Learning lessons in medicine: reflecting on the case of Dr Bawa-Garba

In my first week of pathology training my Wednesday afternoon schedule was listed as 'mortality meeting' and my Sunday afternoon schedule was listed as 'mortality conference'.

On Wednesday the head of medicine – or a designated deputy – arrived with a pile of folders. These were the case notes of every patient who had died the previous week. The two heads of the Tel Hashomer (now Sheba) Hospital Pathology Department were very different people, but both were expected to be present. Wolman was Polish-born, Italian-educated, and had served with the British Army under Wingate. He recalled having to immunise Haile Selassie through his clothes before the triumphal entry into Addis Ababa – exposing the Imperial buttock was forbidden. Selzer was South African trained, where she had played a unique role in practical opposition to inequalities while working as the lone woman pathologist (Hendrickse, 1998).

The purpose of the Wednesday meeting was to review not only case notes but also autopsy findings. Autopsy rate was almost 100%, although sometimes partial; delay in release of the body was always less than 24 hours, and the treating clinicians (junior and senior) were expected to view the macroscopic findings before release. The only concessions to a junior pathologist who said the autopsy was not completed by the post-death Wednesday were neuropathology for brain fixation, neonatal pathology or ultrastructural studies. The Wednesday outcome was selection of cases where our bosses felt there were lessons to be learned, and thus these were scheduled for formal presentation on Sunday.

Of course there are flaws in this approach. Did the notes tell 'the truth'? Maybe the senior on call had not responded to a call for help, maybe there was a bullying culture on some wards and units which did not come to light in the hierarchical system? What was the role of the family? How was 'fitness to practice' defined? It is ironic in retrospect, given current pressures on medicine by voluble 'patient safety advocates' to comply with airline systems, that my bosses joked that when certain junior doctors joined these sessions they queried: had Tel Aviv University perhaps used the wrong pro forma for medical student and resultant junior doctor selection – maybe it had been mixed up with the pro forma for selection of Israeli airline pilots?

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Implications of the Bawa-Garba case

These memories were re-triggered recently when reading the details of the Bawa-Garba case, the determination (Medical Practitioners Tribunal Service, 2017) and judgement [GMC v Bawa-Garba 2018], the responses, the opprobrium with which the different 'interested parties' view each other, and the complex legalistic and bureaucratic framework, all of which made me shudder.

The horror stories told about the culture of the department in which the doctor was working have the ring of truth. Surely there are several doctors involved – singling out one individual, junior, and a woman from an ethnic minority, has a whiff of prejudice about it – or was she, sadly, perhaps the only public face that the bereaved parents could identify? While applauding Jeremy Hunt's general decision to explore legal issues surrounding 'manslaughter with gross negligence', surely his prime responsibility is to take steps to prevent it occurring in the UK health-care system? Long before one gets to the details about abuse of reflective practice *vs* justified expressions of personal insight, surely there are urgent lessons to be learned from this tragedy?

Whose responsibility is it?

The first crucial lesson is about collective responsibility and teamwork. Every death is a potential 'serious event'; every death in hospital is not more so, but in hospital there is possibly more opportunity to explore 'what if's'? This exploration needs to be de rigeur, rapid, documented and discussed transparently. Clinicians accept 'multidisciplinary team review' as essential for many conditions, so why is death excluded from this process? It may take time, and many deaths may require only brief discussion, but at the very least it may reassure the families. And should 'multidisciplinary' include compulsory participation by management, and by all ranks of clinicians?

Related to this is the collapse of the hospital 'firm' structure which has had a huge adverse impact on the education and training environment. The 'pecking order' within a firm is part of it but so is the sharing of impact that one can have as a doctor. Again ironically, academic physicians confront 'impact' compulsorily in their university role as part of the Research Excellence Framework (Higher Education Funding Council for England, 2016) – where they seem to score particularly well – rather than in their more direct clinical role where 'service delivery' is the impact, called also the target. Words convey messages that we ignore at our peril.

The role of the medical examiner

The second more direct linkage to my past experience, and crucial lesson, is that one of the tools which might not have prevented the death of Jack Adcock, but which might have prevented the current conflagration – some might say erroneous individual blame and misjustice – is already in our grasp. One of the major recommendations of the coroner reform, as brought in by the Coroners and Justice Act 2009, was that a new role would be created – that of medical examiner (www.legislation.gov.uk/ukpga/2009/25/section/19). One part of this role was to encourage only appropriate referral to the coroner, and as a result to speed up body release for burial, as required by Muslim and Jewish communities.

The medical examiner recommendation has quite simply not been implemented properly. It is rumoured that the reasons for this relate to costs and sharing of responsibility and/or power. It is long overdue for Mr Hunt to make it a priority. We have a field marshal – Professor Peter Furness, past president of the Royal College of Pathologists – but no troops? It is worth reading what he says: 'I spend some of my time working as a Medical Examiner, contacting bereaved families to ask whether they understand the cause of death and whether they have any concerns about the quality of the health care we provided. Feedback makes it very clear that the relatives very much value being contacted by a senior consultant rather than by a secretary or an administrator' (Furness, 2018).

We have to accept the possibility that some families, such as the Adcocks, might be too distressed to accept any form of intervention, but the fact that it is not in place universally – when the warning signs are so self-evident – is a disgrace.

There have, of course, been vast improvements in diagnostic accuracy, in particular in imaging and laboratory medicine, and the techniques that can be used to guide or replace invasive autopsy have also evolved since my early days as a trainee. The role of pathologists has changed, and one suspects that recruitment into this part of the profession – perhaps more so in the autopsy than direct diagnostic field – is not as robust as it was. The factors which contribute to this are not directly relevant to the Bawa-Garba case. However, the principle stands – that it is in the best interests of patients and their families to have rapid comprehensive and critical analysis of deaths.

Accounting for system failures

Against this background the criticism being levelled at the General Medical Council about their decision to appeal is likewise unlikely to prevent repetition of tragedy. The questions that the General Medical Council needs to address lie deeper. Where system failure occurs how is this incorporated into their prosecuting role? Should the supervisor always be held accountable alongside trainees? The General Medical Council are effectively 'prosecuting patient advocates' before the Medical Practitioners Tribunal Service – how exactly does this fit with their simultaneous role as protectors of 'public confidence in the profession'?

Each time there is public controversy of this nature the consequence is that the public indulges in an outpouring of concern. As a side consequence there will be others for whom this outpouring itself causes distress because they too have suffered with the death of a child, even if there was no system failure and care was immaculate. There have been two recent UK prime ministers – Brown and Cameron and their families – who might fall into this category. Their insights and understanding might be deeper and more valuable than the current media bombardment.

The other consequence is that there is to be an 'investigation' which is 'welcomed', almost irrespective of level and scope. It is salient that there are already several such reports in the public domain, but it seems that the one that is being invoked is Berwick (2013), and that Francis (2013) is less specifically mentioned. Is this perhaps because Francis was more of an in-depth analysis of the kind of environment in which this tragedy occurred, and it is to our shame that it still happens?

Keogh: mortality and quality of care

A third report – Keogh (2013) – is never even mentioned. Why? Surely the question Keogh addressed was to look at mortality? He proposed a study looking at the relationship between 'excess mortality rates and actual avoidable deaths' with 'retrospective case note reviews on a substantial random sample of in-hospital deaths from trusts with lower than expected, as expected and higher than expected mortality rates' which would be put into practice by 'the introduction of a new national indicator on avoidable deaths in hospitals'. Has this agenda ever been promoted and used as a benchmark?

Keogh went further, saying that medical institutions that fail lack a culture of professional and academic ambition. 'The best treatment is delivered by those clinicians who are engaged in research and innovation'. In other words, if there is failure to create the right environment, accidents are more prone to happen. Looking back, maybe what I, too, was forgetting when I described my weekly mortality sessions above was that my two supervisors often spent Wednesday and Sunday mornings on their research. That – perhaps putting words into Keogh's mouth – when the government distributes new medical school places, then selection of location should not be given to those that deliver service functionaries. Rather the 1000 new doctors need to be trained in places where they are engaged actively in a constant questioning culture of education, training, research and innovation, a crucial part of which is learning the lessons of death, avoidable or unavoidable. **BJHM**

KEY POINTS

- The General Medical Council *vs* Dr Bawa-Garba case raises serious concerns about system failures and collective responsibility for patient care.
- Neither the 2009 legislation introducing the role of medical examiner, nor lessons from three 2013 reports (Berwick, Francis and Keogh) have been implemented effectively.
- The underlying issues highlighted need to be investigated thoroughly, as a questioning cultural environment in medicine, including about death, is critical for both patients and doctors.

Conflict of interest: Professor D Katz is Emeritus Professor of Immunopathology at UCL; he is also deputy Co-Chair of the Medical Academic Staff Committee, served for many years as chair of General Medical Council or Medical Practitioners Tribunal Service panels and tribunals, and represented the UK Jewish community in discussions on coroner reform. He writes in his personal capacity. The views expressed are his own but he would like to acknowledge in particular discussion over many years with Dr Amitava Banerjee, Mr David Cloke and Professor Michael Rees.

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