Association of Anaesthetists Trainee Committee formal response to the independent review of gross negligence manslaughter and culpable homicide.

The Association of Anaesthetists (the Association) represents the medical and political views of over 11,000 anaesthetists in the United Kingdom and the Republic of Ireland. The Association has a broad remit including education, safety and research in anaesthesia, as well as the professional aspects of the specialty and the welfare of individual anaesthetists.

The Trainee Committee represents the views and interests of trainee members of the Association. We promote training, the practice of anaesthesia, and communication amongst trainee anaesthetists.

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

A mistake is a genuine error where there is no negligence and no intent to cause harm; it is often the consequence of a series of smaller errors. We believe a mistake becomes a criminal act if there is clear intent to cause harm (not necessarily death) or the reasons leading to the mistake are recognised yet the situation is allowed to continue and results in the patient's death. The criminal act could be attributed to the person or the Trust/Health Board (the latter would be more likely if there are a series of errors attributable to the system staff work within).

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

If the events that occurred involved or result in negligence that is so severe and falls so far below that which is expected of the medical personnel that it results in a criminal act.

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.

When analysing factors contributing to the incident it is vital to look at all aspects of the situation including human factors. For example, if an event occurs at night or toward the end of a long shift then fatigue may play a larger role. The Association of Anaesthetists (the Association) and its Trainee Committee have launched a Fight Fatigue campaign specifically to raise awareness of this issue This would need to be taken into account and may be missed if a pure root cause analysis is occurring. The ergonomics of the equipment involved should also be addressed when conducting an investigation that includes human factors.

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)

Firstly, it is important that an open and non-accusatory culture is encouraged. This will not only allow more transparency in reporting of clinical incidents but also promote learning from incidents rather than apportioning blame. Routine formal and informal debriefing should be encouraged, as should personal and professional reflection. It is important that any appropriate reflection should be without worry of repercussion.

Formal methods of learning from clinical incidents exist e.g. root cause analysis. These continue to have a place in understanding potential changes to practice that may be of benefit in the future. In

order for the outcomes of investigations to have a positive impact the results must affect real change, be incorporated into teaching and be available to the wider audience.

Teaching and learning from the results of investigatory processes can be in a variety of contexts and may be formal or informal. The information should be available to the whole multidisciplinary team and management staff and education should be targeted at all grades including the more junior staff. Examples of national enquiries with available data from which we have learned and made tangible changes to practice include NCEPOD, NELA and NAP.

We must learn not just from what could have been done better during an incident but also from what went well. 'Learning from excellence' is a positive way to approach incidents and can be highly motivating for staff.

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?

Support available for doctors following a serious clinical incident varies widely depending on local protocols and procedures. Although there may be members of staff who have formal roles in support, often it is very personal how relationships and trust are formed and informal support from colleagues will often be the mainstay.

Many departments will hold formal or informal debriefing sessions for staff involved in such incidents. These should be encouraged to take place at an appropriate time in relation to incident. Increasingly we are seeing that anaesthetic departments across the country may have a designated 'wellbeing lead'. This person is often, although not exclusively, a consultant.

For doctors specifically in training roles their Educational Supervisor and Royal College Tutor may be involved in providing both educational and professional support. Deaneries may also provide various forms of support via 'Professional Support Units'.

In some areas more structured pathways exist for accessing emotional and psychological support for doctors. Examples include the 'Practitioner Health Program' in the London area and 'Health for health professionals' in Wales. These services are not available nationwide however, the Trainee Committee believes such support should be available nationally in the UK. Occupational health departments at hospitals may play a role if required and will assist in such things as aiding return to work programs for doctors in difficulty.

Legal guidance is often an area in which doctors, particularly trainees, feel under supported. Trust indemnity will cover certain areas of practice and most doctors belong to a medical defence union such as the MPS or MDU, who provide indemnity insurance and may provide some limited legal advice. Many doctors will access the information available via the BMA (or other union) if they are a member, in such incidences.

The introduction of a recognised pathway for personal, and professional, help and support following significant events, such as the death of a patient, may improve speed and effectiveness of recovery for some doctors and healthcare professionals. This would need to be publicised appropriately and use of the service not stigmatised.

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?

Reporting deaths to the coroner is usually done by a doctor who has been involved with that patient's care, since they will be responsible for writing a death certificate and will be knowledgeable about that patient. Deaths do not have to be reported to the coroner by a doctor and may be reported by anyone who has concerns.

Whilst it is likely to remain that doctors report such cases, since they are most practically placed to do so, it is important that anyone is able to make a referral to the coroner's officer. It is important that transparency exists at all times and thus this process should be open to anyone.

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?

The GMC has publically stated that there is persistent "over-representation" of complaints against ethnic minority doctors in recent years. BME doctors are twice as likely to be given sanctions or warnings by the GMC. Between 2010 and 2016 the GMC received a complaint against 8.8 per cent of all white doctors, compared to 10.2 against those from a BME background. They have also reported that there may be under-representation of doctors from a white background and have suggested doctors from this group may find it easier to get away with mistakes.

The British Medical Association (BMA) report that BME doctors are more likely than their white counterparts to experience bullying, harassment and abuse from other NHS staff and the GMC have reported how ethnicity can negatively impact upon a doctor's career progress.

Difficulties in communication exist even if you are a fluent English speaker, but are not British. The subtleties and nuance of language in these situations are not always appreciated. Culturally, we shy away from direct statements as these may be construed as rude. For example, a senior doctor saying "that was ok" to a junior doctor can be taken in two very different ways. Someone brought up in this country may realise straight away that this statement meant their work was below par and needed improvement, whereas someone from a different background may take this statement at its literal meaning, that they performed the task satisfactorily. Also doctors from different backgrounds may find that their directness in communication is mistaken for rudeness. Education and awareness of such issues is an easy way to tackle this problem, and communication difficulties may be a driving factor leading to complaints and subsequent investigation.

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?

From a Trainee's perspective, the GMC Fitness to Practice process is poorly understood. However, notably there has been concern in light of the Dr Bawa-Garba case.

There has been a particularly emotionally driven response – specifically anger and fear. Part of this may be fuelled by the lack of understanding of the process. Trainees have a poor grasp of when a complaint to the GMC becomes a matter for the Fitness to Practice tribunal. On the GMC website this is not well explained or easily found and the experience is a little limited to what has been publicised in the media.

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?

Although as trainees we understand and support the statutory duties set out by the GMC, there also needs to be a focus on education and learning. Despite setting out professional standards, mistakes are inevitable and can be multifactorial. It is important to understand that some mistakes can have serious consequences for patients. However, it is also important to consider the consequences on the individual doctor and team who may be involved in a mistake. It is important that the GMC formulate

guidance on how root cause analysis +/- human factor analysis should be conducted locally. The focus should be on learning from the incident, both positive and negative factors, helping to support those involved and giving patients and their families the answers they need. There needs to be a clear distinction between genuine mistakes, those where there is no insight or remorse and those where the system has not helped to protect patients ('Swiss cheese' model). The emphasis should be on learning from mistakes and ensuring that the factors contributing to an unfortunate outcome are addressed.

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?

As trainees we understand the importance of self-reflection; giving us a better insight into our practice as professionals and aiding further self-development. There is an expectation to reflect and this is greatly encouraged by supervisors and the GMC. In light of the Dr Bawa-Garba case, there were concerns from trainees that her reflections were used against her as part of the process. This has been refuted by both the GMC and medical defence unions and we understand that her reflections were submitted by her legal team but not used in her 'prosecution'. However, there are still concerns about the potential use of reflections in Fitness to Practice proceedings. We would encourage the GMC to release clear guidance on the importance of reflective practice and whether reflections can be used in the Fitness to Practice process. Guidance about whether verbal reflections with a supervisor are acceptable as an alternative method of reflecting would be welcome. We also understand that reflections are being considered as part of the draft Health Service Safety Investigations Bill and hope that this may provide more clarity on their status. It is important that any guidance issued is consistent with the draft legislation.

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?

We understand that the GMC funds a free Doctor Support Service which is independently run by the BMA and provides confidential emotional support from fellow doctors although not medical or legal advice. The Association and its Trainee Committee, have a great interest in wellbeing. The Association and its Trainee Committee offer a mentoring scheme which enables reflection leading to change which produces valued outcomes and helps to make a positive difference in anaesthetists working life or career. Although there have not been any trainees using the mentoring scheme following an allegation of gross negligence manslaughter, pastoral and emotional care will always be offered to members and non-members of the Association and its Trainee Committee.

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

Learning from mistakes and fatal incidents is important as this helps to shape future practice. Analysing and investigating the factors that may have contributed to the incident can help to put safety measures in place to avoid a similar incident in the future. This can be shared locally in departmental and Morbidity & Mortality meetings. Having frank discussions within departments and hospitals will ensure that necessary changes are made and learning opportunities are shared. The regulator can be involved in highlighting anonymised examples more widely and, more importantly, what the learning points have been and how departments have changed practice. This will enable departments to learn on a national level.