



Is an Apology an Admission of Guilt?

The Peculiar Case of GMC vs Pandian

EDITORIAL

Background

Regulation 20 (2014)[1] of the Care Act 2008 mandated a statutory duty of candour on all healthcare providers in the UK. The Regulations stipulate that health bodies must provide care and treatment to service users openly and transparently. If something goes wrong, the affected “relevant” person must be told about it and given complete information and, specifically, (under Regulation 20(3)(d)) be given an apology.

Following this regulation, the General Medical Council and Nursing & Midwifery Council jointly issued practical advice and guidance on being open and honest about mistakes in practice, *whose responsibility it is to explain and record what has gone wrong and when and to who you should apologise to, what to include in an apology and how to say sorry*. A section also encourages you to report errors, not only with patients but at one’s place of work, to help promote a learning culture. [2] Paragraph 15 of the guidance says, ‘Apologising to a patient does not mean admitting legal liability¹³ for what has happened. This is set out in legislation in parts of the UK, and NHS Resolution also advises that saying sorry is right.

Additionally, a fitness-to-practice panel may view an apology as evidence of insight. Then what went wrong in the case of Pandian vs GMC, where the MPTS tribunal based their entire verdict on the admission of guilt implied by the apology ‘for the distress caused’ offered by Dr Pandian in responding to the patient’s complaint? The premise of this case rested on the patient reporting that Dr Pandian had not examined them but documented her examination findings contemporaneously in the notes. It is essential training for all health professionals that ‘what has not been documented is likely not to have happened’.

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Hence, much infrastructure and professional time are spent recording each interaction and rationale for clinical decision-making elaborately and contemporaneously in the notes, often using inadequate digital infrastructure and archaic equipment.

Dishonesty

There is no denying that it is always possible that a professional may falsify their entry in the notes. Health professionals often describe dishonesty as an embarrassment that pervades the profession and undermines its core values of truth, integrity, philanthropy, and altruism. Without question, dishonesty comes in all shades, and sometimes it can be a matter of interpretation. That said, dishonesty (as defined here) encompasses any form of professional or academic misconduct, including fraud, deceit, cheating, lying, evading responsibility, abuse of authority, conflicts of interest, plagiarism, alteration of medical records, forgery, false representation, and knowingly assisting another person in dishonest acts.[3] Dishonesty in premedical and medical school seems as prevalent as in students from other disciplines. The reported prevalence of cheating among United States medical students ranges up to 58%. Cheating behaviours include copying from others, using unauthorised notes, sharing information about observed structured clinical encounters, and dishonesty about performing physical examinations on patients. Correlates of cheating in medical school include prior cheating behaviour, burnout, and inadequate understanding of cheating. [4] Although there may be differences of opinion amongst professionals on what constitutes unethical or dishonesty and what lies are harmless. There is evidence that cheating while in medical school may predict similar behaviour continuing in later life as a professional.[5] In a case-control study, disciplinary action among practising physicians by medical boards was strongly associated with unprofessional behaviour in

medical school. Students with the strongest association were those described as irresponsible or having diminished ability to improve their behaviour. [6]

System vs Personal Factors

Often professionals operate in less-than-optimum environments, and there is a strong influence of organisational culture, leadership and bullying or undermining, which leads to circumstances when professionals may be forced to act dishonestly. The relative roles of personal versus institutional accountability and the degree to which personal responsibility should be enforced by outside parties (such as peers, patients, healthcare systems or regulators) versus professionals themselves ('professionalism') is a matter of debate in the professional circles. [7] The moral responsibility for actions and behaviours is a fundamental element of professional practice. Still, individuals are not somehow 'outside' and separate from 'systems': they create, modify and are subject to the social forces that are an inescapable feature of any organisational system; each element acts on the other. Thus, the broader institutional and socioeconomic context has structuring effects on opportunities to 'be good'. [8] Still, the balance of probabilities must demonstrate from an assessment of character or supporting evidence that this professional is likelier to do so than not. In this case, there was no evidence that the honesty of this doctor was ever called to question.

Racism & Justice

Detecting lies is essential for social relationships, professional negotiations, to law enforcement; successfully identifying lies facilitates healthy relationships, satisfying economic exchanges, and meaningful security.

Typically success at detecting lies is only slightly better than chance (54% accuracy vs 50% guessing based on an analysis of the accuracy of deception judgments, synthesising research results from 206 documents and 24,483 judges. Individuals tend to achieve an average of 54% correct lie-truth judgments, correctly classifying 47% of lies as deceptive and 61% of truths as nondeceptive.[9] The results from a metanalysis suggest that intuitive notions about deception are more accurate than explicit knowledge and that lie detection is more readily improved by increasing behavioural differences between liars and truth-tellers than by informing lie-catchers of valid cues to deception. [10] While there is a growing body of evidence and opinion amongst professionals from a Black and Minority Ethnic (BME) background of the existence of institutional bias in the way the UK National Health Service (NHS)[11,12] and the regulators deal with them, it is essential to understand this context and its potential impact on such judgements. Dr Pandian hails from a BME background. Investigation into such racial biases and their impact on decisions from the USA reveals systematic race-based effects in deception judgments. White perceivers consistently judged Black targets as more truthful than White targets on deliberative measures of deception-detection bias, resulting from White perceivers' prejudice-related concerns. Whites unmotivated to control prejudice toward Blacks showed the most negligible impact of race on truth bias. Whites who are effective across most contexts in being nonprejudiced (i.e., primarily internally motivated) were paradoxically the most biased in their judgments of Black relative to White targets (i.e., discriminating in favour of Black targets).[13] However, opinions from system leaders' analysis of real decisions show systematic race-based biases in deception judgments by the regulator. [14,15]

Recall Bias

It is also true that recall bias is likely once substantial time has passed from the time of the incident. Self-reporting is a common approach for gathering data in epidemiologic and medical research. This method requires participants to respond to the researcher's questions without his/her interference. Examples of self-reporting include questionnaires, surveys, or interviews. However, relative to other sources of information, such as medical records or laboratory measurements, self-reported data are often argued to be unreliable and threatened by self-reporting bias. [16] There is ample evidence from the literature that often, in times of distress, such as being admitted to a hospital with an emergency, recall accuracy is adversely impacted. Hence in any research study, recall bias restricts the collecting of information retrospectively. This could occur if disease status influences the ability to recall prior exposures accurately. It is important to note that exposure information generated in the past, before disease onset, is not affected by recall bias, only exposure information generated after disease onset or diagnosis. In this case, whether Dr Pandian had examined the patient was only recalled after a long time.

Conclusion

The statutory duty of candour explains somewhat why healthcare professionals are increasingly spending their days looking over their shoulders, afraid of litigation, and this encourages the defensive practice of medicine,[17] at a significant detriment to their patients, to themselves and the health service. Perhaps however, the flip side of the imposition of a duty of candour on the providers of health care, including the obligation to apologise for an error regardless of its legal significance, is a corresponding need to protect those providers from any legal

consequences which might otherwise attach to the mandated apology?[18]

While it is true that one cannot assume that healthcare professionals will not fall at the altar of truth and integrity, like any other human or professional- it is essential that judgements of their actions or words must be accorded the same principles of justice enshrined in law. The regulator and healthcare institutions are mired in a lack of faith from the professionals they regulate and the public they seek to protect on the fairness of their judgements and decisions. The BME community, in particular, have lost faith in their judgements and working in a highly complex healthcare environment - the findings are still being meted out to the individual scapegoat. At the same time, institutional accountability remains outside the regulator's remit. This dichotomy must stop.

Improving patient safety and fairness for regulated health professionals demands a move away from blaming the individual who makes a medical error towards examining the factors within the healthcare system that contributed to it. Such "collective accountability" may offer a way to balance a "just culture" and a doctor's specific responsibilities within the framework of team care delivery. Collective accountability requires doctors to adopt transparent behaviours, learn new skills to improve team performance, participate in institutional safety initiatives to evaluate errors and implement plans to prevent recurrences. It also means that institutions must prioritise team training, develop robust, nonpunitive reporting systems, support clinicians after adverse events and medical errors, and develop ways to compensate patients harmed by mistakes. A conceptual leap to collective accountability may help overcome longstanding professional and societal norms reinforcing individual blame, impeding patient safety, and leaving the patient and family without a true advocate. [18,19]

References

- 1 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. <https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents> (accessed 4 Jun 2023).
- 2 Openness and honesty when things go wrong: The professional duty of candour. <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/candour---openness-and-honesty-when-things-go-wrong> (accessed 4 Jun 2023).
- 3 Fred HL. Dishonesty in Medicine Revisited. *Tex Heart Inst J* 2008;**35**:6–15. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2322888/> (accessed 4 Jun 2023).
- 4 Kusnoor AV, Falik R. Cheating in medical school: the unacknowledged ailment. *South Med J* 2013;**106**:479–83. doi:10.1097/SMJ.0b013e3182a14388
- 5 Sierles F, Hendrickx I, Circle S. Cheating in medical school. *Academic Medicine* 1980;**55**:124. https://journals.lww.com/academicmedicine/Abstract/1980/02000/Cheating_in_medical_school.6.aspx (accessed 4 Jun 2023).
- 6 Papadakis MA, Teherani A, Banach MA, *et al*. Disciplinary action by medical boards and prior behavior in medical school. *N Engl J Med* 2005;**353**:2673–82. doi:10.1056/NEJMsa052596
- 7 Wachter RM. Personal accountability in healthcare: searching for the right balance. *BMJ Qual Saf* 2013;**22**:176–80. doi:10.1136/bmjqs-2012-001227
- 8 Aveling E-L, Parker M, Dixon-Woods M. What is the role of individual accountability in patient safety? A multi-site ethnographic study. *Sociol Health Illn* 2016;**38**:216–32. doi:10.1111/1467-9566.12370
- 9 Bond CF, DePaulo BM. Accuracy of deception judgments. *Pers Soc Psychol Rev* 2006;**10**:214–34. doi:10.1207/s15327957pspr1003_2
- 10 Hartwig M, Bond CF. Why do lie-catchers fail? A lens model meta-analysis of human lie judgments. *Psychol Bull* 2011;**137**:643–59. doi:10.1037/a0023589
- 11 Iacobucci G. The BMJ Interview: Victor

- Adebowale on systemic racism in the NHS. *BMJ* 2020;**371**:m4111. doi:10.1136/bmj.m4111
- 12 Robinson-Lane SG, Patel RV. The imperative to address institutional racism in nursing practice. *Nurs Outlook* 2022;**70**:691–3. doi:10.1016/j.outlook.2022.06.001
- 13 Lloyd EP, Hugenberg K, McConnell AR, *et al.* Black and White Lies: Race-Based Biases in Deception Judgments. *Psychol Sci* 2017;**28**:1125–36. doi:10.1177/0956797617705399
- 14 julietwalker. Racism and the General Medical Council. The BMJ. 2021.https://blogs.bmj.com/bmj/2021/06/29/racism-and-the-general-medical-council/ (accessed 4 Jun 2023).
- 15 Lind S. GMC data lays bare stark racial inequalities in medical training. Pulse Today. 2023.https://www.pulsetoday.co.uk/news/regulation/gmc-data-lays-bare-stark-racial-inequalities-in-medical-training/ (accessed 4 Jun 2023).
- 16 Althubaiti A. Information bias in health research: definition, pitfalls, and adjustment methods. *J Multidiscip Healthc* 2016;**9**:211–7. doi:10.2147/JMDH.S104807
- 17 Berlin L. Medical errors, malpractice, and defensive medicine: an ill-fated triad. *Diagnosis (Berl)* 2017;**4**:133–9. doi:10.1515/dx-2017-0007
- 18 <http://disputeresolutionblog.practical-law.com/author/practical-law-dispute-resolution>. Sorry, not sorry... the case for an apology law in UK dispute resolution (Part 1). Dispute Resolution blog. 2021.<http://disputeresolutionblog.practical-law.com/sorry-not-sorry-the-case-for-an-apology-law-in-uk-dispute-resolution-part-1/> (accessed 4 Jun 2023).
- 19 Bell SK, Delbanco T, Anderson-Shaw L, *et al.* Accountability for medical error: moving beyond blame to advocacy. *Chest* 2011;**140**:519–26. doi:10.1378/chest.10-2533