

COMMENT

Between a rock and a hard place: the dilemma of a prospective whistle blower: Commentary on "To talk or not to talk," by Ashok Sinha

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I empathise with Dr Sinha's dilemma of what to do with inefficient doctors (sometimes your own peers and colleagues) who are negligent, unsympathetic and sometimes unskilled, often to the detriment of the patient (1). While keeping silent is not the solution, one also wonders whether whistle-blowing will really change practices. Indeed, what is needed is to develop a culture in which medical errors can be discussed in a manner that will prevent them from occurring again. This means acknowledging that all of us doctors are human, prone to errors and each of these errors has a potential to cause distress or even death to patients.

I have debated this topic extensively and my thoughts about the actions one should take are varied. From reporting a doctor to the Medical Council (for an error in reading a report that may have caused damage to a young woman's life), to providing skills and education (to surgeons who are ignorant about pain relief), the options are many and may vary with the nature of medical error or negligence.

In my opinion the challenge in India is not whether we should inform someone and what action should be taken against a doctor for medical negligence or error. It is about how to make the doctor aware of the mistake so that it will not happen again, in addition to making other doctors aware that such medical errors can happen. A bigger challenge is how to be professional about the whole process without appearing to be engaged in a personal vendetta.

One of the biggest problems in India is the lack of clinical governance related to many doctors, especially those not working in institutions or systems. While in no way implying that those working in institutions do not commit any errors, there are several systems in place in institutions (working in teams, trained nurses, pharmacists) which decrease the likelihood of error. In the event of an error (provided it is detected and reported), there are reporting mechanisms in most institutions which might take the form of an institutional enquiry and hence act as a learning not only for the doctors involved, but also for their peers. For physicians working on their own, the personal responsibility is even greater, because these external monitoring systems may not exist.

If someone indeed decides to be a whistle-blower, what information does he have about the pathways and methods by which this action will be responded to? I compared the Medical Council of India (MCI) website with the General Medical Council

(GMC) website of the UK in relation to grievances and methods of reporting them (2). The GMC is replete with methods and guidelines for whistle-blowing and reporting and also has a calendar of events of the various enquiries underway. The Medical Council of India website has a grievance cell with a contact number but no further guidance. However, during my search, I found to my dismay that several Indian consumers had chosen to lament about difficult and negligent doctors on a website run by a private limited company, for want of any other channel and obviously with no recourse (3).

It is evident from both the related article and the cases that come up in consumer forums that patients and even the medical fraternity are crying out loud for guidance on safety, quality assurance and reporting methods.

If one does not have any quick, reliable and easy recourse to reporting a colleague, what does one do? If one does not have any forum where one can discuss medical errors without blame or shame and in a learning environment, then what does one do?

I think the solutions must lie within ourselves and it is our responsibility to have groups and forums where we can discuss medical errors, patriarchy in medicine and the need for clinical audit of our services. If every doctor can have forms in his clinic waiting room that ask for information on patient satisfaction and deficiencies in service; if we are willing to open ourselves to scrutiny by consumers and listen to their feedback and are secure enough to admit that errors are human and need to be rectified, a decrease in such incidents can happen.

There are several studies and debates on medical errors and the best way of handling them (4). The views have ranged from an honest disclosure to the patient or relative about the error and tendering an apology, to having more robust reporting methods in a manner that is not confrontational yet helps the doctor to become aware of the issue and learn from it.

Human behaviour, however, can be difficult to change unless a sense of personal risk and responsibility is instilled. While there may be no one right way, I would suggest that in the cases discussed by Dr Sinha, the patients should be encouraged to inform the doctor about the error in a non-confrontational manner (so that the doctor learns instead of becoming defensive). Peers also have a responsibility to discuss an error if it occurs – it may not be rectified but at least you can prevent it from happening again.

Some ways in which one can increase accountability in medicine in India, so that doctors become more aware and are willing to be scrutinised, include the following areas:

Teaching and learning as compulsory exercises for registration: The medical councils of most countries have specific guidelines for continuing professional development. Unfortunately, in India, we feel that we are immune from this. While many doctors attend meetings and want to learn more, the focus of teaching should not be just on new techniques or medicines that might improve practice, but also on good governance, clinical audits, safety protocols, patient satisfaction and documentation.

A focus on risk awareness: It is important that the doctor be aware of the risks of any medication or procedure, take safeguards to minimise the risks and educate the patient and family about these risks.

Patient education about rights: Patients must know that they have rights to information, pain relief, and recourse to compensation or explanations.

Removing patriarchy from medicine: Medical training needs to focus on giving importance to patient feedback and using patients as teachers.

Peer supervision and feedback: If we can all be open to scrutiny not only by licensing agencies but also through peer feedback and openness, such errors that cost the patient dearly may be minimised. In every annual conference, we must try and have a session on medical errors and how to minimise them and if they happen how to handle them (without becoming defensive).

The answer I have to Dr Sinha's poignant question – whether to talk or not to talk – is that we must talk and keep talking; how we talk and what we talk about are the more important issues to be debated.

References

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