Questionnaire: written submissions to inform Dame Clare Marx's review of gross negligence manslaughter and culpable homicide

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

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

The Association of Surgeons of Great Britain & Ireland consider that death should only be regarded as the consequence of a **criminal** act by an individual doctor when that concerns:

1. The **deliberate** omission or commission of an act with the **intent** to harm or kill (in which case criminal law would be engaged in the usual manner, as for an ordinary member of the public).
2. An act undertaken in the delivery of healthcare, which:
   a) Fell short of responsible professional practice so as to engage liability in clinical negligence, **AND**
   b) The doctor demonstrated indifference to an obvious risk to the patient's life, the doctor was (or should have been) aware of that risk, yet they exposed the patient to it for no accepted medical benefit, **AND THERE WERE NO**
   c) significant mitigating factors, such as the doctor was working in circumstances that substantially impaired their ability to provide adequate care, or lacked the experience or capacity to deliver the treatment in question.

The Association of Surgeons of Great Britain & Ireland consider that a genuine **error,** occurring during the delivery of medical care, should not be considered a criminal act. With regard to gross negligence manslaughter, we reject the legal position, set out by Lord Mackay, in 1994, which noted that "whether having regard to the risk of death involved, the conduct of the defendant convicted of gross negligence manslaughter is so bad in all the circumstances as to amount in their judgment to a criminal act or omission, is **supremely a jury question".** This seems to us to us to be a flawed argument, not only because of its circularity (i.e. the fact that a jury considers a criminal act has been committed makes it a criminal act), but also because we consider that the highly technical complexities of many of the clinical scenarios in which gross negligence manslaughter is alleged to have occurred is likely to make these concerns judgments unsuitable for a jury decision.

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

There are very significant differences between "manslaughter and culpable homicide and it would be very wrong for the review to regard the two as 'equivalent'.

It is ASGBI's view that a **deliberate** act of omission or commission, with **intent** to harm or kill constitutes a criminal act. A genuine **mistake** should not be considered a criminal act unless it not only engaged liability in clinical negligence (i.e. fell short of the relevant professional standards) but there was also clear risk to the patient's life, clear indifference on the part of the doctor concerned to the risk of that act to the patient's life, and the patient was exposed to that risk for no proven medical benefit.

The key factors, in our view, relate not to the death of the patient, but to the allegations of criminality relating to the circumstances in which that death has occurred (see above).

This section focuses on the experience of patients and their families

- 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?

If a serious clinical incident results in a patient's death, it is not the patient that may require an

explanation but their family.

Investigations are often process-driven and acute sector organizations often see the formal investigation process as the only available option for learning from incidents which have resulted in avoidable harm. In some cases, an alternative approach would be more beneficial, using less complex but more efficient ways to address the needs of the deceased patient's family and identify any mitigating actions that could prevent similar incidents from happening again.

There also remain concerns that investigation reports do not properly evidence the involvement of patients and/or family members. Similarly, staff are not appropriately involved and Boards are not consistently and/or effectively applying extant guidance. We recommend that, as matter of routine, a deceased's family are sent the outcome of any investigations undertaken following an unexpected death and invited to comment on and contribute to the findings before the investigation is closed.

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

It is our experience that the deceased's family is often not involved as part of the investigation, but would usually be given feedback either in a face-to-face meeting or in written form. We believe that they should be offered the opportunity to contribute, in all cases, to the investigation, setting out their key areas of concern.

- 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?

There may be a role for mediation, however it is also important for all clinicians involved to provide a clear explanation under their duty of candour.

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

Generally, a case worker / liaison adviser will support families during an investigation.

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

It is sixteen years since the Donaldson report into patient safety 'An organization with a memory' was published, and the fundamental concepts of clinical governance espoused. In this report, Donaldson was critical of an NHS that had no systemic way of identifying and learning from mistakes to reduce risk for future patients.

Since then, various high-profile inquiries and reviews have consistently identified similar themes, including the need for a standardised investigation process and a change in culture whereby staff feel they can report mistakes and adverse incidents without fear of retribution.

Some improvements have been made. However, it is clear that, despite long-standing calls for an open learning culture in the NHS, barriers remain.

It is important that there is sharing of the results of investigation widely – to the whole clinical team, across directorates and departments at a local level and via regional and national forums, including across and between NHS Boards, with Colleges / Specialty Associations.

This needs to be undertaken in a "no blame" culture, emphasising learning and development. Where relevant, reviews of change of practice, identification of resource shortfalls and audit of the process should be documented. The Association of Surgeons of Great Britain & Ireland feel that the current application of the law on gross negligence manslaughter in highly publicized cases such as R-v- Bawa-Garba has actually reduced the likelihood of these measures taking place in the open and transparent manner required for safeguarding patient safety.

This section focuses on processes leading up to a criminal investigation

- 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?

The membership of The Association of Surgeons of Great Britain & Ireland report widespread concerns about disciplinary actions which may arise from patient safety investigations. They believe that there is currently a focus on blaming individual clinicians, because these are seen as "easy" targets, and because there are no robust mechanisms for identifying systemic or corporate failings, and for holding the management of the relevant organizations directly accountable when these failings result in death.

The Association of Surgeons of Great Britain & Ireland believe that, when resource, training and education shortfalls within an organization result in incidents which lead to avoidable death, greater emphasis should be placed on the Corporate Manslaughter (2007) to address organizational liability in criminal law.

The Association of Surgeons of Great Britain & Ireland also support the following additional approaches, which will enhance opportunities for learning and improvement :

- Prioritizing serious incidents that require full investigation and developing alternative methods for managing and learning from other types of incident
- Routinely involving families in investigations
- Engaging and supporting staff involved in the incident and investigation process
- Using skilled analysis to move the focus of investigation from the acts or omissions of staff, to identifying the underlying causes of the incident
- Using human factors principles to develop solutions that reduce the risk of the same incidents happening again.

- 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.

Clearly – yes. A human factors / ergonomics approach would be valuable. Currently in healthcare, human factors has often meant a narrow focus on Team Resource Management, but there is much more we could learn from HF/E. This may require an external body to investigate.

- 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?

A variety of individuals are involved in conducting investigations related to SIARCs/SUI's in healthcare settings. These include senior clinicians, clinical and medical directors, clinical governance leads, executive nurses, medicolegal advisors and senior trust management. The exact composition of the team responsible for conducting these investigations, reporting their findings and determining what actions (if any) should be taken varies from organization to organization.

No specific training in these matters is usually offered (and may not be available). Moreover, there is usually no internal quality control for the investigation nor routine independent review of the investigation process, for example to determine whether evidence has been sought from the appropriate individuals for each investigation, and whether all appropriate issues have been identified and suitable recommendations made.

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

This is not routinely undertaken.

- 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

These are not issues relevant to the remit of ASGBI

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

These are not issues relevant to the remit of ASGBI. However, an external review of investigation findings is not routinely undertaken.

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

Truly independent (i.e. external) medical expert evidence almost never forms part of the process of local investigation. Occasionally, where the findings of a local investigation are challenged by the family of a deceased patient, the responsible Medical Director of a Trust may appoint an external medical expert both to independently review the incident and to comment upon the local investigation. An independent medical expert may occasionally be commissioned by HM Coroner as part of the Coroner's inquest process, in order to undertake similar duties.

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

Selection of an independent expert seems to be undertaken at times on a relatively ad hoc basis, related to recommendations by senior clinicians, Trust solicitors, the relevant Specialty Associations etc. There seems to be no formal process for selecting and instructing an expert, access to appropriate expertise may not always readily be available and most experts will have had no training in unconscious bias.

ASGBI questions whether it is not necessary (or necessarily appropriate) for an "expert" involved in reporting upon an SUI or the process of an investigation, to have received expert medicolegal training, unless their role is specifically to support a judicial process (i.e. civil or criminal litigation).

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

There are no quality assurance processes for expert evidence used to support local investigations. Expert evidence used in this way may subsequently be reviewed and considered during civil and /or criminal proceedings. This does not strictly constitute "quality assurance", and it is unclear whether there are any mechanisms by which experts who are subsequently found, during a judicial process, to have provided poor quality, misleading or biased reports are identified and this information fed back to those who have commissioned them.

- 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)

There is a need to ensure that the outcome of all serious clinical incidents is fed back directly to the organization, division, directorate, department and even individuals involved, even when there seem to be "no lessons to learn".

The relevant organizational morbidity and mortality/clinical governance meeting should have a specific section set aside to consider the learning points resulting from such investigations, and signing these off should be the responsibility of the relevant clinical director.

ASGBI recommend that all serious incidents which each clinician has been involved in, whether as a responsible clinician, a reporter, or even as an investigator/expert should be recorded (anonymously) in annual "significant incident report", which forms part of the supporting documentation for annual appraisal.

- 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?

The support provided is variable. The support of the relevant postgraduate deanery will be available for doctors in training. For senior clinicians, the arrangements are more variable and rather ad hoc. No formal arrangement exist, although senior doctors will usually seek and receive support from their colleagues, a clinical director or clinical governance lead. Occupational Health departments may be able to provide psychological support. Educational and professional support is usually a matter for the relevant specialty associations, whereas legal support is usually the remit of the relevant defence organization.

- 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?

The criteria for referring a fatality to HM Coroner are well-established.
Any senior hospital doctor may do this on behalf of the responsible Medical Director.

- 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?

ASGBI are unaware of any robust evidence to suggest that any groups of doctors are proportionately more (or less) likely to be subject to investigations leading to criminal (or civil) charges.

- 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?

See above

- 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?

ASGBI are unaware of any evidence to support the suggestion that there are barriers to reporting serious incidents, other than anxieties that a "blame culture" may result in identification and apportioning of individual culpability, in incidents arising from systemic failings and/or resource shortfalls, rather than an honest and transparent analysis of all relevant factors which led to the incident in question. ASGBI are not aware of any evidence to support the suggestion that these factors specifically represent barriers for BME doctors.

This section focuses on inquiries by a coroner or procurator fiscal

- What is your knowledge or experience of cases involving clinical fatalities that have been referred to the police or procurator fiscal?

HM Coroner has a duty to investigate a clinical fatality occurring in circumstances set out in the Coroners and Justice Act 2009 Commencement No. 14 Order 2013 commences the provisions of section 43 [Coroners (Investigations) Regulations 2013] and section 45 [Coroners (Inquests) Rules 2013] of the Coroners and Justice Act 2009.

ASGBI have no specific comment to make with regard to the role of the Coroner in such cases, over and above their usual responsibilities with regard to the inquest process.

- What can we learn from the way those cases have been dealt with?

See above

- 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?

In ASGBI's experience, the coronial inquest process relies heavily on the information obtained in SIARC/SUI investigations supplied to the Coroner (and family). The report of this investigation frequently provides a template for the line of investigation pursued by HM Coroner during the inquest and allows the Coroner, the family and other interested parties to discuss concerns regarding perceived (or actual) healthcare failings which resulted in death.

- What is the role of independent medical expert evidence in inquest or fatal accident

inquiry processes?

The independent medical expert may advise the Coroner as to the adequacy of the local investigation and provide additional commentary as to the actions of the clinicians concerned. The independent medical expert's role is **not** to advise HM Coroner as to whether civil or criminal liability may have been engaged in the outcome of the relevant investigation.

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

See above.

- 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?

The Medicolegal committee of ASGBI take the view that the independent expert advising the Coroner will be qualified to comment upon the adequacy of local investigations and to assist the Coroner with the interpretation of medical evidence. They do not require specialist medicolegal training in respect of these duties as these reports will not (and should not) be used directly to support civil (or criminal) proceedings.

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

No

This section focuses on police investigations and decisions to prosecute

- 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?

This evidence is usually available to those responsible.

- 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?

ASGBI considers this question to be beyond its remit

- 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?

ASGBI considers that the current political landscape makes it considerably easier for authorities to target the actions of individual clinicians and attempt to hold them individually liable, than to critically examine the environment they work in and determine whether systems factors, resource

shortfalls etc. may be equally (or principally) responsible.
ASGBI takes the view that, in doing so, individual clinicians have frequently been "sacrificed" in order to avoid potentially politically uncomfortable revelations concerning resource shortfalls, lack of workforce planning, lack of training, lack of supervision of juniors etc.

ASGBI considers the apparent tendency to focus on the actions/omissions of individual clinicians, rather than all aspects of their working environment to be an important oversight, which may result in both a failure to solve the underlying problems and also a significant impairment of the healthcare system to openly and transparently learn from (and consequently to rectify) errors

ASGBI fully endorse the views of Sir Ian Kennedy :https://www.bmj.com/content/360/bmj.k1376

- 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?

ASGBI do not know what support key decision makers have in this regard. However, we doubt that they usually have the skills, knowledge and experience to satisfactorily address issues of this complexity.

- Is there a need for detailed prosecutorial guidance for this offence (similar to that for assisted suicide)?

ASGBI believe that substantial legal reform is required, and submitted their views, together with that of the Surgical Royal Colleges, to the Williams enquiry in April 2018.

http://asgbi.org.uk/news/position-statement-on-the-legal-aspects-of-medical-manslaughter/ASGBI%20and%20Colleges%20Position%20Statement%20on%20the%20Legal%20Aspects%20of%20%E2%80%9CMedical%20Manslaughter%E2%80%9D.pdf

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

ASGBI considers that this in itself reflects the flawed system currently employed to address this issue. ASGBI also wish to point out that whether or not a serious incident results in a death seem an inappropriate approach to the public interest with regard to patient safety. Specifically, exactly the same type of incident could conceivably result in criminal prosecution, simply because it resulted in death, or end in local (or no) investigation (because death was avoided).

Whether or not a death occurred as a result of the incident (which could result from a multitude of factors, entirely unrelated to the incident itself, including patient age and fitness, availability of resources) seems to ASGBI to be a vicarious and entirely unsatisfactory approach to such problems.

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

ASGBI consider that in almost ALL cases, fatal clinical incidents should not engage liability in criminal law but should represent regulatory issues.
ASGBI have suggested the following (see above):

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a. Fell short of responsible professional practice so as to engage liability in clinical negligence, **AND**
b) The doctor demonstrated indifference to an obvious risk to the patient's life, the doctor was (or should have been) aware of that risk, yet they exposed the patient to it for no accepted medical benefit, **AND THERE WERE NO**
c) significant mitigating factors, such as the doctor was working in circumstances that substantially impaired their ability to provide adequate care, or lacked the experience or capacity to deliver the treatment in question.

However, in order for the current healthcare regulator to address such cases, and to have the support of both the public and the profession, it seems likely that very significant reform of the regulator itself will be required. ASGBI note that, whether or not it is appropriate, the reputation of the GMC within the profession at large has been very significantly impaired as a result of recent events.

https://www.gmc-uk.org/news/news-archive/responding-to-the-case-of-dr-bawa-garba

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

Expert evidence is required to support criminal investigation and prosecution (as well, of course, defence). The role of the expert is to provide an objective and unbiased opinion for the Court.

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

As in all criminal (and indeed civil) cases, the availability of high quality, detailed, comprehensible evidence is essential for the conduct of a hearing. This evidence is used in an adversarial process, which may be less than appropriate given the nature of such cases. ASGBI believes that an inquisitorial process may be better suited to the assessment of expert evidence related to clinical fatality.

quality control or accreditation of experts. This has been discussed more widely elsewhere https://onlinelibrary.wiley.com/doi/pdf/10.1002/tre.573).
Access to appropriate expertise may not always be available and there is no definition of "appropriate expertise" (which is likely to vary from case to case in any event). Many experts will have received specific training in preparing reports for a Court, or in Court-room skills. Few training courses address unconscious bias.

- 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?

There are no currently applicable "standards".
ASGBI believe that the level of **clinical** expertise required to support a coronial process (which principally deals only with the cause of death) should be the same as that required to support prosecution. However, experts instructed in the course of criminal (or civil) prosecution should be able to demonstrate a track record of expert medicolegal training.

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

None at present

- 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?

Firstly, ASSGBI believe that it is inappropriate and an illogical that, although the principles and standards of healthcare, and the regulatory framework in which it is provided are the same throughout the devolved nations of the UK, the potential application of criminal law resulting from an alleged breach of duty which arises during the deliveryof that healthcare is different in England and Wales, Scotland and Northen Ireland. ASGBI believe that the law in this area should be harmonized urgently.

ASGBI notes that no doctor has been convicted in Scotland for the culpable homicide of a patient in their care and that the medical director at the Medical Protection Society (MPS) has stated as follows.

(https://blogs.bmj.com/bmj/2018/03/13/rob-hendry-gross-negligence-manslaughter-does-not-exist-in-scotland-is-it-time-to-move-english-law-towards-the-scottish-position/)

In England and Wales, when it is proven that a death has occurred as a result of a grossly negligent act, or omission, the defendant is guilty of GNM. The leading case law in respect of GNM is known as the Adomako Test. The four stages of the test are the existence of a duty of care to the deceased, a breach of that duty of care, which then causes (or significantly contributes to) the death of the victim, and that the breach was grossly negligent—meaning that the departure from the proper standard of care was so serious it is judged as criminal.

In the Adomako judgment, Lord Mackay also makes reference to "all the circumstances" as part of the legal test for GNM and many legal commentators believe that this has introduced a fifth feature to the test; criminality or badness—which is almost entirely subjective.

A further crucial piece of case law in respect of healthcare professionals charged with GNM is Misra. In the case of Misra, the court held that the conduct of the defendant in the course of performing professional obligations to their patient was "truly exceptionally bad," and showed a high degree of indifference to an obvious and serious risk to the patient's life.

A striking feature of the law in England and Wales is that intent, recklessness, or public interest in the prosecution are not required for a conviction. This means that the legal bar for convicting healthcare professionals of manslaughter is low, and I find it hard to see who benefits from this. A family has lost a loved one through tragic circumstances, a doctor may lose their career and face a prison sentence, the NHS has lost a valuable doctor, and fear of personal recrimination becomes increasingly embedded across healthcare.

Scotland has its own distinct legal and judicial system and the offence of GNM does not exist. The closest equivalent offence in Scotland is that of culpable homicide—an offence often thought of as the little brother to the offence of murder.

Culpable homicide requires there to have been a death (a homicide) where someone is to blame (culpable). It requires the causing of someone's death by an unlawful act, but in situations where the actions do not meet the test for murder.

For the prosecution to prove a charge of culpable homicide they would—in stark contrast to the GNM offence in England and Wales—need to establish that the accused committed an unlawful act; that the unlawful act was intentional, reckless, or grossly careless; and that the death was a direct result of the unlawful act.

A further salient point from the approach in Scotland is that the prosecution of a healthcare

professional for culpable homicide must be deemed as serving public interest. Each prosecution is considered by the procurator fiscal and authorised by the Lord Advocate before it can proceed. In arriving at a decision they have to balance the interests of justice with supporting a patient safety culture.

Clearly, the legal and public test facing doctors in Scotland is quite different, and the bar considerably higher, to that in England and Wales.

Notably, there have been no convictions of culpable homicide in a medical setting in Scotland, although the Crown has considered cases and there has been one attempted prosecution resulting in acquittal.

The Medical Protection Society (MPS), in its response to the government's rapid review into GNM in healthcare, is proposing a bold approach. Firstly, that the law in England and Wales move towards the legal test for culpable homicide in Scotland, which requires an act to be intentional, reckless, or grossly careless, and which is better suited to determining the culpability of a doctor in a patient death.

Secondly, MPS is proposing that the director of public prosecution authorises all GNM prosecutions involving healthcare professionals. This, as in Scotland, would ensure that the vital question of whether public interest is served by a prosecution is considered.

The law surrounding GNM in England and Wales needs to be reformed and there has never been a more important time to debate the options and learn from other judicial systems, such as Scotland. The rapid review of GNM presents a crucial opportunity to explore this further. If the government is serious about creating an open, learning culture in healthcare, it is an opportunity that cannot be missed.

We would however note the concerns raised by Claire Raftery, Senior Associate at Clyde & Co :

https://www.clydeco.com/insight/article/dr-bawa-garba-could-it-happen-in-scotland

"It is likely the GMC's review of the law will highlight the inconsistencies in the offences in England and Scotland and the apparent difference in climate towards the criminalisation of clinicians. The result of the review is likely to draw attention to the proposed bill to provide clarity to the relevant offence. While certainty should be welcome, there is a risk though that this will bring Scotland in line with England. Increased clarity of the offence may prompt increased criminal prosecutions of healthcare practitioners in Scotland. That would be strongly contrary to the Scottish Government's stated aim of moving towards a "no blame" culture, in the practice of medicine."

This section focuses on the professional regulatory process

- 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?

ASGBI represent the views of General Surgeons and, inevitably, some of its members have been subjected to GMC fitness to practice procedures.

- 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?

ASGBI understands the GMC's statutory duty but believe that decisions taken by the GMC should not

only take into account the performance of the doctor but also reflect the circumstances that the doctor is working in. ASGBI take the view that the GMC is not responsible for regulating other aspects of the healthcare system and that the role of the GMC should be confined to those cases in which individual and isolated actions of doctors expose the public to harm or bring the profession into disrepute.

ASGBI believe that its ability to maintain public confidence in the medical profession is undermined (in public eyes) by its receipt of financial support by the profession itself and that the GMC should not be funded by subscriptions by doctors but, like other regulatory bodies, by general taxation.

- 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?

ASGBI is aware of the joint guidance shortly to be published by the GMC, COPMED UK and the UK Academy of Medical Royal Colleges. We support this guidance.

ASGBI believes that the GMC's stated position "that doctors may want to submit their reflective notes in mitigation during proceedings" is untenable and notes that since such records are not legally privileged, they will not only expose medical practitioners to legal challenge but also restrict the willingness of medical practitioners to make such records in future. ASGBI believe that this is not conducive to patient safety because it will encourage lack of openness and reduce the ability of the profession to learn from mistakes.

- 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?

ASGBI is unaware of any specific support available in addition to that set out above

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

ASGBI do not believe that the regulator (as least as the GMC currently functions) should have a role in learning from fatal incidents.

Finally…

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