Why sorry doesn't need to be the hardest word

The question of open disclosure in medical errors has crept up the political agenda in the UK and doctors should brace themselves for a culture change in this area. **Jane Feinmann** reports

"It was a classic case of multiple observer error and one that we didn't believe could happen in our unit," recalls Iain Johnstone, consultant paediatric intensivist at Newcastle upon Tyne Hospitals NHS Foundation Trust. He was describing his feelings after the discovery of a clinical error by a junior doctor and planning the next stage of management of the patient.

The question of what doctors should do in Dr Johnstone's position has been on the political agenda for years—at least since it was memorably summed up by former chief medical officer Liam Donaldson in 2004. "To err is human, to cover up is unforgivable and to fail to learn is inexcusable," he told the Alliance for Patient Safety's conference in Washington.

Yet despite repeated attempts by the UK National Patient Safety Agency to bring about a "being open" framework, enabling clinicians to communicate patient safety incidents with patients and their relatives, there is evidence that this still does not happen routinely.

Around half a million NHS patients experience avoidable harm every year. Yet statistics show that only a quarter of NHS trusts routinely provide information to patients about such incidents, with 6% admitting to never providing this information.[1] A recent Medical Protection Society survey found that a third of its members did not believe doctors would be willing to be open with patients about mistakes they had made.[2]

Now the UK government is planning further action. Its programme for government, published jointly by David Cameron and Nick Clegg in May 2010,[3] included "a commitment to require hospitals to be open about mistakes and always tell patients when something has gone wrong." This promise was repeated in the white paper, *Liberating the NHS*.

Apart from the moral case for openness and honesty, disclosure makes financial sense. The cost of litigation against NHS bodies is rising, with £787m (€905m; $1.3bn) paid in clinical negligence claims in 2009-10, compared with £769m the previous year [4] A growing body of international evidence suggests that introducing a policy of open disclosure could substantially reduce litigation and complaints.

Full open disclosure was introduced at University of Michigan Hospitals in 1999, and the number of claims fell from 136 to 61 over the following seven years with litigation costs dropping from $3m in 1999 to $1m in 2006.[5] When the US based Copic Insurance Company began to offer its open disclosure 3Rs (Recognise, Respond to, and Resolve patient injury) programme in 2000, malpractice claims fell by 50%, with settlement costs dropping by 25% over the next five years.[5]

Culture change

An announcement on how the coalition government will implement its commitment to openness

bmj.com

Farewell, 12 good men and true (*BMJ* 2010; 340:c1881)

is expected in the next few weeks. The original plan proposed by Dr Donaldson was to introduce a legal "duty of candour" to force doctors to tell patients the truth at all times.[6] But an alternative approach, summarised as "culture change" and persuasively articulated by the Medical Protection Society, now looks more likely to inform the department's action in this area.

"Doctors are very aware of the importance of consent, of a patient being fully aware of the pros and cons of different options for treatment. What is now needed is that every doctor also understands that this therapeutic conversation must continue on those rare occasions when treatment goes wrong—and that it's a doctor's duty to explain what has happened and what can be done about it," says Stephanie Bown, director of policy and communications at the society.

Indeed, the same point was made by Ken Lowndes, spokesman for Cure The NHS, the Staffordshire patients' organisation that has led support for investigating the Mid Staffordshire NHS Foundation Trust, currently the subject of a public inquiry and already slated by the Healthcare Commission for its culture of denial and cover-up. "What's often called a culture change is, in reality, just fixing things that have been festering for years," he said, addressing the Association of Surgeons in May. He called on his audience to "review all complaints, errors, incidents, and near misses—and agree with your team that you will be fully open and honest with patients and their loved ones when errors are made."

The error by a junior doctor that Dr Johnstone had to deal with resulted in no harm to the child, and he might have considered the option of avoiding open disclosure. Yet he says the possibility of saying nothing to the parents was never a serious option. Instead, he took a deep breath, showed them into a private room and, after first apologising, went on to explain in detail exactly what had occurred.

"It's quite different and perhaps more difficult to be honest about a mistake that's been made than it is to deliver bad news about the patient's health"

"It's quite different and perhaps more difficult to be honest about a mistake that's been made than it is to deliver bad news about the patient's health, something we sadly have to do regularly, he says. "Certainly, it's far more of a blow to the ego when you are the legitimate object of anger from the patient or their relatives.

"But I was taught that open disclosure was the right thing to do at medical school. And though I have been aware of a more paternalistic or defensive practice since I started working in hospitals, I feel instinctively that patients and their relatives have a right to know everything about their treatment. Our trust also has a policy of being open about errors."

Martin Elliott, medical director at Great Ormond Street Hospital and a paediatric cardiothoracic surgeon, is also a passionate campaigner for open disclosure as a key tool in improving both patient safety and the doctor-patient relationship—as well as being essential for the doctor's mental health.

"If you cover up a mistake and lie to others about what has happened, it's the first step to lying to yourself," says Professor Elliott, who has also had practical experience in this area. Two years ago, he had to report to relatives that the team's failure to highlight a tiny but potentially lethal congenital abnormality had caused brain damage to a patient having surgery.

"Being open and honest was truly distressing. But I had to take full responsibility for the mistake just as I take full responsibility for the success of 98.2% of the operations I carry out. It was important to explain in great detail what had gone wrong and how we would move to the next stage of initiating the right treatment to bring about the boy's recovery—something that fortunately was exactly what happened."

He says that in this case, as so often, open disclosure was essential to patient safety. "We did everything correctly, including carrying out reviews of the case and the literature on two occasions and using the surgical checklist during the operation—and still the mistake occurred," says Professor Elliott. "We have now tightened up these procedures even further—with the parents' active support. It was something we could not have envisaged as being necessary before this error was made."

A similar process occurred in Dr Johnstone's unit. The doctor responsible for making the original error was shocked and distressed that the error had occurred. However, he was given full support, having been judged to have made a mistake "that is just one of those things rather than a pervasive pattern of behaviour."

The Medical Protection Society believes the Department of Health must provide exactly this kind of support for doctors to come clean when they make errors rather than threaten them with legal sanctions if they keep quiet. "We want to see every hospital appointing an 'openness champion' as a strong and fearless crusader for this change," says Dr Bown. "And we also want to see health providers offering intensive confidential professional mentoring and explicit support for the health practitioners involved in adverse incidents."

Professor Elliott says the NHS needs to have its "Willie Walsh" moment, modelled on the former British Airways chief executive's explicit support for staff aboard the Boeing 777 that crashed at Heathrow in January 2008 with no lives lost. That same day—and long before an inquiry had established the cause of the crash—Mr Walsh went on to the runway to say he was "very proud" of the crew.

He added: "We train hard for incidents such as this and all that training has paid off today." Says Professor Elliott: "We need more of that spirit in the NHS. It's what happens after things go wrong that is so important."

Jane Feinmann freelance journalist, London, UK
jane@janefeinmann.com

Competing interests: None declared
Provenance and peer review: Commissioned; not externally peer reviewed.

1 National Audit Office. A safer place. NAO, 2005.
2 Medical Protection Society. Accountability in healthcare survey. MPS, 2009.
3 HM Government. The coalition: our programme for government. 2010. ww.direct.gov.uk/prod_consum_dg/groups/dg_digitalassets/@dg/@en/documents/digitalasset/dg_187876.pdf.
4 NHS Litigation Authority. Annual report 2010. NHSLA, 2010.
5 Boothman R, Blackwell AC, Campbell DA, Commiskey E, Anderson S (2009). A better approach to medical malpractice claims? *J Health Life Sci Law* 2009;2:1250-9.
6 Department of Health. Making amends—the CMO's proposals for reforming the approach to clinical negligence in the NHS. DH, 2003.

Cite this as: *BMJ* 2011;342:d3258