Royal College of Physicians and Surgeons of Glasgow
Submission to Professor Sir Norman Williams'
Review into Gross Negligence Manslaughter in Healthcare
At the request of the Secretary of State for Health and Social Care

The Royal College of Physicians and Surgeons of Glasgow was founded in 1599 to improve quality and practice of Medicine.

Although based in Glasgow, the College has 14,000 Fellows and Members who work as senior clinicians throughout the United Kingdom and across the world. Unlike our sister Royal Colleges, we have a multidisciplinary membership. This review mainly affects the Faculties of Medicine, Surgery and Dentistry.

The College has been concerned that recent cases in the Courts (GMC v Bawa-Garba 2018 EWHC 76, R v Sellu 2016) have had a considerable impact on our membership particularly our trainees in medical and surgical specialities. It is noted that recruitment and retention of staff is difficult throughout the United Kingdom. Many training posts are empty and rosters are incomplete and frequently trainees are asked to do extra work on their shifts or working extra shifts. They are often asked to do work in areas where they have not had formal induction. In addition many advertised consultant posts are not filled (up to 40% consultant physician posts). There may not be a locum in post. The system has been stressed over the winter period and morale has fallen.

Our trainees particularly point

- To lack of induction when working outside normal areas
- To worry about written reflection being used to support legal cases (although reflections were not used in open court in recent cases).
- To systemic failures not being taken into account and that when something goes wrong, it is one person who may take the blame
- To the difficulty that the current environment does not allow mistakes to be acknowledged, reflection made and learning to take place to prevent further mistakes without blame.

This College has issued guidance to trainees as what to do when there they are put in a situation where there is potential risk. This has been well received by our Members and Fellows (RCPS Glasgow website College News 30 January 2018[https://rcpsg.ac.uk/news/2103-college-publishes-new-guidance-for-trainees], updated 4 April 2018 [https://rcpsg.ac.uk/documents/publications/college-news/777-college-news-spring-2018/file]).

The General Medical Council has responsibilities for training, examinations, appraisal and revalidation. Since its inception it has oversight of Undergraduate Curricula and Medical Degree Examinations. It is responsible for oversight of Foundation Year, Core and Speciality Training. It also has responsibility for oversight of higher examinations such as (MRCP UK, Intercollegiate MRCS and Speciality Certificate Examinations [SCE]). The responsibility for postgraduate training and higher

examinations were formerly the sole responsibility of the Royal Colleges and latterly the Postgraduate Medical Education Board (PMETB 2005-2010) before its merger with the GMC.

It also registers Medical Practitioners and runs the Specialist Registers. It administers Appraisals and Revalidation. As a Regulatory Body it conducts fitness to practise assessments and refers cases to the independent Medical Practitioners Tribunal Service. Approximately 60% of its expenditure is on fitness to practise cases (Departments of Health Briefing Paper on "Promoting Professionalism Reforming Regulation" 2017).

There is therefore a conflict between the GMC's role in supervising and controlling education and its role as the regulator. On the one hand it wants to promote lifelong learning and reflective practice, while on the other it is considered by some to be hard on errant doctors (its role to protect the public). It is responsible to the Professional Standards Authority and Parliament. The former has not issued guidance on the current situation.

The College has noted that following the High Court ruling (Bawa-Garba currently subject to appeal), Officers of the GMC were unable to give consistent advice to trainee doctors if they found themselves in a situation which was unsafe and could bring harm to patients. Its subsequent statements have been slow and did not deal with the obvious lack of confidence in the regulator. The GMC has had difficulty in understanding that those regulated have lost confidence in their regulator which, in turn, has lost touch with issues of concern to the profession.

The practice of medicine is now complex, relies on multiple systems to be in place and is dependant on multiple practitioners. Mistakes rarely happen as a result of one individual's error. The GMC has yet to recognise that systems have to be reviewed in addition to individuals' performance. Some of the individuals concerned may not be regulated by the GMC. NHS Hospitals have system review of Serious Untoward Incidents (SUI), where root cause analysis looks at multiple factors involved. Individuals will reflect in their portfolios (if a trainee doctor) or in their annual appraisal (if a consultant or principal). This aims to prevent or mitigate the effect of further incidents. There is no practical mechanism for NHS Trusts and Boards to be held accountable (Corporate Homicide prosecutions are rare in the NHS) and there is no regulator for non-medically qualified managers. There appears to be no mechanism where system review and SUI review are routinely brought into fitness to practise cases.

The review by Professor Sir Norman Williams has raised three questions

1. How do we ensure that Health Care Professionals are adequately informed about:

a) **Where and how the line is drawn between gross negligence manslaughter and negligence.**

Doctors are not lawyers. There are very few clinicians who could give a reliable description of or define the difference between gross negligence manslaughter, culpable homicide and manslaughter. The possibility of a prosecution for gross negligence manslaughter may cause doctors and other health professionals to lose self-confidence such that they perform their duties at a lower standard resulting in suboptimal care. We also question whether these definitions are clearly understood by

juries under the present system (R v Sellu Appeal 2016 where the appeal was allowed on the grounds that the jury was given no guidance on the meaning of “gross negligence” [Dyer C, Br Med J 2016;355:i6274]).

There is a strong argument to be made that gross negligence manslaughter (culpable homicide in Scotland) should not be an offence. Sir Ian Kennedy QC (Br Med J 2018;360:k1376) has stated that “we need to rethink the role of the criminal law and medical manslaughter. Does it have any place in how we deal with things going wrong... because medical manslaughter means you can pick someone, blame them and imagine you have solved the problem. And what you have done is exacerbated it”. The College believes this should be actively considered.

There are certainly errant doctors who should be charged with this type of offence (manslaughter). What should distinguish these individuals from those who are put in an impossible situation and have made a mistake or mistakes? **It is surely intent to do harm**. If someone prescribes a treatment which has no proven benefit (either measured by research or practice), this would potentially harm. If the intent was worse such as to cause death this would fulfil the definition. If the intent was to relieve distressing symptoms and but led to earlier death, this would **not** fulfil the criteria (the argument often used to justify use of opiates in terminal illness).

The legal terminology is unknown to most clinicians. If gross negligence manslaughter (GNM) is to continue they need to understand what the term means. A clear dividing line needs to be defined with clear criteria.

b) **What processes are gone through before initiating a prosecution for GNM**

The internal processes such as a SUI meeting should take place and an action plan initiated. If GNM is to continue the Crown Prosecution Service (or Procurator Fiscal) needs to take independent expert advice before proceeding. Systems failure must be part of the assessment. Commissioning Bodies (e.g. Clinical Commissioning Groups [CCGs]), NHS Trust and Boards must take an active part in this process and non-medical managers must also engage. At present the trigger for a prosecution is not clearly defined (current criteria include a realistic prospect of conviction **and** that the prosecution is in the public interest). It could be argued that the current cases may not be in the public interest and can therefore have the opposite effect. We understand having taken advice, the threshold for prosecution in the Scottish Jurisdiction may be higher and definitions may differ.

For individual Doctors and hospital staff, this process will require significant education. The Royal Colleges may have a role in this. The GMC needs to balance its educational role with its regulatory role. Its guidance needs to be framed constructively in an educational manner.

2. **How we ensure the vital process of reflective learning, openness and transparency is protected where a Health Care professional believes a mistake has been made to ensure lessons are learnt and mistakes not covered up.**

Reflective practice either individually or within teams is part of modern practice. As a College, we wish to continue to recommend to our members that they incorporate this into practice. Given the

recent publicity it will take time for written reflection to be given the prominence it ought to have in self-directed learning. At present individuals feel threatened despite the GMC's statements to the contrary and they are using general themes and non-patient identifiable information. The GMC has stated it will not use personal reflection and in its submission to this review, has suggested that this should be legally privileged. While the College would support this, it is not sure how practical and acceptable this would be to the general public and the legal world. However there needs to be absolute clarity over whether or not the entire e-portfolio can be used within GNM proceedings. The College encourages and supports unit/hospital SUI reviews, peer review and Morbidity and Mortality meetings. These provide the best opportunities for learning and the sharing of that learning.

3. Lesson that needs to be learnt by the GMC and other health care professionals' regulators in relation to how they deal with professional following a criminal process for GNM

This College believes that the GMC needs to reconsider its relationship with those it aims to educate and those it regulates. In maintaining its independence, it neither engages with the public or the profession. It needs to reconcile its educational function and its regulatory function. The GMC is funded by doctor's subscriptions but it seems to fail to actively support the profession.

The GMC rightly or wrongly has lost credibility within the profession. Eventually, hopefully, the reasons for the prosecution in the Bawa-Garba case will be more clearly stated. At present it has failed to properly articulate how it could have had a discretionary position in the case, yet felt compelled to take the action it did. Its position is seen as incoherent, illogical and inconsistent. Attempts to continue to justify itself have been perceived adversely by the profession and this has produced an unfortunate and inflammatory reaction. As it stands it is seen as an authoritarian body which does little to advise, support and help doctors in difficult situations.

The role of the GMC is "an independent organisation that helps to protect patients and improve medical education and practice across the UK". It should reflect and reconsider its response to recent events to improve medical education or practice. It needs to learn to become much more supportive towards doctors, not just after a criminal process, but also during the investigation of any complaints. Doctors are interested in public safety as much, if not more, than any other group.

Summary

The College believes this review has raised important issues for the practice of medicine in the UK. There are lessons to be learnt by all. There is a need to put remedial action in place sooner rather than later. We need a high quality medical workforce to maintain a viable National Health Service

Dr Richard Hull FRCP Glasgow
Honorary Secretary
Royal College of Physicians and Surgeons of Glasgow
10 April 2018