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

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OVERVIEW

**Editorial comment on 'Should trainees be the "eyes and the ears" of both good and bad practice in hospitals?' by Jason Kwasi Sarfo-Annin.**

Jason Sarfo-Annin should be congratulated for his Teale Essay Prize-winning paper, published in this issue, which is an engaging attempt to highlight the potential of trainees as agents of change in a brave new world of quality improvement (QI). He makes a number of very valid observations regarding the barriers which trainees encounter and proposes solutions which, at the very least, challenge the medical establishment to offer alternatives. As notable as the explicit content of the essay is the barely concealed frustration of a trainee aware of the many benefits of a health service reorganised to deliver patient-centred and safe care, knowing that not only the system, but also his older colleagues, have repeatedly failed to learn and respond. He is correct to suggest that peripatetic trainees working in ward-based roles are in a unique position, first, to be able to judge their new institutions with a 'fresh set of eyes', second, to compare practice between the organisations through which they have rotated and, third, to cross-pollinate innovation. It is also reasonable to argue that trainees with safety concerns may not feel empowered to raise these in the first place, let alone speak loudly enough to have their voices heard, in part because of fears of jeopardising their own careers.

The initial focus of the essay is on whistleblowing. At first this seems incongruous – surely this is a last resort to be used once other avenues have been explored and exhausted; a sign of failure and not the most effective strategy for trainees interested in using their eyes and ears in the service of clinical excellence. However, the author has recognised that many major inquiries over several decades have been initiated in response to whistleblowing, which could lead to the perception that this is the only way to achieve change; in this he may be unconsciously promoting the development of an independent centre to receive such concerns. Whether this will emerge as a recommendation of Sir Robert Francis QC when he completes his review *Whistleblowing in the NHS* remains to be seen.

Dr Sarfo-Annin quickly moves on to a series of concrete proposals intended to promote the effectiveness of trainees as the eyes and ears of the NHS. The first proposal suggests reform of safety incident reporting and mandates detailed feedback for every incident to encourage yet further reporting in a virtuous circle. Certainly this should be a standard for most incidents,[1] but how should organisations respond formally to minor events, for which reporting should still be encouraged but for which a written report may be unnecessarily time-consuming? Perhaps a dashboard of all incidents should be posted to an organisation's intranet so that trends in minor events may be revealed. A second suggestion, to launch a journal for medical error to promote transparency and learning, might not find many organisations willing to submit papers given that the author has recognised a tendency for such cases to develop into 'compelling stories for print media'. Since 'societal change' is unlikely in the short term, the mandatory submission of incident reports to a national online database is an alternative which could foster system-wide learning and encourage further reporting.[2]

Dr Sarfo-Annin's calls for organisational change also reflect wider debate. As discussed in the last edition of the FHJ Forum, it is essential that education in QI should involve all healthcare professionals from the outset of their training, rather than only an isolated cadre of enthusiasts. Training fellowships – such as those hosted by the Royal College of Physicians, the National Institute for Health Research and the Faculty of Medical Leadership and Management – must just be the start of widespread training dedicated to QI.[3] While many, including employers, will contest the suggestion that QI should be a protected activity for trainees and their accredited colleagues, it would be a clear sign that the health service was beginning to understand the level of commitment required for fundamental change to be realised.

The essay suggests the trainee could be the 'main' agent of changes in practice, a concept open to challenge. No organisation dedicated to sustainable improvement can depend on trainees who may be in-house for as little as four months and usually for a maximum of one year. The challenge for healthcare organisations is how to capture and coordinate all of the passion and insight trainees can bring to QI and how to release their latent energy most productively in tandem with

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their permanent colleagues. It would have strengthened the piece if there had been some discussion of how trainees might fit into rotational roles within improvement teams rather than promoting themselves as single actors.

The issues raised in the manuscript are of real value and importance: how we encourage early career doctors to become engaged and respond to the observations they make to generate sustained service improvement will require leadership from trainees, acceptance of their role from senior colleagues and parent organisations, and team working and a sense of corporate responsibility from all three. Only in this way will improvement occur independently of whistleblowing and not only because of it. ■

## References


1 Mahajan RP. Critical incident reporting and learning. *Br J Anaesth* 2010;105:69–75.
2 Denning MW. Medical incident reporting needs a global online system. *BMJ* 2013;347:f6166.
3 Melley D. Health and safety: effecting a cultural change? *Future Hosp J*, 2014;1:123–5.