ARTICLE

Mid Staffordshire Hospital and the Francis Report

Narinder Kapur asks what psychology has to offer

The Mid Staffordshire Hospital scandal and the resultant Francis public inquiry caused major reverberations across the NHS. Psychology as a discipline can contribute to an understanding of key parts of this event and to ways in which change for the better can occur. In particular, psychology can inform discussion of nine salient issues – psychological aspects of patient safety, why inhumane behaviour occurs, the nature of moral dilemmas, the generation of clinical excellence, the discovery of truth in legal or quasi-legal settings, communication and its breakdown, the psychology of culture, target-driven behaviour, corporate memory and the implementation of intentions.

questions

Can the distinction between conscious and unconscious cognitive and affective functioning be applied to the behaviour of staff in healthcare settings?

How can one accurately and reliably measure the quality of performance of healthcare professionals, whether they be clinicians or managers?

resources

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www.abetternhs.com
www.reallylearning.com

Poor care in the Mid Staffordshire Foundation NHS Trust between 2005 and 2009 reportedly contributed to the avoidable deaths of many patients, possibly hundreds. The recent public inquiry into this calamity cost the taxpayer £13 million, interviewed more than 160 witnesses and sifted through one million pages of evidence. Robert Francis QC produced 290 recommendations in a four-volume report that stretched over 1800 pages. Within two months of the publication of his report in February 2013, the government produced an initial response (Department of Health, 2013) and set up a number of further inquiries to bring about improvements to the NHS. This article considers what psychology has to offer in understanding some of the issues surrounding the Mid Staffordshire scandal, and how it can help to bring about changes for the better. Each section begins with a short quotation from the Francis Report.

Patient safety

'Organisational boundaries and cultures should not prevent the use by all of information and advice designed to enhance patient safety.'

Psychology has directly or indirectly made major contributions to patient safety research and practice. Three of the leading researchers in patient safety have trained in psychology (James Reason, Charles Vincent, Pat Croskerry) and authored or edited books that have dealt with patient safety issues (Croskerry et al., 2009; Reason, 2008; Vincent, 2010). Some applications of psychology can be found in research and publications under the rubric of 'human factors research' (e.g. Flin et al., 2013; see also www.chfg.org). Areas where psychology has made or can make a major contribution include: the use of checklists in medicine and surgery; team working in theatre and other settings; situational awareness; organisational culture; cognitive biases that can lead to medical misdiagnosis (Gaber et al., 2012) and surgical errors (Santry and Wren, 2012); the role of attentional lapses in patient safety (Li et al., 2012); stress management in healthcare staff; errors in communication; understanding bullying and whistleblowing; environmental design and labelling; safe medication delivery; preventing 'Never Events' (catastrophic clinical events); carrying out a 'psychological post-mortem' of such events; compliance with rules and standards; and the implementation of such guidance and other patient safety measures. There would seem to be a strong case for a 'patient safety psychologist' to be appointed in every major teaching hospital.

Inhumane behaviour

'...it is clear...the system as a whole failed in its most essential duty – to protect patients from unacceptable risks of harm and from unacceptable, and in some cases inhumane, treatment.'

One of the more astonishing and distressing facts to emerge from the Francis Report was the number of instances of not only poor care, but inhumane care. Patients were left lying in their own urine, or were left for hours without food or drink. Psychological studies have helped to shed light on the mechanisms underlying inhumane behaviour, such as ignoring distress and harm to an individual, although it is worth bearing in mind that none of the

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studies included samples where nurses were caring for vulnerable patients. Particularly pertinent is the 'bystander effect', in which individuals stand by and fail to help a victim in distress. Relevant variables (see Fischer et al, 2011) include the number of bystanders present (more means it is less likely that a victim will be helped); the ambiguity of the situation (more ambiguity leads to less help); and the similarity of the victim to the bystander (the greater the similarity, the more likely that help will be offered). Research has also shown that pressing situational factors may readily override explicitly enounced value systems and beliefs, such that a person in great distress is ignored (Darley & Batson, 1973), something that could find parallels in busy clinical settings.

Also relevant is Philip Zimbardo's Stanford Prison Experiment (Haney & Zimbardo, 1998) where those who were in put in charge of prisoners subjected them to inhumane treatment that seemed to transcend all moral boundaries. Relevant issues are discussed by Miller (2011) and by Haslam and Reicher (2012). The latter's findings indicate that a positive hospital culture of strong leadership in human values and appropriate peer support should help to counteract any negative tendencies.

In Mid Staffordshire, neglect rather than specific acts of violence characterised the behaviour of some staff – that is, there were errors of omission rather than errors of commission. However, it would seem that psychological mechanisms may overlap with those documented by Zimbardo – deference to power or to what appear to be acceptable norms regardless of the suffering that follows; lack of empathy towards those in distress; and a numbing of sensitivities.

The Asch conformity experiments, first carried out by Solomon Asch in 1951 and replicated many times (Bond & Smith, 1996) are also relevant. The prototypical study showed how an individual can feel pressurised to agree with others who have made an obviously erroneous judgement about whether a line is the same length as three just-seen lines. This illustrates how difficult it can be to avoid conforming with prevailing opinions, however erroneous they may be. In particular, Ballatt and Campling (2011, p.70) refer to a parallel situation to the Mid Staffordshire clinical setting, where staff were very unwilling to speak out against the prevailing view. A fear of being disloyal to their employer was common amongst staff. A positive step would be to encourage a socially cohesive network of like-minded individuals who speak out when they sense things are going wrong.

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Moral dilemmas

'it [is] morally wrong to put targets of that sort ahead of the nursing needs of patients'

Moral dilemmas abound in healthcare – should the health of many be sacrificed for the health of a few who may be vulnerable and in great need? Should healthcare staff be judged by the outcome of their actions or primarily by their intentions? Is failure by a doctor or a manager to prevent harm to someone as blameworthy as actively causing it? In his commentary on professionalism in medicine, Hafferty (2006) goes so far as to say 'medicine is a moral community, the practice of medicine a moral undertaking, and professionalism a moral commitment' (p.2152).

> "A fear of being disloyal to their employer was common amongst staff"

In situations where justifiable goals conflict, where risk to one set of patients has to be weighed against risk to another set of patients, where self-image and personal goals may be at stake, and where pain or suffering may be inflicted on others, moral dilemmas are bound to emerge. Relevant cognitive perspectives have been outlined by researchers such as Cushman and Greene (2012). Moral decisions may be intuitive, largely unconscious and influenced by affective responses, rather than being deliberate, conscious attempts to rationally solve a particular problem (Cushman et al., 2010). Social norms also exert a strong influence.

Understanding how divergent feelings, norms and values in a particular healthcare-related moral dilemma can conflict with each other may make such dilemmas more tractable, and make easier the processes of adjudication and negotiation. Gandhian values might help in resolving such dilemmas (see Kapur, 2010). Such values include Truth and Compassion (Love), and the principle that the end rarely justifies the means. A healthcare example of an end not being justified by the means is compromising patient safety to reduce waiting lists. In the case of the principles of Truth and Compassion, the latter is cited 16 times in the executive summary of the Francis Report, with lack of compassion being a key criticism of the NHS culture in question. 'Truth' can be seen in the calls from healthcare leaders for greater transparency and openness in the NHS.

Clinical excellence

'It is professionalism which encourages maximum performance, rather than reliance only on regulatory compliance.'

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Psychology can help to unpack some of the key components of clinical excellence. In earlier articles I have outlined 15 'pillars' of clinical excellence in medicine (Kapur, 2009), and applied psychology (Kapur and Wilson, 2010), which can be grouped into three domains – technical, personal and future-based. (Two pillars of excellence that may closely relate to events at Mid Staffordshire are the technical pillar of 'learning and risk management' and the personal pillar of 'moral principles'.) Similar work has been carried out by Howard Gardner at Harvard University in his 'Good Work Project' (Gardner, 2007). He defines 'Good Work' as that which is excellent in quality, socially responsible and meaningful to its practitioners. Clinical excellence requires that professional standards are rigorously followed where possible, and professional bodies have a key role in ensuring that this occurs.

The British Psychological Society could be involved in hospital inspections to help ensure high standards of excellence for services relating to clinical and health psychology, and adherence to professional standards and guidelines. Implicit in most inspections is a form of 'peer review', whereby specialists in a particular field are more likely to detect shortcomings such as a failure to adhere to professional standards – a form of review that the Francis Report specifically supported.

Discovering the truth

'...the truth was uncovered in part by attention being paid to the true implications of its mortality rates, but mainly because of the persistent complaints made by a very determined group of patients and those close to them.'

During the Francis Inquiry many witnesses tried to recollect events that took place up to seven years previously. There is a burgeoning literature on cognitive issues relating to eye-witness testimony in legal settings. Such testimony can be subject to major distortion from the truth, with witnesses usually being unaware of such distortion, and in fact being very confident in their erroneous recollections. This research has been well summarised by Lilienfeld and Byron (2013), who have pointed out that there needs to be a greater recognition that the frailties of the human mind can lead to difficulties in discovering truth and implementing justice in judicial and semi-judicial settings.

Ozubko and Fugelsang (2010) reported that the act of retrieval itself can give rise to an illusion of truth for the person doing the recalling. Although the Francis Inquiry was not a specific legal exercise with the aim of attributing blame and bringing individuals to justice, there was a legal flavour to it, with a number of barristers playing a key role. It is therefore worth noting the observations of Morley (2009) that in legal settings issues other than the careful discovery of facts can influence the ascertainment and representation of truth.

Being aware of certain facts about human memory and about the nature of deception may help to guide judges and others to decide on the veracity of recollections (BPS, 2008; Schacter & Loftus, 2013; Vrij & Granhag, 2012). These facts include: memory is reconstructive rather than the simple reproduction of a record of past experience; very detailed recollection of specific events from many years ago is unusual; a high degree of confidence or conviction in recollection of an event or fact is no guarantee that it is veridical; unconscious factors, deep-seated beliefs and strong feelings may lead to unintended distortions in memory of which an individual is unaware; the simple act of a statement being repeated can lead to an illusion that it is truthful (the 'illusory truth' effect); independent corroboration is a key way of knowing whether a statement is truthful; and deliberately telling lies involves additional cognitive effort, which is made evident after further increasing cognitive load on an individual by such means as asking unanticipated questions or asking for events to be recalled in reverse order.

Communication

'This situation was exacerbated by a lack of effective communication across the healthcare system in sharing information and concerns.'

Coiera (2009) and Cosby (2009) have outlined the main types of communication failures in healthcare settings and ways these can be rectified. Errors in communication are more likely to occur where there are distractions and interruptions; in situations of high information load, time pressure and multitasking; where there is ambiguity or duplication of roles; and where there are authority gradients – highly organised, hierarchical structures where a significant degree of control is exercised by authority figures. Although research in healthcare settings has traditionally been focused on these types of communications between health professionals or during doctor–patient interaction (e.g. Taran, 2010), there is also a recognition that failures in communication within and between organisations, such as those outlined by the Francis Report, are both widespread and amenable to analysis using psychological tools and concepts. Thus, Dayton and Henriksen (2007) refer to a number of factors that can adversely influence organisational communication, such as cognitive workload, implicit assumptions, authority gradients, diffusion of responsibility and transitions in care. They called for more structured and explicitly designed forms of communication to help send unequivocal signals that a particular course of action is required.

Communication audits (such as those described by Hargie and Tourish, 1996), also show how failures in effective communication can emanate from a psychological culture where there tends to be suppression of bad news; where those

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expressing concerns are stereotyped as 'lobbying', 'misfits' or 'troublemakers'; where hierarchical management systems impede the sharing of information or concerns; where territorial behaviours and 'turf wars' predominate; and where the reputation of an employer is considered more important than patient safety concerns. Mutual stereotyping can also contribute to poor communication between clinicians and managers (Klopper-Kes et al., 2009).

Psychology of culture

'Aspects of a negative culture have emerged at all levels of the NHS system.'

Psychological studies have helped to tease apart some of the key factors and variables that pertain to institutional culture and its impact on the performance of individuals within an organisation. Schneider et al. (2013) note the existence of several tools to measure culture in organisations, such as the Organizational Culture Inventory, the Denison Organizational Culture Survey and the Organizational Culture Profile. Leaders play in an important role in directly articulating values and policies, and taking indirect measures to support them.

Schneider et al. note that a particular framework, the Competing Values Framework, is useful in distinguishing various types of culture and associated behaviours. This framework contrasts and combines Flexibility versus Stability, and an Internal versus External focus. This can result in four sets of cultures with a distinct set of values, beliefs, behaviours and criteria for effectiveness, each focused either on human affiliation, change, achievement or stability. The idea that particular values, beliefs and behaviours will contribute to certain culture features, such as well-being or innovation, opens up the possibility of planned interventions.

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Newdick and Danbury (2013) have outlined how cognitive biases in reasoning may influence interactions between managers and clinicians, and thus contribute towards harmonious or conflict-laden cultures in healthcare organisations. Specific areas of culture, such as patient safety, have been subject to a psychometric analysis. Thus, Sarac et al. (2011) examined a measure of culture, the Hospital Survey on Patient Safety Culture, and found evidence to confirm a 12-factor structure in respect of patient safety culture. These factors included openness of communication, non-punitive response to error, and frequency of incident reporting. A further study from the same group found a relationship between safety climate and safer patient care by NHS staff (Agnew et al., 2013).

Target-driven behaviour

'Finances and targets were often given priority without considering the impact on the quality of care.'

In general, while recognising that targets may have their value, target-driven approaches to healthcare delivery have been subject to criticisms, with a view that they tend to distract from more important aspects of patient care (Rawlinson, 2008). In the area of delivery of healthcare, there has been debate on the relative value of process versus outcome measures, with a general consensus that both approaches have their value in certain settings. To the extent that quality of care and a focus on errors are regarded as more process-driven, the latter approach may tend to be more beneficial (e.g. Gross, 2012; McClimans & Browne, 2012).

This discussion of process versus outcome has its parallels in certain areas of psychology research. Compared to cognitive behaviour therapy, dynamic psychotherapy has traditionally placed a greater emphasis on processes rather than outcomes, for example intrapersonal and interpersonal reflections rather than symptom remission (Shedler, 2010). In other health-related applications, Freund and Hennecke (2012) reported that in the field of weight control, a focus on process (dietary behaviours) was more likely to achieve difficult health-related goals and enhance self-regulation rather than a focus on outcome (weight loss). Freund et al. (2010) found that older individuals were more likely than younger participants to adopt a process rather than an outcome focus when considering the attainment of goals. These examples from psychology research support the idea that the NHS should focus on process rather than outcome measures.

Corporate memory

'Recommendation 126 – Preserve corporate memory.'

The study of organisational memory, corporate memory and corporate amnesia (e.g. Kransdorff, 1998; Lahaie, 2005) has addressed questions such as How can key sets of knowledge be preserved in organisations, especially those with a high turnover? Which representations of

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knowledge and experience should be formalised and used? What is the best way to integrate such knowledge and experience with current and future needs of an organisation? How do we motivate key former employees to pass on knowledge and experience? And how do we similarly motivate key current and future individuals in an organisation to avail themselves of such knowledge and experience.

An Organization with a Memory was the unusual name given to a report published by the UK Department of Health in 2000. It highlighted ways in which lessons should be learned from adverse clinical events occurring in hospitals and other healthcare settings. Its author, the chief medical officer at the time, Sir Liam Donaldson, noted: 'If an organisation focuses intensively on a problem for a short period of time but forgets about it when new priorities emerge or key personnel move on, effective learning has not taken place' (pp.29–30).

Many good intentions have been documented in reports into healthcare failings, but the real task is how to ensure their effective implementation (Cohen et al., 2012). In experimental and health psychology, the study of implementation of intentions has seen a resurgence in recent years, and some of the findings of these studies may be worth considering at an organisational level. Michie and Lester (2005) found that improving the style and behavioural specificity of mental health guidelines resulted in stronger intentions to implement the guidelines, more positive attitudes towards them, and greater perceived behavioural control over using them. In a meta-analysis of experimental studies, Sheeran et al. (2013) noted that greater implementation of intentions followed when situations were appraised as being particularly risky, and that this effect was stronger when individuals felt that a particular behaviour would change the situation, and when they were confident about being able to execute the particular behaviour.

At the level of the individual, intentions may not be implemented for a variety of reasons: the person may completely forget the intention and related knowledge; they may retain this information but forget to carry it out; they may lack motivation, be distracted or distressed by other events; or circumstances may have changed and it may now be too costly to implement the intention. Most of these obstacles to intention implementation find parallels in the behaviour of organisations. Recent studies with individuals have shown that such problems can sometimes be overcome by techniques such as 'if-then' plans; that is to specify in advance particular situations where the intention should be carried out, and picturing such implementation taking place. Areas of application have included voting (Nickerson and Rogers, 2010), shopping (Fennis et al, 2011) and healthy eating (Allan et al., 2011). At an organisational level, this technique could be implemented by being as precise as possible about the time and the setting when implementation of, for example, a safety recommendation should take place.


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Conclusions

It is over 40 years since George Miller delivered his memorable and moving presidential address to the American Psychological Association, where he called for psychology to be 'given away', so as to help promote human welfare (Miller, 1969). I was a fledgling undergraduate student at the time, but his address moved me then, and it moves me still. In the past 40 years, there have arguably been two revolutions in psychology – the 'splendiferous revolution' in cognitive neuroscience by which advances in brain imaging and related procedures have brought new insights into our understanding of human behaviour, and also a (perhaps more important) 'silent revolution', whereby advances in our understanding of behaviour and of related cognitive processes have enabled new approaches to the assessment and management of human behaviour. This silent revolution has brought the field of applied cognitive psychology to the fore, contributed to at least one Nobel Prize (Daniel Kahneman, in 2002) and to an influence at the heart of government in the form of the Behavioural Insights Team.

Although it is clear that psychology as a discipline has a key role to play in patient care, it has perhaps not promoted itself in the best possible ways. One way forward could be for a Special Interest Group in Patient Safety to be formed within the British Psychological Society. Other ways include research collaborations in patient safety between psychologists and medical professionals; psychologists taking up advisory roles in regulatory and other healthcare bodies, and working directly with health trusts on the provision of psychology services or indirectly by having a place on the board of governors. Psychology now has the knowledge and tools to tackle real-life problems, such as those highlighted by the Francis Report. As others have also pointed out (Beck, 2013; Whitby and Gracias, 2013), psychology as a profession now needs to take up the challenge, and to gain the respect of society by using such knowledge and tools to bring about change for the better.

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