

Scottish Public Services Ombudsman response to the GMC Consultation: Reviewing how we deal with concerns about doctors.

The SPSO is the final stage for NHS complaints in Scotland. We receive concerns from patients, their families and friends about the care they have received from the NHS. In 2013/14 we received 1,379 complaints. We upheld 55% of the cases we investigated.¹ While it is the Boards who are under our jurisdiction the complaints we receive do, at times, raise issues of the care provided by individuals.

In responding to this consultation we have answered the questions where we considered our experience was most helpful. The two questions we are responding to relate to the importance of apology and the relationship between apology and insight.

Questions: 10: Do you think panels should be able to require doctors to apologise where patients have been harmed. And 11 the proposal to introduce more detailed guidance on whether a doctor has insight and how that may link to any apology given.

We are answering yes to both questions 10 and 11.

We have long acknowledged the power of an apology that recognises the wrong that has been done and is linked to steps to take forward actions to prevent the problem recurring². The most frequently cited reason given by people for coming to our office with a complaint about NHS care is that they do not want this to happen to someone else. The provision of an apology and the confidence that any individuals involved have shown insight are key steps to providing such reassurance. We are, therefore, very supportive of the GMC's proposed approach.

Apologies are fundamentally about relationships and they can help to rebuild relationships and trust where that has been broken. However, as is noted in the consultation, an apology alone is not evidence of insight. We would point to the importance of the timing; the way an apology is delivered and actions taken following the apology as aspects that can all help to demonstrate that the apology was made with insight.

In our experience, the most effective apologies tend to be the ones that are given closest to the incident and which express real, genuine regret. They are the ones which allow for the most human interaction. They are usually delivered orally by those directly involved. They are not defensive and may reflect uncertainty where appropriate. They are not likely to be one-off events but may be part of wider support and discussion which will allow the person receiving the information including the apology to understand the incident that has resulted in harm. They involve the person making the apology seeking to work out what went wrong and how to prevent it happening again and involving others, including the patient and/or their family, in that process when appropriate.

However, when an apology has not been made at the best time, that does not mean one is still not required. An apology is the human response to harm caused and, even late, is required to redress that harm. This is why we frequently recommend apologies usually by organisations though occasionally by individual clinicians. It is also possible to see in the response to that recommendation whether appropriate insight has occurred.

¹ Our annual health report is available here: <http://www.spsso.org.uk/news-and-media/ombudsman-publishes-annual-health-complaints-report>

²http://www.spsso.org.uk/sites/spso/files/communications_material/leaflets_buj/2011_March_SPSO%20Guidance%20on%20Apology.pdf

It is interesting to note that we sometimes find an organisation very happy to accept recommendations that they make significant changes to the way they operate and yet they struggle to fulfil the recommendation on apology. In some cases, we have had to push very hard for an apology. In others we have had to refuse to accept a clearly sub-standard apology and have to ask for a second apology to be issued. This clearly undermines the apology given and raises concerns that lessons have not been fully learned and that, therefore, there is no insight into either the real cause or the harm caused.

While our experience is mainly with apology made by organisations, we think the GMC may find interesting parallels in key barriers that we have found when seeking apologies.

- An unwillingness to accept fault. This is the most significant barrier. In fairness, a full apology is only appropriate if it is accepted there has been a failing and there are cases where organisations genuinely do not accept there has been a failing even when they accept there may be room for improvement. However, the ability to accept and recognise failings is a critical part of insight and without it it is difficult to restore trust.
- A complete breakdown in the relationship. Where, for whatever reason, that relationship has become difficult and fractured, organisations feel it is hard to apologise to someone they feel has behaved badly towards staff/them. We appreciate this can be the case but when an action has clearly led to harm, we do not think the behaviour of the individual who has been harmed, however, difficult, negates the need for that harm to be recognised.
- A desire to protect others. The professional reputation of staff is important and organisations can sometimes struggle with their dual responsibility to protect staff but also to respond appropriately to a member of the public. Sometimes, we find that the more powerful a staff member is the more reluctant a body is to apologise. For example, in our experience, NHS boards at times find it easier to apologise for nursing failings than for problems at consultant level.

When these barriers are considered together, it seems clear that there is an implicit fear that by apologising the organisation is being put or is putting their staff in some position of vulnerability with which they are uncomfortable. The resolution to this is to ensure that apologies are seen as a normal part of practice. GMC has already recognised the importance of apology by making this a duty in their Good medical practice. We would hope that ensuring that this is reflected in the sanctions available to panels and the guidance they use to consider insight will further strengthen and highlight the importance of this duty.

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Ombudsman
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