



Evening Medical Update: Keeping up with Modern Medicine **Tuesday 25 February 2020**

Insight and reflection when things go wrong – Dr Michael Devlin

Does reflection cause healthcare professionals to think of their practice in a more negative light?

There is a real risk that is the case, but I would encourage doctors to identify and reflect on what is good, rather than limiting it to those events that went badly. I gave an example after the presentation of a doctor being told by a patient that their explanation of the patient's illness has been really clear, and the patient had much better understood what was going on. It would be too easy to simply think of that as a compliment, and leave it at that. A reflective practitioner might think: what did I say that made that explanation so clear – was it my manner, empathy or use of language? How might I try and do that with all (or more) patients in the future?

How do you prevent things from going wrong in A&E with targets and winter pressures when it's overflow and shortages of beds?

I appreciate that reflection might not appear to have a particular key role in the circumstances described. But it is still important to reflect on what goes wrong, and indeed part of that reflection will almost certainly be the context that you found yourself in. Part of the "what now" question that you are asking could reasonably be what action do you personally, need to take. This could be, for example, raising concerns through appropriate channels in your department, having discussions with your trust Freedom to Speak Up Guardian (if you are in England), or joining colleagues in a coordinated response. The fact you have reflected, and made a note of what that was, will in my experience be helpful should things go wrong – it helps to show that you appreciated there were problems and did what you could to have them addressed.

The Civil Aviation Authority (CAA) investigations are confidential and cannot be used by CPS to prosecute. Why are medical professions not protected like this?

This is a really interesting point and something that I have a particular interest in. On behalf of the MDU I have evidence to a [Parliamentary Select Committee](#) back in 2015, the result of which led to the formation of the Healthcare Safety Investigations Branch, which led by ex-piolet and Air Accident Investigation Branch chief investigator, Keith Conradi. You may be aware that legislation to make HSIB a statutory body was in the Queen's Speech in 2020 and again on behalf of the MDU I have evidence to a parliamentary [Joint Committee scrutinising the Health Service Safety Investigation Bill](#). One of the key features of that Bill is the introduction of a "safe space" mechanism, which will do exactly as you say, and is something we welcome.

When mandatory reflection entries were introduced for training, has there been subsequent evidence of decrease in medical error or some form of better practice? Is there any evidence based studies proving that frequent reflection by employees in a work place has improved the overall quality of care provided?

I think it would be difficult to demonstrate association between reflection and improved patient safety. My view is because patient safety is in essence an all-encompassing activity and reflection forms part of that. But what I can be certain about is that since reflective practice has become the norm the NHS has become no less safe – in many publications it ranks among the safest healthcare organisations in the world. Furthermore, with almost 25 years' experience in the MDU I am struck by how powerful a tool it can be in demonstrating that you take professional development seriously, so when things do go wrong, which they will, then you put yourself in a position to try and work out how to do things differently in the future. The non-reflective practitioner eschews that opportunity. Sadly there is no correlation between improvements to quality of care and some proxy measures, such as damages paid out in clinical negligence claims – these increase exponentially and are more to do with the law and how compensation is quantified.



Police requested (and were denied) legally protected records relating to the Shoreham crash. How can we be reassured unprotected reflections won't be requested?

You are right in that Sussex Police applied to the High Court for an order compelling the Air Accident Investigation Branch to disclose, among other things, statements made to it in the course of its investigation. Detail about that judgement is [here](#). The High Court, correctly, upheld the principle that statements made by witnesses to the AAIB were protected from disclosure. The HSSIB Bill (see above) also establishes this principle in that disclosure would require a High Court order and it is likely that the course will be reluctant to depart from the principle. As to investigations that are not carried out under the safe space protections you are right that the police could request a doctor's reflections. But you will see from the Williams Review it was noted on page 34, "Both prosecuting authorities and professional regulators have been clear that they would be unlikely to use a healthcare professional's reflective material either for a criminal investigation or in considering a registrant's fitness to practice". This statement is consistent with the opinion of a senior solicitor at the MDU, who points out that the document would be unlikely to disclose any information that would not be available elsewhere and would be unlikely to disclose recklessness or other states of mind that could be helpful to prosecutors.

Do you think there could still be a negative bias against reflecting due to past cases which can cause wariness to take part fully?

This is a key point, and I am grateful to you for raising it. Perhaps the central theme of my presentation was to emphasise that reflection is a good thing: it helps professional development, learning from mistakes and also learning from what went well. It is absolutely fundamental in demonstrating insight. The publicity surrounding the case of Dr Bawa-Garba clearly worried a great number of doctors, particularly those in training. I hope that my talk, in some small way, will help to reassure you that reflection is a positive thing to do and that in time my hope is that the negative bias will diminish to the point of extinction.

From your experience, do you think that BAME doctors get similar outcomes vs others?

Another really important area for discussion. You may have read the clear conclusions of Atewologun and Kline in the GMC report, "[Fair to Refer](#)". This report was necessary because of consistent findings that BAME doctors are over-represented in GMC fitness to practise investigations and tribunals. Six key points were identified by the authors and we must hope that these are incorporated into organisational cultures throughout the UK.

What do you think of how the media handles BAME doctors? And how do they fair compared to non-BAME?

This was not something that Atewologun and Kline reported on, but I am acutely aware that it is a view shared by many. I think it is really important for all doctors to join a medical defence organisation as we have press officers who can give advice or deal with the media on a members' behalf. I realise it doesn't answer the question, but I am keen that we can use our expertise to best help those who need it.

When do you recommend to write reflection notes? Only with serious incidents?

No, please try to broaden it out, although I appreciate that when you are busy probably the last thing you feel like doing is reflecting on something and then writing a note about it. So your reflections should also cover things that went well – the important thing is to use reflection to learn from. And it also does not need to be restricted to serious patient safety incidents. For example, there may be as much (or more) learning from a near miss incident, which resulted in no harm, than from an incident which resulted in harm but which might have been difficult to avoid.

If lack of insight is so risky - why is criticising knowledge gaps and insight into ability labelled "bullying" when dealing with underperforming juniors?

I appreciate that it can feel like you are walking a tightrope at times when it comes to giving constructive feedback. In my experience most doctors do this well, but if you think that you may be perceived as bullying or harsh it may be something to look at within your own appraisal process and personal development plan – are these changes you could make to your approach that might "soften" the criticism, or depersonalise it (e.g. this is something many of us have done and what I have found helped is...). The other piece of advice I would give is to take advice if you think you



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need to formalise your concerns about a trainee's or colleague's performance. If it is a trainee, and you are their educational supervisor that might be discussing your concerns with the deanery so that a plan of action is agreed. If it is a colleague that discussion might have to be with the directorate head, or even medical director. If you then follow that advice it is unlikely that any criticism subsequently made will be upheld.

Can findings from root cause analysis (RCA) be used by criminal prosecution team?

Yes, I think it is likely that it would be considered by criminal prosecutors. They are of course different to personal reflections in that they are systematic analysis of what happened and why. But to reassure you, in my experience their disclosure does not result in a prosecutorial Aladdin's Cave of material that is going to make life difficult for a particular doctor. This is because the prosecutors normally adduce the evidence they need from the clinical records, witness statements, etc. (i.e. first-hand evidence) which is then reviewed by an independent expert as well as experienced prosecutors. So although it may happen, I hope I can reassure you that it is not something to be unduly concerned about.