Should trainees be the 'eyes and the ears' of both good and bad practice in hospitals?

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ABSTRACT

A strong voice is critical for junior doctors to report witnessed poor care delivery. Current incident reporting systems foster a sense of vulnerability and under-reporting of events. Provision of adequate incident report feedback and dedicated time to undertake audit and quality improvement projects are required to facilitate discussion and learning from errors that take place in the workplace. A independent whistleblowing centre specific to healthcare is required to reduce the likelihood of future inquiries into poor patient care.

KEYWORDS: Medical leadership, education and training, culture, medical error, whistleblowing

Introduction

If patient safety is a car, then trainees have long been the gauges, indicators and warning lights on the dashboard. Trainees are well placed to highlight the good and the bad of medical practice due to the ward-based nature of their work. There is no doubt that that their role as advocates for patient care is appropriate. However, the recent acknowledgement of trainees being 'eyes and ears' of patient safety has brought into focus that they are also the 'voice', and currently a quiet one.

The role of doctors in raising concerns is a professional duty set out by the GMC.[1] NHS trusts have developed and implemented incident reporting systems over decades. However, the focus has been on the individual, rather than on the system and organisational culture. Evidence shows that events are under-reported in spite of improved reporting systems.[2] Knowledge of where and how to relay concerns has been highlighted as an obstacle at a 2013 GMC conference on medical professionalism. This is in spite of guidance released by the GMC and various medical royal colleges, and the introduction of the requirement for trainees to highlight concerns in the annual GMC survey, prior to the Francis and Keogh reports. A national meeting of foundation doctors in 2012 highlighted the drawback to the GMC survey, as with many reporting systems – a lack of anonymity.

The need for anonymity is borne out of fear of retribution. This fear was highlighted as the most significant barrier to raising concerns at the GMC conference, and is corroborated by a BMA survey finding that doctors had been told speaking out could negatively affect their employment.[3] Many doctors, after using internal routes of raising concerns, have felt a need to go public. Some have been removed from their posts and have experienced difficulty in obtaining employment thereafter.[4] Some of these doctors are consultants, who are perceived to have more powerful voices and greater job security than trainees, thus perpetuating the sense of vulnerability by juniors when raising concerns.

The outcome of these problems is a feeling of futility. This outlook is depicted by the following passage from a group of prominent whistleblowers:

> *Whistleblowing in the NHS is a traumatic undertaking and generally not to be recommended. There is scant evidence for ethically sound disclosures, by morally and legally justified professionals, designed to improve outcomes for patients, delivering the requisite changes without repercussions.*[5]

In spite of these issues, trainees want to know and learn from errors that have taken place in the workplace to improve patient safety.[6] Trainees also want to know and learn from good practice. The 'voice' of doctors is in desperate need of amplifying.

Therefore I propose the following measures.

First, NHS Trusts must provide feedback for every submitted incident report. Feedback is recognised as key part of an effective incident reporting cycle and provides validation for the author.[7] Many of the current electronic systems merely provide an automated acknowledgement of receipt and a subsequent deafening silence. Feedback will engage trainees and ensure that future incidents and potential 'near misses' will actually be reported when they occur.

Second, trainees regularly undertake audits and quality improvement projects, but the information is infrequently used to make sustained progress. Rotation-based work by trainees between departments and hospitals provides exposure to different ways of delivering care – providing fertile ground for innovative service improvements. Clinical leads and audit teams must be seen to advance completed projects once the main 'change agent' (the trainee) has left the department.

Third, trainees carrying out projects related to patient safety should be given protected time for these activities which could be validated at their annual review of competence progression (ARCP). A system for protected time and appraisal is already in

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place for clinical academic trainees. Universities and academic clinical networks pride themselves on their research; why shouldn't NHS trusts and royal colleges also take pride in the projects that are produced by trainees and provide additional support to facilitate this work?

Finally, continuous professional development is a requirement of medical training. Organisations such as The Network and the Faculty of Medical Leadership and Management provide audit and quality improvement competitions and, along with the *BMJ Quality Improvement* journal, provide channels for the dissemination of good practice. If healthcare aspires to a truly open culture, there must be frankness and transparency when discussing shortcomings. Where are the channels for discussing substandard practice? A UK-based journal for medical error would be enlightening and educational reading for doctors and managers alike.

There are also societal factors outside healthcare that need tackling. It is far more palatable for society to blame a rogue individual than a 'faceless' system or organisation for a medical error, and it provides a compelling story for print media. Furthermore, there are a growing number of medical negligence claims and subsequent payments for damages.[8]

Robert Francis stated that a 'fundamental change' in healthcare culture is needed. The aviation industry underwent a significant shift in organisational culture following plane crashes during the 1970s. Aviation is now widely used as an example of an open and honest culture, and it has an ethos of rewarding those who expose safety issues. In healthcare, inquiries related to patient safety have occurred for decades. In 1967 a member of staff at Ely Hospital in Cardiff made allegations of misconduct by other employees. The following was stated in the report from the inquiry:

> *The system for the investigation… has not proved capable of reconciling the diverse objectives that have to be achieved. XY not unreasonably felt that he had to take his complaint outside 'the system'.*[9]

Following the Kennedy inquiry into paediatric cardiac surgery at Bristol, an editorial in the *British Medical Journal* stated, 'British medicine will be transformed by the Bristol case'.[10] Publicly funded healthcare will have failures. However, the fact that the themes within the Francis report are the same as those highlighted in previous inquiries suggests that not only has a transformational change been lacking, but we are no further forward than forty years ago.

The measures proposed earlier require a change in organisational culture to succeed. Organisational culture is dynamic and complex, and a variety of factors need to be considered before instigating top-down change.[11] Unfortunately, in comparison to other professions, healthcare has less academic focus on organisation, systems and safety management. This may be a reflection of the medical training curriculum and the perception that this is domain of managers. The outcome is that when good practice is noted there is often little thought as to what makes it good; simply acceptance that the system and associated behaviour is as it should be.

While attempting to change the culture in healthcare, there are two further actions needed to create something lasting:

- Involve every trainee in an open NHS-wide consultation about culture. This, rather than using an advisory board of a handful of representatives, will ignite discussion the Mess and hopefully create the initiative for some trainees to become active in the search for solutions.
- In the meantime, initiate a feasibility study into an independent whistleblowing centre specific to healthcare. There are already systems for protected disclosure and associated legislation; however, trainees do not feel safe and desire the option of anonymity.

The last action will be a bitter pill for healthcare organisations to swallow, but something radical is needed to break from the recurring themes of various inquiries. Difficult actions are needed to encourage all healthcare workers to speak up. NHS trusts and royal colleges need to theme their interventions to support trainees in doing so. A health system with a continuous awareness of the views of its employees will be able to adapt and learn from good and bad practice – and be far better off for it. ■

Note

This essay was the winning entry in the Royal College of Physicians' Teale essay prize for trainees 2014.

References

1 General Medical Council. *Regulating doctors, ensuring good medical practice. Duty to raise concerns.* Available online at www.gmc-uk.org/guidance/ethical_guidance/11864.asp.
2 Mahajan RP. Critical incident reporting and learning. *Br J Anaesth* 2010;105:69–75.
3 BMA Health Policy and Economic Research Unit. *BMA survey: speaking up for patients – final report.* BMA, 2009.
4 A Better NHS. *Stories of NHS staff.* www.ajustnhs.com/case-histories-of-victimised-nhsstaff/
5 Bolsin S, Pal R, Wilmshurst P, Pena M. Whistleblowing and patient safety: the patient's or the profession's interests at stake? *J R Soc Med* 2011;104:278–82.
6 Garbutt J, Waterman AD, Kapp JM *et al.* Lost opportunities: how physicians communicate about medical errors. *Health Affairs* 2008;27:246–55.
7 Benn J, Koutantji M, Wallace L *et al.* Feedback from incident reporting: information and action to improve patient safety. *Qual Saf Health Care* 2009;18:11–2.
8 Donnelly L. 'Jaw-dropping' rise in NHS claims after scandals. *The Telegraph*, 19 Jul 2013. Available online at www.telegraph.co.uk/health/healthnews/10189204/Jaw-dropping-rise-in-NHS-claims-after-scandals.html [Accessed 15 December 2014].
9 *Report of the committee of inquiry into allegations of ill-treatment of patients and other irregularities at the Ely Hospital, Cardiff.* HMSO, 1969. Available online at www.sochealth.co.uk/national-health-service/democracy-involvement-and-accountability-in-health/complaints-regulation-and-enquries/report-of-the-committee-of-inquiry-into-allegations-of-ill-treatment-of-patients-and-other-irregularities-at-the-ely-hospital-cardiff-1969/ [Accessed 15 December 2014].
10 Smith R. All changed, changed utterly. *BMJ* 1998;316:1917–18.
11 Davies HT, Mannion R. Will prescriptions for cultural change improve the NHS? *BMJ* 2013;346:f1305.

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