Telling patients the truth: health professional regulators' role in embedding candour

THE UNIVERSITY *of* EDINBURGH
Edinburgh Law School

professional standards authority

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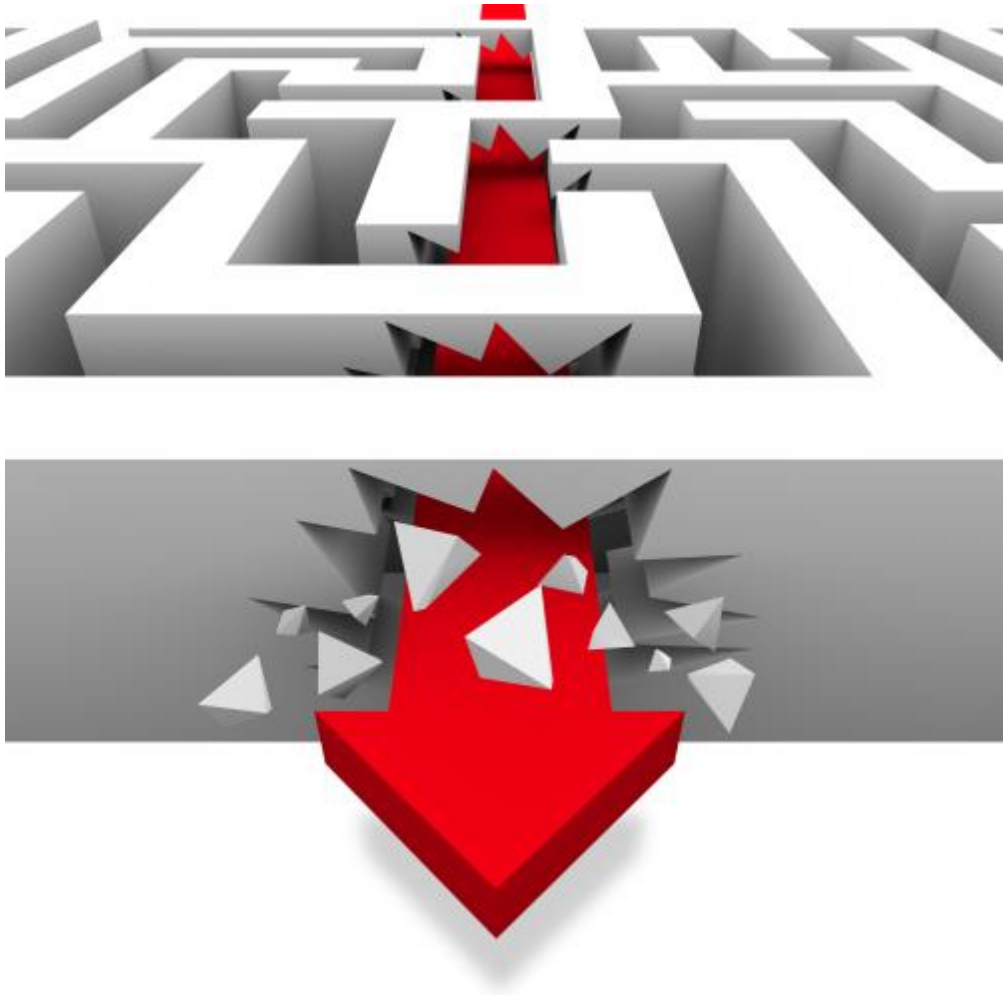
Jennifer Roberts, whose nine-year-old daughter Claire died of hyponatraemia in October 1996, was comforted by her son Gareth following the publication of the findings of the hyponatraemia inquiry.

The Irish News

‘In language not normally associated with such inquires, the judge spoke of his frustration with health professionals who had to have "the truth dragged from them" during hearings held in Banbridge’.

1 March 2019

Why is it so hard?



Defining candour

Healthcare professionals must:

- tell the patient (or, where appropriate, the patient's advocate, carer or family) when something has gone wrong;
- apologise to the patient (or, where appropriate, the patient's advocate, carer or family);
- offer an appropriate remedy or support to put matters right (if possible); and
- explain fully to the patient (or, where appropriate, the patient's advocate, carer or family) the short and long term effects of what has happened.

Candour: a recent timeline

2013	Francis report published PSA advice to Sec of state: literature review and advice paper
2014	Statutory duty of candour comes into force in England Joint statement by regulators PSA report on progress of regulators
2015	Joint guidance by GMC and NMC specifically on candour
2016	GCC and GDC produce candour specific guidance
2017	GOC produce candour specific guidance
2018	Statutory duty of candour comes into force in Scotland Hyponatraemia Inquiry published in Northern Ireland
2019	*Telling patients the Truth*

Case Study 1 – Dr B

- Wrong site surgery.
- Failed to tell patient.
- Performed second successful operation without explaining to patient or colleagues why.
- Patient brought complaint against hospital.
- Patient's medical advisor found out from medical record.
- Doctor lied to patient, lied to colleagues, lied to hospital.
- Doctor said 'I acted in patient's best interests.'

Future research agenda: short term

- Collaboration between University of Edinburgh, Professional Standards Authority and Royal College of Surgeons of Edinburgh

Aim:

- To build on findings of 2019 Report in specific context of surgery
- To further develop research agenda

Future research agenda: working RQs

In the specific context of surgery:

- To what extent is the professional duty of candour embedded currently in the surgical setting?
- How, if at all, do the five factors that can encourage / discourage candour, as identified in the 2019 Report, impact on patient safety in surgery?
- What role(s) might organisations across healthcare (including regulators) have in successfully embedding candour going forward?

Research design: Literature review; focus groups; dissemination

Future research agenda: longer term

- How do patients and wider publics experience the duty of candour?
- What lessons can be learned across contexts?
- What lessons can be learned across jurisdictions?
- How can these findings be operationalised to further embed candour?

Questions