

Visit with Ardgowan Hospice – 21 September 2015
Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill
Part 2 – Duty of Candour

Attendees:

Duncan McNeil MSP
Dennis Robertson MSP
Malcolm Chisholm MSP
Staff from Ardgowan Hospice

Summary of areas discussed:

The members heard that Ardgowan Hospice had not had any formal complaints in 33 years which reflected the clear defined pathways they had for service users and staff to raise concerns.

Highlighted to members was evidence that 10-20% of patients do not want all the information about unintentional harm and it was a concern that these patients needs might be overruled by the duty of candour (see Annexe A for information provided by Ardgowan Hospice). In that regard it was the patient's wishes which should guide how much information should be provided.

There was discussed about the complexities of prescribing some drugs such as opioids which may feature in 60-70% of cancer patients and which have known side effects. Also discussed was whether the duty of candour might change doctors behaviour to become more about how should I protect myself compared with treating the patient.

Participants highlighted that Palliative Care is different from the rest of the health service given there can be multiple and complex links in the treatment and care pathway, treatment can serve different purposes and where the patient complaint may be the first flag that something has gone wrong. In that case it was questioned how you might identify where the unintended harm was caused.

It was highlighted that the duty of candour should be more about improving care rather than providing lots of information which may then cause distress (more likely in a Palliative Care setting).

There was a discussion about the current protocols and measures. The GMC system currently in operation can result in staff being suspended or struck off and is about personal responsibility to patients which is more important than having an overarching duty. The policy is that if harm arises then staff should seek to see the patient and discuss how much they wish to know about it. Members heard that the GMC is doing a lot of work in this area and it was questioned whether culture can be changed by a legal policy.

Members heard that if a mistake is ignored then that could be considered negligence. It was questioned if whether the duty of candour came into force it might result in staff leaving if they felt penalised more making genuine mistakes. It was highlighted that anyone can make a mistake and most do not realise – it may be

other staff that notice. The benefits of clinical supervision in driving improvement and learning from mistakes was seen as important. The Nursing and Midwifery Council saw this as very important and participants explained that more staff should be encouraged to take it up especially in busy hospitals.

Members heard that Ardgowan Hospice had a practice in place for a number of years whereby staff could discuss concerns or practices with someone else. It was also highlighted that clinical supervision was mandatory in Northern Ireland for clinicians but not statutory. More generally participants questioned whether systems failures might result in individuals being punished when the focus should be how to protect patients.

What do patients really want to know?

Ami Schattner

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Quoted from this article:

“.....In contrast with the commonly held view, a considerable number of patients express significant reservations about their doctors being completely frank with them regarding their condition and prognosis. For example, among 250 cancer patients in Scotland, 4% did not want to know whether they had malignant disease (too late, they had already been told!) and 9–10% did not want to know either about their progress or their chances of cure.⁹ Similarly, another study revealed that 15% of 80 cancer patients desired to have minimal detail about their illness.¹⁰ A recent large study on the information needs of 2331 patients with cancer in Britain yielded unexpected findings. Although most patients wanted as much information as possible, a substantial minority of 13% preferred to ‘leave it up to the doctor’ or ‘to have information only if it was good’, thereby signalling significant reservations about overall truth disclosure.¹¹ This tendency is even more evident when patients seen for medical conditions rather than cancer are evaluated concerning their wishes to learn of a serious illness which their physician may diagnose. In three different studies conducted in Western countries, 17–20% of 284 patients disagreed with the notion that the patient should be told of his having incurable cancer (references 7 and 8, and Schattner & Tal, unpublished data). Looking at specific subsets of patients (e.g. patients >70 years of age, males, Japanese), the data show that the number of patients opting for limited disclosure might all but increase.^{8, 11} Given the large cultural diversity in most developed countries today, individual patients’ preferences may be even more varied than we expect.

.....Anecdotal evidence suggests that full insight might actually be detrimental to some patients.¹⁴

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