EXPLORING THE SILENCE: BARRIERS TO MEDICAL ERROR REPORTING IN UROLOGY

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ABSTRACT

Objective: To explore barriers to medical error reporting among urology healthcare professionals at tertiary care hospitals in Peshawar.

Methodology: This qualitative study utilized a case study approach. Maximum variation purposive sampling was employed to select faculty of Urology (assistant professor and above) with at least two years of experience, resulting in five interviews using a structured interview guide. The interviews were recorded, transcribed, and analyzed through thematic inductive analysis. Data collection and analysis were done concurrently.

Results: Four main themes precipitated from the data. Understanding the medical error landscape focuses on what constitutes a medical error. Reporting Roadblocks identified the barriers to reporting medical errors. Institutional Bottlenecks originate from the hurdles in the healthcare system to report medical errors. The last theme, pathways to progress, shows how to improve the process of reporting medical errors.

Conclusion: The study highlights the complex systemic, organizational, and human factors contributing to the underreporting and mismanagement of medical errors in urology units. Addressing these challenges is essential for advancing patient safety and fostering a culture of accountability in healthcare.

Keywords: Medical errors, urology, error reporting, patient safety

INTRODUCTION

Medical errors pose a significant threat to healthcare and can jeopardize the safety of patients. The Medical Dictionary defines a medical error as an inadvertent mistake or oversight in healthcare that results in harm or adverse effects to the patient.[1] Medical errors play a substantial role in increasing mortality and injury rates, with a report from the Institute of Medicine estimating that these mistakes lead to between 44,000 and 98,000 deaths each year in the United States.[2]

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Currently, around one out of every ten patients faces accidental medical mistakes, which has led the World Health Organization to assert that this situation is extensive and ongoing.[3]

Healthcare errors can generally be categorized into two main types.[4] Errors of omission happen when essential actions or interventions are not taken or steps are missed, such as not securing a patient in a wheelchair.[5] Errors of commission happen when incorrect actions are taken, like giving a medication that the patient is allergic to or mislabeling a lab specimen.[5]

Nearly all doctors make mistakes, yet these are often not disclosed to patients or their families. Human errors occur frequently in clinical settings but are often not reported, resulting in a poor understanding of their causes and effects.[6] Furthermore, admitting a medical error is difficult, which leads to its frequent non-disclosure.[7] The New York State Health Commissioner, Antonia Novello, has imposed a fine on a hospital in New York City for the third time in two months, this time for covering up a surgery where a healthy kidney was removed, leading to the patient's death.[8]

In the realm of healthcare, the acknowledgment and reporting of medical errors are fundamental

to improving patient safety and care quality. While errors are an inherent part of medical practice, their management becomes particularly critical in specialized fields such as urology. Urological procedures, often involving intricate techniques and high-risk scenarios, present unique challenges that can lead to significant clinical errors. [9] Despite their prevalence, many of these errors are underreported, hindering efforts to understand and address their root causes effectively.[10]

This study explored the barriers to medical error reporting among urology healthcare professionals at tertiary care hospitals in Peshawar.

MATERIAL AND METHODOLOGY

This qualitative research was conducted using the case study approach at five Tertiary Care Hospitals in Peshawar. The study's Ethical Approval was obtained from the Khyber Medical University Peshawar Ethical Committee via letter no: 1-12/IHPER/MHPE/KMU/23-38 dated 30-06-2024. The healthcare providers included in the study were assistant professors, associate professors, and urology professors. Five faculty members were selected using maximum variation purposive sampling and interviewed using a structured interview guide. The saturation point determined the number of interviews.

The interviews were recorded, transcribed, and analyzed through thematic inductive analysis. Data collection and analysis were done concurrently. The study employed respondent validation and triangulation during data analysis to reinforce the quality of the research.

RESULTS

Four main themes precipitated from the data. Understanding the medical error landscape focuses on what constitutes a medical error. Reporting Roadblocks identified the barriers to reporting medical errors. Institutional Bottlenecks originate from the hurdles in the healthcare system to report medical errors. The last theme of pathways to progress shows the way to improve the process of reporting medical errors.

Figure 1: Themes from the transcribed data.

1. Understanding the medical error landscape

Medical errors are inadvertent acts or omissions in the medical field that may cause patient harm. These mistakes frequently result from a variety of causes, such as poor communication between medical staff and patients, systemic problems like understaffing and disjointed workflows, human factors like stress and exhaustion, and environmental variables in hectic or chaotic healthcare settings. Adverse

occurrences are negative outcomes during care, whether or not they can be prevented. These are not the same as medical errors.

Surgical errors are especially dangerous and can include operating on the wrong portion of the body, leaving equipment inside a patient, or giving the wrong amount of anesthesia. Errors in postoperative care and inadequate infection control protocols can potentially lead to worse patient outcomes. Medical mistakes have far-reaching effects. The subthemes and their representative responses are shown in Table 1.

Table 1: Subthemes and Responses for Theme 1

Subtheme	Responses
1.1: Defining Medical Errors	"We call every such mistake a medical error, whenever we do any treatment or operation and we make a mistake." (Interview 1) "A medical error is when we administer treatment or perform any procedures to patient. In this duration, some mistakes occur." (Interview 2) "For example, if a patient comes for check-up and we find him to be normal through observation, in terms of BP and we don't check him with proper equipment." (Interview 3)
1.2: Common Errors in Practice	"An error can occur when we write a treatment plan for a patient, or if we perform a procedure on the wrong side." (Interview 2) "Sometimes we write an investigator and it would not be done on time, or we write one and do another by mistake." (Interview 1) "We tested him for HIV, but it was only simple screening, not proper done on PCR, which is recommended." (Interview 5) “Due to a documentation error, we mistakenly operated on the right kidney instead of the left.” (Interview 4)

2. Reporting Roadblocks

It is challenging to report medical errors for several reasons. Fear is one of the main causes. A common fear among healthcare professionals is that reporting an error will damage their reputation, result in disciplinary action, or hinder their chances of advancement. Since honesty isn't rewarded, there isn't much incentive to report mistakes. Alternatively, they may experience unfavorable outcomes such as legal action, humiliation, or a loss of confidence from their colleagues and clients.

Healthcare professionals are, therefore, less likely to admit errors because they worry about taking the fallout. Societal issues contribute to this problem. While doctors undoubtedly aim to avoid causing harm to their patients, negligence can occur and pose a threat to their reputation. Lack of confidentiality and fear of everyone knowing about the medical error hinder the reporting. Additionally, doctors often worry that reporting an error might impact their chances of promotion. In severe cases, if an error is significant enough to be brought before the Pakistan Medical and Dental Councils, there is a risk of license revocation. The subthemes and their representative responses are shown in Table 2.

Table 2: Subthemes and Responses for Theme 2

Subtheme	Responses
2.1: Fear and Stigma	Sometimes it happens that we make a mistake, but we have fear that it will destroy our career or our licenses should be cancelled." (Interview 5)

	"Doctors' licenses can also be revoked. His/Her reputation and career get on the stake." (Interview 3)
2.2: Cultural and Societal Hurdles	"Our society is very rival. They are uneducated. All the medical errors and adverse events are known events and known complications." (Interview 1) "Our society's level of education often leads to a lack of understanding and forgiveness." (Interview 4)
2.3: Lack of Confidentiality	"No, they cannot keep it private; that's why I said, at some level somehow leakage, and privacy becomes compromised." (Interview 4) "If 10 people know about it, the margin of error will be increased." (Interview 1)

Institutional Bottlenecks

Making sure that medical professionals, nursing staff, and administrative personnel all know how to report errors and are at ease doing so is essential to ensuring effective reporting. Unfortunately, this is not clear in the majority of cases and needs rectification. The institutions themselves don't have clear systems and guidelines for reporting medical errors. The medical staff also needs to be aware of the system in place, and the medical error reporting process should be part of the orientation process. After an error is reported, a mechanism must be in place for investigating and resolving the problem. The subthemes and their representative responses are shown in Table 3.

Table 3: Subthemes and Responses for Theme 3

Subtheme	Responses
3.1: Flaws in Reporting Systems	"Yes, the reporting system is not smooth. There are many hurdles in the way from the administration." (Interview 3) "If the government could facilitate the committee or hospital, instead of making new buildings, the existing infrastructure should be developed." (Interview 1)
3.2: Gaps in Training and Awareness	"Not at all; there is no training conducted on how to report any medical error." (Interview 5) "There must be sessions and SOPs... We need time and budget." (Interview 1)

Pathways to Progress

Establishing a transparent and encouraging procedure for managing and resolving errors is essential to improving medical error reporting. Establishing an appropriate error reporting procedure is crucial first. This involves providing healthcare professionals with an easy-to-use way to report problems as soon as they arise. The standard operating procedure to report medical errors should be part of the training for healthcare professionals.

Here, a cooperative strategy is crucial, in which several departments cooperate to promote open communication and identify fixes for faults that have been identified. Technology, such as digital platforms, could be added to the medical error reporting system to improve it and make it simpler to track and record faults while preserving privacy. Healthcare personnel should be taught to report mistakes without fear of repercussions, and facilities ought to establish procedures that shield employees from unfavorable outcomes when they report in good faith. The subthemes and their representative responses are shown in Table 4.

Table 4: Subthemes and Responses for Theme 4

Subtheme	Responses

4.1: Creating a Supportive Culture	"When we recognize our mistakes, it improves the health system, and the best way to recognize mistakes is to report them." (Interview 2) "There must be assurance that if medical staff report errors, it will not impact their career." (Interview 4)
4.2: Education and Empowerment	"Through training, doctors will know how important medical error reporting is, and they will definitely report medical errors." (Interview 3) "Workshops and SOPs are needed. We need to train juniors." (Interview 1)
4.3: Strengthening Systems and Safeguards	"There should be a coding system to keep the identity of those who make the error confidential." (Interview 2) "An online system should be developed for every doctor to report errors anonymously." (Interview 5)

DISCUSSION

The qualitative findings of this study shed light on the complexities of medical errors, highlighting their commonality and the different circumstances that contribute to their occurrence. Medical errors are not simply isolated instances; they represent a systemic concern within healthcare, which can profoundly damage patient outcomes and trust in medical institutions. This is congruent with the findings of Sutcliffe KM et al., who discovered that insufficient communication among healthcare personnel is a primary factor in medical errors.[11] Recognition of the characteristics and the consequences of medical mistakes is essential for improving the errors of medical care.

Concerning surgical mistakes, the study establishes that there are extreme outcomes like operative mistakes, including surgical operations on the wrong site or operating without removing the tools from the cohort and infected patients. Such mistakes are especially dangerous as they may cause serious complications, longer hospital stays, and heightened costs of healthcare. Huang et al. pointed out that the use of surgical checklists helps eliminate such mistakes because they act as a reminder of certain protocols to follow.[12] This backs the rationale and importance of structured checklists recommended by the WHO.[13]

Another issue that is a primary concern in this study relates to the failure of practitioners to report errors because of fear of consequences: Many practitioners are concerned that reporting mistakes would damage their careers or they could be disciplined. Vincent et al. noted that the culture of blame deters healthcare workers from expressing the truth about errors.[14] Mello et al. likewise elaborate that those concerns with litigation and professional implications for negligence also keep errors unreported and reduce sources of failure without learning.[15]

Lack of reporting due to cultural and systemic barriers in healthcare organizations is the next factor contributing to the incidence of medical errors. Short staffing, high workloads, and lack of managerial support contribute to the occurrence of mistakes and hinder reporting. Aghighi et al. also reported that systemic factors significantly affect medical errors and stress the need to address the organization's healthcare systems.[16]

To overcome these difficulties, the study participants recommend the introduction of anonymous reporting systems as a way of enhancing safety culture. Reason, J. posited that reporting errors is possible once the working environment does not have punitive measures in place. A new approach is to create a blind coding system where the error could be reported without having to know the identity of the person who made the mistake, which could lead to reduced reporting of errors due to its social implications.[17]

CONCLUSION

The study highlights the complex systemic, organizational, and human factors contributing to the underreporting and mismanagement of medical errors in urology units. Addressing these challenges is essential for advancing patient safety and fostering a culture of accountability in healthcare.

CONFLICT OF INTEREST

There were no conflicts of interest

DECLARATION

No grants or funding was availed by any authors for this research project. The authors don't have any conflict of interest to declare.

AUTHOR CONTRIBUTIONS

Author	Area of contribution
Rizwan Ullah	Idea conception, Design of the study, Data Collection, Data Analysis and Manuscript Critical Appraisal.
Nowshad Asim	Idea conception, Design of the study, Data Analysis and Drafting the Manuscript.
Naveed Afzal Khan	Data Analysis and Drafting the Manuscript.
Brekhna Jamil	Idea conception, Design of the study, and Manuscript Critical Appraisal.
Syed Muhammad Shabbir Ali	Data Analysis, Manuscript Critical Appraisal.
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