comment

"Political advocacy to improve health should be central to our values" **DAVID OLIVER**
"Primary care networks have got off to a shaky start in our city" **HELEN SALISBURY**
PLUS Ending gender inequality and harassment; Brexit, the Irish border, and healthcare

WOUNDED HEALER Clare Gerada

Doctors and their defence mechanisms

Working as a doctor is draining—emotionally, intellectually, and physically. Doctors witness trauma, and they regularly deal with loss. And no one benefits if doctors break down every time they have to give bad news to a patient.

To survive a lifetime in medicine doctors must learn techniques to cope with their job. They need to stay emotionally present without becoming distant. They must prevent over-identification, remain patient centred, and maintain professional boundaries.

Some of these techniques are practical: time management, delegation, safety netting, and "housekeeping." Others involve friends, family, mentors, and peer groups who can provide a buffer for work related stress and improve job satisfaction. But the most useful coping mechanisms are beyond conscious control. These are psychological defence mechanisms.

During a career in medicine doctors learn a set of important defence mechanisms, through modelling and attachment to well functioning groups. The most commonly used in medicine are denial, altruism, depersonalisation, and even humour. Humour can alter the content of a potentially disturbing scenario, making it lighter and more tolerable.

Some others are used when in an unfamiliar role—intellectualisation, for example. When unwell, doctors can read and research their own medical condition exhaustively to help distance themselves emotionally from its impact on their life.

Psychological defences, first defined by Sigmund Freud, are strategies brought into play by the unconscious mind to manipulate, deny, or distort reality to defend against feelings of anxiety and unacceptable impulses. Without these defences doctors would be more vulnerable to the effects of exposure to distress, disability, and death and more prone to depression, anxiety, and burnout. These defences are needed to protect against over-identification with patients and to mask feelings of guilt, fear, and hopelessness.

But these defences can also create problems and work against the individual's wellbeing. Altruism, for example, can become martyrdom, with doctors neglecting their own needs or those of their families. Denial can lead to rejection of vulnerability, with loss of insight and perspective. It can even lead to denial of responsibility in an error or significant event at work, as doctors may instead blame others or outside forces, including the regulator or inspectorate. And emotional distancing, or depersonalisation, can become emotional deadening—leading to burnout, loss of compassion, and even dislike and resentment of patients.

Ensuring a balance between using defence mechanisms to cope with a medical career and their potential to lead to serious personal and professional problems is vital. This can be achieved by making sure that doctors are supported throughout their career. They must also have the space and time to discuss the emotional impact of their work and their own ways of coping in a safe, confidential, and supportive setting.

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These techniques can also create problems and work against the individual's wellbeing

PERSONAL VIEW Rhonda Acholonu, Christina Mangurian, and Eleni Linos

Can we stop gender inequality and harassment in medicine?

Female doctors are calling for safer and more equal workplaces for the benefit of both their colleagues and their patients

Time's Up Healthcare recently launched with a mission to ensure that our workplaces are safe, equitable, and dignified. It comes at a unique time in history. In 2017, the Association of American Medical Colleges reported that for the first time there are more women entering US medical schools than men.

A year later, the National Academies of Science, Engineering, and Medicine published a report on the culture of sexual harassment in academic institutions. It found that sexual harassment is common in all scientific fields, with the highest prevalence in medicine. Nearly 50% of medical students experience sexual harassment before they even start their careers. In addition, more than a quarter of nurses have endured sexual harassment, more than a third have been physically assaulted in the workplace, and almost two thirds have experienced verbal abuse.

Time's Up Healthcare has been founded by 50 women and more than a dozen advisers. It includes a diverse group of women in leadership roles in US medicine, nursing, pharmacy, research, and healthcare administration. It is affiliated with Time's Up, an organisation with partners across various sectors all committed to working to drive change and promote equity. Time's Up Healthcare's diversity extends beyond job titles to include representation across race, ethnicity, sexual orientation, and gender identity. The primary goal is to raise awareness about gender inequalities and sexual harassment and to create a call to action for organisations—and their key leaders—to tackle these systemic problems.

Unequal power dynamics

Time's Up Healthcare focuses not only on sexual harassment, but also on gender discrimination. Since unequal power dynamics are at the root of both harassment and discrimination, these problems are worse for women from ethnic minorities or for those belonging to other marginalised groups.

One of the clearest manifestations of such discrimination is remuneration. On average, women doctors earn less than men, even after controlling for education, experience, and productivity. This is true across healthcare. For example, although almost 90% of registered nurses in the US are women, the average salary of male nurses is $5000 (£3781) higher than female nurses.

We are uniquely positioned to work on systemic solutions to sexual harassment

It is important to note that Time's Up Healthcare differs from other Time's Up initiatives in three key ways. First, healthcare workers are at risk of harassment not only from colleagues, but also from patients. In a recent US survey of 790 physicians, harassers were often reported to be patients (32%) or relatives of patients (11%). This creates the inevitable tension of balancing the professional role in caring for patients with their personal safety. The potential impact of this tension on mental health, burnout rates, and career satisfaction warrants further study.

Second, many healthcare workers specialise in direct physical and mental care to people who have suffered from sexual harassment or assault. This makes them knowledgeable about the resources available and support systems. As experts in evidence based treatment, we are uniquely positioned to add to the dialogue and work on systemic

BMJ OPINION Karen Donnelly

Doctors with Irish borders: is this going to hurt?

"Are you a Protestant or a Catholic?" my patient gruffly asked as he lifted his non-invasive ventilation mask.

It was 3 am on my first night shift as a quaking foundation year 1 doctor in Northern Ireland. This gentleman had become more unwell so I carried out an assessment. I deduced that he needed an arterial blood gas and the medical registrar's review. Conscious of my thick Dublin accent and the predominantly unionist district general hospital in which I was working, I could feel a lump gather in my throat. I needed his radial pulse, yet I didn't know how to respond.

Working as a foundation doctor in Northern Ireland, I've come to the simple conclusion that the movement of British and Irish doctors on either side of the border should be as straightforward as it is necessary. Integration fosters understanding. Understanding negates hate. On a daily basis Northern Ireland quietly yet palpably rises above the sectarianism, provocation, graffiti, banners, flags, and fear.

Like many people living and working here, I worry about the return of friction at the Irish border. Will I have my car checked? Will I have to roll down my window? Will I be late to the ward round on a Monday morning?

In the countdown to 29 March, we mustn't forget that the peace process extends to our ambulances, GP practices, and emergency departments and wards. Even if it's not always obvious, we mustn't forget the

solutions to tackle sexual harassment in our own workplaces, and beyond. Third, solving the problems of gender inequity and harassment has potential benefits not just for the women affected, but also for the system and patients.

Equal partners

Diversity in the workforce has been shown—again and again—to benefit research and patient care. Having women as equal partners will mean that providers more accurately reflect their patient population, and the delivery of innovative, high quality, and patient centred care will improve.

The launch of Time's Up Healthcare will no doubt raise awareness about the challenges that women working in healthcare face. Awareness is not enough. It is time for systemic solutions to tackle gender disparities in the workforce. The time is now. We owe it to our patients, to our colleagues, and to our profession as a whole.

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impact that the movement of our British, Irish, and European healthcare professionals has on both sides of the border. We mustn't forget the relevance of this to the weary foundation doctor facing an agitated patient under the bedside lamp. We need a frictionless border. We need a border that supports our peace process, our patients, our healthcare professionals, and our care.

So, that night, I swallowed the lump in my throat. I decided to go with my gut and tell him the truth.

"I'm an atheist," I replied.

"Even worse!" he retorted as he wryly smiled and held out his wrist.

Karen Donnelly is an academic foundation year 2 doctor in Belfast, Northern Ireland

ACUTE PERSPECTIVE David Oliver

Can doctors be too politicised?

The Conservative MP Johnny Mercer, a former army officer, is concerned that doctors have become "too politicised." He told the *Health Service Journal* in December 2018 that he was "really worried" that this politicisation had led to "unprofessional behaviour" and started to "affect patient care."

He didn't provide examples beyond recounting that on a school visit a GP's child had told him, "My daddy says the Tories kill more people than cancer."

I'd like to challenge the notion that doctors can somehow be "too politicised." Doctors have a long and noble tradition of influencing policy that affects the public's health. Consider the work of Julian Tudor-Hart, Douglas Black, or Michael Marmot on health inequalities; doctors' campaigns on smoking, clean air, tuberculosis, alcohol policy, or developing a national dementia strategy; and evidence based calls to decriminalise drugs.

Medically qualified experts have rightly set out the risks Brexit poses to healthcare provision and public health policy. Why shouldn't they? This kind of advocacy to improve population health and services should be central to our values—as essential to our role as the doctor-patient relationship or developing evidence based practice.

It's also surely legitimate for organisations representing doctors to try to influence or oppose government policy. The BMA advocates for its members, flags problems in the medical workforce, and seeks to shape policy on NHS funding, priorities, and staffing. As registered charities, medical royal colleges and specialist societies tend to avoid overtly party political positions but have key roles in influencing and shaping policy relevant to healthcare.

Some doctors, such as chief medical officers, national clinical directors, or national improvement leads, also have senior advisory and leadership roles in government and its arm's length bodies. And, as local system leaders in clinical commissioning groups or integrated care systems, doctors have a legitimate role in influencing policy and local politicians. Doctors are also private citizens and have as much right as anyone else to be campaigners, party activists, councillors, or MPs—and to express views on public platforms.

Doctors make up the health service's second largest clinical staff group, so have a stake in an organisation that spends around £124bn of taxpayers' money a year and employs around 1.2 million people. This group is subject to intense ministerial oversight, and inter-party debate. Its funding, provision, and performance are intensely political.

I don't know for certain what Mercer meant by "too politicised." My best guess is that he meant, in particular, "too challenging of government policy." Given that nurses and doctors top the Ipsos MORI table of public trust in professions—with politicians second bottom—such challenges are an inconvenient thorn in the side of government. That doesn't mean that we should stop.

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Doctors have a long and noble tradition of influencing policy that affects the public's health

Trying to raise a cheer for networks

The 2019 GP contract has been announced, and the main news is that we can have more money—but only if we start working together in bigger units.

GPs are being encouraged to join up with neighbouring practices so that, between us, we have a registered list of 30 000-50 000 patients. NHS England says that these networks will "enable greater provision of proactive, personalised, coordinated and more integrated health and social care." The exact details about how we'll work this magic are still being finalised.

A previous attempt to get such clusters of practices going in England seems to have fizzled out, but this time money is attached. The idea is that we'll group together to employ additional staff, such as pharmacists, social prescribers, physios, and paramedics, and some of the costs will be reimbursed. In case this carrot isn't tempting enough, there's also a stick: the funding that we currently get for covering extended hours will now be channelled through the networks. So, unless practices can afford to lose that money, they really have no choice.

The timescale is short: we're meant to submit our network arrangements to the clinical commissioning group by the end of April and be ready to go live by 1 July, which is when the money will start to flow. Some of this money is earmarked to pay for one day a week of a lead clinician for each network, and these people will need to be selected and their clinical hours backfilled. Admin staff will also be needed, and many other details will need to be finalised (bank accounts, network contracts) before we're up and running.

Networks have got off to a shaky start in our city: intense discussions are going on about which practices will group with which others. There's a worrying possibility that practices perceived as being in the least good shape financially, or run by people who are hard to work with, will be left like Billy No Mates at the edge of the field, with no one to play with. Our clinical commissioning group doesn't yet know how this will be solved.

I have many unanswered questions. We expect that funding for locally enhanced services will in future reach us through the network, so what happens if the network partners aren't equally willing or able to provide these services? More immediately, where exactly are we supposed to find these vital extra clinical workers?

The cynic in me sees networks as a way of whittling away the value and autonomy of our traditional partnerships as, over time, more and more of our funding comes from these new structures. The pragmatist in me is just intensely weary at the thought of the extra meetings this is going to take to set up. I'm trying to prod the optimist into life.

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The cynic in me sees networks as a way of whittling away the value and autonomy of traditional partnerships

LATEST PODCASTS

Diabetes insipidus: how to avoid missing a diagnosis

Diabetes insipidus can be challenging to spot, but a new podcast offers practical tips for non-specialists to aid diagnosis. The discussion includes advice from Pat McBride, a patient with diabetes insipidus and head of family services at the Pituitary Foundation, who describes her experience:

"I was so dry and gulping drinks but they weren't quenching my thirst. I thought it was really odd. I was then weeing every 20 to 40 minutes, 24 hours a day, and I thought this was due to me drinking so much. I couldn't sleep.

"I planned any trip out of the house around a toilet route. The thirst was agony. My lips were almost peeling as I was so dehydrated. My GP checked my blood sugar, which was normal, and never mentioned diabetes insipidus. I didn't know about diabetes insipidus."

How the NHS can be a better employer

At last week's Nuffield Trust health policy summit, *The BMJ* gathered a panel of speakers to discuss how the NHS can offer staff lifelong, fulfilling careers. Here James Morrow, a GP in Cambridge, talks about the increasing intensity of doctors' work:

"One of the most common reasons for people leaving the workforce is they find that even if they're working part time the intensity is unsustainable. It comes at a personal cost which is too great.

"For too long we've sought efficiency gains by racking up the pressure on the clinicians in the workforce. And we've focused on the ability to cope in the face of adversity, rather than saying we should be creating a system which doesn't require that level of resilience.

"We should be engineering a sustainable, rewarding, long term vocation rather than simply a service delivery unit."

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Curated by Kelly Brendel, assistant web editor, *The BMJ*

TACKLING FGM IN THE UK

Concerns about statistics and safeguarding

Findings from our recent work with Somali families living in Bristol provide empirical support for the concerns raised by Creighton and colleagues about the UK's response to female genital mutilation (Editorial, 26 January). Focus group discussions documented the myriad ways in which safeguarding against FGM stigmatised and criminalised families who had done nothing wrong.

There was a sense that the evidence on which policies were based was inaccurate. Universally, FGM was considered to no longer be a part of British Somali culture. That the lack of successful prosecutions was treated by officials as a "collective professional failure" rather than actual low prevalence was seen as testament to the exclusion of groups affected by FGM from policy making processes, and to the Islamophobia inherent in much current policy, which treats Muslims unquestioningly as "suspect communities."

There is also a dire need for a comprehensive examination of the statistics on which these policies are based. This will be the focus of our next study.

Saffron Karlsen, senior lecturer in social research; Magda Mogilnicka, senior teaching associate; Christina Pantazis, professor of zemiology, Bristol; Natasha Carver, research associate, Cardiff

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Alerts will put up barriers to accessing care

We have concerns about the FGM information sharing system. This policy places an alert on the summary care record of the female children of women identified as having FGM. This alert will be visible in primary care consultations, without linkage to the safeguarding assessments that were done surrounding this.

In implementation, the alert will likely be placed on the newborn's records by maternity professionals. But primary care holds the ongoing relationship with the child and family. When the child presents with a routine minor illness and the alert appears, how should clinicians respond? We are concerned that repeated questioning risks deterring the family from seeking healthcare.

Sharon Dixon, FGM lead; Joy Shacklock, RCGP clinical champion good practice safeguarding; Jonathan Leach, joint honorary secretary, Royal College of GPs

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Why we must avoid euphemisms

I urge that we avoid using euphemisms such as "cut." We must be clear that this is mutilation of little girls' genitals, which although not publicly visible is just as severe as any other deliberate mutilation.

Please describe it as it is and ensure that the abbreviation FGM is always explained in full.

Piers J A Lesser, consultant in pain medicine and anaesthesia, Halifax

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LETTER OF THE WEEK

Parental alcohol misuse affects children of all ages

Fetal alcohol spectrum disorder is one part of a larger problem (This Week, 2 February); parental alcohol misuse affects children across the life course. It often goes unnoticed and impairs parenting, with major effects on children's health and development. We found a substantial rise in parental increased risk drinking after birth (›14 units a week), using repeated cross sectional data from the Millennium Cohort Study, the Avon Longitudinal Study of Parents and Children, and the Born in Bradford cohort study.

We found that about 2.2% of mothers in the Bradford study and 5.6% in the Avon study met the criteria for increased risk drinking during pregnancy. By the time the children were aged 11-12, the prevalence of increased risk drinking in mothers had risen to 10.9% and 15.2% in the Millennium and Avon studies, respectively.

Questions about parental alcohol use could be included in early routine child health assessments and when children present with psychological problems. All services should consider the effects of alcohol misuse on the family and routinely ask about parental responsibilities and children at home. Parents at risk can then be referred to early intervention, with support that is sensitive to stigma and the family needs.

Shabeer Syed, researcher in epidemiology; Ruth Gilbert, professor of clinical epidemiology, London

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LGBT+ ADOLESCENTS

Students need better training on LGBT+ needs

Education about treating LGBT+ patients needs to start in medical school (Practice Pointer, 2 February). Currently, sexuality is reduced to a risk factor for sexually transmitted infections.

Medical students are conditioned to assume HIV-related immunosuppression when reading a scenario of a male patient who has sex with men and to assume that any purple rash is Kaposi's sarcoma. Considering the risk of sexual behaviours is important, but the absence of any other training on LGBT+ patients skews attitudes and perpetuates negative stereotypes.

Instead of men who have sex with men being synonymous with promiscuity, learning how to consider the social and economic struggles that affect their health would be more helpful.

This will ultimately lead to a more diverse workplace with less discrimination, as well as better patient care, bringing us a step closer to the NHS goal of serving each and every one of us.

Jeremias L K Reich, medical student; Kanay Khakhria, medical student, London

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OLDER ADULTS WITH FRAILTY

Mental disorders in older adults with frailty

Quinn and colleagues discuss assessment of older adults with frailty (Practice Pointer, 2 February). But they don't consider the role of substance misuse. Over the past 15 years, older people have shown the highest rises in rates of morbidity and mortality from alcohol and drug (both illicit and prescribed) misuse.

Consideration should also be given to routine screening for mood, given the higher prevalence of mental disorders in this patient population. Well validated tools such as the Geriatric Depression Scale can have a role in busy clinical settings. By detecting and treating mental disorders, we can improve health outcomes in older people with frailty.

Amanda A B Thompsell, old age psychiatrist; Kapila Sachdev, old age psychiatrist; Jayati Das-Munshi, old age psychiatrist; Tony Rao, old age psychiatrist, London

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ANALYSIS

Criminalisation of unintentional errors

Legal reform in New Zealand changed the prosecution of health professionals for gross negligence manslaughter and may have important lessons for the UK in light of the recent Hadiza Bawa-Garba case, say **Rohan Ameratunga and colleagues**

On 18 February 2011, Jack Adcock, a 6 year old child, died at the University Hospitals of Leicester NHS Trust. Hadiza Bawa-Garba, a paediatric trainee doctor, under light supervision and with many other responsibilities, was tasked with his care and subsequently charged, tried, and convicted of gross negligence manslaughter. This case was complex. The legal and regulatory aftermath was protracted and controversial (see box on bmj.com),[1] which prompted England's health secretary to commission a rapid review of gross negligence manslaughter.[2]

The failures in Jack's care undoubtedly called for a substantive response.[4] But this does not, in itself, imply that criminal prosecution of individual practitioners was appropriate.[5] We do not argue a special case for doctors—we would have similar concerns in equivalent circumstances in other socially essential services. Nevertheless, we doubt that the decision to prosecute in this case was a safe way to pursue justice or to advance the important goal of promoting a safe, effective, and affordable healthcare system.

In New Zealand in the 1990s, there was a series of prosecutions of health professionals for gross negligence manslaughter related to similar tragic deaths from errors in the care of patients. A review by a retired judge of the Supreme Court found that the criminal law was poorly designed to deal with the complex mix of error, violation, and system failure that typifies the deaths that lead to such prosecutions.

The NZ government, through the Crimes Amendment Act of 1997, gave a clear signal that the threshold for such prosecutions should be elevated.[6] Since then only one health professional has been charged with gross negligence manslaughter (and not convicted), yet healthcare seems to be at least as safe in NZ as in England. We reflect on differences between these two countries in their approach to unintended harm to patients.

Errors and violations in a complex adaptive system

In a complex adaptive system, such as healthcare, some errors are inevitable. That errors, by definition, are unintentional is fundamental to our position. Their incidence may be reduced by better system design but they cannot be eliminated by simply trying harder to practise safely. Thus, the criminal prosecution of an individual cannot be expected to deter errors.[7] Violations involve decisions, so they can be avoided, but when people are trying to work in an under-resourced and overstretched system, certain types of violation (such as working while fatigued) may be difficult to avoid.

Deterrence should, therefore, include those who can influence the system, such as managers and service directors.[7-9] Many errors and minor violations are without consequence, but sometimes, typically when several failures align (as in James Reason's "Swiss Cheese" model of accidents),[10 11] serious harm or death occurs. Reliable data on the incidence of prosecution are not available, but the number of criminal and coronial investigations has increased under English law (although not under Scottish law) since late last century.[12] The severity of sentencing also seems to have increased.[13]

Importantly, doctors' anxiety over the risk of prosecution in England seems to have grown in recent years and, whether well founded or not, this could inhibit open disclosure and reflection, and promote defensive medicine.

For many doctors, this raises the spectre of "there but for the grace of God go I." The widespread protests related to the Bawa-Garba case show that many doctors readily identified with her position. But a serious crime should be clearly recognisable as such. Facing serious criminal charges based on inadvertently getting things wrong while trying to do one's job conscientiously under difficult circumstances seems unjust. Even one unjust prosecution is too many.

KEY MESSAGES

- Healthcare systems should provide an adequate and effective response to patients who have been unintentionally harmed while receiving care
- To improve patient safety we need a greater focus on learning and resolution rather than on retribution and blame, recognising the importance of protecting confidential personal reflective practice and encouraging open disclosure
- In line with the recommendations from the Williams review, England needs a higher threshold for criminal prosecution in response to deaths that arise despite conscientious efforts to care for patients under difficult circumstances
- We urgently need to improve the clinical working environment and resourcing for safe functioning of hospitals

Understandably, some members of the public saw this case differently. Their concerns were captured by Jack's mother, who referred to "the number of errors that doctor made on the day for the judge to say 'truly exceptionally bad.'"[1] Similarly, the GMC's action in challenging the decision of its (albeit independent) Medical Practitioners Tribunal Service to suspend Bawa-Garba and to demand erasure was presumably based on a desire to safeguard the public from "bad doctors," and to be seen to be doing so.

One can imagine that it would be difficult for a parent to accept any outcome short of incarceration and erasure from the medical register as an adequate response to the loss of a child. Nevertheless, although punishment is an important component of justice, it needs to be proportionate to the blameworthiness of the behaviour, and this is not necessarily reflected by outcome. There should be the possibility for rehabilitation of a doctor widely seen as generally competent and well motivated, but for whom things once went badly wrong.

New Zealand's parliament raised the threshold for criminal prosecutions

Should a jury have heard the case?

In cases of gross negligence manslaughter, the prosecution must establish "beyond reasonable doubt" that the defendant's alleged failures caused the death. This requirement is one of the weaknesses of criminal law in the context of complex medical cases. On one hand, a not guilty verdict may seem to imply that care was acceptable, when it may be that the jury was unable to reach a firm conclusion on causation. On the other hand, it may be hard to understand how they could have reached such a conclusion.

The direction to the jury on this point may have been nuanced. Judge Andrew Nicol told the jury that they could convict if they were sure that the defendant's failures "significantly contributed to Jack's death or led him to die significantly sooner than he would otherwise have done."[14] This may be good law, but it is not clear to us when a "significant contribution" would become causation beyond reasonable doubt. The jury had the benefit of expert evidence—but they disagreed on most points. Surely, the "beyond reasonable doubt" standard should, as a minimum, require alignment on causation between experts accepted by the court as credible?

A further difficulty for the jurors was that they were asked to determine whether what Bawa-Garba "did or didn't do was 'truly, exceptionally bad.'"[14 15] But her failure involved competence rather than behaviour. She did not show laziness nor was she working under the influence of illicit drugs or alcohol. She was taking on extra duties and responsibilities in an overstretched hospital, with very little supervision.

Typical of criminal prosecutions, little attention was given to the role of the wider team or the healthcare system. Little or no evidence was presented on recommendations or standards regarding safe staffing, clinical and educational supervision, return to work programmes, or activation of the IT major incident route. The prosecution and defence agreed that the report commissioned by the University Hospitals of Leicester Trust should not be placed before the jury, and the judge said that there was a "limit to how far these issues could be explored at trial."[19] These are the very issues that lie at the heart of this case, and this view provides further support to our argument that it was, in several respects, too big an ask for a jury.

Role of the GMC and tribunal

The GMC's appeal against the tribunal's suspension was the final trigger for widespread protest from the medical profession and for the Williams review. The tribunal seems to have taken a holistic view of the case and concluded that rehabilitation was both possible and appropriate. By contrast, the GMC seems to have seen the conviction for gross negligence manslaughter in itself as justification for permanent erasure. This view is understandable. If this doctor was "so exceptionally bad" that the courts found her guilty of manslaughter, why would one allow her to practise again?

Yet Bawa-Garba's successful appeal against erasure indicates otherwise. Again, we think this reflects the poor fit of the criminal law to complex cases of this sort.

Responding to inadvertent patient harm in New Zealand

Under NZ's codified criminal law, the standard for gross negligence manslaughter is not obviously dissimilar to that set by precedence under English common law. Criminal prosecution in the absence of *mens rea* (ill intent), however, is now seen as purposeless in most cases.[7 20] In the words of Ron Paterson, former NZ health and disability commissioner, "Prosecution has a limited part to play in accountability for unintended patient harm, and

DESIRABLE ELEMENTS OF A RESPONSE TO INADVERTENTLY CAUSED HARM IN HEALTHCARE

- Patients or their families should receive open disclosure and an apology. Where possible, the treatment injury should be treated, without charge and as a priority
- When relevant, compensation should be paid
- Appropriate mechanisms should be in place to hold to account those responsible for the delivery of care
- Punishment may be appropriate,[3] but should be proportionate to the moral culpability of the behaviour rather than to the outcomes of complex clinical problems
- Responses to problems (including patient harm) should be timely—complex adaptive systems need repeated and rapid adjustment to function effectively and patient safety is not well served by responses that take years to be determined and implemented
- Motivated staff who try hard to care for sick people, often under difficult circumstances, should be afforded the safety of a "just culture" rather than either a "no blame" or an undue focus on finding "the individual who is to blame"

Approaches to inadvertent patient harm in New Zealand

As in the UK, patients in NZ can be assured of medical care for treatment injury without the need for litigation or prosecution. In addition, the Accident Compensation Commission (ACC) provides preferential support for patients with treatment injury without the requirement to show fault. The Nordic countries have similar systems, but uniquely in NZ the no-fault element is explicit and is linked to a loss of the right to sue for accidental injury.[20 29]

The ACC assesses all claims for risk of future harm and notifies relevant authorities when there may be a potential risk to the public.[29] It also invests proactively in initiatives to reduce mishaps in healthcare and more generally.

Following the highly publicised scandal that led to the Cartwright inquiry,[30] the NZ government established the Office of the Health and Disability Commissioner to tackle deficiencies in accountability to patients. A code of patient rights was established.[31] Patient advocates are provided to assist any patient to lay a complaint. The commissioner can investigate any health professional and also the institutions that deliver healthcare, primarily in an inquisitorial manner.

This has led to a more systems oriented response to complaints. The commissioner can find practitioners, managers, or institutions to be in breach of the code and can refer them to other authorities including the relevant professional council and/or the police.

In 2010 the government established a Health Quality and Safety Commission to advance quality improvement across the healthcare and disability sectors. Among other things, this commission coordinates a national programme of reporting of serious adverse events. This reporting, and the associated analyses of the cases, is supported in some cases by legislated privilege for quality assurance activities, but it mostly operates in an atmosphere of trust that open disclosure and the processes of root cause analysis will be respected within a just culture.

rehabilitation is an important goal in addressing the shortcomings of individual practitioners."[20 12]

Over many years, NZ has progressively developed an increasingly novel organisational and legislative approach to the provision and regulation of healthcare that today goes a long way towards ensuring the accountability of all who work in the sector (managers as well as frontline clinicians) while promoting the quality and safety of healthcare (see box above).

NZ has strict health and safety laws that place high expectations on the directors of organisations to ensure a safe working environment. There are two strong unions—the NZ Resident Doctors' Association and the Association of Salaried Medical Specialists—which represent trainees and senior doctors, respectively. These have contributed to robust contractual protections as a bulwark against unsafe employment practices.

Clearly, the clinical working environment for junior doctors and the safe functioning of the trust overall were key factors in this case.

Unfortunately, the fortune of junior doctors is not perfect in NZ; for example, there has recently been considerable concern over bullying, and anecdotal evidence suggests trainees in some specialties feel obliged to exceed agreed limitations on hours of work. Nevertheless, we think that there is at least a cultural commitment by consultants to appropriate supervision as a cornerstone of high quality medicine.

The best response to iatrogenic harm is to reduce its occurrence in the first place

The case of Hadiza Hawa-Garba highlighted faultlnes in the UK system

We think that the same can be said of most UK hospitals, and we note that isolated failures in aspects of patient care do also occur in NZ. Ultimately, our observation goes to culture, and we cannot see how the fear of unjust prosecution for gross negligence manslaughter would be helpful in promoting a patient centred culture of excellence in any country—whether that fear is well founded or not.

Reducing harm

Jack should have received better care, regardless of whether this would have resulted in a different outcome. In general, the best response to iatrogenic harm is to reduce its occurrence in the first place.

Neither NZ nor the UK are short of relevant guidelines.[21] The challenge everywhere is to increase engagement with these guidelines and to simply get things right for patients.[22 23] A strong culture of safety that encompasses everyone from the health minister to the most junior clinician on the front line of patient care is the key to improving the quality (and therefore the safety) of healthcare for all patients. It is hard to envisage how the costly and protracted criminal and disciplinary proceedings discussed here would advance such a culture or achieve anything else of value.[24]

The commissioning of a rapid policy review of gross negligence manslaughter by England's health secretary reflects this concern. The Williams report made numerous recommendations aimed at improving patient safety and moving the focus away from blame.[2] It also recommended that "a clear and consistent position on the law of gross negligence manslaughter" should be developed and that steps should be taken to ensure that this position is consistently understood and applied when making the decision to prosecute.

It also recommended enacting legislation to remove the GMC's right to appeal the findings of the independent professional tribunal. It recommended changes to improve the standards and consistency of expert evidence to protect and enhance its value. Just as the Crimes Amendment Act of 1997 gave a clear signal for a change in policy to police and public prosecutors in NZ, the Williams report similarly signals a positive direction for change in England. We call on legislators and policy makers to implement its recommendations urgently.

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Amit Sengupta

Founder of the People's Health Movement in India

Amit Sengupta (b 1958; q Maulana Azad Medical College, Delhi, India, in the early 1980s), died in a swimming accident in south Goa on 28 November 2018

In death, as in life, Amit Sengupta was recognised as one of the most vocal advocates of universal access to healthcare and a leader of the People's Health Movement (PHM), a network of organisations committed to democratising global health governance. As news of his untimely death spread, PHM's website was inundated with tributes from across the world.

Health activism

Sengupta was a true champion of the masses. Born in Kolkata in 1958, he studied medicine at Maulana Azad Medical College in Delhi, where he organised and participated in a number of student led agitations.

As a young doctor, he used his newly acquired medical skills to help others in times of need. He provided medical treatment during the Delhi floods of 1978 and helped in the relief camps set up after the 1984 riots. He also set up a low cost medical clinic in Deoli, a working class area in south Delhi, to provide healthcare to poorer families.

Subsequently, Sengupta became involved with the Delhi Science Forum and the All India People's Science Network, two organisations focused on popularising science. "Amit made important contributions towards building public understanding of health policies and of the political economy of health and healthcare," said T Sundararaman, professor at the School of Health Systems Studies at the Tata Institute of Social Sciences in Mumbai.

In addition to community health projects, Sengupta was involved with literacy programmes in urban Delhi. For a while, he continued his medical practice even as he was engaged with social initiatives, but he eventually decided to focus full time on his role as a health activist.

Over the years, he became increasingly concerned with larger social and public health matters, such as access to healthcare and the impact of privatisation, corporatisation, and globalisation on healthcare delivery. He was a vocal opponent of the growing presence of private corporations in healthcare. He also came to be known as an authority on many facets of healthcare and its delivery, including access to drugs and the impact of intellectual property rights on access.

In the late 1990s Sengupta began working with various organisations on matters of health and actively contributed to the first National Health Assembly held in Kolkata in 2000, which was instrumental in the formulation of the Indian People's Health Charter. The Jan Swasthya Abhiyan (JSA), PHM's India chapter, was formed at the same time and successfully organised national health assemblies in 2008 and 2018, to highlight and mobilise on matters of health in India.

Civil society

Sengupta coordinated the South and East Asia civil society engagement for the Commission of Social Determinants of Health. He was instrumental in developing the overall civil society report. From mid-2009 he held office at PHM. Colleagues at JSA remember him for his strategic role in giving it direction, in building the movement, and bridging the gap between the new young activists and the more seasoned ones. He became the associate global coordinator of the movement and was one of the architects behind its governance renewal programme, which was adopted in 2010.

Sengupta had a major role in coordinating and editing Global Health Watch, civil society's alternative to the World Health Organization's World Health Report. During the 1990s, he played a major part in the national working group on patent laws—a group that brought a far reaching research based perspective to the regime and regulations of intellectual property rights in India. He was also instrumental in advocating substantial "pro-people" amendments to the proposed reforms to the Indian Patents Act at a time when the legislative machinery in the country was under pressure from the World Trade Organization.

Sengupta was recognised as one of the most vocal advocates of universal access to healthcare

"Amit had a central role in preserving India's ability to produce and supply affordable generic drugs to patients in the country and the developing world. He was very knowledgeable about drugs and intellectual property. He combined his intellectual ability with a passion for people," said Leena Menghaney, access campaign India coordinator at Médecins Sans Frontières. "Amit believed that India should develop its own capabilities in drug development and production. If it hadn't been for people like him, India might not have got to where it is," she added.

Sengupta leaves his wife, Tripta Narang, and a son.

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OBITUARIES

Margaret Holland

Senior medical officer in community paediatrics (b 1924; q King's College London, 1949; MRCS), died from bronchopneumonia on 26 September 2018

Margaret Holland (née Green) married John de Bary, a fellow student from Belgium, in 1949. Their first home was in Clapton, east London, where John went into general practice while Margaret worked as a dental anaesthetist. In 1951 they moved to Fawley, on Southampton Water, where she continued in dental anaesthetics. In 1971 John died from a stroke. Margaret undertook further training and spent the following nine years working in community paediatrics, as a senior medical officer in child health in Southampton and, after her second marriage in 1976, in Gloucestershire and south Wales. She was widowed for a second time when Leslie Holland died in 2002. Margaret was active in local charities and the church. She leaves three children, five grandchildren, and 10 great grandchildren.

Philip de Bary

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Louie Mary Mangar

General practitioner (b 1937; q Sheffield University 1959), died from aspiration pneumonia, thrombosis of the middle cerebral artery, and atrial fibrillation on 17 November 2018

In 1955 Louie Mary Mangar was one of a mere handful of young female students in the first year of medicine at Sheffield University. After a period of research, she chose a path in family medicine to devote herself more to her older son. Later in her career, she provided pioneering services within the Women's National Cancer Control Campaign, an early precursor to national breast and cervical screening programmes. Travelling the country in the company of other female GPs and nurses, she provided voluntary medical services and undertook screening in large organisations. She ended her career in general practice working as a salaried doctor in deprived areas of east London in the late 1970s and 1980s. Widowed twice, she leaves two sons.

Will Mangar

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Lawrence Peter Ormerod

Consultant respiratory physician Blackburn (b 1950; q Manchester 1974; MRCP (UK), MD Manch, FRCP Lond, DSc), died from motor neurone disease on 29 January 2019

A form of childhood tuberculosis at age 7 prompted Lawrence Peter Ormerod's decision to become a doctor. As consultant in Blackburn in 1980, his remit was to tackle TB in the district that then had the fourth highest incidence in the UK. He devised a full TB service from scratch; many of his innovations later became national standards. Appointed to the Joint Tuberculosis Committee of the British Thoracic Society in 1987, he was its chair twice. He was an adviser to the Department of Health and the National Institute for Health and Care Excellence. He was awarded a personal chair in respiratory medicine by the University of Central Lancashire in 2000 and by Manchester University in 2011. He leaves Pauline, his wife of 48 years; two children; and four grandchildren.

Pauline Ormerod

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Alan Tadashi Otaki

Consultant physician (b 1922; q St George's Hospital Medical School 1953; MD, FRCP Lond), died from leukaemia on 26 July 2015

Alan Tadashi Otaki brought back from Japan the first fibrescope gastro camera to be used in British clinical practice and first tried it out on his wife, Lorna, in their kitchen in Ealing. Appointed consultant physician specialising in gastroenterology to Medway Health District in February 1969, he was also physician to the diabetes clinic at St Bartholomew's Hospital, Rochester, and physician to the intensive care unit at Medway Hospital. In 1979 he was appointed to the Riyadh Military Hospital in Saudi Arabia as consultant physician in gastroenterology and later to the National Guard King Khalid Hospital, Jeddah. He left Saudi Arabia in 1985. Back in England Alan worked in health screening for BUPA. He died after a short final illness at his former family home, with his daughters around him.

Michael Parkinson

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Mohan Radja

Associate specialist in ear, nose, and throat medicine Frimley Park Hospital (b 1964; q Madras University, India, 1987; FRCS), d 14 December 2018

Mohan Radja was born and brought up in Pondicherry in south India, where he completed his training and met his wife, Neelam, a fellow doctor. They moved to the UK in 1993, and Mohan worked in Coventry, Swansea, and Basingstoke before moving to Frimley Park Hospital, where he worked for more than 15 years. Mohan excelled at mentoring juniors. His calm and reflective demeanour earned him the respect of colleagues and patients. An avid traveller and photographer, he was most at home with a camera on safari or in the wilderness. He taught himself to swim so as to be able to take underwater photographs. He was an exceptional cook and was knowledgeable about classical music and fine art. He leaves Neelam and a son.

Raj Mathur

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Leslie Shapiro

General practitioner (b 1928; q Leeds 1952), died from multiple myeloma on 2 April 2018

Leslie Shapiro grew up in London's East End, the son of impoverished Russian Jewish immigrants. The family was evacuated to Leeds in 1940, where he won a scholarship to grammar school. After medical school, Leslie spent three years on national service in Hamburg, and married Lilian in 1956. He was a GP in Leeds for 38 years; the practice had no appointment system and every patient who walked in was seen. An astute clinician, he relied on the time-honoured approach of listening to his patients. In 1995 he retired to London, where he continued to work as a locum. Leslie was self educated to a high level in Jewish texts and had an active role in the synagogue. He leaves Lilian, five children, and numerous grandchildren and great grandchildren in the UK and Israel.

David Spitzer

Linda Goldberg

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