

DUTY OF CANDOUR David Oliver

The hardest word: NHS leaders should also say sorry

Doctors, nurses, and midwives have been told to apologise when at fault, but so too should organisational chiefs

The two inquiries of Robert Francis QC into the failings in care at Mid Staffordshire NHS Foundation Trust have had far reaching implications, for hospitals in particular.¹⁻⁴ Since Francis's recommendations on "transparency," hospitals publish far more information on complaints, feedback, safety incidents, and staff and contact details.

For frontline clinical staff one big change concerns the "duty of candour," requiring them to be open and honest about mistakes.⁵ Anyone who has investigated or tried to resolve complaints that have escalated or become litigious knows that in many cases they wouldn't have reached such a stage if only staff had communicated openly and early, answered questions, and offered apologies when at fault. Yet too often complainants think that they're facing a closed and defensive culture.⁶

Openness and honesty

In June 2015 the professional regulators the General Medical Council and the Nursing and Midwifery Council issued joint guidance setting out what a duty of candour means in practical terms.⁷ The guidance says that when something goes wrong with treatment or care that causes harm or distress to patients or has the potential to do so, we should tell the patients or their families or advocates, apologise to them, offer appropriate remedy or support, and explain fully the short and long term effects. The guidance reinforces the need for doctors and nurses to raise concerns with employers, colleagues, and regulators and to avoid suppressing concerns raised by others.

The guidance even tells us how to apologise, by using plain, first person language: "I or we are sorry that." More formulaic "expressions of regret on the organisation's behalf" often further the impression to patients or their families that their concerns are being minimised and that staff

are being evasive. It's also likely, the guidance says, that in fitness to practise hearings staff who have admitted error and apologised early will be looked on more favourably.

So far so good. But we'll have to wait to see how well this guidance works. Why do I say this? Firstly, the guidance applies only to doctors, nurses, and midwives. Other professionals, not least NHS managers, have a major role in creating conditions for care but aren't necessarily subject to registration and professional codes, despite Francis recommending this.²

Secondly, the guidance encourages first person apologies for errors of individuals or clinical teams but not for organisational or system failings. That's often a hard distinction to make. Indeed, evidence shows that most error concerns systems as much as human factors and that individual blame is rarely helpful.⁸

Consider the nurse who omits an important drug dose because the ward is short staffed and she is dealing with an emergency. Or the on-call junior doctor who can't review a ward patient for hours because the demand is so great throughout the hospital. Or the patient who feels rushed out of hospital too early in the day because of massive need for beds and repeated calls for staff to "find patients to discharge." Should individual frontline staff members apologise for these poor systems in these situations?

Thirdly, the guidance is "not intended for circumstances where a patient's condition gets worse due to the natural progression of their illness." Yet it is precisely these circumstances that often distress patients' families and can create the conditions for complaint. Discharge from hospital and urgent readmission, for instance, are a common cause of concern. But many readmissions happen because of failures in systems outside hospital, new illnesses, a relapse or



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progression of existing conditions, or because we are respecting a mentally competent patient's right to go home despite the risks.⁹

Falls in hospital often lead to complaints, litigation, or a coroner's inquest, but much evidence has shown that only some falls can be prevented, and many are a consequence of encouraging older people to regain mobility. Of course, families should be told when their loved one has fallen, but it doesn't follow that an individual nurse should personally apologise for something that can never be a "never event." Likewise, evidence is lacking that all pneumonia acquired in hospital can be prevented.

Duty to listen

Finally, despite the guidance saying that "apologising does not mean admitting liability for what has happened," frontline clinicians will take much convincing that these fine words will protect them. In too many organisations clinical staff feel unsupported by managers and ignored when they raise concerns about patient safety, care quality, or their own working conditions.¹⁰

A duty to raise concerns must be matched by a reciprocal duty to listen. A duty on staff to offer apologies when things go wrong must be fully backed up by organisational leaders giving staff the confidence that they will be fully supported and not hung out to dry.

And for faults at the organisational or system level, the organisational or system leaders should apologise—including the health secretary himself. Clinical professionals should be personally accountable for care within their gift to deliver. But they shouldn't be sacrificed for circumstances completely beyond their control.

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NO HOLDS BARRED Margaret McCartney

The zombie statistic on 24/7 working

Apparently, if you are admitted to hospital at the weekend you are 16% more likely to die. This was featured on Radio 4's *News Quiz*, indicating that it's passed into the realm of the "zombie statistic"—namely, completely spurious but widely accepted as fact.

It started with a 2012 paper in the *Journal of the Royal Society of Medicine*.¹ The BBC then reported that patients were "more likely to die" if admitted at weekends.² The *Guardian* said, "Those admitted on a Sunday have a 16% higher risk of dying within a month than those admitted on a Wednesday."³

The retrospective observational study of admissions in England in 2009-10 followed up patients for 30 days after admission and adjusted for diagnosis and comorbidities.¹ Full data were available for 14 217 640 admissions and 187 337 deaths.⁴ That's a 1.32% absolute risk of death in the 30 days after admission; a 16% difference in this absolute risk is tiny. How certain can we be that adjustment for morbidity, for example, was accurate? Not very.

Studies of this design can identify association, not causation. To assume that mortality rates should not vary with the day of admission is to assume no differences in the kinds of reasons patients are admitted on different days. For example, if palliative care community services are not running at normal levels, are people admitted to hospital at the weekend to die?

Less prominent in the media was the same researchers' finding of the same pattern in the US, where working patterns differ from those in the UK. But the same researchers also found that people admitted to a UK hospital on a weekend were the least likely to die there on a weekend. The meaning of these associations is unclear: how patients end up in hospital on different days has yet to be properly described, let alone understood.

Yet the 16% statistic is being used to push government policy for seven day working in the NHS. Consultants, just like GPs, already work weekends. Fewer of them are present, because



Shifting routine work to the weekend because of uncertain data may waste resources and do harm

the routine weekday work is absent. Analyses of staffing at the weekend have been of poor quality.⁴ Full seven day working would mean doing more routine work at weekends—which, with no more staff, would mean that fewer doctors were available in the week.

We do know that dedicated consultant time with continuity is associated with better outcomes.⁵ But put the policy brakes on: the NHS should run on fair use and high quality evidence. Shifting routine work to the weekend because of uncertain data may waste resources and do harm. Meanwhile, seriously ill people are now scared to be admitted to hospital at the weekend, and some ask to be admitted on a Monday instead.

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BLOG Martin Marshall

The travesty of the 10 minute consultation

"Perfunctory work by perfunctory men." That's how an eminent physician once described general practice. "A ridiculous claim," cried GPs, rising to the defence of their discipline: "Specialists just don't understand the nature of general practice. They don't value our ability to make quick decisions based on a deep understanding of our patients and their context, our exceptional skill at managing risk and uncertainty."

GPs went even further. Not only could they deal with the presenting problem in 10 minutes, but they could also manage ongoing conditions, offer advice about prevention and health education, and modify help seeking behaviours. Was there no end to their efficiency?

But it's time GPs stopped fooling themselves. In 2015 the 10 minute consultation is an anachronism. It is damaging to patients, damaging to clinicians,

and damaging to the reputation of general practice as a specialty that provides holistic and patient centred care.

Perhaps the short consultation was never really viable; it is certainly becoming less and less so. The pressure is mounting as the complexity and intensity of the consultation increases. More patients to see, more problems presented, more information sources to search, more solutions to consider, more templates to complete, more ideas to discuss and negotiate. Something has to give, and it shouldn't be the quality or safety of clinical care that patients receive—or the humanity that underpins that care, or the mental health of clinicians. It is the travesty of the too brief encounter that must give.

Even within the constraints of the established system and the strangely modest expectations of too many patients, clinicians,



"Show me the legislation that restricts the consultation length," the politician retorted

managers, and policy makers, there is good research evidence that time matters. For most patients longer consultations are associated with greater satisfaction, a stronger focus on health promotion and disease prevention, increased willingness to tackle psychological problems, and fewer prescriptions. Time is a key component of the effectiveness of the clinical encounter; rushed consultations are the enemy of high quality care.

Some years ago a GP leader complained to the then health secretary about the time constraints in general practice. "Show me the legislation that restricts the consultation length," the politician retorted. Some of the solutions do lie in professional hands. Some practices already offer 15 minute appointments, actively support patients to self care, use triage, and make more effective use of nurses, pharmacists, and healthcare assistants.

All these approaches help and should be used more intensively and in a more coordinated fashion. But the solution is also a political one: we need more GPs and an aligned set of values and incentives that encourage longer consultations.

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Patients may prefer radiation risk in diagnosing appendicitis

Computed tomography may provide a cost effective way to avoid unnecessary appendicectomy, writes **Nigel D'Souza**

Many normal appendixes are removed in the United Kingdom. I have worked at hospitals with negative appendicectomy rates (NARs) of 16.8% to 35%,¹ consistent with the 20.6% NAR from over 3000 appendicectomies in a largely UK based audit.² Colleagues from abroad are incredulous at this high rate despite the availability of accurate diagnostic tests. I had always believed that, in cases of clinical uncertainty, diagnostic laparoscopy was a better option than computed tomography (CT)—until my wife, an anaesthetist, disagreed with me.

Negative appendicectomy

Several factors contribute to the UK's high NAR. Emergency surgery teams work in shifts with frequent patient handover, which has eroded the role of observation and serial examination that can rule out appendicitis. Routine CT is not common, owing to surgeon preference or lack of access. Beds are frequently scarce, pushing surgeons towards an early, definitive management plan: discharge safely or operate. Yet premature discharge may result in a patient with early appendicitis deteriorating outside hospital, and complications can include peritonitis, infertility, and death.

To avoid this scenario, in cases of uncertainty surgeons may perform laparoscopy both to diagnose and treat appendicitis. However, intraoperative diagnosis of appendicitis is not straightforward; more than 30% of appendixes that look normal at laparoscopy are inflamed on histological analysis.^{3,4} If no other disease is seen at laparoscopy, most UK surgeons remove a normal looking appendix to treat possible non-visible appendicitis and to prevent future appendicitis. "Diagnostic" laparoscopy not only probably lowers the threshold for surgery but usually commits the patient to appendicectomy, leading to a higher NAR.^{5,6}

Finally, patients do not want to be observed in hospital for days, and nor are they happy to be discharged in pain with a clinical diagnosis of "abdominal pain of unknown cause." Patients expect a definitive diagnosis and treatment of their symptoms.

CT has been used to reduce NAR. The US Surgical Care and Outcomes Assessment Program study achieved an NAR of 4.5%



"Diagnostic" laparoscopy usually commits a patient to appendicectomy

with routine CT in more than 20 000 appendectomies.⁷ A meta-analysis of 28 studies found that imaging reduced the NAR to 8.7%, down from 16.7% with clinical evaluation alone.⁸ CT is readily available, easy and quick to perform, and easy to interpret, with a high sensitivity (94%) and specificity (95%).⁹

CT is not used routinely in the UK to evaluate acute right iliac fossa pain, because of its cost and radiation dose. Instead, ultrasound is the most commonly performed imaging test.² Ultrasound is cheaper and radiation-free but is operator dependent, and its real world diagnostic accuracy conflicts with the literature; in UK clinical practice as many as 45% of ultrasound scans fail to visualise the appendix.¹ Surgeons and radiologists must audit the diagnostic accuracy of ultrasound locally to justify its inclusion in diagnostic pathways.

The expense of CT precludes its routine use for diagnosing appendicitis in the NHS—yet it could reduce the considerable costs of a high NAR. A conservative estimate of the cost of a quick laparoscopic appendicectomy is £960 (£1350; \$1510) for theatre time alone.¹¹ An unnecessary operation could be prevented by a scan costing £200 to £400. Surgery and inpatient stay in a hospital with a high NAR can cost more than imaging all patients with right iliac fossa pain, studies have shown.^{12,13} Further costs from unnecessary surgery include treatment of complications and the indirect costs to the wider economy of sick leave for patients and caregivers during convalescence.

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Risk of cancer

Radiation exposure from CT increases cancer incidence, although directly determining the exact risk is difficult. Contemporary, low dose CT appendix protocols have reduced the additional lifetime cancer risk in a 30 year old woman to an estimated 0.016%.¹⁴ Efforts to avoid CT and its radiation exposure are laudable but should be weighed against the complications that occur in 10.7% of patients who have normal appendixes removed.² While morbidity from appendicectomy is mostly minor in fit patients, it may require further radiological or operative intervention. Balancing a 0.016% risk of cancer against a 10.7% risk of complications is difficult, but surgeons currently do so without discussing it with patients.

It is unclear whether all patients should be scanned routinely to achieve a lower NAR. However, studies have shown that routine use of CT can result in a lower NAR than its use in selected patients.^{15,16} These studies were underpowered, so further research is needed to determine which patients to scan to decrease the NAR.

CT seems to provide a cheaper and better service for patients, enabling early diagnosis or patient discharge without the need for prolonged observation or unnecessary surgery. We should ask patients whether they prefer the risks of radiation to the risks of surgery to diagnose appendicitis.

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