General Medical Council

GMC comment piece from Charlie Massey, Chief Executive Responding to today's High Court decision

This has been a tragic case, in which a family has lost their son in terrible circumstances and a doctor has lost her career. It has also generated anxiety and concern among some doctors at a time of unprecedented pressure.

This case may have set back some of the gains we have made in recent years to develop a better relationship with the profession, and I acknowledge there is much more work to do.

I have spoken to many people about this case – including many frontline doctors – and it is clear that some of the anxiety, although by no means all, is not based on a full understanding of the facts.

In 2015 Dr Hadiza Bawa-Garba was convicted of gross negligence manslaughter, following the death from sepsis of six-year-old Jack Adcock at Leicester Royal Infirmary in 2011. She was sentenced to 24 months custody, suspended for 24 months. Nurse Isabel Amaro was also convicted of manslaughter and was later struck off by the NMC.

In June 2017 the Medical Practitioner Tribunal found Dr Bawa-Garba's fitness to practise was impaired because of her conviction and decided to suspend her registration for 12 months.

Charges of gross negligence manslaughter against medical practitioners are extremely rare. Gross negligence manslaughter is not about mistakes such as missed diagnosis, a series of failings or even several missed opportunities. In this case the judgment was clear that 'the failures that day were not simply honest errors or mere negligence, but were truly exceptionally bad… Nor were the Doctor's mistakes mere mistakes with terrible consequences. The degree of error, applying the legal test, was that her own failings were, in the circumstances, "truly exceptionally bad" failings.' The judge was also clear that wider systems issues and pressures had been taken into account in the original criminal conviction, and in the appeal where that conviction was upheld.

We thought very carefully before we appealed the Tribunal's decision. We did so because we believed the panel was wrong in the approach it took: that they had not taken proper account, as required in law, of the criminal court's judgement. Their approach on sanction

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did not take sufficient account of our statutory duty to consider public confidence in the profession in light of the court's findings when convicting the doctor in these circumstances of so serious an offence.

The judgment handed down by the High court confirms that the Tribunal's approach was wrong, and said: "The Tribunal did not give the weight required to the verdict of the jury, and it was simply wrong to conclude that, in all the circumstances, public confidence in the profession and its professional standards could be maintained by any sanction short of erasure."

"The ruling clarifies that tribunals cannot go behind the jury's verdict when a doctor is convicted in a criminal court. As the ruling makes clear, the Tribunal were wrong when they decided to suspend the doctor's registration because in doing so they "reached their own less severe view of the degree of Dr Bawa-Garba's personal culpability" than was established in the criminal court.

Supporting medical professionalism

We recognise that a case such as this has wider implications. We are completely committed to engendering a speak-up culture across health services and we have a pivotal role in making health services a place for learning, not blaming. That is why we want to provide a stronger focus to our work to support doctors by emphasising medical professionalism, promoting and protecting excellence in education and training, and reducing the number of cases we investigate.

Indeed, we have pushed our outdated legislation to the limit over the last few years so that we only fully investigate those complaints involving serious or persistent concerns. As a result, the number of full investigations is falling, from 2,265 in 2011 to 1,436 in 2016. Those downward trends also apply to full investigations opened against doctors around clinical incidents.

However, we do recognise that any doctor, no matter how experienced, can make a mistake, particularly when working under pressure. The duty of candour requires health professionals to be open and honest with patients or, where appropriate, families, when things have gone wrong.

Our guidance makes clear that doctors should share information about all they know and believe to be true about what went wrong and why, and what the consequences could be. If our guidance is followed then there shouldn't be anything recorded in reflective notes that the patient, or those close to the patient, isn't aware of.

In cases where a doctor has made a mistake, shown insight and taken steps to apologise to a patient or their family this weighs very heavily in their favour if concerns are raised about their fitness to practise. Indeed, those questions around insight, remediation and remorse are central in our consideration of whether to investigate and what sanction may be necessary to protect the public or public interest. And in the vast majority of the

complaints we receive around clinical care, it is that judgement on an individual's risk to future patients that determines whether we investigate and take action.

It is only in very rare cases such as this, where even after patient safety concerns have been addressed and insight and remediation demonstrated, that the question of maintaining public confidence still remains.

Reflecting regularly on your practice is a core aspect of professionalism and reflection is linked to improved learning and performance. We want to do more to support the profession in this area so we will shortly be publishing updated guidance for all doctors.

The GMC will always be called upon to make difficult decisions about a doctor's fitness to practice. My commitment is that we will continue to do so with the same reflection and willingness to learn as the profession we regulate.