Williams Review into Gross Negligence Manslaughter in Healthcare
Comments from the Royal College of Physicians of Edinburgh

The Royal College of Physicians of Edinburgh ("the College") was founded in 1681. We support and educate doctors in the hospital sector throughout the UK and the world with over 12,000 Fellows and Members in 91 countries, covering 30 medical specialties. 50% of our UK Fellows and Members work in the NHS in England, and we welcome the opportunity to submit evidence to the Williams Review into Gross Negligence Manslaughter in Healthcare. This response has been informed by the views of senior College Office Bearers; our Trainees and Members' Committee and our Recently Appointed Consultants' Committee. The College is committed to promoting the highest clinical standards and the implementation of robust, evidence-based medical practice to ensure the highest quality of care for patients.

Complaints, litigation, negligence and Gross Negligence Manslaughter (GNM) all have potentially devastating effects on the individual(s), teams and the institution involved. All of these groups need significant support, rehabilitation and supported re-training when such instances arise. Fellows and Members have advised the College that they feel that regulatory bodies and institutions have a considerable way to go to achieve this supportive environment. The College suggests that there is a fundamental need for reflection on how we have reached this point, and how circumstance, culture, context and system structures have contributed to this position.

Investment in our current and future workforce is essential to create a culture where colleagues have the time to care, time to train and the time to research. The medical workforce faces significant challenges. The College supports improved medical workforce planning across the UK to recruit and retain the highest quality doctors. There are workforce shortages across the country with rota gaps creating additional pressures in an already difficult environment. There is a pressing need to value healthcare professionals at every stage in their careers, to ensure that medicine remains an attractive career choice and offers support for medical professionals as they progress throughout their careers.

We need to ensure that we continue to recruit and retain a world class workforce to deliver the best possible patient care. The College is committed to working with Government and other allied organisations to address issues around recruitment and retention such as consultant vacancies, rota gaps and trainee attrition rates, as a matter of priority. The College is concerned that workforce morale is low and that new medical graduates continue to leave the profession[i] .

Our Fellows and Members feel strongly that providing safe, patient-centred, high quality medical care is their prime concern: no clinician comes to work with the intention of doing a bad job or harming patients. Sadly errors in care can and do occur, but in order to address these, the College and others have highlighted the need for all healthcare professionals to learn from serious failings in care. Doctors of all

grades should not be made to practice in an environment of fear and retribution, leading to defensive and poor medical practice.

To enable such learning and thereby improved patient care, the College encourages an open and no-blame culture where focus is on identifying and addressing system and, where appropriate, individual failures and risks; where staff feel empowered to raise concerns over standards of care and confident that action will be taken to address these and improve quality. It is important to note the introduction of the Duty of Candour (Scotland) Regulations 2018 and Apologies (Scotland) Act 2016 have been intended to help enable this kind of environment. Only by doing so can we ensure that learning and improvement occur, and that similar incidents are prevented from occurring. This has been highlighted by Ian Kennedy QC, speaking at the Royal College of Surgeons of Edinburgh's triennial conference on 22 March 2018, who said "…*medical manslaughter means that you can pick someone, blame them, and imagine that you've solved the problem. And what you have actually done is exacerbated it".*[ii]

There is a wide-ranging activity on this subject involving different organisations and it is vital that workstreams are not looked at in isolation. The College President, Prof Derek Bell, is meeting the Lord Advocate to discuss these matters on 12 April 2018 and is leading a Scottish Academy of Medical Royal Colleges workstream, which is likely to examine many issues of interest to the Williams Review.

Other notable work includes the General Medical Council (GMC) review into how gross negligence manslaughter and culpable homicide (in Scotland) are applied to medical practice, led by Dame Clare Marx. The College also notes that the Medical Protection Society (MPS) has suggested that the law that is applied in gross negligence manslaughter (GNM) cases in healthcare in England and Wales should move towards Scotland's comparable offence of Culpable Homicide, where charges are only brought against doctors if an act is proved to be intentional, reckless or grossly careless[iii].

Looking specifically at the Review's Terms of Reference and the purpose of the Review, the College has the following comments:

How we ensure healthcare professionals are adequately informed about:

- **where and how the line is drawn between gross negligence manslaughter (GNM) and negligence;**

  Feedback from College Fellows and Members indicates that this terminology is not clear or widely understood: a key challenge is the lack of alignment between terms and definitions used by employers and the GMC and those used by the legal profession. There needs to be uniform terminology and clearly defined distinctions between poor performance, misconduct, negligence and criminality. This is fundamental to any review into GNM in healthcare. There also needs to be a clear understanding of the potential consequences of both GNM and negligence legalistically and professionally. How GNM is applied to an individual must be made clear, as must whether or not it can be applied to a system. For example, what would make the police investigate an individual without investigating the employer?

  Healthcare professionals and their employers must be clear on the processes to deal with each circumstance. This should be included in the remit of the employer and encompass induction as

standard. It should also be publicised by the GMC, Royal Colleges and through postgraduate training bodies.

Adequate teaching of medical and all healthcare staff on risk and patient safety, and heightened focus on medicine, ethics and the law must be mandatory and commence early in undergraduate or apprenticeship training. There is no doubt that many staff have the belief that they are protected by their employer and by the law unless they commit a deliberate act of harm. There should be increased emphasis on the importance of good quality note keeping throughout training. Defence organisations currently provide training on this subject, and this knowledge needs to be rolled out across the NHS as a whole.

Staff must also have access to clear information setting out defence and/or insurance options. The College has been advised that few clinicians have a clear understanding of what the NHS as an employer will cover and the clinician's options need to be clearly laid out. There needs to be recognition of the fact that there are multiple different contracts, including honorary contracts in particular, where the legal status / provision is much less clear than in the standard Junior Doctor contract and the Consultant contract. Doctors must understand what protection is available and can be afforded to them, and employers should have an obligation to provide access to information such as the level of NHS indemnity provided and signposting to defence unions.

- **what processes are gone through before initiating a prosecution for GNM;**

Views from College Fellows and Members indicate that clinicians have limited knowledge of the processes. The College recommends clear guidance for employers, the accused and those investigating where this is not already consistently offered or applied. There should be a set of standards for which data is collected and assessed for every prosecution in a healthcare setting. These should include but not be limited by: number and skill mix of staff; number and complexity of patients; presence or not of safety procedures including safety brief, multidisciplinary huddle, escalation policy; has individual/s accused recently returned from career break and if so, what support/induction was offered; were all staff present familiar with the unit or had they been adequately inducted; availability of senior decision maker/s and their communication with team if not on site.

It should be made clear to the accused and their defence team, what documents/evidence are mandatory to submit and what does not need to be offered, and how that evidence will be reviewed and assessed.

There also needs to be clarity of how a criminal prosecution may come about - what is the relationship between coroner's court and criminal charges? Who brings the charges against the doctor? Such incidents should be thoroughly investigated by the institution's Serious Incident process and possibly through the legal team defending a claim.

- **In addition, provide any further relevant information gained from engagement with stakeholders through this review about the processes used in cases of gross negligence manslaughter;**

Our Fellows and Members are primarily clinicians; clinical / educational supervisors; clinical / medical directors and training program directors and generally do not have specific expertise or training in medico-legal issues. Those who have additional roles, for example in postgraduate deaneries, have been engaging in discussions about the reflection process for trainees. Clear guidance is essential. The legitimacy of individual reflections being used as evidence has been queried with concerns including validity and difficulty with corroboration.

Reflection is critical for doctors in daily practice and it is essential that reflection on both good and poor outcomes continues. This should be emphasised as part of good medical practice, and the College suggests there should be a renewed focus on teaching of reflective practice, report writing and best practice. Openness and candour must not be discouraged, and it is important to recognise that different personalities and communication styles can lead to very different outcomes of reflection, making it a complex process. Therefore it can be difficult to draw conclusions from submissions.

There should also be regard given to the likely bias of reflective practice towards negativity, such is the nature of training regarding reflective practice, for example through questions such as "*what have you learnt*?" or "*what could you improve upon for next time?*" However notwithstanding this, there is recognition that reflection is essential and must continue to be an intrinsic part of daily practice.

- **how we ensure the vital role of reflective learning, openness and transparency is protected where the healthcare professional believes that a mistake has been made to ensure that lessons are learned and mistakes not covered up;**

The College has received a variety of views on whether verbal or written reports are most appropriate in situations where the healthcare professional believes that an error has been made. The crucial point is that an open and no-blame culture is encouraged, where focus is on identifying and addressing system and, where appropriate, individual failures and risks; where staff feel empowered to raise concerns over standards of care and confident that action will be taken to address these and improve quality.

The College suggests that the aviation industry model is worthy of further examination, as this has delivered full disclosure for learning by valuing reflective practice and, to a certain extent, excluding it as a record available to other agencies. If reflective practice documents are readily available to the courts they should be documented with that in mind such that practitioners should still be encouraged to reflect but should be advised around how those reflections are recorded: this will of course be likely to make reflection less full. If the NHS Board/Trust has other procedures (for example Mortality and Morbidity meetings and event reporting) to promote safety culture and how events are recorded, this should be encouraged and supported from board/trust level. Board/Trust level processes should also be clear on confidentiality, recording and sharing of outcomes and should similarly encourage candour rather than promote defensiveness.

- **lessons that need to be learned by the General Medical Council (GMC) and other healthcare professionals' regulators in relation to how they deal with professionals following a criminal process for gross negligence manslaughter.**

  It is fundamental that regulators are transparent and open, and provide clear information and offer open discussion about processes. It is likely that very few clinicians will have more than negligible understanding of the Medical Practitioners Tribunal Service (MPTS) and its establishment and processes.

  Recent events have shaken doctors' faith in the system enormously. The impact of this should not be underestimated. Fellows and Members have told the College they already feel disenfranchised, overwhelmed and unsupported generally. It is vital that professional organisations are trusted to appraise situations such as this critically, but with absolute honesty and openness. If doctors feel that this is not the case, then they may choose to leave the NHS or practise increasingly defensive medicine. This will impact communication, collaboration and ultimately be extremely detrimental to the provision of high quality, safe patient care.

  There also needs to be much clearer understanding of the impact of a clinical conviction. Are all doctors with a criminal conviction removed from the register? When the regulator makes a decision on registration, what factors are taken into consideration – the conviction, the issues and events surrounding the circumstances of conviction? Peer/senior experiences of the doctors? All of this is now essential knowledge for clinicians and must be clearly set out.

  The recent cases have perhaps highlighted the differing roles of the GMC and the criminal justice system and it is important that one does not try to replicate the job of the other. For the most part the sanction imposed by the GMC would be commensurate with the conviction but it is entirely reasonable that the response to an incident would differ in some circumstances. However, in one recent case it has become apparent that many consider the resulting conviction to be unreasonable and, given that, have difficulty comprehending why the regulator acted as they did.

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[i] *Most junior doctors leave after training* (16 March 2018): The Times https://www.thetimes.co.uk/article/9cb272d4-28ac-11e8-acc5-262aff1ca7a6

[ii] The role of medical manslaughter must be reconsidered, says leading lawyer https://doi.org/10.1136/bmj.k1376 (Published 23 March 2018) BMJ 2018;360:k1376

[iii] English law on gross negligence manslaughter in healthcare must move towards Scottish position - Medical Protection Society (13 March 2018) https://www.medicalprotection.org/uk/about-mps/media-centre/press-releases/press-releases/english-law-on-gross-negligence-manslaughter-in-healthcare-must-move-towards-scottish-position