Health Committee

House of Commons London SW1A 0AA
Tel: 020 7219 6182 Fax 020 7219 5171 Email: healthcom@parliament.uk
Website: www.parliament.uk/healthcom Twitter: @CommonsHealth

From Dr Sarah Wollaston MP, Chair

Charlie Massey
Chief Executive and Registrar
General Medical Council

5 February 2018

Dear Charlie

I write following the High Court judgement in the case of GMC v Bawa-Garba.

As you are aware, a great deal of concern has arisen, particularly in the medical profession, in the wake of this case and of the related criminal case against Hadiza Bawa-Garba. These concerns touch not only on the position of doctors who may find themselves having to answer a case either in the criminal courts or in front of the GMC, but on the vital issue of how patient safety can best be assured, especially in the context of a system which is under strain.

I should emphasise that it is not for me, nor for the Committee which I chair, to comment on the judgements of the courts in the particular case of Hadiza Bawa-Garba. Neither I nor the Committee will be attempting to challenge decisions made in that case although there are some points relating to it which need clarifying. My intention in this correspondence is to address the broader issues which have been raised in the debate which has followed the tragic death of Jack Adcock.

I would be grateful if you would comment on four issues. The first concerns the use, in criminal cases and in GMC proceedings, of doctors' own reflections on their practice. I understand that the Medical Protection Society, who represented Dr Bawa-Garba at her criminal trial, has issued a statement clarifying that her e-portfolio did not form part of the evidence before the court and jury, and that the court was clear that reflections were irrelevant to the facts to be determined and that no weight should be given to remarks documented after the event. I have also noted the comments on the vital role of reflection in the GMC's own public statements following the case. **It would, however, be helpful if you could clarify for the Committee the GMC's position on reflective practice, and in particular its implications for possible criminal or fitness to practise cases; and how the GMC is ensuring that the vital role of reflective practice in ensuring patient safety is maintained.** You will be aware that some clinicians are effectively stating that they will not take part in reflective practice as a result of their fears about its role in litigation or fitness to practice hearings. I would appreciate your comments on this and whether there needs to be any change to regulations or legislation to ensure that the

right balance is struck. We all recognise that it is in the public interest for clinicians to be able to reflect on and learn from their practice.

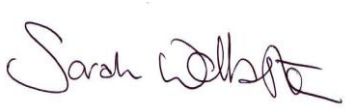
The second concerns the GMC's decision to appeal the Medical Practitioners Tribunal Service (MPTS) decision in Hadiza Bawa-Garba's case. Many commentators have suggested that the Tribunal's decision not to erase her from the medical register was appropriate given all the circumstances of the case. As I have said above, it would not be appropriate either for me or for the Committee to challenge the decision of the High Court in that case. Nor would it be right for us to criticise the GMC's power to appeal MPTS decisions in this way—a power granted by Parliament and supported by the Committee's predecessor. **It would nevertheless be helpful if you could set out what considerations the GMC takes into account when deciding that an appeal against an MPTS decision is merited, and how those considerations applied in this case.**

The third issue relates to the very serious concerns which have been raised by commentators who have suggested that Hadiza Bawa-Garba's ethnicity was a factor in the decisions to proceed against her. It has been put to me that doctors from an ethnic minority are appreciably more likely to be subject both to fitness to practise proceedings and to criminal proceedings arising from their practice, and in circumstances that would not lead to similar action in the case of non BAME colleagues. **I would be grateful if you would set out for the Committee what monitoring the GMC undertakes of ethnicity in such proceedings, whether this concern is supported by the evidence, and what steps the GMC is taking to ensure that any institutional bias against doctors from an ethnic minority is identified and eliminated.**

Finally, many concerns have been raised about the application and inconsistency of manslaughter charges where there have been allegations of medical negligence. **Does the GMC feel there needs to be a review of the legislation or guidance in this area?**

I look forward to hearing from you. It is likely that the Committee will wish to publish your reply.

Yours sincerely,



Dr Sarah Wollaston MP
Chair of the Committee

From the Chief Executive and Registrar

General Medical Council

Regent's Place
350 Euston Road
London NW1 3JN

Email: gmc@gmc-uk.org
Website: www.gmc-uk.org
Telephone: 0161 923 6602

Chair
Professor Terence Stephenson

Chief Executive and Registrar
Charlie Massey

9 February 2018

Sarah Wollaston MP
House of Commons
London
SW1A 0AA

Dear Sarah,

High Court judgement in the case of GMC v Bawa-Garba

Thank you for your letter of 5 February. This has been a tragic case. 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 across the healthcare system. I am very alive to those concerns.

In your letter, you raise a number of specific issues. In particular, you ask for our wider views on the implications of this case for reflective practice.

Firstly, I want to make it clear that the GMC never asks doctors to provide their reflective statements if we are investigating a concern about them. They are not used in GMC processes unless a doctor decides to share them as part of a fitness to practice investigation that they are subject to. More broadly, recorded reflections (such as e-portfolios) are not subject to legal privilege under UK criminal law. As a result, these documents might be requested by a court if it is considered that they are relevant to the matters to be determined in the case. As you acknowledge in your letter, in this case, the doctor's medical defence body has clarified that her reflective notes were not part of the evidence considered at her criminal trial.

We are committed to ensuring the vital role of reflective practice in ensuring patient safety is not just maintained, but enhanced. I appreciate that some doctors have concerns about the role that it could have in legal or other proceedings against them. With this in mind, I publicly reaffirmed last week our commitment, as part of a wider discussion with the British Medical Association (BMA), that we will never ask doctors to provide their reflective statements if investigating concerns about them. In partnership with the BMA, Royal Colleges and others we will be taking steps to ensure this understanding is fully embedded across the profession.

You also draw attention to the basis under which the GMC might seek leave to appeal a Medical Practitioners Tribunal Service (MPTS) decision, and how those considerations applied in the case of Dr. Bawa-Garba.

In this specific case, the legal advice we obtained was clear that the MPTS was wrong in law when it took a decision not to take appropriate account of Dr. Bawa Garba's criminal conviction in reaching its original decision. Having considered our appeal, the court agreed with this view, stating that the MPTS were '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.

More widely, the specific considerations we make in determining whether to seek leave to appeal MPTS decisions are made according to clear and published guidance[*]. Since we obtained the right of appeal in 2015, we have been successful in 80% of all appeals, and in 100% of appeals against MPTS decisions relating to the fitness to practise of doctors on our register. This implies that we are using our right of appeal appropriately.

The relevant guidance outlines the need for us to have regard to whether the case concerned raises ongoing questions about a doctor's fitness to practice. If these concerns are not evident, we do not take such an appeal forward. Wider 'system pressures' are also a factor that we look at. In practice, everyday mistakes made in the context of challenging environments are highly unlikely to lead to a doctor being taken to tribunal in the first place, let alone see us appeal one.

With that in mind, it is important to note that convictions for gross negligence manslaughter are not the result of everyday mistakes. It is regrettable that in the wider reporting of this specific case, the two have often been conflated. Moreover, systemic issues were taken account of in Dr. Bawa-Garba's criminal trial. In ruling on our appeal of the MPTS's decision, the judge stated that 'the failures that day were not simply honest errors or mere negligence, but were truly exceptionally bad' even when the systemic issues that many doctors face on a daily basis were considered alongside them.

You also ask about our efforts to monitor whether doctors of certain ethnicities are more likely to be subject to fitness to practice procedures. On an ongoing basis, we conduct detailed research to improve our understanding of what drives overrepresentation of different groups, and whether cases are treated fairly.

The consistency of our fitness to practice decision-making is also audited independently to ensure it is in line with our published guidance, and is not discriminatory. These audits have always found our decisions to be consistent with this guidance, and that the guidance itself does not introduce bias.

[*] This guidance can be viewed at https://www.gmcuk.org/DC8221_Guidance_for_decision_makers___s40A_appeals.pdf_64121775.pdf

We make every effort to be as transparent as possible about our fitness to practice data, and analyse it to understand what drives particular trends. It is true that certain groups, including BME (Black and Minority Ethnic) doctors, are disproportionately represented in the complaints that are made to us. 10.2% of all BME and 8.8% of all white doctors had a complaint made to the GMC about them over the period 2012-16. We conduct analyses to improve our understanding of what drives those trends, and we publish our data every year in our State of Medical Education and Practice (SOMEP) Report. Looking across all of our analyses and research we see no evidence of bias in GMC decision making related to ethnicity.

We also identify a wide range of factors that influence the proportion of complaints about doctors that are formally investigated and from there, result in sanctions or warnings. These include the source of complaint, type of work done by the doctor, and the types of allegations made about them. For example, a higher proportion of complaints about BME doctors are made by employers (10%) than white doctors (6%). In turn, these employer complaints are more likely to be investigated than complaints from the public. 84% require investigation compared to 16% respectively.

We also know that a lower proportion of BME doctors are specialists (28%) than white doctors (34%), and that specialists have lower rates of being complained about compared to, say GPs (11% of specialists and 17% of GPs from 2012-16). We continue to investigate these and other factors as part of our ongoing research and will continue to publish our analyses as they are completed.

More widely, it is clear to us doctors who trained overseas and are new to UK practice are also more likely to be complained about. This is not because they are bad doctors. In our view, it is more to do with how they are inducted into the NHS. We provide free 'Welcome to UK Practice' training for all such doctors. It is highly regarded and provides much needed support for doctors new to our health system. We've recently increased investment in this scheme and, in the medium term, we aim to increase take up from around 33% to over 80%. We've combined this with the expansion of our field force, which provides direct support to doctors, and advice to Responsible Officers (ROs) in handling complaints locally. In 2017, we engaged with over 46,000 doctors, patients, medical students and other individuals. 18,000 of these were medical students. A further 23,000 were doctors, of which over 7,000 were foundation doctors and more than 5,000 GPs. The remaining 5,000 were a combination of patients, nurses, commissioners, employers, royal colleges, regulators and medical educators.

Finally, you raise the matter of whether we believe there needs to be a review of legislation or guidance as a result of the various issues this case has raised. This is something we are currently considering. We do see a pressing need to ensure due consideration of all the factors that influence how gross negligence manslaughter

cases are initiated and investigated, the expertise and consistency applied to those investigations, and the role of reflection in such matters.

On the 30 January, we announced that we would be bringing together health professional leaders, defence bodies, patient, and legal and criminal justice experts from across the UK to explore how gross negligence manslaughter is applied to medical practice, in situations where the risk of death is a constant and in the context of systemic pressure. This work will include a renewed focus on reflection and provision of support for doctors in raising concerns. There may be a role for updating relevant guidance in these areas.

It is too early to say whether legislation will need to be amended or laid before parliament as a result of this initiative. However, you are no doubt aware that on 5 February, the Secretary of State announced a 'rapid review' into the application of gross negligence manslaughter in healthcare that will be led by Professor Sir Norman Williams. It will look at this issue in more detail, and will complement the work we are doing on the application of gross negligence manslaughter to medical practice.

We fully support this initiative and see it as complementary to our work. It will be for the Government to consider whether the law governing gross negligence manslaughter is appropriate for medicine. Our own focus will be on whether the current legislation is applied appropriately and proportionately by the relevant agencies involved.

We are committed to working with Ministers, and with your Committee, to explore these questions. If you, or your committee, would like to discuss any aspect of this case further, I would be happy to do so.

Yours sincerely,

Charlie Massey,
CEO & Chief Registrar