PDA statement to the Williams review on the case of Dr Bawa-Garba and the disclosure of reflective accounts

Pharmacists are trained to reflect on their practice on an ongoing basis. Often following an error, omission or other significant event, they go through a process of reflection and analysis in order to aid their learning and development and ultimately improve safety and care for patients.

The recent criminal prosecution and striking off of Dr Bawa-Garba has highlighted the potential that healthcare professionals' reflective accounts could be used in a manner detrimental to them. Like others, the PDA is concerned that this may result in a chilling effect on the recording of reflections, thereby impairing learning and having an adverse effect on patient safety.

Pharmacists might record reflections in a dispensing error report, at the request of the employer or as part of their submissions to the GPhC's new “revalidation” process, for example. Indeed, in fitness-to-practise hearings, it can be well-regarded by a panel that a pharmacist has shown insight into what he/she could have done differently. However, the recording of such reflections also has the potential to disadvantage pharmacists and patients. For example:

- **In criminal proceedings.** Pharmacy is unique among health professions in that there is a risk of criminal prosecution for inadvertent dispensing errors in the course of routine practice, many of which are a criminal offence.¹
- **In regulatory hearings.** Whilst self-reflection can be beneficial, the nature of what a pharmacist has recorded in a reflective account is important. If such accounts are done hurriedly or prematurely in response to pressure to do so (e.g. from an employer) and do not demonstrate insight where an FtP panel believes they ought, this could be disadvantageous to a pharmacist.
- **By employers.** A unique characteristic of the pharmacy sector is the number and size of large multi-national corporate organisations, who have an interest in
• protecting their brands. Disclosure of self-reflection (which is intended to be a personal process) may be used by employers to protect themselves in court proceedings related to an error. The PDA has noticed an increase in requests for reflective accounts to be submitted to some employers since the issues in the case of Dr Bawa-Garba came to light.

• **At coroner's inquests or fatal accident inquiries.** The purpose of these is not to apportion blame. However, the reality is that they are publicly-held hearings which determine a cause of death and can result in directions to organisations or individuals to take certain action. A reflective account from a pharmacist which acknowledges responsibility for an error may deflect attention in the course of the proceedings and determination of the cause of death from wider systemic causes.

• **In civil claims.** A patient may seek compensation for any losses in the event of an error. If the pharmacist inappropriately admits or infers responsibility within a reflective account without fully weighing up all of the systemic factors which led to the error, a claim may be improperly made against the pharmacist, where in fact the systemic conditions may be more relevant.

In writing a reflective account, the pharmacist is likely to focus on what he / she could improve personally in his/her practise. Reflective accounts are not intended for recording a full analysis of the cause of an error. However, employers may focus on the pharmacist’s personal actions and may push for a full “confession” of responsibility. This creates tension in which an employer’s desire for self-protection in the event of an error can overshadow patient safety learning.

Reason (2000) said “**Seeking as far as possible to uncouple a person's unsafe acts from any institutional responsibility is clearly in the interests of managers. It is also legally more convenient, at least in Britain.**” The PDA has witnessed this behaviour among some large corporate pharmacy providers. Indeed, NHS Improvement is currently consulting on the future of NHS patient safety investigations – acknowledging the need for a greater focus on the system rather than the individual. The systemic causes of safety issues include
environmental conditions which are the responsibility of employers. NHSI’s consultation document states: “Decades of learning in healthcare and other industries has shown that individuals are rarely to blame when things go wrong. It is not true that if people simply try hard enough they will not make errors, or that punishment when they make errors leads to them making fewer of them. The safest organisations and industries recognise that people make mistakes and that the best approach to ensuring safety is to create systems, processes, practices, environments and equipment that support people to do their jobs as safely as possible. This systems approach to safety recognises that incidents are linked to the system in which individuals are working. Looking at what is wrong in the system helps organisations identify and address the root cause of a particular incident and therefore prevent it from happening again.” The PDA is very much in agreement with this.

Our view is that to enhance patient safety, pharmacists and other professionals ought to be able to freely write reflective accounts without the fear of incriminating themselves and without the need for legal training on how to avoid doing so.

We have six proposals we’d like to see the government implement to aid openness and transparency among pharmacists:

1. A commitment from the GPhC and the PSNI to never ask pharmacists to provide their reflective statements if investigating concerns about them (as per the commitment from the GMC secured by the BMA).4

2. A commitment from the government to decriminalise inadvertent dispensing errors.1 Consideration should be given, involving debate within the pharmacy profession, as to whether a demonstrable history of commitment to open reporting of pharmacy incidents should offer amnesty from criminal prosecutions under the Medicines Act, Human Medicines Regulations and any associated legislation. The discussion should include the need for appropriate support in the working environment for error reporting.

3. A national NRLS error reporting system better tailored to pharmacy. The PDA would welcome the opportunity to assist with the development of such a system and its experience from the front-line could help ensure a systems approach to error causation was incorporated.
4. Guidance for pharmacists on the circumstances in which they could face a gross negligence manslaughter prosecution.

5. A central independent repository for recording reflective accounts, which acts as a legal “safe space” for health professionals. The professional must be free to choose whether and to whom the record is disclosed. He or she may disclose only the fact that such a record has been made. This would be separate to any reflective account that the professional wanted to share with an employer (for example), and potentially different (e.g. in the level of detail it includes).

6. Training for pharmacists and other healthcare professionals on writing reflective accounts of incidents, such that they include reflection on environmental and systemic issues and not just their own practice.

1. A statement from the Department of Health and Social Care’s Rebalancing Medicines Legislation and Pharmacy Regulation programme board on 9 April 2018 appears to state that the threat of criminal prosecution for inadvertent dispensing errors has been removed. This is wholly incorrect. Efforts to do so have been ongoing since 2006. https://www.gov.uk/government/groups/pharmacy-regulation-programme-board#minutes-and-associated-papers

2. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1117770/
