



PROPOSAL FOR A LEGAL DUTY OF CANDOUR IN HEALTHCARE ("ROBBIE'S LAW")

Introduction

Action against Medical Accidents (AvMA) - the charity which promotes patient safety and supports people affected by medical accidents - is proposing a practical and pragmatic way of introducing a legal Duty of Candour about harm caused in healthcare. (A legal requirement to practice being open and honest with patients or their next of kin when harm is caused).

The proposal is to introduce this duty as a requirement in the regulations covering registration with the Care Quality Commission (CQC) in England (and the equivalent bodies in the rest of the UK). This would mean that any organisation registered to provide healthcare would have a corporate Duty of Candour. Failure to demonstrate compliance could result in refusal or removal of registration, fines, and/or requirements to take remedial action.

AvMA wants the Duty of Candour to be known as "Robbie's Law" in honour of Robbie Powell and his parents. Robbie's case has come to symbolize the need for a legal duty of candour (see below).

STOP PRESS: Regulations for the Care Quality Commission laid before Parliament on 30th November 2009 will make it a legal requirement to report incidents to the National Patient Safety Agency. This has added extra urgency to our campaign to make it an equal requirement to inform patients. The Liberal Democrats have prayed against the regulations on the same basis.

Why is there a need for a legal 'Duty of Candour'?

There is a wide consensus that whilst things may have improved, and that the vast majority of health professionals *are* open and honest, providers of healthcare are not always as open and honest with patients or their relatives when things go wrong as they should be. That is certainly AvMA's experience, as the main supporter of people when things do go wrong in healthcare for over 25 years. However, don't just take our word for it:-

- The House of Commons Health Committee report on Patient Safety (July 2009) recommends reconsideration of a legal Duty of Candour, and the campaign is widely supported by patients' activists and other organisations.
- A National Audit Office report in 2005 revealed that only 24% of NHS trusts routinely informed patients of a patient safety incident and, astonishingly, 6% admitted to never informing patients ([A Safer Place for Patients, National Audit Office, 2005](#)).

- The Department of Health itself accepts that there is a 'culture of denial' in the NHS (Safety First, Department of Health, 2006).
- Although there are estimated to be over 1 million patient safety incidents alone in English hospitals alone each year, 50% of which are estimated to cause avoidable harm, the NHS receives only about 6,000 clinical negligence claims each year. Reporting of incidents to the National Patient Safety Agency (NPSA) from primary care is negligible.
- AvMA's casework regularly comes across examples of where there has not been open and honest reporting of incidents to patients or their families even after a complaint has been made, and even in the majority of clinical negligence cases which eventually settle in favour of the claimant, opportunities to be open and honest have been missed.
- The Chief Medical Officer for England, Sir Liam Donaldson, formally recommended a legal Duty of Candour in his report Making Amends in 2003. The Government have never offered a satisfactory explanation to justify their rejection of this recommendation.
- The UK is lagging behind other parts of the world that have made such a legal duty with successful results, helping create a genuinely open and fair 'patient safety culture'. (For example, some states in the United States such as Pennsylvania, and European countries such as Sweden, France Denmark, Cyprus, Estonia, Hungary and Slovenia)¹.

The failure to report incidents means that the NHS is deprived of information which could help prevent reoccurrence of the same mistakes, as well as depriving injured patients or their next of kin their natural right to know what happened and why.

Widespread Support for the Campaign:

Harry Cayton, Chair of the Council for Healthcare Regulatory Excellence (the regulator of health professional regulators) said:

"We support the introduction of a duty of candour in the CQC's registration requirements, which would mean that the ethical responsibility of health professionals would be shared by organisations delivering healthcare services".

Ruth Marsden, Vice Chair of the National Association of LINKs members, said:

"NALM is committed to the protection of patients in health care and believes that there should be a legal 'duty of candour' which places a duty of all health care professionals to be open and frank with patients. We are disturbed that the opportunity to introduce a legal 'duty of candour' has been side-stepped by Government, which has decided to introduce a requirement to report adverse events in health or social care in England to the regulator but not the patients and carers who should be at the centre of health care.

We will be demanding that the Government amends the draft regulations for Care Quality Commission (CQC) laid before Parliament this week to include a duty of candour to patients as well as regulators".

Claire Rayner, President of the Patients Association, said:

“This is an issue that should have been dealt with years ago. As one who has personally suffered iatrogenic damage I know the sense of helpless anger it (failure to be open and honest) induces”.

Frequently asked Questions and Misunderstandings

‘Doesn’t the professional duty that all health professionals have to be honest with patients mean that a legal duty is unnecessary?’

The so-called ‘professional duty’ of health professionals contained in health professionals’ codes of conduct only applies to health professionals. The duty should rest equally with health managers and boards as well. Also, the ‘professional’ or ‘ethical’ duty on health professionals is not a legal duty. It is guidance contained in their professional codes. Regulators have been inconsistent in how they use their discretion to enforce this duty.

‘The NHS already promotes ‘Being Open’ through the guidance and training provided by the National Patient Safety Agency, and there is the NHS Constitution, so there is no need for a law’

The *Being Open* guidance produced by the National Patient Safety Agency (NPSA) is a useful tool and says the right things, but it is only guidance. This sends out the wrong message. NHS boards have many targets and other ‘must do’s’ on their agenda and are unlikely to give this guidance top priority. Also, it only applies to the NHS whereas a legal duty would also cover private healthcare. The NHS Constitution also is restricted to the NHS, and whilst it makes a valuable statement of principle, there is no way of enforcing it.

‘Making laws does not change culture’

It may be true to say that simply passing a law does not in itself change culture and behaviour, but it can make a massive difference in helping bring about change. Take for example the effect of legislation to ban smoking in public places; for the use of seat belts; and on drink-driving.

“It is too complex or difficult to regulate something like candour/being honest”

The draft regulations for the Care Quality Commission already contain duties such as obtaining informed consent and treating patients with dignity and respect. These are complex and difficult to define also but, quite rightly, are a requirement of registration. The approach is to have a ‘high level’ requirement stated in the regulations themselves. The accompanying guidance will provide more detail on what is expected and how the Care Quality Commission will judge whether the requirement is being met.

“Would health providers have to report ‘near misses’?”

No. It is accepted that discretion is needed as to whether it might do more harm than good to tell a patient about a ‘near miss’ in their care. It is proposed that the new duty only covers incidents which meet the NPSA definition of ‘patient safety incident’ which are known to have resulted in harm to the patient.

Why call it "Robbie's Law"?

Although there are many other cases where there has not been openness and honesty when things go wrong in healthcare, and even of deliberate 'cover-up', Robbie Powell's case has become a symbol for the need for a legal duty of candour. His family have campaigned tirelessly and courageously for nineteen years not only for justice for Robbie, but to ensure that other families to not have the same experience. It was Robbie's case which highlighted the absence of a legal duty of candour. Robbie's case has been the subject of a landmark judicial review challenge by AvMA of a General Medical Council decision not even to investigate serious, evidenced allegations of forgery as part of an attempted cover-up and ongoing dishonesty by doctors involved in Robbie's case.

¹ 'Simpatie' – Safety Improvement for Patients in Europe