First Do No Harm – Whistle-Blowing is Not a Bad Word

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In many professions when a mistake is recognized, it is documented so that others are able to learn and take measures to prevent the mistake from occurring again. In the field of medicine, which has been given the responsibility to protect and preserve life and one in which healthcare professions hold the Hippocratic oath in the highest regard, "first do no harm," the mantra seems to be different: overlook mistakes and allow them to persist in long-term practice. There are few laws mandating how medical errors should be reported and third parties such as the College of Physicians and Surgeons (CPSO) and Canadian Medical Protective Association (CMPA) rely too heavily on institutions to set guidelines on medical error reporting. In the healthcare field, reporting medical errors is uncommon and even discouraged. Reporting medical errors carries a high risk as it has the potential to affect reporters' professional careers and personal health. In addition to the lack of professional support provided to individuals seeking to report mistakes, there is minimal infrastructure to help guide them through the process. In the end, mistakes remain a secret. Neither the professional nor the profession learns from the mistakes, the observer is cemented in ethical turmoil, and patients are left to face the medical consequences.

Modern medicine often emphasizes the significance of accountability, ethical action, and systematic processes to secure the best outcomes for patients. Despite this, it overlooks many mistakes that are often under-reported, leaving patients to suffer while weakening the very pillars that the healthcare system stands on.

The Importance of Medical Errors

Healthcare is complex and involves numerous risks for both professionals and patients. While healthcare systems have taken multiple approaches to ensure patient safety, the rates of medical errors resulting in adverse events and premature deaths are extremely high. In fact, some have estimated medical errors to be one of the leading causes of death in the United States, and several healthcare professionals have labeled their continued presence in the healthcare field a modern "epidemic."[1] According to the Institute of Medicine, it is estimated that 44,000 to 98,000 Americans die each year as a result of medical errors, which exceeds the number of deaths as a result of both accidents and breast cancer.[1] Furthermore, the Canadian Adverse Events Study reported 7.5% of patients admitted to hospitals experience an adverse event, with 36.9% of those errors being highly preventable.[2] It has been estimated that the total cost of these errors ranges from $17 to $29 billion per year.[1] Given the high rates of non-reporting, it is likely that the actual number of adverse events and premature deaths associated with medical errors is significantly higher, burdening the healthcare system ethically and financially.

Issues Related to Reporting Medical Errors

Medical errors are common in healthcare and when they occur, they are usually evident to colleagues. Despite this, the majority of errors often remain under-reported. In a cross-sectional survey, 50% of respondents admitted to witnessing a colleague committing a medical error, but less than 10% confronted their coworker.[3] It was also reported that one in five doctors had experienced harm because of a healthcare professional's actions in their workplace.[3]

Given that many medical errors are recognized and are preventable, why are medical professionals so reluctant to report errors? Protection of those who speak out is a major issue. While laws have made it mandatory for professionals to raise concerns, the law does not provide full protection for reporters. Anonymous error reporting is often not offered by the workplace, resulting in fear of retaliation. Indeed, there have been many reported cases where whistleblowers have been taken to court for defamation lawsuits, often resulting in personal and professional losses.[4,5] There are no financial compensation and emotional support for those who report medical errors, leaving them defenseless and at a loss.

Furthermore, healthcare professionals train and work as part of a team, with a mutual understanding that clinical decisions must take into consideration the best interests of the patient. Placed in a position where they feel an immoral or unjustifiable approach is being taken to patient care, these healthcare professionals are likely to be conflicted between a sense of responsibility towards the patient and a sense of loyalty to the decisions of their team. Moreover, there may be a fear of gaining a negative reputation and provoking an environment of hostility. In one cross-sectional study, nurses who reported medical errors were stripped of respect, framed as being deviant, and placed in compromising circumstances, often encountering hostility from their colleagues. Many of these nurses reported suffering from emotional stress that had compromised their psychological health over time, referring to nightmares,

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anxiety, panic attacks, and depression.[6] These emotional obstacles and stresses make confrontation regarding errors even more difficult to address.

In addition to emotional stresses, the consequences of reporting medical errors can be financially costly. In a recently published case in the *British Medical Journal*, Dr. Edwin Jesudason, a pediatric surgeon, took a lawsuit to High Court in the United Kingdom when he reported cases of staff bullying and unsafe surgery to the hospital administration.[5] He eventually left the case when he realized that he was not likely to return to the hospital for work. Further to his career loss, Dr. Jesudason was given a bill of £100,000 for legal fees. Many cases follow this pattern, leaving the reporter in a compromising position, and discouraging further medical error reporting. As a result, those who stand up against patient maltreatment often face financial, employment, and legal repercussions, and the judicial and healthcare systems fail to protect those who hold ethical principles to the highest regard.

Part of what contributes to the hostility and fear amongst those aware of medical errors is the lack of support from administrations and professional healthcare colleges. While those who report often do so on the basis of their professional integrity and sense of personal morality, individuals have indicated that establishments will place their own interests before interests of reporters and the patients.[4,5] As a result of this sense of insecurity and lack of investment from upper-level management, many reported cases are silenced and a significant number of cases remain unexposed to authorities.[6] For example, in a reported 2009 case in the *British Medical Journal*, Dr. Bousfield, a senior consultant gynecologist, raised serious concerns about insufficient facilities and staff for surgery.[4] After a meeting with the Board of Directors at the hospital, he was mailed a letter with a serious threat of dismissal. While reporters often have difficulty reporting problems to upper-level administrative authorities, numerous healthcare professionals have also experienced difficulty sharing their perspectives with colleagues: 56% of nurses were reported to have issues communicating with physicians.[7]

Medical error reporting is not only hindered by the inherent dangers it carries for reporters, but also by the lack of formal reporting procedures. Provincial medical administrative bodies and institutions often identify what constitutes maltreatment for the patient, but reporting guidelines are usually unclear. In Ontario, while the CPSO has provided information on disclosure of harm, they have not provided information on when and how disclosure should be made.[8] They have suggested to disclose harm "as soon as reasonably possible" and provided a few "tips" on how disclosure should be done (e.g. offering an apology, providing a short explanation, etc.), but their guidelines remain vague and focus on the perpetrator, without providing guidance to the observer. Similarly, the CMPA has not set out steps on medical error reporting.[9] CMPA states that these policies should be set by the institutions themselves and if not in place, CMPA highly encourages the institutions to develop them.[9] However, reliance on the institutions to develop appropriate guidance results in the aforementioned outlined problems. Moreover, only a minority of healthcare students and trainees receive training in medical error reporting.[10] The lack of infrastructure to help assist reporters leaves many confused with the process and frustrated on how to approach errors, which is likely to influence the number of cases that remain unreported.

Improvements to Reporting Medical Errors

Often, the failure to report medical errors has focused on the individual. Why did *he* not report the mistake? Why did *she* not stop the nurse from injecting the wrong dose of medication? On the contrary, medical reporting failures need to be addressed from the root of the issue: our current system does little to address under-reporting over ethical considerations. The interests of patients need to be emphasized and open discussions on medical errors need to be encouraged in educational and professional settings. It is important that the curriculum include discussion and practical application for identifying and addressing errors. It is also important that consistent infrastructure for medical error reporting is put in place to improve the overall quality of patient care. While individuals remain accountable for their actions, the system needs to systematically investigate each reported case and identify a process that facilitates the implementation of a revised course of action in order to prevent the same mistake from reoccurring. Similar to crime cases, establishments should also offer anonymity to those who report errors in an effort to protect and support them, and in doing so, promote similar approaches among other healthcare professionals. Greater protection, more support from regulatory bodies, and consistency and clarity in definitions in terms of what constitutes an adverse event or patient harm, are all essential to promote a culture change within the healthcare profession.

In addition, more research is required to understand which system of medical error reporting is most optimal in promoting reporting efforts and addressing adverse events through systemic and procedural improvements. Further research exploring effective methods of incorporating an adequate understanding of the significance and process associated with medical error reporting is also necessary. Government support, investment, and promotion of these solutions are also essential to establishing public recognition of the issue and eliciting a response from the healthcare profession at large.

Conclusion

Many healthcare professionals are likely to feel damned if they do raise concerns regarding medical errors they observe, and damned if they do not. Healthcare professionals encounter many obstacles in reporting medical errors, which leads to a culture of uncertainty over ethical activism. Those who choose to report medical errors often face retaliation and hostility from other colleagues, and are provided minimal support and protection from upper-level administrations, judicial bodies, and workplaces. The focus needs to

shift from blaming individuals for failing to report medical errors to improving the system in order to promote a culture where individuals are encouraged and supported to report errors. The new system needs to be evidence-based in nature, and must gain the support of both political and healthcare-based governing bodies in order to be successfully adopted and implemented consistently. This is an essential step to nurturing an approach that upholds the tradition of placing patient safety to the highest regard and encompasses the message that unifies the healthcare profession: "First do no harm."

References

1. Institute of Medicine. "To err is human: Building a safer health system." Washington DC: National Academy Press; 2000.
2. Baker GR, Norton PG, Flintoft V, Blais R, Brown A, Cox J, Etchells E, Ghali WA, Hebert P, Majumdar SR, O'Beirne M, Palacios-Derflingher L, Reid RJ, Sheps S, Tamblyn R. "The Canadian adverse events study: The incidence of adverse events among hospital patients in Canada." CMAJ: Canadian Medical Association journal =journal de l'Association medicale canadienne. 170 (2004): 1678-1686.
3. David Maxfield JG, Ron McMillan, Kerry Patterson, Al Switzler. "Silence kills [Internet]." Provo: VitalSmarts. 2005. 4 Jan. 2013 http://www.silent-treatmentstudy.com.
4. Gornall J. "The price of silence." British Medical Journal. 339 (2009): b320.
5. Dyer C. "Whistleblower abandons his case and resigns from alder hey children's hospital." British Medical Journal. 345 (2012): e8695.
6. Peters K, Luck L, Hutchinson M, Wilkes L, Andrew S, Jackson D. "The emotional sequelae of whistleblowing: Findings from a qualitative study." Journal of clinical nursing. 20 (2011): 2907-2914.
7. Kim J, An K, Kim MK, et al. "Nurses' perception of error reporting and patient safety culture in Korea." Western Journal of Nursing Research Online. 29 (2007): 1-17.
8. College of Physicians and Surgeons of Ontario. "Disclosure of Harm." Dialogue. 2 (2009): 1-4.
9. Learning from Adverse Events: Fostering a just cultures of safety in Canadian hospitals and health care institutions. Ottawa, ON: Canadian Medical Protective Association; 2009.
10. White A, Gallagher TH, Krauss MJ, Garbutt J, Waterman AD, Dunagan WC, Fraser VJ, Levinson W, Larson EB. "The attitudes and experiences of trainees regarding disclosing medical errors to patients." Acad Med. 83 (2008):250–256.