Royal College of Obstetricians and Gynaecologists written submission: Professor Norman Williams Review

Introduction:

- The issues raised in relation to the recent GMC appeal against Dr Bawa Garba[1] have led to a significant response from RCOG members, particularly its trainees. The RCOG welcomes this opportunity to share its views with the panel and hopes that this review will help to address some of the uncertainties that clinicians are currently experiencing. It is not the RCOG's position to comment on either the specific facts of the case or the judgement that was reached by the high court.

- The RCOG supports clear and full investigation, which should be communicated clearly for all parties. We do not feel that "scapegoating" is a helpful response in cases of Gross Negligence Manslaughter (GNM).

- The RCOG notes the overwhelming response to the case, both from the clinical community and via the media. The complexity of the issues in the Bawa-Garba case has fuelled the misinformation and anxiety in the profession. As a medical royal college, the RCOG feels that it is important to support members with clear information and signpost them to guidance on the *issues* that have been raised in relation to this case. Information can be found on the RCOG website here.

- Since the judgement the RCOG has been actively engaging with its members, particularly its trainees, to explore the issues and to support clinicians to regain the confidence which some have expressed has been lost. The RCOG is aware that social media has been a primary source of information for many, again particularly trainees. In response the President of the RCOG has met specifically with the Trainees' Committee on this matter, to direct and encourage them to access the publicly available information and guidance. The RCOG is providing regular updates in response to the developing external landscape on the issues that have been raised by the GMC appeal and it has communicated the scope of this review with its members. The RCOG plans to disseminate the final recommendations from this review to its membership.

- The RCOG is committed to sustaining a high level of engagement with its members and will support a continued dialogue once the findings and recommendations of this review are published and implemented.

- This response was developed with RCOG members, drawing on evidence from the RCOG Supporting Our Doctors Task Group, its Trainees' Committee, and its Workforce Taskforce and from anecdotal feedback. This written submission has been produced following a roundtable discussion between the panel and presidents of medical royal colleges held on 5.4.18. The RCOG has also submitted the following supporting documentation as examples of best practice from O&G. These include the following:

    - *Supporting Our Doctors Task Group remit and terms of reference*
    - *The RCOG revised CPD Framework*
    - *Curriculum human factors case studies for O&G*
    - *GMC Top Tips Guide developed in partnership with GMC*
    - *Human factors training video, RCOG Each Baby Counts programme*
    - *Bullying and undermining toolkit*

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[1] GMC v Bawa Garba [2018] EWHC 76 Admin

Key Messages:

- **Obstetrics is a high risk specialty**: Clinicians need to be clear about the purpose and impact of all investigation processes and how and where GNM fits in. Equally clinicians need to be provided with clear guidance on what is expected of them and of the organisations that they work for when a process has been started for a suspected GNM charge. Obstetrics is also a high-litigation specialty. There are several investigation processes already in place for reporting poor care in maternity services. It is critical that providers and individual clinicians working in obstetrics are clear about the circumstances and, importantly, the process in which a serious incident could be escalated into a charge of GNM.

- **Pre-charge for Gross Negligence Manslaughter**: The RCOG supports the need for greater consistency in the process that is taken before a charge of GNM is made. Little evidence exists to demonstrate how a charge of GNM is bought or the circumstances in which a referral for GNM is to be made. The lack of clear guidance on the criteria that must be met for a case to be escalated and investigated as a charge of GNM is something that needs to be addressed urgently.

- **Gross Negligence Manslaughter Charge:** Greater clarity and reassurance is required to support doctors to understand when and how the criminal law applies to medicine when a patient dies, including processes for initiating a prosecution.
- Improving the standards of Medical Experts – The RCOG supports the development of cross-college criteria to standardise the qualification and expertise of a Medical Expert. It welcomes the opportunity to work via the Academy of Medical Royal Colleges (AoMRC) to develop these criteria.

- Establishing the difference between error and criminal negligence is important. A learning culture must consider the wider factors which affect the outcomes in a case, and thorough review of those factors is critical to driving improvements in care.
- The RCOG's Each Baby Counts programme is a good example of how doctors can be supported to learn from mistakes and be open when things go wrong. The programme has credibility with staff, families affected by stillbirth and system leaders.

- **Reflective practice**: The RCOG fully supports a campaign to demonstrate the value of reflective practice. The RCOG recognises that reflective practice notes is just one aspect, it is committed to supporting all members across all career stages to engage when mistakes are made and to collectively learn from them and use them to improve future ways of working. The RCOG is actively working across O&G to understand and create the ways of working which are needed to support clinicians and their employers in this way.

- The RCOG is actively working with clinicians to understand more about the working environment where a mistake has occurred and is working with system leaders and maternity units to improve culture and practice to minimise mistakes happening in the future.
- The RCOG would be happy to offer access to its Supporting our Doctor's members and more detail of its work if this would be helpful to the panel.

- **GMC Tribunal Process**: In light of the evidence on the number of successful appeals which have been upheld, the RCOG supports this panel in making recommendations for a review of the role and purpose of the GMC tribunal process of investigation and decision making.

Question 1: How do we ensure that healthcare professionals are adequately informed about where and how the line between gross negligence manslaughter and negligence and what processes are gone through before initiating a prosecution for gross negligence manslaughter?

- The RCOG does not have a position on the need for reform of the law; this is a decision to be taken by the government based on expertise from the Law Commission, who have twice reviewed the law in this area.

  Inconsistency upstream before a charge is made: the process and threshold for referral, investigation and decision to charge is heavily inconsistent, and focus should be on tackling this issue. The RCOG supports the need for greater guidance on the process that is taken before a charge of GNM is made. Little evidence exists to demonstrate *how* a charge of GNM is bought or the circumstances in which a referral for GNM has been made (coronial referral, CPS route, police route, trust reporting routes).

- The RCOG has concern about the grounds under which a Trust may initiate an investigation for GNM. Greater clarity is required about the role of the Serious Incident (SI) process, in light of the updated standards and the proposed bespoke SI framework for maternity care, it is important that those processes are informed by this findings from this review.

- The RCOG recognises the adverse impact and personal cost of investigations on individuals and, we welcome initiatives which seek to keep professionals in work where appropriate, such as offering alternative clinics or teaching opportunities to reduce the risk of absolute exclusion. Evidence has shown the highly detrimental impact that arrangements for removing clinicians from the workplace can be for mental wellbeing in the longer term.

- The medical royal colleges played a positive role in providing medical expertise to the development of the sentencing guidelines for GNM. The RCOG would suggest that more is done with the colleges to inform the GNM pre-charging routes and process.

- Improving the standards of Medical Experts: The variable quality of medical experts has been problematic for a long time. The RCOG supports the development of cross-college criteria to standardise the qualification and expertise of a Medical Expert. It welcomes the opportunity to work via the Academy of Medical Royal Colleges (AoMRC) to develop these criteria.

- The RCOG feels it is important that any “accredited” Medical Expert is supported by processes and resources to ensure that the role is appealing and that clinicians are motivated to provide this service. Backfill and agreement from providers will be critical. The RCOG supports the suggestion of these roles being described as “in service of the public good”, as this provides language which values the role and skill required and will be instrumental in motivating individuals to become medical experts.

- Establishing the difference between error and criminal negligence is important. A learning culture must consider the wider factors which affect the outcomes in a case, and thorough review of those factors is critical to driving improvements in care.

- Police specialist units: During the roundtable discussion, the panel suggested the development of several specialist units within the police to offer medical advice to investigations of GNM in healthcare. The RCOG would urge caution with regards the establishment of units to specifically offer medical expertise to investigations of GNM in medicine and would welcome guidance from the CPS on this proposal.

- The RCOG's Each Baby Counts programme is a good example of how doctors can be supported to learn from mistakes and be open when things go wrong. The programme has credibility with staff, families affected by stillbirth and system leaders. More info can be found https://www.rcog.org.uk/eachbabycounts

- Investigation: Clinicians need to be clear about the purpose and impact of all investigation processes and how and where GNM fits in. Equally clinicians need to be provided with clear guidance on what is expected of them and of the organisations that they work for when a process has been started for a suspected GNM charge.

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- Obstetrics is a high-litigation specialty. There are several investigation processes already in place for reporting poor care in maternity services. It is critical that providers and individual clinicians working in obstetrics are clear about the circumstances and, importantly, the process in which a serious incident could be escalated into a charge of GNM.

- Obstetrics and maternity care can also be highly unpredictable in terms of risk. For example, the RCOG Each Baby Counts programme, which investigates both the quality of SI reports and the factors affecting care for all intrapartum stillbirths, neonatal deaths and brain injuries, found an average of six contributory factors in each case which affected the outcome of care. We have provided analytical evidence from Each Baby Counts in Appendix 1 to demonstrate both the number of factors and the interdependency between the factors. This complexity demonstrates the strong relationship association between individual, system and organisational factors.

- The RCOG is concerned that the complexities and realities of healthcare (as exampled by the Each Baby Counts findings), when coupled with a lack of a clear definition regarding the *severity or extent* of negligence for GNM, leaves clinicians with inadequate support and guidance on this important issue.

- Gross Negligence Manslaughter Charge: Greater clarity and reassurance is required to support doctors to understand when and how the criminal law applies to medicine when a patient dies, including processes for initiating a prosecution.

- The RCOG would like to note that there is currently a proposal to expand coronial investigation into all cases of intrapartum stillbirth for obstetrics. The RCOG would like to note the concerns expressed during the roundtable regarding the quality of guidance and advice provided to coroners when investigating cases of death in medical settings. The RCOG would strongly urge this panel to address this issue before any further responsibilities are considered for coroners.

- The RCOG would like the panel to consider as part of its recommendations the points made earlier regarding pre-charge investigation and decision-making process for establishing a charge of GNM within the independent sector. O&G members may be working in the independent sector and it is important that processes are consistent across those settings and engage healthcare professionals clearly, where appropriate.

Question 2: How do we ensure the vital role of reflective learning, openness and transparency is protected where the healthcare worker believes that a mistake has been made to ensure that lessons are learned and mistakes are not covered up?

- *Reflective practice*: The RCOG supports the AoMRC guidance on reflective practice and this is an important aspect of a trainee's learning experience. We encourage anonymisation of patient information and provide a template to guide trainees.

- Our trainees have reported taking a more defensive attitude towards the written process of reflective learning in e-portfolios because of the case. However, RCOG trainees are continuing to promote the use of the AoMRC template.

- The RCOG supports the suggestion of an education/communication campaign aimed at trainees, to reiterate the value of reflective practice and the risk of not undertaking reflection. This should be cross-specialty, perhaps via AoMRC, and should provide case studies demonstrating how best to capture contextual or situational factors in the e-portfolio.

- Our trainees have suggested that reflective practice and learning from mistakes are wider issues and more work should be done to communicate how to support a learning culture across the career course, rather than just on the e-portfolio tool and only addressed at trainees. There is an appetite to produce more on learning from mistakes and creating an open culture. This was why the RCOG set up the Supporting our Doctors working group.

- *Learning from mistakes: Each Baby Counts* – Establishing the difference between error and criminal negligence is important, particularly where a case is focusing on a single event rather than being considered as part of a complex system of related factors. The Each Baby Counts programme has focused its attention on providing support to doctors on situational awareness and human factors. This is also reiterated in our curriculum, training courses and our CPD framework, with both our curriculum and our CPD framework currently being updated. We have submitted to this review panel for information examples of case studies which we offer to members to help develop their skills.

- The RCOG acknowledges that the duty of candour is still not fully understood, and that evidence exists where clinicians are unclear about in what circumstances they should say sorry. The RCOG curriculum provides a clear framework on candour (see attached evidence). The panel should consider what further work is required to ensure that clinicians are clear about the duty of candour and that concerns or misunderstandings about admittance of culpability that may lead to litigation are addressed.

Supporting our Doctors (APPENDIX 2):

- *Complaints management and defensive practice:* The RCOG believes more work should be done “upstream” to prevent complaints escalating. We believe that a large number of complaints can be managed more effectively at a local level with appropriate support for professionals. We responded to the regulatory reform consultation along these lines. Our Supporting our Doctors Task Group is specifically working with the GMC to improve communication with doctors when a complaint is made (GMC Fitness to Practise Complaints - top tips for doctors) We are particularly concerned about the impact an investigation can have on an individual going through the process.

- *Defensive practice:* The impact of these processes has been shown by Tom Bourne and colleagues in a seminal study of nearly 8000 doctors. This study reports high rates of psychological morbidity in doctors facing all types of complaints. Unsurprisingly, the impact was greatest on those undergoing GMC investigation.
- Bourne and his team also examined how doctors changed their clinical practice in response to complaints. Over 80% of doctors reported changing the way they treat patients after complaints against themselves or others. The most common changes were “hedging” behaviours, such as over-investigation, over-referral, and over-prescribing. Just under half of doctors described avoiding high-risk patients and

procedures, 23% reported suggesting invasive procedures against their professional judgement, and 16% reported abandoning procedures early[2]. This undermines the use of professional judgement and demonstrates the worry and lack of confidence that professionals experience when dealing with fitness to practise investigations[3].

- *Leadership:* The role that leaders play is critical in ensuring a positive workplace culture. We have found huge variability in the ways in which local leaders (for example Clinical Directors and Medical Directors) manage complaints. We would recommend that more work is done to standardise the quality of support and response to issues arising from complaints. Clinical Directors are not provided with any formal support and may not be experienced in managing complaints. The RCOG is holding a forum/national event for Clinical Directors in the summer to specifically develop support for leaders. The programme is in your pack. We will be discussing safety investigations, consent and management of complaints.

- *Bullying and undermining*: Undermining and bullying behaviour has long been recognised as a problem for trainees in O&G, as shown by repeated GMC trainee surveys. O&G trainees report more undermining behaviour than any other medical specialty. Inappropriate workplace behaviours represent a threat to those subject to the unacceptable behaviour (victims), as well as organisations and institutions that they currently or may later work in. In 2016, the RCOG published a study exploring the incidence of bullying and undermining among O&G consultants. It showed that 44% (290) of those who responded had been persistently bullied or undermined. This represents 14% of the consultant workforce. To address the challenge of poor behaviour in maternity and gynaecology services, the Royal College of Midwives (RCM) and RCOG have developed a joint web-based Undermining Toolkit[4], an eLearning package[5], and developed *Workplace Behaviour Champions*[6]

- Return to practice: The RCOG trainees support a flexible training programme. We endorse this and have recently agreed entry at ST3 for trainees. We acknowledge the value that flexibility offers in terms of achieving work life/balance and retention. O&G has an attrition rate of trainees averaging approx. 30%. We also recognise that the demographics within O&G are skewed towards women, therefore return to practice following maternity leave is common among O&G doctors. The RCOG has recently secured funding from HEE to develop a Return to Training toolkit for trainees. This will be co-designed by doctors and could serve as a template for other specialties. We believe that this will be important when ensuring a supportive culture and way to ensure that practitioners are supported back to work, avoiding the risk of mistake.

Question 3: How do we ensure that lessons are learned by the GMC and other healthcare professionals' regulators in relation to how they deal with the practitioner following a criminal process for gross negligence manslaughter?

- Perception: The anxiety expressed by the profession is symptomatic of the perceived lack of transparency regarding the way in which the GMC handled this case. The length

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[2] Bourne T, Wynants L, Peters M, van Audenhove C, Timmerman D, van Calster B, et al. The impact of complaints procedures on the welfare, health and clinical practise of 7926 doctors in the UK:a cross-sectional survey. *BMJ Open* 2014;4:e006687.

[3] http://careers.bmj.com/careers/advice/Can_I_avoid_complaints_by_practising_defensively%3F

[4] https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/improving-workplace-behaviours-dealing-with-undermining/undermining-toolkit/

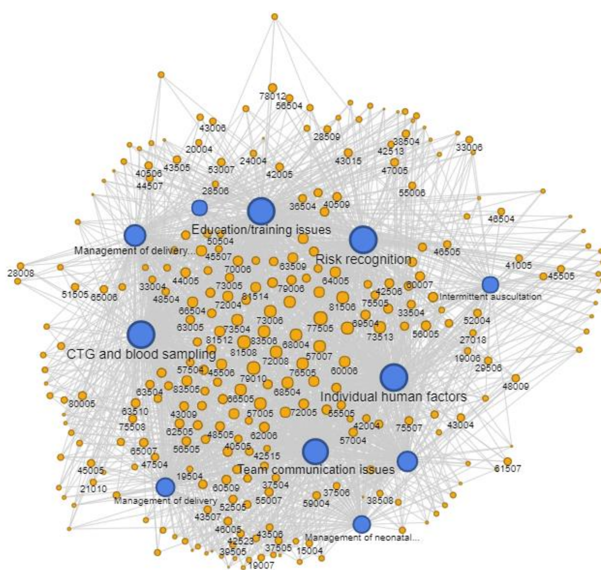
[5] https://stratog.rcog.org.uk/tutorials/non-technical-skills/improving-workplace-behaviour/online-resource-improving-workplace

[6] https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/improving-workplace-behaviours-dealing-with-undermining/workplace-behaviour-champions/

of delay between the original case and the appeal decision has also been highlighted as unhelpful by our trainees.

- Right of appeal: during the roundtable session with the panel, there was a discussion regarding the GMC Right of Appeal. The RCOG acknowledges that in the majority of cases where an appeal was lodged by the GMC, the appeal was upheld, and agreed with the suggestion from the panel that this evidence suggests that the focus should be on the role of the tribunal process.
- Erasure: There is a lack of clarity about which offences are listed by the GMC which lead to auto-erasure. The RCOG would welcome clarity from the panel on the current list. The act of erasure for GNM in the case of Dr Bawa Garba has divided opinion particularly amongst our trainees. The RCOG feels that more work could be done specifically with trainees to define the role that the regulator fulfils with regard to maintaining public confidence.

APPENDIX 1 Each Baby Counts – 2015 full report



This network graphic aims to portray the thematic analysis that affected each case with over 6 contributing factors, and should be taken as a visual aid to comprehend the extent of the complexity. This network analysis is created by compiling each case by all of the individual contributing factors, and then aggregating them by both case and thematic analysis areas.

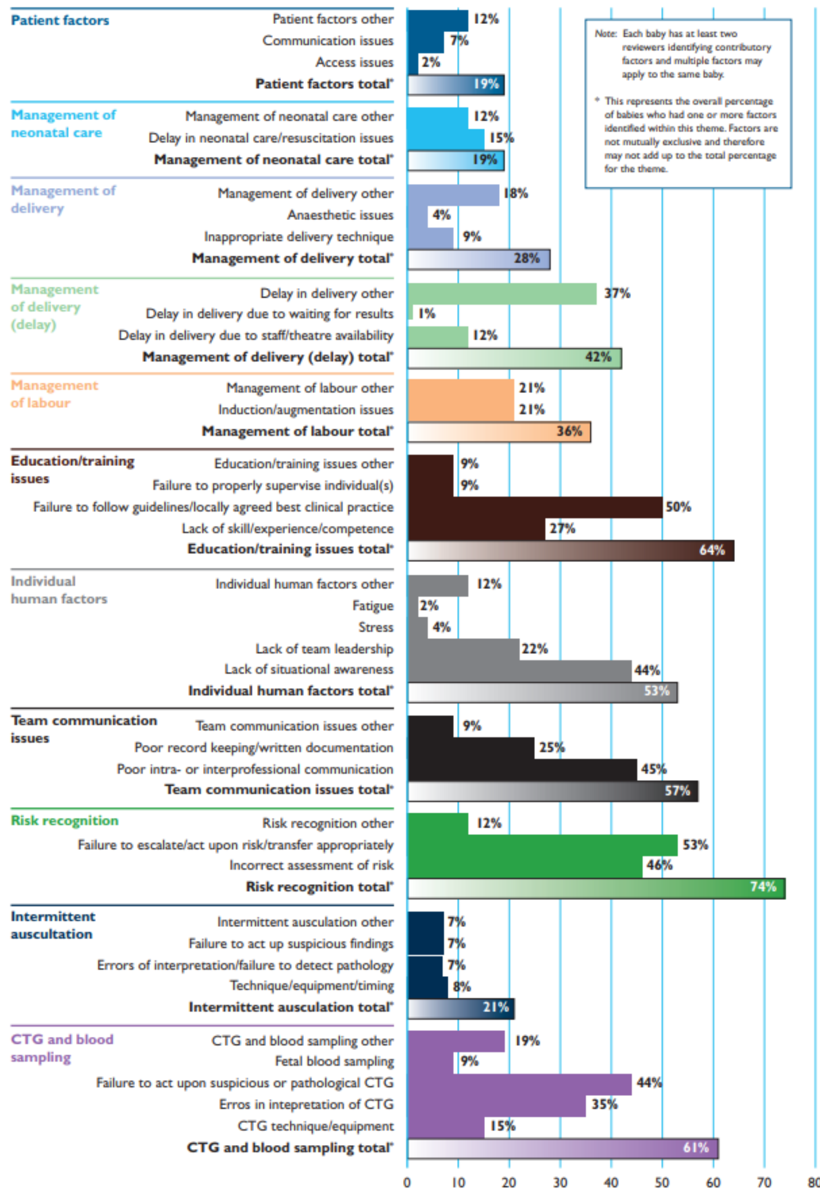


Figure 7 Critical contributory factors identified in babies for whom different care might have prevented the outcome (N=556)