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Consultation on a statutory duty of candour

Thank you for the opportunity to provide input into the Expert Working Group's consultation on a statutory duty of candour.

Avant is Australia's largest medical defence organisation, providing professional indemnity insurance and legal advice and assistance to more than 75,000 healthcare practitioners and students around Australia.

In addition to assisting members in professional conduct claims, coronial inquiries and civil proceedings, Avant regularly provides members with advice, information, education and support about open disclosure and open disclosure processes.

Avant has long supported open disclosure in accordance with the Australian Open Disclosure Framework.[1] Avant has been involved in the development of open disclosure policies and procedures and in informing and educating our members about open disclosure.

Key points

1. Avant supports greater transparency in health care and supports open disclosure.
2. There are barriers to increased transparency and effective open disclosure that should be addressed.
3. Cultural change is needed in healthcare from a culture of blame to a culture of support, transparency and learning from error.
4. We are not convinced that a statutory duty of candour is necessary to achieve the aim of encouraging a just culture.
5. Hospitals and other health care organisations are already required to comply with the Australian Commission on Safety and Quality in Healthcare's open disclosure framework under the NSQHS standards.
6. Individual health practitioners have an ethical and professional obligation to disclose errors to patients.

[1] Avant's open disclosure position 13 February 2013

7. Victorian apology laws need to be strengthened, and the entire process of dealing with an adverse event, including open disclosure, incident investigation and root cause analysis should attract qualified privilege, whether or not a statutory duty of candour is introduced.

Before commenting on the issues raised in the consultation paper, we outline our experience of open disclosure.

Avant's experience with open disclosure

Patients are entitled to transparency especially when an adverse event occurs. Open disclosure is not about apportioning blame to an individual practitioner or others. It is about informing a patient about what has happened, ameliorating any harm to the patient and learning from the experience. Saying sorry is not only good patient care but it's the right thing to do.

In our experience of assisting members around Australia, practitioners are generally open with their patients when an adverse event occurs.

There are however some key barriers to effective open disclosure:

a. The current healthcare culture is a culture of blame, rather than a just culture. This means that practitioners can be wary that they may be blamed and targeted when adverse events occur. This is a disincentive to open and honest communication about adverse events and errors.
b. There are variable levels of understanding and knowledge about open disclosure. The right people are not always involved or adequately trained to effectively participate in an open disclosure process. We are aware of one hospital that went through a period of simply notifying doctors that they had to meet with the family after incidents but did not ensure the doctors were appropriately trained or prepared to have an effective discussion.
c. Practitioners are often concerned that by participating in open disclosure processes they may be exposing themselves to legal liability. We have seen matters where documents prepared by a hospital following an open disclosure process are handed to a patient who then commences legal proceedings against a practitioner involved in the incident.
d. Practitioners are often concerned that by participating in an open process they may be in breach of their professional indemnity insurance policy.
e. There is a lack of awareness and understanding about apology laws. Apology laws are not consistent around Australia, adding further confusion.
f. There is uncertainty around the availability of legal protections such as qualified privilege for root cause analysis and other processes. Greater clarity is required in Victoria.

Unless these barriers are addressed, improved transparency and better engagement with open disclosure processes will not occur, whether or not a statutory duty of candour is introduced.

We are not convinced that a statutory duty of candour is necessary

We accept and support the sentiments and rationale behind the duty of candour, particularly the need for greater transparency in healthcare. We agree with the need to encourage a just culture where open and honest communication with patients and their families occurs, where better detection and awareness of risk is encouraged, and where trust in health care institutions is strengthened.

However, Avant is not convinced that a statutory duty of candour is necessary to achieve these aims.

Hospitals and health services are already required to comply with the open disclosure framework. Failure to do so can lead to loss of accreditation.

Practitioners working in health services and hospitals are required to comply with hospital policies and procedures. Failure to comply with hospital policies and procedures can lead to disciplinary action and consequences for the practitioner's continued engagement at the hospital or health service.

Individual medical practitioners have an ethical and professional obligation to disclose errors to patients.[2] Failure to comply with this obligation can lead to regulatory action.

The recommendation in *Targeting Zero* to introduce a statutory duty is based on the position in the United Kingdom following events occurring at the Mid-Staffordshire Trust. However the UK position was different from that in Australia, primarily because before the introduction of a statutory duty in the UK, there was no open disclosure framework in place. Further, a recent report in the UK media casts doubt on the success of the statutory duty of candour in encouraging a just culture.[3]

Leadership, together with education and training is the key to the effective implementation of open disclosure. We believe rather than introducing a statutory duty of candour, it would be preferable to ensure that there is more education and training of practitioners about the current open disclosure framework and how to implement it effectively.

We are also concerned that the introduction of a statutory duty of candour may limit the existing practice of open disclosure, contrary to the intention of the *Targeting Zero* report. While it is proposed that the statutory duty will not replace the current open disclosure obligations, there is a risk that the addition of a statutory duty may cause confusion about whether the statutory duty or the open disclosure framework (and/or associated policies/procedures) should be followed.

[2] *Good Medical practice : A Code of Conduct for doctors in Australia* Available at: http://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx

[3] Vize, R : *Cost of NHS negligence claims soarsmas staff fear speaking out on safety*. Available at: https://www.theguardian.com/healthcare-network/2017/dec/01/nhs-negligence-claims-soars-staff-fear-speaking-out-on-safety

If a statutory duty of candour is introduced

If the aim of enacting a statutory duty of candour is to encourage open and transparent communication and to change the culture of healthcare, there may be benefit in imposing the duty on Boards and executives as a governance responsibility. A top-down approach that encompasses the whole system may encourage the deep cultural change needed to shift from the current blame culture to a culture of support, transparency, and learning from error to prevent recurrence. Supportive leadership is essential.

If a statutory duty is introduced, then in our view it should have the following features:

a. The statutory duty should not apply to individual practitioners. In our view, applying the duty to practitioners, if accompanied by penalties and AHPRA notifications for non-compliance, will reinforce a blame culture and will not lead to cultural change.
b. The statutory duty should align with and complement the existing open disclosure standards and policies. We are concerned that rather than clarifying the obligation it will cause confusion about whether the statutory duty or the open disclosure policy/procedure should be followed.
c. If the statutory duty is implemented as a governance responsibility for Boards and executives it should not contain detail about operational matters or specify elements of the open disclosure process. These are contained in the open disclosure framework.
d. The definition of the nature of the harm which would trigger the statutory duty of candour should mirror the open disclosure framework. In the framework, incidents of harm are categorised as 'low' or 'high' level thereby directing the response required.
e. If the aim of this new duty is to promote an honest, open and just culture in health care, the approach to non-compliance should be educative and proportionate not punitive. We believe that learning lessons from adverse events and fostering safety and quality in health care requires such an approach.
f. If the statutory duty of candour applies to organisations and not individuals, non-compliance with policies and procedure should not be grounds for notification to AHPRA or other regulators.

Victoria's apology laws should be strengthened and legal protections should be introduced

As noted above, potential medico-legal consequences are a barrier to participating in open disclosure practices. Many practitioners are concerned about their legal liability if they apologise to a patient. Many are unaware of the existence of apology laws. Further, as noted in the consultation paper, apology laws around Australia are inconsistent.

Regardless of whether a statutory duty is introduced, we agree that Victorian apology laws need to be strengthened, as recommended by the Victorian Ombudsman. Apology laws should be nationally consistent.

In our view, the relationship between open disclosure and incident investigation, including root cause analysis, needs to be considered holistically. The entire process, including open disclosure, incident investigation and root cause analysis, should attract qualified privilege. This will reassure practitioners that they are not exposing themselves to liability and will encourage a just culture where lessons are learned from adverse events.

General comments

There appears to be an assumption that whenever there is an adverse outcome, something has gone wrong and that the outcome could have been prevented.

However, sometimes nothing has gone wrong. Sometimes harm may result from a known or inherent risk of a procedure and with the best management, care and skill. While apologising and saying sorry for the adverse outcome is still appropriate in these circumstances, the discussion will be of a different nature from one where harm arose because of an avoidable error.

Whether or not a statutory duty is introduced, there should be comprehensive training on open disclosure and support for staff (who can be the second victim of an adverse event) during the process.

How a statutory duty will work in practice and its impact on operational issues is unclear, and may depend on how the relevant legislative provision is drafted. If a statutory duty is introduced, we would appreciate the opportunity to provide input into the wording of the legislation when it becomes available.

Please contact me on the details below if you require any further information or clarification of the matters raised in this submission.

Yours sincerely

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