Annex B to 11

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community research

Bringing the voices of communities into the heart of organisations

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Background and approach

In osteopathy and 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 and GOsC identified that work was required to explore candour as understood by patients.

Community Research was commissioned to conduct a face to face deliberative workshop. The day-long session was attended by 22 participants; all of whom had recent experience of attending a chiropractic or osteopathic appointment.

Key findings

The patient starting point

The term 'Duty of Candour' meant little to most participants. Once explained, the onus on the individual practitioner to raise issues prompted questions about levels of compliance and barriers to practitioners living up to these standards. There was very low awareness of how practitioners are regulated. There was a prevalent tendency to assume that there are Ofsted-like, inspections of practices or some form of 'mystery' shopping type exercises. Participants placed greater importance on the Duty of Candour when they discovered that regulation does not operate in that way.

There were a number of factors which impacted on patient expectations in relation to Duty of Candour, including:

- A sense that patients are inherently vulnerable when visiting a practitioner (because they may be in pain, find it difficult to make an informed decision about which practitioner to visit, or have limited understanding of treatments).
- The commercial setting, in some instances, raised expectations of service and care with some seeing themselves as 'consumers' rather than 'patients'.
- The practice setting itself was felt to influence expectations with some patients indicating that they might have lower expectations of practitioners who are practising in a more informal setting than those in a more medicalised one.
- There was a diverse range of views expressed. Expectations were quite individualised. Some participants were more cynical about both a practitioner's motivations and possible response to errors and hence more phlegmatic about what should happen in certain situations.

Expectations when things go wrong

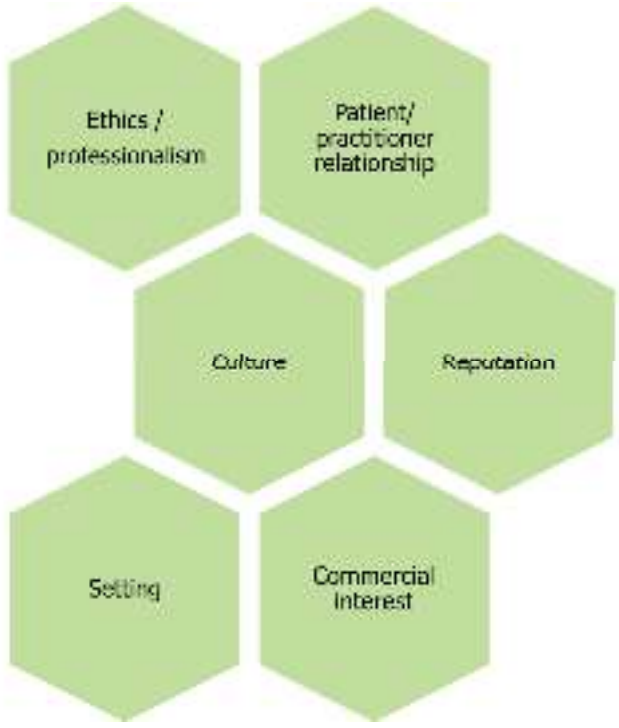
Patients were largely empathetic in relation to the challenges practitioners face in their practice, including those relating to compliance with the Duty of Candour. They

also placed some responsibility on the patient for taking an active interest in their treatment and engaging in a dialogue with the practitioner.

Various factors were identified by participants which they felt could influence compliance with the Duty of Candour, including the following:

- **Ethics / professionalism** – this was felt to be a key driver with being open and transparent with patients being at the heart of what it means to be professional.
- **Patient/practitioner relationship** – some felt that practitioners being candid would help cement relationships with patients and build trust. Others felt that practitioners could be concerned that it would diminish trust because patients may begin to question the practitioner's competence.
- **Organisational culture and setting** – participants felt that organisational culture could encourage or discourage candour depending on prevailing attitudes regarding blame. Setting was also felt to be influential i.e. those working alone or in smaller settings could have fewer sounding boards, or there could be less scope for errors to be identified.
- **Reputation and commercial interest** – participants felt that a key driver of candour was the need for practitioners to protect their reputation i.e. if mistakes later come to light which hadn't been brought to the organisation's or the patient's attention. However, they also felt that a desire for damage limitation may also encourage practitioners not to speak up, particularly if they felt it was not in their commercial interest to do so.

Figure 1: Factors influencing compliance with Duty of Candour



The importance of a practitioner reflecting on and learning from mistakes was a recurrent theme throughout the discussions. 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 were some instances that participants felt were clear cut in terms of their expectations of the practitioner in relation to the Duty of Candour. These tended to be where practitioners had not done the basic things right e.g., taken a full medical history or kept very sensitive information safe or confidential. However, they recognised that there were many potential situations that were much more nuanced, where there was considerable debate and no clear consensus about how the Duty should be applied.

Expectations of apology and redress

Participants appreciated apologies might be a challenging area for practitioners, raising perceived potential legal implications of a practitioner saying sorry. There was a presumption that any apology equated to an admission of guilt.

There was a broad consensus that a 'good' apology takes skill and considerable thought to get right. It should involve a dialogue with the patient. The majority 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, although it should be noted that some participants were much more focussed on (financial) redress.

It was felt that redress should be tailored and appropriate to the issue e.g., free clinical treatment for a clinical error if the patient is happy to return to the same practitioner. There was some discomfort with the idea of other forms of redress (e.g., flowers).

Patient information needs

Participants were clear that other patients needed to know the following:

- Some basic information on how chiropractors and osteopaths are regulated.
- How to find information on practitioners that have done something wrong (i.e. information held on GCC/GOsC registers).
- How to report a complaint.

There was less call for patients to be told explicitly about the Duty of Candour. Participants placed more emphasis on practitioners being given support in the form of clear guidance and examples to help them navigate this challenging area. If patients are informed about the Duty, participants felt that information could be provided on GCC or GOsC websites (ideally avoiding the term 'candour' which was not easily understood).

2. Background, objectives and approach

Background

Registrants are specifically required under GCC Guidance and GOsC Guidance to fulfil the Duty of Candour as part of the professional relationship between chiropractor/ osteopath and patient. This relationship depends on trust, and the Duty of Candour is key to that relationship. In any health care 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 2014 there was a joint statement and a renewed commitment from the Chief Executives of statutory regulators of healthcare professionals on the professional Duty of Candour. This stated:

- Every healthcare professional must be open and honest with patients when something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress.
- This means that healthcare professionals must:
  - tell the patient (or, where appropriate, the patient's advocate, carer or family) when something has gone wrong;
  - apologise to the patient (or, where appropriate, the patient's advocate, carer or family);
  - offer an appropriate remedy or support to put matters right (if possible); and
  - explain fully to the patient (or, where appropriate, the patient's advocate, carer or family) the short and long term effects of what has happened.
- Healthcare professionals must also be open and honest with their colleagues, employers and relevant organisations, and take part in reviews and investigations when requested. Health and care professionals must also be open and honest with their regulators, raising concerns where appropriate. They must support and encourage each other to be open and honest and not stop someone from raising concerns.

In 2019, the Professional Standards Authority Report into Candour[1] noted that 'public awareness of the duty of candour is debatable, with…participants suggesting that the public rarely mention of candour' with recommendations centred on professionals and guidance for professionals.

In 2022, the GMC and NMC published updated joint guidance about candour which went into further detail about patient expectations during a 'candour event' (when things go wrong as a result of care or where there is uncertainty around this), for

[1] telling-patients-the-truth-when-something-goes-wrong---how-have-professional-regulators-encouraged-professionals-to-be-candid-to-patients.pdf (professionalstandards.org.uk)

example, how best to support the patient to make a shared decision about candour, how to make an apology.

In osteopathy and 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 or conflict of interest. Given this opacity, GCC and GOsC identified that work was required to explore candour as understood by patients. In particular, better understanding of patient expectations in these circumstances and how patients can be supported to be partners in their care before, during and after, if things go wrong.

Objectives

Key objectives of the engagement were:

- 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 GCC and GOsC websites and information regarding Duty of Candour for registrants, i.e. what do patients need to know about the Duty of Candour?

Approach

Community Research was commissioned to conduct a face-to-face deliberative workshop. The day-long session, held on the 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.

Recruitment of patients

GCC and GOsC both have established vehicles which facilitate ongoing patient engagement. GCC has a Patient Advisory Panel which has given their views and perspectives on a range of topics including consent and professionalism. GOsC has its own Patient Involvement Forum, where patients have the opportunity to take part in a range of activities such as focus groups, surveys, working groups and consultations.

In total, six members of GOsC's Patient Involvement Forum attended the session. It should be noted that Forum members had had ongoing involvement with GOsC and so had a little more insight into the regulatory context than other patient participants. They also differed from the other participants in that one worked in healthcare, one was a carer rather than a patient and one only saw an osteopath in a university setting.

In addition to the Forum members, sixteen patients were recruited to match a pre-agreed specification, reflecting a range of demographics. The specification was designed to be broadly reflective of the UK population, with reference to the following criteria:

- Gender
- Age group
- Ethnic background
- Working status
- Social grade

Of these sixteen, twelve were chiropractic patients and four were osteopathic patients. All saw practitioners working in private practice and none were working in healthcare. Further details are provided in Appendix 8.1.

Anyone who had been involved in a Fitness to Practice complaint was excluded so as to ensure that discussions did not focus on a specific (potentially sensitive) instance where things had gone wrong.

Participants were offered a payment of £120 to thank them for their participation. This is common practice in market research, and an important principle to demonstrate the value placed on the time and effort people give to take part in research. This approach aided the inclusion of individuals who would not otherwise have been able or willing to take part in research.

Design and facilitation

There were three tables of participants; two of which were mixed osteopathic and chiropractic patients and the other comprised members of the GOsC Patient Involvement Forum. The discussion content at all tables followed the same agenda which was designed to ensure that participants were given an opportunity spontaneously to discuss their thoughts on Duty of Candour, prior to listening to a presentation to help them to understand the issues from a regulatory perspective. This presentation was given by Steven Bettles from GOsC and Penny Bance from GCC.

Facilitation at the discussions was undertaken by Community Research and observed by representatives from GCC and GOsC. The plenary sessions were audio-recorded and fully transcribed with the permission of the participants.

The approach, which built on workshops conducted with osteopaths, patients and key stakeholders in 2016, employed a range of hypothetical scenarios to help bring the topic to life.

The final agenda for the workshop session and the scenarios are provided in Appendix 8.2.

Notes on the report

There are a number of caveats to bear in mind when considering the research findings.

It is worth noting that participants who took part in the workshop 'opted in' to the process and actively responded to communication about the research saying that they were willing to participate. It could be that those who opted into the process were different in some way (in terms of their approach or attitudes) than the wider sample of patients eligible to participate.

It is also important to note that qualitative research is not intended to be statistically reliable and, as such, does not permit conclusions to be drawn about the extent to which something is true for the wider population.

These caveats do not negate the value of the research but should be borne in mind when considering the findings.

Throughout the report, quotes have been included to illustrate particular viewpoints. We have distinguished between quotes made by members of GOsC's Patient Involvement Forum and those from the other two tables of mixed chiropractic and osteopathic patients. It is also important to remember that the views expressed in the verbatim quotes do not always represent the views of all participants who attended.

It should be noted that throughout the discussion there was no differentiation between expectations relating to chiropractors and osteopaths. The report, therefore, refers to 'practitioners' rather than the two specific professions.

3. The patient starting point

Section summary

The term 'Duty of Candour' meant little to most participants. Once explained, the onus on the individual practitioner to raise issues prompted questions about levels of compliance and barriers to practitioners living up to these standards. There was very low awareness of how practitioners are regulated. There was a prevalent tendency to assume that there are Ofsted-like, inspections of practices or some form of 'mystery' shopping type exercises. Participants placed greater importance on the Duty of Candour when they discovered that regulation does not operate in that way.

There were a number of factors which impacted on patient expectations in relation to Duty of Candour, including:

- A sense that patients are inherently vulnerable when visiting a practitioner (because they may be in pain, find it difficult to make an informed decision about which practitioner to visit or have limited understanding of treatments).
- The commercial setting, in some instances, raised expectations of service and care with some seeing themselves as 'consumers' rather than 'patients'.
- The practice setting itself was felt to influence expectations with some patients indicating that they might have lower expectations of practitioners who are practising in a more informal setting than those in a more medicalised one.
- There was a diverse range of views expressed. Expectations were quite individualised. Some participants were more cynical about both a practitioner's motivations and possible response to errors and hence more phlegmatic about what should happen in certain situations.

Levels of awareness

Low awareness of the term 'Duty of Candour'

The term 'Duty of Candour' meant little to most participants. A few associated candour with honesty and openness but they also tended not to have a clear understanding of what it meant in relation to osteopathic or chiropractic care. Only one participant (who was from the GOsC Forum) was able to articulate what it meant in this context.

> Well I'm thinking, based on what I know candour to mean, it's about you need to speak honestly about something. So I assume Duty of Candour means duty to be honest about something, to speak openly about something. (Participant from the mixed tables)

> It is about being transparent if they've made a mistake and to be up front about it; but candour really means honesty, so it's about being transparent with the patient, not just trying to beat around the bush, to not upset or to worry people. It's just actually being really clear as to what they're seeing in the patient and not hiding things. (GOsC Forum member)

When initially asked about it, participants at all the tables asked if it meant or was related in some way to 'duty of care'. They were much more familiar with this phrase (although not necessarily totally clear about what it means).

> 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. (Participant from the mixed tables)

> So for me, Duty of Candour is a duty of care, just another word. I was saying osteopathy is having duty of care for their patients, to give them the best quality of care and treatment. So that's what I thought it was the whole time. (GOsC Forum member)

Whilst there was low recognition of the phrase, the duty made intuitive sense to participants, once explained. Some likened it to the Hippocratic Oath taken by doctors. Some felt that it was such an obvious thing for practitioners to be doing, they questioned whether it actually needs to be outlined in the regulatory guidance and standards at all – it was seen as an implicit part of being a professional and behaving with integrity.

> I would have thought that most people in health or people that are dealing with people would have to abide by that kind of rule *anyway*. So the fact that it's been outlined like that, I don't know, it just feels a bit weird. (Participant from the mixed tables)

> I wouldn't think they would put that as explicitly in there, because that is just the social norm, if you've done something wrong. (Participant from the mixed tables)

Low awareness of the regulatory context

Linked to this, in common with other research we have conducted for GCC, GOsC and for other health professions' regulators, there was very low awareness of how practitioners are regulated.

There was a prevalent tendency to believe that there are Ofsted-like, regular inspections of practices which monitor whether practitioners are complying with standards or some form of 'mystery' shopping type exercises.

> [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? (GOsC Forum member)

The onus on the individual to raise issues prompted questions about levels of compliance and the barriers to practitioners living up to these standards. Participants placed greater importance on the Duty of Candour when they discovered that regulation does not operate in the way that they expected[2].

> For example, my father is in care and they don't rely on the honesty of the carers. There is an infrastructure around the carers, where they check the carers' work and they don't rely on their word. (Participant from the mixed tables)

> At least in a hospital, you may have other nurses witnessing things and they might be a whistleblower but most people don't whistleblow themselves, so they need to be held to a higher account. (Participant from the mixed tables)

Factors influencing patient expectations

The context in which patients receive treatment was important as it had a bearing on their expectations more broadly as well as in relation to the Duty of Candour.

The patient as inherently vulnerable

Whilst some patients used a chiropractor or osteopath as part of a general health-management programme to ensure that they continue to be in good health, others reflected on how they tend to visit a practitioner when they are in pain and are, therefore, inherently vulnerable.

They also discussed the fact that, because osteopathic and chiropractic treatment tends not to be available on the NHS, patients themselves are responsible for deciding to visit a practitioner and selecting which practitioner to use. They do not have the reassurance of knowing that they have been referred for a course of treatment that they definitely need and to the right practitioner for them. In this more commercial environment, some also highlighted the risk of patients being mis-sold treatments that aren't actually needed.

[2] Few had actively considered how regulation might operate prior to the workshop, but when considering the issues raised in the workshop participants frequently expressed these Oftsed-style expectations.

> 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, whatever. I mean, 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?' (Participant from the mixed tables)

> I think people feel safer when they get a referral from their GP to see a particular specialist; they feel confident. But no one's going to give you a referral to go and see a chiropractor or an osteopath; you do it of your own free will. (Participant from the mixed tables)

This was compounded by the fact that they felt that they would not necessarily know if something had gone wrong with their treatment as they do not have the knowledge or experience to make a judgement. They made the point that sometimes treatment does result in soreness afterwards but this isn't necessarily a negative.

> Well I was just thinking, like, how does that apply to … because I was thinking, like, for me, personally, for my appointments, I don't know what she *would* have done that would be wrong, so I don't know if I would ever know. (GOsC Forum member)

They felt that this context (and the perceived differential in power) means that patients need to have trust in their practitioner to act professionally and responsibly. Practitioners complying with the Duty of Candour became more important through this lens.

The patient as a 'consumer'

This picture was complicated by the fact that some patients also highlighted that they tend to pay for treatment and see it as a more commercial relationship than they would NHS treatment. For some, this translated into having higher expectations of their care generally – both when it is going well and if something has gone wrong. They indicated that they are well aware of the pressures on the NHS at the moment and so may let something slide 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.

> If I ever get admitted to an NHS – and my little ones have – and there's a mistake, I tend to overlook it, as long as it's not detrimental, because I know the staff are working tirelessly hard, underpaid…. It's like someone giving you something for free and I'm not going to moan about it; you can swallow certain parts; but if you're paying a premium, I want premium service. (Participant from the mixed tables)

> That's why I think it's different when you're paying, because if I was paying, I would expect top notch; but when I go to the hospital, when it's not the staff who are choosing their team size, they're given people to care for, that's different. (Participant from the mixed tables)

The impact of setting

It was also highlighted that some patients might have 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.

> The patient's expectations might differ though, so they might be more or less likely to hold the osteopath to account, because we're kind of trying to expect certain things from medical settings and certain things from a home setting, but it shouldn't be, but it might happen. (GOsC Forum member)

> 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.' (Participant from the mixed tables)

> I see this Duty of Candour as something that puts that burden on them, not on me because it's them that have to be open and honest with me. So irrespective of whether or not I feel that they should be, I feel that it's something that is their job to actually do it, irrespective of what the patient expects. (Participant from the mixed tables)

Individual perspectives

It should be noted that, whilst there was a broad consensus in some areas, there was a diverse range of views expressed. Expectations were quite individualised. This is perhaps unsurprising given that expectations may have been formed through a combination of previous experience, the nature of their current relationship with their practitioner and each individual's general view of the world. Some participants were clearly more cynical about both practitioners' likely motivations and possible responses to errors and hence they were more phlegmatic about what should (or would) happen in certain situations.

At one of the tables there was a discussion about what they *hope* a practitioner would do in a specific hypothetical scenario being different to what they *expect* they would actually do in practice:

> Because, I mean, if the patient doesn't know that you've done something wrong, I mean, we *hope* that they would be honest; but I reckon how many people really *would* be? (Participant from the mixed tables)

4. Expectations when things go wrong

Section summary

Patients were largely empathetic in relation to the challenges practitioners face in their practice, including those relating to compliance with the Duty of Candour. They also placed some responsibility on the patient in terms of taking an active interest in their treatment and engaging in a dialogue with the practitioner.

Numerous barriers were identified to practitioners complying with the Duty of Candour, including organisational culture, commercial interest and a lack of a sounding board when working in sole practice. Drivers for practitioners being open about mistakes included:

- The need to act ethically and professionally.
- Potential to enhance the patient/practitioner relationship.
- Damage limitation / preventing reputational damage.

The importance of a practitioner reflecting on and learning from mistakes was a recurrent theme throughout the workshop. 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 were some instances that participants felt were clear cut in terms of their expectations of the practitioner in relation to Duty of Candour. These tended to be where practitioners had not done the basic things right e.g., taken a full medical history or kept very sensitive information safe or confidential. However, they recognised that there were many potential situations that were much more nuanced, where there was considerable debate and no clear consensus about how the Duty should be applied.

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 the Duty of Candour.

Challenges in practice

Whilst expectations of practitioners were high, there was a strong sense that participants appreciated that practitioners are working in a challenging field and mistakes will happen.

There was a presumption that practitioners have good intentions and are not intentionally out to cause harm.

> Did you manipulate the back and the neck [and cause a problem] because you're aware that it may be linked and you may believe the issue? Or did you just do it for fun? (Participant from the mixed tables)

They felt that sometimes practitioners are doing their best in the absence of important medical information. They also stressed that 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. Some 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).

> Because for me, 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? (Participant from the mixed tables)

> Is there not also an element here of patient honesty as well, that it's a two-way street? I'm sorry, I've been binge-watching House and of course, he always says: 'All patients lie.' So if you've withheld a condition from somebody treating you and then they do damage…there's the patient honesty, the practitioner honesty and the obligation of a practitioner to come clean. (GOsC Forum member)

Others focussed more on infrastructure issues, believing that medical notes between NHS and private practitioners should be shared more systematically and seamlessly.

Challenges complying with the Duty of Candour

Participants 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.

> It's the repercussions of what will come to the practitioner. If I'm honest and actually say, 'This is what went wrong, or this is what happened,' am I going to

> lose my job now? You know, am I going to not then be able to afford my lifestyle or my care, whatever other responsibilities I have? (Participant from the mixed tables)

> You wouldn't expect an osteopath to go wrong, would you? If they did, some people, I don't think this would happen; some people would keep it inside, instead of admitting that they'd done something wrong. (Participant from the mixed tables)

Participants also noted that the environment in which practitioners are working could have an impact on the ability and willingness of individuals to be candid.

- Some flagged that, in larger settings, organisational culture has a huge bearing on whether individuals feel comfortable speaking up.
- However, in smaller settings, practitioners do not have the support of colleagues which would be beneficial in identifying issues and tackling them.

> So sometimes, it's just about creating a culture, where it says, 'We'd like you to own up about your mistakes; we'd like you to own up about your errors, because we're humans and we do make errors.' And just because you made an error does not mean you're a bad person, or that you've done a bad job. (GOsC Forum member)

> When they talked about the fact that they're not necessarily employed or working with colleagues and there's a lot of scope for covering up wrongdoing – or maybe not even realising that there has been, that they've got something wrong. So how important this is and how they can be supported in monitoring themselves, or putting in remedial actions, when they might not have anything to measure it to, or any colleagues to learn from, you know? (GOsC Forum member)

Rationale for transparency when things go wrong

For many participants, there were 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.

> 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.' (GOsC Forum member)

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.

It was felt that a practitioner being candid about what has or could have gone wrong would help build trust rather than necessarily diminish it. This would enhance the patient/practitioner relationship and also be good for the practitioner's business in the long term.

> I mean it's about building trust and little moments like that is what builds trust. (GOsC Forum member)

> The practitioner shouldn't feel anxious that he's done anything wrong. I think he should be professional and raise it with the patient and his family, loved ones….And I think the family will respect him more for that, because he's taken away the anxiety of what's caused it, why has he got the bruise? (GOsC Forum member)

Some also flagged the potential negative repercussions of not saying something as being a key driver for openness.

> It's just like, even in my field, for example, if you've made a mistake, rather than hiding it – because accidents happen, we're humans, so it's in your interest to raise it, if anything. If you *don't* talk about it, or *don't* highlight it, there will be severe consequences because of that. (Participant from the mixed tables)

In discussions, in relation to some of the hypothetical scenarios introduced in the session, participants could imagine issues coming to light at a later stage and it being worse for the practitioner if they hadn't raised the issue at the time. For example, in relation to Scenario C where the patient experienced bruising, participants flagged that another health professional or individual may see the bruising and report it.

> [In relation to Scenario A] They still should say it, to be honest and in case further down the line, he then comes in, a few weeks later and goes: 'Oh, my other shoulder's hurting now.' You might think: 'Crap, it was me the other week. (Participant from the mixed tables)

> [In relation to Scenario B] The practitioner, also, will be more encouraged to report it himself. Because if he's got the feeling that patient might report it, he's more likely to report it himself. That way it shows that at least if he's made a mistake, he wasn't trying to hide it. (Participant from the mixed tables)

A further key driver for transparency was the need to ensure that there is shared learning from anything that goes wrong or could go wrong. This is further explored in Section 4.4.

Importance of listening to the patient

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 throughout the discussions.

> It's not a kind of confession; it's about having it within a conversation (GOsC Forum member)

It was felt that practitioners need to be openminded to hearing the patients' 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.

> But at the same time, the patient's experience of being in their body, if they say something's not right, that is gospel. The osteopath is not in the patient's body; they cannot assess how they feel. Only the patient can do that. (GOsC Forum member)

Importance of individual reflection/organisational learning

The importance of a practitioner reflecting on and learning from mistakes was a recurrent theme throughout the session. 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.

> Yes, they need to have a curiosity to ask more questions, so say: 'OK, what's the pain? Is it sharp, is it dull?' All these questions to decipher what it is. And once they have enough information, they'll be like, 'OK, well, I did do this. It possibly could be this. It might be that I've done something wrong.' (GOsC Forum member)

> I feel like the fact that [in Scenario A] his question is good, it's reflective of him as a person and their practice, thinking: 'Is it me or is it … have I gone above? Let me just check.' (Participant from the mixed tables)

There was also a strong focus on the importance of organisational learning and a 'no blame' culture. There was a call for all issues to be documented and recorded in a transparent way to allow for learning to be shared.

> But I suppose with near misses, there's learnings in there. So even like 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. (Participant from the mixed tables)

> The practitioner needs to, obviously, come clean, tell the patient [in relation to Scenario C], but also, tell the patient about improved systems, to make sure that this sort of thing doesn't happen again. (Participant from the mixed tables)

Participants wanted to know and be reassured about how this is being done in a profession like chiropractic or osteopathic where professionals don't tend to work in very large settings or in multi-disciplinary teams.

> Because the important thing is that these Councils [GCC/GOsC] need to know about these situations. They keep a record of all these little mishaps that happen and they can all learn from it. (Participant from the mixed tables)

Scope of the Duty of Candour and specific areas of debate

There were some instances that participants 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.

They also felt that practitioners should inform the patient if something relatively serious has gone wrong but the patient is not aware of the issue.

> I don't think there's ever, ever a scenario where you don't tell the patient your actions caused that, based on all of those scenarios. I think it will be really hard in a tribunal to stand there and go, 'I just didn't want him to worry, so all the bruising on his back, I thought I'd just keep it quiet.' (Participant from the mixed tables)

There was general sense that the practitioner should err on the side of caution and be open about any issues with patients.

> 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. (GOsC Forum member)

However, it was acknowledged that this is a complex area. For example, even determining what 'going wrong' actually means is difficult.

> I feel like it depends on what you mean by it going wrong. So, for example, if my expectation is that I'm going to get a particular outcome from this treatment and that didn't happen, then a conversation or accountability can be discussed. But if you mean wrong as in, I came in with a condition and you've worsened it, then that's a different, to me anyway, a different conversation, or a different step forward. (Participant from the mixed tables)

Specific debates

Participants were given a range of hypothetical scenarios to discuss to help draw out specific issues in relation to Duty of Candour. They were particularly aimed at teasing out some of the nuances and shades of grey.

Duty of Candour in relation to non-clinical issues

Although clinical issues tended to be top of mind initially for participants, there was a broad consensus that Duty of Candour should also be applied to non-clinical issues.

> At the end of the day, like when you said the word transparency, I think that just should be the blanket thing for all of it. I don't think it should make a difference whether it's clinical or not. (GOsC Forum member)

Participants were given a scenario relating to patient notes being left out in a treatment room and another patient seeing them. They were also asked for their views on an instance of the notes being mistakenly left in a public place.

There were some quite mixed views on this scenario. A small number of participants felt that the data breach was not an issue and shouldn't be flagged to any affected patients.

> I think theoretically, by the book, they should probably ring the patient and say: 'I'm really sorry, I left your notes out, that's a breach of GDPR. I felt obliged to let you know.'…But in reality? I would think they were nuts if they rang me to tell me that. (GOsC Forum member)

> Sometimes you can be a bit economical, to keep the patient at ease. (GOsC Forum member)

The majority felt that it was an issue which called for openness but tended to feel that the action depended on a number of factors:

- **What information has been left out** i.e. if just a patient name was visible, then no action is needed (other than ensuring that future processes are robust) as this information is not sensitive. They likened this to being at a GP practice and patient names being called out in the waiting room. However, leaving detailed medical notes visible did call for action.

  > If it's just a name, generally, you're signing in and out of a register and start filing, names are names. You see people walking in and out. It's a chiropractor; it's not like GCHQ. (Participant from the mixed tables)

- **Where the information has been left** i.e. leaving any information in a public place was felt to be a significant issue.

  > That will be recorded at the Council [GCC/GOsC] and information about that would be visible to potential patients. You know you were saying about you can

> go on to the register and look up and see if any practitioner has any issues? That would be one of those, I think. (Participant from the mixed tables)

This spectrum in relation to the perceived seriousness of the issue does reflect the Information Commissioner's Office (ICO) guidelines[3] which state that individuals need to inform the ICO if, left unaddressed, such a breach is likely to have a significant detrimental effect on individuals (but not otherwise).

Some of the concern about this scenario centred around the fact that the practitioner in question had asked the patient who saw the notes to not tell anyone about the breach. They felt that this behaviour raised huge red flags.

> I mean saying to patient, 'Don't tell no one,' is almost like saying things like, 'I've done something really wrong and you're going to help me keep it a secret.' It's not the way to speak to them and it's not going to work. (GOsC Forum member)

Duty of Candour in relation to small things going wrong / near misses

There were similar debates in relation to the Duty of Candour both in relation to small things going wrong and having minimal impact on the patient and things that went wrong but had no impact on the patient (but could have) i.e. near misses.

In both instances there was a broad consensus that practitioners should record and highlight the issues to colleagues and the profession more widely to ensure that there are shared learnings.

> If you aren't going to tell the person, in terms of the patient, because it *didn't* happen, you don't need to freak them out from the fact that you've acknowledged that that you've done something you *shouldn't* have; but you make sure that your manager or a person above you is aware that *you* are aware that you made that mistake. (Participant from the mixed tables)

> I think in *that* scenario [Scenario A], there's valuable information, potentially valuable information to share with the entire health team that might be concerned with the patient and that's why transparency might be a good idea; and that doesn't include saying: 'it's your fault' or telling you something's wrong. (Participant from the mixed tables)

However, there was less consensus about whether patients should be told. Some felt that it was not necessary to tell the patient as it could cause anxiety or a loss of trust which would be unnecessary, given that there have been no adverse impacts.

[3] Personal data breaches | ICO

> This is a bit tricky. Sometimes, it's better not to let people know when something's gone wrong, especially if it doesn't make that much of a difference to the patient. (Participant from the mixed tables)

> Yes, I can't think of a situation where the patient would *need* to know, because no relationship's been broken, no trust has been broken, no incidents occurred. It's almost *irrelevant* to the patient. (GOsC Forum member)

> I personally don't *think* so, because I think it is the opposite to building trust. I think it potentially can break ... I don't know; it's hard, isn't it? Because nothing wrong has happened, no mistakes have been made. (GOsC Forum member)

However, others felt strongly that patients should be told so that they can decide whether it does actually matter to them or not – rather than the practitioner deciding for them. They should have the full information and then they can decide how they feel about that practitioner.

> That's fair enough from a *personal* point of view, but from a *professional* point of view, it's your duty to have to give the patient the ability to choose. OK, they might tell me something that doesn't really matter to me personally, or I might choose to say, 'You know what? No, that actually *does* matter to me.' So it's all about giving the patient choice. (Participant from the mixed tables)

> Like a near miss, that's like a bit too close for comfort to being a mistake, isn't it? And then, if it's not been told, then how do you know that that's not going to happen again? The next time you go to see your osteopath, what if another near miss happens and they just keep not saying anything? That's really *awful*. (GOsC Forum member)

Others were quite conflicted in terms of what they felt was the best approach.

> I think if one practitioner made ten mistakes or mishaps that didn't impact a customer or a patient but then, because they're used to that kind of error, not doing things in other practices, and then, the eleventh time, it has really material impact, if they were honest before and said, 'Oh, I made a mistake, but it hasn't really impacted you,' you, as a customer would probably…start to question their credibility a bit. And that's bad for them, because you're paying to see them, but you're also paying for them to be professional as well. (Participant from the mixed tables)

Duty of Candour in relation to the practitioner being unsure if they have made a mistake

Participants were given a scenario (A) which outlined a situation where there was uncertainty about whether the practitioner had done anything wrong (and where the patient was very happy with their treatment).

Participants had different responses to this which largely reflected their own relationship with their practitioner. Some felt that osteopathic/chiropractic care is not a perfect science and can involve a practitioner 'feeling their way'. In this spirit, they felt that a practitioner should be open about their uncertainty as part of a wider discussion about the treatment.

> I don't think he's made a mistake. Everything is so connected in the spine and the patient is happy, but if the *practitioner* is happy, then he owes it to himself *and* to the patient to discuss it, to have the conversation, to conduct, maybe, further tests. (GOsC Forum member)

> I would expect that as a minimum, not to raise it like something's gone crazily wrong, but at least, 'OK, well, you know what? Actually, let me assess.' So, they can have a second look at it, because at the end of the day, there could be a link. There might not be, but there could be and it's to do with health. So if there's a possible chance, you look into it. It doesn't mean you're guilty. (Participant from the mixed tables)

For others, this would undermine confidence in the professional. They felt that they wouldn't have to raise the issue as there was some discussion about risks before the treatment started and highlighted that the patient in that particular scenario was very happy with their treatment.

> For me, I think nothing, because he did warn the person before he started the treatment, saying it could make it worse. (Participant from the mixed tables)

> And also it's telling if the patient is willing to go back. And if he didn't think the practitioner did do a good job, it shows me that he wouldn't go back if he wasn't happy with it. (Participant from the mixed tables)

One patient felt that the decision would depend on the level of doubt in the practitioners' mind i.e. their perception of the likelihood of their creating the issue.

> 'Well, when I treat one area, I'm automatically, in a high percentage of cases, going to cause a pain somewhere else.'? Or do they know in their heads: 'I didn't do well that day'? (Participant from the mixed tables)

5. Expectations of apology and redress

Section summary

Participants 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.

There was a broad consensus that a 'good' apology takes skill and considerable thought to get right. It should involve a dialogue with the patient. The majority 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, although it should be noted that some participants were much more focussed on (financial) redress.

It was felt that redress should be tailored and appropriate to the issue e.g., free clinical treatment for a clinical error if the patient is happy to return to the same practitioner. There was some discomfort with the idea of other forms of redress (i.e. flowers).

There was 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. Participants felt that some situations needed acknowledging, but didn't actually require an apology per se.

> It's care, because I mean you're in the care field, so it's all about being empathetic. It doesn't mean you're admitting the liability of guilt. And again, I think it links to the … it's almost customer service, also, in a way, because they're still a client of yours. (Participant from the mixed tables)

> Well you don't want to indict yourself too much or leave yourself too vulnerable for legal action; but you've got to give full disclosure in terms that will not result in greater impunity than the situation warrants. (GOsC Forum member)

> They're not apologising for something that they didn't do; they're just saying: 'You've come to me with that problem; let's explore it a little bit and then if it isn't me, I'll point you somewhere else." (GOsC Forum member)

> In terms of openness, they should own the fact that it may be something that they've done, but not necessarily say, 'Oh yes, I've done it; I've caused you a problem,' because actually, it's probably perfectly normal practice to make these alignments, or the adjustments, or whatever. (Participant from the mixed tables)

There was a general consensus that language used in this context was crucially important and that time should be taken to craft any response.

> 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. (GOsC Forum member)

One participant differentiated between saying sorry and a full apology.

> 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. (Participant from the mixed tables)

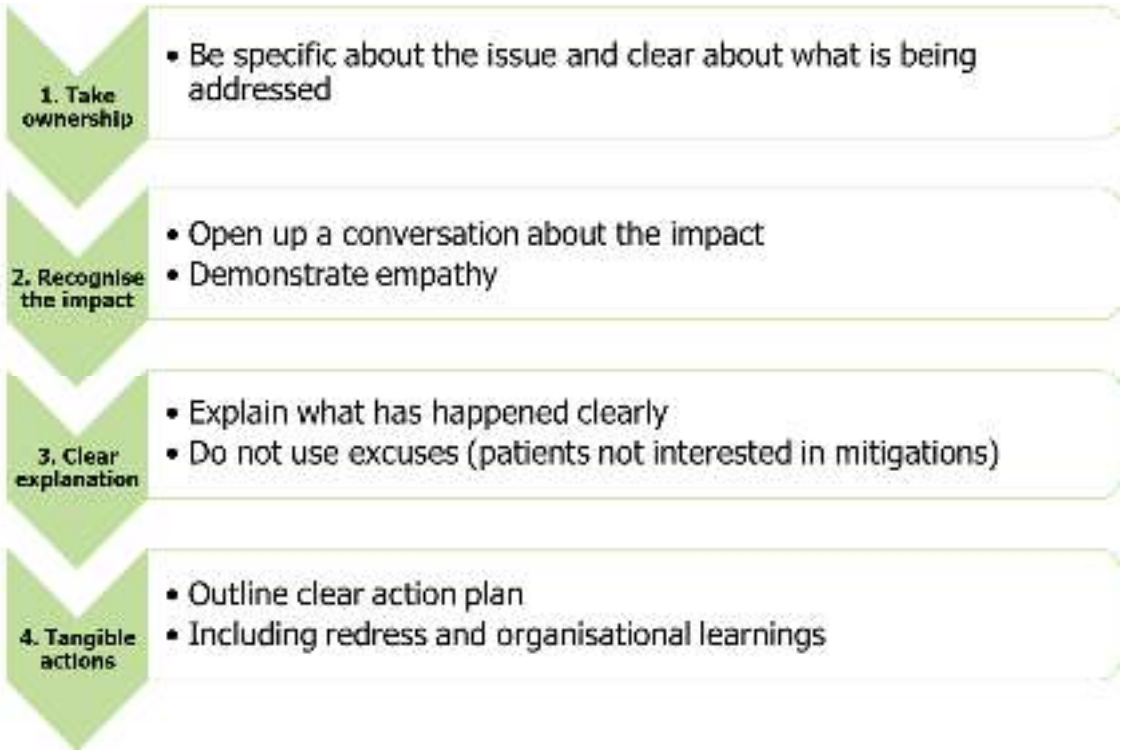
The 'ideal' apology

A phased approach

One group couched their apology in terms of a 'restorative conversation' in four parts as outlined in the diagram below.

> The truth of the matter is, many people in life – professional or not – don't know how to give a proper apology and so really, a proper apology has got many stages. One of the latter stages is talking about what steps you will do to make sure that this doesn't happen in the future. (GOsC Forum member)

Figure 2: The stages of an 'ideal' apology



Once again there was some focus on the importance of practitioners reflecting on what happened and organisational learning.

> It is a chance of showing the learning as a moment of reflection, as to how we can make changes and how committed you are to make changes in the future, to prevent a similar mistake, near miss, incident from happening again and a plan of action, as to what you're going to do. And I think that's really important to say that, because otherwise, if you're just saying sorry and that's it, how do you know it's not going to happen again, basically. (GOsC Forum member)

> I'm reminded of the suffragettes thing: deeds, not words. So a bad apology is words only. So a good apology is words that explain what actions we're going to take. And the best apology is actions that makes my life better. (Participant from the mixed tables)

However, it should be noted that a small number of participants were not interested in what the practitioner was doing in terms of future learning but purely on the actions that they propose to put things right for them.

> Well, putting things right, I'm less concerned about it. When I say about me, if you've done something wrong, how am I going to be compensated for this thing? That's straight up. Am I getting a free chiropractic session? (Participant from the mixed tables)

Key considerations when apologising

- **Consider the tone** - ensure it is and sounds genuine.

> Right, That's one of those wiggly apologies. 'I'm not sorry *I* did anything; I'm sorry that you're in pain.' (Participant from the mixed tables)

- **Keep it simple** in terms of language i.e., don't over complicate, use jargon or 'blind with science'.
- **Encourage a dialogue.**

> So, it's not just you talking at the person; this is where you open a conversation. And that's to get better understanding of the impact. And so the feelings are valid and making your person feel valid. (GOsC Forum member)

> We used the word 'active listening', in the sense that they're part of that conversation, rather than going: 'really, really sorry; here's your bill written off.' (Participant from the mixed tables)

- **Make it patient centred** i.e., focus on what they want and tailor it to them (for example, offering to give more information if required).

> Well yes, I mean, so engage them in in terms of remediation, in terms of making them whole. In other words: 'Look, I hurt you on this. What would you like me to do, so it feels better?' And then, you also look at whatever process had let you make that error in the first place. (GOsC Forum member)

> You could say, 'Here's how we could address this; what would you like to do?' Would you like to come in and read the notes?… And going: 'Oh, it's kind of up to you. This is what happened. You can ask any questions, you can do whatever you want,' and then, that goes back to putting the patient in the centre of the situation. (Participant from the mixed tables)

Who from?

In most instances participants 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, it may be more appropriate for correspondence to come from an insurance company or lawyer.

> 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. (Participant from the mixed tables)

When?

It was 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). There should also be a clear timeline in terms of any actions.

One group felt that the issue should be flagged immediately but that the full apology could come later.

> He needs to do it immediately, yes, I'd say so [in response to Scenario D]. And it wouldn't even take long; it would just be like, maybe five minutes longer, to maybe ten. Be like, 'Oh, I'm sorry, I've jumbled it up, I've been treating the incorrect side; I'll just do the proper side.' (GOsC Forum member)

> Well, we thought that a good apology should be offered as soon as possible, after reflection, you know: time to really consider it. (GOsC Forum member)

> Like we were saying, maybe you might have to work out what information you can provide, or double check your facts; there might be a reason why it's not offered and you want to get your ducks in a row; but within a reasonable timeframe. (Participant from the mixed tables)

Who should be told?

There was a clear consensus 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. Participants were clear that the person who lacks capacity (i.e. vulnerable adult or child) also should receive an apology.

> 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. (GOsC Forum member)

> If it's a child and they might lack the capacity and they might not have given the consent, as they might have had with the parent or guardian, but they still deserve the apology. (GOsC Forum member)

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.

> 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. (Participant from the mixed tables)

Views of other forms of redress

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

> I would just expect there to be a formal, complete procedure and almost, maybe like … I mean, depending on what the issue is. If it was serious, then it to be highlighted to a council or a body that a chiropractor should probably be working in accordance with. And then, yes, it be dealt with accordingly and kept in the loop from start to finish. (Participant from the mixed tables)

Other forms of redress were felt to be important in certain circumstances. Participants felt that the offer of further, free treatment would be appropriate in instances where something had gone wrong with treatment which could potentially be rectified by further work. However, 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.

> But actually, I feel like in that situation [Scenario A] it would be like: yes, offering a free session would feel more like the normal, right thing to do, versus the: 'Oh, I'm sorry I left your paperwork out.' If someone then went: 'Do you want a free session?' it would feel a bit disjointed. (GOsC Forum member)

There was some discomfort with the idea of other tokens of apology e.g., flowers or wine. Participants 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.

> Yes and I suppose, let's say that 78-year old person is a lady and then, they've called and said what's happened and they've also sent you a letter and they've said that it's not going to happen again, but they sent me these flowers also, just to say, 'We're so sorry and we appreciate …' I don't know. So it's not *that* weird; I think it depends on who you're sending them to. (Participant from the mixed tables)

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.

> 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. (Participant from the mixed tables)

6. Patient information needs

Section summary

Participants were clear that other patients needed to know the following:

- Some basic information on how chiropractors and osteopaths are regulated.
- How to find information on practitioners that have done something wrong (i.e., information held on GCC/GOsC registers).
- How to report a complaint.

There was less call for patients being told explicitly about the Duty of Candour. Participants placed more emphasis on practitioners being given support in the form of clear guidance and examples to help them navigate this challenging area. If patients are informed about the Duty, participants felt that information could be provided on GCC or GOsC websites (ideally avoiding the term 'candour' which was not easily understood).

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

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

- That the professions are regulated in the same way as other health professionals.

  > Well, that's the bit that I'm going to walk out the door here with, is that I didn't know that was real. So when I visited the chiropractor, I didn't realise there was anyone above them in the food chain, to whom I could even report to, so that is something which might be useful to know. That's something of a superstructure, a bit like exists in the NHS. (Participant from the mixed tables)

- How to find information about practitioners that have done something wrong.

  > So if you didn't know where to go and just say you were looking for someone in your area and you went on their [GCC/GOsC] list of practitioners and you phoned them up or emailed them and said, 'Can you give me any history, disciplinary or professional history on this particular …' would they be transparent about giving *you* that information as well? (Participant from the mixed tables)

- How to report a complaint and the complaints process.

> Well, I suppose that's why there has to be somebody that you're able to go to in times like that, because maybe you need to know that there's someone you can trust and that's going to help with your issue and who's non-biased. (Participant from the mixed tables)

> Do you know how you go into the doctors and it's like: 'This is what you should expect, here's what you do if something goes wrong, here's who you can contact'? I don't think that's quite as obvious, necessarily, so maybe there could be more done to help the patients hold practitioners to account. (GOsC Forum member)

However, there was less consensus about whether patients need 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.

> If you have an open, honest relationship and a trusting relationship with your practitioner, then you're not necessarily having to, all the time … like when everyone's saying about … which I *do* get, when everyone's like, 'Oh, people don't understand what the terminology is.' Like, for someone like me, I just *know* that my osteopath does *all* of this without ever having to say the Duty of Candour to me, because of how she works. (GOsC Forum member)

> 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. (Participant from the mixed tables)

- However, a small number felt that it should be mentioned at the start of treatment as part of a general conversation about how the practitioner works and their responsibilities or potentially put on the practitioner's wall.

> [I wouldn't say]: 'OK, so now we're going to talk about what Duty of Candour is.' …I think you say, 'If we make a mistake, we'll be open and honest about it. We expect you to do the same.' (GOsC Forum member)

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.

> You were talking about the jargon, etc. I'm just wondering and mindful of why we use the word Duty of Candour, if practitioners, patients, those studying don't actually know what it means and as part of your regulatory document, are we using terms like that because, as a patient – or even as a practitioner – we're using words that aren't general English or make sense and is it just a status quo, because we've always done it, it remains, or is there a space to actually just change the name of it, so it simplifies it? (Participant from the mixed tables)

> I think it's quite interesting that documents are written that we should be informing the patients and educating, but they're written only for the professionals to understand. (GOsC Forum member)

> 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? (GOsC Forum member)

How should 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.

> Like: 'What you should expect from us.' And then, like, duty of care, we should do XXXX. If we do something malpractice, we will tell you about it and be honest with you. (Participant from the mixed tables)

Some felt that information could be provided on GCC and GOsC websites so that it is there 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 them in the direction of the regulator. One participant likened it to the Red Tractor logo which means food standards are assured.

> I don't need you [the practitioner] to spend three pages talking about candour. So, red tractor, I know it's British Farm, blah, blah, blah; I don't need to see too much. (Participant from the mixed tables)

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

> I think there is guidance, but I think one of the big things is that the regulatory body needs to have, for practitioners to have really good access to them. So they're not just a regulatory body, but also, they're an information centre, because a lot of this is built through guidance and policy and authorised professional practice. (Participant from the mixed tables)

7. Conclusions

Response to the concept

The Duty of Candour was not a familiar term or concept to the majority of participants. A small number could make an educated guess on its meaning based on their understanding of the word 'candour'.

However, once explained, the concept made intuitive sense. Some initially felt that it was a core component of what it means to be professional and should be so engrained in an osteopath or chiropractor's practice that it shouldn't actually need to be spelled out in the code of conduct or standards i.e. it should be something that should be done by practitioners automatically. However, on further discussion, participants appreciated some of the shades of grey and the need for explicit guidance.

The importance of the Duty was further reinforced by the provision of information on the regulatory context (and specifically the knowledge that GCC and GOsC do not conduct regular inspections of practitioners' practices) and also discussion about the environment in which practitioners are working. The difficulty of practitioners being open and honest about issues when they are working in private practice and when they don't necessarily have the sounding board which comes from working in a large (multi-disciplinary) team were noted. Participants were largely empathetic about the challenges faced by practitioners both in terms of practice itself and also in adhering to the Duty of Candour in this context.

Notwithstanding the challenges, participants did identify a number of drivers for practitioners to be candid about issues with patients. These included:

- An ethical driver - it is very simply the right thing to do.
- A benefit in terms of cementing patient/practitioner relationship i.e. rather than diminishing trust, it can actively help build the relationship.
- Avoiding reputational damage i.e., if the mistake comes out into the open and the practitioner has not fulfilled the Duty of Candour, then the repercussions will potentially be worse than the practitioner not speaking up in the first place.

Applying the concept to practice

In the event of a clear-cut error where the patient has been harmed, there was a consensus that the patient should be told. There was also agreement that the practitioner had 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.

However, there were grey areas and participants did not always agree on more nuanced scenarios. Some participants were realistic and pragmatic about how Duty of Candour may be applied in the real world. They felt 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. They felt that this could, in fact, 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, others felt 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?

Participants had some clear messages about the form and tone of any apology from a practitioner in the event of an error. They called for it to be clear about the issue and any resulting actions. They felt that a practitioner should guard against any explanation sounding like they are providing excuses. For a significant issue, there was a call for a verbal apology as well as something in writing.

Whilst most called for information on what the practitioner would do in order to ensure that the mistake isn't repeated, for some this information grated. They simply wanted 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?

There was a strong call for practitioners to be given information and support in relation to adhering to the Duty of Candour. This was felt to be 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.

There was less call for patients to be given information on the Duty of Candour. A small number of participants felt that this could be done at the start of a consultation with a practitioner, but most felt it unnecessary. They felt that information could potentially be provided on regulators' websites so that it is there if patients want to seek it out. If information is provided, they cautioned about using the word 'candour' given the low levels of understanding of the term.

8. Appendices

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.

Quota categories	
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

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. They have signed up to take part in the Forum and so have an ongoing relationship with GOsC.

Workshop agenda

Timings	Content		Materials / Stimulus
From 9.30am	• Arrival	• Refreshments available	

10.00-10.10	• Intro
	• Warm up
		• Welcome and introduction
		• Housekeeping
		• Facilitator explains:
		  ◦ What today is about
		  ◦ Session timings
		  ◦ Role of facilitator
		  ◦ Stress exploratory nature of session and collaboration
		  ◦ Permissions to record and plans for reporting
		  ◦ Introduces observers	

10.10-10.30	**Session 1 – discussion in 3 small groups - initial views about Duty of Candour**
	
	AIMS: To set the scene and help get participants thinking about the issues
	
	• Introductions
	  ◦ Each participant briefly introduces themselves.
	Initial discussion:
	
	  ◦ What does the term Duty of Candour mean to you (if anything)?
	  ◦ What words come to mind?
	  ◦ What do you think it involves?
	
	• What would you expect of a chiropractor/osteopath when something has gone wrong?
	• How does this differ from other health professionals (if at all)?
	FACILITATOR GIVES VERY BRIEF VERBAL DESCRIPTION OF THE DUTY OF CANDOUR - THE DUTY OF CANDOUR IS A RESPONSIBILITY TO BE OPEN AND HONEST WITH PATIENTS AND FAMILIES WHEN SOMETHING THAT GOES WRONG WITH THEIR TREATMENT OR CARE, OR HAS THE POTENTIAL TO CAUSE, HARM OR DISTRESS. THIS INCLUDES SAYING SORRY AND TAKING ACTION TO PUT THINGS RIGHT WHERE POSSIBLE
	
	• In what instances would you expect your chiropractor or osteopath to be candid?
			Flipchart

	• Explore spontaneous views on level of injury and risk and if discussions focus purely on treatment risks or if the need for candour viewed more widely i.e. data breach or non-clinical error.	
10.30-10.50	**Session 2 - Plenary presentation – by GCC/GOsC** *AIM: To provide sufficient background information on the context to allow for a meaningful discussion* To cover the following: • Regulators' role • Introduction to the Duty of Candour • Introduction to the guidance • Outline any complexities and considerations Q&A	PowerPoint slides

10.50-11.10	**Session 3 - discussion in 3 small groups**
	AIM: To begin to discuss and understand the patient perspective
	• Initial response to issues
	• Anything surprising
	• In what circumstances do they expect candour? Probing on specific examples i.e.
	  • When a patient is unaware that something has gone wrong
	  • When there is no risk of injury or distress
	  • When it is a near miss
	  • When the patient hasn't yet suffered harm but may in future
	  • When treatment is not working due to progression of an illness or condition
	• What are the potential challenges or obstacles that prevent a chiropractor/osteopath meeting these standards?	

11.10-11.25	**Break**	
11.25-12.40	**Session 4 - discussion in 3 small groups: Considering the issues raised in the scenarios** *AIM: To start participants thinking Duty of Candour in practice / bring the issues to life*	Printout of scenarios

	THE FACILITATOR INTRODUCES THE SCENARIOS, MENTIONING THAT THEY HAVE BEEN DELIBERATELY DRAFTED TO INCLUDE DIFFERENT PERSPECTIVES, CIRCUMSTANCES AND SETTINGS. FOR EXAMPLE, BREACH OF CONFIDENTIALITY, SAFETY INCIDENT, TREATMENT REACTION, DELAYED DIAGNOSIS, NEAR MISSES ETC.
	
	THE FACILITATOR ASKS THE SMALL GROUPS TO CONSIDER 4 SCENARIOS EACH, THINKING ABOUT THE QUESTIONS BELOW AS WELL AS ANY ADDITIONAL PROMPTS THAT ARE INCLUDED IN THE DOCUMENT.
	
	• Has the Duty of Candour been observed or not?
	• What is important to the patient and why?
	• What would be in the best interest of the patient?
	• What would you like the practitioner to be thinking about in deciding how to respond?
	  ◦ What factors should be important in their decision making?
	• What other actions are important?
	  ◦ For example, reflecting and learning, reporting to other organisations?
	• What are the challenges from the perspective of a chiropractor/ osteopath?
	• For data breach scenario, note ICO requirements which are at the end of the agenda. ICO requirements could be less stringent than those expected by patients.
	
	PREPARING PLENARY FEEDBACK AS A GROUP CONSIDER:
	
	◦ WHAT ARE THE MAIN THEMES THAT COME OUT FROM ACROSS ALL THE SCENARIOS?
	◦ WHICH OF THE SCENARIOS DISCUSSED WERE MOST CLEAR CUT AND WHICH WERE MORE DIFFICULT
	◦ DID ANY OF THE SCENARIOS MAKE YOU THINK DIFFERENTLY?
	◦ ANY THOUGHTS ON HOW PRACTITIONERS MIGHT FIND MEETING THESE STANDARDS?	

12.40-13.00	**Session 5 - plenary discussion: feeding back views on Duty of Candour and the scenarios** *AIM: To get a sense of what issues are emerging from the patient perspective from around the room*	

	Each scenario will be discussed in turn FACILITATOR ASKS ONE TABLE TO GIVE THEIR THOUGHTS ON THE SCENARIO AND THEN OTHERS ARE ASKED TO CHIP IN WITH THEIR VIEWS (THE TABLE THAT GOES FIRST IS ROTATED EACH TIME)	
13.00-13.40	**LUNCH**	
13.40-14.10	**Session 6 - discussion in three small groups** *AIM: To explore more informed views once the scenarios have introduced some of the more nuanced issues* • Since discussing the scenarios, have their views changed in any way? FACILITATOR TO EXPLORE SOME OF THE KEY QUESTIONS FROM SESSION 3 IN RELATION TO EXPECTATIONS OF CANDOUR AND THEN MOVE ONTO THE FOLLOWING: • How should a practitioner handle a situation in which a patient is unable to receive the apology (for instance they are a child, have died, or lack capacity)? • Are there cultural/generational issues that chiropractors should be aware of regarding candour? • Does the setting make a difference in terms of expectations i.e. individual working from home vs. a private clinic vs MDT working in an NHS setting • If a practitioner has concerns about another treatment that the patient is receiving, should they raise those concerns with the patient or with the other practitioner directly? • Explore any differences between situations where the patient raises the issue and where the practitioner know there is an issue but the patient is unaware • How should a situation be handled where a patient doesn't want to know the details • Should a Duty of Candour apply only when things have gone wrong or should it extend further (e.g. prevention/being proactive)?	
14.10-14.30	**Session 7 – discussion in three small groups – apology and redress**	

	AIM: To tease out issues in relation to apology FACILITATOR INTRODUCES SHORT EXERCISE: 2 SUBGROUPS OF 4 ASKED TO SPEND A FEW MINUTES COMING UP WITH THE KEY COMPONENTS OF A "GOOD" APOLOGY. THEY WILL BE ASKED TO THINK ABOUT THE APOLOGY IN RELATION TO ONE OF THE SCENARIOS INTRODUCED IN SESSION 4 The groups will be prompted to consider • Who should the apology come from? (practitioner, clinic owner, receptionist)? • What form should that apology take (written, over the phone, in person)? • When should an apology be made (as soon as a mistake is realised? Next visit? Special visit?). • What would a 'bad' apology look like? Facilitator then brings both sub-groups together to discuss what they have developed and to explore the following: • Patient attitudes to tokens of apology (flowers, token compensation, free session?) or is the apology enough? • Patient attitudes to redress – covering financial loss or other inconvenience. • Importance of the inclusion of actions/lessons learned • How does an apology affect their approach to taking a complaint further? • How should the apology differ for the different scenarios discussed – i.e. are some elements more important than others for different scenarios?	

14.30-14.50	**Session 8 – discussion in three small groups - patient information requirements**
	
	AIM: To draw findings together and consider patient resource requirements in light of discussions
	
	• What do other patients need to know about the Duty of Candour?
	  • What are the key elements that are essential to know (if any)?
	• How would you describe Duty of Candour to others?
	• Do you think a practitioner should make their patients aware of the Duty of Candour?
	  • If they should share it, when should they do so?	

	• How should they share it?
	  ◦ Actively (telling them about it)
	  ◦ Passively (a policy on the website/ in the office)
	  ◦ As part of their complaints process
	• Reflecting back on the discussion – what are your final thoughts?
	• Any further comments - anything further that you would like to say? Anything that is important that you haven't been asked about?	

14.50-15.00	**Thanks and close** Thanks and brief response to feedback from GCC/GOsC representative	Evaluation forms Conduct voxpops

Hypothetical scenarios

Scenario A

A practitioner sees a new patient with acute low back pain. As a result of the case history and physical examination, the practitioner thinks that the symptoms are musculoskeletal in origin, and though painful, are likely to be sorted relatively quickly. As part of the treatment, as well as treating the low back area, the practitioner feels the patient's upper back and neck. Although this area isn't painful, there are some tender areas in the neck, and the practitioner suggests some treatment. As part of their general discussion with the patient, they mentioned that treatment can sometimes result in post-treatment soreness or a worsening of symptoms for a while. The patient was happy with this approach and consented and the practitioner used a combination of deep massage on the muscles around the base of the neck with an attempted manipulation of two vertebral segments between the shoulder blades, which caused the patient some discomfort.

Two weeks later, the patient returns. They report feeling much better in the low back, and are now largely back to normal. They have, however, experienced considerable neck pain and headaches, which came on the day after the first treatment, and caused them to see their GP. Both the patient and the GP think that the neck pain is probably a result of the low back problem, with the body trying 'to sort itself out'. The practitioner, wonders but isn't sure, whether the first treatment actually caused the neck problem. The patient doesn't blame the practitioner at all. The neck symptoms are now easing somewhat, and they have come for the follow up session hoping now to focus on the neck.

Scenario B

A practitioner sees a new patient. After the case history, the practitioner leaves the room to allow the patient time to undress before examination. When the practitioner re-enters the room, the patient says that they'd seen the previous patient's name on their notes, and they realised that they knew them – they thought they looked familiar when they crossed in the waiting room, and now they realise why.

The practitioner is horrified that they hadn't locked the previous patient's notes away before they left the room and had inadvertently left these visible on top of the filing cabinet in view of the new patient.

They reply that patient records are confidential and that they should have locked these away. They ask the new patient not to mention the other patient's name to anyone.

Scenario C

Mr Ullah is a 78 year old new patient.

He has pain in his lower back that varies with certain positions or activities and comes and goes. The practitioner thought that he also has a mild amount of osteoarthritis that may be making his back pain worse. His medical history was largely unremarkable, except for his memory which he describes as "terrible". He is seeing a "memory" doctor at the hospital in the next few weeks. Mr Ullah is unsure what medications he takes. He promised to bring the practitioner a list of his medications at his next visit and said that the practitioner could ring his daughter now if they wanted to. The practitioner decided that this could wait until the next week, as they were running a little late and Mr Ullah's problem seemed straight-forward. At his first visit, the practitioner's treatment included a soft massage to Mr Ullah's para spinal and gluteal muscles, as well as some manipulation of the joints. He provided advice about possible side effects including additional pain and got consent on this basis.

At his next appointment, Mr Ullah has brought in a list of his medications and the practitioner sees that he is taking Warfarin (a blood thinning medication which can mean you bruise more easily). He has made progress since the last treatment and is pleased with the results. However, when Mr Ullah undresses for treatment and the practitioner examine his back, there is extensive bruising where he was treated at the last appointment. Mr Ullah has not had any accidents that may explain the bruising and is unaware of it. The practitioner realises that it is likely that they have caused this bruising.

Scenario D

The practitioner has had a busy few weeks and filing has got a little behind and today is running ten minutes late. The practitioner has a quick look at the notes and sees that the next patient, Mr Smith, has been having treatment for left shoulder pain for 10 weeks.

The practitioner calls in the patient who is keen to get on with treatment as he in a hurry. The patient says he's feeling quite a bit better but is still getting some shoulder pain first thing in the morning and some left-sided neck stiffness. A brief examination shows that his shoulder has full and pain-free movements now, but he can't move his neck very easily on the left hand side. Feeling the neck does not reveal any particular muscular or skeletal findings other than left-sided tenderness in the muscles of the neck down to the shoulder.

The practitioner gets on with treatment by massaging Mr Smith's left shoulder. The patient looks at the practitioner a little quizzically when asked to lie on his right-hand side and the practitioner assumes this is because his neck is a little stiff.

While chatting to the patient about his work, the practitioner realises that he has been thinking about the wrong Mr Smith. He glances down at the notes and sees that the notes he has been referring to are for Adam Smith, rather than Alan Smith who is now being treated. He realises that he has been working on the wrong shoulder – he has treated the left side instead of the right.