RESPONSE TO GMC & NMC CONSULTATION ON DRAFT GUIDANCE RE: "THE PROFESSIONAL DUTY OF CANDOUR"

Introduction

Action against Medical Accident (AvMA) is the UK charity for patient safety and justice. For decades, achieving more openness and honesty with patients or their families when things go wrong in healthcare has been a top priority for AvMA, based on our daily conversations with thousands of people affected by medical accidents each year. No other organisation has done more to raise awareness of the need for a 'duty of candour' and to make sure it comes about. Failure to be open and honest when things go wrong causes serious harm and distress in itself as well as being unfair and unethical. It also feeds a defensive culture in healthcare which mitigates against learning and patient safety. Yet, for the entire history of the NHS until this year, there has been no legal or statutory requirement for organisations to tell patients about the harm they have been caused. Whilst a 'professional duty of candour' has existed for years in the codes of the GMC and NMC, it has been poorly promoted and inconsistently enforced. In effect, up to now, the system as a whole has frowned upon cover ups but has tolerated them.

The introduction of the organisation duty of candour through the Care Quality Commission in England in November 2014, plans for similar statutory rules in the rest of the UK, and the new found enthusiasm from health professional regulators to re-invigorate their professional duties of candour have the potential to change that. A change which, if properly implemented, would be the biggest breakthrough in patients' rights and patient safety we have ever seen.

We welcome the joint statement by regulators and the consultation on the draft GMC / NMC joint guidance, however we think important changes are required to make sure this change is made a reality.

What we would like to see changed or improved in the guidance

1. **Proper promotion and regulation of the Duty of Candour, not just guidance.** Whilst clearer guidance for health professionals is welcome, it only describes in more detail what in theory has been a professional duty for years. What is urgently needed is an assurance alongside and reflected in the guidance, that the regulators themselves will change the way that they promote and enforce the duty of candour. For example, we would like to see commitments from the regulators that they will
   - Treat the duty of candour and any breach of it as seriously as any other grievous breach of their professional codes and, if proven, apply severe sanctions. Revised sanctions guidance for panels need to reflect that
   - Build education about the duty of candour into the education curriculum for trainee doctors, nurses and midwives and into post graduate education

- Promote awareness and understanding of the new approach to the duty of candour in a proactive and high profile way
- Systematically record and report on numbers of allegations received of breaches of the duty received; investigated; referred to panels and the outcome
- Not having any time bar (such as the "five year rule") in regulators' regulations which in effect would make it harder to deal with cases the longer cover-ups have been going on

2. **Application to potential harm – not just actual harm**. This guidance (and if possible the codes themselves) must make clear that the duty of candour applies not only to where harm is known to have been caused, but also where an error, omission or system failure *may* result in harm at a future point. For example, a baby deprived of oxygen for too long at childbirth or a system failure regarding diagnostic testing where the potential harm has not yet materialised. It would clearly not be acceptable to withhold this information from the parents/ patient in these circumstances. However the wording in the guidance and the codes refers to "harm or distress", "suffered harm", "harm caused" etc. It should be noted that the regulators' joint statement refers to: ***"when something that goes wrong with treatment or care causes, or has the potential to cause, harm or distress."*** (Our underlining). This is a much better form of words. This point needs to be made perfectly clear to health professionals, some of whom will be under the impression that the duty of candour only applies when harm has already resulted and there is a clear causal link.

3. **"Near Misses "**

The existing draft guidance refers elsewhere to "near misses" and describes them as *"adverse events which did not result in injury, illness, harm or damage, but had the potential to do so"* (paragraph 19). We have no problem with what the guidance says about near misses. This must be clearly distinguished from the kind of "potential harm" which may at some point still materialise, as described above.

We agree with the principle that where something has gone wrong in a patient's care but it has not resulted in harm patients should be told about these 'near misses' unless there is a credible reason for believing it is not in the patient's best interests to be told. We think that the guidance could be more clear and helpful about this. In other words the default position should be that the patient is told about a near miss unless the professional can justify withholding the information from the patient and a second opinion has been sought which concurs with that judgement. The decision should be recorded in the patients notes and an incident report should be made to the organisation's system. We think that there needs to be more clarity about what a 'near miss' means in this context , e.g. something actually having gone wrong that could have resulted in harm but didn't. This is different from something that could have gone wrong but didn't.

4. **Timing of disclosure discussion.** Paragraph 11 says "you must speak to patients as soon as possible after you realise that something has gone wrong". We think this probably needs to be qualified. The patient (or family member) may be too ill or distressed for it to be possible to have the discussion in a way that is in their interests or with which they can cope that soon. It is more important that the disclosure is done well and done sensitively than it is that

it is done as soon as possible. There should be some flexibility to delay the discussion, within reason, so as to take account of the patient's or family members' needs (provided that there is no danger that that discussion does not take place as soon as reasonable to do so, and that the details are recorded in the patients records so that there is no danger the information is lost or forgotten).

5. **Apologies.** The guidance (and associated training) could be more clear and helpful about the meaning and role of "apologies". The regulators are right to expect the professional to take some personal responsibility (when appropriate) for something that has gone wrong. There remains some confusion in some quarters between "apologies" and "expressions of regret/sympathy". Expressions of regret/sympathy are of course appropriate when something has gone wrong, but saying one is 'sorry' that something has happened is not the same as saying sorry for having had a part in allowing something to happen. Care must also be taken to avoid unintentionally promoting a formulaic approach to apologies. An apology only has value if it is genuine and heartfelt. It is not something that people can be required or forced to do, and an insincere apology can do more harm than good.

6. **Information about advice and support.** This will be a particularly difficult time for patients or family members. The guidance should say something about offering advice and information about available support and advice, including specialist independent advice and support from agencies such as AvMA. Please refer to what the '*Being Open'* guidance and the CQC guidance on Duty of Candour say about this. AvMA specialises in providing support and advice to patients / families following a medical accident and should specifically be brought to people's attention as part of the disclosure process.

7. **Speaking to patients' bereaved family/partner.** We have some concern about the wording of paragraph 17: *"taking into account what you know of the patient's wishes about what should happen after their death, including their views about sharing information".* This could be interpreted as meaning that a health professional could use their own discretion as to whether to disclose information if they believe the patient would not have wanted the information shared - even about something that had gone wrong in their treatment which may have caused their death. We question as to whether this can ever be justified.

   The guidance should include advice on giving patients / family members the option to exercise their right not to be told everything. In some circumstances a patient or relative may not want to know, and this information should not be forced upon them in a robot like way. It is perfectly possible to open a discussion with an invitation such as..."It is my professional duty to tell you that something went wrong in this treatment and I would like to explain more fully. Are you happy for me to do that?"

8. **Application to system flaws as well as human errors.** We hope it is just unfortunate wording in the draft, but paragraph 21 should be amended to make clear that the professional duty of candour applies just as much to incidents which involve what might be described as 'flaws in the system' or "system failures" in the care of the patient that have caused harm or may lead to harm – as it does to "errors". This needs to be spelt out as

some health professionals will have the impression the duty only applies when they themselves have made an error.

9. **Clarity of status of the Guidance and Codes.** The co-operation between GMC and NMC in producing this draft guidance and between all the regulators in producing the joint statement is laudable. However, there is a danger that health professionals will be confused. The joint statement says slightly different things to the codes and the guidance. All the professional codes should be refined so that they are consistent with each other, the joint statement, and the guidance. It should be clear that the joint GMC/NMC guidance has the same standing as the guidance produced individually by GMC and NMC. It should be made clear that not following the guidance is likely to result in fitness to practise action being taken.

10. **Support for Health Professionals.** Being involved in an incident in the treatment of a patient which causes or may cause harm is incredibly stressful for any health professional, as is having to explain to the patient or family member that something went wrong leading to actual or potential harm. We think that the guidance should say more about the need for health professionals to seek training in how to deal with such situations, and give information about sources of advice and support for the health professionals themselves who are caught up in such incidents. There could also be useful information added to the guidance on existing resources and guidance available such as the *"Being Open"* guidance and materials.

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