Editorials

Is honesty the best policy?

Why trustworthiness is no easy answer

A CULTURE OF CANDOUR

The Department of Health recently commissioned the Royal College of Surgeons (RCS) to review the medical profession's statutory 'duty of candour'. The RCS has now published its report, *Building a Culture of Candour* (BCC).¹ The report seeks to explore the barriers for doctors, other healthcare workers, and healthcare organisations to their duty, and hopefully their desire, to be honest to patients when things go wrong.

The Oxford English Dictionary defines candour as 'the quality of being open and honest; frankness'. It is therefore about being truthful, but with the emphasis on our openness to disclose uncomfortable truths. Onora O'Neill helpfully reminds us that trust can only exist if we are consistently trustworthy.² So truth is vital to our craft. No one is going to argue with this, so why does it need to be said?

BCC lists powerful barriers to openness that exist within the medical culture of the UK. These include the obvious, such as our natural human reluctance to admit that we are wrong, the fear of litigation, and the fear of a punitive response from regulators such as the Care Quality Commission (CQC) and the General Medical Council (GMC). It also identifies more subtle barriers such as reluctance to talk about other people's errors when we do not know the whole story, anxiety about unleashing a bureaucratic burden, and worry about organisational reputation. And who is clear about the boundary between minor problems and 'significant harm' that needs reporting? Worryingly the report cites soft evidence of general practice as an area where harms may be underreported. Michel Foucault saw the relationship between the doctor and the patient as inherently abusive.³ I suspect that most of us would wish to disagree, yet there have been enough abuses of patients' trust in UK general practice to question any easy reassurance.⁴

BCC calls for care organisations to sustain a culture that supports staff where they seek to be candid. It recognises that:

'... a culture of candour will not be brought about by legislative requirements and duties alone.'

It points out that:

"It is not reasonable to demand two things that are incompatible on the grounds that we want both."

'... support and learning rather than blame and punishment from the leaders of health care organisations and from regulators is likely to lead to a far greater willingness from staff to act in a candid manner.'

BCC also cites *A Promise to Learn — A Commitment to Act*, published by the National Advisory Group on the Safety of Patients in England in 2013. This covers similar ground, looking at patient safety itself. Quality and patient safety are closely related. Following on from the Report of the Health Service Ombudsman into NHS care of older people in 2011, the Francis Report in 2013, and others, one wonders whether words on paper will ever change the culture of the NHS. So what is the problem?

COME FLY WITH ME?

Much has been made of the comparison between airline safety and patient safety.⁵ This is a valid and useful comparison, with medicine having much to learn from the open, non-blaming, and safety-oriented culture of the airline industry. But many grassroots medics also resent the comparison because of what is left out. In the airline industry safety trumps all. If the co-pilot is sick or a warning light flashes the plane will not fly. But in general practice if a partner is sick or the computer takes one of its mornings off then the show must go on. We will be held in breach of contract if we do not muddle by, yet the courts or the GMC will not go easy on us if any mishap occurs. In the NHS safety trumps all according to numerous government reports and utterances but targets trump all according to most NHS contracts. A pilot's workload is strictly regulated; a GP's workload is not. We will be punished if our surgeries do not

fly, and we will also be punished if they do not fly safely.

Managers and politicians may insist that many safety mechanisms and quality standards are written into contracts, and indeed into CQC requirements. In response I ask one thing: will we then not be penalised if we do not open our surgeries one day because of manpower or resource issues? Will our secondary care colleagues not be penalised if they fail to meet NHS targets because of similar concerns? It is not reasonable to demand two things that are incompatible on the grounds that we want both. Something has to give.

So, there is a fundamental policy inconsistency at the heart of the NHS. NHS contracting mechanisms prevent safety from being the outright winner. Morally one can see this as the worn-out argument between duties (deontology) and outcomes (consequentialism). In medicine our duties are set out appropriately by the GMC and by numerous best-practice statements and guidelines. Simultaneously the goals and workload to which these apply are set out by numerous management and contractual targets determined by the Department of Health, clinical commissioning groups, the CQC, and others. What happens when these will not fit together? Deontology and consequentialism only ever fit together within unstressed systems, and the NHS is hardly that. Truth is said to be the first casualty of war. Perhaps honesty is a frequent casualty of the NHS.

A NEGOTIATED TRUCE?

Because duties and outcomes are sometimes incompatible ethics has always sought some form of negotiation. In principlism we are used to balancing

"Truth is said to be the first casualty of war. Perhaps honesty is a frequent casualty of the NHS."

"... a report will not fix the fundamental policy inconsistency that lurks at the heart of the NHS."

the demands of potentially incompatible principles.⁶ In virtue ethics we are used to finding the most appropriate middle course. In politics however moderation and reflection do not always appear to win.⁷ According to a recent report in *The Times* the Secretary of State for Health, Jeremy Hunt, feels that the answer is more whistleblowers.⁸ Presumably if only we could identify more people to beat with a big stick then all will be well. What is clear, from the same online page of *The Times*, is that being a whistleblower is still a pretty hazardous business.⁹ And, as Clare Gerada pointed out, GMC referral may be a disproportionately traumatic experience for doctors.¹⁰ Thus we have a potentially abusive environment all round: a system where both doctors and patients can be unsafe. The answer to issues of patient safety must surely be to look at the whole system and not rely on crushing individuals who have been judged to fail. This is not to argue against individual responsibility and accountability. Rather it is to claim that these must be seen within the context of the systems in which individuals function.

Aristotle stated that:

*'Someone who loves the truth, and is truthful when nothing is at stake, will be all the more truthful when something is at stake.'*¹¹

We mostly want to be truthful but the barriers may deter us. Ancient Greek philosophers sometimes paid a high price for their honesty and not all of us are made of the same stuff.

This report is to be welcomed. It is right to hold the medical profession to its duty of honesty in thick and thin. It is helpful to analyse and enumerate the hurdles to honesty. But a report will not fix the fundamental policy inconsistency that lurks at the heart of the NHS.

David Misselbrook,

Senior Lecturer in Family Medicine, RCSI Bahrain, Dean Emeritus Royal Society of Medicine, Senior Ethics Advisor, *BJGP*.

Provenance

Commissioned; not externally peer reviewed.

DOI: 10.3399/bjgp14X682129

ADDRESS FOR CORRESPONDENCE

David Misselbrook

RCSI Bahrain, P.O. Box 15503, Adliya, Kingdom of Bahrain.

E-mail: dmisselbrook@rcsi-mub.com

REFERENCES

1. Dalton D, Williams N. *Building a culture of candour. A review of the threshold for the duty of candour and of the incentives for care organisations to be candid*. Royal College of Surgeons of England, 2014. <http://www.rcseng.ac.uk/policy/documents/CandourreviewFinal.pdf> [accessed 10 Oct 2014].
2. O'Neill O. *A question of trust*. The BBC Reith Lectures 2002. Cambridge: Cambridge University Press, 2002.
3. Foucault M. *The birth of the clinic*. London: Routledge, 1989.
4. Misselbrook D. The general practitioner and abuse in primary care. In: Subotsky F, Bewley S, Crowe M, eds. *Abuse of the doctor patient relationship*. London: Royal College of Psychiatrists, 2010.
5. Sexton B, Thomas EJ, Helmreich R. Error, stress, and teamwork in medicine and aviation: cross sectional surveys *BMJ* 2000; **320**(7237): 745-749.
6. Beauchamp T, Childress J. *Principles of biomedical ethics*. 6th edn. Oxford: Oxford University Press, 2008.
7. MacIntyre A. *After virtue*. London: Duckworth, 1985.
8. Woolcock N. Hunt calls for health staff to raise concerns. *The Times* 2014; **May 23**: <http://www.thetimes.co.uk/tto/health/news/article4097577.ece> [accessed 10 Oct 2014].
9. Bennett R. NHS whistleblower cleared after £10m battle. *The Times* 2014; **Apr 19**: <http://www.thetimes.co.uk/tto/health/news/article4067517.ece> [accessed 10 Oct 2014].
10. Matthews-King A. RCGP chair calls for 'urgent review' of support for doctors under GMC investigation. *Pulse* 2013; **Nov 7**: <http://www.pulsetoday.co.uk/your-practice/practice-topics/regulation/rcgp-chair-calls-for-urgent-review-of-support-for-doctors-under-gmc-investigation/20004986.article#VCVGr43ai7g> [accessed 10 Oct 2014].
11. Aristotle. *Nicomachean Ethics* [Cambridge Texts in the History of Philosophy]. Trans: Crisp R. Cambridge: Cambridge University Press, 2000.