

## Promoting Advocacy in Health Care: A Tool to Combat Medical Error

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### Introduction

Medical errors are a major contributing factor to patient mortality, resulting in continually increasing attention to this issue [1]. Despite receiving much attention, changes in procedures and regulations, there is no firm objective evidence of progress [2]. Difficulty in determining the error rate arises from insufficient data on frequency and the type of errors [2]. Reportable events are non-routine within the healthcare facility and that may result in injury, harm, or loss to a patient [3]. The purpose of reporting medical errors is to help institutions identify potential risks in order to improve the quality of patient care [4]. The reporting of errors falls under the arch of patient advocacy, which is concerned with patient protection, including support and education [5-7].

Health care has evolved towards patient-centered care [8]. Patient safety relies on the coordination, input, and vigilance of many individuals [9]. Advocating for the patient should be the goal of each team/individual involved in patient's circle of care. Increasingly complex health-care systems have arisen and patient safety concepts have shifted from individuals to systems, thus societal and physicians' perceptions of accountability also need to change [9].

Using laboratory medicine as an example, patient advocacy is concerned with pre- and post- analytical phases, which have been shown to be relatively vulnerable to errors [10]. Therefore, to further improve patient safety in laboratory medicine, attention must be focused on these areas, and the concept of patient safety as a multi-disciplinary system embraced [10]. For instance, laboratory physicians are the most qualified to educate caregivers on appropriate test ordering, specimen collection, and accurate interpretation, and should advocate for optimal patient management.

### Discussion

Research has identified the failure to speak up and/or communicate effectively as a factor in many incidents of patient harm [11,12]. For example, some health care professionals, such as nurses, fail to offer verbal advocacy for patients in certain situations, which is concerning because: (i) Silence may result in harm to patients; (ii) Nurses are in a key position to speak up for patients; and (iii) Nursing has a strong moral and ethical

imperative for patient advocacy [12]. In one study, 50% of nurses described situations that should have resulted in speaking up, but only did so 10% of the time [13]. In another report, when asked if physicians would provide support if reporting a fellow nurse, 10/16 said yes, but only six said yes if this involved reporting a physician [14]. One report stated that 31% of US physicians are reluctant to report impaired colleagues and 12% fear the consequences of reporting; figures are even higher for junior doctors in the United Kingdom [15,16]. It is imperative for patient safety that regulatory bodies assure potential whistleblowers that they will not be penalized [17]. The literature supports the idea of creating a safe reporting culture that rewards speaking up are important to improve patient safety. Organizations that adopt formal methods of reporting likely have a stronger safety culture [12].

As mentioned, health care workers are reluctant to report error, which creates a void in the data regarding numbers of errors. Consequently, it is difficult to determine the number of errors happening and the contributing factors [18]. Physicians hesitate to disclose most errors to their patients even if they agree that it is the right thing to do because they fear that they might lose their patient's trust, get sued, and lose the respect of their colleagues. The culture of perfection in the medical field also plays a great barrier in disclosing because errors are downplayed, treated as rare occurrences, or viewed as a shameful act. If we are going to improve safety, we need to be able and willing to identify errors

without the fear of reprisal. Failing to report is to fail our patients. It also fails to highlight processes that may prevent future incidents [18]. Health care agencies can work on transparency in reporting, but actions regarding individual employees must be kept confidential. An alarming reason for lack of reporting may be that small errors that happen frequently come to be seen as normal. In some cases, a system design encourages behavior that has become the norm [18]. Promoting bad behavior around reporting can influence the behavior of medical students during their training [19]. This behavior change has been attributed to the 'informal' or 'hidden curriculum' of medicine, which is well described [20]. Error disclosure training should be a part of a resident's education because the absence of it causes the residents to learn through the 'hidden curriculum' and from direct observation of their supervisors. Few suggestions have been made with regards to disclosing errors in medical education, such as disclosing errors within 24 h with emphasis on preparing for the disclosure meeting and talking with a colleague within the same field and looking for solutions to prevent the error from reoccurring. Of even more concern is the ethical response from students at the start of medical school. For instance, one study found that only 13% of students would report a senior colleague at the start of their training and <5% at the end [21]. In Canada, advocacy is supposed to be a key teaching component, yet it seems to fall short at the expense of other interests.

One impediment to reporting is the aforementioned fear of litigation. Policies and laws that protect health care workers who come forward, not only from retaliation from coworkers and employers, but from criminal prosecution and civil suits as well should be promoted. It is our ethical duty to advocate for our coworkers and our patients [18]. Future errors may be prevented if a previous incident is investigated and the contributing factors are acted upon. If the incident is not reported, there is unlikely to be any reduction in the risk of recurrence. Reporting is the first step in a process that can identify system failures, facilitate learning and bring about change. In order to improve patient safety, it is therefore vital to have a mechanism of reporting safety problems of all kinds [10]. One solution may be disclosure and offer programs [9,22], which may help physicians advocate for their patients with reduced fear of litigation. These programs have been studied and suggest a favorable outcome for patients [23-25].

Advocacy also involves efficient health care, such as not subjecting patients to unnecessary procedures. The clinical laboratory plays a major role in the determination of a patient's diagnosis as well as the choice and monitoring of therapy [26]. With over 4000 different laboratory tests available, and limited education about them, it is inevitable that clinicians will sometimes have questions regarding optimal use of ordering appropriate tests with the appropriate timing, and/or to make an accurate interpretation [10]. For example, tests may be ordered out of habit rather than a specific indication, excessive tests may be ordered due to being grouped on the same form, and once ordered, inaccurate or incomplete request forms can affect interpretation and thereby

compromise patient safety [27,28]. Furthermore, medical schools traditionally do not require courses in clinical laboratory science and physicians are dependent upon the clinical laboratory as the single largest supplier of objective, scientific information on patients [26]. Laboratory physicians must also take an active role in the regulation of laboratory testing. It is unfair to the system and unacceptable to the principle of patient autonomy to subject a patient to unnecessary, outdated, or repetitive testing. Laboratory professionals are the first healthcare professionals to view objective, scientifically validated, patient data. The decision-making power to perform immediate follow-up testing based on the data found in primary testing would effectively lessen the length of stay for many patients in both emergency treatment and inpatient stays, making healthcare more affordable while increasing the efficiency and quality of medical care. Laboratory professionals using their clinical judgment to cut back on unnecessary testing is as defensible as utilizing skills to reject specimens of questionable value alter methodologies or change laboratory protocols [26].

Having ordered the test, retrieving the specimen has vast potential for error. First, inadequate patient preparation (for instance food intake, time of day, stage in menstrual cycle, smoking, medication, or co-morbidities) can influence the interpretation of results [29]. Further risks occur during the collection of the specimen (for instance inappropriate volume, hemolysed/clotted specimens, specimen contamination, wrong type of specimen for the analysis, and inappropriate timing) [10]. After collection, transportation errors include delays, inappropriate temperature, and specimen damage [30]. What should be the position of clinical laboratory professionals as the confront requests for out of date, repetitive, or inappropriate tests? What should be the position of clinical laboratory professionals as they deal with colleagues who are incapable or unwilling to maintain quality? [26]. Consulting the lab personnel, who possess the most in-depth knowledge of the aforementioned factors, can eliminate, or at least reduce, these potential errors. Therefore, advocacy on the part of the laboratory clinician involves the education of primary clinicians and residents, which could be seen as a sort of indirect advocacy.

Despite a perceived limited advancement in the reporting of errors, healthcare professionals should remain optimistic that with a continued emphasis on advocacy, including error reporting, the situation will move in a positive direction. Over time, the delivery of medicine has become increasingly complex and patient care, including safety, has become multi-disciplinary, which needs to be fully understood. There needs to be a continued emphasis on optimizing the system, both in terms of achievement and blame, rather than singling out individuals. When the interest is centered on avoiding consequences of an error, rather than patient safety, the idea of advocacy is lost. Even when physicians are not in direct patient contact, they must think about how the tests that are ordered and results given affect patients and intervene when necessary. Although at times it may seem like an endless struggle, our patients deserve a continuing best effort.

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