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Response to *A statutory duty of candour consultation paper*

Thank you for the opportunity to provide feedback on *A statutory duty of candour Consultation Paper.*

The Royal Australasian College of Surgeons supports efforts being undertaken to improve the safety, quality and efficiency of all health services and hospitals in the Victorian health system.

As the leading advocate for surgical standards, professionalism in surgery and surgical education in Australia and New Zealand, the Royal Australasian College of Surgeons (RACS) is committed to taking informed and principled positions on issues of public health at both state and federal levels. RACS represents more than 7000 surgeons and 1300 Surgical Trainees and International Medical Graduates (IMGs) across Australia and New Zealand.

Much of what is proposed in this set of legislative reforms is already adequately covered by current open disclosure requirements and multiple professional codes of conducts across the medical professions. Acknowledging that the recommendation for this change arose from significant organisational failures the focus of this legislation should be on improving transparency and disclosure requirements at the senior organisational level.

If this legislative reform is progressed it is imperative that there is a clear distinction between an apology for an adverse outcome and an admission of guilt.

Although the Consultation Paper acknowledges that a statutory duty of candour is not meant to encourage the practice of defensive medicine or lead to an increase in litigation both are a significant risk of these proposed reforms. If this legislation is ambiguous in stating that an apology is not an admission of guilt it could have significant negative impacts on the medical profession through increases in the cost of insurance premiums and changes in practice behaviour and scope whereby doctors are less willing to treat certain types of patients.

There must be absolute clarity in any legislation that an apology from an individual for an adverse outcome does not indicate any fault in medico-legal terms. Without this any legislation of this type will not be acceptable to surgeons, or other registered doctors.

The Victorian Regional Committee of RACS would also like to offer the following comments in relation to several specific questions in the Consultation Paper:

Q1. Do you agree that the statutory duty of candour should apply to the set of health services [regulated by the *Health Services Act 1988*] including private sector organisations?

If a statutory duty of candour is introduced it should apply to all health services, public and private, in Victoria.

Q2. Which, if any, other healthcare providers should be in scope for the statutory duty of candour?

All registered health professions should be in scope for a statutory duty of candour. The delivery of medical care to a patient is done by a team of people, not an individual. These teams rely on each other to deliver safe, effective care but are not responsible for monitoring each individual action the team member undertakes.

All health professionals, including nursing, para-medical and administrative staff, have a role to play in the delivery of are and therefore the capacity to make an error that has an adverse effect on patient outcomes. If an error is made it should be attributed to the person making the error, not to the doctor managing the patients care. If a single person "in charge" of patient care is held solely responsible this will set a dangerous precedent whereby they would be forced to supervise the actions of every person who comes into contact with the patient instead of focusing on patient care.

Q3. Do you believe the statutory obligation should apply to individuals instead of, or as well as, organisations?

Any statutory regulation must apply to the organisation as well as the individual. The recommendation for this legislative reform arose from the discovery of systemic, organisational issues being identified highlighting the real possibility that an adverse outcome is attributable to an organisations processes, not individual error.

Where the responsibility for an adverse event lies with an organisation the disclosure and discussions of this outcome should make it clear that the organisation, at a senior level, accepts responsibility and not attribute it to actions undertaken by a member of the health care team.

Q4. At what threshold of harm and/or for what type of incidents should the statutory duty of candour apply?

A statutory duty of candour should apply when material harm occurs due to an intentional act or act of omission by an individual in the care of a patient or when material harm is caused by systemic issues within the organisation.

The duty of candour should not apply if events happen despite all reasonable and medically applicable precautions are made to prevent such an event from happening, an apology should not be required for an event that could not have been prevented.

Q5. Should the statutory duty of candour apply to instances of psychological harm as well as physical harm?

Yes.

Q6. Should the statutory duty of candour apply to near misses and/or complications of treatment that result in no harm and/or no lasting harm? Should it apply where the wrong treatment was given or non-evidence-based treatment was given if there is no harm as a result?

An apology is probably not required if no harm has occurred.

There is such a variation of guidelines treating conditions that it would be nearly impossible to determine whether correct treatment was given (other than very obvious examples). There are too many possible treatment options that could be employed for any given condition so saying sorry for "non-evidence based " treatment will be controversial as someone would have to define what the accepted guidelines were for any given condition. In addition to this the documentation should represent why treatment that was non-evidence based was given or advised.

Q7. Do you agree that there should be provision for 'consumer declared harm' as a trigger for the statutory duty of candour to apply?

This should not be contained in legislation. Consumers often bring vexatious accusations against doctors and medical staff should not be obliged under legislation to apologise for an event that does not require an apology. Including consumer declared harm in legislation is likely to create a burden of investigations for claims that either vexatious or misunderstood by the patient. There is already an appropriate outlet through the Australian Health Practitioner Regulation Agency (AHPRA) for consumers to make a complaint if they feel they have not received appropriate treatment from a medical professional.

Q11. What are the most important factors to ensure the statutory duty of candour achieves its intended aims?

There are a number of key issues that must be managed correctly:

- that an apology is made only for the correct medical events,
- that there needs clarity around who is responsible for an error when the patient is cared for by multiple physicians or surgeons,
- there needs to be clarity that this obligation does not indicate fault in medicolegal claims, without that protection this will not be an acceptable piece of legislation for doctors or surgeons

Q19. What consequences or sanctions should be available in response to identified breaches of the statutory duty of candour?

If there is a clear relationship between open disclosure and subsequent medicolegal litigation then education would be enough to promote this principle.

Having consequences or sanctions legislated is too rigid, and the definitions as to who needs to apologise and for what are too broad to be practically outlined in legislation. If people breach these requirements they would be reportable to the AHPHRA or leave themselves open to litigation, both of which are sufficient to promote compliance with the legislation.

Thank you for the opportunity to provide input into this consultation process. If you would like to discuss any of the points made in this submission please contact me via the Victorian Regional Office.

Yours sincerely

Mr David Love
Chair, Victorian Regional Committee
Royal Australasian College of Surgeons