Royal College of Anaesthetists

13 April 2018

Evidence from the Royal College of Anaesthetists to inform the Williams Review into Gross Negligence Manslaughter in Healthcare

About the Royal College of Anaesthetists (RCoA)

- Sixteen per cent of all hospital consultants are anaesthetists making anaesthesia the single largest hospital specialty in the UK[1,2,3]
- Anaesthetists play a critical role in the care of two-thirds of all hospital patients[4] and 99% of patients would recommend their hospital's anaesthesia service to family and friends[5]
- With a combined membership of 22,000 fellows and members, representing the three specialties of anaesthesia, intensive care and pain medicine, we are the third largest Medical Royal College by UK membership.

Should you have any questions on this submission, please contact Elena Fabbrani at efabbrani@rcoa.ac.uk or by phone on 020 7092 1694.

General comments

The Royal College of Anaesthetists strongly believes that improving the safety and quality of care being provided to patients must be a priority in all decisions relating to clinical errors. For many years we have called for steps to facilitate a 'no-blame' learning environment where staff and healthcare organisations can learn from mistakes when they do occur.

This review is against a backdrop of an NHS under unprecedented pressure. NHS staff, including our fellows and members, are understandably concerned that genuine mistakes made in difficult, challenging circumstances where there are wider systemic failings may lead to a criminal conviction. Doctors must feel able to reflect openly and truthfully on their practice without fear that this will be used against them, or learning will not take place.

As our President, Dr Liam Brennan, said in a speech at the recent RCoA President's Dinner - attended by the Secretary of State for Health and Social Care, Jeremy Hunt MP– "it is right that doctors should be held accountable for their actions. But it cannot be just, with current knowledge of human factors and risk management, for an individual to be held solely culpable for tragedies that have been contributed to by systemic failings".

Summary of recommendations in our submission

- We propose designating a limited number of police constabularies or police unit(s) in England to investigate these rare cases of alleged healthcare professional criminal activity and to work with the Crown Prosecution Service to an agreed set of standards and procedures to ensure consistency and equitable processing of cases.
- The police, judiciary and coronial service need to recruit credible expert witnesses who are up to date and hold a current licence to practise, in order to offer balanced evidence and clinical advice that takes into account systemic failures, alongside issues around clinical competence.
- The status of the role of 'expert medical witness' should become an optional pathway in senior doctors' careers. This should include producing a framework of essential and desirable criteria that expert witnesses should be expected to reach and maintain, underpinned by appropriate training and life-long learning. In addition consideration

should be given to setting up registers to ensure that appropriately qualified and experienced expert witnesses are available to provide advice.
- We recommend the application of a 'deliberate harm and recklessness test' to ascertain whether a healthcare professional should be prosecuted for gross negligence manslaughter (GNM). Confidence in the profession would be enhanced and that of the public still maintained if this principle was applied.
- Steps must be taken to ensure that doctors' reflections are not used in an adversarial fashion in judicial proceedings or by healthcare regulators.
- The Review should look at governance arrangements for regulators as greater clarity is required on how decisions to appeal are made and who is accountable for making them.
- Regulators need to:
    - develop a more supportive approach in guiding doctors through fitness to practise processes
    - apply a more balanced methodology when making decisions to appeal fitness to practise decisions, with considerations of extenuating circumstances and evidence of systemic failure applying to each case
    - work more closely with other regulators and independent investigators, such as the Healthcare Safety Investigation Branch.
- In these rare, and often tragic cases, the focus for regulators and everyone else involved needs to be primarily on learning, not punishment, especially if there is evidence to show that there was no intention to cause harm and the practitioner shows insight into their failings and has learnt from them.

Specific comments on the issues covered by the Williams Review

1. How we ensure healthcare professionals are adequately informed about:
- **Where and how the line is drawn between gross negligence manslaughter and negligence**

In the UK the likelihood that an error resulting in the death of a patient will end in prosecution for manslaughter has increased in recent years. Prosecutions were rare until the 1990s and studies have shown a rise in the number of doctors charged in the period between 1990 and 2005, although few were convicted.[6]

In medical practice, cases where doctors breach their duty of care to their patients by acting irresponsibly or recklessly remain extremely rare. Most untoward incidents arise from a combination of individual and systemic failures or genuine error, often as the result of challenging working conditions and lack of adequate resources.

We believe that the line between GNM and negligence should be drawn by whether the incident is caused by the reckless behaviour of a healthcare professional or whether other factors, often outside of the control of the accused, involving systemic or organisational failings have played a part in the incident.

The RCoA is concerned that too often clinicians are left exposed to the risk of legal proceedings, while those in senior non-clinical managerial roles, responsible for overseeing failing organisations, may not be held to account. We note that charges of corporate

manslaughter have rarely been levied at any UK healthcare organisation or their leadership, whilst prosecutions for GNM amongst clinicians have increased in recent years.

We also wish to highlight the dichotomy in sanctions that exists depending upon whether the patient dies or not as a result of inadequate care. If a patient survives, even if permanently harmed and/or however serious the individual failings that led to it, the doctor normally only faces a civil charge of negligence. If a patient dies criminal charges are more likely to come into play. The mistakes made in some specialties, including those in anaesthesia, due to their intrinsically hazardous nature, are more likely to result in serious harm or death of patients. Some other doctors' mistakes, however egregious, tend not to have such serious and immediate consequences. The RCoA believe that the law should be reviewed in this area.

It would be helpful to issue guidance, supported by examples and case studies, on what scenarios might lead to a prosecution for GNM produced in conjunction with healthcare professional organisations, regulators and the legal profession.

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

Appropriate evidence should be gathered through an early investigation of:

- the patient safety incident to establish its cause and specifically to ascertain what, if any, contributing factors have led to it, and
- whether the healthcare professional deliberately or consciously acted in a reckless manner.

Time, resources and training need to be made available to ensure that local investigations are conducted to a high and consistent standard, as the outcomes from these may be the prompt to initiating a police investigation.

The recently published 'A just culture guide'[7] by NHS Improvement contains a series of steps to help NHS staff conduct an honest conversation between managers and individuals involved in patient safety incidents. The guide is not a replacement for an investigation of a patient safety incident. However, the first step in the document is a 'deliberate harm test', asking the question *'Was there any intention to cause harm?'.* A 'yes' answer to this question automatically initiates proceedings for referral of the case to the GMC or the police. A 'no' answer will instead guide NHS staff through steps to identify whether an individual might require additional support and interventions in the work place to prevent recurrence of the same error.

A similar 'deliberate harm test', to also include consideration of whether the error was compounded by reckless behaviour, could be used by regulatory bodies, the police and the coronial service when deciding if a case should be referred to the Crown Prosecution Service.

Currently, due to the large number of different constabularies, when cases of suspected GNM are referred to the police, there can be inconsistencies in how decisions are made to prosecute doctors and other healthcare professionals. It is the RCoA's understanding that local police forces across England are expected to make these decisions with no standardised processes or guidance, and simply because the alleged offence occurred within their geographical jurisdiction.

As prosecutions for GNM in healthcare are rare, we propose that one or two constabularies in England are assigned responsibility for investigating these cases before referral to the Crown Prosecution Service. Applying an agreed set of guidelines would ensure that prosecutions for GNM in healthcare follow a consistent and equitable process across the country.

It is also critical that the police and the CPS work with credible expert advisors in reviewing suspected cases of GNM. We strongly believe that specialist clinical knowledge needs to be married with that of other legal and investigative experts in order to effectively assess a case.

However, we are concerned by the sometimes inconsistent quality of expert witnesses involved in criminal proceedings concerning healthcare professionals and the lack of a stable pool of credible experts which can be drawn from at all stages of investigations and legal proceedings.

We believe that a credible expert witness is someone who has the required clinical expertise and training, which must be current and up to date, but also has direct experience and understanding of applying clinical judgement in pressurised and challenging healthcare environments. Evidence from such experts would offer a balanced view of both clinical expertise and the human factors at play in challenging healthcare scenarios.

The role of an expert witness should be incorporated as a recognised career development for those clinicians with the aptitude and experience to fulfil this important role and regarded with the same status as other non-clinical roles, such as postgraduate examining, which provide benefit to the wider healthcare sector.

In order to develop a cadre of such witnesses to fulfil the role the following will require defining:

- the appropriate professional attributes
- training and lifelong learning requirements and
- the appropriate level of relevant current clinical experience required.

The RCoA believes the status of an expert witness/advisor should be time limited and subject to periodic review, which may include successful appraisal of the role as part of the medical revalidation process. We believe that medical royal colleges may have a part to play in setting standards for expert witnesses through the Academy of Medical Royal Colleges, who had set up a working group to look at the issue in 2015.

A register of experts would logically need to be set up and maintained and it would be for discussion who would be best placed to manage, resource and administer this but input from medical, legal and lay persons would seem appropriate.

2. 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 Academy of Medical Royal Colleges is carrying out a full review of the guidance on reflective practice with the GMC, the Academy Trainee Doctors Group, the BMA's Junior Doctors Committee and the Conference of Post-Graduate Medical Deans (COPMeD).

In the meantime, the RCoA supports the interim guidance on reflective practice produced by the Academy and COPMeD [8], containing ten key principles of reflective practice for doctors in training to use.

The interim guidance states that:

> 'Reflective practice results in a better understanding of the situation and enables the individual concerned to recognise the possible impact of their actions. The aim of this process is to aid individual development and support enhanced performance when similar situations are encountered in the future, allowing the experience gained from previous situations to be put into action.
>
> Doctors in training must feel able to have honest and open discussions and should be confident that engaging in the process can provide them with the required evidence of a professional approach to learning.'

We are concerned that recent high profile cases and negative media will prevent doctors from being open in their reflections for fear that these will be used against them. This will not only harm the learning process and obstruct improvements to patient safety, but it will also decrease the public's confidence in the medical profession and their ability to be honest and admit when there has been a mistake.

In our opinion, documents produced by doctors in good faith to support their professional development should be protected from legal disclosure in order to foster a culture of openness and learning in healthcare. This protection should also extend to verbal, written or digitally recorded reflections as part of appraisals, learning management systems, logbooks, e-portfolios and CPD diaries. We are aware that this may require revision of the existing law or entirely new legislation.

3. Lessons that need to be learned by the GMC and other healthcare professionals' regulators in relation to how they deal with professionals following a criminal process for gross negligence manslaughter

The RCoA has been concerned for some time about the stress that doctors experience from fitness to practise proceedings and the risk of litigation that have increased in recent years for the medical profession.

Doctors and health care professionals experience considerably higher level of work related stress than the general working population[9]. Anaesthetists and critical care practitioners in particular suffer from high emotional exhaustion due to the level of responsibility and 'life and death' decision-making expected of them. This is often exacerbated by long shifts, sometimes worked in isolation from other colleagues.[10] Doctors in training are at particular risk from increased stress and even burnout as, depending on the stage in their training, they may lack the skills and experience necessary to deal with the after effects of stressful situations and untoward events. This can lead to feelings of exclusion and low self-esteem.

An internal review by the GMC has revealed that doctors undergoing fitness to practice investigations are at a higher risk of suicide, as these can be extremely stressful and isolating.[11]

It is important to understand the context in which doctors work:

- In December 2017 the RCoA published a report on the welfare, morale and experiences of anaesthetists in training[12] showing that this cohort experiences high levels of stress and fatigue due to system pressures, inflexible working patterns, and inadequate facilities for rest and catering.

- This report makes a number of recommendations to change the workplace culture in relation to the welfare and morale of not only anaesthetists in training, but for doctors of all grades, working in all specialties. Recommendations include a Government-led national welfare and morale strategy for all NHS staff, a call for capital funding to improve staff facilities, greater provision for flexible training programmes, and a cultural shift towards a no-blame learning environment that prioritises the safety of patients and the development of staff.

Doctors in training are at the start of their career and are receptive to recognising the benefits of reflective practice and, with adequate support from management, to change and improve their performance. These factors need to be taken into account in fitness to practise and appeal decisions.

The RCoA also believes this Review should consider whether it is appropriate for regulators to be able to appeal decisions made by fitness to practise tribunals. In addition we seek clarity on:

- how decisions to appeal are made,
- who makes the decision,
- according to which criteria and
- based on what evidence and legal advice.

We are concerned that under the current governance arrangements, the role of GMC CEO and Registrar are co-terminus in one individual. This has potential to be a conflict of interest. We are also aware that the decision to lodge an appeal rests solely with the Registrar, which we feel is a vulnerable position for the individual concerned, the GMC as an organisation and the medical profession at large. We believe that this aspect of the GMC's governance should be urgently reviewed. Finally, we note that the GMC is the only healthcare regulator who has right of appeal independently of the Professional Standards Authority and we believe that the advisability of this legal privilege should be reconsidered.

The most serious cases could also be referred by regulators and providers to the Healthcare Safety Investigation Branch (HSIB), whose current remit is to *' investigate up to 30 safety incidents each year in order to provide meaningful safety recommendations and share what we learn across the whole of the healthcare system for the benefit of everyone who is cared for by it and works in it'.*

Increasing the HSIB's remit and involving them at an earlier stage may also help reduce the length of time proceedings take to run their course and the likelihood of repeat investigations by different authorities. Prolonged and multiple investigations have a detrimental effect not only on the accused, but also on their colleagues and on patients' relatives. We are aware that this would require significant increased resourcing of the HSIB, particularly if they are

tasked with cascading training in the delivery of high quality and consistent local investigations.

The overriding priority should be to enhance patient safety by learning from errors rather than a focus on punitive sanctions and litigation, whilst recognising that doctors are not above the law and should be held to account for their actions when appropriate. We believe it is critical that the GMC listens to the concerns of doctors and works with medical professionals and other regulators, including the CQC, when investigating such cases to ensure that individual and systemic failings are taken fully into account.

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