

Duty of candour: encouraging a culture of openness and honesty

In a climate where there is a fear of blame and litigation associated with medical practice, this editorial discusses the current guidance within the UK on the duty of candour, both professional and statutory, highlighting cases where action has been taken.

What is the duty of candour?

Healthcare professionals must be open and honest with patients and those in their care when something goes wrong – this is known as the duty of candour. Doctors in the UK have a professional duty of candour, as outlined by the General Medical Council and Nursing and Midwifery Council (2022). As per the principles of medical ethics, this duty falls under medical beneficence (doing good), but it also respects patient autonomy in understanding what happened with their healthcare and how they wish to respond (Quick, 2022; Sokol, 2023).

Guidance

The World Health Organization (2023) estimates that adverse events are one of the ten leading causes of death and disability worldwide, and up to 80% of harm is preventable. With £83.4 billion ‘set aside’ for settling future liabilities, the UK government faces substantial public sector financial liabilities to manage medical negligence (Yau et al, 2020). The professional duty of candour was created in 1990, following the death of 10-year-old Robbie Powell from Addison’s disease, whose case involved forgery and dishonesty (Quick, 2022).

The updated guidance from the General Medical Council and Nursing and Midwifery Council (2022) stresses the importance of being open and honest with patients (as well as advocates, carers or family) when something goes wrong with their care or has the potential to cause harm or distress. In these circumstances, healthcare professionals must also apologise to the patient. Patients expect to be informed about what happened, its short-term and long-term effects, what can be done to deal with the harm caused and what will be done to prevent someone else from being harmed. Apologising does not imply legal liability for what has happened, according to the Compensation Act 2006, the General Medical Council and Nursing and Midwifery Council’s (2022) guidance and NHS Resolution (2023). The duty of candour also requires healthcare professionals to be open and honest with colleagues and employers, and to be involved in investigations and reviews where required.

A recent Medical Practitioners Tribunal Service (2023) tribunal decision caused controversy and concern across the medical community, when it suspended a doctor accused of not examining a patient, while the doctor claimed that she had. The General Medical Council’s representative suggested to the tribunal that an apology made by the doctor was evidence that she had not examined the patient. The doctor provided a statement explaining that the apology was for the distress caused to the patient, and not an acceptance of wrongdoing. While the tribunal accepted this and agreed it was not an admission of legal liability, the representative’s suggestion contradicted the General Medical Council’s guidance, which states that apologising does not mean an admission of legal liability. As a result, doctors across social media expressed concern about whether apologies should be offered at all (Sokol, 2023). Subsequently, the General Medical Council clarified with *Pulse* that this suggestion in the tribunal was wrong, and its representatives will be mindful of this for future cases (Parr, 2023). The General Medical Council and Nursing and Midwifery Council’s (2022) guidance on this matter remains unchanged.

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How to cite this article:

Naeem H, Demoulin EJ, Allen J, Andronic A, Howard A. Duty of candour: encouraging a culture of openness and honesty. *Br J Hosp Med*. 2023. <https://doi.org/10.12968/hmed.2023.0254>

In addition to a professional duty of candour, doctors and their organisations are bound by a statutory duty of candour. This arose following the Mid-Staffordshire enquiry and resultant Francis report which investigated high rates of mortality and claims of poor care within the Mid-Staffordshire NHS Foundation Trust. This report recommended the imposition of a statutory obligation to observe a duty of candour on healthcare providers, registered medical professionals, and directors of healthcare organisations, with an associated criminal offence, enforced by the Care Quality Commission. In November 2014, the statutory duty of candour was made enforceable by law in the updated Health and Social Care Act 2008. The process of the statutory duty of candour is similar to that outlined by the General Medical Council (Quick, 2022).

As a result of this legislation, the Care Quality Commission has the power to fine or prosecute NHS trusts that fail to be honest and forthcoming in their duty of candour to patients. They may serve requirements and warning notices, place conditions on or suspend or cancel registration, impose penalties, and prosecute cases.

Human factors

Errors rarely occur as a result of the actions of a single individual (Stein and Heiss, 2015). Being frank with patients and their families regarding these errors can be difficult because this involves confronting issues to do with reputation, fear of being blamed and risk of litigation (Quick, 2022).

Following the success of human factor training in improving safety in the aviation industry, the General Medical Council (2018) has advised that human factor training be included within undergraduate and postgraduate curricula. The goal of the training is to not only prevent mistakes from occurring, but to create a healthy environment which encourages learning from mistakes and performing the duty of candour.

Duty of candour in other countries

The traditional response following patient harm is defensiveness, which can erode trust in the professional relationship. In 2009, the Agency for Healthcare Research and Quality in the USA launched a \$23 million patient safety and medical liability grant initiative to expedite the implementation of communication and resolution programmes (Brenner et al, 2022). Hospital systems using such programmes found that they did not lead to higher liability costs, particularly when they commit to offering compensation proactively (Quick, 2022).

Having open disclosure is not only a vital part of health policy in some American states, but also in some English-speaking countries such as New Zealand, Australia and Canada. However, in some non-English speaking countries, such as Germany, open disclosure does not play a significant role in health policy. This was attributed to both a lack of a systemic approach to errors in hospitals, as well as a lack of recorded data on practice (McLennan et al, 2012). Legislation has since been introduced in the German Civil Code through the Patient's Rights Act 2013, which states that if circumstances arise in which there is presumed malpractice by the treating party, they are to inform the patient upon them making inquiries, or to avert health hazards (Palmer, 2013).

Following numerous scandals in a range of countries, there is generally a greater international stress on transparency, with countries such as Norway – where hospitals are publishing their adverse event rates and complaints publicly, among numerous other performance indicators – demonstrating accountability (Wiig et al, 2018).

Examples of actions taken

Following the Francis report in 2013, which identified a catalogue of preventable harms in an NHS Trust, the Care Quality Commission has acted against numerous trusts to enforce the statutory duty of candour. In 2018, the Care Quality Commission confirmed to the charity Action against Medical Accidents that it had taken 15 actions against NHS trusts for breaching the duty of candour, and 90 actions against primary and private care providers (Quick, 2022).

Key points

- Healthcare professionals must be open and honest with patients when something goes wrong – this is known as the duty of candour.
- The duty of candour has been re-enforced in the 2022 guidelines from the General Medical Council and Nursing and Midwifery Council.
- Despite recent controversy following a medical practitioner's tribunal in relation to an apology that was given, the General Medical Council's guidance remains unchanged.
- The duty of candour is an important part of patient safety and quality improvement in healthcare, and aligns with a rising global emphasis on transparency.
- The creation of professional and statutory duties of candour has formalised the requirement for healthcare workers and organisations to be honest with patients, advocates, carers or families when treatment has gone wrong.
- Breaches in these duties can result in serious consequences for both healthcare professionals and providers.

Notable actions include:

- In 2019, Bradford Teaching Hospital NHS Foundation Trust was fined £1250 for failing to apologise to the bereaved family of a baby within a reasonable period of time (Care Quality Commission, 2019a)
- Royal Cornwall Hospitals NHS Trust was fined £16 250 for 13 breaches of the duty of candour with regards to notifying patients or their families of facts as soon as reasonably possible (Care Quality Commission, 2019b)
- West Suffolk NHS Foundation Trust was fined £2500 for two breaches of duty of candour in relation to the death of a patient after complications during childbirth. This included failing to notify the family as soon as reasonably possible after the incident, and not providing them with an account of the incident or offering an apology in a timely manner (Care Quality Commission, 2021)
- In 2020, the Care Quality Commission prosecuted an NHS trust for the first time (Care Quality Commission, 2020). University Hospitals Plymouth NHS Trust was fined £1600 after they admitted failure to disclose details or apologise in relation to the death of a 91-year-old patient following an unsuccessful endoscopic procedure.

Conclusions

This article discussed the professional and statutory duty of candour, which requires health professionals to be honest and open with patients, employers and colleagues when something goes wrong or has the potential to cause harm. The authors presented the implications of the duties through case studies of actions taken by Care Quality Commission against health organisations and professionals.

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