Candour, disclosure and openness

Learning from academic research to support advice to the Secretary of State

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professional
standards
authority

About the Professional Standards Authority

The Professional Standards Authority for Health and Social Care[1] promotes the health, safety and wellbeing of patients, service users and the public by raising standards of regulation and voluntary registration of people working in health and care. We are an independent body, accountable to the UK Parliament.

We oversee the work of nine statutory bodies that regulate health professionals in the UK and social workers in England. We review the regulators' performance and audit and scrutinise their decisions about whether people on their registers are fit to practise.

We also set standards for organisations holding voluntary registers for people in unregulated health and care occupations and accredit those organisations that meet our standards.

To encourage improvement we share good practice and knowledge, conduct research and introduce new ideas including our concept of right-touch regulation[2]. We monitor policy developments in the UK and internationally and provide advice to governments and others on matters relating to people working in health and care. We also undertake some international commissions to extend our understanding of regulation and to promote safety in the mobility of the health and care workforce.

We are committed to being independent, impartial, fair, accessible and consistent. More information about our work and the approach we take is available at www.professionalstandards.org.uk.

We are compiling a catalogue of academic and other literature which is relevant to different aspects of professional regulation, and can be found on our website here: http://www.professionalstandards.org.uk/policy-and-research/research/research-links.

We would be pleased to receive feedback on further literature not referenced here or on our website which is relevant to candour and disclosure, or to professional regulation more generally.

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[1] The Professional Standards Authority for Health and Social Care was previously known as the Council for Healthcare Regulatory Excellence

[2] Professional Standards Authority. 2010. Right-touch regulation. Available at http://www.professionalstandards.org.uk/policy-and-research/right-touch-regulation

Contents

1. Introduction

1.1 This research supports our advice to the Secretary of State for Health on how professional regulation can encourage health professionals and social workers to be more candid when things have gone wrong. The main report containing our advice can be found at www.professionalstandards.org.uk.

1.2 In order to understand the limits and potential for regulatory action in this area, we have explored literature from around the world on the topics of disclosure, whistleblowing, patient safety, adverse events, medical ethics, regulation, and the behavioural sciences. This is not however a comprehensive, formal academic literature review. We have looked for a sample of literature relevant to this specific issue across a number of academic disciplines over a relatively short period of time. In the longer term, we are working to compile a catalogue of academic and other literature which is relevant to different aspects of professional regulation, and can be found on our website here: http://www.professionalstandards.org.uk/policy-and-research/research/research-links. We would be pleased to receive feedback on further literature not referenced here or on our website which is relevant to candour and disclosure, or to professional regulation more generally.

1.3 The bulk of the relevant literature concerns doctors; other than a handful of studies on nurses, we found little that related to other healthcare professions or social work. We have therefore made clear where findings may be specific to a profession or professional context. Most of the research originates from the US and Australia. We have highlighted any findings or conclusions we believe may not be applicable to the UK context.

1.4 We have used the term 'candour' to describe both whistleblowing, which we take to refer to the reporting of concerns about care provided by others, and disclosure, which refers here to the reporting of one's own mistakes. This is broader than the terms used in the commission that triggered this research and in our subsequent advice to the Secretary of State. However, we felt it was important for us to consider the full scope of relevant literature.

The scope of impact of professional regulation

1.5 Our thinking on this topic should be understood in the context of the research we commissioned from Dr Oliver Quick in 2011 to try to understand the influence that professional regulation can have on the behaviour of professionals. While the regulators of products can exercise direct control through the specification of the equipment that is used every day, the influence of the professional regulators on the behaviour of their registrants is far harder to determine, both in terms of its nature and its scale. *A scoping study on the effects of health professional regulation on those regulated*[3], identified that professional regulation was just one

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[3] Oliver Quick, 2011. *A scoping study on the effects of health professional regulation on those regulated. A report for CHRE*. Available at: http://www.professionalstandards.org.uk/policy-and-research/research/research-links. Accessed 12/09/13.

among many influences on registrants' daily behaviour, judgements and decisions, and it is probably true that the regulator is not overtly present in the small ethical decisions of everyday life.

1.6   Even if the nature of regulation's influence was known, it could not be assumed that it would be desirable for regulation to be able to exercise direct control of the behaviour of registrants. Professional regulation should support but not supplant the appropriate application of professional judgement in given situations. The power to mandate or authorise particular behaviours in too specific a way might engender deprofessionalisation and dependency on the part of registrants. Furthermore, research undertaken by Meleyal[4] on the effects of introducing a statutory register of social workers on the behaviour of those regulated found (amongst other things) that professional regulation can have perverse, unforeseen, and unintended consequences on people's behaviour. So, it cannot be assumed that the purpose, role and influence of regulation as perceived and experienced by registrants is always that which the regulator intends.

1.7   With this in mind, we have explored the academic literature to try to understand what encourages and discourages people from disclosure and whistleblowing, and what influence professional regulation could exert to promote candour.

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[4] Lel Meleyal. 2011. *Reframing conduct: a critical analysis of the statutory requirement for registration of the social work workforce*. Available at http://sro.sussex.ac.uk/7665/1/Meleyal%2C_Lel_Francis.pdf. Accessed 20/08/13.

2. Factors that encourage and discourage candour

2.1 Conceivably, regulation could play a part both in enabling candour, and in removing the barriers to it. We found a considerable amount of literature on the factors that inhibit and motivate health professionals to be candid, covering both whistleblowing and disclosure.

2.2 One of the strongest themes to emerge from our review is the marked mismatch between people's stated attitudes and their actual behaviours in relation to disclosure. A number of pieces of research carried out in the US and Australia suggest that professionals' support for disclosure in principle does not regularly translate into action[5, 6, 7, 8]. This contrast is accentuated for major errors, which doctors say, hypothetically, they would be more inclined to report than minor errors, but are much less likely to report in reality[9]. In Australia for example, this is in spite of efforts by the Australian Government to embed open disclosure by doctors to patients through professional codes[10] and health and quality policies[11].

2.3 This suggests competing motivations and enablers, inhibitors and prohibitors. The challenge for regulators is to seek to understand those influences, in order to better assess the potential for them to exert influence; or to what extent others might be better placed to support professionals to be candid about their errors and concerns.

An ethical imperative?

2.4 In such situations, professionals seem to have to reconcile competing emotions, desires, and external pressures. Academics from the University of Iowa carried out a mixed-methods study incorporating both qualitative and quantitative research to describe the competing factors affecting error disclosure by

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[5] Andrea C. Kronman, Michael Paasche-Orlow, Jay D. Orlander. 22 September 2011. *Factors associated with disclosure of medical errors by housestaff*. BMJ Qual Saf. 2012: 21: 271-278

[6] Lauris C. Kaldjian, MD, PhD; Elizabeth W. Jones, MHSA; Barry J. Wu, MD; Valerie L. Forman-Hoffman, PhD, MPH; Benjamin H. Levi, MD, PhD; Gary E. January 14, 2008. Rosenthal, MD. *Reporting medical errors to improve patient safety: a survey of physicians in teaching hospitals*. Arch Intern Med. 2008;168(1):40-46.

[7] David M Studdert, Donella Piper and Rick Iedema. 20 September 2010. *Legal aspects of open disclosure II: attitudes of health professionals — findings from a national survey*. MJA 2010; 193: 351–355.

[8] Angus J. F. Finlay, Cameron L. Stewart, Malcolm Parker. May 2013. *Open disclosure: ethical, professional and legal obligation, and the way forward for regulation.* Medical Journal of Australia, Ethics and Law Series. 198 (8).

[9] See footnote 6.

[10] Medical Board of Australia. *Good Medical Practice: a code of conduct for doctors in Australia*. Available at http://www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx. Accessed 06/08/13.

[11] The Australian Commission on Safety and Quality in Health Care. First published in July 2003, reprinted April 2008. *Open disclosure standard: a national standard for open communication in public and private hospitals following an adverse event in health care*. Available at: http://www.health.qld.gov.au/psq/od/docs/odst.pdf. Accessed 06/08/13.

physicians[12]. They determined that desires relating to one's responsibility to the patient, to the profession, to oneself and to one's community were all factors that might facilitate disclosure. On the other hand, the barriers that people reported were their own negative feelings and attitudes towards disclosure, uncertainties about how and what to disclose, fears and anxieties about negative consequences, and feelings of helplessness about what happens next.

2.5   We were struck by the extent to which in this account, the facilitating factors are, broadly speaking, driven by the individual's sense of duty and ethical responsibility, whereas the barriers are more readily determined by external factors such as reporting systems and attitudes of colleagues. This echoes the point made elsewhere that the arguments in favour of both whistleblowing[13] and disclosure[14] largely pertain to ethics. They tend to be about telling the truth, respecting people, preventing harm to others, treating people justly, maintaining one's integrity, doing 'the right thing', and so on. To some, they are so compelling that they barely require a justification.[15]

2.6   Why then, are we are we still engaged in what, in 2005, Leape and Berwick[16] were already calling an 'ethically embarrassing debate'? What could be more compelling than an ethical impulse to do the right thing?

The bystander effect: the diffusion of responsibility to act when things go wrong

2.7   The 'bystander effect'[17] is one of the most replicable phenomena in social psychology, and offers a striking insight into why professionals do not report their concerns about patient safety. The classic case that is cited in illustration of the effect is the murder of Kitty Genovese, who was stabbed to death in Queens, New York City, in March 1964. Some accounts claimed that up to 38 people witnessed at least part of the attack but that none took any action. While the facts of the case have been disputed at great length, and it is probably untrue that there were so many witnesses or that absolutely nothing was done, the case has come to encapsulate the phenomenon of the 'bystander effect' or 'bystander apathy'. Where someone is in trouble, the more people are around, the less likely it is that any will take action. The effect has been witnessed time and again in real life situations, and in experiments[18]. This phenomenon appears to us to have direct relevance to situations in healthcare organisations where many people

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[12] Lauris C Kaldjian, MD, PhD, Elizabeth W Jones, MHSA, Gary E Rosenthal, MD, Toni Tripp-Reimer, PhD, RN,3,4 and Stephen L Hillis, PhD. September 2006. *An Empirically Derived Taxonomy of Factors Affecting Physicians' Willingness to Disclose Medical Errors.* J Gen Intern Med. 2006 September; 21(9): 942–948.

[13] Ann Gallagher. February 2010. *Whistleblowing: what influences nurses' decisions on whether to report poor practice?* Nursing Times 1 February 2010.

[14] Oliver Quick, July 2012. *Patient Safety and the problem and potential of law.* Professional Negligence, vol 28, no 2, 2012.

[15] See footnote 14.

[16] Lucian L. Leape, Donald M. Berwick. May 2005. *Five years after "To Err is Human": What have we learned?* Journal of the American Medical Association May 18, 2005. 293 (19): 2384–90.

[17] For our description of the bystander effect in these we have drawn on Gross R, *Psychology – the science of mind and behaviour.* Sixth Edition, 2010 pp 467-71.

[18] An example, introduced by Dr Philip Zimbardo, is available on youtube: http://www.youtube.com/watch?v=z4S1LLrSzVE

know that something is wrong but nothing is done, because of a 'diffusion of responsibility' to act across many potential witnesses or 'bystanders', where none feels a sufficient degree of responsibility to take action.

2.8   Latane and Darley[19] who led research into bystander apathy in the wake of the Kitty Genovese case developed a model of bystander intervention, a logical sequence of questions or steps through which the bystander must pass before giving help or taking action. If the answer to any question in the sequence is 'no', then the bystander will not act. The sequence of questions is: does the bystander notice the event; does the bystander interpret the event as one requiring help; does the bystander assume personal responsibility; does the bystander select a way to help; does the bystander implement the selected decision?

2.9   We are interested in further research by Milgram[20] which suggests a contributory factor to bystander inaction is stimulus overload. We understand that this theory was developed to account for the phenomenon whereby in an urban setting people are less likely to help than in a rural setting. We know that health and social care professionals can be subjected to extremely stressful situations and heavy workloads, and are often required to process large volumes of complicated and sometimes conflicting information from different sources, while at the same time having to focus on specific goals and targets. We wonder therefore whether this could also create the conditions for stimulus overload, which might prevent people from intervening. The problematic situations are then either 'screened out', or judged insufficiently important if the time and effort involved in taking action would jeopardise the achievement of other objectives.

2.10   Another model which was developed by Piliavin, Dovidio and others[21, 22] to account for bystander apathy is the 'arousal-cost-reward' model. In this model, any action taken by a witness will aim to reduce the 'negative arousal' inspired by the witnessed events, at the lowest possible personal cost. In other words, the focus of any action is the relief of a witness' negative feelings. A calculation is made by the witness of the cost and rewards of helping, and of the cost and rewards of not helping. The resultant course of action (if any) taken will depend on the balance of these factors. Where the witness experiences a 'high-cost-for-helping/high-cost-for-not-helping dilemma', (for example, a serious situation where reporting concerns risks personal retribution and vilification, but the witness experiences profound guilty feelings at not taking action) an interesting phenomenon of 'cognitive reinterpretation' has been observed. The witness may reinterpret events in order to render the dilemma less acute or non-existent by either redefining the situation; diffusing responsibility; or blaming the victim. These insights have clear parallels with other work we discuss in this paper about the inherent dilemma of whistleblowing, and the strategic reinterpretation of events.

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[19] For example: Latane B and Darley JM. *Group inhibitions of bystander intervention in emergencies. Journal of Personality and Social Psychology*. (1968) 10, 215-221.
[20] Milgram, S (1970) *The experience of living in cities*. Science, 167, 1461-1468.
[21] Piliavin IM et al. *Good Samaritanism: An underground phenomenon?* Journal of Personality and Social Psychology (1969) 13, 289-299.
[22] Dovidio JF et al, *The arousal-cost-reward model and the process of intervention*. In Clark, MS (ed) *Prosocial behaviour: Review of Personality and Social Psychology* (1991).

2.11 Both of these models suggest ways to encourage professionals to take action or report concerns. In the first model, we can work through the stages and identify things that could be done in the environment of care to make individuals pass more easily through the series of questions. So for example, 'does the bystander select a way to help?' might provoke us to ask whether we are confident that health professionals are aware of the means by which they can raise concerns, and know how to do so. If we are not confident, what can we do to raise that awareness? The second model prompts us to ask how we can reduce the 'cost of helping' – for example, how can we reduce the time and effort involved in reporting concerns, and how can we protect people who have taken a personal risk to do so?

2.12 Nevertheless, the most important observation that we draw from the bystander effect, whichever model accounts for it, is that the phenomenon of the 'diffusion of responsibility' is real and widely occurring. There is an inherent risk, therefore in any policy interventions which would lessen professionals' sense of their responsibility for their own actions, in particular, to report their concerns or to be candid where they know that things have gone wrong. While we support analysis of adverse and other incidents which includes systemic and situational factors, we would not want this to supplant a focus on the professional responsibility of individuals to act on what they know. A keen sense of personal responsibility is an important factor in a professional's daily self-management and therefore to the continuing safety of patients.

Profession-specific cultures

2.13 In addition to bystander apathy, other common human responses to feelings of guilt and failure, and the reluctance to engage in difficult conversations[23], there are a number of reported psychological reasons why doctors specifically may fail to confess to a mistake. Waring points out that in order to manage errors, there must be an acceptance that an error has occurred in the first place.'[24] Mizrahi, as quoted by McGivern and Fischer[25] describes three forms of social defence associated with mistakes by doctors: 'denial' through the notion that medicine is more of a judgement-based art than an exact science; 'discounting', which involves blaming circumstances beyond the doctor's control; and 'distancing' through which it is argued that mistakes are inevitable in medicine. These defences may be linked to professional cultures, particularly in medicine which is portrayed in the literature as having a complex relationship with error.

2.14 Some have argued that many doctors believe medicine should be flawless, an exact science, meaning that errors become synonymous with incompetence[26, 27].

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[23] See footnote 7.

[24] Justin J. Waring. 2004. *Beyond blame: cultural barriers to medical incident reporting.* Social Science and Medicine. 60 (2005) 1927-1935.

[25] McGivern and Fischer. 2010. *Medical Regulation, spectacular transparency & the blame business.* Journal of Health Organisation and Management 26 (2010): 597-610.

[26] Rona Patey, Rhona Flin, Brian Cuthbertson, Louise McDonald, Kathryn Mearns, Jennifer Cleland, David Williams. April 2007. *Patient safety: helping medical students understand error in healthcare.* Qual Saf Health Care 2007; 16: 256-259.

[27] Alexander Putnam Cole, Lauren Block, Albert W. Wu. 2012. *On higher ground: ethical reasoning and its relationship with error disclosure.* BMJ Quality and Safety 2013. 22: 580-585.

This contrasts with Waring's findings[28] from a study undertaken in the operating department of a teaching hospital in the north of England. The research found that surgeons and anaesthetists normalised abnormal events, as a way of dealing with the high-risk nature of their day-to-day activities. Suboptimal, uncertain and dangerous situations became 'normal' features of care. This passive tolerance of abnormal events meant that they did not communicate information about the event to colleagues, and no remedial action was taken, as the abnormality or error was not recognised as such. These two differing accounts may appear to contradict each other, but they both highlight the same characteristic – the ways in which errors and other risks to patient safety are not acknowledged, and the loss therefore of the opportunity to learn from and better manage these risks.

2.15 Looking further afield, Waring's findings in medicine are reminiscent of the thoughts of Vaughan in her analysis of the Space Shuttle Challenger disaster (as quoted by Jones et al[29]). She found that there had been what she calls a 'normalization of deviance' in which incremental deviations from normal procedures were accepted, despite their resulting in standards that would not have be tolerated if the slippage had happened suddenly.

2.16 Whether we can expect this type of attitude to extend to other professions in health and social care is a matter for debate – particularly if the behaviours identified in medicine are driven by the level of risk and responsibility specific to doctors. Research with nurses suggests that they favour a more open approach than doctors when it comes to their own professional territory[30] – they see patient advocacy as an important part of their role – but that for incidents that take place in a multidisciplinary context, they may envisage a shared approach to disclosure with doctors leading the process[31]. Nurses' greater inclination to report wrongdoing is further highlighted in Jones's paper on whistleblowing in health and social care[32].

2.17 This highlights the potential for inter-professional tensions stemming from different approaches to disclosure, and the heightened risk of non-disclosure because of hierarchical effects, that is, responsibility for disclosure being transferred to another professional group of perceived higher status. Nurses report developing strategies for encouraging their colleagues to disclose, such as confronting the doctor directly, and persuading patients to confront them about an adverse event[33]. It certainly seems that there might be benefits to embedding a shared understanding and shared expectations among the health and care professions in relation to disclosure.

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[28] Justin Waring, Steve Harrison, Rut McDonald. April 2007. *A culture of safety or coping? Ritualistic behaviours in the operating theatre.* J Health Serv Res Policy. 12 Suppl 1:S1-3-9.
[29] Dr Aled Jones, Prof Daniel Kelly, Tricia Brown. *Whistleblowing in health and social care: a narrative review of the literature.* Older People's Commissioner for Wales and Cardiff University.
[30] Fiona Donaldson-Myles. 2005. *Nurses' experiences of reporting a clinical incident: a qualitative study informing the management of clinical risk.* AvMA Medical and Legal Journal 2005 11: 105.
[31] Elaine O'Connor, Hilary M. Coates, Iain E. Yeardley and Albert W. Wu. 13 August 2010. *Disclosure of patient safety incidents: a comprehensive review.* International Journal for Quality in Health Care. Volume 22, number 5, pp 371-379.
[32] See footnote 29.
[33] See footnote 31.

2.18   We note that the literature around whistleblowing is more focused on nursing[34, 35, 36], than the literature around disclosure, which relates mostly to doctors. There are many possible explanations for this, for example, it could reflect the differences in professional cultures or the different whistleblowing opportunities that present themselves to doctors and nurses, or it could simply be a quirk of the research. It is perhaps a matter that merits closer inspection.

Divided loyalties

2.19   Disclosure relates by definition to incidents or actions in which the person disclosing has had some involvement. However whistleblowing may also refer to acts in which the whistleblower is, or at least feels, in some way implicated, a point that is argued by Paeth in his paper on the ethical dimensions of whistleblowing[37]. In this respect, the motivation to keep quiet about the mistakes of others may resemble those identified above for one's own mistakes – but there are also a number of barriers that are specific to whistleblowing.

2.20   Collegiality is regularly cited as one such barrier[38, 39]: professionals may choose not to report their colleagues' mistakes both because they would feel they were betraying them, and because there is a hope that if roles were reversed their colleagues would do the same for them.

2.21   Paeth's paper[40] evokes another brand of divided loyalty. He explains that whistleblowing brings into direct conflict one's loyalty to one's employer on the one hand, and one's freedom to play a part in stopping immoral or dangerous practices on the other. He argues that 'the decision to engage in whistleblowing is not an act of pure unvarnished moral righteousness. Rather, it involves the evaluation of competing moral claims on one's identity and action, and a decision to act in ways that honour one set of moral obligations at the expense of others.' This concept of loyalty to an organisation also features in Ann Gallagher's paper[41], though she is quick to point out that on its own, without such values as wisdom and integrity, it can be misplaced in support of unethical activities. She goes on to quote Kleinig: 'when an organisation wants you to do right it asks for your integrity; when it wants you to do wrong, it demands your loyalty'[42].

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[34] See footnote 30.

[35] Debra Jackson, Kath Peters, Sharon Andrew, Michel Edenborough, Elizabeth Halcomb, Lauretta Luck, Yenna Salamonson, Lesley Wilkes. May 2010. *Understanding whistleblowing: qualitative insights from nurse whistleblowers.* Journal of Advanced Nursing. 66(10), 2194-2201.

[36] See footnote 13.

[37] Scott R. Paeth. 2013. *The Responsibility to Lie and the Obligation to Report – Bonhoeffer's "What does it mean to tell the truth?" and the Ethics of Whistleblowing.* Journal of Business Ethics (2013) 112: 559-566.

[38] Caroline Bond. December 2004. *Education and a multi-agency approach are key to addressing elder abuse.* Nursing Times, 1 December 2004. Available at: http://www.nursingtimes.net/nursing-practice/clinical-zones/older-people/education-and-a-multi-agency-approach-are-key-to-addressing-elder-abuse/199530.article

[39] Justin J. Waring. 2007. *Doctors' thinking about 'the system' as a threat to patient safety.* Health: an interdisciplinary Journal for the Social Study of Health, Illness and Medicine. Vol 11(1): 29-46.

[40] See footnote 37.

[41] See footnote 13.

[42] J Kleinig. 2007. *Loyalty.* Stanford Encyclopedia of Philosophy.

Organisational and institutional influences

2.22   The influence of organisational and institutional factors is frequently referred to in the literature around candour. One such commonly reported impediment to disclosure among doctors – which could no doubt be extended to other contexts and professions including private practice – is the fear of medico-legal action[43, 44]. The Anglo-American world has embraced the tort system, under which individuals are legally liable for their actions as professionals, whereas countries such as Denmark, France, Sweden and New Zealand have adopted a no-fault approach to compensation[45]. Amendments to the English scheme flowing from the NHS Redress Act 2006 might address some – though arguably not all[46] – of the shortcomings of the tort system, but the scheme has yet to be implemented in England.

2.23   That said, in England, under the Being Open guidance[47] for the NHS, trusts and staff are encouraged to acknowledge, apologise and explain when things go wrong, but for professionals outside the NHSLA framework, such as those in private practice, indemnity insurers may well discourage anything that could be construed as an admission of liability. Helpfully, in the US the Supreme Court has ruled that insurance policies going against the public interest or sound morality should never receive the sanction of the Court. This provides professionals with legal grounds to fight back if they have been denied insurance coverage on the basis of an admission to a patient, because it is a requirement under their Code of Ethics[48]. All this suggests that reforms to litigation and indemnity insurance systems, especially those like the UK's which are based on tort law, should perhaps be considered alongside any other reforms.

2.24   Individuals' fears about the risk of malpractice claims can be fuelled by employers' negative attitudes to disclosure. A 2002 survey of hospital risk managers carried out in the US by a number of academics including Berwick[49], found that respondents were twice as likely not to disclose preventable harm if the hospital itself had concerns about the malpractice implications of disclosure. This was in spite of the introduction of new patient safety standards requiring hospitals to disclose all unexpected outcomes to patients. It is worth noting at this point that there is little evidence to back up concerns that increased openness about medical errors will lead to an increase in litigation. For example, the University of Michigan Health System has pioneered a malpractice scheme based on early disclosure of errors to the patient, and found that both the litigation costs and the number of claims decreased as a result. [50] This research

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[43] See footnote 7.

[44] Rae M. Lamb, David M. Studdert, Richard M.J. Bohmer, Donald M. Berwick, Troyen A. Brennan. 2003. *Hospital Disclosure Practices: Results of a National Study*. Health Affairs. 2003; 22 (2).

[45] See footnote 14.

[46] See footnote 14.

[47] National Patient Safety Agency. November 2009. *Being open: saying sorry when things go wrong.*

[48] John D. Banja. 2005. *Does Medical Error Disclosure Violate the Medical Malpractice Insurance Cooperation Clause?* Agency for Healthcare Research and Quality (US), Advances in Patient Safety: From Research to Implementation. Volume 3: Implementation Issues.

[49] See footnote 44.

[50] Richard C. Boothman, Sarah J. Imhoff, Darrell A. Campbell Jr. Winter 2012. *Nurturing a culture of patient safety and achieving lower malpractice risk through disclosure: lessons learned and future directions.* Frontiers of Health Services Management. 28:3. Accessed 06/08/13.

is encouraging in a field where evidence about the impact of greater openness on the volume and cost of malpractice claims is scant[51].

Impact on careers

2.25 Putting concerns about litigation to one side, doctors are worried about the negative impact of candour on their professional situation, both current and future. Kaldjian et al's taxonomy of factors affecting doctors' willingness to disclose[52] includes the fear of professional discipline, which would certainly encompass the fear of being brought to the attention of the professional regulatory body. This concern features in a small number of articles we reviewed (including the only relevant article we could find relating to social workers)[53, 54, 55, 56], but perhaps not as prominently as we might have expected. Interestingly, although several studies carried out in the US suggest that in a hypothetical situation many patients would want the professional to be reprimanded or punished by an authority such as the professional regulator, this desire for punishment can be significantly dampened by an honest, sensitive and accountable approach to communicating an adverse event[57, 58].

2.26 Also present in the Kaldjian taxonomy[59] are preoccupations about loss of reputation, position, and advancement as impediments to disclosure. Finkelstein as quoted by O'Connor et al[60], found that physicians had different motivations for not disclosing depending on their grade, with junior physicians being concerned about the impact on their professional advancement, while seniors were interested in preserving their authority. Waring too found that the fear of blame from both non-peers and peers discouraged reporting, because of the damage it could inflict on reputations, and because it may result in 'unjustified reprisals'.[61]

2.27 Nurses have reported fearing the consequences of whistleblowing on their careers, with any positive outcomes for blowing the whistle being heavily outweighed by the negative impact on their jobs, and consequently on their general wellbeing.[62] Again, these fears appear to be symptomatic of workplace culture. When Leape and Berwick considered the progress that had been made since the publication of the landmark US report To Err is Human[63], they found that an absence of commitment at the top of the organisation was impeding the transition to a more safety-focused culture[64]. Waring suggests that a 'safety

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[51] See footnote 31.
[52] See footnote 12.
[53] TH Gallagher, Wendy Levinson. 2005. *Disclosing Harmful Medical Errors to Patients: a Time for Professional Action.* (Reprinted) Archive of Internal Medicine. Vol 165, September 12th, 2005.
[54] See footnote 25.
[55] See footnote 12.
[56] Frederic G. Reamer. 2008. *Social Workers' Management of Error: Ethical and Risk Management Issues.* Families in Society, Vol 89, No1.
[57] See footnote 31.
[58] See footnote 56.
[59] See footnote 12.
[60] See footnote 31.
[61] See footnote 24.
[62] See footnote 35.
[63] Institute of Medicine. November 1999. *To Err is Human: Building A Safer Health System.*
[64] See footnote 16.

culture', which encourages openness and learning, is to be contrasted with a 'blame culture' in which staff fear being punished and therefore do not report their mistakes.[65] In a study of an NHS District General Hospital in England[66], he found there was a widely-held assumption that openness and transparency meant that individual responsibilities could be determined, paving the way for blame and possibly even retribution. The tone set by policy and management went so far as to provide doctors with a 'widely recognised reason for not reporting'.

A positive role for employers

2.28 The absence of a blame culture may not be sufficient, however, to encourage staff to be open about mistakes. Much of the literature suggests that there are positive steps that need to be taken by employers to encourage effective disclosure. Firstly, employers may need to provide support to the practitioners themselves to allow them to come to terms with the mistake they are expected to disclose. Wu, whose work we have referenced several times already, coined the phrase 'the second victim' to the describe the situation of a medical professional responsible for a mistake: 'although patients are the first and obvious victims of medical mistakes, doctors are wounded by the same errors.'[67] He laments the lack of support provided by peers when a mistake has occurred, and explains how confessing to colleagues is passively discouraged by the 'lack of appropriate forums'. The need to come to terms with the mistake and the importance of peer and employer support in this respect is evoked elsewhere in the literature with respect to both doctors[68, 69] and nurses[70].

2.29 A UK study by Donaldson-Myles of nurses' experiences of reporting of adverse events[71] showed that nurses felt the experience had been worthwhile if the institution had subsequently taken action to prevent recurrence – something which can may be obstructed by the 'deaf effect', i.e. the reluctance of senior decision makers to hear bad news. This phenomenon was originally described by Keil and Robey in management and information studies literature, and subsequently picked up by Jones[72] as one that could be applied to health and social care. Jones suggests that this type of attitude means that 'organisations continue with a course of action that fails everyone except for the perpetrator of the mistreatment'. Where this attitude prevails, it will need to be overcome if professionals are to be motivated to report concerns.

2.30 The Donaldson-Myles research also showed that nurses themselves wanted to be able to learn from their mistakes, and viewed this as a motivation to report. This echoes Waring's suggestion[73] that openness and learning go hand in hand,

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[65] See footnote 28.
[66] See footnote 24.
[67] Albert W. Wu. March 2000. *Medical error: the second victim, the doctor who makes the mistake needs help too.* BMJ. Vol 320, 18 March 2000.
[68] See footnote 5.
[69] N. Berlinger, A. W. Wu. 2003. *Subtracting insult form injury: addressing cultural expectations in the disclosure of medical error.* Journal of Medical Ethics 2005; 31: 106-108.
[70] See footnote 30.
[71] See footnote 30.
[72] See footnote 29.
[73] See footnote 28.

and is backed up by further research with doctors[74]. It has also been suggested that collective reflection on issues of concern could help to remove the stigma associated with errors and the need for individuals to blow the whistle.[75]

2.31 Not knowing how to report, what to report, or when to report it are also seen as barriers to candour[76, 77]. TH Gallagher talks about the three common disclosure mistakes: hypodisclosure (insufficient information), hyperdisclosure (excessive information) and misdisclosure (information later found to be incorrect).[78] There is a clear role here for the employer, who should be telling staff what they are expected to disclose, when, and how.

2.32 Some research has shown that doctors may presume it is in the patient's best interests not to be told about an adverse event.[79] This leads Gallagher to conclude that appreciating a patient's desire to know about an error's cause and prevention could encourage physicians […] to examine errors more closely.'[80] Here too, there would seem to be a role for employers in setting the tone and emphasising the patient's right to information about their care when things have gone wrong.

2.33 The literature tells us that patients are as sensitive to the way the message is delivered as they are to its content[81], so it is unfortunate that professionals appear to be let down by an absence of communication skills relating to disclosure. The research talks about people needing to develop the skills to address sensitive issues[82] and be 'comfortable and effective at disclosing'[83]. The Australian Open Disclosure scheme has been reported as having been held back by a lack of training in how to disclose[84, 85]. Once again, employers can try to redress this shortcoming, but Berlinger and Wu conclude that 'learning how to disclose errors, apologise to injured patients, and ensure that these patients' needs are met' should become part of medical education[86].

A positive role for education and training

2.34 There is perhaps therefore an important part for education and training to play – alongside that played by employers – to encourage candour. This may be particularly important for sole practitioners who do not benefit from the support structures that should be provided by employers. While employers should be creating an environment in which candour is encouraged, and supplying staff with the practical tools to do so, pre-qualifying education can equip individuals from the outset with an understanding of the importance and basic principles of

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[74] See footnote 6.
[75] See footnote 35.
[76] See footnote 12.
[77] See footnote 6.
[78] See footnote 53.
[79] See footnote 31.
[80] See footnote 53.
[81] See footnote 56.
[82] See footnote 31.
[83] See footnote 14.
[84] See footnote 7.
[85] See footnote 8.
[86] See footnote 69.

candour. It can teach some of the softer skills to allow professionals to come to terms with their own errors, and talk about them sensitively and constructively with colleagues and patients – including an appreciation of cultural sensitivities in this area[87]. It could also be a lever for a more widespread culture change in healthcare and social work[88]. The research also indicates that there may be value in delivering multi-disciplinary disclosure education and training to more accurately reflect the realities of the working environment[89] – and perhaps this could help to address some of the cultural differences between the professions that we described in paragraphs 2.13 to 2.18 above.

2.35 We found two studies, one in the US[90] and one in the UK[91], both in medicine, which had tested the impact of a patient-safety curriculum on students' awareness of and attitudes to patient safety. They both found an absence of patient safety elements in the core medical curriculum, and developed modules that included disclosure as a role-play element. The results of the UK study were mixed but nevertheless concluded that knowledge of patient safety matters and the perceived personal control over safety had improved. The results of the more extensive US study were even more encouraging, and found that 'a brief, experiential educational intervention was shown to increase and sustain awareness of patient safety issues and medical error disclosure to patients.' Further longitudinal research could no doubt be carried out to gauge the longer-term impact of this type of teaching.

2.36 In the opening paragraphs of this section, we suggested that in the main, the reasons a person might have to be candid pertained to ethics. There may therefore also be a role for education in strengthening what academics refer to as ethical reasoning – which in layman's terms could be called 'moral courage'. This hypothesis has been tested, with encouraging results, in a study looking at the relationship between ethical reasoning and error disclosure.[92] It found 'an association between more sophisticated, principled ethical reasoning and important aspects of open, honest communication.' It seems that training in ethical reasoning, which prior studies suggest can be taught and measured, could help to improve disclosure of medical errors.

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[87] See footnote 69.
[88] Joseph L. Halbach, Laurie L. Sullivan. June 2005. *Teaching medical students about medical errors and patient safety: evaluation of a required curriculum.* Academic Medicine. 2005: 80: 600-606.
[89] See footnote 31.
[90] See footnote 88.
[91] Rona Patey, Rhona Flin, Brian Cuthbertson, Louise McDonald, Kathryn Mearns, Jennifer Cleland, David Williams. April 2007. *Patient safety: helping medical students understand error in healthcare.* Qual Saf Health Care 2007; 16: 256-259.
[92] Alexander Putnam Cole, Lauren Block, Albert W. Wu. 2012. *On higher ground: ethical reasoning and its relationship with error disclosure.* BMJ Quality and Safety 2013. 22: 580-585.

3. In summary – a role for professional regulation in encouraging candour?

3.1 The literature we reviewed suggests that while being candid is almost universally acknowledged as 'the right thing to do', health professionals and social workers still struggle, for a variety of reasons, to be as open as they might be when things have gone wrong.

3.2 People are no doubt held back by the common human reactions to these sorts of situations – the bystander effect, reluctance to acknowledge error, feelings of guilt, and so on – but prevailing cultures in different professions may also exert an important influence. Doctors and nurses, for example, appear to have different attitudes and approaches to disclosure, indicating that any regulatory responses may need to be profession-specific to address the different cultures, while attempting to establish common expectations across the professions.

3.3 Professional regulators will need to take into account professionals' sense of loyalty to their peers and employers, and their concerns about retribution, negative impacts on their career, and referral to the regulator. They will also need to be aware of undoubtedly justified concerns about the impact of candour on indemnity insurance.

3.4 In addition, it seems clear from this review that employers and the culture they foster – safety or blame – have the greatest influence. Not only do they set the tone with respect to disclosure and whistleblowing, there is also much they can do to encourage staff to be candid. They should be supporting them to come to terms with any mistakes they might have made, and ensuring that they know how to disclose or blow the whistle and are fully equipped and supported to do so.

3.5 It seems that alongside any professional regulatory developments, professional bodies, employers, service regulators, and indemnity insurance providers all have an important role to play to encourage candour. Such a joined-up approach could build some resilience into the system and help professionals, including sole practitioners, who do not benefit from the support structures that should be provided by employers.

3.6 Professionals should also be taught about candour as part of their professional training. This would give them the opportunity, at an early stage, to get to grips with the realities of professional error, and to assimilate the principles and skills relating to candour. There may also be a role for ethical training to reinforce the 'moral courage' necessary to combat some of the disincentives to candour.

3.7 We conclude our review of the literature with a summary of what this could mean for the different professional regulatory functions.

Standards

- In the face of the many impediments identified in this report, the presence of a standard relating to candour in the professional code might encourage some to be candid in situations when they otherwise would not be.

- Having a common standard across the professions could help to redress some of the differences between the professions' approaches to candour.

- Guidance on the new standard would reinforce messages about the primacy of candour.

Education and training

- The standard could underpin the introduction of a candour-related curriculum in pre-qualifying training.

Continuing fitness to practise and continuing professional development (CPD)

- The introduction of the standard could encourage the development of relevant post-qualifying learning opportunities.

- Continuing compliance with the standard could be checked periodically through continuing fitness to practise mechanisms.

Fitness to practise

- The standard could form the basis of decisions about professionals' fitness to practise.