

HEALTHCARE LIABILITY

LEADERSHIP & INNOVATION

Has the Duty of Candour fostered a Culture of Candour?

The public inquiry examining the failings of the Mid Staffordshire National Health Service (NHS) Foundation Trust in 2013, recommended that there should be a statutory duty of candour for healthcare providers. This includes registered medical practitioners and nurses, and requires them to disclose information to a patient where there was a belief or suspicion that treatment has caused death or serious injury. It was clear that the provision of information should not be an admission of civil or criminal liability.

When the duty of candour was implemented, Peter Walsh, the Chief Executive of Action Against Medical Accidents, said it represented 'potentially the biggest advance in patients' rights and safety since the creation of the NHS.'

Sir Norman Williams, as President of the Royal College of Surgeons in England, and Sir David Dalton, Chief Executive of Salford Royal Hospital, reviewed the proposals to enhance candour in the NHS. They commented that the 'commitment to candour has to be about values, and it has to be rooted in genuine engagement of staff, building on their own professional duties and their personal commitment to their patients... the reality of candour is a matter of hearts and minds more than it is a matter of systems and processes'.

The same review recommended that a duty of candour required that all organisations registered by the Care Quality Commission should:

- Train and support staff to disclose information about unanticipated events in a patient's care and to apologise when appropriate;
- Improve the levels and accuracy of reporting patient safety incidents so that this information is used as the basis for organisational learning and not for criticism of the individuals;
- Close the audit loop by spreading and applying lessons learned into practice and publicly report these.

Almost four years on since the implementation of the duty of candour, one begs the question on the effectiveness of this reform. Although individual institutions in the private and public sector may be able to demonstrate meeting certain measures of the criteria, has it truly changed the 'hearts and minds' of practitioners when raising incidents or concerns of patient safety? We can try to answer this question by studying doctors' clinical incident reporting behaviour.

Evidence to answer this question is limited, however, namely because of the lack of data in relation to reporting behaviour prior to the passing of the statute.

In a cross sectional study published in November 2017, over 580 doctors from 11 different NHS trusts in England were surveyed in order to assess whether doctors recognised incidents and reported them accordingly.

Most notably, the study found that of the 43.7% doctors reported being involved or witnessing more than five incidents, only 13.5% reported completing more than five incident reports; this was statistically significant. Consultants were more likely to complete an incident form compared to junior doctors [65% cf. 28% respectively].

The reasons for not reporting drew out a number of themes:

- 1) **Organisational issues.** Doctors felt that incident reports were completed to meet set targets rather than improve patient care; that there was a sense of issues being ignored due to system failures; and that the form is not the right tool to address minor errors;
- 2) **Culture of blame.** 13% of the sample felt fear of repercussions contributed to a poor reporting culture, alluding to a blame culture;
- 3) **Lack of feedback.** Doctors felt that they often receive no feedback, which can make them feel disengaged from the process.

The authors felt that the culture of blame might be a bigger issue than people are prepared to directly report. At the time of publication of this study, there was a lot of media attention on the case of Dr Chris Day. This junior anaesthetic trainee in the NHS tried to 'blow the whistle' at an intensive care unit (ICU) that he worked at,

which, routinely did not adhere to national staffing levels as defined in the ICU core standards. Dr Day then suffered 'career loss' and is currently litigating against the relevant institutions involved in this case. Further details are not disclosed lest this prejudices the legal process. However, this example demonstrated the lack of legal protection for this junior doctor, cautioning others who may wish to whistle blow, of experiencing a similar fate.

In addition, we draw on the case of Dr Bawa-Garba. This is a case of a paediatric trainee, where, it seems that a combination of her mistakes and system errors had led to the avoidable, and untimely, death of a young boy who had been admitted with sepsis. Dr Bawa-Garba was convicted of manslaughter by gross negligence and was suspended from the General Medical Council (GMC) register for 12 months. The GMC tribunal had considered her previous track record, provision of excellent care for four years at the same hospital after the event and her good character. However, the GMC was unhappy with their own tribunal's decision and appealed the decision to the High Court. The High Court upheld the appeal, and substituted the suspension with erasure from the register.

It was reported that Dr Bawa-Garba's reflections in her training portfolio were used as evidence for her prosecution; however, this was later refuted by the Medical Protection Society.

The consultant in charge was not charged nor had restrictions placed on their GMC registration.

Doctors across the country are shocked at the GMC's decision to appeal the suspension. Questions are being raised over the protection and guidance of the supervising consultant, and the role of the training portfolio. Dr Zoe Norris, of the British Medical Association (BMA) GP sessional subcommittee, commented that she would advise doctors to be more cautious with their written reflections and to amend them with the following: 'I am happy to reflect on this case one-to-one with my appraiser. However, following the unjust treatment of a UK doctor by the GMC on 25 January 2018 I am not prepared to reflect in writing'.

The GP survivor, a journal for practicing GPs, further commented that 'the outcome of this case exemplified that the blame for system failures was placed unfairly on individual doctors.'

This presents challenges to the practice of candour in the NHS.

Norman Williams and David Dalton suggested that the reality of candour is 'a matter of hearts and minds'. It is concerning that the rate of incident reporting for junior doctors is lower compared to consultants; that a junior doctor who whistle blows can suffer career loss; and that a junior doctor can suffer criminal conviction and permanent erasure from the register in a clinical situation which juniors can often relate to. Thus, I would argue that the current environment does not foster the culture of candour. It is imperative that the medical profession can now demonstrate to doctors that it will protect and support them in their professional duties, in order to allow them engage in candour, and ultimately improve patient safety.

Sources and further reading

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