

How real is the NHS commitment to *Being open?*

Peter Walsh, chief executive of Action against Medical Accidents

The drive to improve patient safety in the NHS has openness as a key component. Peter Walsh asks when the NHS will truly achieve an open and honest response to medical errors.

The publication of *Safety First* by the Department of Health (DH) at the end of 2006 represented a sea change in the official view of how open and honest the NHS really is when things go wrong. Amazingly, for a DH publication, it referred to the need to challenge the “culture of denial” in the NHS.

This was music to the ears of those, like Action against Medical Accidents (AvMA), who have campaigned to raise awareness of the need for the NHS to ensure more openness and honesty when things go wrong. It represents a frankness that would have been unthinkable just a few years ago.

Also, as a result of *Safety First*, there has been a review of England’s National Patient Safety Agency’s (NPSA’s) *Being open*² guidance which has now led to a commitment to update and reinvigorate this initiative. However, other events in 2008 suggest that the NHS still has much further to go before it can say that the culture of denial is not alive and thriving.

The NHS Litigation Authority (NHSLA) has an enormously important role to play. I was encouraged to hear that the NHSLA periodically writes to NHS bodies, encouraging them to offer “apologies and explanations” to patients affected by errors or their families, and reassuring them that this will not affect their indemnity. However, when a friend in the NHS forwarded the latest version of the circular (dated August 2007) to me¹, I was shocked to see that it does quite the opposite of what it purports to do.

Stark warning

The main thing that strikes any careful reader of the 2007 circular is the stark warning issued to NHS bodies that:

“Care should be taken in the dissemination of explanations so as to avoid future litigation risks....”

The circular goes on to imply that if this warning is not heeded and if “opinions” as opposed to “facts” are explained to injured patients, then the NHS body’s indemnity might be at risk. This is completely at odds with the principles of *Being open* which states that being open involves “acknowledging, apologising and explaining when things go wrong”. The Compensation Act 2006 states that apologies cannot be interpreted as an admission of liability and it is vital that apologies and explanations should not be tempered in any way to try to reduce the chance of litigation.

Expressions of regret and true apologies

The paragraph in the circular headed “Apologies” does not refer to actual apologies at all. The NHSLA’s definition of an acceptable apology is restricted, it would seem, to sympathising with patients

or relatives, or expressing “sorrow or regret at the outcome”. This shows an astonishing lack of insight as to what injured patients or their relatives most need when something has gone wrong, which all of AvMA’s experience and the results of various studies show is a genuine apology – one which acknowledges responsibility for something going wrong, not just sympathy or regret at an outcome.

It would appear that many NHS organisations follow the NHSLA advice closely, as AvMA has seen numerous examples of where insult has been added to injury by offering sympathy or expressing regret at an outcome without acknowledging responsibility of any kind (see box). NHS staff often tell AvMA that their own desire to be fully open and honest and offer meaningful apologies to patients is often thwarted by the NHSLA or defence legal advisers who replace the wording of their letters with the watered-down terminology advocated by the NHSLA.

Imagine knowing that a close relative of yours had been killed or grievously injured as a result of perfectly avoidable errors or omissions in healthcare, and simply being told that the NHS body

SEBASTIAN’S PARENTS’ EXPERIENCE

Sebastian died at the age of two following negligent care at an English NHS foundation trust hospital. Staff diagnosed viral gastritis instead of a streptococcal throat infection which led to septicaemia, multi-organ failure and death 24 hours later. The trust did conduct an internal investigation, which appeared to identify shortcomings in care and made recommendations for improvement.

The report was eventually shared with Sebastian’s parents, but the correspondence from the trust closely mirrored the advice given to all trusts by the NHSLA. It expressed sympathy for the parents over the “outcome” (their son’s death), but never made an apology for the shortcomings in care.

It then took nearly two years for the trust to admit liability for Sebastian’s death in spite of obvious failures which were identified by the Healthcare Commission and the trust’s own internal inquiry. When the admission of liability did come it came in the form of two sentences from the hospital’s solicitors.

Sebastian’s mother, Kirren, said: “The fact that [the hospital] has taken so long to admit liability but has still not been round to apologise in person is outrageous and has prolonged our agony.”

The trust did exactly what the NHSLA circular warns trusts to do. The hurt this caused to Kirren and Sebastian’s father Michael, and the anger it inspired, is typical of many cases AvMA sees.

concerned sympathised with your loss and regretted the outcome. No-one should be surprised that such shallow expressions of regret actually increase people's pain and stimulate anger.

Putting the circular on hold

When AvMA learnt of the content of this circular we immediately brought our concerns to the attention of the NHSLA. We did this in a constructive way, acknowledging that when the circular was first drafted, in 1997, it was probably a step in the right direction. We suggested amendments to the wording to bring it up to date with modern-day thinking about openness and patient safety.

Our suggestions were simply ignored and, in October 2008, the NHSLA's chief executive announced to the National Patient Safety Forum, that the circular was about to be re-issued with essentially the same wording. It took the strongest of appeals from me to prompt the forum, chaired by the chief executive of the NHS, David Nicholson, and the chief medical officer, Sir Liam Donaldson, to agree to hold it back and think again³.

Quite apart from what this says about the NHSLA's understanding of listening to patients, what worries us is that even a well-meaning body such as this either simply can't understand our concerns or doesn't care.

This is a body charged with checking that the *Being open* guidance is adhered to by members of the Clinical Negligence Scheme for Trusts and would, if the NHS Redress Act is ever implemented, be the manager of an NHS Redress Scheme.

A relaunch for Being open

The review of *Being open* has led to an acknowledgement that it needs to be re-launched and given teeth. There was consensus on this at a multi-agency meeting convened by the NPSA at which the review, by Professor Albert Wu from the World Health Organization, was presented. He found that the guidance and intents that go with it compare favourably with any similar initiative around the world. In the discussion, the main perceived problems with it appeared to be that:

- It is only guidance. With the best will in the world, with all the challenges and "must do" targets that NHS boards face, they are hardly likely to give top priority to something which is optional.
- People do not know about it.
- People tend to assume that because they are caring and professional, this is something they do well anyway.
- There is a fundamental misunderstanding about what being fully open and honest when things go wrong actually means. Hence, the attitude of the NHSLA described above.

AvMA has been calling for the principles of *Being open* to be made mandatory and enforced by law for years. We are in good company too. The chief medical officer himself called for a legal "duty of candour" in the report *Making Amends* in 2003. MPs of all parties have called for something similar for years. Yet the recommendation was rejected by the Government.

The only explanation given for this was that such a legal duty was not needed because all health professionals have a duty of candour in their professional codes. Whilst this is factually correct, it is not a credible argument for not introducing a legal duty, as several other countries have. The chief medical officer knew about the professional duties when he made his recommendation. Most managers and chief executives are not covered by any such professional code.

Refusal to investigate allegations of "cover up"

AvMA has good reason to believe that professional regulators are far from enthusiastic about enforcing the duty of candour. We have asked the General Medical Council (GMC) for details of any cases brought against doctors on the basis of a breach of this part of their code and to date, it have been unable to provide any.

AvMA has also been forced to take out a judicial review of a GMC decision not to investigate doctors in a particular case. These doctors were alleged to have been involved in a cover-up following medical negligence which led to the death of a young boy named Robbie Powell. This case says a lot about how seriously the establishment really takes the principles behind *Being open*, which is why AvMA has invested so much time, energy and resources to testing it. Robbie's father, Will Powell, has shown remarkable courage, tenacity and skill in forcing the powers that be to take note not only of the original negligence (for which the case was settled out of court) but also the alleged cover-up. Mr Powell's efforts over his son's case have led to the GMC revising its code to explicitly require openness and honesty with parents when things go wrong with their child's treatment.

In this case, the police and Crown Prosecution Service found evidence of forgery (of the medical records and a referral letter) and of preventing the course of justice. Whilst a prosecution did not result because of procedural issues, they and everyone else were given to believe that the GMC would deal with the doctors. Yet the GMC decided that in spite of the availability of evidence it would not investigate, citing its "five year rule" by which cases are not investigated if over five years have elapsed since the events giving rise to the complaint. The GMC does have the discretion to waive this rule in exceptional circumstances and for public interest reasons, but clearly does not think that having doctors practising who are allegedly prepared to stoop so low meets its criteria. So much for the professional duty of candour.

Next steps for openness

So, how do we move forward? There is hope that significant strides will be taken in 2009 which may yet make *Being open* more of a reality.

First, it is to be hoped that the Government may agree with AvMA's suggestion that the legal duty of candour is brought in via a new clause in the NHS Constitution.

Second, the *Being open* guidance is due to be re-launched and, we hope, given more teeth. Hopefully it will be made mandatory and its implementation by NHS organisations will be monitored by the Care Quality Commission.

Third, we hope there will be a joined up approach from all parts of the NHS, with the NHSLA replacing its apologies and explanations circular with more enlightened advice which is in tune with *Being open*.

Finally, if AvMA wins its judicial review of the GMC decision it will send a clear message to all regulators that they must enforce the professional duty of candour. HCR

References

1. NHS Litigation Authority (2007), *Circular: apologies and explanations*. This can be found in the "Claims publications" folder at www.nhsla.com/publications [accessed 2.1.09]
2. National Patient Safety Agency (2005) *Being open: communicating patient safety incidents with patients and their carers*. London: NPSA. www.npsa.nhs.uk/
3. See www.dh.gov.uk/en/PublicHealth/Patientsafety/DH_073927