The Doctors’ Association UK response to the Professor Sir Norman Williams Review

Dear Sir Norman,

In the wake of the case of Dr Hadiza Bawa-Garba doctors are angry and fearful\(^1\). Angry, that someone like them, who was just trying to do their best for patients in a system at breaking point, has faced criminal prosecution and erasure from the medical register for what many feel were essentially honest mistakes. Fearful, that a simple error will see them subject to criminal proceedings, in which their written reflections will be used against them, and taken to court by their regulator to have their career ruined.

We, the Doctors’ Association UK (DAUK), were formed in response to the fear and anger that has united our profession. In January this year we formed an online forum for doctors, a much needed safe space for many to express their outrage, but also to come together to effect grassroots change. This is now a vibrant, active, 29,000 strong social media movement, with representation from junior doctors both within and outside the training system, GPs, and consultants.

The Doctors’ Association UK is a nascent campaigning and lobbying organisation representing the membership of the forum. The steering committee has achieved significant successes in a short space of time, such as coordinating 4500 doctors and members of the public as joint signatories to a letter to Charles Massey, GMC Chief Executive\(^2\), and writing the lead letter published in the Sunday Times on 25 March, which was signed by almost 1400 doctors\(^3\). Our aim is to empower doctors to speak out and be heard on issues of vital important to our profession’s future. We are currently campaigning for radical reform of the way medical error is approached in the UK, in a recently launched campaign called “Learn, Not Blame”.

Your review is a key point in this process. The law on gross negligence manslaughter (GNM), and how it is currently applied in healthcare, is a stumbling block to much needed progress on achieving a just culture within the NHS. We welcome any Government attention on the matter. However, we are disappointed that the Terms of Reference of your review were drawn so narrowly. The wider context cannot be ignored, and our recommendations therefore address this wider context of whether the law relating to GNM, and how it is interpreted by the Crown Prosecution Service (CPS), is fit for purpose.

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\(^1\) [https://inews.co.uk/news/health/dr-hadiza-bawa-garba-anger-striking-off/](https://inews.co.uk/news/health/dr-hadiza-bawa-garba-anger-striking-off/)
\(^3\) [https://www.thetimes.co.uk/article/ignore-the-vitriol-doctors-are-key-to-safe-childbirth-n8sjd0fmz](https://www.thetimes.co.uk/article/ignore-the-vitriol-doctors-are-key-to-safe-childbirth-n8sjd0fmz)
Our recommendations to the review, in summary, are:

1. A higher bar for the CPS to consider pursuing a prosecution for GNM.

2. The law on gross negligence manslaughter (GNM) be urgently reformed, with a legal test of GNM related to healthcare to include actions being “wilful or reckless”, and system failures taken into account as mitigation.

3. The creation of an independent investigative body, or significant strengthening of the Healthcare Safety Investigation Branch, whose first priority will be to explore the systemic failures that ultimately surround medical error.

4. Written reflections undertaken by doctors for the purposes of education or training be subject to legal privilege.

5. An amendment to Section 35A (1A) of the Medical Act 1983 that currently allows the General Medical Council (GMC) to compel doctors and organisations to disclose written reflections for Fitness to Practise hearings.

6. The repeal of Section 40A of the Medical Act that allows the GMC to appeal MPTS verdicts, which should be final.

7. Assurance from the Department of Health that Parliament will not grant the GMC the power of automatic erasure for the offence of GNM.

We are happy to present our evidence in person and look forward to engaging with you on this review.

Yours sincerely,

The Doctors’ Association UK
Introduction

The Doctors’ Association UK (DAUK) is a nascent organisation which is a campaigning and lobbying group representing doctors of all disciplines, drawn together in the wake of the case of Dr Hadiza Bawa-Garba. We have a large scale, vibrant, grassroots social media movement which aims to give doctors a voice about issues of vital importance our profession’s future. This has 29,000 members, with representation from junior doctors both within and outside the training system, GPs, and hospital consultants. The steering committee has achieved significant successes in a short space of time, such as coordinating 4500 doctors and members of the public as joint signatories to a letter to Charles Massey, GMC Chief Executive⁴, and writing the lead letter published in the Sunday Times on 25 March, which was signed by almost 1400 doctors⁵. We are currently campaigning for radical reform of the way medical error is approached in the UK, in a recently launched campaign called “Learn, Not Blame”.

Doctors perceive the culture of the NHS as one of fear and blame. Progress made in recent years towards openness and learning from error has been halted, or even reversed. We are afraid to admit to our errors and near misses, with the fear that unilateral and disproportionate action may be taken by the GMC, and now that we may be subject to criminal proceedings for simply making an honest mistake when system failures and pressures leave us working in a sub-optimal environment. Whistleblowers are actively discouraged from speaking up. Investigations within the NHS are notoriously opaque and lengthy for relatives, and the culture of pinning the blame on one healthcare professional leads to the loss of crucial opportunities to learn from the systemic failures that often surround medical error. We are afraid to commit reflections to writing, for fear this will help convict us or erase us from the GMC register.

The issue of “medical manslaughter”, or how gross negligence manslaughter (GNM) is applied to healthcare, is therefore of vital importance to doctors, and we were pleased when this review was announced by the Secretary of State.

Whilst we welcome this review, our strong view is that the Terms of Reference of this review do not go far enough. Healthcare professionals do not need information about the current flawed law and processes surrounding it. They – and patients – need urgent wholesale review of the law on GNM and how it is applied to healthcare. We cannot continue to ignore the impact that the threat of criminal proceedings has on doctors trying to do their best for patients in a health service under ever-increasing strain. We will therefore be addressing the wider question of legal reform in our submission rather than focusing narrowly on the first point of the Terms of Reference. We will also be providing recommendations on the second and third points of the Terms of Reference, relating to written reflections and the role of the GMC.

⁵ https://www.thetimes.co.uk/article/ignore-the-vitriol-doctors-are-key-to-safe-childbirth-n8jd0fmz
Evidence and recommendations

1. Gross negligence manslaughter in relation to medical professionals

Doctors that wilfully harm should be punished to the full extent of the law. Thankfully, this is incredibly rare. The use of gross negligence manslaughter in cases where a doctor has simply been trying their best to save a life under immense pressure is grossly inappropriate and disproportionate. In an over-stretched system, doctors increasingly find themselves doing the jobs of several doctors at once, and many are concerned that working under this pressure, mistakes are inevitable. Yet currently, working in a failing system appears to be no mitigation when an error is made.

As doctors working in the NHS, we all recognise many of the features of the day experienced by Dr Hadiza Bawa-Garba when Jack Adcock tragically died. Poor induction, lack of handovers, rota gaps, IT failures, and long hours without adequate breaks. Research on Human Factors shows that such pressure is detrimental to performance and is inevitably linked to medical error. Doctors can all recount errors we have made. Fortunately for most of us, and our patients, harm is avoided because we do not work alone, and checks and balances are built in to the system to allow for human error. Where error leads to serious harm, it is almost always multi-factorial and in the context of system failures.

The CPS decides whether to charge a medical professional with GNM. The previous Head of Special Crime at the CPS, Mr Nick Vamos, stated in a lecture in 2017 that this decision was “a judgement... the most difficult legal decision to make”, and noted that individuals making this decision “were human beings”, who had to decide whether the acts or omissions could even be described as a crime at all. For a case to be taken further, the CPS has to decide that pursuing it is in the public interest. Yet, explicitly, the CPS has stated that this public interest test does not consider either the ramifications for patient safety, or for the NHS more widely, such as encouraging the practice of defensive medicine.

We believe that the CPS needs to have a higher bar for considering a prosecution for GNM. “Public interest” needs to be defined more widely than the current interpretation. Specifically, we believe that it needs to be demonstrated that pursuing a case in the court will be in the wider public interest and will improve patient safety. If this test was applied, it is our belief that many of the recent prosecutions for GNM would never have been pursued.

Recommendation 1: A higher bar for the CPS to consider pursuing a prosecution for GNM.

For a case to be convicted of GNM, four tests need to be satisfied: that there was a duty of care; that this duty of care was breached; that the breach caused the death; and that the breach constituted gross negligence rather than just negligence. “Grossness” being defined as something “truly, exceptionally bad... and such a departure from the standard to be expected”. The Misra case stated that “mistakes, even very serious mistakes, and errors of

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6 For example, Harold Shipman. https://www.britannica.com/biography/Harold-Shipman
7 https://videos.rsm.ac.uk/video/gross-negligence-manslaughter-the-decision-to-prosecute
8 R v Adomako (1994) 3 All ER 79
judgement, even very serious errors of judgement... are nowhere near enough for a crime as serious as manslaughter to be committed.” The final judgement on whether a medical professional falls on the side of making simply a very serious mistake, or whether an act or omission in the care provided was truly, exceptionally bad, lies with a jury, who are not instructed by the law to consider the nature of their behaviour.

We believe that this is too fine a line for a jury of lay people to judge with regard to what are inevitably highly complex and technical medical situations. Instead, the law on GNM as relates to healthcare should be reformed, as a matter of urgency, to include a test of whether the act or omission is “wilful or reckless”. Moreover, the law should also include a requirement for the jury to consider the environment within which the act or omission happened, with system failures such as understaffing or IT failures being taken into account as mitigating factors when errors occur.

**Recommendation 2:** The law on gross negligence manslaughter (GNM) be urgently reformed, with a legal test of GNM related to healthcare to include actions being “wilful or reckless”, and system failures taken into account as mitigation.

Court proceedings are necessarily adversarial, and the threat of criminal charges against medical professionals who may make errors whilst working in high-stress, high-risk environments, is detrimental to the creation of an open, learning safety culture within the NHS. The aviation industry has been revolutionised in recent decades with the creation of the Air Accidents Investigation Branch, established to investigate the causes of accidents and incidents in aviation without attributing blame. Key to this is that the “information supplied by individuals within the framework of a safety investigation should not be used against that person, in full respect of constitutional principles and national law”.

The Healthcare Safety Investigation Branch, set up in 2017, but not yet fully independent, shows promise as being an effective way to facilitate a safety culture within the NHS. We are calling for the HSIB to be made fully independent and adequately resourced to deal with many more investigations, with a specific remit to explore how systemic failures contribute to medical error, in an explicitly non-punitive way.

**Recommendation 3:** The creation of an independent investigative body, or significant strengthening of the Healthcare Safety Investigation Branch, whose first priority will be to explore the systemic failures that ultimately surround medical error.

2. Protecting the role of reflective learning, openness and transparency when mistakes are made

Medical professionals are mandated by the GMC to be open and honest with patients when things go wrong, with a duty of candour to patients and their families, reporting not just when mistakes are made causing actual harm to patients, but when mistakes could have

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9 R v Misra and Srivastava [2005] 1 Cr App R 328
11 https://www.hsib.org.uk
compromised patient safety. GMC guidance also mandates doctors to reflect on all aspects of their practice, including significant events and, specifically, complaints. This reflects the current practices within the NHS of dealing with error and consequent sub-optimal care. Most patients and families just want to ensure that such a situation never arises again, and measures are put in place to prevent this; they are rarely seeking punishment of individuals. Yet, the NHS is set up only to facilitate feedback through an adversarial complaints system.

This way of dealing with error in the NHS renders doctors vulnerable psychologically. Complaints are known to carry severe psychological morbidity for doctors, especially where referral to the GMC has been made. It is crucial that doctors feel able to reflect, including surrounding situations where there has been error, in an environment where they feel psychologically safe. Doctors urgently need a safe space to debrief and reflect.

Too often, even in the most supportive of NHS environments, there is no capacity for reflection to happen in a meaningful way in person with colleagues. The “eportfolio” or written reflection system has provided a useful safety valve for doctors to offload their experiences and consider the learning – not always medical – from both positive and negative situations. But we now find ourselves in the unprecedented situation where doctors now feel too wary to reflect in writing after a reflective document relating to Dr Hadiza Bawa-Garba was fed into her criminal trial and used against her in court. As a result, doctors are now reporting to us that they are only prepared to commit the bare minimum to writing, providing only a statement that they have reflected on their experiences and discussed it in person with their supervisor or appraiser.

We are therefore calling for legal privilege for all written reflections made by doctors as part of their training or for purely educational purposes. We welcome the statement made by the GMC in their evidence to this review that they are also now supporting this proposal.

**Recommendation 4: Legal privilege for all written reflections made by doctors for training or education purposes.**

We also welcome the GMC’s earlier statement of assurance that they will not use reflective records within Fitness to Practise investigations. However, in light of an unprecedented lack of confidence in the GMC as regulator amongst doctors following the case of Dr Bawa-Garba, we would seek amendment to Section 35A (1A) of the Medical Act (1983) that allows the GMC to demand the production of documents by a practitioner for Fitness to Practise hearings to explicitly exclude written reflections made for training or educational purposes.

**Recommendation 5: An amendment to Section 35A (1A) of the Medical Act 1983 that currently allows the GMC to compel doctors and organisations to disclose written reflections for Fitness to Practise hearings.**

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12 https://www.gmc-uk.org/guidance/ethical_guidance/27233.asp
13 https://www.gmc-uk.org/education/continuing_professional_development/26744.asp
3. Lessons that need to be learned by the GMC

The General Medical Council (GMC) is the medical profession’s regulatory body in the UK. It receives its powers through the Medical Act (1983), which lays out its “over-arching objectives” as threefold:

- to protect, promote and maintain the health, safety and well-being of the public,
- to promote and maintain public confidence in the medical profession, and
- to promote and maintain proper professional standards and conduct for members of that profession.

The GMC has been the subject of widespread anger amongst the medical profession in recent months, a fact acknowledged by the GMC, including in its own submission to this review\(^\text{14}\). Doctors were particularly angered by the GMC’s action in challenging the decision of the Medical Practitioners Tribunal Service (MPTS) not to erase Dr Bawa-Garba from the medical register – a decision which took multiple system failures into account as mitigating factors. The GMC argued that to pursue any less sanction than erasure for a doctor convicted of GNM in the courts would be to undermine public confidence in the profession. Furthermore, the GMC has recently responded to a Department of Health consultation on regulation and is now seeking the power of “automatic erasure”, wishing to bypass their own tribunal altogether\(^\text{15}\).

We argue that the GMC, in placing so much emphasis on the maintenance of public confidence as to seek erasure of all doctors convicted of GNM, has actually caused detriment to the first of its objectives in law, namely, promoting, protecting and maintaining the health, safety and well-being of the public. The ramifications of the GMC’s decision to seek to strike off a conscientious doctor deemed fit to practise by the MPTS, who made errors in the context of system failures familiar to all of us, are immense. The potential for doctors to be less open and transparent about error and to move towards the practice of defensive medicine will undoubtedly be at the detriment of the health, safety and well-being of the public. We would strongly argue striking off doctors convicted of GNM does not fulfil the GMC’s objectives in law. We have had correspondence from Charles Massey, the Chief Executive of the GMC, which has suggested that the GMC is no longer wishing to pursue automatic erasure for this offence, and if this is the case, we welcome this. However, we will still be seeking assurance from the Department of Health that Parliament will not grant the GMC the power of automatic erasure for the offence of GNM.

**Recommendation 6: Assurance from the Department of Health that Parliament will not grant the GMC the power of automatic erasure for the offence of GNM.**

The Medical Practitioners Tribunal Service was set up in 2012 to hold hearings to assess doctors’ fitness to practise, separating out the adjudication function of the GMC from the

\(^{14}\) [https://www.gmc-uk.org/Written_submission_Williams_Review_74084026.pdf](https://www.gmc-uk.org/Written_submission_Williams_Review_74084026.pdf)

prosecution function. Each panel necessarily includes at least one medically trained member. Its decisions are subject to regulation by the Professional Standards Authority, but in 2015, the GMC was granted the power to appeal its decisions.

As in Dr Bawa-Garba’s case, we feel strongly that a professional tribunal is best placed to unpick complex medical decisions and to judge professional competence and safety in the context of widespread system failures. The MPTS has demonstrated in its recorded decisions that it considers the wider question of the public interest, including protection, promotion and maintenance of the health, safety and well-being of the public. We are therefore calling for the repeal of section 40A of the Medical Act (1983) that allows the GMC to appeal MPTS verdicts if they consider the decision is “not sufficient for the protection of the public”. We believe that MPTS decisions should be final, and subject to appeal only by the PSA.

**Recommendation 7: The repeal of Section 40A of the Medical Act that allows the GMC to appeal MPTS verdicts.**

**Conclusion**

This review is a welcome step in the wake of the Bawa-Garba case, and we have submitted evidence and made the recommendations detailed above in a spirit of constructive engagement. But the fact remains that the Terms of Reference do not go far enough on the issue of gross negligence manslaughter in healthcare. It is time to decriminalise the honest error of otherwise competent doctors in the context of system pressures and failures where those responsible for these system pressures and failures are not called to account. Reform of the law in England and Wales is urgently needed. We urge the Williams review not to shy away from this wider issue in constructing its report.