The Medical Protection Society (MPS) would like to take this opportunity to respond to your request for views on the issue of clinical governance as part of the inquiry into the culture within NHS Scotland. Although not all the questions fall directly within our remit, we would like to provide our views on the last question regarding the quality of care and what should happen when things go wrong.

MPS is the world’s leading protection organisation for doctors, dentists and healthcare professionals. We protect and support the professional interests of more than 300,000 members around the world and over 11,000 members in Scotland. We are a not-for-profit membership organisation, not an insurance company. Membership provides access to expert advice and support together with the right to request indemnity for complaints or claims arising from professional practice.

MPS has played an active role in the Scottish Government’s deliberations on proposals for a statutory duty of candour, and a criminal offence of wilful neglect. We have long called for a culture of improved openness in NHS Scotland. From experience we know that cultural and organisational failure to be open when something goes wrong plays a significant role in clinical quality and rates of adverse events.

Healthcare professionals remain fearful of blame or personal recrimination if they report incidents. We believe that the optimal way to change healthcare professionals’ behaviour is through cultural change: creating an environment of normalising reporting errors and engendering an eagerness to report, investigate and learn from adverse events.

MPS has always been of the view that whilst you can mandate disclosure through legislation, it is not an instrument that would appropriately address the attributes of high quality and open communication. MPS remains concerned that the new legal duty of candour on organisations could become a distraction and may inadvertently result in a “tick-box” process when something goes wrong. This may mean that patients do not get the meaningful and sincere explanation and apology they deserve.

It must be ensured that new laws and obligations on healthcare professionals do not themselves add to the culture of fear. Staff should be encouraged to act appropriately when something goes wrong and to feel confident to demonstrate individualised empathy, sincerity, and comprehensiveness in subsequent investigation.

MPS wants to continue playing an active role in ensuring that any duty placed upon healthcare professionals is effectively communicated and that any new requirements assist in fostering an open, learning culture. Our Medical Director, Dr Rob Hendry, is a member of the working group that is developing the duty of candour regulations and we are delighted to be involved in this process and to offer our extensive global expertise in such matters.

When things go wrong, an appropriate apology plays a vital role. We welcomed the Apologies (Scotland) Bill in 2015, although we were disappointed to see that some provisions in the Bill regarding the protection of healthcare professionals have been weakened. It is useful for doctors to know that an apology cannot be used as an admission of negligence. We understand the rational that this may mitigate the fear of recrimination, which can stifle an open approach to errors, but would be concerned that legislation will not provide the requisite cultural change within the workforce. A conversation with a patient after an error is one of the most difficult a doctor can face, but a natural apology and truthful
discussion about what happened plays an important part in helping the patient to heal and move on.

Ultimately we believe that a cultural change within healthcare is needed. A culture where the norm is for doctors to feel able to admit errors, apologise, and learn from mistakes. We need an environment where staff are trained and supported to be open about mistakes and to learn from them, and where senior clinicians lead by example. We welcome a wider discussion on how this environment could best be achieved and stand ready to do our part.

We are keen to work with NHS Scotland in the future on issues such as this to assist in improving patient care and safety by supporting our members and the profession. Improved safety will ultimately help reduce errors and will help reduce complaints and claims in the long-term, which will be beneficial to all.