Clinical errors and mistakes: civil or criminal liability?

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Civil liability of doctors arises when there is a clinically negligent act or omission resulting in harm as a consequence of a doctor not meeting the standard of care as expected from reasonable medical practice or failure to warn.[1] Do clinical errors and mistakes necessarily equate to negligence? The essential elements required to establish negligence, are: (1) the existence of a duty of care owed to the patient; (2) a breach of duty as determined by standard of care; (3) the patient has experienced harm; and (4) a causal connection, between the defendant's careless act and the resulting damage incurred with the damage considered foreseeable and not too remote.[2] In *Hatcher v Black*,[3] Lord Denning explained a case that a woman P, who suffered side-effects from an operation on her throat and sued the surgeon concerned. Denning J stated that:

"...on the road or in a factory there ought not to be any accidents if everyone used proper care, but in a hospital there was always a risk. It would be disastrous to the community if a doctor examining a patient or operating at the table, instead of getting on with his work, were forever looking over his shoulder to see if someone was coming up with a dagger. The jury should not find the defendant negligent simply because one of the risks inherent in an operation actually took place, or because in a matter of opinion he made an error of judgement. They should find him liable only if he had fallen short of the standard of medical care, so that he was deserving of censure..."
(The jury found in favour of the defendant).

According to the *Bolam test*,[4] "*a doctor will not be found negligent if he/she has acted in accordance with a practice accepted as proper by a reasonable body of medical opinion*". It appears unreasonable or of limited social value to impose a criminal sanction on a medical practitioner for genuine clinical errors and mistakes.

The majority of litigation, following alleged medical malpractice, is brought under the tort of negligence (civil claims) and the remedy sought is monetary compensation. Criminalisation of medical malpractice falls into the realm of retributive justice which is a system of criminal justice focusing solely on punishment, rather than deterrence or the rehabilitation of offenders. The punishment should be in proportion to the seriousness of the crime committed.[5] The negligent act should be culpable to constitute a criminal act, such as gross negligence manslaughter (GNM).[6] This raises pertinent issues and questions in health care, such as: *Is criminal prosecution really promoting patient safety and safeguarding public interest? Should the focus be on conduct rather than outcome? Should the use of restorative justice, emphasising retribution, surpass deterrence and rehabilitation?*[7]

An expert panel conducted a pre-recorded seminar, followed by an interactive panel, to analyse GNM, in the healthcare setting, across different common law jurisdictions (including Australia, England, Hong Kong, Singapore and the United States) in November 2021.[8] A paper is under preparation which reports the critical points of those presentations, together with further analyses of cases and literature in jurisdictions adopting common law, to provide a better understanding of how clinical negligence might lead to criminal proceedings. This editorial aims to recap the English case of

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Bawa-Garba,[9] to discuss the factors to be taken into consideration for medical crime. There were a number of high-profile criminal investigations and prosecutions of healthcare professionals (HCPs) in England, with no offence recorded in Scotland and only 14 HCPs being charged with offences of criminal negligence in Canada and just over 30 GNM prosecutions since 1830 in England.[7]

In the *Garba* case,[9] the jury found the defendant paediatrician's conduct to be "*truly exceptionally bad*" (meaning it was far below the standard of care expected by a competent paediatrician and that it amounted to the criminal offence of GNM). The literature has raised criticisms of the findings for failing to give due consideration to organisational factors, such as system failure or lack of permanent supporting staff.[6,10] The Box summarises the negligence of the defendant doctor and factors contributing to her negligence.

The investigations and prosecutions regarding *Garba* were perceived as arbitrary and inconsistent.[11] This resulted in a rapid policy review, as described in *Gross Negligence Manslaughter in Healthcare* in 2018.[12] The panel was clear that HCPs could not be, or be seen to be, above the law and should be held to account where necessary. It was equally evident that HCPs are working in the complexity of a modern healthcare system, under a stressful environment and this should also be taken into consideration when deciding whether to pursue a GNM investigation. Doctors who have made an erroneous or suboptimal decision, without the intent to harm, acted in a manner that arguably does not rise to the level of criminal blameworthiness.[13]

A negligent doctor should not be held criminally liable for a brief lapse of concentration or an inadvertent error of judgement and it has been argued that three factors: (1) awareness; (2) choice (choose to run the risk); and (3) control (has the opportunity to act differently) should be present for the establishment of the negligent conduct to be considered culpable within the criminal context.[13] An error is trying to do the right thing but performing same wrongly which does not reflect an intentional deviation from accepted practices.[14]

Would *Garba*[9] be ruled differently, with consideration of culpability and violation of the three factors of awareness, choice and control? Dr Bawa-Garba's fitness to practise had been found to be impaired causing her suspension from practising for 1 year by the tribunal. The General Medical Council appealed, on the ground that the tribunal should have ordered her to be erased from the register and substituted the sanction of erasure for that of suspension.[15] The ruling led to a backlash from doctors who believed that she should not have been singled out for punishment because of the multiple system failures which led to the boy's death. Dr Bawa-Garba finally won an appeal against being struck off, restoring the 1-year suspension.[16] The judgement states that the task of the tribunal was to decide what sanction would "*most appropriately meet the overriding objective of protecting the public*."[16] Taking into account the particular circumstances of this case and the aggravating and mitigating factors, the Court of Appeal felt that erasure was not necessary to meet the objectives of: protecting the public; maintaining public confidence; and promoting and upholding proper professional standards. The Court considered that the expert tribunal was entitled to form the view that a suspension order could meet these statutory objectives.

Dr Bawa-Garba is now back at work and has finished her specialist training.[17] The main lessons learned are: to analyse all circumstances; to assess whether the negligent act is truly exceptionally bad; and whether there were extenuating circumstances that need to be taken into account.

BOX. *R v Hadiza Bawa-Garba*[9]

Dr Bawa-Garba (the "Doctor") ignored obvious clinical findings and symptoms by not reviewing the chest X-ray (CXR) properly which confirmed pneumonia, failing to obtain results from blood tests ordered, failing to act on obvious clinical findings and marked abnormal results which indicated infection and organ failure, mistaken belief that decision was not to resuscitate (resuscitation would not make significant impact on the child's condition).

The Doctor ordered the blood test at about 10:45 am but she did not receive the blood test results from hospital laboratory, until 4:15 pm despite her best endeavours to obtain the results, due to problems with the computer system. She was then without assistance of a senior house officer.

Agency nurses were used due to shortage of permanent nurses. One of the agency nurses had failed to observe the patient and communicate, to the Doctor, the deterioration of the patient and the Doctor was busy treating other children. The nurse also turned off the oxygen saturation monitoring, without informing the Doctor, and she was also not told of the patient's high temperature 40 minutes earlier or extensive changing of nappies.

The Doctor had prescribed antibiotics for the patient at 3:00 pm, as soon as she saw the CXR. The CXR was ready but the nurses failed to inform her so antibiotics was administered late.

The patient was transferred to another ward, out of care of the Doctor. The patient received his usual dose of enalapril for his unrelated condition which the Doctor deliberately did not prescribe, as it would lower the blood pressure of a dehydrated child.

Author contributions

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Acquisition of data: All authors.
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Drafting of the manuscript: A Lee, T Cheung.
Critical revision of the manuscript for important intellectual content: All authors.

All authors had full access to the data, contributed to the study, approved the final version for publication, and take responsibility for its accuracy and integrity.

Conflicts of interest

All authors have disclosed no conflicts of interest.

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