NZRDA

New Zealand Resident Doctors' Association

The Case of Dr Bawa-Garba

February 2018

On 28 January 2018 the English High Court released its decision to de-register Dr Hadiza Bawa-Garba, a paediatric trainee, who had been convicted of manslaughter by gross negligence. The decision has shaken the UK medical profession. Although we operate under different legal parameters and clinical settings in New Zealand, this decision should nonetheless serve as a wake-up call to NZ resident doctors.

Summary of events of 18 February 2011

On 18 February 2011, Dr Bawa-Garba was a year 6 paediatric registrar working in the Children's Assessment Unit of the Leicester Royal Infirmary Hospital. The 18th of February was her first shift after 13 months' maternity leave; she was cross-covering an absent registrar and an absent house officer in addition to her own duties. She worked a 13-hour shift with no breaks that day.

Dr Bawa-Garba saw Jack, a six-year-old boy with Down's Syndrome and a heart condition, at 10.30am, and saw he was seriously unwell. Dr Bawa-Garba prescribed a fluid bolus, and arranged blood gas and blood tests and a chest x-ray. Initially treated for acute gastro-enteritis and dehydration, Jack actually had a group A streptococcal infection. This infection had caused his body to go into septic shock.

Although blood gas results at 12.12pm showed improvement, blood tests did not arrive from the hospital laboratory until 4.45pm because the hospital's computer systems failed that day. At 3pm, Dr Bawa-Garba prescribed antibiotics after an x-ray suggested pneumonia.

Dr Bawa-Garba spoke to a consultant twice about the patient but did not raise any concerns about Jack except to say he was improving and "bouncing about". Dr Bawa-Garba's lawyers argued that agency nurses had failed to adequately monitor the patient and communicate his deteriorating condition to her (a nurse was also charged with and convicted of manslaughter). At 7pm, Jack was transferred to a ward. At 8pm, Jack developed heart failure and a resuscitation call went out – Dr Bawa-Garba was one of the responding doctors. She mistook Jack for another patient who was DNR. Dr Bawa-Garba called off the resuscitation for between 30 seconds and 2 minutes before her mistake was identified and resuscitation was restarted. Although this mistake did not contribute to Jack's death, he was pronounced dead at 9.20pm.

Conviction and deregistration of Dr Bawa-Garba

The NHS Trust that administered the hospital carried out an investigation. The investigation highlighted multiple system failures existing at the time of these events. These included:

- failings on the part of the nurses and consultants
- medical and nursing staff shortages
- IT system failures which led to abnormal laboratory test results not being highlighted
- deficiencies in handover
- accessibility of the data at the bedside, and

- the absence of a mechanism for an automatic consultant review.

Dr Bawa-Garba continued to work at the Trust, and both before and after the events of 18 February had an "impeccable record". Charges against her were laid a year later, and 3 years and 10 months after Jack died, Dr Bawa-Garba was convicted of manslaughter (by gross negligence). She received a suspended sentence of two years' imprisonment. Dr Bawa-Garba application to appeal was rejected, and the Criminal Court of Appeal summarised the prosecution case as follows:

1. Dr Bawa-Garba's "initial and hasty assessment . . . ignored obvious clinical findings and symptoms" including diarrhoea and vomiting; lethargy and unresponsiveness; raised body temperature with cold hands and feet; poor skin perfusion; acidotic and significant lactate levels in a blood gas reading.
2. Dr Bawa-Garba's other failures were not reviewing the x-ray at 12.01pm which would have confirmed pneumonia much earlier; not acting upon the 12.12pm blood gas results; not making proper clinical notes; not giving antibiotics until 4 hours after the x-ray; not obtaining blood test results in a timely manner and not acting on the results which "indicated both infection and organ failure from septic shock".

After the conviction, the Medical Practitioners Tribunal suspended Dr Bawa-Garba for 12 months "to maintain public confidence in the profession and uphold proper standards". This decision was appealed by the United Kingdom's General Medical Council (GMC) to the High Court of Justice on the basis that "the Tribunal should have ordered that she be erased from the [medical] register".

The High Court decided in the GMC's favour, allowing the appeal and erasing Dr Bawa-Garba from the register. One of the judges said:

> Dr. Bawa-Garba, before and after the tragic events, was a competent, above average doctor. The day brought its unexpected workload, and strains and stresses caused by IT failings, consultant absences and her return from maternity leave. But there was no suggestion that her training in diagnosis of sepsis, or in testing potential diagnoses had been deficient, or that she was unaware of her obligations to assess for herself shortcomings or rustiness in her skills, and to seek assistance. There was no suggestion, unwelcome and stressful though the failings around her were, and with the workload she had that this was something she had not been trained to cope with or was something wholly out of the ordinary for a Year 6 trainee, not far off consultancy, to have to cope with, without making such serious errors. It was her failings which were truly exceptionally bad.

Outrage in the UK medical profession

What particularly angered UK medics was that Dr Bawa-Garba's self-reflections on the event – which aimed to improve supervision and training (her "training encounter form") – were used against her as evidence by the prosecution.

The profession has rallied behind Dr Bawa-Garba in a remarkable way. Online fundraising has already raised £320,000 to appeal the decision. Within 36 hours of the decision, 10,000 doctors signed a letter to the public asking that they see the mistakes Dr Bawa-Garba made in the context in which she was working:

> [E]very doctor has worked in similar conditions and we have all made mistakes. In other safety critical industries there is clear understanding that human error is a fact of life that must be planned for; a pilot would never take-off if the captain and most of the crew were not on the plane. Doctors do not have this option and frequently take on the work of two or more in order to keep our hospitals open. We have seen doctors punished for whistle-blowing about unsafe staffing levels. We now see them being held criminally responsible for mistakes made whilst working under these pressures, which, with chronic staff shortages, prolonged underfunding and low morale, now occur with worrying frequency.

Jeremy Hunt, the British Health Secretary, has ordered a review of the case. The British Association of Physicians of Indian Origin has accused the GMC of treating black and minority doctors "differently and harshly".

Could it happen in New Zealand?

Could a case similar to Dr Bawa-Garba's happen in New Zealand? The inescapable answer is yes.

Although New Zealand prosecutions for manslaughter against medical professionals are rare, with no prosecutions since 2006, that could change. In a recent lecture, Law Professor Warren Brookbanks discussed the issue of medical manslaughter prosecutions:

> Although there was a trickle in the 1990s, even in the few occasions where convictions were entered the resulting penalties tended to be very lenient and non-custodial . . . At the present time there appears to be no appetite for prosecuting doctors whose acts or omissions lead to the death of patients. However, times and social values do change and we could face a situation in the future where a more medically informed and perhaps punishment focused community demands doctors be prosecuted where death results from a medical mistake. Where strong emotions drive law reform there is no such thing as a settled approach to the law.

In addition, it is easy to imagine an RMO in New Zealand getting into the same kinds of difficulties as Dr Bawa-Garba found herself in – being scheduled to provide inappropriate cross-cover without adequate workplace induction. RMOs often report to us situations in which they feel they are providing cross-cover in an unsafe way because of absences in the roster or the requirement to work without breaks.

It is important to remember it is your individual responsibility not to take on the medico-legal responsibility of providing cross-cover beyond your ability to provide an adequate standard of care for all your patients. You are protected in NZ insofar that the MECA makes cross cover voluntary – you can (and should) say no if you believe it is unsafe.

Manslaughter by gross negligence requires a "major departure from the standard of care". In Dr Bawa-Garba's case this amounted to a hasty assessment; a failure to ask her consultant for help; and a failure to review test results in a timely manner and act upon them. Providing cross-cover increases your risk of making the sorts of mistakes Dr Bawa-Garba was prosecuted for. Similarly,

not taking regular rest breaks, being fatigued and not eating increased the risk of making an error for which you will ultimately have clinical responsibility.

Again, you are better protected in NZ than our colleagues in the UK because our MECA provides for safer rostering, regular breaks and meals; however, you do have to avail yourself of these provisions!

That being said, it is less likely for a New Zealand RMO to face the same legal outcome. The UK High Court relied strongly on parts of the United Kingdom's Medical Act 1983, which assesses the appropriateness of disciplinary action on its ability "to maintain public confidence in the medical profession". In contrast, in New Zealand under the Health Practitioners' Competence Assurance Act 2003, the principal purpose of the Act is to "protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practice their professions." Although a practitioner may be disciplined for an action that "brought or was likely to bring discredit to the profession", this is not a primary purpose of our law.

Importantly, too, the New Zealand Medical Council differs from its UK counterpart in a key way. We have the ability to elect four doctors to represent us on the 12-person Council. This is an important right that makes our Council more representative and responsive than the GMC.

We also have further laws and institutions that should assist – the Health and Disciplinary Commission and ACC, as examples – as well as our health and safety legislation, which puts some responsibility on the employer to ensure a safe workplace for employees. Fatigue is one example of a recognised hazard to safety: employers are required to monitor and take practical steps to minimise the risk of fatigue. However, we cannot abdicate all responsibility to "someone else". As doctors we have a duty of care that includes being fit to practice. If we are fatigued, overworked, or if we lack proper supervision or are afraid or reluctant to call for help, and do not take reasonable steps to bring these issues to the attention of those in authority, we fail in this obligation.

Medical mistakes and faulty systems

The UK medical profession may be right to be upset about the case of Dr Bawa-Garba. Her mistakes, like most other medical mistakes, are not solely the result of negligence or recklessness but a consequence of "faulty systems". Prosecuting well-intentioned individuals who make a careless mistake in the context of chaotic understaffing does seem to be a wasteful distraction from addressing the systemic issues of health care underfunding and understaffing.

New Zealand residents should be familiar with the clauses in the MECA around cross-cover, limits on hours and rest breaks, and remember that these protections have come about through hard struggles with DHBs over issues such as Safer Hours and, before that, the provision of meals to on-duty resident doctors. As this case in the UK shows, these contractual protections should not be taken for granted.

However, doctors should not be under any illusions. In the UK and in New Zealand, doctors who bring about a patient's death by a major departure from the standard of care could be convicted of manslaughter. The best course of action for us is to continue to recognise that our safety is also about our patient's safety. We must advocate for our patients because, so often, they cannot advocate for themselves. We need to be proactive, raise issues of concern to management (including MECA breaches over rest breaks, handover, orientation or supervision, access to protected training, cross cover, fatigue, and understaffing) as soon as they become an issue. The

harsh but important lesson of Dr Bawa-Garba's case is that raising these issues after an adverse event is too late.

Some thoughts to ponder:

What clinical orientation do we get when returning to practice after a significant break?

- Should we insist on no acute duties for the first week after we return in order to acclimatise?

Do some of us have to rethink our attitudes to cross cover?

- Too hard to say "no" even when it is unsafe is probably not a good enough excuse.
- Should anyone ever cross cover a more senior rank (e.g. first-year house officer for registrar?)
- Is cross cover ever appropriate if you are acute admitting or in theatre?
- When confronted with cross cover outside ordinary hours, do we always register the breach with RDA for follow up?

We have made good progress with reducing the risks of fatigue and as a result are safer to practice, but . . .

- Should we condone working on our recovery days to earn more money?
- Never get a rest or meal break? Breaks are another proven mechanism to reduce fatigue: have you alerted management or the RDA to get the matter resolved?

Are you too scared to call an SMO either because they are grumpy or because you don't want to be "seen to need help"?

- SMOs are there for a reason – they have extensive knowledge, experience and skill, so consulting with them is good for patient care.
- Noting the work NZRDA is doing around bullying within the profession, whatever the reason, we should actively resolve individual issues around the "why".