Encouraging Candour

August 2013

MPS's response to the Professionals Standards Authority's call for information 'How can professional regulation encourage healthcare professionals and social workers to be more candid when care goes wrong?'

About MPS and DPL

The Medical Protection Society (MPS) is the leading provider of comprehensive professional indemnity and expert advice to doctors, dentists and health professionals around the world.

We are a mutual, not-for-profit organisation offering more than 280,000 members help with legal and ethical problems that arise from their professional practice. This includes clinical negligence claims, complaints, medical council inquiries, legal and ethical dilemmas, disciplinary procedures, inquests and fatal-accident inquiries.

Dental Protection Limited (DPL) is an autonomous but wholly owned subsidiary of MPS. DPL serves over 60,000 members in 70 countries around the world, including approximately 70% of UK dentists and a higher proportion of UK dental therapists and hygienists. DPL is the acknowledged international leader in dental risk management and provides assistance with Regulatory and Dental Council inquiries in all of the other jurisdictions in which we work.

Fairness is at the heart of how we conduct our business. We actively protect and promote the interests of members and the wider profession. Equally, we believe that patients who have suffered harm from negligent treatment should receive fair compensation. We promote safer practice by running risk management and education programmes to reduce avoidable harm.

MPS is not an insurance company. The benefits of membership are discretionary - this allows us the flexibility to provide help and support even in unusual circumstances.

General Comments

We welcome this work by the Professional Standards Authority on encouraging candour amongst healthcare professionals following the Francis Inquiry.

MPS fully supports the focus of the Francis Inquiry Report on the need to achieve an open culture in the NHS. The report rightly identifies that there is a culture of fear in the NHS and a need to tackle the reluctance of healthcare professionals to be open with patients, as well as colleagues, when things go wrong.

However, MPS has for several years expressed concerns about a statutory duty of candour, that is now being introduced, and we remain of the view that a legal duty will not be effective at providing the impetus needed to change behaviour in the NHS. We understand the appeal to the public and others of using regulation to mandate openness but think that this will be ineffective and prove a distraction from the real task of developing an open culture in healthcare. Only through cultural change can we alter healthcare professionals reactions to incidents from one of fear into an eagerness to report, explain and learn from what happened.

The key issues to be addressed in supporting this culture change are: mentoring, training and supporting staff to communicate effectively and sensitively with patients when things go wrong; ensuring senior clinicians lead by example; developing leadership skills in the professions; helping professionals to recognise that their responsibilities are broader than their clinical specialism and must encompass patient experience; and ensuring organisations support their staff to fulfil their professional and ethical obligations.

We think the regulators can play an important role in encouraging this culture change through making clear the professional obligations of their registrants and ensuring education standards have a sufficient focus on the importance of openness and the communication skills necessary to support it.

Questions

1. **In your view, are all the regulators listed above effective at encouraging the professionals they regulate to be candid when something goes wrong?**

The GMC makes its expectations to its registrants very clear in its guidance. For example, their core guidance *Good Medical Practice* states:

> *You must be open and honest with patients if things go wrong. If a patient under your care has suffered harm or distress, you should:*
>
> *a. put matters right (if that is possible)*
>
> *b. offer an apology*

> *c. explain fully and promptly what has happened and the likely short-term and long-term effects.*[1]

In addition, the GMC publishes explanatory guidance *Raising and acting on concerns about patient safety* which provides a detailed explanation on doctors responsibilities when something goes wrong as well as more practical advice on what action should be taken. Specifically it states:

> *All doctors have a duty to raise concerns where they believe that patient safety or care is being compromised by the practice of colleagues or the systems, policies and procedures in the organisations in which they work. They must also encourage and support a culture in which staff can raise concerns openly and safely.*[2]

Importantly the guidance also highlights the importance of an open culture and doctors responsibilities in supporting this culture:

> *All doctors have a responsibility to encourage and support a culture in which staff can raise concerns openly and safely.*[3]

Whilst the GMC's expectations and guidance are very clear we cannot be sure how effectively this is communicated to doctors. MPS invests extensive resources in highlighting the GMC's position, and the importance of openness in general, to its members through our own guidance, publications and education workshops.

We note that the GDC has launched it *Standards for the Dental Team* guidance which will come into force in September 2103 and that they are currently developing an action plan to implement recommendations from the Francis Inquiry. We recognise the work being done by the GDC and welcome the opportunity to comment on the policy once it has been developed.

[1] General Medical Council, *Good Medical Practice,* (2013), para 55
[2] General Medical Council, *Raising and acting on concerns about patient safety,* (2012), para 7
[3] Ibid. para 19

2. **What could the regulators do differently to encourage the professionals they regulate to be more candid/open/honest about treatment or care that has gone wrong or incidents that have caused harm or nearly caused harm? For example are there any improvements you think should be made to:**

   a. **Their codes of practice and how they support professionals to be open**

Whilst the expectations in the GMC's core guidance are clear and there is additional guidance on candour we note that the importance of being open with patients and colleagues when something goes wrong is not touched on in the GMC's *Leadership and management for all doctors* guidance[4]. MPS thinks that encouraging and supporting openness is a key component of being in a leadership and management position and that one of the lessons from the Francis Inquiry is that the profession needs to take greater responsibility for providing leadership in this area. We think the GMC should add this to their guidance and organisations should invest in the training necessary to support this leadership skill.

   b. **Their fitness to practise/disciplinary investigation and adjudication processes**

We think these processes are an important opportunity for the GMC to demonstrate support for the protection of registrants who have been open about adverse events as a strong mitigating factor against disciplinary action. This could operate in a similar way to apology laws which exist in several jurisdictions, for example Canada.

   c. **How their education standards and processes encourage education providers to satisfactorily prepare new professionals to be candid**

As noted above we think that education on the importance of openness and also the communication skills necessary to support this could be improved. Training in professional ethics and obligations should be a fundamental part of training in the early years at medical school and it should receive more attention than it currently does throughout pre- and post- graduate education.

   d. **How their registration and registration renewal processes work**

We note that there is a potential conflict of interest in the role of the Responsible Officer when it comes to promoting openness with patients and the public. The Responsible Officer is charged with ensuring doctors comply with their GMC responsibilities. They are also an employee of a Trust, often holding the post of medical director, and may therefore have a strong vested interest in not allowing (or not

[4] General Medical Council, *Leadership and management for all doctors,* (2012)

encouraging) adverse information about mistakes and incidents to be publicised given their responsibilities to the Trust for such incidents. Clear guidance and support needs to be given to Responsible Officers to help them overcome this potential conflict

3. What good practice is there in this area, either from overseas or here in the UK, which we could learn from?

As noted above we think apology laws, or similar, would be helpful in encouraging openness from professionals. These could provide some protection in disciplinary and regulatory proceedings for those professionals that have been open about adverse events.

4. Are you aware of any reasons why a duty of candour on professionals may benefit or disadvantage patients, people who use social care services, carers or professionals differently depending on their age, gender, disability status, transgender status, ethnicity, nationality, sexual orientation, marital or civil partnership status, religion or belief?

It should be recognised that there will be occasions where open disclosure is not in the interests of a particular patient, perhaps because of the worry and anxiety this may cause outweighs the benefits of openness. There should always be a presumption of openness but this can be rebutted with adequate reason in the interests of the patient and to achieve patient centered care.

CONTACT

Should you require further information about any aspects of our response to this consultation, please do not hesitate to contact me.

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