Response from the Royal College of Anaesthetists to the consultation on the draft guidance ‘Openness and honesty when things go wrong: the professional duty of candour’

Please note that this response includes the view of both lay and clinical members of the College

CONSULTATION QUESTIONS

Question 1: Is it helpful to have additional guidance on this issue?

Our lay committee members welcome the guidance and believe that this would be helpful to doctors and ensure a consistent approach in the way patients are treated.

Our clinical members agree that additional guidance would bring consistency in dealing with patients and would encourage all doctors to act appropriately in these situations. They have however some reservations; guidance on openness and duty of candour is already issued by the GMC in ‘Good Medical Practice’ for doctors, and it is not clear what exactly the proposed guidance will add in its proposed form, mainly because complications happen for different reasons, and every case is different and requiring a different approach; moreover some clinicians would have liked to see how the guidance can be applied to managers, who must also take responsibility and appropriate action, depending on the situation, when things go wrong.

Question 2: How easy is this guidance to understand?

Both lay and clinical members agree that the guidance is clearly written and easy to understand.

Our clinical members have commented that, the way the guidance is written, it implies an element of ‘fault’ (from clinicians/nurses) when things go wrong. Although it is good practice to apologise and explain when things go wrong, it may not always be appropriate to place the blame on someone or something, and our clinical members do not feel the guidance addresses this strongly enough.

Question 3: Do you think there is anything else that the guidance should cover?

Our clinical members have put forward the following for consideration as issues to be added to the guidance:

- Better clarity on who specifically within the clinical team should speak to the patient and offer an apology/explanation. It would be advisable for one agreed clinician to speak to the patient in order to avoid confusion and duplication, rather than several members of the team.
• Some guidance as to what the obligations of medical professionals and healthcare workers are if they observe colleagues not following this guidance.

• The guidance should address ‘no fault’ events and ways to deal with these particular cases, especially when communicating with patients what has gone wrong with their care.

**Question 4:** Is there anything you think could be removed from the guidance?

No.

**Question 5:** Do you have any ideas about how we could illustrate how the guidance works in practice (eg case studies or decision tools)?

All respondents agree that case studies would be helpful, in particular those who tell the story from the patient perspective, as this would help clinicians to see the problem from the side of the patient. Other useful case studies would be those which portray how clinicians and organisations have successfully changed systems following adverse incidents or near misses; this would be helpful in conveying to clinicians/organisations the importance of incident reporting and learning.

**Question 6:** Do you think there is anything else that doctors, nurses and midwives should consider when apologising to patients or those close to them?

Please see below:

• Our lay respondents suggest that patients and their families would appreciate some follow up on any lessons learnt and actions taken to prevent the incident from occurring again.

• Our clinical respondents feel that it might be hard to offer an apology in a setting which protects the privacy and dignity of the patient as the availability of private rooms in the NHS is very limited. The guidance should acknowledge that, although it would be ideal, it may not always be possible to have these conversations in a private area.

• Patients should be given advance notice of the conversation, so that they can make arrangements for family members, friends or other witnesses to be present.

• Clinicians should consider carefully the consequences of apologising; offering an apology is not necessarily an admission of malpractice or negligence, however there is real risk of litigation when an official apology is offered.
If a decision is reached not to offer an apology, then the reasons for doing so should be given in the conversation with the patient.

**Question 7:** To what extent do you agree that patients should always be told about near misses?

Both lay and clinical respondents agree with the guidance that it is not always in the best interest of the patient to be told about near misses, furthermore there is variation in patients’ wishes on this issue, with some wanting the full details and others not requiring any information at all. Clearly this will depend on the circumstances and various factors should be considered. It would be helpful for these decisions to be carefully made by senior clinicians in the team.

What is felt most important by our respondents is for near misses to be addressed internally at regular departmental meetings, such as mortality and morbidity meetings, to ensure that lessons are learnt from incidents and systems are put in place to protect patient safety. We welcome that this issue is addressed in paragraph 28 of the guidance and the medical Royal Colleges issue guidance improving quality and safety, via various initiatives, such as national audits and accreditation schemes.

Sadly, however, many of our clinical members have reported that it has become increasingly difficult to have effective incident reporting and mortality and morbidity meetings, due to time and financial pressures, requiring consultants to dedicate most of their working hours to direct clinical care.

**Question 8:** Do you have any other comments or suggestions about the draft guidance?

Overall our respondents feel that the guidance will be useful. Our clinical members are however concerned that the guidance will not be effective and widely adopted by healthcare workers unless the current culture of blame is replaced by one encouraging candour and open discussion, where doctors and nurses can be open about adverse events without fear of being singled out for punishment. The guidance addresses this issue in paragraphs 29 and 30 in general terms, but it would also be helpful for any new laws to include an element on the responsibility of organisations and senior managers to foster a culture of openness and candour and to offer real support to their staff when things go wrong.