community research

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General Chiropractic Council

Duty of Candour

The Patients' Perspective

GCC Patient Community: Project Four

December 2023

> Well, I always thought it was like a duty of care, but sometimes, I think Duty of Candour - is that something to do with care or something different? I'm not really quite sure.

Patient panel member

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Executive Summary

Registrants are specifically required under GCC guidance to fulfil the Duty of Candour as part of the professional relationship between chiropractor and patient. This relationship depends on trust, and the Duty of Candour is key to that relationship. In any healthcare profession, there are situations in which unexpected or unforeseen consequences of care can occur. The Duty of Candour sets out expectations of a registrant when these situations occur.

In chiropractic, serious adverse events are rare; candour events are more likely to centre around uncertainty. For example, delayed diagnosis, whether an adverse symptom was caused by treatment or non-clinical issues, such as breach of confidentiality.

Given this opacity, GCC, working with the GOsC, recently undertook research to explore candour as understood by patients.

Understanding candour

This research with a patient panel aims to better understand a patient's expectations in these circumstances and how patients can be supported to be partners in their care before, during and after, if things go wrong.

More specifically, the research set out to explore:

- To explore the principles and key components of candour within musculoskeletal (MSK) treatments for patients.
- To understand patients' understanding of risks within MSK treatment, their understanding and expectations of when they would be informed of something going wrong with their treatment (including a near miss, an adverse incident and when treatment is not working due to progression of an illness or condition).
- To inform what additional resources may be required for the GCC website and information regarding Duty of Candour for registrants, i.e. what do patients need to know about Duty of Candour?

Key findings

- **Patients have low recognition and understanding of the term 'Duty of Candour'.**

The term 'Duty of Candour' means very little to patients but, when explained, patients considered Duty of Candour to be an implicit part of being a professional practitioner and therefore doesn't require explanation. Patients prefer words such as honesty, openness and transparency.

- **Patients understand the challenges facing chiropractors in relation to compliance with the Duty of Candour.**

Patients recognise that mistakes may happen and appreciate the challenges facing practitioners. There is an understanding that patients must also take some responsibility for their care. If something does go wrong with a patient's care, then ongoing dialogue between patient and practitioner is critical and can help to build trust.

- **Patients recognise that apologies are difficult and 'getting it right' requires careful reflection as well as using the right language and tone.**

Patients believe a good apology should involve dialogue with the patient and provide a clear description of what went wrong, together with an action plan. The language used should be jargon-free and centred around the patient.

Recommendations

- **For the GCC** to provide guidance to registrants to help understanding around Duty of Candour.
- **For registrants** to reassure patients of their commitment to openness, honesty and transparency by promoting their GCC registration via the 'I'm Registered' mark.
- **For patients** to check they are visiting a registered chiropractor so they feel reassured that their chiropractor will act with integrity and honesty.

One: Patients' understanding and expectations in relation to candour

There was low recognition and understanding of the term 'Duty of Candour' amongst members of the research panel, particularly in relation to chiropractic care. Some members associated candour with honesty and openness.

Once the term was explained, it made intuitive sense to the panel, but some felt that it was such an obvious thing for practitioners to be doing and questioned whether it actually needs to be outlined in the regulatory guidance and standards at all.

Duty of Candour was seen as an implicit part of being a professional and behaving with integrity and likened to the Hippocratic Oath taken by doctors.

The patient panel:

1. **Low awareness of the regulatory context**

Members of the patient panel had very low awareness of how practitioners are regulated, with some believing there are Ofsted-like, regular inspections of practices which monitor compliance with standards or some form of 'mystery' shopping type exercises.

Greater importance was put on the Duty of Candour when panel members discovered that regulation does not operate in the way that they expected. The onus on the individual to raise issues prompted questions about levels of compliance and the barriers to practitioners living up to these standards.

What the patient panel said:

"[In a school setting] you are monitored to within an inch of your life. So, is that the same for things like that? So, like what you were saying, like how do people know if they're doing it right? Are they monitored annually, or six monthly or whatever?"

2. **Patients seeking treatment can be vulnerable**

Some panel members reflected on the vulnerability of patients who tend to visit a practitioner when in pain and are responsible for deciding to visit a practitioner and selecting which practitioner to use, without the reassurance of a referral. In such cases, compliance with Duty of Candour became more important as patients need to trust that their practitioner will act professionally and responsibly.

The risk of patients being mis-sold treatments that are not actually needed was highlighted as well as the fact that patients do not have the knowledge or experience to know if something had gone wrong with their treatment.

What the patient panel said:

“I think there’s like a level of trust that you have with a doctor or a surgeon. With any kind of complementary therapist, if you like, if they come under that banner, you know chiropractor, acupuncturist. When I first went and used their service, I was really very nervous, because it's like: ‘What's their qualifications? What's the process that these people go through to get to be able to practice?’”

3. Expectations for private and formal settings

Members of the patient panel have higher expectations of the care generally when paying privately for treatment, indicating they may let something slide in the NHS which wouldn’t be the case in a private healthcare setting, which they perceived as having more resources and scope to give the best care and customer service.

Some members of the research panels had lower expectations of practitioners who are practising in a more informal setting than those in a more medicalised one. Nevertheless, it was pointed out that the practitioner should uphold standards, regardless of setting.

What the patient panel said:

“I think some patients would have different expectations on the environment. but it's up to the practitioner to reinforce the standards, that: ‘irrespective of the environment, this is what we do, and this is how we do it.’”

Two: A patient's expectations when things go wrong

Members of the patient panel recognise that mistakes may happen and appreciate the challenges facing practitioners, including those relating to compliance with the Duty of Candour. The need for ongoing dialogue between practitioner and patient was highlighted, noting that patients must also take some responsibility for their care. There was a general expectation that Duty of Candour is simply part of being professional.

It was noted by some panel members that if issues came to light at a later stage, it could be worse for the practitioner if the issue hasn't been raised at the time.

The patient panel:

1. **Appreciation of challenges faced by practitioners**

Patients were largely empathetic in relation to the challenges practitioners face in their practice, including those relating to compliance with Duty of Candour, and appreciated that mistakes will happen. There was a presumption that practitioners have good intentions and are not intentionally out to cause harm.

The panel felt that sometimes practitioners are doing their best in the absence of important medical information and also recognised that there may be significant barriers to practitioners living up to the Duty of Candour. They appreciated that practitioners may feel that they have a lot to lose if they admit to mistakes in terms of their professional reputation and also financially if it is their own business.

2. **Recognising a patient's responsibility**

Some members of the patient panel felt that the relationship between patient and practitioner should be two-way and that patients also had a responsibility for honesty and transparency (as well as aiding their own recovery).

Patients must take some responsibility for their care in terms of providing the practitioner with as full information as possible on their medical history and being open about their lifestyles where it potentially impacts on their treatment.

What the patient panel said:

"I feel that a practitioner's job is only going to be as good as the person that they're working with. So, for example as a patient am I taking care of, as best I can, the things that are going to impact my condition? And while I sit there and think about if my condition isn't improving, is that something that I've done, that you've done, or is it my circumstance, for example?"

3. A professional approach

Many members of the patient panel highlighted the ethical drivers for practitioners to be candid. There was a sense that Duty of Candour should be embedded in everything they do – it is an integral part of being a professional.

However, in addition to this rationale, there were also some practical drivers for practitioners being candid. Transparency and openness when things go wrong were felt to be crucially important in terms of cementing the patient-practitioner relationship and building trust, which could be good for the practitioner's business in the long term.

What the patient panel said:

"I think professionalism is at the heart of it. If you're a professional, then your competence and your professionalism should give you the self-esteem to say, 'You know what? I'm going to deal with this. It's something that needs to be done.'"

4. The value of two-way communications

Duty of Candour was essentially seen in terms of a continuum – as part of the dialogue with a patient which starts at the first session in discussions about treatment, risks and consent and continues throughout the treatment programme. The importance of good communication and two-way dialogue was stressed by members of the research panel.

It was felt that practitioners need to be open-minded to hearing the patient's concerns and listening to their version of events even if it does not necessarily accord with their own. Having a discussion helps the practitioner understand the issues and learn from them.

What the patient panel said:

"It's not a kind of confession; it's about having it within a conversation."

5. The importance of individual reflection/organisational learning

The importance of a practitioner reflecting on and learning from mistakes was a recurrent theme raised by members of the research panel. There was a call for practitioners to be open to the possibility that they might have done something wrong or that they could have done something better.

There was also a strong focus on the importance of organisational learning and a 'no blame' culture. The need for issues to be documented and recorded in a transparent way to allow for learning to be shared was also highlighted, with patients wanting reassurance about how this is achieved in the chiropractic profession where professionals don't tend to work in very large settings or in multi-disciplinary teams.

What the patient panel said:

"But I suppose with near misses, there's learnings in there. So even with work, like construction, something could have happened, but it didn't; but if I highlight it and it's recorded somewhere, it could be taken seriously. Because anything that has the potential of going wrong – again, human error – it's likely that someone else will do the same thing."

6. **The need for openness and transparency**

There were some instances that members of the research panel felt were clear cut in terms of the Duty of Candour. These tended to be where practitioners did not do the basic things right e.g., take a full medical history or keep very sensitive information safe or confidential.

The panel also felt that practitioners should inform the patient if something relatively serious has gone wrong, but the patient is not aware of the issue. There was general sense that the practitioner should err on the side of caution and be open about any issues with patients. However, it was acknowledged that this is a complex area. For example, even determining what 'going wrong' actually means is difficult.

What the patient panel said:

"So, if they're thinking, I don't know whether I should tell them, I think the answer would be I should. Because I think if you're even questioning whether you are in a grey area, you are."

7. **The impact of environment and culture**

Members of the patient panel noted that the environment in which practitioners are working could have an impact on the ability and willingness of individuals to be candid. With practitioners working in larger settings influenced by the organisational culture around speaking up whilst those working in smaller settings may have the support of colleagues which would be beneficial in identifying issues and tackling them.

Three: A patient's expectations of apology and redress

There was a broad consensus amongst members of the research panel that a 'good' apology takes skill and considerable thought to get right and that any redress should be tailored and appropriate to the issue. The tone and language were highlighted as critical to ensuring the apology is clear and genuine.

The panel appreciated that this is a challenging area for practitioners to get right, raising perceived potential legal implications of a practitioner saying sorry. There was a presumption that any apology equated to an admission of guilt.

The patient panel:

1. **Dialogue with the patient**

According to the patient panel, a good apology should involve a dialogue with the patient. The majority of the panel felt that it should include a clear description of what went wrong, together with a clear action plan. For most, this included how to prevent the same thing happening again.

What the patient panel said:

"For me, there is a difference between saying sorry and an apology and it is the accountability or the recognition that actually, there's an action that needs to come as a result of what's taken place."

2. **Getting the language right**

There was a general consensus amongst the research panel that language used in this context was crucially important and that time should be taken to craft any response. The importance of keeping language simple and jargon free was emphasised.

Members of the panel raised some uncertainty about the legal implications of saying sorry i.e., whether it would serve as an admission of guilt.

There was a sense that practitioners would feel reluctant to put themselves in this situation, particularly in relation to scenarios where they were unsure if they had actually done anything wrong. The research panel suggested that some situations needed acknowledging, but didn't actually require an apology per se.

What the patient panel said:

"So, I think it's really important that they sit down, and they reflect on what is it? And then, they reflect on how they're going to word it. Because how you word the apology is going to make a big difference."

3. **The right timing**

When discussing the right time to make an apology, the patient panel felt that the apology should be given as soon as possible after the issue is identified (but that this should be balanced against the need to discover the facts, reflect on and craft the response). It was also noted that there should be a clear timeline in terms of any actions. Some members of the research panel felt that the issue should be flagged immediately but that the full apology could come later.

What the patient panel said:

"… a good apology should be offered as soon as possible, after reflection, you know: time to really consider it."

4. **Who should apologise?**

Most of the patient panel members indicated that they would like to receive a response directly from the practitioner themselves. However, some felt that there may be some circumstances in which it was more appropriate to get a response from their manager or someone more senior.

In relation to financial compensation, the patient panel agreed it may be more appropriate for correspondence to come from an insurance company or lawyer.

What the patient panel said:

"[the apology should come] from the person who is capable of doing something about it, the responsible person. So perhaps, in a larger organisation, it would be a manager or an owner and also, perhaps, depending on the incident, let's say there was something untoward happened and it was embarrassing, or it was inappropriate, maybe you don't want to get together with the person who's been inappropriate with you."

5. **Who should receive the apology?**

There was a clear consensus amongst the patient panel that the patient should receive the apology/explanation and also a guardian/carer if they do not have capacity themselves. The practitioner was felt to be responsible for identifying the responsible person and the person who lacks capacity (i.e. vulnerable adult or child).

What the patient panel said:

"Find out if there is other care involved and whether anyone else needs to be involved, because he obviously doesn't want to be violating patient confidentiality. He should satisfy himself about whether someone else needs to be told or not, I think."

6. In what form?

It was felt that the form of apology should be tailored to the seriousness of the issue. Less serious issues could be dealt with by telephone, but more serious issues should be sorted in person. Some felt that there should also be a written response for clarity.

What the patient panel said:

"Because the written format has longevity and gravitas in other scenarios that the spoken one doesn't. And also, if you're not prepared to put it in writing, that also feels a little bit like not taking full responsibility, because then you're reduced to: he said, she said, I remember that. But no, I phoned you and I basically repeated what was in the writing. Now, that feels substantial and like it's really credible, so I'd want both."

7. Other forms of redress

Even with an ideal apology, members of the patient panel felt that there were some instances where the issue would need to be escalated.

Other forms of redress were felt to be important in certain circumstances. This includes the offer of further, free treatment in instances where something had gone wrong with treatment which could potentially be rectified by further work. However, it was noted that the practitioner would need to be alert to how the patient was feeling i.e. they may not feel confident going back to the same practitioner who has made a mistake. Furthermore, offering free clinical treatment was not felt to be an appropriate form of redress for non-clinical errors.

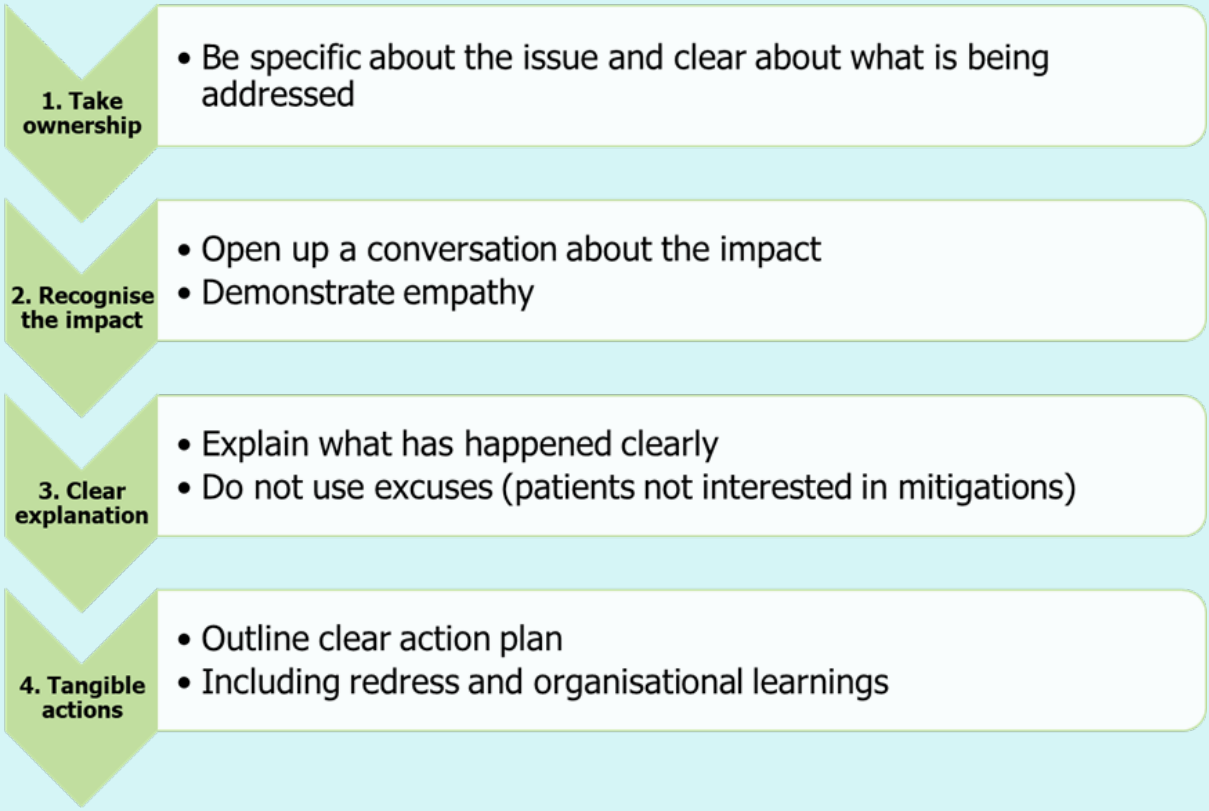
Some members of the patient panel felt discomfort with the idea of other tokens of apology such as flowers or wine. The panel felt this sort of thing could be appropriate but could also strike the wrong tone. For some it gave the impression of the practitioner trying to 'buy them off' or trying to ensure that they don't escalate things further.

There was also some discussion about serious mistakes which have a significant impact on a patient i.e., they are unable to work for a certain time. In these instances, financial compensation was felt to be appropriate.

What the patient panel said:

"I'm guessing that any mistake would need to be rectified, or have a ramification on the patient's life, which ultimately, is something that can be calculated in pounds and pence. So, either they're going to need more osteopathy, or physiotherapy, or hospitalisation, or some kind of work, or whatever; it amounts to money."

The phased approach of an ideal apology



Four: What do patients need to know in relation to Duty of Candour?

Members of the patient panel did not feel patients needed to be actively informed about the Duty of Candour. Some felt that it was implicit in what their practitioner does, and it doesn't need to be spelt out to patients unless there is a specific issue. Some felt that this could potentially be off-putting to new patients.

Rather than provide information on Duty of Candour, a mark of reassurance on the practitioner's website would give the research panel confidence. The panel placed more emphasis on practitioners being given support in the form of clear guidance and examples to help them navigate this challenging area.

There was broad consensus that patients need to know the following:

- Some basic information on how chiropractors are regulated.
- How to find information about practitioners that have done something wrong.
- How to report a complaint and the complaints process.

The patient panel:

8. **How should Duty of Candour be communicated?**

There was a strong call for the phrase 'Duty of Candour' not to be used in any communication with patients. Instead, there was a preference for terms such as honesty, openness, transparency, responsibility for mistakes; how practitioners respond when things go wrong/when things don't go to plan.

What the patient panel said:

"The power imbalance with the language. I know we've already had this conversation, but to say Duty of Candour, patients aren't going to know what they don't know. If you don't know what Duty of Candour means, how can you hold people to account?"

9. **How should information about Duty of Candour be disseminated?**

Those who felt that patients should be aware of Duty of Candour felt that it should be communicated by practitioners at the start of a consultation, potentially at the same time as a conversation about consent and as part of a general conversation about how the practitioner works and their responsibilities or potentially put on the practitioner's wall.

Some felt that information could be provided on the GCC website so it's available if patients want to look for it. It wasn't felt necessary for it to be on the practitioner's own website as long as they have a mark of assurance and are pointing patients in the direction of the regulator. One participant likened it to the Red Tractor logo which means food standards are assured.

There was more appetite for ensuring that the Duty of Candour is clear to practitioners i.e. that they are given clear guidance, examples and access to individualised support with a specific query.

What the patient panel said:

"I knew what it was when I came in here and my expectation was that if I go to a healthcare provider, they're going to be honest and open with me. And I'm not sure you need to have a leaflet or a thing like, you know, almost, to me, that would be: 'When you come to us, we're going to be honest and open with you.' Well yes, of course you are."

Five: Conclusion

Patients are not familiar with the term Duty of Candour but are able to make an educated guess on its meaning based on their understanding of the word ‘candour’. However, once explained, the concept makes intuitive sense.

To many patients, candour is a core component of what it means to be professional and therefore should be engrained in a chiropractor’s practice. It shouldn’t actually need to be spelled out in the code of conduct or standards. However, patients appreciate there are some shades of grey and the need for explicit guidance.

Patients are more likely to understand the importance of the Duty of Candour when recognising the regulatory context (and specifically the knowledge that GCC do not conduct regular inspections of practitioners’ practices).

Patients are largely empathetic about the challenges faced by practitioners both in terms of practice itself and also in adhering to the Duty of Candour but believe there are benefits to being candid with patients which include building a trusted relationship with a patient and avoiding reputational damage.

Applying the concept to practice

Patients believe they should be told in the event of a clear-cut error where the patient has been harmed and that practitioners have a duty to highlight any issues (including those involving marginal or future patient harm) so as to facilitate learning in the organisation and also in the profession more widely.

Patients recognise that there are some grey areas in relation to Duty of Candour, with some more realistic and phlegmatic about how Duty of Candour may be applied in the real world, noting that a practitioner telling a patient about a ‘near miss’ or about an issue that had only a marginal impact on them was unlikely and, importantly, unnecessary. Some patients feel that this approach could have an adverse impact in relation to making a patient unduly anxious and that the patient would feel that it was ‘odd’ behaviour on the part of the practitioner.

However, some patients feel strongly that patients should be given all the information so that they can draw their own conclusions.

What do patients need to hear from practitioners in the event of something going wrong?

Patients have strong views about the form and tone of any apology from a practitioner in the event of an error, calling for the apology to be clear about the issue and any resulting actions, without providing excuses.

For a significant issue, patients believe a verbal apology is appropriate as well as something in writing. Information on what the practitioner would do in order to ensure that the mistake isn’t repeated is important to some patients but some simply want to hear how the error would be rectified for them. This reinforces the need for apologies to be tailored to the patient and patient-centred.

What do patients need to know about Duty of Candour?

Patients do not believe they need specific information relating to Duty of Candour but urge information to be provided to practitioners to support their work in relation to adhering to the Duty of Candour. This is particularly important given the challenges identified by patients in relation to practitioner compliance i.e., the potential obstacles to practitioners adhering to the standards and also the shades of grey, meaning that practitioners will need to use their judgement and discretion.

According to patients, discussion around Duty of Candour can take place at the start of a consultation with a practitioner, but it is not completely necessary. Information could potentially be provided on the GCC's website so that it is there if patients want to seek it out. If information is provided, patients would like to avoid using the word 'candour' given the low levels of understanding of the term.

Six: Recommendations with explanations

For the GCC to provide guidance to registrants to help understanding and communication around Duty of Candour.

The research suggests a need for further guidance to help registrants adhere to the Duty of Candour, using the findings from the patient panel to address how to talk to patients about candour and outlining a patient's expectations on the issue.

For registrants to reassure patients by promoting their GCC registration via the 'I'm Registered' mark to reinforce their commitment to openness, honesty and transparency.

We will highlight the comments from the research panel to encourage registrants to use the 'I'm Registered' mark on their practice website and marketing, sharing key quotes across the GCC's social media channels.

For patients to check they are visiting a registered chiropractor so they feel reassured that their chiropractor will act with integrity and honesty.

We will engage with patients via our social media channels to reinforce the importance of checking that a chiropractor is registered with the GCC, highlighting that GCC registration demonstrates a registrant's commitment to honesty and openness.

We will also review the patient information on the GCC's website and update, where necessary, to reflect the views of the research panel.

Appendix One

Research methodology

Community Research was commissioned to conduct a face-to-face deliberative workshop in late September. The day-long session, held on 28th September 2023, was attended by 22 participants; all of whom had recent experience of attending a chiropractic or osteopathic appointment.

A deliberative workshop approach allowed participants to be fully informed and then gave them the time and space required for meaningful dialogue. Recruiting a heterogeneous group of participants ensured that individuals were exposed to others' views on the subject and were able to discuss the issues with people from a different background to themselves.

Participant profile

The demographic mix for the 16 participants who were not from the GOsC Patient Forum is shown below. All were from the London area to allow for easy access to the workshop. The six members of the GOsC Forum who attended were also a mix by gender, age and ethnicity. One was a carer and so not an osteopathic patient themselves. They represented a larger geographic spread than the other patients.

Gender	
Male	8
Female	8
Age	
Under 35	3
35-60	10
60+	3
Ethnicity	
Minority ethnic group	9
SEG	
B	4
C1	8
C2	3
D	1
Type of care in the last 6 months	
Chiropractic	11
Osteopathic	4
Both	1

Research panel quotes

On occasion, quotes from the research panel have been edited or amended for grammatical and ease of reading/interpretation reasons. The context and outcomes of all quotes have not been changed in any way. A copy of the original, unedited quotes can be provided upon request.

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