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Mistakes and near misses: insights from Hadiza Bawa-Garba case for health systems on creating a safety net to learn

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Abstract

The case of Dr. Hadiza Bawa-Garba, a UK paediatric registrar convicted of gross negligence, manslaughter following the death of a child under her care, inspired global discussion on a rather neglected aspect which is the interplay between individual accountability and systemic healthcare failures. This perspective article explores the multifaceted implications of the Bawa-Garba case, drawing key lessons for the Sri Lankan healthcare system. It emphasizes the role of structural deficiencies, the potential misuse of reflective practice documentation, the necessity of adequate supervision and support for junior doctors, and the importance of cultivating a no-blame culture. Additionally, it highlights the educational value of learning from near misses, which are often ignored in clinical practice. By looking at these issues with a local perspective, the article advocates for system-level changes that support safe, ethical, and sustainable medical practice in Sri Lanka.

Key words: Hadiza Bawa-Garba, medical errors, systemic failure, reflective practice, no-blame culture, junior doctor supervision, near misses, burnout prevention, medical accountability

Introduction

Hadiza Bawa-Garba case is one of the litigations that has raised intense debate within the global medical community. It involved Dr. Bawa-Garba, a specialist registrar in paediatirics in the UK returning after her maternity leave, who was convicted of manslaughter due to gross negligence in 2015 following the death of a six-year-old boy, Jack Adock having Down's syndrome complicated by congenital heart disease. He died of sepsis which was inappropriately treated in 2011 due to a series of medical errors during his care at Leicester Royal Infirmary.[1]

Dr. Bawa-Garba who became the scapegoat, oversaw Jack's care on a day with significant staff shortages, IT system failures delaying test results, miscommunication and several other systemic issues. She was also criticized for not asking the on-call consultant to review the patient when she handed over even though the consultant noted that the pH was 7.08 with very high lactate. Although Dr. Bawa-Garba had omitted enalapril in the drug chart, the mother had not been informed. The mother had continued to give the routine enalapril dose after asking a nursing officer which resulted in worsening of circulatory failure. The most striking concern of the inquiry of General Medical Council (GMC) and subsequent legal proceedings was the disputable use of her e-portfolio which included reflective writing.[2]

Key messages for the Sri Lankan health system

1. Systemic failures and accountability

The case highlights how problems in the system like inadequate staffing, IT system delays and lack of support from colleagues can lead to medical errors.1,3 Sri Lankan trainees should be conscious of legal implications in a healthcare setting where there is widespread criticism about the system due to lack of infrastructure and resources, improper allocation of staff and deficiencies of coordination. It is vital to document concerns, raise issues with the staff in a professional

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yet amiable manner and take precautionary steps, even if those steps may feel risky in the moment. Thus, it might prevent being unfairly blamed for larger system deficiencies.

2. Reflective practices

The possibility of reflective notes intended for self-learning and improvement being used as a legal weapon is a major concern. Truthful reflection is a crucial element in medical training which should be encouraged rather than discouraged in the fear of ridicule or punishment.[4] It was pointed out by Dr. Atul Gawande in one of his books "*Are doctors who make mistakes villains? No, because then we all are*." [5] While it is important to learn from one's own mistakes, it is far more important for doctors to be able to share their experience in an unprejudiced forum so that they can advance together as a community for better healthcare. While not a direct quote, the following resonates with insights from Steinberg's bibliography of Bismark[6]: "*Those who are unwise fail to learn from their errors, while the average individuals gain wisdom from their own mistakes. Intelligent individuals, however, grow by observing others' errors, and the truly exceptional anticipate and avoid potential pitfalls before they occur*." It is incumbent upon postgraduate training and regulatory authorities in Sri Lanka including Sri Lanka Medical Council (SLMC) and Postgraduate Institute of Medicine (PGIM) that they take necessary steps to ensure that reflective notes are not permissible as evidence in a court of Law or in an inquiry by the Ministry of Health, SLMC or PGIM.

3. Strengthening support and supervision

Dr. Bawa-Garba's case highlights the repercussions of the lack of support and supervision of overworked junior medical trainees.[3,7] In Sri Lanka, it is not uncommon for senior doctors to feel that since they endured significant hardships during their training, junior doctors should also be able to handle similar challenges. As a result, the struggles of overworked junior doctors often go unnoticed. While it is true that handling difficult situations is a crucial part of medical training, this process should occur under *proper supervision and support*. Without adequate guidance, the risk is that the stress of managing *patient overload,* combined with a deficient emotional intelligence, poor work-life balance, and limited support from colleagues, will lead to burnout which is a vicious cycle compromising training and patient care.

These systemic issues are compounded by a culture where junior doctors' concerns are often dismissed, making it difficult for them to voice the pressures they face. Addressing these challenges through better supervision and a more empathetic environment will not only improve their training but also foster a healthier, more productive workforce.

4. The culture of blame

The case teaches us the necessity for a no-blame culture in healthcare, where errors are seen as opportunities to improve systems rather than solely punish individuals.[3,5,8,9] Although hierarchical healthcare systems generally maintain a chain of command, juniors often do not raise their concerns due to the fear of repercussions. Workplace environments should aim to foster a sense of order and responsibility through promoting accountability, mutual respect and emotional intelligence rather than through stress and fear. When team members are motivated by a shared commitment to excellence instead of using fear of punishment, they are more likely to be engaged, proactive and supportive of one another. Open communication, constructive feedback and a culture of continuous learning should be motivated. Transition of the culture would ensure system-wide improvement rather than individual scapegoating.

5. Importance of learning from near misses

In healthcare, near misses are situations where harm was narrowly avoided which can be a goldmine of learning opportunity even though heavily underestimated.[10] Like transient ischaemic attacks if not timely treated, leading to major strokes, if near misses are neglected, they can lead to catastrophic morbidity and mortality. There could have been several near misses at Leicester Royal Infirmary which could have gone unnoticed leading to the death of Jack Adock.

Another advantage of learning from near misses is that the parties involved can be more open to discussion compared to morbidity and mortality meetings where parties involved can be too defensive. It is also important to hold these meetings in a professional and nonjudgmental manner avoiding destructive criticism and prejudice.

An irrefutable truth about healthcare in a country is that its progress depends on learning from both triumphs and failures. As educational philosopher, John Dewey pointed out, "*We do not learn from experience, we learn from reflecting on experience*."[11] The Bawa-Garba case serves as a stark reminder that failures of the system should never rest solely on individuals. As a community, we must strive for a healthcare system

that learns from every near miss, every error and every reflection, transforming these changes into actionable changes for the future.

Author declaration

Conflict of interests

None.

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