A culture of openness

The MPS perspective
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References
“To err is human, to cover up is unforgivable and to fail to learn is inexcusable.”

1
The Medical Protection Society is the leading provider of comprehensive professional indemnity and expert advice to doctors, dentists and health professionals around the world.

We are a mutual, not-for-profit organisation offering more than 270,000 members help with legal and ethical problems that arise from their professional practice. This includes clinical negligence claims, complaints, medical council inquiries, legal and ethical dilemmas, disciplinary procedures, inquests and fatal-accident inquiries.

Fairness is at the heart of how we conduct our business. We believe that patients who have experienced an adverse event are entitled to, and should receive, a full and open explanation. We also believe that patients who have been harmed through a member’s negligence should receive fair compensation.

We actively protect and promote the interests of members and the wider profession. We promote safer practice by running risk management and education programmes to reduce avoidable harm.

MPS is not an insurance company. The benefits of membership are discretionary – this allows us the flexibility to provide help and support even in unusual circumstances.
Poor communication and staff attitudes are the top reasons for complaints in the NHS, and seven out of ten claims involve poor communication. This is a strong indicator that what patients want when something goes wrong is the truth. An open and honest explanation of what happened, why, and an apology where that is due. This document sets out the reasons why we believe that a cultural shift is what is needed to achieve greater openness and trust with patients.

However, we stress that openness is just the first part of a three stage journey. The second stage is being open with each other in reporting adverse events, and near misses, so that they can be explored and analysed. The third stage is a commitment to implement the learning, to prevent the same mistakes happening again.

It is much harder to change culture than to pass laws, but this is what is needed. We hope that you will support our call for a culture of openness as the route to improving communications between healthcare professionals and patients.

Finally, I would like to thank the MPS members who participated in our online poll, Ms Farzana Hakim for sharing her story and also Professor David Studdert and Dr Paul Nisselle for their contributions to this document.

Dr Stephanie Bown
Director of Policy and Communications, MPS
Introduction

A culture of openness in the NHS is critical to improving the quality and safety of healthcare. The overwhelming majority of patients receive safe and effective care. However, when things do go wrong, it can be catastrophic for all involved.

Effective communication after an adverse outcome lies at the core of rebuilding trust and supporting healing for the patient, their loved ones and the healthcare team involved. Poor or no communication compounds the harm and distress that has already been experienced. Ninety two per cent of MPS members surveyed state that they are open and honest with patients and recognise that good communication drives down patient complaints.\(^3\)

MPS has long supported and advised members to be open with patients when something has gone wrong.

Despite the reassuring support reflected in our survey of members about the importance of open communication, in our experience many doctors have concerns about the process relating to the legal consequences and their lack of training in the skills required to be open and do it well.

MPS, with other stakeholders, has been actively involved in discussions with the Department of Health about the best way to achieve the levels of honest and open communication that today’s patients rightly demand and should receive.

This report presents the results of an online poll of MPS members and a survey commissioned by MPS and conducted by ComRes which explored themes around communication, medical errors and barriers to openness. We explain why we believe a cultural shift in the NHS is what is needed to achieve openness. We review legislation used in the US and the extent to which this has worked, and summarise how we believe openness can be achieved through cultural change.
The patient has no more right to all of the truth than he has to all of the medicines in your saddle bag. He should get only so much as is good for him.”

Lord Denning found in favour of a surgeon who deliberately lied to a patient, accepting that the lie was in the best interests of the patient.

“Pretending that nothing happened, or telling about it in incomplete ways, is lying.”

“Discussing patient safety incidents promptly, fully and compassionately is the best way to support patients and staff when something does go wrong.”

See how culture has shifted over time:

1871: “The patient has no more right to all of the truth than he has to all of the medicines in your saddle bag. He should get only so much as is good for him.”

1954: Lord Denning found in favour of a surgeon who deliberately lied to a patient, accepting that the lie was in the best interests of the patient.

2006: “Pretending that nothing happened, or telling about it in incomplete ways, is lying.”

2009: “Discussing patient safety incidents promptly, fully and compassionately is the best way to support patients and staff when something does go wrong.”
There has been a significant cultural shift in the relationship between the medical profession and patients over recent years.

The traditional, paternalistic doctor–patient relationship has been largely replaced by a doctor–patient partnership, where patients can rightly expect open and honest communication and shared involvement in decision-making. “No decision about me, without me” is the current government’s guiding principle. Patients increasingly see themselves as consumers, and have consumer expectations.

What do patients want when things go wrong?

Most patients want doctors to be open and honest about the mistakes that have been made. Ninety five per cent of people surveyed by ComRes think that it is ‘fairly important’ or ‘very important’ that they receive an open and honest explanation of what went wrong, or assurance that the problem that occurred is corrected.

A similar proportion (94%) think it is important that those responsible learn lessons in order to prevent the same thing happening again, while nine in ten say that it is important that they receive an apology.

This supports the many studies that show that patients are motivated to take legal action primarily because they are angry, and their anger is often precipitated by no, incomplete or delayed information about what happened and why. The majority of patients say that the main reason they initiated litigation was “to make sure this doesn’t happen to anyone else”. Patients want information, and they want that information used to make healthcare safer.

“In my experience openness with patients and families is an essential component of good clinical practice and if things go wrong not only is honesty essential, it usually leads to understanding rather than hostility.”

MPS member
Last January, I presented at the Emergency Department (ED) with a terrible pain down my arms and back after a fall. After some investigations, which came back negative, I was given some painkillers and sent home.

The next day, I went to see my GP because I was in so much pain. She prescribed me four different painkillers and advised me the pain should settle in a week or two.

Six and a half weeks later, the pain was as bad as ever. I was referred to a neurologist, who thought I might have a slipped disc. He arranged a CT scan, which showed that a vertebra in my neck was broken in three places.

I was horrified that the fracture had been missed for so long. I now know that I could have been paralysed and should have been placed in a neck collar immediately. Instead, I had spent the past six weeks following my doctor’s advice to be as active as possible, even going for a 10k run.

I understood that the doctors missed the fracture because they were more concerned to find out why I had had the fall. They were trying to do their best. We’re all human and fallible.

Immediately, the neurologist acknowledged they had missed the fracture and was very open about the mistake. He apologised, but at that point, saying sorry wasn’t high up on my agenda. I was more interested in what was going to happen and whether I was going to be ok.

He didn’t try to cover anything up and asked for an internal investigation straightaway. He also said that I was under his care. This made me feel like I wasn’t just another patient being moved from one place to another. This doctor would look after me. He reassured me everything would be ok.

Once I was feeling a little better, I kept running through my mind what could have been. I knew something bad had happened, and that something even more catastrophic could have happened. I realised there was a problem in the system; another woman on my ward had a slipped disc which wasn’t picked up in the ED. I didn’t want this to happen to anyone else. I decided to write a letter of complaint.

The hospital wrote to confirm receipt of my letter and stressed they were taking the complaint seriously. However, I waited months for a response. The time lapse made me think they had something to hide, or were scared of legal action.

After months of chasing, when the response came, I was initially relieved. They apologised, admitted the mistake, and explained they were changing systems. However the hospital had not answered my key question – whether their failure to diagnose had made my condition worse. I wanted someone to take responsibility for what had happened to me.

By Farzana Hakim, NHS patient
Doctors already have a professional and ethical obligation to be open and honest when things go wrong. GMC guidance states: “Patients who complain about the care or treatment they have received have a right to expect a prompt, open, constructive and honest response including an explanation and, if appropriate, an apology.”

Our members support this approach; 92% believe they are always open and honest with patients.

Eighty seven per cent of MPS members surveyed recognise that open and honest communication can help to reduce complaints.

Patients support this approach too. When receiving treatment, patients think it is very important that their doctor listens to them and explains things in a way they can understand. Our survey shows that 79% of patients think it is very important that their doctor listens to them (Fig 1).

When things go wrong, saying sorry is not enough. Patients want an explanation of what went wrong and why, and doctors need to rebuild the relationship of trust. Ninety-five per cent of the public surveyed feel it is very important for doctors to give an open and honest explanation of what went wrong, or ensure that the problem is corrected (Fig 2).

Notably, patients are least likely to think that financial compensation is important; 52% think it is fairly or very important.

Poorly handled explanations serve only to compound the harm, distress and loss of trust that has already been experienced, increasing the likelihood of litigation.

Twenty eight per cent of the doctors we surveyed said they find it difficult to communicate effectively with patients when things go wrong. We believe there is still much work to be done to help them learn how to manage these situations.

“Listening and honesty is almost as important as clinical acumen when it comes to being the best doctor you can within the resource and time constraints of modern medicine in the UK.”

MPS member
**Figure 1**
How important, or otherwise, would you say each of the following are to you when using healthcare services?

- My doctor listens to me: 3.79
- My doctor explains things in a way I can understand: 3.72
- I feel my doctor treats me with courtesy and respect: 3.71
- I can see my doctor when I need to: 3.69
- I am given enough time with my doctor in my appointment: 3.67
- I feel I can tell my doctor anything: 3.47
- I see the same doctor on every appointment: 3.03

**Figure 2**
If something went wrong when you were receiving medical treatment or medication, how important, or otherwise, would it be to you that each of the following took place?

- An open and honest explanation of what went wrong: 3.82
- Ensuring that the problem is corrected: 3.86
- Those responsible learn the lessons in order to prevent it happening again: 3.78
- An apology: 3.6
- Disciplining those responsible: 3.2
- Financial compensation: 2.76

**KEY:** Individual responses were given numerical scores whereby 4 = important and 1 = not at all important. Mean scores were calculated to aid analysis.
Two thirds of our members express the view that there is a pervasive blame and shame culture within the NHS and believe this will be difficult to overcome. They also highlight time constraints as a key factor in restricting their ability to communicate as effectively as they would wish (Fig 3). When a mistake occurs, 70% of doctors said they received no or limited support from their organisation (Fig 4).

These are significant barriers but can legislation address these challenges?

"I could frequently do with more time in clinic to discuss issues with patients in more detail."

**Figure 3**

Were you given support to deal with the consequences following the error?

**Figure 4**

Which of the following are barriers to good communication with your patients?
Mandatory disclosure laws in the United States

The US experience

The US is often cited as a country that has successfully introduced legal requirements on healthcare providers to communicate details of adverse events with affected patients and their families.

MPS commissioned Professor David Studdert, ARC Federation Fellow at the University of Melbourne and formerly Associate Professor of Law and Public Health at the Harvard School of Public Health, to describe the statutory obligations that have been introduced in the US and to assess the merits of this approach.

What is mandatory disclosure?

The term “mandatory disclosure” refers to legal requirements placed on health professionals or healthcare institutions to conduct disclosure. Such requirements may be introduced by statute, regulation, or possibly common law.10 The effect would be to create legal obligations on health professionals and/or healthcare institutions to ensure disclosure occurs in the aftermath of some specified incident or event (the “triggering event”).

Joint Commission’s Standard

In 2001, the Joint Commission on Accreditation of Healthcare Organizations in the US, now called the Joint Commission, issued the country’s first nationwide disclosure standard.11 This standard requires that patients are informed about all outcomes of care, including “unanticipated outcomes.” The standard was very general: it did not specify the content of disclosure, nor did it mandate that patients be told when unanticipated outcomes were due to error.12

Does the Joint Commission’s standard operate as a disclosure mandate? At one level, it is tempting to conclude that it does. However, it is a stretch to treat the standard as equivalent to a mandatory disclosure law. It is one of a large basket of measures the Joint Commission examines in reviewing hospitals. Moreover, the standard’s non-specific nature means that, in practice, the conformity is tested primarily against process measures (eg, existence of an appropriate disclosure policy), not audits of specific episodes of care and searches for breaches.
As of June 2010, six US states had passed mandatory disclosure laws: California, Florida, Nevada, New Jersey, Pennsylvania and Vermont. A seventh state, Oregon, has a quasi-mandatory regime in the sense that disclosure is mandatory for participants in the state’s Patient Safety Reporting Program, but participation is voluntary.

Key elements of these laws are summarised in Table 1. Several features are noteworthy. First, there is considerable variation across jurisdictions in the approach taken to certain elements, particularly the wording of the obligation and the triggering event chosen. Second, the laws are not models of clarity. The main areas of confusion are the definition of the triggering event (not shown), the mechanism or mode by which the disclosure is expected to be made, and the penalty, if any, for breaches. In a recent review of US disclosure laws, Mastroianni et al raised similar concerns about clarity.15

“Time constraints may limit openness but not honesty.”

MPS member
## Key elements of mandatory disclosure laws in seven US states

<table>
<thead>
<tr>
<th>State</th>
<th>Key provision(s) establishing obligation</th>
<th>Triggering Event</th>
<th>Whose Duty?</th>
<th>Prescribed mode</th>
<th>Timing requirement</th>
<th>Prescribed penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>“The facility shall inform the patient or the party responsible for the patient of the adverse event…”</td>
<td>Adverse event</td>
<td>Facilities</td>
<td>Unclear</td>
<td>“By the time the report is made”**</td>
<td>Yes</td>
</tr>
<tr>
<td>Florida</td>
<td>“Every licensed healthcare practitioner shall inform each patient…”; “An appropriately trained person designated by each licensed facility shall inform each patient…”</td>
<td>Adverse incidents that result in serious harm</td>
<td>Facilities and licensed health care practitioners</td>
<td>“In person”</td>
<td>“Within three business days after [adverse incident’s] occurrence”</td>
<td>Yes</td>
</tr>
<tr>
<td>Nevada</td>
<td>“A representative [of the medical facility]… shall … provide notice… to each patient who was involved…”</td>
<td>Sentinel event</td>
<td>Facilities</td>
<td>Unclear - “provide notice”</td>
<td>“Not later than seven days after discovering or becoming aware…”</td>
<td>None clearly prescribed</td>
</tr>
<tr>
<td>New Jersey</td>
<td>“A healthcare facility shall assure that the patient affected… is informed…”</td>
<td>Serious preventable adverse event</td>
<td>Facilities</td>
<td>“In person”, “by telephone” or “by certified mail”</td>
<td>By end of the episode of care, or, if discovery occurs later, “in a timely fashion” as established by regulation</td>
<td>None clearly prescribed</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>“A medical facility through an appropriate designee shall provide written notification to a patient affected…”</td>
<td>Serious event</td>
<td>Facilities</td>
<td>Written notification</td>
<td>Within seven days of the occurrence or discovery of a serious event</td>
<td>None clearly prescribed</td>
</tr>
<tr>
<td>Vermont</td>
<td>“Hospitals must “disclose to patients, or, in the case of a patient death, an adult member of the immediate family…”</td>
<td>Adverse events that cause death or serious bodily injury</td>
<td>Facilities</td>
<td>No</td>
<td>None specified</td>
<td>None clearly prescribed</td>
</tr>
<tr>
<td>Oregon</td>
<td>“After a serious adverse event occurs, a participant must provide written notification… to each patient served by the participant who is affected by the event.”</td>
<td>Serious adverse event</td>
<td>Participating facilities **</td>
<td>Written notification</td>
<td>“In a timely manner”</td>
<td>None clearly prescribed</td>
</tr>
</tbody>
</table>

* This refers to reporting of the adverse event to the relevant government department, which is to occur within five days after the adverse event has been detected, or within 24 hours if the adverse event presents an ongoing threat to health and safety.

** “Participation” refers to participation in the Oregon Patient Safety Reporting Program (Table1)
Understanding mandatory disclosure as a regulatory approach

Mandatory disclosure is a form of legal intervention commonly referred to as command-and-control (CAC). This is a classic form of regulation characterised by close monitoring of the behaviour of regulated actors and the use of sanctions to punish non-compliance. These characteristics distinguish CAC from other approaches to oversight, such as self-regulation and use of economic incentives.

An alternative approach that has drawn considerable interest both inside and outside the healthcare sector is Braithwaite’s model of responsive regulation. The model begins with the recognition that large, complex systems consist of many actors and entrenched cultures. Regulatory strategies that are responsive to the cultures of those being regulated, the theory runs, are more likely to achieve their goals.

For example, bringing about change in hospitals must take into account professional and organisational cultures, as shown in the research on “magnet” hospitals (so termed because of their success in attracting and retaining nursing staff). Similarly, designing safer systems must take into account human factors. Responsive regulation is an approach that values trust, transparency and professionalism.

The touchstone for any evaluation of the merits of mandatory disclosure laws should be their objectives. What are the objectives? A review of the medical and legal literature does not provide a clear answer.

This is perhaps not surprising given the novelty of disclosure as a topic of serious attention in health policy. What commentary exists in the media and grey literature suggests that the objective of mandatory disclosure is essentially indistinguishable from the core goal of the broader disclosure movement, namely: to ensure that when adverse events occur providers consistently disclose information about those events to patients and do so in an effective manner.

Consequently, the rest of this report focuses on evaluating mandatory disclosure’s potential to drive more consistent and higher-quality communications between providers and patients following adverse events in care. How effective is mandatory disclosure likely to be in achieving these twin objectives?

Analysis of the merits and feasibility of mandatory disclosure

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**Conditions needed for effective regulation**

The appropriateness and effectiveness of the CAC regulatory approach turns on the existence of several key conditions in the regulatory environment:

- **Clear rules**
- The ability of the regulator to monitor actors’ compliance with those rules
- The ability of the regulator to enforce the prescribed sanctions.

**Clear rules** – Mastroianni et al’s review identified a troubling lack of clarity around fundamental elements of disclosure laws, beginning with the triggering event, and extending through rules dictating when a disclosure should occur, by what mode, and what items of information it should include.\(^1\) It is important to recall that the objective of mandatory disclosure is not merely to ensure disclosure occurs. The disclosure must be of a high quality. This summons attributes like comprehensiveness, empathy, and sincerity, it demands that disclosure be conducted in appropriate settings, and so on. Prescribing behaviour around such attributes is virtually impossible. In sum, there is potential for legal rules to direct some aspects of disclosure communications but not others. The aspects that fit poorly with the concept of stern external oversight are not trivial ones.

**Ability of regulators to monitor actors’ behaviour** – In the US, the difficulties associated with identification of adverse events present an immediate and substantial challenge for external regulation disclosure practice. But of course this is the first step in a regulatory challenge that involves not just identifying adverse events but monitoring the conversations that surround them. In sum, the feasibility of effective monitoring under a mandatory disclosure regime is highly questionable. Not
surprisingly, anecdotal evidence suggests that there appears to have been no serious attempt to engage in monitoring to do it in the seven US states that have adopted mandatory disclosure laws.\textsuperscript{19}

**Ability of regulators to enforce the prescribed sanctions** – The regulator’s capacity to sanction providers for non-compliance with a disclosure mandate hinges on their ability to monitor compliance and detect breaches, which the above discussion suggests is severely constrained.

**Summary**

In summary, several of the conditions necessary for effective legal intervention are missing in the context of disclosure. Particularly prominent obstacles are the practical challenges that would confront any attempt to regulate the quality of communications, and the technical infeasibility of tracking compliance.

Patient–provider communications around adverse events are a looming policy challenge. The crux of the challenge is that there is wide agreement that disclosure is the right thing to do, yet well-founded concerns that the practice is not consistent or done well enough. How should governments react?

One option is to “shock” providers into submission through a stern form of regulation like mandatory disclosure. This approach may have appeal for politicians and members of the public disturbed by reports of cover-ups or poor disclosure practice. However, the policy choice should follow sober analysis of the prospects various approaches have for meeting the overarching social objectives.

This report has trained such an analysis on mandatory disclosure laws. The conclusions are that some of the conditions necessary for such an approach to work effectively are missing. The review of the situation in US states that have adopted disclosure mandates tends to bolster this conclusion.

A critical question this report does not answer is: ‘if not mandatory disclosure then what?’

Two recent papers analysing disclosure laws point in the same direction:

*The most successful disclosure initiatives are likely to be those that emerge locally, are driven by an institutional leadership and a workforce committed to transparency, and focus on providing healthcare workers with the skills needed to conduct these difficult conversations well.*\textsuperscript{20}

*Policy makers and healthcare providers* should not rely on laws as the primary means of changing the culture of communication with patients following unanticipated outcomes. *Such culture change is likely to be most effective when it originates from within institutions that develop systems to support healthcare workers in conducting these difficult conversations.*\textsuperscript{21}

If it is accepted that legislating to mandate disclosure does not work, what needs to be done to change a culture of fear of consequences to a culture of openness?
Looking forward: How can we achieve a culture of openness?

We’ve come a long way, but more needs to be done.

We need to build on existing successes:

■ In the UK, the Compensation Act 2006 makes clear that an apology is not equivalent to an admission of liability. We need to ensure this message is made clear at all levels in healthcare organisations.

■ MPS is a joint signatory to the NHS Litigation Authority circular to NHS Chief Executives on apologies and explanations. We have contributed to the National Patient Safety Agency’s (NPSA) re-launch of the Being Open package of tools and guidance for NHS trusts. MPS has developed bespoke workshops to encourage open communication.

■ Healthcare organisations must support their healthcare staff in fulfilling professional and ethical obligations to be open with patients when things go wrong, by providing ongoing support, training, mentorship and senior clinicians who will lead by example.

■ MPS provides hundreds of communication skills training workshops for members each year, dealing specifically with the communication tasks required, the barriers encountered and the skills needed to manage adverse outcomes.

■ We need to embed within the medical curriculum an understanding and acceptance that errors can, and do, happen and doctors need to be taught how to deal with them without fear of being thought of as ‘failing’ or lacking competence.

...And promote a culture of openness:

■ In Australia, each of the six states and two territories have enacted Apology protection laws. Each state and territory has adopted different wording in its statute, but in all cases an apology cannot, in personal injuries litigation, be pleaded as an admission of liability. Following this example, we would welcome consideration to extend the principle set out in the Compensation Act, so that an apology or explanation offered to a patient is not admissible in civil or disciplinary proceedings. Adding a definition of ‘apology’ to the Compensation Act would further encourage openness.

“You cannot legislate to create either a change in culture or good behaviour. Only fearful behaviour is created in this way.”

MPS member
The problems with legislation in this area:

- Fear of legal sanction could prove counterproductive, forcing the reporting of mistakes underground.

- As Professor David Studdert writes in his report, legislation gives the wrong message; it deflects attention away from cultural change into doing the minimum necessary to meet legislative requirements.

- Errors are often not immediately apparent (known as latent errors) and on occasion, the healthcare professional is not aware for many months or years of an alleged mistake. It would be difficult for a statutory measure to encompass latent, as opposed to patent (or immediately obvious), errors.

- Legislation would also exclude the “near misses” and minor mishaps that some patients want to know about and which are important in improving patient safety.
Conclusion

Meaningful, open and honest communication with patients and working in a culture that expects it is more likely to be delivered by doctors committed to transparent working at all levels, rather than doctors forced to report adverse incidents through legislation and a “top down” managerial approach.

It is our view that changing a doctor’s reaction to adverse events from one of fear into an eagerness to report, explain and learn from what went wrong can only happen through cultural change.

“We need an entire culture change – teach us from medical school onwards to discuss mistakes in an open and non-judgmental way, a way that encourages learning from mistakes instead of being shunned or blamed for them.”

MPS member
Methodology

The Medical Protection Society commissioned ComRes to conduct a survey of 2028 GB adults online between 28 April and 1 May 2011. Data was weighted to be demographically representative of all GB adults. Where respondents said that they, or a family member, had used any healthcare service in the past year they were defined as “patients”, whereas those who said that they had not used any healthcare services in the past year were defined as other members of the “public”.

Additional results were based on an online poll of 541 MPS members in March 2011, which involved GPs, consultants and non-consultant hospital doctors.

This publication was edited by Sarah Whitehouse, Writer and Editor and Nyree Connell, Public Affairs Manager, with assistance from Catherine Wrigley, Public Affairs Officer at MPS. Designed in-house at MPS by Jayne Perfect.
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