalton from the Criminal Prosecution Service (CPS) then described the process by which the decision to prosecute is made. He stated that the opinion of independent medical experts almost always heavily influenced this decision.

Professor Colin Leys then highlighted the patient safety deficiencies of some private hospitals, especially the smaller ones outside central London. He pointed out that, although they now received 25% of their revenue from the NHS, there was little or no requirement for them to report patient safety data such as 'near misses'. He highlighted the issue of poor record-keeping, and particularly criticised the lack of on-call anaesthetic cover in many private hospitals.

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Lawyer Oliver Quick then described his empiric research findings that highlighted the vagueness of the definition of ‘gross negligence’ and concluded that it could result in unfairness. He also suggested that there seemed to be a disproportionate percentage (almost 50%) of prosecutions brought against non-white doctors. This raised the worrying possibility that there is racial discrimination against non-Caucasian medical practitioners when serious medical accidents occur.

FOCUS ON INDIVIDUAL CLINICIAN

Ian Barker, senior solicitor for the Medical Defence Union, agreed that there has been a very noticeable upwards trend towards doctors being investigated by the police, and subsequently prosecuted. The coroner, relatives and the hospital where the mishap occurred can all inform the police. Once an investigation is commenced, the process often focuses exclusively on the role of the individual clinician, rather than the team or the institution. He emphasised that no NHS Trust or private hospital board wants to be prosecuted for ‘corporate manslaughter’, so they were not always supportive of clinicians who make errors. He also mentioned that it is usually easier to achieve the conviction of an individual doctor, as opposed to a particular private or NHS institution.

Mr Ken Woodburn, FRCS, then touchingly described his own personal agony following a police prosecution for manslaughter after a teenager with leukaemia tragically died following a mishap during insertion of a subclavian line in 2001. Mr Woodburn described the isolation he and his family felt, as well as the bitterness about the process, which still lingers. Eventually he was cleared of the charge of manslaughter by the jury, which deliberated for only an hour. ‘I was working with a team that I’d never worked with before. It was an extra list on a Saturday morning to achieve waiting-list targets forced on me by managers, and it was an extra case added to that list’, he stated. He also complained about the lack of support from the Trust during the investigation and trial, and emphasised that as a doctor these days you are ‘only one error away from a manslaughter trial’.

Peter MacDonald, surgeon, emphasised the variation in skill and expertise of so-called ‘expert witnesses’, whom he felt were sometimes less than impartial and too often simply followed the line of the prosecution, whose objective is to obtain a guilty verdict. In the discussion there was concern that the CPS could change or ‘flip’ their selection of expert witness if they felt that their original choice was insufficiently robust.

One of the authors of this report (RSK) then stressed the point that most medical accidents are the result of an ‘error chain’, which leads inexorably to one individual committing the eventual ‘fatal mistake’.4 A ‘systems’ as opposed to a ‘person’ approach to medical accident investigation allows the team and the institution to learn from the mistake, instead of focusing the blame exclusively on one individual doctor and making him or her the ‘second victim’.5 In the aviation industry and other high-risk industries, this lesson has already been learnt, and applied for more than two decades.

SUMMARY

Jenny Vaughan then summarised the meeting as follows. The David Sellu case illustrates some of the problems associated with the criminal prosecution of a clinician after a mishap that results in a patient’s death. The police and the CPS tend too often to focus purely on the clinician who makes, in their eyes, the ‘fatal error’. In fact, as a result of the complexity and interdependency of modern medicine, there is almost always an error chain involving multiple other individuals. In modern healthcare it is usually the team and the organisation as a whole that require balanced scrutiny, as opposed to a single member of the team at fault.

It appears to be easier for the police, the CPS and the criminal justice system to go after an individual. Ultimately, this does not make patients safer as there is no incentive for organisations to change the things that may have allowed the incident to happen in the first place. No doctor should be above the law, but the impact of defensive medicine and the loss of chances for high-risk patients these prosecutions necessarily cause should be of great concern to society as a whole.

Bernard Jenkins, Chairman of the Public Administration Select Committee, has recently commented that the handling of clinical failures ‘fails to foster positive outcomes or learning from mistakes. Instead there seems to be a culture of blame and of responding only to mistakes’. We most certainly agree; there really has to be a better way forward than imprisoning a doctor for two and a half years in the twilight of his career.

REFERENCES

2. Leape L, Berwick DL. 5 years after “To Err is Human”, what have we learned? JAMA 2005; 293:2384–90.