"We try our best", but we should still be open and transparent

In a recent discussion with colleagues, someone recognised that many, when asked what they do, say, "I am a doctor". Rather than "I work as a doctor". This sense of belonging, pride and duty comes with responsibility. Becoming a surgeon, or indeed any clinician, is a vocation rather than a career, which requires a commitment to lifelong learning. Learning defined as "the acquisition of knowledge or skills through study, experience, or being taught" [1] encompasses the journey that trainees go through from the first time their interest in a speciality is lit, whether that be from personal experiences, a patient they have seen, or an inspirational senior clinician or mentor. Like on any journey, we can get lost or things can go wrong, operations can go wrong. Treatment carries risks. As clinicians we will unintentionally make mistakes, despite trying out best.

Duty of candour

The Francis report which looked at failings in care at Mid Staffordshire NHS Foundation Trust between 2005 and 2009 made 290 recommendations. One of these recommendations (181) explains there should be a statuary obligation of candour for registered medical practitioners and other colleagues involved in the provision of care to patients "where there is a belief or suspicion that any treatment or care provided to a patient by or on behalf of their employing healthcare provider has caused death or serious injury" [2,3]. Candour is defined in the report as "The volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made" [2]. The principle has become a favourite at interviews and will likely feature in future postgraduate exams.

Given this, in a joint statement the chief executives of the statutory regulators of healthcare professionals including the General Medical Council, explain that we must be open and honest with patients when things go wrong, known as the 'duty of candour' [4,5]. Guidance from the regulatory bodies also explains that clinicians must:

- tell the patient (or, where appropriate, the patient's advocate, carer or family) when something has gone wrong
- apologise to the patient (or, where appropriate, the patient's advocate, carer or family)
- offer an appropriate remedy or support to put matters right (if possible)
- explain fully to the patient (or, where appropriate, the patient's advocate, carer or family) the short and long-term effects of what has happened [4,5].

We must recognise our limitations, say no before we assume responsibility for something we do not have the correct training or experience for, and know when to ask for help when things are going wrong. This is an integral part of our commitment to lifelong learning and always trying our best.

As a doctor, nurse or midwife, you must be open and honest with patients, colleagues and your employers [5]. This statement broadens the healthcare professions' need to be honest for any errors. Beyond this, the guidance offered by various organisations includes the need for us to encourage a learning culture by reporting adverse incidents that lead to harm, as well as near misses.

Who has a responsibility?

We work in multidisciplinary teams (MDTs) and it is understood teams might involve various members. We should ensure someone in the team has taken on responsibility for each of the tasks of reporting adverse events and you should support them as needed [5].

What is the statutory standing?

Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 intends to make sure that providers are open and transparent in relation to care and treatment with people who use their services.

In England the Care Quality Commission (CQC) has put in place a requirement for healthcare providers to be open with patients and apologise when things go wrong.

For Northern Ireland the Donaldson report inspired the implementation of a duty of candour. In Scotland the Healthcare Quality Strategy for NHS Scotland is aiming to achieve an NHS culture in which care is consistently person-centred, clinically effective and safe for every person, all the time. The Scottish Patient Safety Programme is a national initiative that aims to improve the safety and reliability of healthcare and reduce harm. In Wales the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 place a number of duties on responsible bodies providing NHS care. This includes a duty to be open when harm may have occurred [5].

The CQC guidance

Interestingly, emphasis is also placed on the 'providers'. This is important to note, as the responsibility is extended beyond individuals.

- Providers must promote a culture that encourages candour, openness and honesty at all levels.
- Providers should have policies and procedures in place to support a culture of openness and transparency, and ensure that all staff follow them.
- Providers should take action to tackle bullying and harassment in relation to duty of candour, and must investigate any instances where a member of staff may have obstructed another in exercising their duty of candour.
- Providers should have a system in place to identify and deal with possible breaches of the professional duty of candour by staff who are professionally registered.
- Providers should make all reasonable efforts to ensure that staff operating at all levels within the organisation operate within a culture of openness and transparency, understand their individual responsibilities in relation to the duty of candour, and are supported to be open and honest with patients and apologise when things go wrong.
- Staff should receive appropriate training, and there should be arrangements in place to support staff who are involved in a notifiable safety incident.

"As a doctor, nurse or midwife, you must be open and honest with patients, colleagues and your employers."

- In cases where a provider is made aware that something untoward has happened, they should treat the allegation seriously, immediately consider whether this is a notifiable safety incident and take appropriate action.

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(All links last accessed December 2017)

TAKE HOME MESSAGE

- We all have a duty of candour.
- Tell the patient (or, where appropriate, the patient's advocate, carer or family) when something has gone wrong.
- We should ensure someone in the team has taken on responsibility for each of the tasks of reporting adverse events and you should support them as needed.

AUTHOR

Vishnu B Madhok,

General Practitioner, Parkhouse Surgery, Bagshot; Clinical Director, Care UK, Surrey Out of Hours, UK.

E: vishnumadhok@nhs.net

SECTION EDITOR

Tafadzwa Young-Zvandasara,

Ophthalmology Specialty Trainee Year 7, TSC VR Surgery, Wales Deanery, UK.

E: tpzvandas@hotmail.com