# Openness and transparency in surgery

THE ROYAL COLLEGE OF SURGEONS OF ENGLAND

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RCS
ADVANCING SURGICAL STANDARDS

**The reputation of the NHS has continued to suffer from a real or perceived notion that hospital staff are afraid to be open with patients, managers and other healthcare organisations about errors or poor working practice. This is thought to be a core contributing factor to poor working environments, demotivated staff and, ultimately, patient safety failures.**

This briefing outlines some key policy issues relating to transparency and openness, and discusses their implications for patient safety and the quality of healthcare. We believe cultural change is the key to embedding clear and open communication. While culture change towards openness and transparency is not easy to achieve, it must be the basis upon which the NHS strives for excellence in patient safety and quality.

## RAISING CONCERNS: OPENNESS WITHIN ORGANISATIONS

The Public Interest Disclosure Act (PIDA) is the legislation in the UK that protects individuals raising their concerns (sometimes referred to as 'whistleblowing'). PIDA protects individuals who first raise a concern about wrongdoing internally and subsequently with a regulator. It also protects workers who make wider disclosures (for instance to the media) where there is a valid reason and the particular disclosure is in the public interest.

Where effective arrangements and clear guidance for raising a concern are in place, there should be less need for staff to seek legal redress for whistleblowing. The College believes that all hospitals and providers of healthcare should have clear policies and procedures written in plain language and accessible to all staff. The College also recommends that individuals and organisations seeking advice on raising concerns should contact Public Concern at Work, the independent whistleblowing charity with a track record of working in the NHS.

## RAISING CONCERNS: OPENNESS WITH PATIENTS

All doctors have a professional, moral and ethical duty to be open and honest with their patients at all times. It is the responsibility of the clinical team – led by the most senior clinician involved – to make a judgement about disclosure, which should be personalised according to the needs of the individual patient. The College regards the quality and manner of this disclosure with patients to be a critically important aspect of clinical practice.

The College's publication, *Good Surgical Practice*, sets the standards for surgeons.[1] *Good Surgical Practice* states that surgeons must:

- fully inform patients and their supporters of progress during treatment;
- explain any complications of treatment as they occur and explain the possible solutions; and
- act immediately when patients have suffered harm and apologise when appropriate.

The College is concerned that there is evidence to suggest this guidance is not always implemented. Although the extent of this is unknown, the College believes that lack of openness with patients is symptomatic of a more fundamental problem – a closed and defensive culture.

## DUTY OF CANDOUR: THE COLLEGE PERSPECTIVE

A legal duty of candour has been proposed to address openness with patients, making it a statutory obligation to inform the patient when a safety incident has occurred.

The College, however, has reservations about a legal or statutory duty of candour as it only addresses one discrete element of openness between the clinician and patient. On a practical level, such legislation would be very hard to interpret, apply and enforce – particularly in surgery, in which an incident of harm may not be immediately apparent following treatment.

Instead, the College supports the approach described in the *Being Open* guidelines produced by National Patient Safety Agency (NPSA).[2] The *Being Open* framework aims to do this through enabling organisations to foster supportive and open working environments, rather than imposing compliance with legal redress. There are many benefits of the *Being Open* approach, including greater openness overall (not only with patients) and the promotion of a learning environment (as opposed to blame) that will ultimately lead to improvement in patient care.

## DUTY OF CANDOUR: THE PATIENT'S PERSPECTIVE

"*Patients are at their most vulnerable when they are receiving treatment and have a right to have open and honest communication with those treating them. They should not have to seek information. Anything to encourage this openness is a good idea but should be meaningful for the patient and not dictated by processes or tick-box requirements.*"
**Susan Woodward**
Chair, RCS Patient Liaison Group

## RAISING CONCERNS: OPENNESS ACROSS THE NHS

When something happens that affects the safety of patients, whether it results in actual harm or not, healthcare staff in England and Wales can make confidential reports to the National Reporting and Learning Service (NRLS). Reports are analysed by clinicians and safety experts, identifying issues that are then sent to healthcare providers in the form of feedback and guidance. The NRLS database now holds over four million incident reports and has been growing exponentially since its establishment in 2003, with 1.19 million reports made in 2009–2010. Healthcare providers are legally obliged to report all incidents of a serious or fatal nature either to the NPSA or the healthcare regulator, the Care Quality Commission.

A recent survey, published in the *Bulletin* of the Royal College of Surgeons, examined the prevalence of patient safety incidents.[3] The survey of 549 general surgeons found that 40% said they had been involved in an untoward event in which a patient was nearly harmed and 19% in an incident of actual harm during the two-week period covered by the survey. The authors of the paper estimated that problems arose in about 3% of operations. Comparing this to estimates by the NPSA of an incident rate of around 1.6% suggests a potential under-reporting of incidents. The College encourages the reporting of all incidents and near misses to prevent future safety incidents and capture learning for continual service improvement.

The College, as an independent organisation, sets the very highest standards of practice and training for surgery and works to ensure these standards are achieved. We offer support to surgeons who raise concerns. We also participate in the NPSA's Clinical Board for Surgical Safety, which analyses safety incident data and makes recommendations for change.

## References

1. Royal College of Surgeons of England. *Good Surgical Practice*. London: RCS; February 2008.
2. National Patient Safety Agency. *Being Open. Communicating with patients, their families and carers following a patient safety incident*. Patient Safety Alert. London: NPSA; November 2009.
3. Pritchard C, Brackstone J, MacFie J. Adverse events and patient safety in the operating theatre: perspectives of 549 surgeons. *Ann R Coll Surg Engl (Suppl)* 2010; **92:** S1–4.

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