Openness and honesty when things go wrong: the professional duty of candour (GMC guideline)

Hannah Jacob,1 Joseph Raine2

INFORMATION ABOUT CURRENT GUIDELINE
In June 2015, the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) jointly published the guidance Openness and honesty when things go wrong: the professional duty of candour.1 This guidance was developed in response to the Francis report about the Mid Staffordshire NHS Foundation Trust.2 It elaborates on the joint statement from eight regulators of healthcare professionals in the UK about the professional responsibility of all healthcare professionals to be honest with patients when things go wrong.3

The guidance builds on the principles set out by the GMC in Good Medical Practice and by the NMC in The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives.4 5 It is guidance for individuals meaning that even if you are not the person reporting adverse incidents and speaking to patients if things go wrong, you must make sure that someone in the team has taken responsibility for this and support them as needed.

This guidance applies to all doctors registered with the GMC across the UK. In addition, there is now a statutory duty of candour, meaning a legal obligation, for NHS organisations within England as well as independent health and social care providers. This follows the Health and Social Care Act, which came into force in November 2014. Different laws apply in other parts of the UK.

WHEN DOES THE DUTY OF CANDOUR APPLY?
The Francis report is explicit that any patient harmed by the provision of a healthcare service is informed of the fact and offered an appropriate remedy, regardless of whether a complaint has been made or a question asked about it. The statutory duty of candour applies when a patient has been subjected to moderate harm or worse, as a result of an error. Cases where an error has led to severe harm or death are usually clear cut. The definition of moderate harm requires a degree of professional judgement but according to the Care Quality Commission it includes harm that results in a longer hospital admission, an unplanned return to surgery or an unplanned readmission.6 Moderate harm is harm that is significant but not permanent.

The following is an example of severe harm in which the duty of candour applies. A 15-month-old presented to clinic with a limp and was found to have developmental dysplasia of the hip. The child’s mother had developmental dysplasia of the hip and though the child’s newborn examination was normal, the positive family history and the hospital’s protocol meant that a hip ultrasound should have been performed. This was not arranged, the diagnosis was delayed and the child required surgery (box 1).

KEY ISSUES ADDRESSED IN THIS GUIDELINE
▸ Patients should be given clear, accurate information about any proposed treatment or care. This includes the risks of the proposed treatment and the risks of any alternative options.
▸ Patients should be told what has happened as soon as someone realises something has gone wrong with their care. It is not necessary to wait for the outcome of any investigations.
▸ Healthcare professionals should offer a personalised apology (‘I am sorry…’). This does not mean that you are admitting legal liability for what has happened or that you are taking personal responsibility for

CrossMark

something that was not your fault (see box 2). Indeed, a GMC fitness to practise panel may view an apology as evidence of insight.

▸ Professional judgement should be used when considering whether to tell patients about a near miss (an adverse incident that had the potential to result in harm but did not do so). Any uncertainty about whether or not to tell a patient about a near miss should be discussed with a senior colleague.

▸ Early reporting when something has gone wrong with patient care is important to ensure that lessons can be learnt quickly and that further harm is prevented. This includes reporting adverse drug reactions and adverse incidents involving medical devices as well as patient safety incidents (see table 1). Many such reporting systems include questions about the duty of candour to ensure that these obligations have been fulfilled and some provide letter templates to facilitate writing to patients and families.

**WHAT DO I NEED TO KNOW?**

*What should I stop doing?*

▸ Assuming someone else will talk to a patient and family when something has gone wrong.

▸ Discouraging colleagues from raising concerns about patient safety.

▸ Waiting until an investigation has been carried out to tell patients and their families about an error.

*What should I start doing?*

▸ Ensure that when you realise something has gone wrong and after doing what you can to put matters right, that you or someone from the healthcare team speaks to the patient and family as soon as possible. This should be documented in the medical notes and followed up with a letter to the patient and their family which includes a written apology.

▸ Share with the patient all you know and believe to be true about what went wrong, why and what the likely consequences are, both short and long term.

▸ Give the patient the opportunity to indicate if they do not want to be given every detail and make it clear to them that they can change their mind and have more information at any time.

**Table 1** Examples of reporting systems and schemes in the UK

<table>
<thead>
<tr>
<th>Reporting system/scheme</th>
<th>Uses</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Reporting and Learning System</td>
<td>Adverse and patient safety incidents in England and Wales—all organisations upload their incidents to this system</td>
</tr>
<tr>
<td>Yellow Card System (run by the Medicines and Healthcare products Regulatory Agency (MHRA) and the Commission on Human Medicines)</td>
<td>Suspected adverse drug reactions in the UK</td>
</tr>
<tr>
<td>MHRA</td>
<td>Adverse incidents involving medical devices in the UK</td>
</tr>
<tr>
<td>Healthcare Improvement Scotland</td>
<td>Adverse incident management across the NHS in Scotland</td>
</tr>
<tr>
<td>Datix incident reporting system</td>
<td>Used by around 75% of NHS hospital trusts to report adverse incidents and near misses</td>
</tr>
<tr>
<td>National Patient Safety Alerting System (run by NHS England)</td>
<td>Cascading important safety alerts to healthcare providers to avoid harm in England</td>
</tr>
</tbody>
</table>
Discuss adverse incidents, near misses and complaints at Jacob H, Raine J. Apologise when something has gone wrong. This should be a personalised apology rather than a general expression of regret on the organisation’s behalf (see box 2). The guidance on the duty of candour from the GMC identifies the professional standard against which a doctor would be judged in any fitness to practise hearing. Ensure you record the details of any apology in the patient’s medical notes.

What can I continue to do as before?

- Apologise when something has gone wrong. This should be a personalised apology rather than a general expression of regret on the organisation’s behalf (see box 2). The guidance on the duty of candour from the GMC identifies the professional standard against which a doctor would be judged in any fitness to practise hearing.
- Ensure you record the details of any apology in the patient’s medical notes.

Box 4 Summary of key points

- All healthcare professionals have a duty to tell patients when something has gone wrong with their treatment or care.
- It is important to offer a personalised apology, offer an appropriate plan for putting matters right (if possible) and explain the short-term and long-term effects of what has happened.
- Healthcare professionals must support each other in being open and honest and not stop someone from reporting concerns.
- Healthcare professionals must contribute to reporting systems and schemes locally and nationally for reporting adverse incidents and near misses.
- Respond honestly to patients’ questions and explain anything that is uncertain.
- Tell patients about risks that occur often, those that are serious and those that the patient is likely to think are important when outlining treatment options.
- Talk to families if something has gone wrong that has caused a patient’s death or moderate or severe harm. (There may be some very rare exceptions to this. For example, in the case of a Fraser competent teenager in whom there have been complications following a termination of pregnancy).
- Report errors and adverse incidents through the reporting system in your organisation as well as to national schemes where appropriate (see table 1). This should be done as soon as possible and certainly within 7 days.
- Participate in reviews and audits of the standards and performance of any team you work in and take steps to resolve any problems.
- Raise your concerns about patient safety initially within your organisation where possible. This may be with your manager, the consultant in charge of the team or the medical director. For doctors in training, it may be appropriate to raise concerns with the Deanery in Northern Ireland, Wales and Scotland or your Local Education and Training Board (LETB) in England.
- Raise concerns if your organisation does not support staff to report adverse incidents or does not have a system in place to do so (box 4).

Acknowledgements Thank you to Liz Bennett for her comments and guidance.

Contributors HJ drafted the initial manuscript. JR provided expert opinion on the initial draft. Both authors have approved the final version.

Funding HJ is an Academic Clinical Fellow funded by the National Institute for Health Research.

Competing interests None declared.

Provenance and peer review Commissioned; externally peer reviewed.

REFERENCES