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Clinicians' perspectives on the duty of candour: Implications for medical ethics education

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Abstract

Content: Truth-telling is an integral part of medical practice in many parts of the world. However, recent public inquiries, including the Francis Inquiry reveal that a duty of candour in practise, is at times compromised. Consequently, the duty of candour became a statutory requirement in England. This study aimed to explore clinicians' perspectives of the implications of the legislation for medical ethics education, as raising standards to improve patient safety remains an international concern.

Methods: One-to-one interviews with clinical educators from various specialties who contribute to the MBChB programme at the authors' university. Once data saturation had been assessed, transcripts were analysed using a thematic approach by the following concurrent activities: data reduction and coding into themes. Example quotations are used to illustrate that key themes are grounded in the data.

Results: Eleven clinical educators were interviewed; 3 general practitioners, 6 physicians and 2 surgeons. Thematic analysis identified three key themes; reaction to legislation, barriers to implementation and areas of the medical curriculum that can be further developed to better prepare future doctors.

Conclusions: Currently, the legislation is not reaching all frontline staff; there remains a lack of appropriate training and teaching on the legislation that responds to the perceived challenges to implementing candour. These challenges include tensions in the clinical workplace and concerns about the patient's best interests conflicting with requirements of the legislation. Both undergraduate and postgraduate curricula need to integrate teaching on the implications of the legislation and take a practice based approach in doing so.

George Fowler 5/4/2017 11:13
Deleted: in light of this legislation,

Keywords

Duty of candour, truth-telling, medical ethics education, interview study

Introduction

Historically being truthful has been an integral part of medical practice in many parts of the world.[1-5] It is underpinned by respect for patient autonomy, and encouraging the facilitation of a shared decision making process. However, truth-telling raises several ethical issues in medicine. It can be complicated by a medical professionals' concurrent duty to do no harm and a duty to tell the truth.[6] Depending on the circumstances these duties can be in conflict about what is in the patient's best interests, especially when moral considerations include truth-telling, patient autonomy and preventing undue psychological stress.[7]

However, there have been instances, such as the Francis Inquiry report into the failings of the Mid Staffordshire NHS Foundation that concluded a duty of candour did not always exist in the clinical workplace.[8] This inquiry identified a number of concerns on how the workplace culture can be a barrier to honesty and transparency during patient interactions.[8] Other inquiries which came to similar conclusions include the Bruce Keogh,[9] Don Berwick[10] and Morecambe Bay Reports.[11] In the report, it was therefore recommended that a statutory obligation should be imposed on healthcare providers and medical professionals to observe the duty of candour (recommendation 181)[8], so there could be consistency in clinical practice about how honesty is implemented in the coalface.[8]

A statutory duty of candour came into force in 2014 in England (Recommendation 20(1)).[a] In other parts of the UK there has been variations in timing and approach to introducing a statutory duty of candour. For example, in Scotland the duty of candour provisions in the Health (Tobacco, Nicotine etc. and care) (Scotland) Bill were given Royal Assent in 2016,[b] with a target implementation date in 2018. The legislation in England initially applied to the hospitals. However, with the amendment to the legislation in 2015, the statutory duty of candour now falls on registered medical professionals,[a] who now have both a moral and legal obligation to disclose to the patient when medical errors are made; although, the patient can decline to have

[a] Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (SI 2014/2936), as amended 2015 (SI 2015/64), Regulations 20-22
[b] Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016.

these conversations. This applies to an “unintended or unexpected incident”; or one that “could result in” psychological harm, or moderate or severe harm to the patient, including “prolonged pain” for at least 28 continuous days, or the death of the patient.[a] The legislation defines ‘moderate harm’ as being significant, but not permanent, such as when a patient returns to surgery, or has an unplanned re-admission.[a] These conversations with the patient should happen as soon as reasonably practicable, be documented and an apology must also be offered and documented, although this does not equate to an admission of guilt.[a]

Behind the driver to legalising a duty of candour in England is the recognition that acceptable standards in patient safety is reliant on a reporting system, which must operate within an open and honest culture.[12] A virtuous cycle has been described where an open culture can lead to more reporting, improved services, enhanced safety and this consequently encourages further reporting.[12] However, known barriers to raising concerns need to be addressed, including the fear of repercussions and frustrations with the current reporting system.[13] The literature suggests that patients want to know the truth, contrary to the belief of some medical professionals who believe that truth may increase uncertainty and distress, hence causing harm.[14] This will need to be communicated with appropriate training and teaching of the duty of candour legislation, but this is currently not happening for all medical professionals, including the nursing profession.[15]

A PubMed search on the duty of candour legislation revealed 18 publications since its introduction, yet none of these appear to be grounded in evidence from stakeholders (for example, doctors, patients and trainee doctors). A gap remains in the literature to address the implications of this new legislation retrospectively, especially for developing medical ethics and law education. The aim of this study was to interview clinical educators’ for their perspectives of the duty of candour legislation in the clinical workplace and its implications for medical ethics education.

Methods

We decided on the one-to-one interview method as it allows in-depth exploration of views. Furthermore it offers the advantages of protecting the confidentiality of the participant and allows them to speak freely. Ethics approval was granted from the Sheffield Medical School University Research Ethics Committee (SMBRER007084).

Recruitment

This study interviewed clinical educators from various specialties who contribute to the MBChB programme. The clinical educators could be working anywhere in the South Yorkshire region which consists of 8 hospitals and one Academic Unit of Primary Medical Care. We invited primary and secondary care doctors with at least one years' experience in medical education to ensure interviewees had appropriate experience of medical education (all interviewees were contributing to teaching at the medical school). Participants were then recruited through direct mailings, which included an invitation letter providing details about the study. If participants were in agreement to being interviewed, then the interviewer discussed the study and obtained written consent.

Interviews

Interviews took place between January and May in 2016, at a mutually agreed place with the first author. Questions were asked to address the study's aims and included the following:

(1) What implications if any does the legislation have in the work place?
(2) What challenges does it bring?
(3) How can we prepare future doctors better in light of this new legislation?

Probing and clarifying questions were asked as necessitated and the interviews lasted between 15-30 minutes. The study information sheet gave a brief description of the duty of candour legislation: that the regulation aims to ensure that medical professionals are honest and transparent in the workplace.

Data collection and analysis

Interviews were recorded digitally and transcribed verbatim with DNS Speech Recognition Software. Data collection included participant's gender, clinical speciality and seniority role. Data collection and analysis occurred concurrently, such that data saturation could be assessed. Saturation was when no new themes were being identified and there was only repetition of previously collected themes in the subsequent interivews.[16] When data saturation was indicated, a further two interviews were pursued to confirm that data saturation had indeed been reached and these interviews were also included in the data analysis.

Transcripts were read several times until both authors had familiarised themselves with the text. Transcripts were analysed using a thematic approach by the following concurrent activities: data reduction, coding into themes and highlighting quotations from the data that corresponded to coded themes. Example quotations have been used to illustrate that key themes are grounded in the data.

Results

Eleven interviews took place with clinical educators who contribute to the MBChB programme, 3 of whom were male. Specialities included 3 general practitioners, 6 physicians and 2 surgeons, who all work across South Yorkshire. Data saturation was reached after 9 interviews, and a further 2 interviews confirmed this.

Thematic analysis identified three key themes. Many of the themes included a number of subthemes, as illustrated in Table 1. The themes are described and quotes from the transcriptions are used as evidence to illustrate that the themes are grounded in data.

Table 1. Themes and sub-themes from the data

Interview questions	Themes	Sub-themes
What implications if any does the legislation have in the workplace?	Reaction to duty of candour legislation	1. Varied awareness of legislation 2. Perceived need for legislation

What challenges does it bring?	Barriers to implementation	1. Workplace factors *a. Time issues* *b. Hierarchy in the medical profession* *c. Workplace culture*
		2. Nature of medical practice *a. Uncertainty of medicine* *b. Professional judgement vs patient's best interests*
How can we prepare future doctors better in light of this new legislation?	Medical curriculum	1. Contextualised learning 2. Role models 3. Reflection

Clinical educators' reaction to legislation

The interviewees' reaction to the legislation encompassed two subthemes: awareness and perceived need. While most clinicians were aware of the legislation, two clinicians indicated that the legislation is not reaching all frontline staff:

> I am not aware of dissemination within the trust (DC01a).
>
> To be completely candid I was unaware of the legalisation of our moral duty of candour until you invited me for this interview (DC05).

There were also mixed perceptions regarding whether the legislation was needed. Some felt the legislation was needed to standardised practice:

> The policy [legislation] was needed because clearly not all professionals were adhering to that moral obligation (DC07a).
>
> I think it forces people's hand, you have to do it in 10 days (DC03).

While others felt that the legislation was unnecessary:

> The same motivations that keep me candid with my patients and keep colleagues candid with their patients before legislation, are motivating us still after the legislation (DC09a).
>
> Changing a moral obligation to be honest and open with the patients, into a contractual obligation to be open and honest with patients was actually unimportant, because most doctors work on the moral plane rather than on the contractual plane (DC09b).

Barriers to implementing the legislation

Two subthemes emerged as barriers to implementing the legislation, (1) workplace factors and (2) the nature of medical practice. Workplace factors included workload issues (DC06) and hierarchy (DC08a) in the medical profession:

> How can you be expected to make good decisions when you are being so overwhelmed with work, but when you are at the Coroner's Court, context I don't think is taken that much into account (DC06).
>
> One of the big barriers is hierarchy within the medical profession […]. If you're quite junior, then that position to question more senior judgement I think is very difficult and I think that the way that people get the next job means that the power dynamic is quite skewed (DC08a).

Interviewee responses indicated that variability in the workplace culture facilitated or hindered the duty of candour legislation:

> If you take your complications, or your mistakes to a mortality and morbidity meeting it can feel a little like a witch-hunt […], because the atmosphere has been such that you feel very criticised (DC04).
>
> So you can have a culture what the mid-staffs talked a lot about, where juniors are constantly questioning senior judgement, but it is to learn. […] But if you don't have a culture to question in order to learn, then the question just becomes difficult (DC08b).

These responses indicate that in some work cultures there is a lack of openness that impedes questioning, whereas in others, there is recognition that questioning can facilitate learning and support.

There were also barriers to implementing the legislation in the workplace relating to the nature of medical practice. These included dealing with uncertainty, and clinicians wishing to use their own professional judgement to serve in the patient's best interests:

> Clearly there are some instances in which something has clearly gone wrong […], but not all of medicine is still black and white. You get a difference of opinion on whether something should've happened or not (DC07b).
>
> There is an obligation to be honest, but in terms of openness there are reasons why one might want not to be completely open, although honest. […] Although it is discredited for doctors to withhold information, in order to spare people's feelings, sometimes actually that is still the best policy (DC09c).

Preparing future doctors for the workplace

The key theme for preparing future doctors in light of this new legislation revolved around changes in the medical curriculum. The interviews revealed two key aspects in the medical curriculum that need attention for educating future doctors. Firstly, the legislation needs to be contextualised. Secondly, future doctors need to see the legislation being implemented while immersed in practice. This is illustrated under the sub-theme 'contextualised learning':

> The other bit again for preparing where the student or future doctor sees somebody not doing the duty of candour, again I think that is something we could maybe do by role-playing, or workshops, or with potential actors, or patients as educators about how would you do that, because that is a very difficult thing to do (DC10).

Opportunities to observe and work with role models and reflecting on experiences relevant to the legislation were perceived to be effective ways in which to embed the legislation into medical education:

> Role models need to be there. People will want to be honest, but when medical students go into clinical practice, they need to see when doctors are honest with human mistakes and that they are being dealt with properly and appropriately (DC01b).
>
> It is giving them the tools to reflect on why they are not being more open and transparent, but also giving them the tools to cope with consultations that are [...] inherently more difficult (DC02).

Discussion

This study explored clinical educators' perspectives of the implications of the duty of candour legislation for medical ethics education. The data indicates that the legislation is not reaching all frontline staff (DC01a; DC05). The data also indicates that there are complexities inherent to the nature of medical practice that may influence how the legislation is interpreted (DC06; DC07b); which may have implications for both quality of service and experience. This also has implications for how the legislation is taught to future doctors.

Even though ours is a single site study, Kleebauer's work[15] also indicates that appropriate training and teaching on the statutory duty of candour is currently not happening for all medical professionals, including the nursing profession.[15] This is reverberated in the AvMA Report[17], which provided examples of how NHS Trusts are failing to either comply, or provide appropriate training and teaching of the duty of candour legislation. This variability in how well the legislation is implemented and the complexities in interpreting the legislation points towards a need for support for medical professionals in developing a shared understanding of how the legislation may be applied to every day practice.

Prior to this legislation doctors may have been honest although not completely open, as to spare a patient's feelings and prevent undue psychological stress, which this study highlighted is still regarded to be important by clinical educators (DC09c). However, it has been shown that most patients do not share this concern,[6,18] and full disclosure typically has positive effects, or

no effect on how patients respond to errors in practice.[19] This is still contrary to the belief of some doctors.[14] This needs to be effectively communicated among medical professionals, as our data indicates that there are still mixed perceptions regarding whether candour needed to become statutory (DC07a; DC03; DC09a; DC05; DC09b). Dissemination of the legislation will also need to illustrate why the legislation is of practical value, as although it is not uncommon for doctors to withhold a poor diagnosis in countries such as Japan, China and Singapore, this is not the dominant view in Western countries.[7]

It is important that the legislation is incorporated into undergraduate teaching. Our data points towards an approach where such teaching is contextualised into clinical problems, so that future doctors develop the insight of how the legislation applies to inherently more difficult consultations (DC02; DC10), such as for example, when a colleague does not disclose (DC10). Secondly, providing future doctors with opportunities for reflective discussions, based on both problem based discussions and through exposure to situations in the workplace related to the legislation (DC01b; DC02). This is important as our data again indicates that previously identified barriers to openness still exist, including the fear of repercussions (DC06).[20] Such learning could be supported by guided reflection before, during and after the experience with a supervisor or mentor who challenges the trainee's views within a supportive environment, an approach already known to be beneficial.[21] By implication this requires clinical mentors and supervisors who have a shared understanding of the legislation.

Role models are a valuable means to shape the professional values, attitudes and behaviours of future doctors.[22,23] However, before candour can flourish through positive role modelling, the variability in the workplace culture needs to be addressed (DC04; DC08b). Interestingly, Grassi *et al.'s* (2000)[24] study demonstrates that candour in practice could vary according to speciality. This was a questionnaire study of 675 medical professionals in Italy, which revealed that doctors in surgical specialties are more likely to disclose a diagnosis than general practitioners.[24] This may reflect that decisions made by surgeons are often more 'clear-cut', with fewer uncertainties, based on hospital investigations being more readily available than for general practitioners. Nevertheless, this raises an area for further research to deepen our

understanding of clinician's perspectives on truthfulness according to speciality and how truthfulness manifests itself in different specialities. This in turn can help our understanding to bring medical ethics and law teaching closer to the coalface of clinical practice and to ascertain that policies and guidelines support the different challenges faced by different specialities.

Limitations

The data here is collected by interviews and represent the perceptions of a self-selected sample of clinical educators from one location; however, the key findings are corroborated by the current literature. A qualitative study is not about generalisability, or about determining what proportion of people hold a certain type of view; instead it is about deepening insight into a problem or issue. We feel that this study has done this by highlighting key issues that are salient to the effective implementation of the legislation and effective education of the legislation for future doctors. Even though the study was from a single site and cannot provide the same information as a large survey, it is possible to be confident of the data for the following reasons: the data reached saturation; and the themes presented recurred between interviewees, enhancing our confidence that the themes accurately reflect the general perceptions of clinical educators. However, further work needs to verify whether the key issues identified through this data apply to other settings.

Conclusions

This study is the first to our knowledge that provides insight into clinician's perspectives of truth-telling after it became a statutory duty in England. Several important findings have emerged from this study. Foremost, our interviewees indicate that the legislation is not reaching all frontline staff; there remains a lack of appropriate training and teaching on the legislation of a duty of candour that responds to the perceived challenges to implementing candour in practice. These issues are closely relevant to the considerations towards raising standards in patient safety, which is now an international concern[25]; and directly relevant to shaping medical ethics education.

Currently the dissemination of the legislation does not convince all staff of its practical value, nor guide them on how to negotiate the complex areas of clinical practice in accordance with this legislation. Situation based learning resources and training that illustrate the complexities that the legislation creates to every day practice may convince the frontline staff of the practical need for the legislation and how to apply the legislation effectively. Both undergraduate and postgraduate curricula need to integrate teaching on the implications of the legislation and take a practice based approach in doing so. We have yet to explore the responses patients may have to the key issues raised in our data, or how truth-telling manifests itself in different specialities. This will no doubt have an influence in how the training in this area is shaped.

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Declaration of conflicting interests

The Author(s) declare(s) that there is no conflict of interests.

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