Academy of Medical Royal Colleges

Jeremy Hunt 17 February 2018

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Dear Rt. Hon Jeremy Hunt MP,

The recent case of the General Medical Council versus Bawa-Garba raises several concerns. The loss of a child is a tragedy and there are opportunities to learn from this sad case to improve the care of future patients.

The court proceedings have highlighted the importance of adequate local induction, appropriate senior clinical supervision and procedures followed upon return to clinical practice after a period of absence. This case involved a trainee doctor. The NHS needs to be a place that allows trainee learning whilst protecting patient safety. We welcome the review you have ordered into manslaughter by gross negligence.

Safeguards can be put in place: the Academy Trainee Doctors' Group has been discussing a concept of "Educational Never Events". Like their clinical counterparts, educational never events are countered by recognised safeguards that should always be in place. For example, no trainee should ever return to clinical practice following a period of leave of greater than 6 months without a structured return to work programme, including a mandated period of supervised clinical practice. Another example of a never event would be: a trainee not being able to contact a consultant or senior whilst at work. We feel that given an appropriate mandate, educational never events will contribute to embodying a safety culture across the NHS.

Despite some misconceptions about the specifics of the case, we recognise a widespread and growing concern about the legal status of reflection by trainee doctors. We support your reviews aim of ensuring "the vital role of reflective learning, openness, and transparency is protected so mistakes are learned from and not covered up." The UK Conference of Postgraduate Medical Deans (COPMeD) and the Academy of Medical Royal Colleges (AoMRC) agree that Doctors need to reflect and learn from experiences, both positive and negative, as part of the essential ongoing development of medical professionals. For each professional, the focus should be on developing as a reflective practitioner who learns from experience, and can demonstrate this approach. Doctors in training must feel able to have such honest and open discussions and should be confident that engaging with this process can provide them with the required evidence of a professional approach to learning. The focus should be on feedback about reflective practice, or descriptions of the increased understanding and resultant actions after discussion, rather than on documenting 'reflection'.

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It is vital that we do not miss opportunities to maximise learning from Jack Adcock's tragic and untimely death. As the Healthcare Safety Investigation Branch (HSIB) investigates where there is a severe outcome impact, high systemic risk and learning potential we ask you to consider requesting an HSIB review of Jack's case. We feel there remains much that the NHS can learn

I know that you are meeting Professor Carrie MacEwen, the Chair of the Academy, this week and she will be able to give you more detail of our thinking and proposed actions.

Yours sincerely,

Dr Alice Wort, Chair Academy Trainee Doctors' Group

Dr JP Lomas, Chair Royal College of Anaesthetists Trainee Committee

Mr Vimal Gokani, Vice Chair ATDG

Mr Simon Fleming, Vice Chair ATDG

Dr Jonathan Frost, Vice Chair ATDG

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