Statutory duty of candour with criminal sanctions

Briefing paper on existing accountability mechanisms
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**Background**

In calling for the culture of the NHS to become more open and honest, Robert Francis QC, Chairman of the Inquiry into Mid Staffordshire NHS Foundation Trust argued strongly in the Inquiry’s final report that the obligation on staff to be truthful when things go wrong is too vague and frequently not observed. He wrote:

“Unless steps are taken to evidence the importance of candour by creation of some uniform duty with serious sanctions available for non-observance, a culture of denial, secrecy and concealment of issues of concern will be able to survive anywhere in the healthcare system”

His report called for the establishment of a statutory duty of candour on both providers and individuals that would require staff to disclose information to their employer where they believe poor care has resulted in death or serious injury to a patient (recommendation 181).

Further, the report proposed that it should be a criminal offence for any registered member of staff to prevent someone from exercising their statutory duty or knowingly to mislead a patient about the details of an incident of such poor care (recommendation 183).

**Duty on providers**

In responding to the Francis report, the government supported the proposal to implement a duty of candour with criminal sanctions on providers. This duty has been written into the Care Bill currently undergoing scrutiny in the House of Lords. Once the Bill becomes law, regulations will follow to limit the criminal offence to providers of NHS secondary care (rather than primary care providers such as GPs) in the first instance. The government says that this will apply to “NHS Trusts, Foundation Trusts, and independent providers of NHS secondary care such as private companies and charities.”

**Duty on individuals**

On the proposed duty on individuals, the government has been more circumspect, opting firstly to review the position once the professional regulators have given consideration to what further action they may take, and once Don Berwick’s review of patient safety which was commissioned by the Government following the publication of the Francis Inquiry report, has reported.

More recently in a letter to the BMA, the Secretary of State for Health has indicated that the government might look to apply existing criminal sanctions more effectively.

In addition to calling for criminal sanctions to apply to staff for dishonest behaviour relating to providing misleading information about patient care, Robert Francis called for criminal liability for individuals in cases where fundamental standards of patient care were not observed. He argued that only then could healthcare adopt a ‘zero tolerance’ approach to poor standards of care (recommendation 28). The letter from the Secretary of State to the BMA appeared to give support to considering this proposal too.
BMA position
The BMA supports the principle underlying the idea of a duty of candour on individuals and providers, and believes that all NHS staff must be honest and transparent in everything that they do in order to best serve and protect their patients. The BMA also supports the upholding of the highest standards of patient care.

Duty on providers
The BMA supports the proposed new statutory duty of candour on organisations, believing that providers should always be open and honest with patients about their care and that existing mechanisms for holding providers to account require strengthening.

The BMA believes that in order to change the underlying culture that discourages people from speaking up, there should be a new duty on employers to listen to staff when they do report concerns, and to protect them if necessary. Staff should be encouraged and recognised for following their professional guidelines, and more training may be necessary to help doctors communicate more effectively with their patients about when, for example, treatment has not gone as well as expected or an error has occurred in the process of their care. More effective policies addressing bullying of staff may also be necessary. The new organisational duty of candour in the Care Bill may go some way towards addressing these areas

Duty on individuals
The existing professional duties on doctors to be open and honest with patients about their care, and the sanction for any failure, underpin these standards. There are already a number of ways in which healthcare workers, including doctors, can be prosecuted using both criminal and civil proceedings in connection with dishonest behaviour or action endangering patients.

We believe the introduction of a new statutory duty of candour with criminal sanctions for individuals is unnecessary and could have the opposite effect of that intended. The threat of criminal prosecution for an act committed in the course of treating a patient (whether accidentally, negligently or purposefully) could, instead, worsen the culture of fear amongst professionals that prevents people speaking out. Even where a staff member was confident that no single individual was to blame for the action that endangered or misled a patient, concern about a criminal prosecution may discourage them from speaking out. The threat of criminal sanctions may also encourage more defensive practice in medicine.

Existing professional duty
Doctors already have a duty to be open and honest with patients about their care through Good Medical Practice, the professional code governing their fitness to practise. Breaching the code can lead to a doctor’s removal from the medical register and a ban on their ability to practise medicine. Good Medical Practice (GMP) states the following:

“Being open and honest with patients if things go wrong

30 If a patient under your care has suffered harm or distress, you must act immediately to put matters right, if that is possible. You should offer an apology and explain fully and promptly to the patient what has happened, and the likely short-term and long-term effects.

31 Patients who complain about the care or treatment they have received have a right to expect a prompt, open, constructive and honest response including an explanation and, if
appropriate, an apology. You must not allow a patient’s complaint to affect adversely the care or treatment you provide or arrange.”

GMP2 also requires doctors to comply with their employer’s patient safety systems and respond to risks to patient safety, and to be honest and act with integrity.3

The General Medical Council may, investigate and pursue individual doctors suspected of poor or dangerous practice, or of dishonest behaviour, through its Fitness to Practise procedures. This can ultimately lead to a doctor being struck off and unable to practise in the future. Many other groups of registered healthcare professionals undergo similar processes in respect of their own regulatory bodies.

Criminal prosecutions

For ‘obstructive dishonesty’:
If an investigation suggests that a healthcare worker has deliberately provided incorrect information about patient care, it may be possible to prosecute for fraud, which incurs criminal liability. Additional training could be made available at the Crown Prosecution Service to give prosecutors an improved understanding of the NHS environment and its systems to assist in taking such cases forward when appropriate.

For breaching standards of care:
In cases where patient care has been so poor that it has led to the death of a patient, prosecutors may bring a charge of medical manslaughter, or gross negligence manslaughter against a medically qualified person, with a maximum penalty of life imprisonment.

Civil proceedings
In addition to their criminal liability, practitioners can be pursued in civil proceedings for claims of clinical negligence or breach of contract. In circumstances where patients have been misinformed or wilfully misled and/or been caused harm, an employer or member of the public may instruct a solicitor to bring a medical negligence case against a practitioner using civil proceedings.

Disciplinary procedures
Doctors who misinform or deceive patients about their care, or whose capability is under question, will also be held to account through their employer’s disciplinary procedures, which can ultimately end in dismissal. In the case of hospital doctors, the employer is obliged to notify the police and the NHS Counter Fraud Service where an investigation into a doctor’s actions leads them to believe a criminal act has been committed. Where an employer’s investigations reveal serious concerns about a doctor’s performance, the employer should inform the GMC so that they may take the appropriate action.

Care Quality Commission’s powers
The Care Quality Commission (CQC) can use the criminal law to hold registered persons (i.e. those organisations and individuals providing a service that is registered with them) to account for causing harm or for failing to meet a range of explicit legal requirements. In addition, it can bring criminal charges against any individual “being obstructive” to the CQC in the course of its inspection of a care provider, including failing to provide the required information.

2 paragraphs 22 to 25
3 paragraphs 65 to 71
Conclusion
There are already a number of robust sanctions that patients, employers, regulators and other authorities can draw on to hold staff to account through the legal system for poor practice or dishonest behaviour. Adding an individual statutory duty of candour with criminal sanctions would not add anything substantive to the existing routes and would add to the confusion about the accountability methods available. If these routes are not currently adequately understood or used, additional advice and guidance for investigators, employers, and prosecutors should be provided to address this, rather than adding yet another provision, which could have the unintended consequence of worsening the existing culture of fear that prevents staff speaking out.

Francis Inquiry recommendations

“Recommendation 181
A statutory obligation should be imposed to observe a duty of candour:
• On healthcare providers who believe or suspect that treatment or care provided by it to a patient has caused death or serious injury to a patient to inform that patient or other duly authorised person as soon as is practicable of that fact and thereafter to provide such information and explanation as the patient reasonably may request;
• On registered medical practitioners and registered nurses and other registered professionals who believe or suspect that treatment or care provided to a patient by or on behalf of any healthcare provider by which they are employed has caused death or serious injury to the patient to report their belief or suspicion to their employer as soon as is reasonably practicable.
The provision of information in compliance with this requirement should not of itself be evidence or an admission of any civil or criminal liability, but non-compliance with the statutory duty should entitle the patient to a remedy.”

“Recommendation 183
It should be made a criminal offence for any registered medical practitioner, or nurse, or allied health professional or director of an authorised or registered healthcare organisation:
• Knowingly to obstruct another in the performance of these statutory duties;
• To provide information to a patient or nearest relative intending to mislead them about such an incident;
• Dishonestly to make an untruthful statement to a commissioner or regulator knowing or believing that they are likely to rely on the statement in the performance of their duties.”

“Recommendation 28
Zero tolerance: A service incapable of meeting fundamental standards should not be permitted to continue. Breach should result in regulatory consequences attributable to an organisation in the case of a system failure and to individual accountability where individual professionals are responsible. Where serious harm or death has resulted to a patient as a result of a breach of the fundamental standards, criminal liability should follow and failure to disclose breaches of these standards to the affected patient (or concerned relative) and a regulator should also attract regulatory consequences. Breaches not resulting in actual harm but which have exposed patients to a continuing risk of harm to which they would not otherwise have been exposed should also be regarded as unacceptable.”
Extracts from GMC Good Medical Practice

Contribute to and comply with systems to protect patients

22. You must take part in systems of quality assurance and quality improvement to promote patient safety. This includes:
   a. taking part in regular reviews and audits of your work and that of your team, responding constructively to the outcomes, taking steps to address any problems and carrying out further training where necessary
   b. regularly reflecting on your standards of practice and the care you provide
   c. reviewing patient feedback where it is available.

23. To help keep patients safe you must:
   a. contribute to confidential inquiries
   b. contribute to adverse event recognition
   c. report adverse incidents involving medical devices that put or have the potential to put the safety of a patient, or another person, at risk
   d. report suspected adverse drug reactions
   e. respond to requests from organisations monitoring public health.

When providing information for these purposes you should still respect patients’ confidentiality.

Respond to risks to safety

24. You must promote and encourage a culture that allows all staff to raise concerns openly and safely.

25. You must take prompt action if you think that patient safety, dignity or comfort is or may be seriously compromised.
   a. If a patient is not receiving basic care to meet their needs, you must immediately tell someone who is in a position to act straight away.
   b. If patients are at risk because of inadequate premises, equipment* or other resources, policies or systems, you should put the matter right if that is possible. You must raise your concern in line with our guidance11 and your workplace policy. You should also make a record of the steps you have taken.
   c. If you have concerns that a colleague may not be fit to practise and may be putting patients at risk, you must ask for advice from a colleague, your defence body or us. If you are still concerned you must report this, in line with our guidance and your workplace policy, and make a record of the steps you have taken.

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Act with honesty and integrity

Honesty

65. You must make sure that your conduct justifies your patients’ trust in you and the public's trust in the profession.

66. You must always be honest about your experience, qualifications and current role.

67. You must act with honesty and integrity when designing, organising or carrying out research, and follow national research governance guidelines and our guidance.

Communicating information
68. You must be honest and trustworthy in all your communication with patients and colleagues. This means you must make clear the limits of your knowledge and make reasonable checks to make sure any information you give is accurate.

69. When communicating publicly, including speaking to or writing in the media, you must maintain patient confidentiality. You should remember when using social media that communications intended for friends or family may become more widely available.

70. When advertising your services, you must make sure the information you publish is factual and can be checked, and does not exploit patients’ vulnerability or lack of medical knowledge.

71. You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents. You must make sure that any documents you write or sign are not false or misleading.
   a. You must take reasonable steps to check the information is correct.
   b. You must not deliberately leave out relevant information.