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RESEARCH ARTICLE

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"Incident Teaching (IT)" Lecture Series – Incorporating Education Surrounding Clinical Incidents and Complaints into Foundation Year 1 (FY1) Doctors' Induction

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ABSTRACT

Patient safety incidents are any unintended or unexpected incidents which potentially could, or did, lead to harm to patients. Incident reports are crucial to improve patients' care and to identify further actions needed to prevent harm. A common view among the FY1 doctors in our local NHS Trust involved a fearful opinion surrounding being involved in clinical incidents. Significant anxiety in those situations prompted the need for a focus on the topic of "clinical incidents" during their induction to the Trust in two consecutive years of 2018 and 2019. A near-peer lecture series was delivered to new FY1 with qualitative pre- and post-lecture series feedbacks. Results from lecture series from two consecutive years showed all FY1 doctors agreed or strongly agreed that they had a good understanding of incidents following the lecture. Compared with their pre-course feedback, there was an increase of 6-fold (2018) and 8-fold (2019) in those that strongly agreed. Post-course, more than 90% of doctors reported that they would feel comfortable sharing with colleagues their involvement in an incident. In a growing culture of blame and litigation, it is important to address the harm associated with a blame-based culture. The process of investigating an incident has the potential to expose the areas of deficiency relating to an individual. Reducing stigma associated with incidents could theoretically reduce the second victim phenomenon. An open culture to incident reporting is a fundamental part of medical education and quality improvement. Encouraging this attitude amongst medical professionals and creating a supporting environment surrounding sharing of experiences will help to form a generation of doctors that see incident reporting in a positive light. Our model of lecture series could be utilised in other UK Foundation Programmes with the aim of enriching the FY1s' induction period.

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Background

"To Err Is Human" [1] is a report by the USA (US) Institute of Medicine encouraging an open culture to learn from adverse events without blame. This attitude was also taken up by the UK's (UK) National Health Service (NHS) safety watchdog [2]. However, there still appears to be a culture where incident reports are often used as threats with the potential of causing significant anxiety to employees, especially junior doctors [3–9].

According to NHS Improvement (2017) [10], patient safety incidents are any unintended or unexpected incident which potentially could, or did, lead to harm to patients. Incident reports cover a wide variety of categories, including non-clinical and clinical issues, in a variety of departments in a hospital. Incident reports are crucial to improve patients' care and to identify further actions required to prevent harm. Reflection upon reported incidents also offers learning opportunities for members of the Multi-Disciplinary Team (MDT).

Methodology

It was observed, that a common view among the Foundation Year 1 (FY1) doctors in the local NHS Trust involved a fearful opinion surrounding involvement in clinical incidents. Significant anxiety in these situations prompted the need for a focused approach to the topic of "clinical incidents" during the induction of new FY1 doctors to their new role as junior doctors after finishing medical school.

A near-peer lecture series (Figure 1), lasting 1 h, was delivered to new FY1 doctors by existing junior doctors for the two consecutive years of 2018 and 2019 during their induction. Presenters were selected on a voluntary basis to share their experience of being named in an incident report, varying from near misses to death. Topics primary involved drug errors, delay in investigations and/or treatment, delay in patient reviews. Unfortunately due to the COVID-19 pandemic we were unable to run

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Figure 1. Logo designed for teaching programme.

it in 2020. Qualitative pre- and post-lecture series feedbacks were gathered from FY1s and analysed.

Results

Feedback was received from 28 out of 32 (2018) and 19 out of 22 (2019) junior doctors who attended the teaching session. Results showed all FY1 doctors agreed or strongly agreed that they had a good understanding of incidents following the lecture (Figure 2). Compared with their pre-course feedback, there was an increase of 6-fold (2018) and 8-fold (2019) in those that strongly agreed.

Post-course, more than 90% of doctors reported that they would feel comfortable sharing their involvement in an incident with colleagues (Figure 3). Furthermore, 96% (2018) and 33% (2019) of doctors agreed that receiving a clinical incident can be a positive experience (Figure 4); an increase of 34% and 4% compared with pre course surveys. It is unclear why the increase in 2019 was less dramatic; this could be due to the smaller sample size, the variety of presenters during the 2 years, or even when the lecture was delivered during the induction programme. Regarding perceived benefit of the attendance at the lecture series, 86% (2018) and 68% (2019) of doctors found the lecture series beneficial.

Discussion

Relevance

A clinical incident is "any unplanned event which causes, or has the potential to cause, harm to a patient" [10]. Incident reporting is a key element of patient safety integrated into the fabric of the current NHS [4,10,11]. Incident reporting ensures that there are systemic measures in place to respond to potential safety hazards surrounding patient care within an organisation.

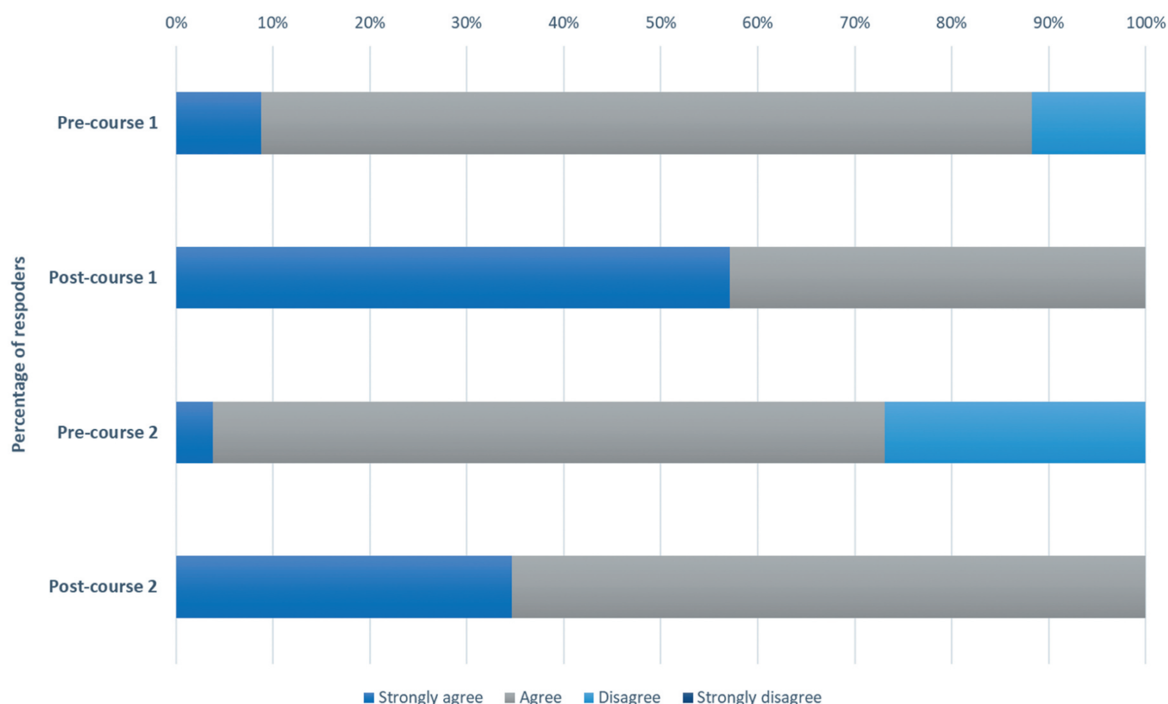

Figure 2. Bar chart demonstrating understanding of what an incident is among FY1s.

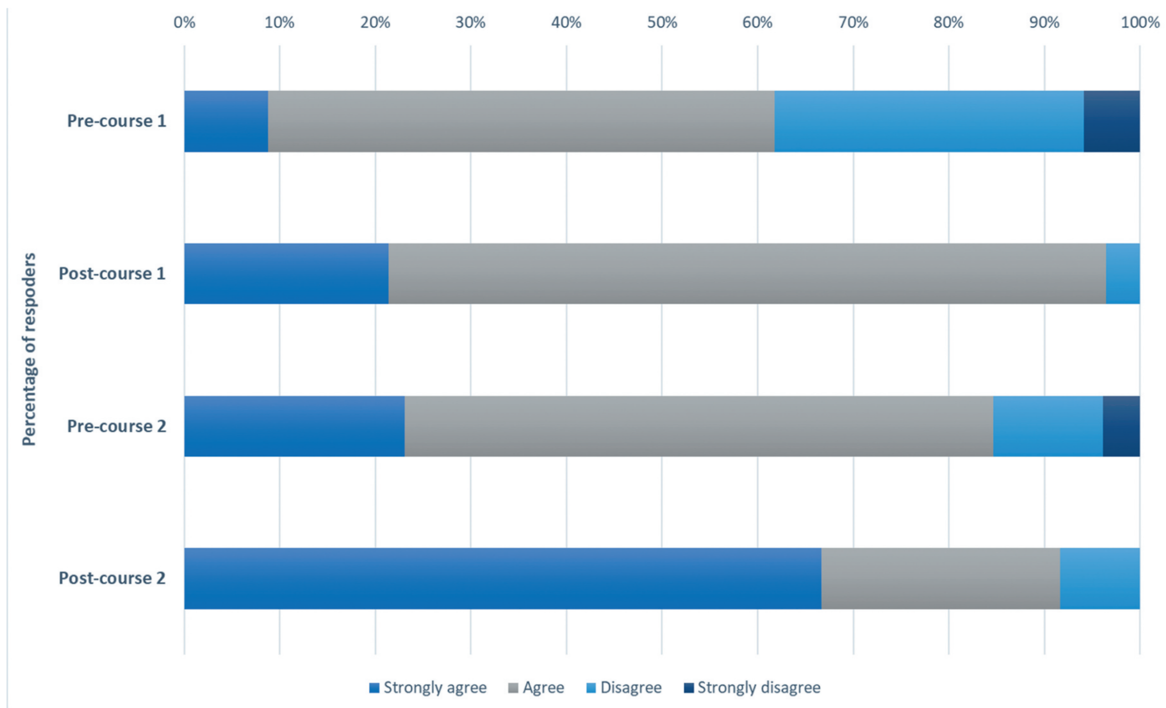

Figure 3. Bar chart demonstrating how happy FY1s are to share details of an incident with colleagues.

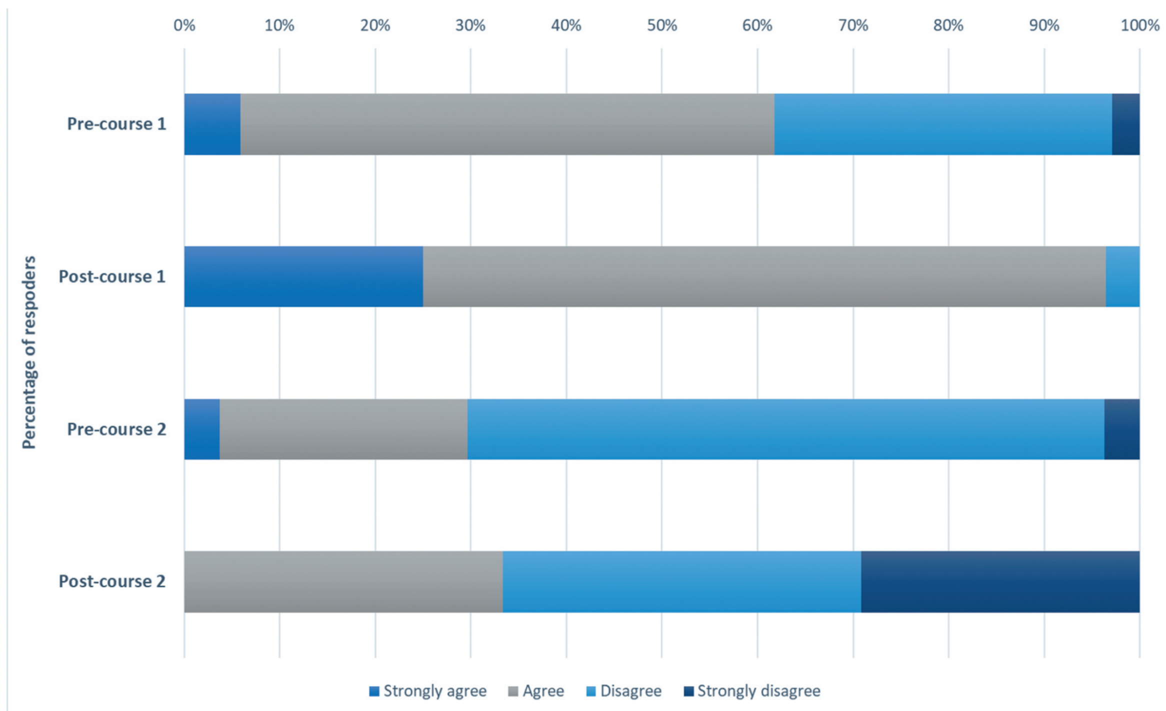

Figure 4. Bar chart demonstrating agreement that an incident can be a positive experience.

Clinical incidents range from near misses to death; it is crucial that staff feel safe openly to disclose any incidents they witness or are involved in while caring for patients [4,5]. Promoting a culture of transparency is one of the fundamental principles of Good Medical Practice as stated by the General Medical Council (GMC) [12]. Despite ongoing emphasis on the importance of a change in culture of incident reporting, there

are many published studies which demonstrate the unresolved issue of stigmatisation [3,5,7–9] relating to healthcare staff involvement in clinical incidents, which negatively impacts upon both the rate of reporting and junior doctors' psychological wellbeing [13–16]. In addition, the presence of stigma has been found to be a contributing factor in the growth of defensive practise among clinicians. The recent and well-publicised Bawa-Garba case has led to increased anxiety among the medical professionals regarding reporting and reflecting on medical errors [17].

Application to Learning Theories

In a growing culture of blame and litigation, it has never been more important to address the harm associated with a blame-based culture (BMA 2018) [18] among health-care professionals. Considering Maslow's hierarchy (1943) [19], a sense of safety is a fundamental element in an individual's journey towards self-actualisation. Without accounting for the fundamental needs of junior doctors, their progress and training may be hindered. From a behavioural psychological perspective, as stated by Skinner (1938) [20], it is important to consider how operant conditioning involvement in incidents can be perceived negatively as forms of punishment. In response to an incident report being completed, doctors will commonly undergo a series of tasks including having to discuss the incident with a supervisor, completing a reflective log on the event and having to disclose the incident at their Annual Review of Competence Progression (ARCP) [21], before advancing to the next stage in training.

The process of investigating the root cause of an incident has the potential to expose the areas of deficiency or errors relating to an individual health-care professional. Inevitably due to these investigative and reporting mechanisms, individuals may consequently associate the involvement in an incident with the stated consequences. As the result, through operant conditioning the incident itself becomes a negative concept. While one might consider that this is advantageous in that it deters individuals from making errors, a large portion of incidents are actually due to systems/process errors rather than individual "mistakes" [22–24]. Consequently, the associated stigma surrounding incident reporting is dissuasive of revealing process errors that need to be identified and rectified in view of patient safety. Lastly, there has recently been an increased recognition of the concept of the "second victim" [25]. This is the idea that the individual who makes the mistake may be negatively impacted and require support. Reducing stigma associated with incidents could theoretically reduce the second victim phenomenon by providing a platform for non-judgemental support.

Our Local Mission

Feedback from junior doctors received during the previous academic year at the Trust highlighted that incident reporting was briefly discussed during their induction in a way that was non-relatable and there was a noticeable gap between the experience and seniority of presenter and audience. This teaching programme begins to tackle patient safety incidents by creating a more open culture, eventually creating a systems wide attitude [26].

Our Future Objective

Our next goal is to deliver the lecture series to a multidisciplinary audience to encourage a team approach in reducing and preventing harm. Our model of lecture series could be utilised in other UK Foundation Programmes with the aim of enriching the FY1s' induction period and encouraging honesty among newly qualified doctors.

Conclusion

An open culture to incident reporting is a fundamental part of medical education and quality improvement. Encouraging this attitude among medical professionals and creating a supporting environment surrounding sharing of experiences will help to form a generation of doctors that see incident reporting in a positive light. The 'Incident Teaching' Lecture Series has created a simple, but sustainable, method to encourage a change in attitude to newly incoming FY1 doctors at a district general hospital. Exposing this concept to the doctors fosters an open culture and allows learning with less stigma from involvement in a clinical patient-safety incident.

Disclosure Statement

No potential conflict of interest was reported by the authors.

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