Duty of candour

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Candour is the quality of being open and honest in your dealings with other people. It embraces similar qualities such as frankness, truthfulness, sincerity, directness, straightforwardness and the avoidance of deception and covert behaviour.

Transparency is another word used to capture the values embodied in candidness/candour, meaning that nothing is hidden from view.

Background

The Francis Report following the Mid-Staffs tragedy may have been the trigger for action, but this was hardly the only scandal in health and social care where patients had suffered avoidable harm and lack of care. The shameful saga of events at the Winterbourne View care home, and cases such as “Baby P”, had created a heated and impatient climate in which the government wanted to be seen to have taken radical action. Against this background, the government of the day sensed the public exasperation at the appearance that lessons were not being learned, and its response was to introducing further legislation, although many expressed the view that legislation was not necessary because so much existed already, and it was also a clumsy and usually ineffective way to achieve a change in organisational culture – which was clearly at the heart of what was required.

Because individual healthcare professionals already had professional conduct rules to follow, as set by their professional regulator, the Government felt that there were three significant areas of weakness that needed to be addressed

- The need for organisational accountability, especially in bodies that were owned and managed by people who were not registered health professionals and therefore sat outside the existing professional regulatory environment (GMC/GDC/NMC etc)
- The fact that these organisations employed many people who were not (and who were not required to be) registered with the relevant regulator. A way needed to be found to make somebody responsible and accountable for their acts and omissions other than through the civil courts.
- The government wished to be seen to respond to the public desire that “heads should roll” in terms of criminal accountability for some of the things that had been turned a blind eye to at mid-Staffs and Winterbourne View

The duty of candour

This could be seen as having three separate but related elements, not all of which apply to the same people or bodies. These elements are :-
• A statutory (legal) duty
• A professional (ethical) duty
• A contractual duty

By way of a simple overview, the table below summarises how these three elements impact upon different types of individual and/or organisation.

<table>
<thead>
<tr>
<th></th>
<th>Statutory (Legal) Duty</th>
<th>Professional (Ethical) Duty</th>
<th>Contractual Duty</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Organisations</td>
<td>Yes since November 27thr 2014</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Registered Providers – (CQC) Medical and Dental Practices and Care Homes</td>
<td>Yes since April 1st 2015</td>
<td>Yes if registrant Otherwise No</td>
<td>Generally no - but may also have NHS contract to this effect</td>
</tr>
<tr>
<td>NHS Providers (Contract holders)</td>
<td>Only if CQC registered provider</td>
<td>Yes if registrant Otherwise No</td>
<td>Yes</td>
</tr>
<tr>
<td>Registrants</td>
<td>No</td>
<td>Yes</td>
<td>Possibly</td>
</tr>
<tr>
<td>Other Individuals</td>
<td>No</td>
<td>No</td>
<td>Probably not</td>
</tr>
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A professional (ethical) duty of candour has long existed for all kinds of healthcare professionals, and this embraced additional members of the dental health team when dental nurses and others became registered with the GDC a decade ago. The ethical requirement is embodied in the professional guidance issued by the various healthcare regulators, and although they use different words and phrases to describe it, and the words also change over time, they amount to more or less the same thing.

Many of the paragraphs contained within the GDC’s Guidance *Standards for the Dental Team* deal with aspects of this honesty, openness and necessary trust between patients and the dental health professionals with whom they interact. For example,

**YOU MUST**

1.2.3 Treat patients with kindness and compassion.

1.3.1 Justify the trust that patients, the public and your colleagues place in you by always acting honestly and fairly in your dealings with them.

1.7.1 Always put your patients’ interests before any financial, personal or other gain. 2.3 Give patients the information they need, in a way they can understand, so that they can make informed decisions.

2.2.3 Give full and honest answers to any questions patients have about their options or treatment.
2.3.4 You should satisfy yourself that patients have understood the information you have given them, for example by asking questions and summarising the main points of your discussion.

2.3.5 You should make sure that patients have enough information and enough time to ask questions and make a decision.

**YOU MUST**

4.1 Make and keep contemporaneous, complete and accurate patient records.

4.4 Ensure that patients can have access to their records.

4.1.4 Ensure that all documentation that records your work, including patient records, is clear, legible, accurate, and can be readily understood by others. You must also record the name or initials of the treating clinician.

This seems at first sight to be pretty all embracing and one wonders what “strengthening” of the existing guidance would be needed. Any apparent breaches of these and other paragraphs are enforced through the Fitness to Practise procedures. Nevertheless, the CEO/Registrar of the GDC greeted the new legal duty of candour with strong words of endorsement:

“Openness and honesty is vital to ensuring a successful relationship between dental professionals and their patients. GDC guidance already very clearly sets out what’s expected of dental professionals, but we will be working to strengthen this through new guidance.”

A Joint statement from the Chief Executives of statutory regulators of healthcare professionals has been issued in support of the introduction of the statutory duty of candour and can be found on the GDC’s website [www.gdc-uk.org](http://www.gdc-uk.org)

**The statutory duty**

The legal duty, which was introduced by the government through regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, already applied to NHS organisations such as trusts and foundation trusts as from November 27th 2014. But with effect from 1 April 2015 they have also applied to bodies including GP practices, dental practices and care homes.

Under the terms of this new statutory duty, a CQC provider - in the case of dentistry this is usually the practice owner(s) - need to make sure that the practice acts in an open and transparent way:

- With relevant people
- In relation to care and treatment provided
- To service users
- In performing a ‘regulated activity’ as defined by the Care Quality Commission

The Regulations impose what is described as a **general duty of candour** and the hope is that it will change organisational culture. Regulation 20 is one of seven standards defined within these new regulations that carry risk of a criminal prosecution with no prior notice being required to be given by CQC. Any conviction would carry a modest fine but also an automatic referral to the GDC as well as the associated adverse media attention.
After becoming aware that a **notifiable safety incident** (*see below) has occurred, you must:

1. Notify the relevant person(s) as soon as is reasonably practicable (this would vary according to the specific circumstances although CQC guidance refers to the ten days required by the NHS standard contract in the context of complaints responses). For many situations 10 days would seem long.

2. Provide reasonable support, such as providing an interpreter for any discussions, or giving emotional support to the patient or allowing other people to be present to support them when you are explaining what has happened.

Your notification must:

- Be given in person by at least one representative of the practice involved, and then followed by a written notification
- Provide a true and accurate account of the incident
- Provide advice on what further enquiries into the incident are required
- Include an apology
- Be recorded in a written record, which should be kept securely.

**What is a notifiable safety incident?**

Regulation 20 states that there are two meanings of a notifiable safety incident; one for a health service body, the other for “registered persons” – which would include dental practitioners who are practice owners and the registered provider of regulated services for CQC purposes.

According to the regulation: “In relation to a registered person who is not a health service body, **notifiable safety incident** means any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional –

1. **appears to have resulted in** –
   a. the death of the service user, where the death relates directly to the incident rather than to the natural course of the service user’s illness or underlying condition,
   b. an impairment of the sensory, motor or intellectual functions of the service user which has lasted, or is likely to last, for a continuous period of at least 28 days,
   c. changes to the structure of the service user’s body,
   d. the service user experiencing prolonged pain or prolonged psychological harm, or
   e. the shortening of the life expectancy of the service user; or

2. **requires treatment by a health care professional** in order to prevent –
   i. the death of the service user, or
   ii. any injury to the service user which, if left untreated, would lead to one or more of the outcomes mentioned in sub-paragraph (a).
Definitions

A number of terms have been specifically defined for the purpose of these regulations.

“Harm”, is defined as meaning either or both of the following:

Prolonged psychological harm - which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days. and/or

Prolonged pain – which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days.

Moderate harm means harm that requires a moderate increase in treatment such as

- an unplanned return to surgery
- an unplanned re-admission
- a prolonged episode of care
- extra time in hospital or as an outpatient
- cancelling of treatment
- transfer to another treatment area (such as intensive care)

and significant (but not permanent) harm.

Severe harm means a permanent lessening of the bodily, sensory, motor, physiologic or intellectual functions, including the removal of the wrong limb or organ or brain damage.

The Statutory Duty of Candour

A general duty to act in an open and transparent manner

Once you become aware of a

Notifiable safety incident

You must

- Notify the relevant person (s) as soon as reasonably practicable
- Provide reasonable support to the relevant person (s)

Delivered in person by one or more representatives of the practice

Confirmed in writing including all of the elements below

Full, truthful and accurate account

Explain what further enquiries are needed

Provide an apology

All of the above confirmed in written record and securely retained
Facts and popular myths about disclosure

Amongst the popular myths about whether or not one should apologise or admit to having made an error (such as taking out the wrong tooth) are views such as the following:-

- Defence organisations always tell you never to apologise because this could be construed as an admission of guilt, fault or liability.
- If you have made a mistake, do not refer to it in the clinical records because patients can get access to them and realise what has happened. If you have to refer the patient to a colleague, make sure they understand the need to keep quiet.
- Never describe adverse treatment outcomes in a way that patients might react badly to. Endo files don’t break or fracture – they suffer “separation” and “partial de-integration”. Roots don’t break off and get left behind - root “fragments” and “tips” are “retained”, no matter how big they are.
- Defence organisations say that you should never admit responsibility when something has gone wrong, and especially never in writing because you can’t deny it afterwards.
- If you admit to a patient that you have done something wrong, it is almost certain that they will want compensation and/or sue you or complain about you. You should always deny liability, no matter what has happened – any defence organisation will tell you that. It is far better to make no comment at all.

The reality is very different. For example, the advice below has been given to Dental Protection members continuously and consistently since 1999 (on our website and in our Annual Review which goes to all members internationally)

Explanation

Dental Protection advocates a policy of open disclosure and honest communication with patients. When complications and errors do arise, you should be prepared to give your patients objective factual information about what has happened, in a caring and supportive fashion. Members are encouraged to explain any clinical issues in terms that the patient is likely to understand. Where appropriate, reassurance should be given to any patient who is concerned about an adverse treatment outcome.

Patients have a right to be informed of any matters which relate to their oral health, or to treatment provided for them; you should try not to withhold objective factual information or an expression of regret or sympathy where appropriate. Saying that you are sorry that an incident has occurred, or expressing your regret that a patient is upset or unhappy, is not necessarily an admission of guilt, fault or liability.

It may not be appropriate, however, to speculate or to cast blame unless and until all relevant facts are carefully established by proper and thorough inquiry. An inappropriate remark could prejudice your own interests and/or those of other practitioners.

If it is self evident that the wrong tooth has been treated, or the wrong tooth extracted, it is perverse to suggest that an apology offered at the time and an acceptance of the error by the clinician could be construed as anything other than a good thing. On other occasions a clinician may have extracted a tooth as indicated by a referring dentist, but always wondering why the tooth was being extracted at all. Here there is clearly an element of vulnerability on the part of both clinicians and the error may not be immediately apparent on the day of the extraction. But as soon as it comes to light, the statutory duty is triggered for the owner of one or both practices.
Food for thought

There is an abundance of evidence that people sue primarily because they are angry or feel let down. The risks of complaints and litigation initiated by patients and family members are strongly influenced by:

- whether or not they like you
- whether or not they think you like them
- whether or not they think you care (enough) about them and / or are (sufficiently) interested in them
- whether or not they trust you and believe that you have their best interests at heart
- how important / special / valued you make them feel

Many of the elements that make people angry are not related to the adverse event directly, but things like:

- Information being withheld from them by people they had respected and trusted
- No one telling them what happened – and what is going to happen.
- No one acknowledging their distress and apologising – the magic “Sorry” word.
- No one telling them what has been learned from what happened to them, so that the same things is less likely to happen to somebody else.

Professor Lucian Leape, of Harvard School of Public Health and previously Professor of Surgery and Chief of Pediatric Surgery at Tufts University School of Medicine is an acknowledged leader in the field of patient safety and the management of medical error comments “Pretending that nothing happened, or telling about it in incomplete ways, is lying. Apologise when you make a mistake and accept the consequences. If we did it more, they would be fewer”

In 2001 the Committee on Quality of Health Care in America published a report To Err Is Human - Building a Safer Health System edited by Linda Kohn, Janet Corrigan, and Molla Donaldson. It remains a standard text 14 years down the track.

Speed is of the essence!

Look what happens after an adverse event:

Effect of delay in disclosure
• Anger:
  A person harmed by negative behaviour attributes the behaviour to causes under the control of
  the other, and becomes angry. This anger may persist or even worsen unless and until they receive
  an acknowledgement and explanation, an apology and the ability to achieve some kind of ‘closure’
  on the event (Aaron Lazare describes these four elements in his book “On Apology” – see references)

• Distancing:
  The person who has caused the injury seeks to attribute his or her own behaviour to circumstances
  outside their control, that is, distances themself from responsibility. The drivers for this range from
denial and sadness through to embarrassment and wounded pride.

It is important that a patient is told quickly that something has gone wrong, with no attempt to deceive
them or keep relevant facts from them. You want them to hear about it first from you, rather than from
someone else, and for them to be in no doubt that you genuinely care for them and for their well - being
and are concerned for them and want to help them through the event. Similarly, when something has
gone wrong from the patient’s point of view, it is important to see the patient quickly to discuss their
concerns. This may be why patients react so angrily when they find out about a buried root or a
fractured and retained endodontic instrument from a subsequent treating clinician. There is then the
compounding effect of the adverse outcome and the feeling of not being told, or possibly even lied to.

Don’t just do something, stands there!
Having said that time is of the essence, you still should take the time needed to prepare yourself for the
conversation. It’s often said that there are always TWO direct victims to an adverse event - the patient
and the dental professional. So you need to give yourself time to settle yourself, gather such information
as is immediately available and think about what you are going to say, how you are going to say it, where
you’re going to say it, who you are going to say it to (especially if the patient is not in a state to receive
the information) and who you think should be with you when you’re saying it. In terms of any reparation
that might be appropriate (it isn’t in all cases), you may need to obtain authority from a practice owner
or perhaps your indemnifier before you make financial or other commitments. There’s always time to
contact your defence/protection organisation for advice and reassurance, and it is preferable to know
where you stand on this aspect of the future management of the event, before you sit down to have the
necessary conversation with the patient. Where this is not possible for any reason, you should make it
clear to the patient that you intend to make enquiries of the relevant people, and you will inform the
patient of the outcome at the earliest opportunity. Once you make such a commitment, it is important
to stick to it.

What to say.
The conversation could start: “I can appreciate how distressing this is for you. This is not the outcome
that either of us hoped for or expected. I’m terribly sorry this happened to you.”

The next sentence should be to ask, “What’s your understanding so far about what happened?” This
enables you to find out what the patient knows or may have been told already. If what they have been
told is wrong, you can gently correct it. (“I can understand why s/he thought that, but since then we’ve
confirmed that…” But if you don’t ask that question, they may be confused – and angry – that different
people are telling them different stories.

It’s important that the information you provide is factual. Don’t assume or guess. If you don’t know
what happened or how it came to happen, just say so, and then tell the patient that you will find out,
and as soon as you know you’ll let them know.
Don’t try to assign - or accept - ‘blame’.

Neither self-flagellation nor blaming someone else is going to help. Very early on, the patient is not interested in ‘fault’; they want to know what happened and what’s going to happen. Choice of words is very important.

Choice of words is important

- Use words that convey empathy.
- Use lay language.
  When we are distressed we tend to retreat into the impersonal and academic language of our science/profession. An anxious or angry patient will be made even more anxious or angry if they can’t understand you. AVOID JARGON – It is a barrier to good and effective communication.
- Don’t use diminishing language.
  Try to avoid saying things like, “There seems to have been a bit of a problem”. That sounds like you’re trying to back away and make the problem seem less significant than it really is.
- Beware of “red flag” words and phrases.
  “But” means “I’m about to disagree with you”. (As in “I hear what you’re saying, but...”). Just leave out the word, “but” and start a new sentence. “Why” questions mean “justify yourself”. How, What, When and Where questions are simply fact-seeking questions. The worst phrase of all to use is “You’ll just have to...” No one likes being dictated to, and when they’re angry, that’s adding fuel to the flames.

Keep close contact with the patient until they have fully recovered.

Try to keep in contact with the patient through their recovery. Obviously this is not possible if the patient does not wish you to contact them. It is sometimes difficult to get the balance right, however a patient may perceive a lack of contact and follow up as uncaring, thus compounding their anger.

Contact should be caring and sympathetic. Be careful to show genuine concern without conveying a feeling of panic. The focus should be on reassuring the patient and showing that you (really) care and are concerned for their well-being.

Learn from the event.

There is a very natural tendency to want to sweep unfortunate outcomes under the carpet. It takes courage, but active commitment to look for the causes and to learn from any adverse event adds to your knowledge and to the standard of care in your practice. Also, learning from an adverse event helps you achieve closure, so you can move on. It can also provide positive reassurance to a patient that something good has come out of their case which helps the patient to achieve closure too.

We are all human. We all make mistakes. It takes detached judgment to determine, objectively, whether what happened was avoidable or unavoidable, and if it was avoidable to learn from the event and minimise the chance of it happening again. This is one of the benefits of discussing an adverse event with a colleague at your defence/protection organisation or elsewhere, who can take a supportive and objective, independent role in helping you learn from the event.
Take away thoughts

- Most patients want and expect honesty and respect, not perfection
- Wrong is wrong even if everyone is doing it. But right is right even if nobody is doing it.
- Treat patients as you would want other health professionals to treat you and members of your family
- Ninety-seven per cent of families that are hurt by medical errors and know who was responsible for the injury don’t sue. There is a wealth of evidence to support the premise that patients tend not to sue or complain about health professionals that they like, and who show respect, compassion and care for them. So the very thing that most people worry most about in terms of candour and open disclosure, is itself founded on a myth (see section immediately following).

It’s all about the people stuff

Linda Sue Mangels, a researcher in San Diego, found a strong correlation between communication deficiencies and adverse perceptions on the part of patients. She went on to highlight the much higher expectations on the part of individuals receiving healthcare (as opposed to other forms of professional service) in terms of the ethics and professionalism of the healthcare provider. When entrusting one’s body to another person, the stakes are high and the interaction is very personal and profound for the recipient.

In a study of 200 US Physicians who had never been sued she identified a number of common characteristics of these clinicians and their practices:-

- The practice atmosphere was warm and friendly
- Everyone worked at developing strong patient relationships
- Patient expectations were kept realistic
- Patients were actively involved in all treatment decisions
- Openness and honesty about mistakes / adverse outcomes
- Awareness of high risk procedures and patients
- Financial arrangements were clear and consistently applied

So not a single one of 200 medical GPs who were open and honest with their patients about every adverse event, had ever been sued. And this was (mostly) physicians based in California, the most litigious State in the USA. But look at the other features of those practices, and how every aspect of the patient relationship is built upon respect and trust. That is the key.

Another useful insight comes from the work of Bunting and others, who found that many complaints are triggered not just by the actual event(s) that tipped the patient over the edge into complaining (the “precipitating factors”) – like a mistake or an adverse clinical outcome of some kind - but also because other things had either already happened (the “predisposing factors”) to create doubts and concerns, or which added fuel to the flames after the adverse event. These factors predisposed the patient to consider a complaint or litigation rather than letting to matter drop.
These predisposing factors included poor communication, a perceived lack of interest, rudeness or a lack of respect – in short, “people” stuff. In isolation, neither predisposing factors nor precipitating factors are generally sufficient to make a patient complain – Bunting’s message is that it is the combination of the two that motivates the patient to take things further.

Good communication creates a better and stronger relationship between patient and clinician. Other dental team members can enhance (or detract from) this relationship, or help to compensate for less-than-ideal communication skills on the part of the clinician.

Bunting’s work also provides an invaluable lesson for young or inexperienced clinicians – you cannot possibly be perfect in every aspect of your clinical dentistry at an early stage in your career. Instead of working in a permanent state of worry and fear about being sued or complained about, work on your communication skills and at building stronger and better relationships with your patients, built upon care, respect and trust. This is your very best protection for those moments when things don’t go to plan.

Further information

The Care Quality Commission, Regulation 20: Duty of candour. Issues for all providers: NHS bodies, adult social care, primary medical and dental care, and independent healthcare (March 2015)

www.cqc.org.uk/content/regulation-20

Further reading and key references


Mangels Linda S. Tips from doctors who’ve never been sued. Med Econ. 1991; 68 (4):56-8, 60-64.


Leape, Lucian L Error in Medicine JAMA. 1994;272(23):1851-1857