



## ANALYSIS

## Will human factors restore faith in the GMC?

The General Medical Council's decision to incorporate human factors into their process for evaluating fitness to practise is an important step in advancing patient safety in the UK, say **Lauren Morgan and colleagues**

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The relation between the General Medical Council (GMC) and the profession it regulates could fairly be described as in crisis. The case of junior doctor Hadiza Bawa-Garba placed the fitness to practise functions of the GMC in the media limelight and fuelled feelings of injustice within the medical profession.<sup>1</sup> The Crown Court verdict of gross negligence manslaughter, combined with the GMC's statutory duty to "maintain public confidence in the medical profession" put the GMC in a difficult position in this complex case, but a profession already at odds with its regulator focused on the GMC's role.

The key questions raised were about how the context in which doctors work is considered when evaluating their performance. The catalogue of adverse factors Bawa-Garba faced included unfamiliarity with her environment, excessive workload and time pressure, lack of appropriate support, technology failures, and miscommunications—none of which could reasonably be attributed to her. The reaction of many frontline doctors familiar with the pressures of modern NHS practice was, "There but for the grace of God go I." The depth of feeling against the GMC openly expressed by doctors, and the condemnation by respected publications such as the *Guardian* and *The BMJ*, suggested a profound breakdown of confidence in the regulator. The views of patients and the public may be different, as much less has been heard about their perspective on this case. How did we end up here, and what can we do about it?

### How the GMC has evolved

The GMC was established under the Medical Act of 1858 to "take charge of registration and medical education across the UK and the publication of a pharmacopoeia." The act was proposed to protect the public from unqualified practitioners. This original purpose has become much less prominent in the GMC's public profile, although it still commits substantial resources to evaluating the credentials of international graduates coming to the UK.

Previous generations of doctors had a very different relationship with the GMC, which they regarded as benign, distant, and largely irrelevant to their clinical lives, provided they practised according to accepted norms. The old nostrum was that you

would never meet the GMC as long as you avoided the "3As"—addiction, advertising, and adultery with patients. This changed when the 1978 Medical Act moved the GMC from a self regulatory body to a professional, independent, regulatory body covering both education and fitness to practise. The GMC was now charged with assessing fitness to practise on the grounds of health as well as professional conduct.

### Roots of conflict

The changes that really led to the deterioration in the relationship with the profession, however, occurred in 1995 and 2008. The Medical (Professional Performance) Act 1995 charged the GMC with evaluating fitness to practise when avoidable harm may have come to a patient because a doctor had acted incorrectly. This gave the GMC powers to suspend or place conditions on the registration of a practitioner whose standard of professional performance was found to have been seriously deficient. The standards of good medical practice that the GMC was simultaneously required to set out were aspirational—consistent with the heroic, vocational model of the good professional underpinning the 1858 act.

The Health and Social Care Act (2008) reduced the standard of proof required in GMC hearings from the criminal (beyond reasonable doubt) to the civil (on the balance of probabilities) level. These changes were associated with a trebling of complaints and an increase in the percentage of erasure decisions at tribunals.<sup>2</sup> The language of *Good Medical Practice* is uncompromising, using the word "must" liberally when referring to expectations of behaviour. Making compliance with these demanding criteria the yardstick for excluding doctors from practice carries an inherent risk of unsafe decisions, but this has been made more obvious by the changing nature of team working in medicine and by advancing scientific understanding of error at work.

## Need for modernisation of investigative processes

How can things be improved? In the long term, new legislation is required, but a large part of the problem is that history has bequeathed the GMC a quasi-judicial investigation process with a narrow focus on the actions of an individual doctor. Modern medicine necessarily involves coordinated team actions, and it is often unrealistic to assign total responsibility to any doctor or other individual. Ensuring fairness in evaluating error in modern medicine requires a different approach.

The transport and energy industries have long recognised the need to understand the full context when evaluating error. Both have used incident analysis based on human factors science to ensure that lessons are quickly learnt and overall safety steadily advanced.<sup>3-5</sup> The same approach could benefit the processes of the GMC's fitness to practise division.

## Human factors in healthcare

Human factors is the science of understanding and optimising human performance in the workplace. Systems of work can be viewed as comprising the technology used, the task being completed, the environment within which work takes place, the teams and communication involved, and the overarching organisational structures and culture.<sup>6</sup> Although key individuals may have a large impact, the system surrounding them can have equally large or greater effects. In analyses of adverse events, the system can often be seen to convert well intentioned and apparently sensible actions into contributory elements of a disaster.

Neither individual doctors nor other system components act in isolation; their effects resonate with each other, sometimes with unpredictable and dangerous results. A new computer system, for example, may help junior doctors but increase the risk of error for others—for example, locums who are less familiar with the technology. Therefore, in fairly judging the practice of one person, we must also consider the system within which he or she is working, examining the potential effect of each component and the resonance between them.

An important element of civil and criminal justice is judgment by a jury of your peers. This is because they are deemed to understand the relevant context and influences in a way that judges may not, and can therefore weigh the actions of the accused against what they would consider reasonable in the light of their understanding. Integrating human factors into fitness to practise investigations upholds the same principle by taking into account the complexities of the work system, the conflicts that constantly need to be resolved, and the power of workplace culture—the “way things are done here.” Practices that have evolved to “get the job done” or even to enhance safety may no longer reflect the way managers had intended or understood the work to be completed. Real life practice may not reflect the prescriptions of national guidelines, and this may be entirely appropriate—for example, when guidelines conflict. Work as done rather than work as imagined or prescribed must be fully understood in the context of an investigation.<sup>7</sup>

Individuals should not be penalised for creating ways to deliver care in suboptimal circumstances when viable alternatives are not immediately clear. Human factors science allows us to understand why actions leading to an error made sense to workers at the time and recognises that humans, while prone to error, also contribute enormously to creating safety in organisations through cooperation and anticipation.<sup>8</sup> This

detailed understanding of context is essential for truly just decisions on culpability.

The track record of the human factors approach to investigations of error in other disciplines is impressive in terms of its ability to identify modifications to key systems factors that can lead to a sustainable improvement in the reliability and safety of systems of work. The association between introducing a human factors approach to safety and decreased incident rates has been consistent across numerous work environments, although the separate effects of human factors based investigations and safety improvement programmes are impossible to disentangle, since they are rarely if ever introduced separately. Introducing human factors into GMC investigations is therefore unlikely to directly affect patient safety generally—but it may do so indirectly, by influencing NHS bodies to increase their focus on systems based solutions to some of the contextual factors involved in incidents such as the the Bawa-Garba case.

Although the primary task of the GMC is to judge whether a doctor's ability to practise safely is impaired, full understanding of the context will help to identify contributory systems problems that need to be eliminated.

Healthcare in general has begun to embrace human factors science over the past decade, beginning with training in non-technical skills to improve team working,<sup>9</sup> and moving on to projects such as redesign of clinical IT systems and of investigations of safety incidents. The GMC in its educational role already specifies that human factors is included in both undergraduate and specialist training curriculums. Healthcare is beginning to make up the considerable distance it lags behind many other safety critical industries (transport, nuclear, software design, etc) in adopting appropriate human factors approaches.

Explicit adoption of human factors approaches to investigation of medical error or “malpractice,” however, does not seem to be widespread internationally. One example of good practice is in the US, where some institutional insurers investigate serious incidents using human factors and may insist on improvements in the safety of systems as a condition of continued coverage.

## Programme for change

The GMC has recognised the serious nature of the problems confronting it and the potential of human factors in contributing to a solution. It has sought advice from our organisation, the Patient Safety Academy, on how to integrate human factors into its processes, both to improve their fairness and to reassure the medical profession. The perceived failings of the GMC are, at least partially, consequences of the legislation dictating what it can and cannot do, and of problems within the medical profession itself. Examples of these problems include the disproportionate number of doctors from black and ethnic minority backgrounds who appear before tribunals (largely explained by the hugely disproportionate referral of such doctors to the GMC by their colleagues and the public) and condemnatory expert clinical opinions from eminent clinicians who have no human factors training to help them to consider context appropriately.

The GMC has made several changes to embrace human factors. These include providing all staff in the fitness to practise directorate with training on the principles of human factors, a redesign of the processes and paperwork that support an investigation, and the use of external human factors experts to advise on referrals (in the way that medical experts currently do). This programme shows an encouraging recognition of the need for change and willingness to implement it in the face of substantial legal constraints. The commitment to recognise the

organisational context within which a doctor is working when their fitness to practise is questioned is a huge step forward in the investigation processes. We hope that it will result in a fairer system of investigation, and that the profession will recognise this and be reassured by it.

All change brings risks and challenges. Many institutional cultures are resistant to change, and success cannot be guaranteed. It is essential that any temporary disruption to process does not affect doctors being investigated, who are acutely vulnerable, and equally that the GMC's ability to recognise and deal with individual doctors whose practice is genuinely and consistently unsafe is not compromised. Lastly, it will be important to explain to the public that, by enhancing justice in the process, this work will enhance fairness for patients as well as for doctors.

We agree with Don Berwick's comments in his report on NHS safety issues after the Mid Staffordshire inquiry.<sup>10</sup> He described the "climate of fear" in the NHS as the single biggest barrier to patient safety. Fear of the GMC and analogous professional regulators such as the Nursing and Midwifery Council, has been among the biggest factors in generating this climate for the past two decades. A profession secure in the knowledge that it can trust its regulator to be just, and to understand the context of clinical error, is much more likely to be able to learn from mistakes and to lead to real sustainable improvements in patient safety.

#### Key messages

- Current GMC processes for investigating fitness to practise cases arising from healthcare error do not adequately consider the context within which doctors work
- Low confidence in the fairness of GMC procedures is an important cause of the culture of fear among NHS doctors
- This culture handicaps efforts to learn from error by conducting open, learning investigations
- The GMC is integrating a human factors analytical approach into fitness to practise procedures to make the process fairer and change the culture
- Its recognition of the need to change is a potentially important step forward in patient safety

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Contributors and sources: LM is a member of the Chartered Institute for Ergonomics and Human Factors and director of the postgraduate certificate course on patient safety at Oxford University. DB is an expert in patient and family inclusion in healthcare safety investigations. PMcC is an academic surgeon with a long held interest in patient safety and human factors research and practice. LM wrote the first draft of the article; DB provided edits, suggestions, and references and contributed to the final draft. PMcC edited the article and wrote the final draft.

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