Grey Areas
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A COMMENTARY ON LEGAL ISSUES AFFECTING PROFESSIONAL REGULATION

Just Culture vs. Blame Culture

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Most recent studies and reviews of professional regulators focus on how they should maintain the confidence and trust of the public. A recent independent review of the medical regulator in the UK examines how it should maintain the confidence of the profession it regulates. The review flows directly from a high profile case in which a trainee physician (Dr. Bawa-Garba) was found guilty of manslaughter, based on gross negligence, and was then disciplined by the General Medical Council (GMC) for the death of a child despite the presence of a number of systemic factors (e.g., understaffing).

Entitled "Independent review of gross negligence manslaughter and culpable homicide" the June 2019 report looks at the operation of the Coroner's system and the criminal process as well as the role of the professional regulator. The Review concluded that, in this context at least, a just culture was beyond the powers of one organization.

In terms of the regulator, the Review found that there was a breakdown in the relationship between the profession and the regulator, partly as a result of the handling of the Bawa-Garba case. There was a widespread view within the profession that the regulator had acted unfairly in pressing for revocation of Dr. Bawa-Garba's registration, possibly motivated by media scrutiny.

The Review's initial recommendations were:

> … The GMC must acknowledge that its relationship with the medical profession has been severely damaged by recent events and then the GMC must learn from those events in the way it regulates.
>
> The GMC must take immediate steps to re-build doctors' trust in its readiness to support them in delivering good medical practice for patients. This should include examining the processes and policies that have contributed to doctors' loss of confidence and considering how it can better support a profession under pressure as well as promoting a fair and just culture.

The Review then reinforced other recent reports (see, for example, https://www.gmc-uk.org/-/media/documents/fair-to-refer-report_pdf-79011677.pdf) regarding the need to address factors that may see a disproportionate impact of the complaints and discipline process on Black, Asian and Minority Ethnic (BAME) practitioners. The recommendations referred to steps to ensure inclusion of BAME practitioners within the workplace and the profession, diversity within the GMC itself and "methods of assurance of fair decision making, including (but not limited to) equity, diversity and inclusion training, unconscious bias training, auditing and monitoring."

The Review expressed concern that expert witness opinions on whether practitioners met the standard of practice were not seen as always being objective, fair and skilled. In addition to ensuring a rigorous selection process for such experts (including that they be in active practice) and having clear standards of neutrality and impartiality, the Review recommended:

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Those providing expert witness reports and evidence should be required:

- To state the basis on which they are competent to provide an expert opinion on the matters contained within the report or evidence.
- To state where their views fit on the spectrum of possible expert opinion within their specialty.
- To calibrate their reports to indicate whether an individual's conduct was, in all the circumstances, within the standards that could reasonably have been expected; below the standard expected; far below the standard expected; or whether the individual's conduct was truly, exceptionally bad. They should also give their reasons for the views reached.

The Review also recommended that before an allegation of clinical incompetence is referred to discipline, that two concurring expert opinions be obtained.

In terms of the complaints and discipline process itself, the Review recommended, in part, the following:

1. The regulator be given discretion not to investigate all complaints. It should focus its resources on the ones with possible merit.
2. The regulator be given greater authority to resolve discipline cases informally.
3. While the regulator has limited ability to support practitioners facing complaints, given its prosecutorial role, it should clearly explain its process and encourage other organizations to provide support to practitioners, including legal advice.
4. The toll taken on practitioners by investigations requires that such inquiries be concluded as soon as possible.
5. Government should enact legislation ensuring that reflective practice notes (created as part of their quality assurance activities) made by practitioners can never be used in criminal or regulatory proceedings.
6. The duty of candour, requiring practitioners to discuss unexpected events with clients and their representatives, be encouraged and fully enforced.
7. The regulator should not be able to appeal disciplinary decisions that it feels were not sufficiently stringent. [However, the independent Professional Standards Authority can initiate such appeals.]

The government has already announced that many of these recommendations will be contained in amendments to the legislation governing professional regulators: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/816914/Promoting_professionalism_reforming_regulation_consultation_reponse.pdf.

The Review expressed concern that some of the lack of confidence expressed about regulators was based on perceptions that may not be accurate. The Review recommended that both the regulator and others involved in health care, make efforts to educate the profession and the public as to their role and activities.

Interestingly, the Review found that over half of the public who responded believed that a practitioner

found criminally responsible for the death of a patient should have their registration revoked. In light of that, one wonders whether there would have been a different type of review if the GMC had not appealed the discipline decision against Dr. Bawa-Garba that had originally imposed a one-year suspension.[1]

The conflict between the "blame culture" and the "fair and just culture" is an ongoing one for regulators. Regulators need to develop tools to distinguish honest mistakes, complicated by systemic circumstances, where the practitioner is remediable, from deliberate recklessness where there is an incorrigible lack of judgment.

The Review's report can be found at: https://www.gmc-uk.org/-/media/documents/independent-review-of-gross-negligence-manslaughter-and-culpable-homicide---final-report_pd-78716610.pdf.

[1] The GMC appeal resulted in an order revoking her registration. However, on further appeal to the Courts, the one-year suspension was restored.