

Would criminalising healthcare professionals for wilful neglect improve patient care?



The government is consulting on bringing such a crime to the statute books. **Jo Bibby** says it would deter poor care that results in severe harm but not death, but **Christine Tomkins** thinks sufficient sanctions already exist and that such a move might be detrimental in several ways, including reducing openness

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News: Healthcare leaders call for end to criticism of NHS in 2014 (*BMJ* 2014;348:g5)

News: NHS must adopt a culture of “zero tolerance” for patient harm, Francis report says (*BMJ* 2013;346:f847)

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YES The House of Commons health select committee held hearings in response to two inquiries into the tragedy that unfolded at Mid Staffordshire NHS Foundation Trust between 2005 and 2009, where many of the excess deaths and harms might have been caused by staff negligence. Giving evidence, the chairman of the two inquiries, Robert Francis QC, said that “there did not seem to me to be a range of criminal sanctions available to reflect the sorts of terrible things I found.”¹ I believe that the government’s proposal in *Hard Truths*,² its response to Francis’s inquiry, to legislate on sanctions where individuals or organisations are unequivocally guilty of wilful or reckless mistreatment of patients is necessary, albeit not sufficient, to improve care.

Purpose of legislation

Legislation serves several purposes. Here, it would be expressive—a statement about boundaries of acceptability and a deterrent to deviant behaviour—and, if necessary, restorative—ensuring society’s need for justice is met. There are many instances

when introduction of legislation to curb behaviours has led to improvements in the quality of other aspects of our lives. For instance, the drink driving laws, contested by many at the time, have been associated with an 82% reduction in drink driving related deaths over the past 30 years.^{3,4}

There are precedents for the proposed new legislation. Children and vulnerable adults are protected from wilful neglect under the Children and Young Persons Act 1933 and the Mental Capacity Act 2005. Whether these laws have led to improvement is hard to prove because, as with any deterrent, the measure of their success is in how seldom they are used. When they have been used, however, such as in the case of Hetherington and Lacey, two care workers found guilty of tormenting and abusing two patients with dementia, the conduct was so far below what any reasonable person would expect it seems hard to argue against its application.⁶ Without legislation that took into account the specific context—that is, the duty to care and the vulnerability of the victim—it is unlikely that the actions themselves would have resulted in prosecution under general assault laws. More important though is Yeung and Horder’s observation that there is no evidence

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NO The UK government is considering whether to adopt Professor Don Berwick’s recommendation to introduce a new criminal sanction in cases where healthcare workers or organisations are “unequivocally guilty of wilful or reckless neglect or mistreatment of patients.”^{10 11}

No doctor would disagree with the premise that sanctions should apply if a patient is wilfully or recklessly mistreated, however, there are already sanctions in place, some of which are criminal, which could be applied in such circumstances.

Although the Berwick report acknowledged the existence of such sanctions, it did not explain why they should be considered ineffective or how an as yet undefined criminal sanction of wilful neglect would be any more effective in protecting patients.

If a new offence is to be considered, it is important to establish why an additional deterrent is necessary. There must also be a careful and thorough examination of the potential adverse and unintended consequences of any new sanction and explanations of how these will be managed or avoided.

How would the new offence be defined?

It is not clear whether the proposed offence would involve only “wilful neglect” or extend also to “mistreatment” or “ill treatment.” It is intended as an additional means of holding to account “those guilty of the most extreme types of poor care.” But will the definition of “care” include treatment and, for example, withholding treatment? Does it have to be a deliberate action or omission or can it involve forgetting to do something if serious harm ensues? This is not just semantics. If as a result of being found guilty doctors and others stand to lose their career and their liberty, the offence needs to be defined precisely.

It has been suggested that the sanction would apply only in serious cases—what Professor Berwick called “egregious acts or omissions.” How will these “serious cases” be defined? Will severity be related to the extent of the harm experienced by the patient or by the seriousness of the action or inaction of the professional? For example, if a surgeon agrees with a competent patient that an operation would be futile and the patient then dies, the family might still be aggrieved that their relative did not get the operation. They might think it could have made a difference and bring a claim for damages, but there might also be allegations of wilful neglect.

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to suggest that the introduction of the Mental Capacity Act has generated a culture of fear or inhibited candour or cooperation between healthcare workers or led to overzealous use of the criminal law.⁷ So, on the basis of equality under the law, shouldn't everyone receiving healthcare—many of whom are incredibly vulnerable—be afforded the same protection as patients covered by the Mental Capacity Act?

An understandable concern expressed in the current debate is that health professionals could be prosecuted where harm has occurred through circumstances outside their control—for example, as a result of insufficiently resourced clinical settings, poorly designed systems of patient care, or human error. This would not be the case. The proposed legislation would apply only to “wilful” neglect, where an individual deliberately or recklessly fails to carry out an action that they know they are under a duty to perform and were able to do so or where they engage in deliberate mistreatment.

Rarely needed but necessary

In a professional context where nearly everyone is driven by their motivation to do the best for their patients, this would, in reality, relate to few cases. Although the infrequency of its likely application might lead some to question the need for legislation, I believe it is supported for four important reasons.

Firstly, effective regulation is widely accepted to rest on regulators having at their disposal a wide and varied range of sanctions of increasing severity. There is currently a gap in sanctions for actions that might result in severe harm but do not cause death.

Secondly, making wilful neglect a criminal rather than a civil liability protects everyone rather than just those with the means to take civil action. It also removes the need to demonstrate that actual harm occurred but would cover an unjustified risk of harm. In a healthcare setting, where people might already be experiencing unavoidable consequences of their condition or treatment, this broader interpretation is important.

Thirdly, given that harm and protocol violations are sometimes unavoidable, legislation can focus minds and create greater awareness of what constitutes

neglect. Vaughan's description of the social normalisation of deviance, where people become so accustomed to a deviant behavior that they don't consider it as deviant, could just as easily have been written about Mid Staffordshire as the circumstances that led to the Challenger shuttle disaster.⁸

Finally, because the proposed legislation could be applied to organisations as well as individuals, a critical contribution could be to strengthen the hand of staff working in situations that seriously impede their ability to deliver safe and compassionate patient care.

Of course, this legislation wouldn't be without potential pitfalls. To be effective and avoid the risk of unintended consequences, we would need clarity in the interpretation of “wilful” and thorough evaluation of its impact. Although legislation will hopefully deter rare and extreme cases of wilful neglect, in debating the appropriate response to a “special cause” problem we must not lose sight of the action that is required to tackle “common cause” factors. Most avoidable harm experienced by patients arises from the challenges of delivering reliable care processes and minimising the risk of human error.⁹

Recourse to criminal sanctions should be rare

When something goes wrong, however, there are often attempts to bring professionals to account in as many ways as possible, and were a new sanction available it seems likely to be considered. It is unrealistic to say in advance that a sanction will be applied rarely because if a sanction exists and a concern is raised the process must be followed. The police have to investigate and the Crown Prosecution Service (CPS) has to decide if the case should proceed to court. Few professionals might be found guilty of wilful neglect and sentenced, but that ignores the process that leads to such findings, which could result in many doctors and others being investigated, often over years, even if ultimately no sanction is imposed.

Consider the experience of one of the Medical Defence Union's solicitors who has helped more than 100 members who have been investigated for manslaughter in the past 25 years. About one in 10 cases resulted in a prosecution. Of those prosecuted, some 20–25% resulted in conviction, compared with the CPS's general conviction rate of about 90%. These figures show that about 75% of these doctors were prosecuted unnecessarily. The number who went through investigations that

lasted months and sometimes years was even greater, and at the end of all this no sanction was imposed.

If investigations for wilful neglect were to have a similar rate, this would cause enormous distress and disruption to those accused and to the NHS generally, affecting patient care through investigation of cases that are not prosecuted and further undermining patients' trust in doctors.

No more of a deterrent

It has been suggested a new crime of wilful neglect will deter those who otherwise might, presumably, neglect or mistreat patients. Do we really think doctors are going to go to work thinking, “I had better do my very best today, in case I get prosecuted?”

The proposed new law might well encourage a culture of fear and blame rather than one of learning and openness. Patients trust dedicated professionals every day with their lives and health. How will another threat do anything but add to the multiple jeopardy doctors already face? If doctors were ever in need of a sanction to remind them to practise safely and competently, they already have the General Medical Council's guidance, *Good Medical*

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*Practice.*¹² This core guidance does not attempt to define wilful neglect or mistreatment but sets out clearly, in several different ways, what is expected of doctors for the protection of patients. Doctors accused of breaching any General Medical Council guidance in such a way that their fitness to practise is impaired might be subject to a wide range of sanctions, including erasure from the register. There is no need for a further sanction.

The prospect of additional criminal investigations and the potential for further punitive criminal sanctions are not the best way to encourage the type of open culture that will promote raising of concerns and learning from mistakes to strengthen protection of patients.

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