20 July 2018

Written submissions by the Royal College of Anaesthetists to the Clare Marx Review of gross negligence manslaughter and culpable homicide

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 RCoA strongly believe 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.

Like the Williams Review, this review is set 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 RCoA President's Dinner last February- 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".*

We welcome many of the recommendations from the Williams Review and we are encouraged that the review by Dame Clare Marx will be informed by its findings. We also hope the latter will go even further in making robust recommendations on the legal protection of doctors' reflections and the role of corporate management in serious incidents.

Summary of recommendations in our submission

- An agreed and clear position needs to be framed, giving medical practitioners clarity on what constitutes a criminal act in medical practice, supported by clear guidance and examples, which should be agreed and used consistently by hospitals, regulators and the legal professions. We support recommendations from the Williams Review for a descriptive statement of gross negligence manslaughter (GNM) in healthcare.

- The quality of local investigations needs to be improved across healthcare providers in all countries, by: agreeing standards for training; dealing with and involving bereaved families; allocating adequate resources; setting of quality assurance processes for the staff involved in investigations.
- More consistency is required in how cases of GNM and CH are handled by the police and we support the creation of a virtual police unit to advise Senior Investigating Officers dealing with these cases, as recommended by the Williams Review.
- There is currently too much variability in coronial services across the countries; greater centralisation is required to ensure that families have access to equality of justice and that clinical staff are treated fairly and consistently when a death occurs.
- 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 and human factors, alongside issues around clinical competence.
- Steps must be taken to ensure that doctors' reflections are not used in an adversarial fashion in judicial proceedings or by healthcare regulators. In these rare, and often tragic cases, the focus for regulators and everyone else involved needs to be primarily on learning, not punishment, and reflections are a powerful tool to achieve this.
- Greater support needs to be available to healthcare staff involved in investigations by regulators and the authorities. In addition consideration needs to be given to the effects of serious incidents on all healthcare staff involved as 'second victims'.
- The Review should look at governance arrangements for regulators, in particular the right of the GMC to appeal MPTS decisions, in light of the fact that the PSA holds the same powers.
- Consideration should be given to the role of managerial accountability and system failures when deaths occur in healthcare; currently individuals incur a higher risk of legal proceedings than the organisations they work for. This balance needs to be redressed, especially if system failures have been found to play a part in the death of a patient.

This section focuses on what you consider to be 'criminal acts' by doctors

9. What factors turn a mistake resulting in a death into a criminal act?

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 a mistake and criminal act in medical practice should be drawn by whether the incident is caused by reckless behaviour or whether other factors, often outside the control of the accused, involving systemic or organisational failings, have played a part in the incident. As the Williams Review report states, only cases where an individual performance is 'truly exceptionally bad' should lead to criminal investigations.

It would be helpful to issue guidance, as a collaboration between the GMC, the Academy of Medical Royal Colleges, the legal profession and the authorities, supported by examples and case studies, on what scenarios might constitute a criminal act in medical practice and we welcome the recommendation in the report of the Williams Review to produce an explanatory statement of the law on GNM.

10. What factors turn that criminal act into manslaughter or culpable homicide?

It would be outside of the remit of a response from a medical royal college to offer advice on charging decisions and specific points of law. However it is clear that the different approaches to the law regarding GNM and culpable homicide in England and in Scotland respectively lead to different outcomes in prosecutions in the two countries and we encourage the review panel to consider this in more detail.

In England a four stage test for gross negligence manslaughter, known as the Adomako Test[6], is currently used. The test involves the following stages:
a) the existence of a duty of care to the deceased;
b) a breach of that duty of care which;
c) causes (or significantly contributes) to the death of the victim; and
d) the breach should be characterised as gross negligence, and therefore a crime.

Whereas in Scotland, 'mens rea' (the intention or knowledge of wrongdoing), rather than duty of care, plays a significant part in proving whether an individual has committed the offence of culpable homicide, comparable to GNM in England.

Perhaps as a consequence of this different approach, the MDU reports that in Scotland there has not been a case to date where a doctor has been successfully prosecuted for the offence of culpable homicide[7].

This section focuses on the experience of patients and their families

11. Do the processes for local investigation give patients the explanations they need where there has been a serious clinical incident resulting in a patient's death? If not, how might things be improved?

Based on some of the inquiries that the RCoA receives from members of the public, it appears that all too often hospitals do not engage with patients and families early enough when things go wrong, keeping them at arms length throughout the investigation. This leads to patients and their relatives feeling excluded and to feelings of anger, resentment and mistrust towards healthcare professionals.

The National Quality Board has this month published *Learning from Deaths,* new guidance aimed at NHS trusts on how to work with bereaved families and carers. The foreword from the families on the Learning from Deaths Steering Group tells of families' traumatic experiences of not feeling supported after the avoidable death of a loved one and of having to fight to get the answers they needed.[8]

This latest guidance stresses the importance of the professional duty of candour as an integral part of the apparatus that forms the structure for transparency, accountability and learning in the health service, which should in turn allow patients to receive the explanations they need following a serious incident or the death of a relative. Sadly the fallout from recent high profile cases involving doctors, the climate of fear which prevents staff from speaking out or admitting mistakes, and the threat of financial liability to healthcare providers all threaten the integrity of this structure.

In addition to *Learning from Deaths*, considerable amounts of guidance have recently being published to help healthcare providers handle these difficult situations, such as *Saying sorry* by NHS Resolution[9] and the CQC's *Learning, Candour and Accountability*[10]. Regulators, government departments, NHS bodies and healthcare providers must now cooperatively concentrate efforts in applying issued guidance to practice and bringing about a change in the culture of the NHS where

candour becomes the norm.

12. How is the patient's family involved in the local trust/board/hospital investigation process and in feedback on the outcome of the investigation?

This seems to be very variable currently, yet, as recommended by the CQC's *Learning, Candour and Accountability*, the contribution that families and carers can make to investigations should not be underestimated by NHS trusts and investigators, as they often have a picture of the whole pathway of care experienced by the patient and can offer valuable insights for improving care.

We note the announcement by the Department of Health and Social Care that all non-coronial unexpected deaths within the NHS in England and Wales are to be investigated by medical examiners in order to improve investigations into the cause of deaths and offer support to families.
We welcome this development, but we would advise lead organisations responsible for the standards of practice and training of medical examiners to ensure that all clinical specialties are appropriately represented both in the development of frameworks and the active cohort of medical examiners.

13. What is the system for giving patients' families space for conversation and understanding following a fatal clinical incident? Should there be a role for mediation following a serious clinical incident?

The latest annual reports and accounts published by NHS Resolution show a marked increase in the use of mediation to resolve cases over the course of the year 2017-18; NHS Resolution carried out 189 mediations last year, of which 75% resolved on the day or within 21 days of the mediation, resulting in better outcomes and reduced legal costs for all parties involved.[11]

Not surprisingly, NHS Resolution intends to build on this momentum and plans to make even more use of mediation as part of its strategy to decrease the number of disputes going to court. We would urge caution, however, in the use of mediation for cases involving serious clinical incidents and deaths of patients, especially in cases where the Health Service Safety Investigations Body is called to interview staff involved in incidents under the provision of 'safe space' as proposed in the homonymous draft Bill currently going through parliamentary scrutiny.

We recommend that the review panel wait for the Joint Committee for this Bill to report on how 'safe space' might be applied by the Health Service Safety Investigations Body in its investigations, before making recommendations on the use of mediation in these rare and complex cases.

14. How are families supported during the investigation process following a fatal incident?

See response to question 12.

15. How can we make sure that lessons are learned from investigations following serious clinical incidents?

See response to question 25 and question 12 (in particular the importance of utilising families' and carers' understanding of the pathway of care experienced by the patient).

This section focuses on processes leading up to a criminal investigation

16. **Do you think that the current arrangements for reporting and investigating serious clinical incidents within healthcare settings are effective and fair? If not, what is wrong and how might they be improved?**

We believe that, despite efforts and initiatives to move away from a culture of blame when mistakes happen, local investigations by healthcare providers are still inconsistent in quality and fairness to the individuals involved, as recent high profile cases have shown.

As we said in our response to the NHS Improvement consultation on the 'Future of patient safety investigations'[12] (to inform the revision of the Serious Incident Framework) local investigation teams require dedicated, independent, trained personnel and expert clinical input. They need to be skilled in making judgements about the incident and also in supporting staff during a very difficult time. This in turn requires NHS managers to provide adequate funding and to release clinical staff to take part in investigations.

We see the Health Service Safety Investigations Body as having an important role – with adequate additional resources - in cascading training in hospitals and investigators for the delivery of high quality and consistent local investigations, thus enabling healthcare providers to apply the HSSIB's principles of focussing on system failures and fostering a culture of learning from mistakes in their own investigative processes.

We are encouraged by the publication of *A just culture guide*[13] by NHS Improvement, containing a series of steps to help NHS staff conduct an honest conversation between managers and individuals involved in patient safety incidents through the application of a 'deliberate harm test'. The guide is not a replacement for an investigation, but we would encourage the review panel to explore how it can be used in the initial local investigative processes to ensure that staff involved in safety incidents are treated fairly and with compassion.

This and many other interventions recently announced show real commitment to improving patient safety and promoting a 'just culture', and we unequivocally support them. However, as the Williams Review recommended, greater clarity is needed on the role of different organisations and individuals involved in investigations (local investigators, ombudsmen, regulators, HSSIB, medical examiners and medical experts) and how they can co-ordinate efforts to avoid duplication and collaborate effectively to establish the causes of serious incidents in a fair and consistent manner.

17. **Would there be benefits in ensuring a human factors assessment approach is used in local investigations as opposed to a root cause analysis? 'Human factors' refer to the environmental, organisational and job factors, and human and individual characteristics which influence behaviour at work in a way which can affect health and safety. A 'root cause' analysis is a systematic process for identifying 'root causes' of problems or events and an approach for responding to them.**

We agree that human factors should be part of local investigations. We are aware that in recent years the effectiveness of 'root cause analysis' methods has been called into question, mainly because these tend to look for causes of incidents in isolation rather than failures in systems that contributed to failings .[14]

18. **Typically, who is involved in conducting investigations following a serious clinical incident in hospital/trust/board or other healthcare settings and what training do they receive?**

Local investigations are usually carried out by senior medical and nursing staff supported by managers. Training for this role is inconsistent, and yet we are aware that often staff investigating incidents can be called by coroners to give evidence as part of their inquiries.

We are especially concerned by the time constraints imposed by managers to which investigators are expected to work to, greatly inhibiting their ability to examine complex incidents in depth. Moreover local investigators are not always released from their clinical duties and often need to try and fit investigations in between shifts or as part of their already small Supporting Professional Activity allowance.

19. How is the competence and skill of those conducting the investigations assessed and assured?

Quality assurance (QA) in local investigation is undoubtedly an issue that needs to be addressed. As for training, QA for these roles is still inconsistent in many hospitals and too often negatively impacted by a desire to meet deadlines, rather than how rigorously and sensitively the investigations are conducted.

20. In your hospital/trust/board or other healthcare setting, is there a standard process/protocol for conducting investigations following a serious clinical incident leading to a fatality? If so, please email a copy to ClareMarxReview@gmc-uk.org

No response to this question.

21. What measures are taken to ensure the independence and objectivity of local investigations in hospital/trust/board or other healthcare settings?

To guarantee that a local investigation remains objective and independent steps must be taken to ensure it is not influenced by management, that it has no link with performance management functions and that it has access to all areas, documents and records relating to the incident[15].

22. What is the role of independent medical expert evidence in local investigations?

This is a crucial role in local investigations as medical experts will assist investigators in identifying the causes of the incident and the factors contributing to it, providing that they possess the necessary current and relevant clinical expertise and understanding of human factors applicable to the incident under investigation. As above, training and QA standards for these roles need to be made consistent across healthcare settings.

23. How are independent experts selected, instructed and their opinions used? Is access to appropriate expertise always available? Do they have training in unconscious bias?

We expect training in unconscious bias to be part of equality and diversity training packages which most clinicians would be expected to complete; nevertheless it would be beneficial for this training to be included as part of a bespoke training package for independent experts, and to be taught in the specific context of investigations following a serious incident.

In addition, we believe that a credible independent medical expert 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.

With regard to how these experts are selected and their opinion used please see question 43.

24. Are there quality assurance processes for expert evidence at this stage, if so, what are they?

It is our understanding that there are no tangible and agreed quality assurance processes for medical experts. We are concerned that too often the quality of experts is established through word of mouth between solicitors, and based on who can argue a case more persuasively, rather than being based on clinical knowledge and understanding of legal processes.

We welcome the Williams Review's recommendation for the Academy of Royal Colleges to lead on the setting of standards and training for healthcare professionals providing expert opinion, and for this role to be recognized as part of a doctor's revalidation and CPD activities.

25. How can we make sure that lessons are learned from investigations following serious clinical incidents? (please respond here if you haven't already responded to this question in the patients and families section)

As stated in the general comments, 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.

Management and investigation teams must foster an environment of trust and support, by engaging constructively and compassionately with staff involved in clinical incidents and by involving them in the learning process.

Once opportunities for learning are identified there must be agreed and robust methods for sharing these across organisations, including on a national basis when in the interest of wider patient safety.

26. What support is provided for doctors following a serious clinical incident that has resulted in the death of a patient (including emotional, educational, legal, professional support)? Could this be improved? If so, how?

It is critical that all staff involved in serious clinical incidents are supported and feel able to talk freely about what has gone wrong, including admitting to mistakes. The absence of mechanisms for 'second victims' to share their feelings and concerns in the aftermath of serious incidents can lead to feelings of guilt and shame and ultimately lead to doctors looking for healing in self destructive behaviours[16].

The Association of Anaesthetists of Great Britain and Ireland has produced a guideline, *Catastrophes in Anaesthetic Practice – dealing with the aftermath*[17], which covers issues such as psychological support for staff, as 'second victims', after the incident and how to deal with relatives sensitively.

Every medical specialty should have such guidelines pertinent to its field and healthcare setting and these should form part of local policies for dealing with the aftermath of serious clinical incidents.

27. How and when are decisions made to refer a fatality to the coroner, or in Scotland, to the police? Who does it? Who do you think should do it?

Some deaths will almost invariably lead to coronial referral, such as death in childbirth or death within 24 hours of a surgical procedure. For other cases, referrals are often made according to local custom and practice, normally driven by instructions from the local coroner as to what type of death

should be reported.

The review panel should consider conducting an analysis of whether hospitals have a formal policy to guide them on which deaths to report to coroners, and how these vary from place to place. For such variation to be addressed, however, there will also be a requirement for greater consistency across local coroners over which deaths should be reported by hospitals.

28. **What evidence is there that some groups of doctors (by virtue of a protected characteristic) are more or less likely to be subject to investigations leading to charges of GNM/CH than other groups? What are the factors that may be driving a greater likelihood for certain cohorts of doctors to be subject to investigations leading to charges of GNM/CH?**

We are aware that the GMC has commissioned a review into why some doctors are referred to their regulator more than others and we look forward to seeing the findings of the report.

29. **Do you think there are barriers or impediments for some groups of doctors to report serious incidents and raise concerns? More specifically are there additional barriers for BME (black, minority and ethnic) doctors? If so, which groups are affected by this and how can those barriers be removed?**

No response to this question.

This section focuses on inquiries by a coroner or procurator fiscal

30. **What is your knowledge or experience of cases involving clinical fatalities that have been referred to the police or procurator fiscal? What can we learn from the way those cases have been dealt with?**

Our experience is that coronial processes across England and Wales are very variable, and may often change quite suddenly in a particular jurisdiction when one coroner retires and another takes up the post. Attempts to centralise coronial processes through the recent Coroners and Justice Act (2009) seem to have had little practical impact. This results in different responses to deaths, so that, for example, a death in one jurisdiction might prompt a full Inquest with witnesses called, while elsewhere the same death will either not be reported at all or will be reported, but identified as 'natural' with no further action taken. There should be better consistency of coronial inquiries and processes across the UK to ensure that families have access to equality of justice and that clinical staff are treated fairly and consistently when a death occurs.

31. **To what extent does an inquest or fatal accident inquiry process draw on or rely on the evidence gathered in the post incident investigation by the hospital/trust/board or other healthcare setting?**

This is again very variable. It is our view that coroners should consider the evidence gathered in local investigations, as this can be helpful in revealing the circumstances in which an incident has occurred and help guide inquiries by coroners into looking at wider issues and factors, rather than just focusing on issues of clinical competence (see also response to question 36).

32. **What is the role of independent medical expert evidence in inquest or fatal accident inquiry processes?**
33. **How are independent experts selected, instructed and their opinions used? Is access to appropriate**

expertise always available? Do they have training in unconscious bias?

34. **Do the same standards and processes for experts apply regardless of whether they are providing their opinion for a local investigation, an inquest or fatal accident inquiry process? If not, why not? For example, is there a higher level or different type of expertise or skill set required?**
35. **Are there quality assurance processes for expert evidence at this stage, if so, what are they?**

For questions 32 to 35 please refer to our comments on medical experts in the previous section.

This section focuses on police investigations and decisions to prosecute

36. **To what extent does the criminal investigation and/or prosecution process draw on or rely on the evidence gathered in the post incident investigation by the hospital/trust/board or other healthcare setting?**

Investigating authorities should take into consideration the findings of initial local investigations, which should aim to establish:

- the cause of the incident 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 (using the *Just culture guide* as a tool).

We support the Williams Review's recommendation for the production of a new Memorandum of Understanding between all organisations involved in patient safety investigations, settting out the roles and responsibility for each, how they should communicate with each other and what is expected of expert witnesses. A requirement for police, coroners and investigative bodies to consider the findings of local investigations could be included in the MoU to ensure that these are appropriately used to inform subsequent criminal investigations.

37. **What is the charging standard applied by prosecuting authorities in cases of GNM/CH against medical practitioners? How does the charging standard weigh the competing public interest in improving patient safety?**

No response to this question.

38. **Are there factors which potentially hamper key decision makers in making fully informed decisions at each stage of the process, taking into account all the circumstances that the medical practitioner found themselves in at the time of the fatality, such as system pressures and other factors?**

As stated in previous answers, more clarity is required on a definition of GNM and when this applies to doctors. In addition, anyone investigating a case or providing expert advice at any stage needs to have understanding of human factors and have received appropriate training.

39. **Do the key decision makers (the police senior investigating officers (SIOs), and/or prosecuting authorities) have the necessary support to enable them to make fully informed decisions on whether or not to charge a doctor of GNM/CH? Is there a need for detailed prosecutorial guidance for this offence (similar to that for assisted suicide)?**

There is a need for greater clarification of what constitutes GNM/CH in healthcare so that prosecutions for

GNM/CH in healthcare follow a consistent and equitable process across the UK.

We welcome the Williams Review recommendations for the development of an explanatory statement of the law on GNM and CH and for guidance by prosecuting authorities to be updated to reflect its contents.

We also welcome recommendations on the setting up of a virtual police unit to offer guidance and expertise to Senior Investigating Officers tasked with appraising these cases.

40. Why do some tragic fatalities end in criminal prosecutions whilst others do not?

As above, the lack of clear guidance on what constitutes GNM and CH in healthcare and the absence of a single overseeing constabulary leads to an inconsistent approach being applied by the authorities, often leading to different outcomes for similar investigations. This is further compounded by lack of expertise in assessing these rare cases by individual local offices of the CPS.

41. Under what circumstances would it be more appropriate to consider cases involving fatal clinical incidents within the regulatory system rather than the criminal system?

When the local hospital, police or coronial investigations do not find that the clinicians involved have reached the threshold of criminal liability, but have breached acceptable standards of professional practice.

42. What is the role of independent medical expert evidence in criminal investigations and prosecutions?

Independent medical experts play a vital role in criminal investigations and their expertise will often be key in determining the outcome of investigations and prosecutions.

43. How are independent experts selected, instructed and their opinions used? Is access to appropriate expertise always available? Do they have training in unconscious bias?

For some time, we have been concerned by the 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.

Similarly to what we have stated for experts in local investigations, 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.

In our submission to the Williams Review we have suggested that 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, which should be regarded with the same status as other non-clinical roles, such as postgraduate examining, providing 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
- the appropriate level of relevant and current clinical experience required, including a licence to practise
- accountability for the evidence provided in investigations, inquiries and legal proceedings.

44. Do the same standards and processes for experts apply with regards to evidence provided for the police or prosecuting authorities as they do for a local investigation, an inquest or fatal accident inquiry process? If not, why not? For example, is there a higher level or different type of expertise or skill set required?

We believe that all medical experts, regardless of process and stage of investigation, should possess up to date clinical expertise and understanding of human factors applying to relevant settings.

In addition, experts in criminal cases need to be aware of the differences between criminal and civil standards of proof, and the rules relating to disclosure with regard to emails, casual comments etc.

45. Are there quality assurance processes for expert evidence at this stage, if so, what are they?

As per answer to question 43, there is currently inconsistency in the quality of expert evidence, but we look forward to the development of a framework by the Academy of Medical Royal Colleges to address these issues.

46. What lessons can we take from the system in Scotland (where law on 'culpable homicide' applies) about how fatal clinical incidents should be dealt with?

See answer to question 10.

This section focuses on the professional regulatory process

47. What is your experience of the GMC's fitness to practise processes in cases where a doctor has been convicted of a serious criminal offence?

The RCoA has been concerned for some time about the stress that doctors experience from investigations 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[18]. 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.[19]

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.

In December 2017 the RCoA published a report on the welfare, morale and experiences of anaesthetists in training[20] 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.

We look forward to feed the findings of our welfare and morale report into the recently announced Wellbeing Review by the GMC.

We also welcome the findings of an internal review by the GMC, which has revealed that doctors undergoing fitness to practise investigations are at a higher risk of suicide,[21] and we are encouraged by a commitment to increase the level of support the regulator offers to doctors undergoing investigations, while at the same time reducing the number of investigations it carries out.

The Association of Anaesthetists of Great Britain and Ireland has set up a working party to look at suicide amongst anaesthetists. The group should report later on in the year and we would encourage the GMC to consider the findings as part of its own review into suicide.

48. The GMC has a statutory duty to: promote and maintain public confidence in the medical profession, and promote and maintain proper professional standards and conduct for doctors. What factors do you think the GMC should balance when trying to fulfil both these duties where there have been mistakes that are 'truly, exceptionally bad' or behaviour/rule violations resulting in serious harm or death?

As the Williams Review reports states, greater clarity is required on what 'public confidence' means and what exactly is the role of the GMC in protecting it, given that the Professional Standards Authority has the same statutory duty and legal powers around this. It would be appropriate to ask the public via independently commissioned focus groups or surveys on their views of what sort of scenarios would erode their confidence in the medical profession.

Given the unforeseen reaction of the medical profession to the GMC decision to overrule the verdict of the MPTS on a recent high profile case, it is our belief that the regulator should focus on regaining the confidence and respect of the medical profession by conducting robust, but fair and compassionate, investigations to protect the public and promote learning.

49. What information would you like to see from the GMC and others about the role of reflection in medical practice and how doctors' reflections are used?

We note confirmation from the GMC that it will not ask for reflective notes as part of its fitness to practise processes and we look forward to joint guidance on reflective practice being currently developed by the regulator and medical royal colleges.

50. What emotional, pastoral and other support is available for doctors who have an allegation or charge of gross negligence manslaughter or culpable homicide and are being investigated by the GMC?

See answer to question 47. We believe that much more needs to be done to support doctors undergoing investigations. Furthermore, we are concerned by the excessive duration of investigations, which have a detrimental effect not only on the accused, but also on their colleagues and on patients' relatives.

51. How can the learning from a fatal incident best be shared? Should the regulator have a role in this?

We believe regulators have an important role to play in sharing learning from incidents. In our response to the Department of Health consultation, *Promoting professionalism, reforming regulation*[22] we have supported proposals for healthcare professionals' regulators to work closely with system regulators to help identify recurring risks to patient safety and to prevent harm.

Finally…

52. Do you have any other points that you wish the review to take into account that are not covered in the questions before?

Legal protection of doctors reflections in criminal prosecutions

We note the reluctance by the Williams Review to recommend that healthcare professionals' reflections should be legally protected in criminal investigations and court proceedings due to a concern that this might be perceived by the public as a 'legal privilege' and damaging the reputation of the medical profession in terms of its ability to be honest and open when things go wrong.

We do not share this view and we believe that the benefit of legally protecting doctors' reflections for the purpose of learning outweighs the risk of doctors being seen as 'closing ranks'.

The statutory duty of candour already offers the appropriate platform for healthcare professionals to be open and transparent to patients about their treatment and when it goes wrong, without the need to implicate a doctor's reflective practice.

We encourage the review panel to consider making robust recommendations around the legal protection of doctors' reflective materials in criminal investigations and court proceedings.

GMC right to appeal MPTS decisions

The RCoA believe this review should consider carefully whether it is appropriate for the GMC to be able to appeal decisions made by fitness to practise tribunals.

We note that the Williams Review has already recommended that this right is removed from the GMC, given that the PSA already has the same right. This duplication of roles between the two organisations leads to an unfair situation where doctors are the only healthcare professionals who can have their MPTS decisions reviewed not only by the PSA, but also by their regulator. This is an anomaly that we feel needs to be addressed.

No other healthcare professional regulator currently has this right and the reaction by the medical profession to recent decisions to appeal by the GMC for high profile cases is an indication that it might be opportune to review these arrangements.

Renouncing the right to appeal MPTS decisions, backed by the required changes in legislation, could go some way to re-establishing trust by doctors in their regulator and show real commitment by the GMC to its pledge to decrease the number of investigations and increasing the level of support it offers to the profession.

Role of senior management in clinical incidents and corporate manslaughter

While it is right that the review should explore issues around specific legal processes which lead to how prosecutions of manslaughter and culpable homicide are instigated, we would like to suggest that the panel considers the wider issue of the imbalanced emphasis on punishment of individuals when these tragic cases occur.

Too often clinicians are left exposed to the risk of legal proceedings as individuals. We note that charges of corporate manslaughter have rarely been levied at any UK healthcare organisation, whilst prosecutions for GNM amongst clinicians have increased in recent years.[23] Both clinical and accountable managerial teams should work together to address systemic failings within organisations and systems, and share responsibility when serious incidents occur.
Although this was an extreme case, the report by Sir Robert Francis inquiry into the failings at the Mid Staffordshire Foundation Trust has shone a light on the danger of poor leadership and cost cutting at the expense of safe staffing levels and patient safety.[24]

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.

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