Medical Professionalism in Relation to Patient Safety: Summary Report
Research Findings Summary

1. The Medical Professionalism in relation to Patient Safety PlayDecide Game is an open access embedded learning serious game.

2. Game content was co-designed to include diverse perspectives and was played in two hospital sites with 101 junior doctors.

3. A majority of junior doctors (98%) supported Position 1 that: "All staff should report all concerns they have regarding patient safety, without fear of recrimination, in the knowledge that learning will happen and the system will be improved. Patient safety should be our top priority as healthcare professionals."

4. The current system is not supporting junior doctors to speak up about patient safety.

5. Suggestions for shaping a safety culture include closing the feedback loop through frequent feedback sessions; changing the culture by providing support and embedding on-going learning.

6. This research highlights the need to educate junior doctors about safety as part of their intern training. The Medical Professionalism in relation to Patient Safety PlayDecide Game provides a framework to enable open discussions.

Introduction

Medical Professionalism is “a set of values, enacted through behaviours and relationships, which underpin the public’s trust in doctors” (Medical Council, 2014; p.13). A recent survey of the Irish public revealed that approximately 8 in 10 people were very confident or fairly confident that their doctor would tell them if there had been a mistake/oversight in the course of their care (Medical Council; 2014). However doctors were divided as to whether they would report a mistake/oversight. The main reasons given by doctors for not reporting a concern are 44% felt “nothing would happen as a result”; 25% had a “fear of retribution”; and 19% “thought someone else was dealing with the problem” (Medical Council, 2014; p.34). In 2014 across Ireland there was a total of 53,108 patient related incidents reported by acute hospitals. The Health Information and Quality Authority (2012) have emphasised the importance of a culture of quality and safety that promotes transparency, teamwork, and open and effective communication. Encouraging such a culture needs to start from an understanding of the factors that make it difficult for doctors and other health professionals to be open about errors.
Study Aim

The aim of this study was to determine whether a customised educational intervention (Play Decide) with junior doctors (interns and senior house officers (SHOs)) can support medical professionalism by encouraging junior doctors to raise issues of concern, whilst shaping a culture of trust, transparency, responsiveness and learning.

Study Methods

This was a mixed method study over 9 weeks consisting of 4 weeks of baseline data collection, followed by the Play Decide intervention and 4 week's post intervention data gathering. The following instruments were used:

- Questionnaire measuring Leadership Inclusiveness and Psychological Safety (Nembhard & Edmondson, 2006);
- Questionnaire on Safety Concerns witnessed based upon the Irish Medical Council's (2014) eight domains of good professional practice;
- Play Decide Intervention is a serious card based game with a role-playing component;

Study Sites

- Hospital A is an acute adult care hospital in an urban area. In 2015 the hospital introduced the electronic National Incident Management System (NIMS) which is accessible on the hospital internet system. Between 1/1/2015 and the 31/12/2015 there were 7,973 incident reports.

- Hospital B is an acute adult care hospital in an urban area. The hospital incident reporting system is paper based which is logged within the hospital and then manually entered onto the State Claims Agency NIMS system. Between 1/1/2015 and the 30/6/2016 there were 3,886 incident reports.

Figure 1: Reporting in Hospital A.

Other, 12%
Medical, 3%
Nursing, 85%

Figure 2: Reporting in Hospital B.

Other, 14.79%
Medical, 2.57%
Nursing/Midwifery, 82.63%
Main Report Results

Questionnaire on capturing Leadership Inclusiveness and Psychological Safety

- Across the two hospital sites 149 junior doctors completed the questionnaire
- 121 (85%) agree that members of the team can speak up about their problems/tough issues.
- 123 (88%) agree that members of the team are open with checking with each other about issues.
- 105 (74%) disagree that if you make a mistake it will be held against you.
- 119 (82.1%) disagree that it is difficult to ask the team for help.

Questionnaire on Safety Concern

In Hospital A, 46 of 52 interns took part (82.14%) and 31 of 52 senior house officers (SHOs) took part (59.62%). In Hospital B, 72 of 86 interns took part (83.72%).

- From 224 Questionnaires on Safety Concerns completed in Hospital A 70 (32%) witnessed an incident in the last week with 43 (61.4%) witnessing 1 incident a week.
- In Hospital B out of 195 questionnaires gathered 65 (34.2%) stated they witnessed an incident in the last week with 72.6% interns witnessing 1 incident per week.

Figure 1: Top three contributory factors to incidents identified by junior doctors

An Incident is an “An event or circumstance or behaviour which could have, or did lead to unintended and/or unnecessary harm. Incidents include adverse events which result in harm; near-misses which could have resulted in harm, but did not cause harm, either by chance or timely intervention; and staff or service user complaints which are associated with harm” (Adapted from HSE, 2014 p.5). Examples include:

- Failure to maintain patient records.
- Prescribing incorrect medication to patient.
- Lack of communication between staff leading to lack of required care for patient.
- Failure to adhere to standard protocols for sterile procedures.
- Failure to detect sepsis.
- Failure to notice patient deterioration.
- Failure to provide information to a patient or their family.
• In Hospital A, 70 (32%) junior doctors witnessed an incident but only 23 (32.9%) formally reported it.
• Out of the 65 (34.2%) that witnessed an incident in Hospital B, 20 (30.3%) formally reported it.
• A majority indicated that they informally talked about their concerns to colleagues - Hospital A, 48 out of 67 valid responses (71.6%) and in Hospital B, 46 out of 62 (74.2%).

**PlayDecide Results**

• A total of 101 Junior Doctors played the *Medical Professionalism in relation to Patient Safety PlayDecide Game*
• Hospital A: Out of the 77 that signed up 57 (74%) took part in the PlayDecide game
• Hospital B: Out of the 72 that signed up in Hospital B, 44 (61%) took part.
• Participants really engaged with the stories and the material content of the game and good discussions took place on patient safety issues. Each group that played was asked to reach consensus on one of four statements about patient safety and speaking up ranging from a utopian to a dystopian view on the issue (table 1).
Table 1: Position statements voted on by junior doctors.

<table>
<thead>
<tr>
<th>Position</th>
<th>Statement</th>
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<tbody>
<tr>
<td>Position 1</td>
<td>All staff should report all concerns they have regarding patient safety, without fear of recrimination, in the knowledge that learning will happen, and the system will be improved. Patient safety should be our top priority as healthcare professionals.</td>
</tr>
<tr>
<td>Position 2</td>
<td>All staff should report only serious concerns they have regarding patient safety without fear of recrimination, in the knowledge that learning will happen, and the system will be improved.</td>
</tr>
<tr>
<td>Position 3</td>
<td>All concerns regarding patient safety should be reported, but only by senior members of staff. Reporting by more junior members of staff is less likely to be effective.</td>
</tr>
<tr>
<td>Position 4</td>
<td>Staff cannot be expected to report safety concerns because they are too busy providing care. There is no value in reporting safety concerns if a patient wasn’t harmed or placed at risk. It is just a waste of people's time and resources.</td>
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Table 2: How junior doctors voted for each position statement.

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<tr>
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<th>Position 1</th>
<th>Position 2</th>
<th>Position 3</th>
<th>Position 4</th>
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</thead>
<tbody>
<tr>
<td>Support</td>
<td>98% (n = 97)</td>
<td>76.3% (n = 71)</td>
<td>13.4% (n = 13)</td>
<td>1% (n = 1)</td>
</tr>
<tr>
<td>Not Acceptable</td>
<td>2% (n = 2)</td>
<td>23.7% (n = 22)</td>
<td>86.6% (n = 84)</td>
<td>99% (n = 97)</td>
</tr>
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Note: Missing data and abstains were excluded from the analysis.
Interviews with Junior Doctors

A total of 15 junior doctors were interviewed (7 in Hospital A; 8 in hospital B).

1. Understanding of the Incident Reporting System

A majority in both hospital sites said they were unclear of the incident reporting process, some could not recall having received any training. Interviewees stressed that they often had no time to report and it often was not a priority for them. Many believed that it was a nurse's job to report and nursing staff reported for them. Junior Doctors noted that they also frequently observed nursing staff creating an enabling environment to report:

"Nurses are definitely more inclined...They would encourage each other to help each other to maybe put in the incident report form and say 'No that is definitively an incident you need to put that in. Listen you go put that in now and I will do your job'. They are definitely more inclined."

Janet (Hospital A)

This was in contrast to a lack of visible reporting by their medical colleagues:

"From the point of my internship I never had a Registrar or SHO or a Consultant that would tell me that they are going to report an incident or do one."

Carli (Hospital B)

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<tr>
<th>Hospital A</th>
<th>Alternative Position</th>
<th>Comment</th>
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<td></td>
<td>Senior members should help filter the concerns from junior staff and support serious concerns.</td>
<td>An intern group (n = 10) came up with this alternate position which received support from 60% of the group.</td>
</tr>
<tr>
<td></td>
<td>All staff should be comfortable/able to report without fear of recrimination, and all staff should make time to report.</td>
<td>A SHO group (n = 7) came up with this alternate position which received support from 100% of the group.</td>
</tr>
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<tr>
<th>Hospital B</th>
<th>Alternative Position</th>
<th>Comment</th>
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<td></td>
<td>All staff should report all reasonable concerns they have regarding patient safety, without fear of recrimination, in the knowledge that learning will happen, and the system will be improved. Patient safety should be our top priority as healthcare professionals.</td>
<td>An intern group (n = 6) came up with this alternate position which received support from 100% of the group.</td>
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2. Barriers to Reporting
Participants were unclear of the rationale for reporting:

*There would be a strong feeling that these forms we fill in just end up in a shredder.*

Angelo (Hospital B)

Many questioned why they would bother reporting when often no feedback was provided when people did report:

*It’s just I suppose a bit depressing but I feel like we cannot change the system at all that there is no point of filling out one form.*

Mia (Hospital B)

Junior doctors outlined that there was an 'informal' culture amongst them where they discussed concerns. Participants noted a reluctance to report on senior colleagues:

*If there is an incident with someone more senior to you on your team that’s when you are least likely to you know to say anything…we cannot really critique people above us as a rule. It just doesn’t happen.*

Angelo (Hospital B)

A source of frustration in both sites was the lack of consistency in Standard Operating Procedures (SOPs) / protocols across hospitals and even across wards within a hospital. This was often the source of conflicts.

3. How to encourage a Culture of Openness and Accountability
Frequent feedback sessions that would support learning was the most popular suggestion. Closing the feedback loop was also stressed:

*‘People want to see the reporting loop closed when you report and seeing on outcome on that…and I think sometimes there is not enough feedback on that in any environment I don’t think Hospital A is different to any other hospital or any large institution’*

Monika (Hospital A)

Participants stressed the need for changing the culture by providing support and embedding learning. Central to any change would be to involve junior doctors as key stakeholders.
Impact for Policy and Practice?

- Existing system is not supporting Junior Doctors to recognise their role in shaping a safety culture;
- The limited training that is provided is seen as a token gesture, resulting in limited understanding of the purpose of reporting;
- Disconnect between academic teaching and the ‘real world’. There is a lack of continuing education or focus on ongoing learning about safety.
- The research highlights the need to educate junior doctors about safety and reporting responsibility as part of their intern training. Focus should be developing a safety culture that is embedded in education and learning. Medical Professionalism in relation to Patient Safety PlayDecide Game provides a framework to enable open discussions and to provide ongoing learning about patient safety.

Knowledge Exchange Activities

17th January 2017
Presentation on the Medical Professionalism in relation to Patient Safety PlayDecide Game to Dr Daragh Fahey, Director of Quality Safety & Risk Management, Tallaght Hospital

7th December 2016
Dr Éidín Ní Shé and Karen Egan delivered presentation on Medical Professionalism in Relation to Safety: Junior Doctors’ Experiences in Practice at the 1st National Patient Safety Office conference on 7th and 8th December 2016 at the PrintWorks Dublin Castle.

23rd November 2016
Training on the Medical Professionalism in relation to Patient Safety PlayDecide Game to St. James’s Hospital Quality and Safety Improvement Team.
27th October 2016
The UCD Health Systems team were invited by the Medical Council to facilitate two workshops of PlayDecide as part of the Medical Council Patient Safety and Leadership Conference held on the 27th of October 2016 at the Radisson Blu Royal Hotel Golden Lane Dublin 2. A total of 64 people played the PlayDecide game at the workshop.

7th November 2016
Christian Korpos et al. presented a poster on Medical Professionalism: Preliminary results of the experiences of interns about speaking up and reporting safety concerns in St. Vincent’s University Hospital at the St. Vincent’s University Hospital Nursing Conference Poster on 7/11/16 to 11/11/16.

7th December 2015
Dr Marie Ward and Karen Egan delivered presentation on Developing a serious game 'PlayDecide' for supporting junior hospital doctors to speak up about safety concerns at the National Patient Safety Conference on 7th and 8th December 2015 at the PrintWorks, Dublin Castle.

7th December 2015
Dr Marie Ward et al. presented a poster on Medical Professionalism: Developing a serious game 'PlayDecide' to encourage junior hospital doctors to speak about and report safety concerns at the National Patient Safety Conference on 7th and 8th December 2015 at the PrintWorks, Dublin Castle.

Academic Outputs

• Ward M. McAuliffe E. Ní Shé É. Duffy A. Geary U. Cunningham U. Holland C. McDonald N. Egan K. Korpos C. 'Imbuing Medical Professionalism in Relation to Safety: A study protocol for a mixed-methods intervention focused on trialling an embedded learning approach that centres on the use of a custom designed board game' BMJ Open *Under Review*

• Ward M. McAuliffe E. Egan K. Holland C. Geary U. Robinson K. O’Grady J. Ní Shé É. Hamza M. Korpos C. 'Developing the 'PlayDecide Patient Safety Game' Health Professions Education *Under Review*

Acknowledgements: The research team would like to thank the junior doctors who contributed to this study and to the hospital sites for facilitating the research. We would like to acknowledge the Medical Council of Ireland, the HSE - Medical Education and Training Unit and the Health Research Board, who funded this research under the auspices of the Medical Education Research Grant No. 2014-907.
### Who was involved in this project?

| School of Nursing, Midwifery and Health Systems, UCD | Eilish McAuliffe - Professor of Health Systems  
Marie Ward - Senior Research Fellow  
Éidín Ni Shé - Research Scientist  
Christian Korpos - Research Assistant |
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<td>Patient and Public Involvement in Healthcare, HSE</td>
<td>Karen Egan - Patient Representative</td>
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</tbody>
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| St. James's Hospital | Una Geary - Clinical Lead Quality and Safety  
Una Healy - Risk Manager  
Julie O'Grady - CNM 3, Nursing Quality, Audit & Research Co-ordinator  
Gaye Cunnane - Rheumatology and Dir. Postgraduate Med Education  
Elaine Bourke - Intern Tutor  
Lucy Chapman - SHO Contact |
| St Vincent’s University Hospital | Alan Watson - Clinical Director-Medicine/Emergency Medicine  
Alan Smith - Director of Quality and Safety  
Kate Murphy - Intern Tutor |
| Mater Misericordiae University Hospital | Catherine Holland - Risk Manager  
Una Cunningham - Head of Transformation |
| State Claims Agency | Anne Duffy - Clinical Risk Advisor |
| Centre for Innovative Human Systems, TCD | Nick McDonald - Professor of Psychology |

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### References


Medical Council (2014). *Talking about Good Professional Practice, views on what it means to be a good doctor*. Dublin, Ireland: Medical Council.

