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EDITORIAL

Duty of Candour Following Avoidable Harm

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Abstract

Duty of candour has emerged as the key expectation in health care at the ongoing judge-led statutory inquiries, including those conducted by Thirlwall and Lampard. Despite legal requirements in Health and Social Care legislation, backed up by the General Medical Council (GMC) and Nursing and Midwifery Council (NMC), both clinicians and National Health Service (NHS) managers have been reluctant to comply with this obligation. This article examines the pressures not to avoid transparency following avoidable harm, and suggests a more preventative approach through ongoing dialogue during care delivery including consulting on potential risks pre-treatment and providing feedback following interventions which have been less than successful.

Key words: duty of candour; avoidable harm; Thirlwall inquiry; Lampard inquiry; moral injury; reputational damage

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Introduction

The concept of duty of candour was initially outlined by Sir Francis (2013) following the mid-Staffordshire Inquiry. He defined it as "the volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made". Specific components include organisational openness on safety issues, transparency of clinical activity and a willingness to disclose relevant information to patients and their carers when untoward consequences occurred. Subsequently, in 2014, the Department of Health, via updates to the Health and Social Care Act of 2012, created a "must requirement" for National Health Service (NHS) organisations on adherence to duty of candour.

The main regulator of this duty was nominated to be the Care Quality Commission (CQC), alongside expectations of professional regulators, the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) via joint updated guidance of 2022 (GMC, 2015). Despite these legal regulations and oversight, there have been repeated failures to disclose relevant information and provide meaningful apologies to bereaved families. These shortcomings have prompted multiple judge-led public inquiries, including the most recent Thirlwall inquiry (2023) into neonatal care at the Duchess of Kent Hospital in Cheshire and the Lampard inquiry

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(2024) examining in-patient mental health care in Essex. Interestingly, a common issue pertinent to both inquiries is inadequate observation to prevent harm, which falls between clinical and corporate responsibility.

Reviewing recent CQC inspection reports, there seems to be three areas of concern undermining duty of candour in practice. Firstly, a number of leading NHS Trusts have been prioritising the need to avoid reputational damage to the organisation (Dunhill, 2023). Second, there appears to be rogue micro-cultures within NHS workplaces which have not been identified (or ignored) by line management (NHS Leadership Academy, 2024). Thirdly, individual doctors have been reluctant to come forward on errors in clinical practice due to long-held beliefs that this would increase the risk of personal litigation (Leung and Porter, 2019). This reluctance becomes even more rational when errors have been precipitated by organisational demands on productivity, for example, double booking in out-patient clinics and forcing early discharges despite inadequate community follow-up. Parenthetically, these productivity expectations are viewed positively by the CQC in terms of quality metrics leading to an "outstanding" grading.

Furthermore, with increasing shift work, locum staff, physician associates, and multi-consultant working, it is difficult to identify the most appropriate clinician to accept responsibility and contact patients and relatives. Individual doctors expressing concern about avoidable errors within their organisation can also be seen as whistleblowing, which can incur career repercussions as suggested in annual NHS staff surveys (NHS England, 2024). Furthermore, there is limited specific training of medical students and trainee doctors on discussing news of errors with patients and families (Swinfen et al, 2023).

Mitigation of Avoidable Harm

In an attempt to mitigate human error and avoidable harm, NHS England has recently introduced the Patient Safety Incident Report Framework (PSIRF). This has four components: (1) compassionate engagement of staff affected by patient safety incidents (PSIs), (2) application of a range of system-based approaches to learn from such incidents, (3) considered (and proportionate) response to PSIs, and (4) supportive oversight focused on strengthening system functioning and improvement. PSIRF heralds a "no blame" culture for staff, but it remains to be seen if traumatised patients and bereaved families will find this committee-based procedure capable in providing prompt explanations on errors in clinical practice. Specifically, there could be a hiatus in contacting families whilst continuing investigations are in place (called "safe space").

The Health and Safety Executive (HSE) appears to be receptive to investigate incidents harmful to NHS staff (for example, assaults on junior medical staff and healthcare assistants), including willingness to carry out prompt unannounced visits. There seems to be an overlap between the HSE and CQC in this regard, as the CQC is also moving from prioritising quality to safety (mainly focusing on patients). The latest iteration of CQC inspections called the 'Single Assessment Framework' (SAF) will allow routine gathering of hard metrics (such as all-cause

mortality) per department or general practitioner (GP) practice to detect trends and to benchmark against similar local providers. Routine data gathering will facilitate machine learning to detect signals of potentially unsafe practices, generate alarms, and trigger inspections.

As for individual doctors, those aware of an error are expected to disseminate the details via the Incident Report Form, which would be picked up by managers thereby activating the PSIRF process. There is no evidence that a prompt explanation, apology and application of learning regards errors increases the risk of complaints or litigation.

Therefore, NHS employers (in theory) should encourage a prompt discussion of errors with the affected patient or family as part of PSIRF. However, employers appear to be fearful about staff directly discussing errors with patients and family members, as this could leave the organisation itself open to future litigation (Wolf and Hughes, 2008). This concern is particularly pertinent given that litigation costs for the NHS currently amount to around £2.7 billion annually.

A specific issue exists for psychiatrists (and for doctors dealing with fitness to drive or sexually transmitted diseases) when a patient declines permission to contact relatives or close others. If there is an issue involving physical safety to members of the public, a process called multi-agency public protection arrangements (MAPPA) can be utilized, which involves communicating and mitigating potential risks to family, police, probation and housing agencies. Nevertheless, there is a potential conflict between the person's right to privacy and the duty of candour on the safety of others, consistent with MAPPA process being underused (Criminal Justice Directorates, 2022).

Cutting the Gordian Knot

Irrespective of the various views of providers and commissioners, patients and their families appear to expect transparency on clinical errors (Hobgood et al, 2002). There is sufficient legislation on this matter, no doubt to be backed up by the 2 ongoing public inquiries when they report. Arguably action on this issue could also reduce the cost of litigation faced by the NHS and Treasury.

It is perhaps sensible to decouple corporate responsibility and governance from clinical responsibility. On corporate governance, it is likely that there will be a "top-down" strategy, led by governmental dictat and further amendments to legislation. For example, the Irish authorities intend to publish "Serious Reportable Incidents" (including deaths and "near misses") per hospital or community site (HSE, 2023). It is possible that NHS England will follow suit as an extension to PSIRF. This as conflicting interests limits health providers from actively applying the corporate duty of candour in practice. A proactive approach might well attract a good rating from the CQC. Continuing education and training of staff is essential to catch up from the hiatus of training during the Covid restrictions.

On clinical responsibilities and expectations on medical staff, perhaps there should be a "bottom-up" approach. Ideally, this could start as early as the medical school admission process, integrating these principles into the University Clini-

cal Aptitude Test (UCAT). Furthermore, training modules involving "breaking bad news" both in undergraduate and postgraduate training should include developing competencies in discussing medical errors with patients and relatives, tested via the Objective Structured Clinical Examination (OSCE) framework.

On breaking news of an error, perhaps it should be the responsibility of the senior staff member of a team (typically a consultant) who should take a lead in speaking to the affected person jointly with a member of management. However, with a small number of patients with complex presentations, multiple consultants are involved, making communication of error (including acceptance of overall responsibility) contentious. Nevertheless, training of medical staff of all grades should include discussion with patients and relatives on incidents of error especially during Foundation and Specialist training. This approach fosters a culture of personal honesty and reinforces the understanding that errors are an inevitable part of medical practice. Indeed, it could be that "moral injury" experienced by many clinicians could be alleviated by self-forgiveness via disclosure (Brémault-Phillips et al, 2022), which has implications when multiple consultants are involved in a patient's care.

On prevention, clear, non-jargon explanations of the benefits and risks of a specific procedure can be helpful in avoiding subsequent misunderstandings and false expectations held by patients and their families. Recent case law, such as the Montgomery Judgement (Ward et al, 2020), emphasizes the importance of providing patient-specific information, which can be seen as a form of precision medicine. Similarly, anticipated risks in ward settings (increased risk of falls and fractures, infections/sepsis, medication errors, loss of personal belongings, harm to the patient from others, suicidality) need to be discussed with family at the onset of a ward admission.

Conclusion

Overall, in developing an open culture among healthcare providers, there needs to be managerial and clinical participation and unanimity of purpose on practical application involving the duty of candour, through policies and mandatory training of all staff in order to prevent the breakdown of relationships between these parties as demonstrated during the Thirlwall inquiry and subsequent investigations across the UK.

Rather than having a clinician set a threshold on discussing news of harm, perhaps what is required is a regular dialogue with patients about what has gone well, what could have been done better, and whether there has been any sub-optimal care. This proactive approach shifts the focus away from only addressing issues when something goes seriously wrong. This will take the duty of candour to a higher level. Clearly this will incur additional costs in terms of time and resources, although potentially creating savings on litigation costs.

Key Points

- Duty of candour following avoidable harm is currently in statute (Health and Social Care Act 2012), alongside GMC and NMC guidance on Professional Practice.
- Restriction to disclosure includes fear of litigation, reputational damage for corporate bodies and rogue micro-cultures.
- Current attempts to mitigate risks and learn from avoidable errors do not provide prompt answers for patients and their families.
- It is possible that clinician and managerial moral injury could be partly alleviated by prompt transparent disclosure of errors.

Availability of Data and Materials

Not applicable.

Author Contributions

PNdS was the sole author and was responsible for the design of the work, drafting and revision of content, and approval of the version to be published. PNdS has participated sufficiently in the work and agreed to be accountable for all aspects of the work.

Ethics Approval and Consent to Participate

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Conflict of Interest

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References

Brémault-Phillips S, Cherwick T, Smith-MacDonald LA, Huh J, Vermetten E. Forgiveness: A Key Component of Healing From Moral Injury? Frontiers in Psychiatry. 2022; 13: 906945. https://doi.org/10.3389/fpsyt.2022.906945

Criminal Justice Directorates. Twenty years on, is MAPPA achieving its objectives? A joint thematic inspection of multi-agency public protection arrangements. 2022. Available at: https://www.justiceinspectorates.gov.uk/hmiprobation/wp-content/uploads/sites/5/2022/07/A-joint-

thematic-inspection-of-Multi-Agency-Public-Protection-Arrangements.pdf (Accessed: 1 December 2024).

Dunhill L. Trust leadership censured for 'negative impact' of focus on 'reputational management'. Health Services Journal. 2023. Available at: https://www.hsj.co.uk/the-christie-nhs-foundation-trust/trust-leadership-censured-for-negative-impact-of-focus-on-reputation-management/7034787.article (Accessed: 1 December 2024).

Francis R. Report of Mid Staffordshire NHS Trust Public Inquiry. The Stationary Office: London. 2013.

GMC. Openness and Honesty When Things Go Wrong: The Professional Duty of Candour. 2015. Available at: https://www.gmc-uk.org/professional-standards/the-professional-standards/candour---openness-and-honesty-when-things-go-wrong (Accessed: 1 December 2024).

Hobgood C, Peck CR, Gilbert B, Chappell K, Zou B. Medical errors-what and when: what do patients want to know? Academic Emergency Medicine. 2002; 9: 1156–1161. https://doi.org/10.1197/aemj.9.11.1156

HSE. Patient Safety (Notifiable Incidents and open disclosure). 2023. Available at: https://www2.healthservice.hse.ie/organisation/qps-incident-management/open-disclosure/patient-safety-notifiable-incidents-and-open-disclosure-act-2023/ (Accessed: 1 December 2024).

Lampard inquiry. 2024. Available at: https://lampardinquiry.org.uk (Accessed: 1 December 2024).

Leung GKK, Porter G. Safety of candour: how protected are apologies in open disclosure? BMJ (Clinical Research Ed.). 2019; 365: l4047. https://doi.org/10.1136/bmj.l4047

NHS England. NHS Staff Survey Results. 2024. Available at: https://www.nhsstaffsurveys.com/results/ (Accessed: 1 December 2024).

NHS Leadership Academy. Subcultures and micro cultures. NHS Leadership Academy Learning Hub. 2024. Available at: https://learninghub.leadershipacademy.nhs.uk/guides/culture/steps/subcultures-and-microcultures/ (Accessed: 1 December 2024).

Swinfen D, Labuschagne M, Joubert G. Disclosing medical errors: how do we prepare our students? BMC Medical Education. 2023; 23: 191. https://doi.org/10.1186/s12909-023-04125-3

Thirlwall inquiry. Department of Health and Social Care. 2023. Available at: https://thirlwall.public-inquiry.uk/documents/ (Accessed: 1 December 2024).

Ward J, Kalsi D, Chandrashekar A, Fulford B, Lee R, Herring J, et al. Shared decision making and consent post-Montgomery, UK Supreme Court judgement supporting best practice. Patient Education and Counseling. 2020; 103: 2609–2612. https://doi.org/10.1016/j.pec.2020.05.017

Wolf ZR, Hughes RG. Chapter 35: Error Reporting and Disclosure. In Hughes RG (ed.) Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Agency for Healthcare Research and Quality (US): Rockville (MD). 2008.