General Osteopathic Council

Osteopathic Practice Committee
13 October 2015
The duty of candour

Classification	Public
Purpose	For discussion
Issue	The paper sets out the GOsC's approach to implementing the duty of candour.
Recommendations	To consider the approach outlined in this paper for developing standards, guidance and resources that support the duty of candour.
Financial and resourcing implications	Engagement costs to date have been accounted for in the current Communications budget. Provision for further costs will be accounted for in financial planning for the review of the 2012 *Osteopathic Practice Standards*.
Equality and diversity implications	Equality and diversity implications have been partially explored in the course of the candour focus group exercises, and will be more fully explored within the review of the 2012 *Osteopathic Practice Standards*.
Communications implications	Contained within the body of the paper.
Annexes	A. References in the OPS to candour. B. Joint statement on the duty of candour. C. Stakeholder Workshops on the Duty of Candour – Community Research report, September 2015. D. GOsC candour vignettes.
Author	Brigid Tucker

Background

1. The report by Robert Francis QC into care at Mid-Staffordshire NHS Foundation Trust (the Francis Report)[1], set out recommendations for a statutory 'duty of candour' for individual professionals and for organisations.

2. In November 2013, the Government published its final response to the Francis Report[2]. The Government decided that it would take forward a statutory duty of candour for health and care organisations in England, but not for *individual* health and care professionals. In addition, the Government recommended that a professional duty of candour should apply to individual healthcare practitioners across the UK and this should be implemented through strengthened references to candour in professional codes and supporting guidance. This should make clear that regulated healthcare professionals are expected to be candid with patients about all avoidable harm, and obstructing colleagues from acting appropriately should represent a breach of the regulator's standards. Regulators were also expected to review their guidance to fitness to practise panels to ensure they take account of whether registrants have acted appropriately, observing their duty of candour.

3. In response to the Government's proposals for professional duty of candour, the healthcare regulators, including the GOsC, established a Working Group to develop a consistent approach to candour across health and care professions. The Working Group agreed that all health and care professionals are expected to be 'candid' and explored the various ways this is expressed in each of the regulated professions' standards. Sections of the *Osteopathic Practice Standards* relevant to the duty of candour are provided in Annex A.

4. As a first step, the GOsC and seven other regulators produced a joint public statement, in October 2014, setting out a consistent position on candour and our expectations of registrants. The duty of candour set out in the joint statement says: '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'. One aim of the public statement was to assist patients and service users in understanding what they can expect from the professionals who care for them. A copy of the statement is at Annex B.

Discussion

5. The GOsC published and promoted the joint statement on candour on our public website and, for the benefit of registrants, provided a lead item in *the osteopath* magazine (Oct-Nov 2014), which also sought osteopaths' engagement in the development of supporting guidance (see also Annex B).

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[1] *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, February 2013, HC 947 London: The Stationery Office. Available at: http://www.midstaffspublicinquiry.com/report

[2] *Hard Truths: the journey to putting patients first* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/270368/34658_Cm_8777_Vol_1_accessible.pdf

6. A review of the 2012 *Osteopathic Practice Standards* is planned for 2016-17 and we anticipate this will provide for more explicit standards in relation to the duty of candour and this is likely to require supporting guidance to assist osteopaths to take appropriate action when mistakes occur in practice or when an osteopath is concerned that a fellow health professional is risking the safety and wellbeing of a patient.

7. In order to inform our thinking on development of standards and guidance in relation to candour that is appropriate to the osteopathic practice context, the GOsC hosted a series of workshops with patients and the public (3 December 2014), members of the GOsC Investigating Committee (18 May 2015) and practising osteopaths (3 June 2015).

8. The workshop content was designed to ensure that participants were well-prepared in advance and had opportunity as a group to discuss their views and experiences, prior to being invited to respond to specific questions. Lead facilitation at the Investigating Committee and osteopath workshops was provided by Community Research, while Mary Timms, a lawyer specialising in regulatory issues, led the patient/public workshop. A report of all three workshops is included in Annex C.

9. To assist workshop discussion, we commissioned in advance a series of 'practice scenarios', produced by senior osteopaths and students within an osteopathic training institution. The Investigating Committee and osteopath workshops used the scenarios to explore the variety and complexity of ethical considerations that could arise in practice in relation to the duty of candour. A secondary outcome was to test the value of scenarios as a potential future learning resource for osteopaths to support the implementation of new standards and guidance relating to candour. The 'candour scenarios' are included with this paper at Annex D.

Candour workshop findings: expectations

10. Expectations of the osteopathic profession in terms of the duty were fairly consistent across all three audiences. There was a broad consensus that being open and honest with patients included discussion of benefits, risks, and options of treatment. Establishing trust and good lines of communication between practitioner and patient, and the ability of the practitioner to provide an appropriate apology when needed, are all key. A clear explanation of the short and long-term effects of the mistake would be expected, along with the offer of appropriate remedial action and/or support. That the practice should have a good complaints procedure was also considered important.

11. There were higher levels of uncertainty about the scope of the duty – for example, if 'near misses' or potential harm and less serious issues should be included. Another significant area of uncertainty related to the duty to raise concerns about another professional's conduct – when was an osteopath qualified to do this, and under what circumstances?

Candour workshop findings: challenges

12. Numerous potential barriers or obstacles to complying with the duty of candour were identified, including:

    - An automatic (and natural) response on the part of the osteopath to protect their reputation and livelihood in the wake of a mistake.
    - The personal and professional repercussions of flagging issues to their professional regulator. The patient/public group recommended that the regulator should provide a 'safe space' for osteopaths, in which a practitioner could explore in supportive environment the best course of action to remedy a mistake or to act on concerns about another professional or practice.[3]
    - A concern that if the osteopath apologises to the patient, then they are admitting liability, and associated legal repercussions and concern that this might invalidate professional indemnity insurance (see also paragraph 15 below).
    - Highlighting all risks of treatment and potential harm, however remote, can create unnecessary worry and concern for the patient.
    - The need for extremely good communication skills at a time of stress.
    - Perceived grey areas in terms of whether the osteopath has actually done anything wrong (causal links) and the difficulty judging whether what happened merited saying anything to the patient.
    - Practical considerations of complying with the duty, including keeping to time during appointments (if the osteopath has to spend longer with patients), and also dealing with distressed patients (or their representatives) who have been informed about things going wrong.
    - The fact that many osteopaths work on their own and not within a structured organisation with the associated support and operating procedures.
    - A range of challenges were identified in relation to raising concerns about other professionals.

Considerations and action for the GOsC

13. There were a number of specific considerations or actions for the GOsC and its partners:

    - Carefully presenting the duty of candour to registrants so that they fully understand the aim and how the duty applies in osteopathic practice, and they recognise this as something that patients actively want, rather than an additional regulatory burden.

[3] The value of 'safe spaces' has also come to the fore in the recent research by Prof. Gerry McGivern around the impact of regulation on osteopathic practice, and the needs of practitioners expressed in feedback arising from the recent consultation on a new continuing professional development scheme.

- The guidance relating to the duty needs to be specifically tailored to the osteopathic context, given differences in how osteopaths practise compared to other health professionals, but should also be consistent with standards and guidance in other healthcare disciplines.
- There were a number of areas where participants felt that additional guidance would be helpful, including:
    - Working in partnership with patients or their representatives and knowing how to communicate well in difficult circumstances.
    - Providing an apology and a satisfactory explanation when something has gone wrong, and implementing remedial action in a way that is appropriate for that patient or their representative.
    - Guidance on what would be a proportionate response.
    - Guidance for osteopaths who employ, manage or lead a team.
    - Guidance on raising concerns about another health professional.
    - Information about what might happen if the duty of candour is not observed.
- The message may need to be disseminated in a range of ways, including face-to-face practical training sessions, online CPD training, publications and through intermediaries, like the professional association.
- There was a broad consensus among the Investigating Committee and osteopath group that the production of scenarios/vignettes to support guidance and learning would be useful in helping osteopaths to understand how the duty of candour applies in their practice. Attention would need to be given also to osteopath undergraduate training.
- The fitness to practise committees should take note of compliance with the duty of candour in their decision-making, and that osteopaths should be made aware that lack of candour could affect their decisions in a case.
- The duty of candour should be mentioned explicitly in the *Osteopathic Practice Standards*.
- The provision of reassurance to osteopaths that compliance with the duty of candour will not adversely affect their insurance status. Apologising to the patient is not the same as admitting legal liability for what has happened.

Engaging partner organisations

14. The GOsC has taken the opportunity of scheduled meetings over the course of this year to brief partner organisations in the sector, including osteopathic training institutions and the professional association, on our commitment to the duty of candour.

15. Concerns were raised with us from a number of sources that there was a risk that the duty of candour could breach the conditions of osteopaths' professional indemnity insurance. In October 2014 the GOsC wrote directly to providers of professional indemnity insurance to osteopaths, as a result of which all major providers confirmed in writing to the GOsC that they supported the duty of candour and their guidance to policy-holders in no way represented an impediment to compliance with the duty. A GOsC meeting with the insurers and the Institute of Osteopathy in late September 2015 reaffirmed this position, and the insurers agreed to consider issuing their own joint statement of reassurance to osteopaths.

16. The GOsC will continue to work closely with osteopathic organisations in developing revised standards, supporting guidance, and learning resources relating to the duty of candour.

17. The General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) have now published joint guidance on candour. The General Dental Council (GDC) has announced a 12-week consultation on draft guidance, closing on 18 December. Other regulators are at various stages of developing guidance on candour and reviewing professional standards. The GOsC is represented on a Joint Regulators' Group on Candour/Professional Standards, and we shall take account of the guidance and resources of other regulators in devising guidance for osteopaths.

Next steps

18. The GOsC is embarking on a review of the 2012 *Osteopathic Practice Standards* (see Item 8 on this agenda) and consideration of the duty of candour will be an integral element of this process. It is likely the revised standards will propose more explicit expectations in relation to candour. Alongside this, we will draft supporting guidance, mindful of the issues highlighted in the candour focus groups report and taking account of the guidance applied in other health practices. Both standards and guidance will be subject to public consultation.

19. Testing in the Investigating Committee and osteopath focus groups highlighted also the value of scenarios/vignettes as a learning aid and mechanism for exploring ethical dilemmas in managing mistakes in practice. Feedback suggested these would also be useful in undergraduate training. In conjunction with developing guidance, we will explore the further development of the current scenarios/ vignettes into online interactive learning for osteopaths.

20. We will be developing a communications and engagement plan to support the review over the coming of the *Osteopathic Practice Standards*, the information on the duty of candour will be reflected in this.

21. While the majority of osteopaths will be unaffected, it will be important also to ensure osteopaths understand the scope of the statutory duty of candour that now applies to healthcare organisations in England that are subject to oversight by the Care Quality Commission and any implications this may have for those

osteopaths who are employees of these organisation or whose businesses. Osteopaths elsewhere in the UK should be aware that governments in Northern Ireland, Scotland and Wales are in the process of considering how they will implement a similar statutory duty of candour in relation to healthcare organisations.

22. A final piece of related work will be a revision to the GOsC's Indicative Sanctions Guidance which must reflect the duty of candour. Any proposed revision will be the subject of a separate future paper for this Committee and could require external consultation.

23. We will provide regular report reports to the Osteopathic Practice Committee on the review of the *Osteopathic Practice Standards* and guidance and resources relating to the duty of candour.

Recommendation: to consider the approach outlined in this paper for developing standards, guidance and resources that support the duty of candour.

References to candour in the *Osteopathic Practice Standards*

Standards that refer to candour:

C9 Act quickly to help patients and keep them from harm

1. You should take steps to protect patients if you believe that a colleague's or practitioner's health, conduct or professional performance poses a risk to them. You should consider one of the following courses of action, keeping in mind that your objective is to protect the patient:

    1.1. Discussing your concerns with the colleague or practitioner

    1.2. Reporting your concerns to other colleagues or the principal of the practice, if there is one, or to an employer

    1.3. If the practitioner belongs to a regulated profession, reporting your concerns to his or her regulatory body (including the GOsC if the practitioner is an osteopath)

    1.4. If the practitioner belongs to a voluntary council, reporting your concerns to that body

    1.5. Where you have immediate and serious concerns for a patient, reporting the colleague to social services or the police.

2. If you are the principal of a practice, you should ensure that systems are in place for staff to raise concerns about risks to patients

3. You must comply with the law to protect children and vulnerable adults.

D7 Be open and honest when dealing with patients and colleagues and respond quickly to complaints

3. You should operate a procedure for considering and responding to any complaints about your practice. You should make sure your staff are familiar with this procedure and know to whom to direct any patient complaints

6. You should inform your professional association and professional indemnity insurers immediately if you receive a complaint.

7. You should ensure that anyone making a complaint knows that they can refer it to the GOsC and you should cooperate fully with any external investigation.

D10 Ensure that problems with your own health do not affect your patients

1. If you know or suspect your physical or mental health to be impaired in such a way that it affects the care of your patients, consider whether you should:

   1.3 Inform the GOsC so that your registration details can be amended

D17 Uphold the reputation of the profession through your conduct

1. The public's trust and confidence in the profession, and the reputation of the profession generally, can be undermined by an osteopath's professional or personal conduct. You should have regard to your professional standing, even when you are not acting as an osteopath.

2. Upholding the reputation of the profession may include

   2.8 Behaving honestly in your personal and professional dealings

D18 You must provide to the GOsC any important information about your conduct and competence

1. You should tell the GOsC straight away, if you:

   1.1 Are charged, anywhere in the world, with an offence relating to:

      1.1.1 Violence

      1.1.2 Sexual offences or indecency

      1.1.3 Dishonesty

      1.1.4 Alcohol or drug abuse

   1.2 Are convicted of a criminal offence, anywhere in the world

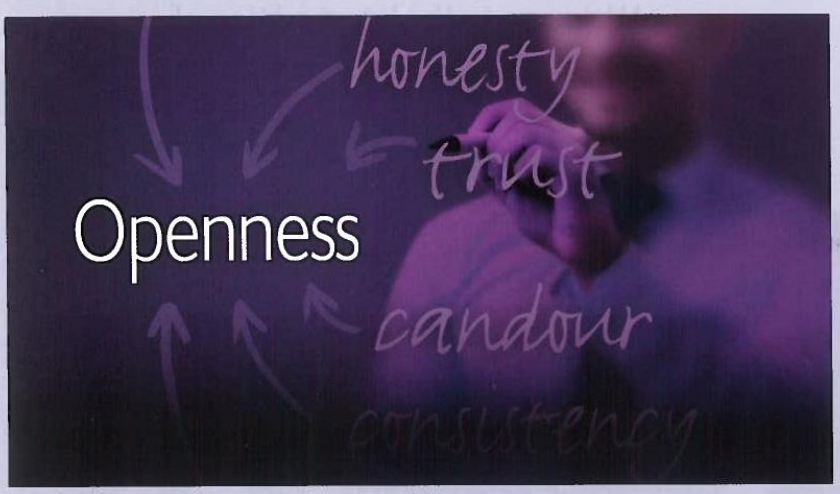
   1.3 Receive a conditional discharge for an offence

   1.4 Accept a police caution

   1.5 Are disciplined by any organisation responsible for regulating or licensing a healthcare profession

   1.6 Are suspended or placed under a practice restriction by your employer or a similar organisation because of concerns about your conduct or competence

Joint Statement and *the osteopath* article



Putting patients first – understanding the duty of candour

When Robert Francis QC recommended that 'the journey to putting patients first', not just in Mid-Staffs but in any healthcare setting, would require a 'fundamental culture change' across the health and social care system, this was not a slur on the integrity and dedication of most health professionals.

However, the Francis Inquiry findings presented stark evidence that when patients come to harm, insensitive handling and poor communication after the event can be as damaging as the original problem.

The real challenge, Francis recognised, is ensuring clinicians and clinical staff are properly supported when things go wrong – that there can be no circumstances when they feel prevented from being open and honest with patients or fulfilling their duty of care.

Responding to the Francis report, the Government has this month introduced a statutory duty of candour, with possible criminal sanctions, for organisations providing health services that are overseen by the Care Quality Commission.

For health professionals, the Government proposes not a statutory but a professional duty of candour:

'In addition to the statutory duty of candour on providers, there is also a professional duty of candour on individuals that will be strengthened through changes to professional guidance and codes. The professional values of individual clinicians are critical in ensuring an open culture in which mistakes are reported, whether or not they cause actual harm.

'The healthcare professional regulators will be working to agree consistent approaches to candour and reporting of errors, including a common responsibility across doctors, nurses and other health professions to be candid with patients when mistakes occur, whether serious or not, and clear guidance that professionals who seek to obstruct others in raising concerns or being candid would be in breach of their professional responsibilities.'

The GOsC joins with other health professional regulators this month in a public commitment to strengthening and harmonising professional standards in relation to candour and the reporting of errors. This joint statement is reproduced on the facing page.

While the duty of candour is common across healthcare professions, it is recognised that different professions and their regulators work in separate ways. For example, the management and working relationships in osteopathic practice settings are clearly very different from those within NHS hospitals. Regulators will work within their own professions, and with each other, to ensure standards that promote candour are both appropriate to your practice and patients, and consistent with other health practices.

The *Osteopathic Practice Standards*

The current 2012 *Osteopathic Practice Standards* (OPS) make numerous references to candour in practice, most notably Standard D7: 'Be open and honest when dealing with patients and colleagues and respond quickly to complaints.'

The renewed professional duty of candour, however, establishes expectations of a more proactive approach: telling patients when something has gone wrong, rather than simply responding to complaints. So while Standard D7 in itself may be adequate, the underpinning OPS guidance may need to be broadened and strengthened.

We intend to undertake a fundamental review of the *Osteopathic Practice Standards* in 2015-16, in the course of which additional guidance can be developed in consultation with the profession.

In advance of this, we are very keen to engage osteopaths in focus group discussions of the issues outlined in the joint statement, exploring scenarios where the duty of candour would apply and identifying issues or difficulties that might arise in practice. This will greatly assist us in the drafting of suitable guidance that will adequately support osteopaths in fulfilling the duty of candour.

Further information

We welcome your views. Email us on candour@osteopathy.org.uk or call Brigid Tucker, Head of Policy and Communications, on x247.

Our duty of candour

A joint statement from the Chief Executives of statutory regulators of healthcare professionals

Health professionals must be open and honest with patients when things go wrong. This is also known as 'the duty of candour'.

As the Chief Executives and Registrars of statutory regulators of healthcare professionals, we believe that this is an essential duty for all professionals working with patients.

Although it may be expressed in different ways within our statutory guidance, this common professional duty clarifies what we require of all the professionals registered with us, wherever they work across the public, private and voluntary sectors.

We will promote this joint statement on 'the duty of candour' to our registrants, our students, and to patients, ensuring our registrants know what we expect of them. We will review our standards and strengthen references, where necessary, to being open and honest, as appropriate to the professions we regulate. We will encourage all registrants to reflect on their own learning and continuing professional development needs regarding the duty of candour.

We will also work with other regulators, employers and commissioners of services to help develop a culture in which openness and honesty are shared and acted on.

The Professional Duty of Candour

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.

David Howell, General Chiropractic Council
Evlynne Gilvarry, General Dental Council
Niall Dixon, General Medical Council
Samantha Peters, General Optical Council
Tim Walker, General Osteopathic Council
Duncan Rudkin, General Pharmaceutical Council
Jackie Smith, Nursing and Midwifery Council
Trevor Patterson, Pharmaceutical Society of Northern Ireland

October 2014

Stakeholder Workshops on the Duty of Candour

Prepared for:
The General Osteopathic Council

Prepared by:
Community Research

September 2015

Contents

1. Summary of findings

After considering evidence from the Francis Report and other reviews, the Government decided to take forward a statutory duty of candour for health and care organisations in England. Rather than introduce a statutory duty for individual health and care professionals, the Government recommended that the professional duty of candour should be strengthened through changes to professional codes and guidance.

To complement its liaison and consultation with other health regulators in relation to the duty of candour, the General Osteopathic Council (GOsC) identified a need for engagement with patients, public and clinicians to explore the perspectives of various stakeholders on this issue. Three workshop sessions were conducted: one with patients and public; one with osteopaths, and one with members of the Investigating Committee (IC) of the GOsC.

Expectations of the profession in terms of the duty were fairly consistent across all three audiences. There was a broad consensus that a clear explanation of risk, establishing trust and good lines of communication, and being able to apologise well, were all key. Offering a remedy or clear course of action and having good complaints procedures were also important. There were higher levels of uncertainty about the scope of the duty (for example, if 'near misses' or potential harm and less serious issues should be included).

Numerous potential barriers or obstacles to complying with the duty of candour were identified, including:

- An automatic (and natural) response on the part of the osteopath to protect themselves.
- The personal and professional repercussions of flagging issues to their regulator.
- A concern that if the osteopath apologises to the patient, then they are admitting liability, and associated legal repercussions and concern that this might invalidate professional indemnity insurance.
- By highlighting all risks of potential harm however remote, creating unnecessary worry and concern for the patient.
- The need for extremely good communication skills at a time of stress.
- Perceived grey areas in terms of whether the osteopath has actually done anything wrong and the difficulty judging whether what happened merited saying anything to the patient.

- Practical considerations of complying with the duty, including keeping to time during appointments (if the osteopath has to spend longer with patients), and also dealing with upset patients who have been informed about things going wrong.

- The fact that many osteopaths work on their own and not within a structured organisation with the associated support and processes.

- Specific challenges were mentioned associated with one specific component of the duty - raising concerns about other professionals.

- There was extensive debate within the Investigating Committee and osteopath workshops about the issue of insurance.

There was a broad consensus among the Investigating Committee and Osteopath group that the production of scenarios/vignettes to support guidance would be useful in helping osteopaths to understand how the duty of candour fits into their everyday practice. There were a number of areas, in particular, where participants felt that guidance would be useful:

- Working in partnership with patients and communicating well.

- Guidance on how to observe the duty of candour, including providing a satisfactory explanation and communicating remedial action in a way that is appropriate for the patient.

- Guidance on what would be a proportionate response (particularly guidance on how to handle 'near misses' and less serious issues).

- Guidance on raising concerns about other health professionals, given the specific challenges associated with this aspect of the duty.

There were a number of specific considerations or actions for the GOsC and its partners:

- Carefully presenting the duty of candour to registrants so that they fully understand the context, how it should be applied in practice, and recognise it as something that patients actively want, rather than an additional burden.

- That the guidance relating to the duty needs to be specifically tailored to the osteopathic profession, given differences in how they practise compared to other health professionals.

- That the message needs to be disseminated in a range of ways, including face-to-face practical training sessions, online CPD training, publications and through intermediaries, like the professional association.

- Consideration of the need for the duty of candour to be explicitly mentioned in the Osteopathic Practice Standards.

- Tackling of the insurance question and the provision of reassurance to osteopaths that compliance with the duty of candour will not adversely affect their insurance status.

2. Background, objectives and approach

2.1 Background

The report by Robert Francis QC into care at Mid Staffordshire NHS Foundation Trust ("the Francis Report")[1], set out recommendations for a statutory 'duty of candour' for individual professionals and for organisations. The report defines candour in the following terms:

> *'Any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it'*[2]
>
> *'Where death or serious harm has been or may have been caused to a patient by an act or omission of the organisation or its staff, the patient (or any lawfully entitled personal representative or other authorised person) should be informed of the incident, given full disclosure of the surrounding circumstances and be offered an appropriate level of support, whether or not the patient or representative has asked for this information'.*[3]

In November 2013, the Government published its final response to the Francis Report[4], also considering the six other reviews that it had commissioned in the wake of the Francis Report. The Government decided that it would take forward a statutory duty of candour for health and care organisations in England, but not for *individual* health and care professionals. Rather than introduce a statutory duty, the Government recommended that the professional duty of candour on individual healthcare practitioners should be strengthened through changes to professional codes and guidance.

In response to the Government's proposals for a professional duty of candour, the healthcare regulators established a Working Group to develop a consistent approach to candour across the health and care professions. The Working Group agreed that all health and care professionals are expected to be 'candid' and explored the different ways this is expressed in their standards.

[1] Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, February 2013, HC 947 London: The Stationery Office. Available at: http://www.midstaffspublicinquiry.com/report

[2] At paragraph 1.176 of the Francis report

[3] Recommendation 174 of the Francis Report [4]Hard Truths: the journey to putting patients first https://www.gov.uk/government/uploads/system/uploads/attachmentdata/file/270368/34658Cm8777Vol1accessible.pdf

The Working Group also agreed that the regulators need to ensure that the expectations of registrants are clear and consistent, especially in the context of the modern delivery of health and social care, where patients and service users are increasingly often treated or cared for by multidisciplinary teams. The regulators want to ensure that all health and care professionals know they have a duty to be open and honest, and that this applies equally to their colleagues across the sector.

On the advice of the Professional Standards Authority for Health and Social Care (PSA), the healthcare regulators, as a first step, issued a Joint Statement to help achieve these aims. The aim of the Joint Statement was to assist patients and service users in understanding what they can expect from the professionals who care for them.

2.2 Objectives

To inform their thinking on the issue of candour, the GOsC identified a need for engagement with patients, public and clinicians to gather some initial understanding of the various stakeholder perspectives on this issue.

For the GOsC, this engagement programme represented an important opportunity to work directly with osteopaths, patients and public to inform the development of appropriate standards and guidance that will support osteopaths to meet their professional duty of candour. The workshops were viewed as an important starting point in developing this work.

Key questions for exploration at the workshops were:

- What should be included in the "duty of candour"? What is the scope of the duty?
- What would you expect of an osteopath when something has gone wrong?
- What are the obstacles and barriers that might prevent osteopaths from complying with the duty of candour?
- What account (if any) should a disciplinary panel take of "candour", when imposing sanctions on a registrant?
- What can the GOsC do in order to foster a climate of openness and honesty amongst osteopaths?

2.3 Approach

A workshop approach was chosen because it would allow participants time and space to explore the complex issues relating to the duty of candour.

Three workshops were conducted in London as follows:

- A workshop with patients and public on Wednesday 3rd December 2014.
- A workshop with the GOsC's Investigating Committee (IC) on Monday 18th May 2015. The IC carries out the initial scrutiny of complaints about osteopaths, to decide if these should be referred on to a conduct hearing.
- A workshop with practising osteopaths on Wednesday 3rd June 2015.

Recruitment

The participants of the Public/patient workshop were recruited from the GOsC public and patient group and through osteopath and local Healthwatch networks across London and East Anglia. The group consisted of 11 participants, ranging in age from 30 to 74 years. Six of the group were female and five were male. Two members identified themselves as having an ethnic minority background and two members self-declared themselves as having a disability. Nine members were osteopathic patients; two were members of the public with no experience of osteopathic treatment.

A training day for the GOsC Investigating Committee was held on the 18th May 2015. The workshop session on the duty of candour was conducted as part of this training day. In total, 12 members of the Investigating Committee were in attendance.

The 13 participants at the Osteopath workshop were recruited directly by the GOsC. In return for their attendance and active participation, they could claim this as continuing professional development.

Participants at all workshops were sent briefing information on the topic in advance of the session.

Design and content

The workshop content was designed to ensure that participants were given an opportunity spontaneously to discuss their views and experiences, prior to being asked to consider specific questions. Scenarios were used for the Investigating Committee and Osteopath workshops in order to present participants with realistic hypothetical case studies that would bring the discussion to life.

Facilitation

Facilitation at the Investigating Committee and Osteopath workshops was provided by Community Research. Facilitation at the Public/ patient workshop was provided by Mary Timms, a lawyer specialising in regulatory issues.

The plenary sessions were audio-recorded and fully transcribed with the permission of the participants. All participants were asked to complete an evaluation questionnaire.

3. Expectations when things go wrong

3.1 Expectations of the scope of the duty

There was consensus amongst the Investigating Committee (IC) that the duty should not relate to poor or unintended outcomes of appropriate treatment, but instead should be applicable when things have gone wrong (and there needs to be a clear distinction between the two).

> *"[It is not] about what might be ... consequences of treatment which might be adverse but would be appropriate treatment. This is about when things have gone wrong, somebody's done something wrong, they've admitted to doing something, they've used an inappropriate technique." (Member of the IC)*

There was a tendency on the part of participants initially to see 'things going wrong' as relating to incidents that result in a fatality or serious harm, rather than less serious and/or potential harm. As a result, some participants felt that the duty of candour is less of an issue for osteopaths than for other health professionals because osteopaths are less likely to cause death or serious harm. However, others interpreted the issue more widely and felt that the duty should relate to less serious issues.

> *"But at the end of the Francis Report they were talking about serious harm and death, which we tend not to see so much." (Member of the IC)*

> *"Yes, but if you read the broader – in fact, I think it was in some of your supplementary information – the broader discussion around that from Francis was actually not only in terms of fatal risk to patients." (Member of the IC)*

Linked to this is the debate over the inclusion of 'near misses' in the duty of candour, i.e. whether the duty of candour requires an osteopath to inform a patient if something has nearly gone wrong or had the potential to go wrong[5]. One Investigating Committee member noted the difference between the scope of the duty referred to in the Francis Report and that of the Joint Statement.

5 The Joint Statement states '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.'

"The original report was 'where it causes death or serious injury', but the Joint Statement is just you've caused, or had the potential to cause; you haven't even caused it – far more distress which is much lower down." (Member of the IC)

- There was some uncertainty, amongst the Investigating Committee in particular, about how this would work in practice and also about the possible negative impact in terms of causing unnecessary stress and concern for the patient. The latter issue is explored further in Section 4.

"I think it's quite difficult to assess in terms of that …. It's when you actually know something's happened, that's where maybe you want to be looking at the idea of candour rather than 'gosh, I may have done this or may not have done'." (Member of the IC)

- There were mixed views amongst the public/patient participants as to whether they would want to be told about a 'near miss'. Most felt that it was important that the issue is logged so that the individual and organisation could learn from this, but there was less consensus over whether the patient should be informed.

"Near misses – if they are all recorded and taken action on, then you prevent the disaster happening, so it is important." (Public/patient workshop participant)

"I would like to be aware of it … I might want to tell [an]other osteopath that he did something like this and this happened so [they'd] be aware of it." (Public/patient workshop participant)

- There was also a certain amount of scepticism over whether the patient would in reality actually be informed, as the 'near miss' would only be known to the osteopath who would have little incentive to report it.

"I would like to know … but in practice I do not reckon it is actually going to happen and then it is going to become redundant really." (Public/patient workshop participant)

Most participants initially saw the duty of candour in terms of the individual professional making a mistake and being honest about it, rather than in terms of raising concerns about another professional's conduct. The latter did not tend to be immediately associated with the duty of candour and, within all the groups, it took some time for this to be raised.

> *"One of the difficulties is most osteopaths work alone or in very small groups, so the duty of candour in a sense is for them telling the patient what they the osteopaths themselves have done wrong, whereas from the Francis report is people telling regulators about what other people are doing." (Public/patient workshop participant)*

However, once raised, participants in the Osteopath and Investigating Committee workshops considered it to be a fundamental part of the duty.

> *"I just wanted to perhaps extend candour away from the idea of the individual practitioner causing a problem and being candid about that, to what the Francis report was also concerned with, reporting other people who may have used inappropriate behaviour or treatment." (Member of the IC)*

Within the public/patient group there was some debate about raising concerns about other health professionals, which arose when one participant related that their osteopath had flagged up an issue with them about their concerns about another health professional. There was some doubt about whether the osteopath would have the relevant knowledge and expertise to identify shortcomings in another branch of healthcare.

> *"What about in another branch of medicine he thinks has done something wrong, what action should they then take as part of the duty of candour? Should they do anything as part of a duty of candour other than just telling me?" (Public/patient workshop participant)*

However, others felt that this was an extremely important part of the duty of candour:

> *"If you look at what happened at Mid Staffordshire and other areas where there are lots of things going wrong, it is because nobody did anything about it." (Public/patient workshop participant)*

3.2 Expectations of the osteopath

There is a perception that complying with the duty of candour should be a natural part of the role and that good osteopaths should be automatically complying with the duty as part of their day to day practice.

> *"This is also really that if you're a very honest open osteopath, the majority are, there are some out there that won't care about candour. That's what worries me a bit, the ones that are good will automatically be doing that anyway." (Member of the IC)*

Actions to mitigate against things going wrong

- There was an expectation that the osteopath would not attempt to offer treatment in which they are not experienced or trained and that they would recognise the limitations of their skill set. This point was spontaneously mentioned at both the osteopath and Public/patient workshops.

- Participants also felt that that the osteopath should provide information about risk and possible outcomes of treatment in advance, so that patients could make an informed choice. This would mean that, if something were to go wrong, then the repercussions would be easier to deal with and would facilitate the osteopath's subsequent compliance with the duty of candour.

  "I often have patients, I'm sure most of my colleagues do, who feel worse after treatment and I always explain to them it's quite possible you might feel bad for a couple of days afterwards …. Because I've explained it beforehand, they're all quite accepting of that, so actually I don't feel bad by apologising; I never feel it's an admission of guilt or poor practice but it's a recognition that they haven't had a good couple of days and I've some empathy with it." (Member of the IC)

  "You would like to be informed that something has gone wrong, I think, as a patient. Before the thing has gone wrong, you would like to know what he is going to do to you so you can be prepared with all the information … I keep the patients longer in order to tell them more, because I think a patient who is informed is less 'trouble' than a patient who is not." (Osteopath workshop participant)

  "It should be candid or perhaps a perfectly legitimate treatment but there are associated risks. You should tell the patient up front what those risks may be." (Public/patient workshop participant)

- Building and maintaining a good relationship with patients was seen as fundamental. Having open lines of communication means that it is easier for an osteopath to have an open and honest discussion with the patient in the event something goes wrong.

  "Be able to have an open discussion of what your problem is, rather than a defensive response of 'it's nothing to do with me, I can't think why that is'. I'd want it to be something that can be resolved." (Member of the IC)

"There may be a couple of possible explanations, but that's very important so that you can have a proper conversation with your patient about why." (Member of the IC)

Actions in the event of something going wrong

- The ability to say sorry, in an appropriate way, was felt to be something that is extremely challenging but a key skill in respect of compliance with the duty.

"For most people if they've had an experience where something has gone wrong, it's the very fact that the person who's been responsible, or they've perceived to be responsible, actually apologised to them. That is actually what they want to hear … And I think for me and candour, that's about communication, it's about how you tell that patient. It's about building a trust relationship …" (Member of the IC)

"But if you showed people that you're apologising, making yourself accountable or you're trying to put it right, you're trying to engage with them, I think it's far more positive. Because most people, really, … just want to know what happened and have it put right; they're not interested in going through this whole complaint thing." (Member of the IC)

"I think the point you are making though is there is candour and you have to be open and truthful. It is then how you deliver that candour. That has to be done in an appropriate way." (Public/patient workshop participant)

"People seem to have to take quite extreme remedies because they are not getting what they actually need, which is somebody saying 'yes, we did it wrong, we should not have done. We are really sorry, we made a mistake." (Public/patient workshop participant)

- Several of the participants at the public/patient workshop also stressed the importance of health professionals having empathy, compassion and kindness.

- Some participants at the Osteopath workshop indicated that they felt that letters of apology should be handwritten to demonstrate a more personal touch. They also commented that any letter would need very careful phrasing.

"And you have to think about 'if they were thinking this when they receive it, how would it be read, and trying to think of all the different possibilities so that you cater for them in your letter." (Osteopath workshop participant)

"I think you could definitely say that you wish you had known earlier to have made the suggestion to him [character in vignettes who was not referred to a specialist] but you want to be careful that you don't infer that you did know but you didn't tell him ..." (Osteopath workshop participant)

- However, others felt that a telephone conversation in which the osteopath could answer queries and judge the patient's mood and response would be a better alternative to a letter.

- Offering a remedy or clear course of action was also important to all audiences.

"You should be clear to the patient, or the family, the issues that have gone wrong, why it's gone wrong and what you're going to do about it." (Osteopath workshop participant)

- There is an expectation that osteopaths will be proactive, anticipate issues and not just act if a problem arises.

"I think what we're talking about is you being proactive and it's a case of being open and honest, not when a complaint's been made." (Member of the IC)

"I mean, I was impressed by what I read about the candour [in one of the vignettes] but apart from the fact he doesn't actually say 'perhaps I should have done this earlier'. That is the missing element for me." (Member of the IC)

- The importance of comprehensive logging of issues and also informing the organisation that they work for (if applicable) was mentioned by the public/patient participants. This was linked to the need to reflect on and learn from mistakes at both an individual and organisational level.

- An ability to deal well with complaints was mentioned by all audiences.

"The flip side of that – and it says in the summary of the Francis Report – insensitive handling and poor communication after the event can be as damaging. I think we see it in the IC that, when complaints aren't handled well, what could have been dealt with at a practice level has then led to a full complaint." (Member of the IC)

4. Potential challenges/obstacles to compliance with the duty

Participants were asked to consider what are the potential challenges or obstacles to compliance with the duty of candour. Numerous issues were mentioned, including:

- An **automatic (and natural) response** on the part of the osteopath to protect themselves,

  "I think that for the patient first, I think in this world you can get very defensive, your first reaction is to think 'oh my God, something's gone wrong, how do I protect myself' and lose sight of the patient." (Member of the IC)

  "It struck me that we all have an understanding of what's right and wrong, we have some sort of moral compass that we grow up with. So there's a point at which we know perhaps we need to say something but there's a normal human inclination not to go and publically sword fall at the first moment and it's a matter of really determining some sort of guidance at that point." (Osteopath workshop participant)

  "We are saying support a duty of candour but that duty of candour that leads to you being up before the Council and potentially losing your living, I am not sure I would be very candid." (Public/patient workshop participant)

- Particular concerns were expressed about the **personal and professional repercussions** for osteopaths of flagging issues to their regulator.

  "I've got a duty of candour, I must tell the regulator, but I'm going to be punished in some way. So that's another issue which I'm sure will be playing on people's minds." (Member of the IC)

  "So I think the general perception within the profession is that, if you highlight an error then you may be liable for fitness to practise proceedings, and I think the general feeling is that if they don't get you on what it is that's gone wrong they'll get you on something else. Which is untrue but I think that's the general fear." (Osteopath workshop participant)

  - Within the Public/patient workshop there was support for the idea that the regulator should provide a 'safe space' for osteopaths to raise issues, around candour without the threat of disciplinary action.

- A reportedly widely-held concern that if the osteopath apologises to the patient they could be **admitting liability**, with the associated legal repercussions or potential for invalidating their professional indemnity insurance.

  "If you're a patient and somebody says to you 'I think something's gone wrong because you've got a broken rib', and then they apologise to you, if you're an average lay patient and someone apologises to you for the fact they've broken your rib, that's as good as admitting liability really." (Member of the IC)

- Some osteopaths raised the concern that if osteopaths feel that they need to share with patients all the risks and potential issues relating to treatment (particularly relating to things that could have gone wrong but did not), then this could result in **unnecessary worry and concern**. There was also some concern about how the osteopath makes a judgement call about which patients would benefit from being informed and which would not.

  "I think you can create undue and unwelcome worry in a patient depending on what the issue is. Obviously, it depends on the seriousness of it but, if there's a theoretical risk that something might happen because of something the osteopath's done, at what level do you inform that patient, that they then go on and worry about, disproportionately about that event that may or may not happen, and then create ill health as an end result of that." (Member of the IC)

  "But the best interests of the patient, going to point 2, is does it help his health from now on in, at the point where he might be depressed, he's certainly not very well, does it actually help his future care to go into all of the details which may or may not now make much difference to his future health?" (Osteopath workshop participant)

  - One of the public participants echoed this sentiment by indicating that there should be openness but that this needs to be handled with a certain amount of discretion.

  "I do not think that it is actually that simple because I mean … I would not like a physician to say in front of a child of mine if either I or the child was dying. There is candour and there is openness but there must be a combination of that with tact and respect." (Public/patient workshop participant)

- Some osteopaths pointed out that compliance with the duty of candour relies on extremely **good communication skills**. Communicating well is difficult at the best of times – a difficulty which is exacerbated during stressful periods (such as something going wrong.)

  "It's all a great concept, a great principle that we'll all be open and tell people when we've done things wrong. But we're all human as well … for an osteopath to be in a situation where something's gone wrong … people find it difficult to communicate with patients anyway, and then to be put in a situation where you know you've gone wrong and then you have to tell them. Then to be able to find a way to communicate that calmly and in a way that's not going to make them even more stressed." (Member of the IC)

  "So the difficulty … is actually being in a situation where you're going to sense all of those stresses that are going on and make a judgement … and behave in a way that uses the correct amount of candour for the moment. It's quite hard to do when you're under pressure." (Osteopath workshop participant)

- Investigating Committee (IC) members and osteopath participants were also concerned about **perceived grey areas** in terms whether the osteopath has actually done anything wrong. Examples were given of where the treatment was appropriate but there was still a poor outcome and also instances where it is very hard to judge if the osteopath has behaved appropriately or not.

  "Although I think there is an aspect of doing everything correctly and there still being a bad outcome. Because healthcare is not a kind of … it's not like changing a wheel on a car, you can do all checks and tests, one treats the patient, there's still a bad outcome." (Member of the IC)

  "I think it's very blurred, I think that's a professional judgement and the broken rib one might be, and we get an expert in that says 'no, that treatment was appropriate, the force was proportionate,'… on the other hand, it could be that the osteopath was far too forceful. But we would be relying on an expert in that sense and it's about your professional judgement, but I think the whole concept of 'wrong' is rather difficult to define." (Member of the IC)

  "I think it's really difficult in practice because when you read it, it's like well, yes, of course we want everybody to be candid but then, when you look at some of the case studies you've given us as well, it's not clear-cut, is it? How you do it?" (Member of the IC)

- Linked to this, was difficulty judging whether what had happened merited saying anything to the patient:

"I think you might see a kind of visual analogue scale where 'I have killed or I might kill someone' at one end and 'I did something wrong but nobody's going to know and no harm's been done' at the other end, and every individual's got to pick the point on that scale where they're going to contact their insurers, contact the iO [Institute of Osteopathy] or whatever. I think that's the biggest problem for the individual, of knowing where on the scale we need to start reporting, need to start apologising to the patients." (Osteopath workshop participant)

"We felt you could argue that this is common and you could kind of fudge this and get over it and manage the situation, [after manipulating the wrong shoulder] or you could actually go full tilt and write to him afterwards and say that actually we've had the wrong notes and this is what we've been doing, this is what happened and it won't happen again, and go full tilt on it. But [it's] probably unnecessary." (Osteopath workshop participant)

"[Do you think this should be for every single mistake], no I think that is yet another set of criteria, that there must be levels. Yes, there will always be the ones that are debatable." (Public/patient workshop participant)

- Some **practical considerations** of complying with the duty whilst being in a busy practice were mentioned, including keeping to time during appointments (if the osteopath has to spend longer with patients) and also dealing with upset patients who have been informed about things going wrong.

"But, in terms of practical logistics in practice, for you to tell someone something like that you've got to allow time for the patient to process that and you've got all your other patients waiting, haven't you, and then you've got to manage all the patient's reaction to whatever you're telling them, in addition to your normal appointment." (Member of the IC)

- Mention was also made of the fact that many **osteopaths work on their own** and not within a structured organisation with the associated support and processes.

"We don't have the structured organisation …, so we've got very particular pressures as a professional, individually I think, because our responsibility is very much we're taking it ourselves. If you're a lone practitioner, it's you on your own in a room with someone and that's where I think we have to make that fit really." (Member of the IC)

- Specific challenges were mentioned associated with one specific component of the duty – **raising concerns about other health professionals (including other osteopaths)**. Participants at all the workshops were mindful of the numerous barriers relating to raising concerns about colleagues or fellow professionals, including potentially having to work with people about whom you have raised a concern, or the possible negative impact on their own practice.

  "And then you've still got to work with people potentially, that you've blown the whistle on them, but you're still in the same clinic while it's all being investigated. That's not easy, is it?" (Member of the IC)

  "It's all very well talking about it in a closed session but in the sort of nitty gritty real world when you're working as an osteopath and you've got a mortgage to pay, working with a colleague, you report that colleague, it makes it difficult, the practice goes belly up, you lose your house. It's interesting operating here because you have two hats on, you have the sort of idealistic hat on and then you have the real world hat on." (Member of the IC)

  "It would be interesting to bring it out as a topic because … not to make it a taboo because, after all, the whole whistleblowing thing and Shipman and all the rest of it were all issues to do with the fact no one said anything. Jimmy Savile even for that matter, all sorts of things were not discussed openly. It's the ultimate taboo actually, in my opinion." (Osteopath workshop participant)

- There was extensive debate within the Investigating Committee and Osteopath workshops about the **issue of insurance**. There was some strong feeling and concern that insurance providers will give advice that contradicts the duty of candour and that if the osteopath fails to adhere to the Insurer's advice, this could invalidate their insurance (and they could potentially lose out financially or not be able to practise).

"Absolutely insurance, but I understand that your first duty at the moment is to inform your insurance provider, who often will say 'don't say anything at all', which is totally contrary to the approach we're trying to adopt here. Where do you draw the line? To me that's a huge issue." (Member of the IC)

"I think a lot of osteopaths, or all osteopaths, would be seriously worried if they thought they were compromising their status of being insured or uninsured. Because to be uninsured and then to face all those legal costs might ruin you." (Member of the IC)

"I think too there were some comments about insurance companies need to work with professionals to decide how best to go forward if there is an issue. At what point are you allowed to step forward and say 'I'm really sorry, I think I made a mistake'. Do you have to ring the iO first or your insurance company before you can make such a statement?" (Osteopath workshop participant)

5. Considerations for the GOsC

5.1 Implications for the Investigating Committee

There was a broad consensus within the Investigating Committee that they would and should take note of the compliance with the duty of candour in their decision-making and they felt that registrants should be made aware that a lack of candour could affect the Investigating Committee's (IC) decision.

> *"I've written 'early and full candour should be noted and viewed positively in any statement…, whether or not there is a case to answer'." (Member of the IC)*

Public/patient participants also felt that compliance with the duty of candour should be a point in an osteopath's favour when the IC considers their sanction, but only so long as it was a genuine response.

> *"If it appears to be genuine and sincere and not a way of 'if I show remorse you will reduce my sanction'." (Public/patient workshop participant)*

However, there was also some debate amongst the Investigating Committee about the difficulty of judging whether the duty had been complied with, because of some of the challenges (identified in Section 4 of this report). Most felt that they would need to review the situation and use their judgement about the balance of probabilities.

> *"So this is what I mean about admitting that you've done something wrong without knowing the full facts. How can you tell what that patient is doing 24/7 when they're at home and not in your immediate care? In the NHS, in a ward situation, where that patient has 24 hour round the dock care [it is different] – this is the conflict that I'm struggling with." (Member of the IC)*

> *"But you'd go on the balance of probabilities. It could have been a huge coincidence even if you hadn't." (Member of the IC)*

5.2 Priorities for guidance

There was a broad consensus from the Investigating Committee and osteopaths that the production of scenarios/vignettes as part of the guidance would help osteopaths understand how the duty of candour fits into their everyday practice.

> *"They really make you think about it, I think, when you get these practical examples, in a way that the formal words are quite difficult to follow through." (Member of the IC)*

> *"For a lot of practitioners it's going to be quite difficult to work out. It's alright for us here, we've been through it and we're doing the training but I think, if you were in a practice and you get the letter through from GOsC, you're going to think what on earth's happening? So you've got to be able to distinguish how to put it into your practice life, how it relates to you and the patient." (Member of the IC)*

One of the public/patient participants also suggested that osteopaths should have 'role play scenarios' on the duty of candour during their training.

There were a number of areas, in particular, where participants felt that guidance would be useful:

- Working in partnership with patients and communicating well.

> *"It almost seems to imply you've got to work out what needs to be done or you sort out the making good, but I think there perhaps ought to be more in here about making time and communicating with the patient to see what they would like." (Member of the IC)*

- Guidance on how to observe the duty of candour, including providing a satisfactory explanation and communicating remedial action in way that is appropriate to the patient.

- Guidance on what would be a proportionate response (particularly guidance on how to handle 'near misses' and less serious issues.)

- Guidance on raising concerns about another health professional given the specific challenges associated with this aspect of the duty.

- Information about what might happen if the duty of candour is not observed.

5.3 Suggested actions for the GOsC and partners/stakeholders

There were a number of specific considerations or actions for the GOsC and partners:

- The duty of candour will need a **very careful introduction and presentation** to registrants so that they fully understand the context and how it should be applied in practice.

"Introducing something that's described as being new, I mean, parts of it may be reflected [in the Standards already] but parts are new, which is fuzzy and unclear. It's going to lead to some unintended consequences and some practitioners may err on the side of caution, as it were, and create more steam and argument than is actually desirable in that sense." (Member of the IC)

"It's got to be presented in … a framework of the Francis Report as well. Because I think for a lot of people practising, they don't really relate … to an NHS organisation or a situation like Staffordshire, we just wouldn't because we don't operate in the hospital system." (Member of the IC)

- A supplementary point was also made that the duty needs to be **framed positively**, not as a burden for professionals but as something that patients actively want and that will improve the quality of practice. There needs to be a shift to a learning culture rather than a blame culture.

"Somewhere in everything that has to be done there has to be a constant reassurance that you can, in theory, have a bad day, you're not going to be perfect, and you can apologise and try and rectify that and it's not the end of your career, it doesn't necessarily mean you're going to be part of a fitness to practise procedure. So, however this comes out, I think the overriding message has to be that actually it is what your patients want and it's what is best for you as practitioner ultimately because you'll be trusted more, and you're providing a much better service all round." (Osteopath workshop participant)

"It's a good note to … end on because, in fact, that is the spirit of the Francis recommendations, actually to support people providing healthcare to do the best thing for their patients and for themselves generally. So it's really trying to provide support and education and not trying to prosecute people for mistakes in practice, everyone makes mistakes in any practice." (Osteopath workshop participant)

"It is almost that the Council needs to set the standard about the expectations but also, to some extent, protect the practitioners not in a negative way but to give them the safety – it is okay to be candid – because there are so many risks attached to being open." (Public/patient workshop participant)

- There was also reference at the public/patient workshop for the regulator to provide a 'safe space' for osteopaths raising issues around candour.

"I think if you want people to be open and honest, there needs to be a safe place, a safe area where they can be open and honest. You need to make it clear that that is possible without them getting reported, striking that balance somehow." (Public/patient workshop participant)

- That the guidance relating to the duty needs to be specifically **tailored to the osteopathic profession,** given differences in how they practise compared to other health professionals:

"When we had the consultation about the revalidation process it came up, didn't it: the PSA did view us as a low risk profession so, therefore, the onus on the revalidation system was much lower for us than it is for say a cardiothoracic surgeon. So, again, maybe the duty of the onus of candour for us might be quite different to people in other settings, other professions, so it needs to be very much tailored to our profession and not one size fits all." (Member of the IC)

- That the message needs to be **disseminated in a range of ways**, including face-to-face practical training sessions, online CPD training, publications and through intermediaries, like the Institute of Osteopathy.

"The thing I'd like to say about introducing something like this is that we're very privileged here to have a bit of time with you to go through this. If we're a registrant on our own out there, not in an educational establishment, then I just hope there will be the opportunity to attend some really good focused training events which will run through things like this. Years ago I think the GOsC did some things called three or four Cs, that would be really good, a really good series of events and I just hope that something like that can be done here, given the importance of this." (Member of the IC)

- There was a particular focus on ensuring that the duty is covered in the early stages of training.

"I think a lot more of what we talk about at this level now for people who are qualified, a lot of that could be talked about at student level. I think there should be far more input in understanding. When you're training you've got so much else to learn, you're not really thinking about being in practice and I think that's where this all needs to fit in. … It's a paradigm shift effectively, that's what we're talking about, because for all professionals there's a shift, isn't there, from closed doors. The Francis Report talked about that, so there's a complete mind-set shift, and that has to start at Year 1, Week 1." (Member of the IC)

- One participant suggested a multi-disciplinary session to discuss candour, working through various scenarios or vignettes:

"I've been pushing this for years, they're trying to get intraprofessional education, getting together. So, actually, if this scenario like we've done today had a few GPs, a few nurses and a few others in this room with us, or for a future event, we'd actually be doing a great deal for osteopathy mixing with others." (Osteopath workshop participant)

- There was some discussion in the Investigating Committee workshop about the need for the duty of candour to be **explicitly mentioned in the standards**.

"Honesty and integrity are in there, but I think candour has to be in there, possibly as a sort of heading." (Member of the IC)

- One of the Public/patient workshop participants also felt that there should be more detail in the standards and associated processes.

"That [the Standards] does not set out what do you do when you have done something wrong. Does that go a step further?" (Public/patient workshop participant)

- **Tackle the insurance question** and reassure osteopaths that compliance with the duty of candour will not adversely affect their insurance status.

"Until we've had some statements as well from insurers, what their position is, I don't see how we can particularly move forward. We're all going to stay as we are until we know that they've moved." (Member of the IC).

GOsC candour vignettes – Osteopath workshop 3 June 2015

1. Breach of confidentiality

Joan, a patient you know well, comes in for a follow up appointment looking flustered and tells you that she is upset because your kind receptionist has just offered her condolences for the death of her brother. She explains that she has been estranged from her brother following a long-standing family dispute with her sister-in-law, Debbie, and brother, John, and that she had not known that her brother had passed away. Joan did not know that any other members of her family attended your practice, but is grateful to have been told about her brother's death.

You recall very clearly the circumstances of John's death as you had been the person who first suspected that John was seriously ill and referred him to his GP. The GP had been kind enough to write back thanking you for your concern and for alerting him to the situation, and he advised you that investigations had revealed metastases in John's liver. Sadly John had passed away some six weeks later. Debbie also had been seeing you at the time of John's illness – you treated her neck pain and you had been supportive of her during John's sudden and terminal illness. Shortly after John passed away, Debbie had been in touch to thank you for your concern and for recognising that John was ill. Subsequently you had written to Debbie expressing your condolences for John's passing.

After Joan has left the practice, you ask your receptionist about this incident. Your receptionist tells you that she knew that John and Joan were brother and sister. Because she had typed the condolences letter for you, she had known about John's death, but was not aware of the family dispute and their estrangement.

What actions do you take, if any?

Consider also:

- Why might you want to contact Debbie?
- What might be the kinds of things you would say to Debbie?
- Why might you want to contact Joan?
- What might be the kinds of things you would say to Joan?
- Are there any actions you might take to identify whether there are training needs for your receptionist or changes that need to be made with respect to the keeping and administration of records/letters?

2. Mistaken Identity

You have had a busy few weeks and filing has got a little behind and today you are running ten minutes late. You have a quick look at the notes and see that your next patient first presented to you some 10 weeks previously with left shoulder pain and is now attending for a follow-up. It's been 4 weeks since you have seen him.

You call in Mr Smith who is keen to get on with treatment as you are late and he is in a hurry. He 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 of his movements show that his shoulder has full and pain-free movements now, but his neck is a little restricted into rotation on to the left-hand side. Brief palpation does not reveal any particular muscular or skeletal findings other than left-sided tenderness in the muscles of the neck down to the shoulder.

You get on with treatment by doing some soft tissue on his left shoulder, working through the rotator cuff muscles in the side lying position. Mr Smith looks at you a little quizzically when asked to lie on his right-hand side and you assume this is because his neck is a little stiff.

Working on Mr Smith, you have a moment of disquiet while chatting to him about his work, realising that you have been thinking about the wrong Mr Smith. You glance down at the notes and see that the notes you have been referring to are for Adam Smith, rather than Alan Smith who you are treating now. As you recall Alan's clinical details, you realise that you have been working on the wrong shoulder.

What actions do you take, if any?

Consider also:

- What might you say to Mr Smith if you decide to tell him you have made a mistake?
- Under what circumstances might you decide not to say anything to Mr Smith and move onto treating his other shoulder?
- Are there any actions you might take to identify whether there are training needs for your receptionist or changes that need to be made with respect to how you manage the keeping and administration of records?

3. Safety incidents

Your new patient Anne has recently had a baby and is suffering from pain localised to the left side of the neck. Anne says that her left hand occasionally feels weird and goes to sleep, but she feels sure this is related to breastfeeding. She has been enthusiastically recommended to you by a friend who you have treated successfully. The delivery of Anne's baby went well and was without complications. Anne is breastfeeding and this too is going well, except for the pain that she is experiencing in her neck.

Anne's medical history is unremarkable. She has had some accidents in the past related to horse riding – her last fall was 18 months ago and although this caused neck pain, she did not seek treatment and the injury resolved over six months or so. She has no concurrent health concerns.

Your examination reveals limited neck movements and some pain at the end of her range of movement. There is localised segmental tenderness and what feels like soft tissue tightness in the neck. She also has stiff dorsals and associated paraspinal tightness. Neurological examination is unremarkable.

You decide that she has mechanical neck pain related to her posture and the demands of breastfeeding. You explain your diagnosis and gain consent for treatment. You elect to treat Anne using a variety of techniques local to her pain and more widely.

Treatment seems to go well and Anne is pleased. When she gets up from the treatment table she even comments that the treatment must be working and doing something as she can feel it all the way into her left hand now and a little bit into her right hand. She describes tingling and some slight numbness in some of her fingers. By the time she has got dressed, the feeling in her hands has subsided.

You decide to wait and see how her symptoms are over the coming week. When you see her again, she is irritated as she has had more persistent hand symptoms, including some weakness when picking up objects. She has read up about her symptoms on the internet and wants to know why you haven't told her that she has a trapped nerve.

What actions do you take, if any?

Consider also:

- It could be argued that this is a transient episode and as no harm has occurred there was no need to discuss this further with the patient. What do you think?
- In hindsight, what action might have been helpful after the initial consultation?

- What might you have said to the patient?
- What might you say in response to her concerns about you missing a trapped nerve diagnosis?

4. Treatment reaction / safety incident

Mr Jones is a 78 year old man who you saw as a new patient several days ago and today he is attending for his follow-up.

At his first consultation, you came to the conclusion that primarily he complains of mechanical low back pain, but you recognised that he also has a mild amount of osteoarthritis that may be contributing to his back pain. His medical history was largely unremarkable, except for his memory which he describes as "abominable". It's been getting so bad of late, that his daughter persuaded him to see his GP recently and now he is scheduled to see a "memory" doctor at the hospital in the next few weeks. Mr Jones described some problems with his "ticker", which sounded like palpitations, and he is unsure what medications he takes. He promised to bring you a list of his medications at his next visit and said that you could ring his daughter now if you wanted to. You decided that this could wait until the next week, as you were running a little late and Mr Jones' problem seemed straight-forward. At his first visit, your treatment included some soft tissue work to his para spinal and gluteal muscles, as well as articulation and some indirect techniques.

Today, Mr Jones has indeed brought in a list of his medications and you see that he is taking Warfarin, as well as some simple analgesia. He has made progress since you last treatment and is pleased with the results. However, when Mr Jones undresses for treatment and you examine his back, you see that there is extensive bruising where you worked on him at the last appointment. Mr Jones has not had any accidents that may explain the bruising. He is unaware of the bruising that you have observed. You realise that it is likely that you have caused this bruising.

What actions do you take, if any?

Consider also:

- What additional safeguards might you put in place to avoid this type of incident happening again?

5. Delayed diagnosis

Ade is a 70 year old black man who has been seeing you pretty regularly over the last 6 months. He enjoys coming to see you, in part because he is rather socially isolated and lonely. He often talks about his working days as a labourer in a company that refurbished buildings. You think that he is mildly depressed. You have built a good rapport with Ade and he enjoys talking to you. He initially presented with dull aching pains in his back and ribs, which were worse on movement. He has also complained of being tired and lethargic, which you have attributed to his low mood and low levels of activity. Ade himself blames his weakness and low energy on the series of minor infections he has been suffering. He is very much hoping to be able to visit family in Nigeria later in the year and he feels sure some "proper" weather and good food will restore him.

During a CPD session in which you are refreshing your knowledge of multiple myeloma, you have a sinking feeling as you realise that Ade pretty much fulfils the criteria for a "classic case". When you get back to work, you get out Ade's notes and read through your initial case history: you find that during the general history, Ade also described being troubled with nose bleeds, feeling sick and frequent micturition, as well as constipation and headaches.

Ade's symptom fall into place – you are now sure he has multiple myeloma. While you can see why various elements of his presentation might have been interpreted differently, you feel now that you have made a mistake in not referring Ade back to his GP at the initial consultation.

You ring Ade and tell him that you have been thinking about his condition and care and you would like him to see his GP for some more tests. Ade is pleased that you have rung and even more pleased that you have offered to write to his GP outlining your concerns, as he always feels a bit rushed at the GP's.

After some weeks you hear back from the GP with a brief note thanking you for your letter and confirming that Ade has been diagnosed with multiple myeloma.

What actions do you take, if any?

Consider also:

- Although there is no indication that Ade is anything other than pleased with your care, you know that his diagnosis could have happened much sooner. What are the arguments for and against contacting Ade to tell him that you think you made a mistake in the management of his care?

6. Delayed diagnosis related to the care of others and organisational responsibility

George is a 40 year old labourer. He has come to see you as he's not getting much better seeing your colleague, the other osteopath in the practice. George has also seen his GP several times about his pain. His symptoms focus primarily on the left side of his lower ribs and radiate around to the front of his body. When you meet George, you are struck by his impressive "beer" belly – George confirms he drinks a lot of beer and is also a heavy smoker, but has been losing weight and doesn't feel well. He also doesn't look well and as part of your examination you assess his shoulder movements and notice that he has a hard, fairly large supraclavicular nodule on the left side. When you comment on this he says that his wife has also noticed this and he has mentioned it to his GP and to your osteopath colleague. The osteopath said it was probably due to a throat infection and the GP was not concerned.

You refer George back to another GP in his practice because you suspect that he has an abdominal cancer of some sort. The GP later confirms that George has terminal stomach cancer and only a short time to live.

What actions do you take, if any?

Consider also:

- What actions if any do you take prior to hearing back from the second GP?
- What might you say to George or a member of his family if you elected to contact them?
- What might you say if you decided to speak to your colleague or to the first GP who had not identified that George was seriously unwell? Are there any other people or organisations you might contact?
- What actions do you take after hearing back from the second GP?
- What might you say to George or a member of his family if you elected to contact them?

7. Organisational responsibility

You're a clinic tutor and following up on a patient who was seen last week by another tutor. The student concerned, David, is in his final year of training. In his preparation for the patient, David tells you with some relief that for once they had been able to make a clear diagnosis, without the usual uncertainty associated with many of the musculoskletal presentations seen in the clinic. The diagnosis of DeQuervans tenosynovitis was made and agreed with the tutor.

When the patient arrives, David spends some time with them and then comes to speak to you. David is not as pleased as he had been, and he tells you that the patient is clearly much worse: the swelling at the base of the thumb has increased two-fold and the patient is experiencing much worse pain. Despite the increase in symptoms, the patient has done as he was asked and has carried out 30 repetitions, using a squeeze ball, 3 times a day.

It is clear to you that this is not an appropriate exercise for a patient with this condition which you know is associated with overuse and where the initial management typically includes rest and avoidance of the activity that brings on the symptoms.

You ask David about the exercise prescription and he says that he wasn't really sure about it at the time but his tutor had been very confident that this was the right thing to suggest.

What actions do you take, if any?

Consider also:

- What might you say to the patient?
- What might you say to the student?
- Are there anyone else you might talk to about the case?
- What might you say to the other tutor?
- Who in the organisation responsible for managing the clinical service might you speak to?
- Are there any other ways that you might let people know about this incident?