MDU submission to the IHRD Duty of Candour Workstream

The Medical Defence Union is a mutual membership organisation owned by our members who are around 50% of the UK's doctors in primary and secondary care, and about 30% of dentists. In return for payment of an annual subscription, members receive access to medico-legal services that include advice and assistance (including legal representation) with criminal procedures arising from their clinical practice. When something goes wrong, the MDU's experience is that an early and sincere apology and explanation can restore a patient's confidence and rebuild trust in the professional relationship. This is something we advocated from as early as 1955.

Given the introduction of a statutory duty of candour at an organisational level in England and Scotland, a similar approach in Northern Ireland would be reasonable and its effect relatively easy to anticipate. However, the Report of the Inquiry into Hyponatraemia related Deaths[1] ("the Inquiry") in its recommendation on candour goes significantly further than the statutory duties that exist elsewhere in UK by proposing that:

a. The statutory duty of candour applies to *individuals* as well as organisations; and

b. *Criminal liability* should attach to a breach of the statutory duty of candour, or where another person is obstructed in their performance of the duty.

It is notable that there is no evidence on the Department of Health website[2] or elsewhere that gives weight to the assertion that an individual duty of candour or the introduction of criminal sanctions are either necessary or likely to improve compliance (or patient safety) generally. For many years, doctors, dentists and other healthcare professionals have had a professional duty of candour that is set out in guidance from their regulator.

Healthcare professionals have an ethical obligation to be candid with patients when things go wrong and cause them harm or distress that includes providing an apology. A failure to comply with a regulator's guidance or code of practice risks action under their fitness to practise procedures, which could result in suspension or erasure from the register. This is a very significant sanction, the risk of which is well understood by healthcare professionals throughout UK. The GMC in its submission[3] makes clear that they can, and do, take action where it is found that a doctor has failed to discharge their ethical duty of candour; furthermore, their submission is supported by evidence in the form of data they have provided relating to cases investigated.

Professional duties of candour are far wider than legal duties as professional duties typically have a low threshold of harm that triggers a need to take action, which means that patients are told about things that go wrong, even if they are low harm, in the normal course of professional-patient interaction. This is in contrast to statutory duties elsewhere in UK where the threshold tends to be high and often complex to understand. Therefore, an additional statutory duty imposed on individuals will add nothing to what they will already have done apart from unnecessary duplication.

[1] http://www.ihrdni.org/inquiry-report.htm
[2] https://www.health-ni.gov.uk/articles/ihrd-get-involved-duty-candour
[3] https://www.health-ni.gov.uk/publications/ihrd-duty-candour-and-being-open-call-evidence-submissions

Unlike individuals, organisations had not been subject to a statutory duty of candour in UK until its introduction in England. Therefore, the organisational duty could reasonably be seen as something additional, and complementary, to the ethical duty of candour that individuals were required to comply with. The organisation duty consequently provides an *additional* layer of reassurance that patients are told in a timely way when things went wrong and cause them harm.

Criminal sanctions attaching to the statutory duty of candour

Candour is about explaining to patients what went wrong, putting things right where possible and apologising. The effectiveness of a national policy of candour in a healthcare setting will largely depend on the organisational cultures in which it is rooted. A just culture, whilst retaining accountability on the part of individuals, expressly recognises that an incident must be looked at not through the narrow prism of blame, but through a broader appreciation and acknowledgement of systemic factors. A just and learning culture promotes openness and reporting of incidents, a point acknowledged by the then Secretary of State for Health in England in a speech[4] at the Global Safety Summit in 2016. The importance of the right culture was emphasised in his report on healthcare in Northern Ireland by Sir Liam Donaldson[5], *The right time, the right place* (2014):

> "*These cultural barriers to reporting and learning are not unique to Northern Ireland. Creating a culture where the normative behaviour is learning, not judgment, is very much the responsibility of political leaders, policy-makers, managers and senior clinicians. This does not mean that no-one is ever accountable when something goes wrong but it does mean that a proper regard should be given to the overwhelming evidence that a climate of fear and retribution will cause deaths not prevent them*."

Creating a criminal offence related to the notification of certain patient safety incidents could, paradoxically lead to fewer reports, not more. We have not seen any published evidence that the introduction of criminal sanctions into healthcare practice has improved outcomes in the UK or elsewhere. But there is evidence that the opposite occurs. In his rapid policy review on *Gross negligence manslaughter in healthcare*[6] (June 2018), Sir Norman Williams noted that where an investigation seeks to blame an individual:

> "*For the healthcare professionals a sense of fear pervades and patient safety is jeopardised as they become cautious about being open and transparent, impeding the opportunity for lessons to be learnt*."

Similar sentiments were expressed in Leslie Hamilton's *Independent review of gross negligence manslaughter and culpable homicide*[7] (June 2019) who, in looking at the causes of harm, noted that blaming individuals "is unlikely to encourage candour when things go wrong". Hamilton also quoted

[4] https://www.gov.uk/government/speeches/from-a-blame-culture-to-a-learning-culture
[5] https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/donaldsonreport270115_0.pdf
[6] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/717946/Williams_Report.pdf
[7] https://www.gmc-uk.org/-/media/documents/independent-review-of-gross-negligence-manslaughter-and-culpable-homicide---final-report_pd-78716610.pdf

Sir Ian Kennedy QC, who referred to the chilling effect of prosecuting gross negligence manslaughter:

> "...*medical manslaughter means that you can pick someone, blame them, and imagine that you've solved the problem. And what you have actually done is exacerbated it*."

Although the two reports referred to above were primarily concerned with gross negligence manslaughter, the general points made about the chilling and paradoxical effect of criminal sanctions on doctors and other healthcare professionals are relevant to the current proposals.

Rather than seeking to introduce a criminal sanction attached to a statutory duty of candour we suggest that the Department of Health's focus is on working to encourage a just and learning culture that promotes and allows candour to flourish.

Response on behalf of the MDU provided by Dr Michael Devlin, head of professional standards and liaison, Medical Defence Union

Contact: michael.devlin@themdu.com