Transparency and courageous leadership: how to improve patient safety

In light of the recently implemented statutory duty of candour, **Dr Mohsin Choudry**, the RCP's national medical director's clinical fellow and **Dr Kevin Stewart**, clinical director of the RCP's Clinical Effectiveness and Evaluation Unit, assess the legal and professional duty of clinicians and how to improve patient safety. They report on the RCP's recent patient safety seminar, which provided perspectives from doctors, patients and managers, and consider why clinicians have nothing to fear from embracing disclosure and transparency.

A defining moment in recent medical history was the publication of the United States Institute of Medicine's 1999 report *To err is human* which estimated that 44,000–98,000 people died from medical error in hospitals in the United Stated per annum. This report launched the modern patient safety movement, however 16 years later little has changed. International studies estimate that around 10% of hospital patients still suffer some sort of adverse event. A medical adverse event is widely defined as an unintentional or untoward outcome, resulting in actual or potential physical or psychological harm following medical intervention, treatment or drug administration.

The need for change

Efforts to reduce harm from adverse events have had disappointing results and rates of reporting of adverse events by clinicians especially have remained low. In the wake of the Francis Inquiry into the events at the Mid Staffordshire Foundation Trust, attention has focussed on the need for increased transparency when adverse events have occurred, both to promote learning to reduce future risks and to ensure that the duty to inform patients and their families after an adverse event is fulfilled.

The NHS in England is now subject to a legal duty of candour that obliges organisations to inform patients and their families if adverse events have occurred, and which reinforces the ethical duty that clinicians already hold.

RCP patient safety seminar

The Patient Safety Committee at the RCP hosted its first patient safety seminar in June 2015, to attempt to understand some of the barriers to increased transparency. We welcomed three leading voices on patient safety, each giving their experiences of adverse events, the challenges to transparency, the pitfalls that they have personally encountered and the systemic learning that has subsequently emerged.

We heard about the personal and professional challenges faced by a consultant surgeon who talked, on the condition of anonymity, of his experiences of dealing with the aftermath of the death of a young patient due to a complex clinical situation. Attempts to engage with the family were unsuccessful, and made worse by a referral to the General Medical Council (GMC). It was clear from hearing him speak that given the opportunity to be candid is just as important to a clinician as to a patient. He described a further experience during another difficult case, which led to adverse comments by an external clinical 'expert' and some highly personalised attacks in the media. Although colleagues were supportive, no formal mentoring or support programme existed in his trust and he had not received any formal training on disclosure or candour. Our speaker detailed the highly stressful emotional, professional and psychological impact of these events which are recognised as the 'second victim' phenomenon and represent a real barrier to increased transparency. His personal and candid account reinforced what we already know from the literature about the 'second victim' phenomenon: the psychological effects of involvement in serious incidents on clinicians can mean that they pose a risk to patients in the immediate aftermath of an event, and can damage safety culture by suppressing transparency or promoting defensive practice in the longer term. Unfair or unbalanced treatment by investigators, regulators and the media, all of which had been experienced by our speaker, exacerbate the situation and damage transparency. This has created a culture in the medical profession, to quote Dr Lucian Leape, professor at Harvard School of Public Health, in which 'the single greatest impediment to error prevention … is that we punish people for making mistakes.'

From a patient representative perspective we heard from Peter Walsh, chief executive of Action Against Medical Accidents (AvMA), a charity supporting patients and families who have suffered adverse events and who usually had experienced unsatisfactory dealings with the NHS or clinicians. AvMA campaigned heavily for the government to introduce a legal duty of candour for the NHS in England, something which many clinicians might think unnecessary, threatening or even counterproductive. Peter shared some tragic stories of patients whose families had spent many years trying to get adequate responses from trusts following adverse events, sometimes not even being able to get accounts of what had actually happened. The stories seemed to contain a mixture of descriptions of inefficient complaints handling systems and deliberate attempts to prevent the truth emerging, in order to preserve the trusts' reputations. Many of the accounts mirrored evidence that had been heard at the Francis Inquiry. AvMA argued that a legal duty of candour was the only thing that would make senior leaders and managers in NHS trusts take their obligations to be transparent seriously and would reduce, not increase, the risk of legal proceedings. Peter was also strongly supportive of training for clinicians in the communication skills necessary to fulfil the duty of candour.

Blair Sadler, former CEO for 26 years at the

Rady Children's Hospital in San Diego and a senior fellow at the Institute for Healthcare Improvement, spoke about his experiences of leading an organisation through several high-profile situations where harm had occurred to a significant number of patients and many others were put at risk. There were obvious parallels with the events at Mid Staffordshire, although his organisation's response was very different. In the United States, where the risk of legal proceedings is much higher than in the UK, the prevailing atmosphere has been to suppress transparency, as clinicians are told that disclosing too much to patients and families will put them and their organisations at risk of litigation, although the evidence is that increased transparency actually reduces litigation risk. Blair spoke of the value of leaders of organisations responding quickly and transparently when it became clear that serious events had occurred, even when the full facts were not yet known.

He described three 'victims' in any healthcare crisis who should be treated in the following order of importance: patients and their families, the staff suffering from post-event stress and finally the organisation, whose reputation could be seriously damaged. Blair gave the example of a mystery virus in the children's intensive care unit and the subsequent deaths of several patients. Without having much information he called in patients' families and the media so he could explain what was known so far and what he and his board were going to do to investigate the matter further. Blair set the precedent of personally speaking with every family member involved confidentially and of personally being available to support staff. The public response to this was compassion and empathy rather than adversarial, and the reputation of the organisation was enhanced as a result.

England's duty of candour

Introduced in November 2014 as a statutory duty for all primary, secondary, social and private care providers, the duty of candour is intended to ensure that healthcare providers are open and honest with patients when things go wrong with patient care. This gives patients the legal right to be informed of an error or an adverse event, which has caused them at least 'moderate' harm, defined by the National Patient Safety Agency as 'significant but not permanent harm'. The law imposes this duty on the organisation (not the individual) although in most instances it will be clinicians who communicate with patients and families on behalf of their organisations.

Patients should be informed promptly and openly of significant harm, regardless of whether the information has been requested or a complaint made.

Professional duty and the mechanics of the duty of candour

A professional duty of candour for clinicians has been in place for many years and has been enforced by both the GMC's Good Medical Practice, and the joint GMC and Nursing and Midwifery Council guidance entitled '*Openness and honesty when things go wrong: the professional duty of candour*'. According to the Medical Defence Union, 99% of doctors are aware of their ethical obligations to patients to provide an apology, 90% have apologised to a patient involved in an incident with 78% stating no repercussions when they had told patients about an incident. There is potential for confusion among doctors, managers and patients about when and how each duty applies as the statutory duty is different to the professional one.

Whilst the statutory duty of candour is ultimately the responsibility of an organisation, doctors, in particular those in more senior roles, are relied on to discharge it on behalf of the organisation. Seniors are in a position to ensure the appropriate actions and investigations are carried out to prevent further harm. There are a number of guidelines in place to advise clinicians on the duty of candour:

- It is important to spend time considering the appropriate response and logistics of the situation. For example, who should be present while the discussions with the patient takes place.
- Consider who will lead the investigation, and which managers need to be informed.
- When there is uncertainty, this should not be an excuse for no disclosure. Clinicians should not wait until the outcome of an investigation before apologising.
- An apology is not an admission of liability.
- Timing and location should be considered and appropriate.
- Offer all patients support, be it emotional or formal psychological support, with a single point of contact.

Questions remain about exactly how much information to share with patients, when a disclosure may cause more harm and when an omission may be misleading due to a real time lack of evidence. With time and more open discussions, we physicians may feel that these questions have firm answers, but the current ambiguity should not prevent us from being candid with our patients.

Conclusions

The insights gained from the patient safety seminar are numerous. We heard from three champions of candour and transparency, each with their own unique experience but striving towards a common goal. There are clearly still significant barriers to increased transparency in many parts of the NHS which will impede progress, despite legal and professional duties of candour. Clinicians will be reluctant to act in a transparent way if a 'blame culture' is allowed to persist, and if they do not feel that they will be treated fairly in any investigation by their organisations or by regulators. There are lessons here not just for trust management, but for the GMC, the Care Quality Commission and others. Courageous, transparent leadership as described by Blair Sadler is difficult to find in many parts of our system. We believe now that the law has been made clear, it will create the momentum for healthcare professionals to exhibit such leadership, as providers' compliance with the law will create a culture of candour, openness and honesty at all levels.

'Second victim' effects in clinicians need to be recognised as a barrier to transparency and processes put in place to mitigate these and to support affected clinicians. On a more practical level the complexity of the communication processes need to be recognised and we have to ensure that there is adequate training for clinicians in the necessary communication skills.

The overriding message from our seminar was that although being transparent is difficult, it is also the right thing to do and, as professionals, we have an obligation to exhibit leadership to colleagues in the interests of improved patient safety. We would encourage all our colleagues to take a lead in ensuring we are candid with our patients at every opportunity in order to firmly root this into our everyday practice rather than see it as 'compliance'. As Don Berwick, President Emeritus and Senior Fellow at the Institute For Healthcare Improvement, recently said: 'A rule-bound organisation cannot be truly safe. [Safety] requires things more important than rules: things like maturity, curiosity, dialogue, daylight, reflection, teamwork, hope and trust. It's a tougher job for leaders than simply writing and enforcing rules. The difference is, it works'. ■