Mid-Staffordshire Hospital and the Francis Report:
What does Psychology have to offer? [1]

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The Mid-Staffs Hospital scandal and the resultant Francis Public Inquiry had 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 10 salient issues – 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, the implementation of intentions and psychological aspects of patient safety.

Poor care in relation the Mid-Staffordshire Foundation NHS Trust is reputed to have been associated with a number of avoidable deaths of patients. Five investigations in all were set up into the Trust. The recent Public Inquiry 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 4-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 to the report (Department of Health, 2013) and it also set up a number of further inquiries to bring about improvements to the NHS. The Health Select Committee of the House of Commons also produced its own response to the Francis Report (House of Commons, 2013). Many articles and editorials were written on matters raised by the recent Francis Report. This article considers what Psychology as a discipline 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. There is a wider picture where Psychology can contribute, one that deals with issues such as error, systems failure and building system safety, but the focus of this article is on issues relating to the Mid-Staffordshire hospital and the Francis Report.

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1. Why inhumane behaviour occurs

Francis Report, Executive Summary, p. 8 –

As a result, it is clear that not just the Trust's Board but 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 that should never be tolerated in any hospital.

Francis Report, Executive Summary, p. 25 –

Large numbers of patients were left unprotected, exposed to risk, and subjected to quite unacceptable risks of harm and indignity over a period of years.

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 in some instances 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 behavior, such as ignoring distress and harm to an individual, although it is worth bearing in mind that none of the studies included samples where nurses were caring for vulnerable patients. One particular effect is the 'bystander effect', in which individuals simply stand by and do not offer to help a victim in distress. This effect has been studied in depth (Fischer *et al*, 2011), and has been found to depend on a number of variables, such as how many bystanders are present (the more who are present, the 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 over-ride explicitly enounced value systems and beliefs, such that a person in great distress is ignored (Darley and Batson, 1973), something that could find parallels in busy clinical settings. A second set of relevant studies include those carried out by Zimbardo in the famous Stanford prison experiments (Haney and Zimbardo, 1998), where those who were in put in charge of prisoners would subject them to inhumane treatment, treatment that seemed to transcend all moral boundaries. Relevant issues are discussed by Miller (2011) and by Haslam and Reicher (2012). In Mid-Staffordshire, neglect rather than the promulgation of specific acts of violence characterized the behavior 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. A third set of studies relates to the Asch conformity experiments, first carried out by Solomon Asch in 1951 and replicated many times (Bond and Smith, 1996). The prototypical study showed how an individual can be pressurised by confederates to agree with others into making an erroneous judgment in tasks such as simply noting whether a line is the same length as three just-seen lines. Conforming to such 'group-think' illustrated how difficult it can be to avoid giving in to social pressures and to avoid going along with prevailing opinions, however erroneous they may be. Ballatt and Campling (2011) have discussed how these observations relate to what is seen in healthcare settings. Trevino et al. (2014) have provided a helpful overview of the role of cognitive, affective and moral factors in the production of unethical behavior in organizations.

2. The nature of moral dilemmas

(Francis Report, Volume 1, p. 665) –

Mr Poynor [then chief executive of East Staffordshire PCT] was concerned at the Trust's approach to the financing of the necessary nursing staff. He perceived that the Trust was expected to make a surplus for the year of £1.6 million, but that it appeared unable to fund sufficient staff for the wards. He told the Inquiry that he had a heated discussion with Mr Yeates [then chief executive of Mid-Staffordshire NHS Foundation Trust] whose position was that the Trust had to meet Monitor targets. Mr Poynor thought it was morally wrong to put targets of that sort ahead of the nursing needs of patients:

'This is when the impact of Foundation Trust status really hit me and I told Martin that the approach they were adopting was morally wrong … I think it was at this point that the business environment at the Trust and the quality of care versus the financial regime really came together for me.

In his commentary on professionalism in medicine, Hafferty (2006) has proposed that "medicine is a moral community, the practice of medicine a moral undertaking, and professionalism a moral commitment" (p. 2152). Chervenak and McCullogh (2001) have noted the importance of moral virtues such as self-effacement, self-sacrifice, compassion and integrity in healthcare settings.

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 and relevant cognitive perspectives have been clearly 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, Young and Greene, 2010). 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? Studies of moral judgment in conflicting settings have highlighted the role of feelings that are aroused in a morally-challenging setting, the role of social norms and the role of core values. 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. Elsewhere, I have pointed to the role that Gandhian values can play in helping to resolve such dilemmas (Kapur, 2010).

3. The generation of clinical excellence

Francis Report, Volume 3, p. 1382 –

Sir Donald Irvine observed a professional culture at the Mayo Clinic, Rochester, USA which was: … patient centred and driven by the pursuit of excellence. It is professionalism which encourages maximum performance, rather than reliance only on regulatory compliance … At Mayo, if a doctor or nurse does not embrace the culture, and reflect it in their practice, sooner than later they will go. Persistent underperformance has direct consequences for the individual.

Psychology as a discipline can help to unpack some of the key components of clinical excellence. In earlier articles, I have outlined how components of excellence can be delineated in the medical field (Kapur, 2009), and in the field of applied psychology (Kapur and Wilson, 2010). In those papers, I outlined 15 ‘pillars’ of clinical excellence, which could be grouped into three domains – technical, personal and future-based. Howard Gardner, the renowned Harvard psychologist, has done pioneering work in his ‘Good Work project’, where he has also tried to unpick what it means to perform to a high standard, and at the same time adhere to clear moral principles (Gardner, 2007). Good work is defined 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 can have a key role in ensuring that this occurs. Professional bodies such as Royal Colleges have in the past carried out invited reviews of hospitals. Inspections by professional bodies should be put back in place, and they should be focused on patient care rather than training. Within the framework of the new

hospital inspections system, the *British Psychological Society* could have a key role in inspections for services relating to clinical and health psychology so as to help ensure high standards of excellence. Experts from such bodies are more likely to detect failures such as refusal or inability to adhere to professional standards and guidelines. These inspections from professional bodies could complement those by health care regulators, and would provide an added safeguard against substandard clinical practice and management failings. Implicit in most inspections is a form of peer review, something that the Francis Report specifically supported – *The creation of a caring culture would be greatly assisted if all those involved in the provision of healthcare are prepared to learn lessons from others and to offer up their own practices for peer review. Whilst peer review will have a specific relevance in cases of practitioners where there may be concerns about substandard performance, it has a far more fundamental role in changing behaviour to ensure a consistent and caring culture throughout the healthcare services* (Francis Report, Executive Summary, 2013, p. 76.).

4. The discovery of truth in legal and quasi-legal settings

Francis Report, Executive Summary, p. 7 –
In the end, 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.

Francis Report, Executive Summary, p. 23 –
It would have been surprising if I had been able to agree with the recollections or views of every witness, but I am satisfied that without exception they were all doing their honest best to tell me the truth as they saw it.

The Francis Public Inquiry interviewed over 160 witnesses, some of whom tried to recollect events which took place up to seven years previously. There is a burgeoning literature on topics such as 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. Some of this research has been well summarised by Lillenfeld 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.

Although the Francis Inquiry was not a specific legal exercise with the aim of attributing blame and bringing individuals to justice, the inquiry did have 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 (British Psychological Society, 2008; Schacter and Loftus, 2013; Vrij and Granhag, 2012). These facts include – a recognition that 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; deliberately telling lies involves additional cognitive effort, and this may be evident after further increasing cognitive load on an individual by means such as asking unanticipated questions (e.g. events to be recalled in reverse order, asking for eye contact to be maintained during narration).

5. Communication and its breakdown

Francis Report, Executive Summary, p. 64 –

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

Francis Report, Executive Summary, p. 65 –

The combination of these "regulatory gaps", lack of effective communication and constant reorganisation led to a systemic culture where organisations took inappropriate comfort from assurances given either by the Trust itself or from action taken by other regulatory organisations.

Coiera (2009) and Cosby (2009) have outlined the main types of communication failures in healthcare settings and also ways in which these can be improved. Errors in communication are more likely to occur where there are – distractions and interruptions, situations of high information load, time pressure and multi-tasking; where there is ambiguity or duplication of roles; and where there are authority gradients. Although communication in healthcare settings has traditionally been focused on these types of communication between health professionals or

doctor-patient communication (e.g. Taran, 2010), there is also a recognition that failures in communication within and between organizations, such as those so clearly outlined by the Francis Report, are both widespread and amenable to analysis using tools and concepts provided by Psychology. Thus, Dayton and Henriksen (2007) refer to a number of factors that can 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 reduce ambiguity, enhance clarity and send unequivocal signals that a particular course of action is required. Communication audits, such as those described by Hargie and Tourish, 1996), may show how failures in effective communication emanate from a psychological culture where there tends to be suppression of bad news, where those 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' may predominate, and where the reputation of an employer is considered more important than patient safety concerns. Stereotyping may also contribute to poor communication between clinicians and managers (Klopper-Kes et al., 2009).

6. The psychology of culture

Francis Report, Volume 3, Chapter 20 on Culture, Key Themes, p. 1357 –
The challenge for the system is to identify a means of ensuring a common culture of positive values and methods prevailing over, and driving out, negative values and methods.
Aspects of a negative culture have emerged at all levels of the NHS system. These include: a lack of consideration of risks to patients, defensiveness, looking inwards not outwards, secrecy, misplaced assumptions of trust, acceptance of poor standards and, above all, a failure to put the patient first in everything done.

The term 'culture' has traditionally been applied to countries rather than to organizations, but from the early 1980s there was a growing consensus that organizations could also be understood by taking into account cultural concepts such as language, ideology, beliefs, myths and rituals. 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 organization. Schneider et al. (2013) have provided a helpful review of many of relevant studies. They note the existence of several tools to measure culture in organizations, such as the Organizational Culture Inventory, the Denison Organizational Culture Survey and

the Organizational Culture Profile. The importance of the behaviour of leaders has been highlighted in directly articulating values and policies, and taking indirect measures to support them. Schneider et al. (2013) note that a particular framework, the Competing Values Framework, has been found to be useful in distinguishing various types of culture and association behaviours. This framework contrasts and combines Flexibility versus Stability, and an Internal versus and External focus. This can then result in four sets of cultures, each with a distinct set of values, beliefs, behaviours and criteria for effectiveness. The four cultures each have a distinctive focus – human affiliation, change, achievement and stability. The idea that particular values, beliefs and behaviours will contribute to certain culture features, such as wellbeing or innovation, opens up the possibility of planned interventions. 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 organizations. As Dixon-Woods et al. (2013) have noted, how staff are managed and treated is an important component of culture in organizations such as the NHS. 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).

7. Target-driven behaviour

Francis Report, Executive Summary, p. 3 –

Above all, it failed to tackle an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities. This failure was in part the consequence of allowing a focus on reaching national access targets, achieving financial balance and seeking foundation trust status to be at the cost of delivering acceptable standards of care.

Francis Report, Executive Summary, p. 65 –

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

In general, while recognizing 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 however tend to be more beneficial (Mant, 2001; Nuckols et al., 2009; Gross, 2012; McClimans and 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.

8. Corporate memory

Francis Report, Executive Summary, p. 4 –
A failure to appreciate until recently the risk of disruptive loss of corporate memory and focus resulting from repeated, multi-level reorganisation.

Francis Report, Executive Summary, p. 98. Recommendation 126 –
Preserve corporate memory

The concept of memory has attracted scholars and public figures from practically every walk of life, including artists, scientists, philosophers and historians (e.g. Wood and Byatt, 2008; Fara and Patterson, 1998; Warnock, 1987). In parallel, the concept of forgetting has also attracted scholars outside the field of human memory (e.g. Mayer-Schonberger, 2009). The study of organizational memory / corporate memory and corporate amnesia has gained attention in recent years (Kransdorff, 1998; Lahaie, 2005). This research has addressed questions such as – how can key sets of knowledge be preserved in organizations, especially those with a high turnover; which representations of knowledge and experience should be formalised and used; how best to integrate such knowledge and experience with current and future needs of an organization; how to motivate key former employees to pass on knowledge and experience, and

how to similarly motivate key current and future individuals in an organization to avail 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. The reported 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 in the report – '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' (2000, pp. 29-30). Smith and Toft (2005) have highlighted ways in which the behaviour of managers may be key in ensuring that this type of effective learning takes place. The science of human memory has taught us how prone to failure memory systems may be, how individuals may not be aware of distorted memory for past events, how individuals can in fact be very confident and have fixed beliefs in false memories, how much of memory is tacit, implicit and unconscious yet also quite influential for behaviour, how some conditions for learning may lead to more effective retention than others, and how certain forms of repeated practice and repeated retrieval may help to sustain long-term memory consolidation (Schacter et al., 2011; Baddeley, Eysenck and Anderson, 2009). There would thus appear to be ample scope for applying such concepts to similar phenomena that occur in organizations such as hospitals to ensure that memory and learning, and where necessary forgetting, takes place in the best interests of patient care.

A number of commentators have compared the safety culture in aviation with the relative absence of a similar culture in the NHS. Captain Chesley Sullenberger, who safely brought down his plane in an emergency in the Hudson River, New York in January 2009 when it hit a flock of birds, has commented – *We have purchased at great cost lessons literally bought with blood that we have to preserve as institutional knowledge and pass on to succeeding generations. We cannot have the moral failure of forgetting those lessons and have to relearn them.* These words apply equally to the NHS, and to learning lessons from both clinical and management failures. In the words of Professor Liam Donaldson, the former Chief Medical Officer in the UK Department of Health – *To err is human, to cover up is unforgivable and to fail to learn lessons is inexcusable.*

9. The implementation of intentions

Francis Report, Executive Summary, p. 18 –

The experience of many previous inquiries is that, following the initial courtesy of a welcome and an indication that its recommendations will be accepted or viewed favourably, progress in implementation becomes slow or non-existent.

Francis Report, Executive Summary, p. 62 –
The former Secretary of State for Health, the Rt Hon Andy Burnham MP, accepted that there was often a disconnect between the policy decisions being made and their practical implementation.

The truism 'actions speak louder than words' is often heard in relation to inquiries such as those set up after the Mid-Staffordshire Hospital scandal. Many of the recommendations of the Mid-Staffordshire Inquiry Report echoed those from the Bristol Heart Inquiry, and there is an understandable feeling that generating words in voluminous reports is only part of the solution to the problems which are identified. Many good intentions have been documented, but how to ensure their effective implementation is an issue that seems to cross the healthcare divide (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 when considering the problems of implementation 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 the heightening of risk appraisals and that this effect was stronger when response-efficacy and self-efficacy were enhanced or response costs were reduced.

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, he/she may retain this information but forget to carry it out, they may lack motivation in carrying out the intention, they may be distracted or distressed by other events, circumstances may have changed and it may now be too costly to implement the intention, and other more important or conflicting intentions may have cropped up in the meantime. Most of these obstacles to intention implementation find parallels in the behaviour of organizations. Recent studies have shown that such problems in the implementation of intentions can sometimes be overcome by techniques such as 'if-then' plans, that is to specify in advance particular situations where the intention could be carried out, and picturing such implementation taking place. Thus, if an intention is to stop off at a cashpoint on

the way home from work, a particular cashpoint would be specified, say one at a petrol station on the way home, this would be clearly pictured. The idea is to try and forge a strong link between a pre-identified situation and a pre-prepared response.

In the case of intention to vote, Nickerson and Rogers (2010) found that asking voters to specify their intention to vote resulted in greater turn out – thus, asking voters what time they would vote, where they would be coming from, and what they would be doing beforehand increased the likelihood of the person actually voting. Fennis et al. (2011) reported that specifying implementation situations, and presenting vivid information relating to critical cues and appropriate behavioural responses, changed the purchasing behaviour of individuals. This was in the context of using a product guide to help persuade the individual to purchase fair-trade items. Specific situational cues were introduced to help in implementing the intention – e.g. at home when composing the shopping list, at the supermarket while putting products in a shopping basket, and at the cash-till when checking the selected products while waiting in line. Vivid information was in the form of a narrative where a shopper expressed major concerns in relation to fair-trade, and then used the product guide. Individuals may differ in their ability to implement intentions – Allan et al. (2011) found that it was those individuals with weak executive control who failed to implement intentions relating to healthy eating.

10. Psychological aspects of patient safety

Francis Report, Executive Summary, p. 60 –

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

Francis Report, Executive Summary, p. 86, Recommendation 12 –

Reporting of incidents of concern relevant to patient safety, compliance with fundamental standards or some higher requirement of the employer needs to be not only encouraged but insisted upon.

The discipline of 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 have authored or edited books that have dealt with patient safety issues (Reason, 2008; Vincent, 2010; Croskerry et al., 2009). Some of the applications of Psychology as a discipline can be found in research and publications under the rubric of ‘human factors research’ (Flin et al., 2013) see 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, the psychology of an organization and its culture, cognitive biases that can lead to medical misdiagnosis (Gaber et al., 2012), cognitive biases that can lead to 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, psychological aspects of bullying and whistleblowing, environmental design and patient safety, the design of equipment and labels, safe medication delivery, preventing 'Never Events' (very serious adverse clinical events), carrying out a 'psychological post-mortem' of such events, the psychology of compliance with rules and standards, and psychological aspects of implementation of such guidance and other patient safety measures. With so many possible applications of Psychology, there would seem to be a strong case for a 'patient safety psychologist' to be appointed in every major teaching hospital.

Conclusions

It is over 40 years since George Miller delivered his memorable and moving Presidential address to the American Psychological Association (APA), 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, and has contributed to at least one Nobel Prize (Kahneman, 2003) and to an influence at the heart of government (www.gov.uk/government/organisations/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. We have a duty, not only to patients but also to our profession, to make sure that this situation is rectified. 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, taking up advisory roles in regulatory and other healthcare bodies, and

working directly with Trusts on the provision of psychology services or indirectly by having a place on the board of Governors.

Psychology as a discipline now has the knowledge and the tools to tackle real-life problems, such as those highlighted by the Francis Report into the Mid-Staffordshire scandal. 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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Additional resources relating to this article are available at – www.abetternhs.com

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