Cover Sheet

Medical Students Raising Concerns

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For submission to the Journal of Patient Safety

Word count 3761
3 tables
1 figure
22 references

Keywords:

Education – Whistleblowing – Professionalism – Patient safety – Raising concerns

Abstract

After a number of high-profile incidents and National reports, it has become clear that all health professionals and all medical students must be able to raise concerns about a colleague's behaviour if this behaviour puts patients, colleagues or themselves at risk.

Detailed evidence from medical students about their confidence to raise concerns is limited, together with examples of barriers which impair their ability to do so. We describe a questionnaire survey of medical students in a single centre, examining self-reported confidence about raising concerns in a number of possible scenarios. Thematic analysis was applied to comments about barriers identified.

Whilst 80% of respondents felt confident to report a patient safety issue, students were less confident around issues of probity, attitude and conduct. This needs to be addressed to create clear mechanisms to raise concerns, as well as support for students during the process.

Introduction

It has become increasingly clear in recent years that qualified health professionals, including doctors, must raise concerns about a colleague's behaviour if it puts patients, colleagues or themselves at risk. This may include clinical conduct and performance or personal conduct or both.[1,2,3,4] The Francis report[3] into the failings at the National Health Service Mid-Staffordshire Foundation Trust in the UK was published in February 2013. Since then issues of patient safety, quality of care and a culture of collective leadership have been in the public eye more than ever, in particular the responsibility of individuals at all levels to report patient safety concerns, if they exist. Although physicians have demonstrated that they know they should report colleagues causing concerns, in one study only two-thirds stated that they were prepared to do so.[5]

The requirement to raise concerns links to the professional 'duty of candour'[6] which focuses on honesty with patients when things go wrong but incorporates organisational support for such a duty, including the creation of a system to report concerns and adverse incidents.[7] There is also a relationship to The Safeguarding Framework, which is a document published in the UK to provide a national framework of standards for good practice and outcomes in adult protection work. This includes a requirement to refer concerns to an appropriate agency as swiftly as possible.[8]

It has become apparent that similar standards need to apply to medical and dental students.[9,10,11] The Francis report[3] made explicit that all doctors, whether fully qualified or in training, work in environments where they are under a duty to protect patients, stating that 'trainees are invaluable eyes and ears in a hospital setting.' Therefore it is incumbent on students to raise concerns, not only within their medical school but also in the wider clinical environment in which they are placed if such concerns are identified. Understanding whether or not they feel confident to do so is important for the medical schools in which they are learning. In the new UK General Medical Council (GMC) guidance on medical student fitness-to-practice, currently under consultation, there is an expanded section on responses to safety risks and raising concerns.[12] Medical schools have a clear duty to foster an open environment in which students can feel comfortable raising concerns.[13]

There have been several reports into whistleblowing and the experience of raising concerns. Among NHS staff there remains a gap between the proportion of people who know about the raising concerns (or "whistleblowing") policy and the proportion of individuals who feel supported in using it.[14] Several barriers have been cited that prevent workers from speaking out, which include being viewed as a troublemaker, fear of reprisals from managers and/or colleagues and feeling that nothing will be done to address the concern.[15,16]

Detailed evidence from medical students about their confidence to raise concerns is limited. Previous studies using questionnaires and focus groups show that students are reluctant to report their peers when they exhibit unprofessional or unethical behaviour.[17,18] These attitudes change little as students proceed through their training.[19] However these studies were carried out some years ago, before the increased awareness of high-profile examples of whistleblowing and of instances where it was felt that students should have raised concerns but did not.[4,6] The recent GMC national survey of student professionalism[20] was carried out online and contained one question around raising concerns in which students were asked to rate the acceptability of a student drawing a concern to their school about being asked to site a cannula despite having never done this before and not feeling competent to do so. Seventy one percent of students felt it was acceptable for a student to draw patient safety concerns to their medical school; however, the barriers or worries around acting on this in practice were not explored.

Several reasons have been outlined anecdotally why students may not feel confident to raise concerns. Students at the start of their studies are beginning to learn the standards that are expected of themselves and of the medical student body as a whole. The camaraderie between medical students may make it difficult for medical students to raise concerns about colleague[s], even if well-founded, and students have also commented that they do not see the reporting as being their responsibility.[17]

Students who raise concerns formally and to an individual in authority may worry that their report will not be taken seriously and that they risk losing friends, or they may feel that, as they have not yet had extensive clinical experience themselves, it is difficult to judge whether others' actions pose a risk to patients in the clinical environment. Students may be

reticent when asked to carry out a clinical duty that is beyond their competence, and may worry that refusing to undertake the duty would be unprofessional, rather than a prompt for them to raise a concern about the request itself. Anecdotally, we note that before raising a concern, students often talk to one another or perhaps junior members of the organisation in which they are learning. Sometimes the reason is to allow them to 'explore' whether others think that their concern is reasonable before committing themselves and indeed to find out whether it is shared with others. This may be part of first steps before gaining the confidence to report more formally or to someone in authority.

Given the critical importance of empowering students to raise concerns in a safe environment, we undertook a questionnaire survey in a single medical school. The aim of this study was to explore current levels of confidence of medical students around raising concerns and reporting concerns in the context of the Francis report. Information was sought with respect to the raising of different types of concern around patient safety, probity, the attitudes and conduct within different professional relationships, as well as the possible differences between the discussion of a concern with peers or a junior doctor and reporting to a senior authority figure.

Methods

Our study took the form of a questionnaire survey of students from a single London medical school. Students had been previously provided with information in various formats on how to raise concerns. At present this information is disseminated at induction sessions at the start of the academic year, in talks at the start of each clinical placement regarding local mechanisms within each NHS Trust, and in instructions in student handbooks regarding how and to whom concerns should be raised. In addition the general responsibilities of doctors and students regarding raising concerns are covered in lectures and in an online governance and professionalism resources. These learning experiences are not formally assessed. In the UK, although there is an online reporting system within the NHS for serious untoward incidents, this is not something accessible to students and there is no formalised national reporting system for students to use.

The project was reviewed by the local ethics committee and deemed not to require formal ethical approval. The survey was created using the Bristol Online Survey tool. As this was an exploratory study, the questions were based on information from the existing literature but were not subjected to detailed reliability or validity testing, nor was there an intention to build a reproducible tool as a consequence. In the UK, most medical schools (including ours) focus on theoretical and problem-based learning together with simulated clinical encounters in the first two years of the programme, followed by three years taught mainly in clinical placements in primary and secondary care. Therefore, the online link to the survey was sent to all students in Years 3, 4 and 5 of the medicine programme – as these students are taught predominantly in a clinical environment, it was felt that they would be most able to respond to the questionnaire. Reminders were sent in three emails before closing the survey to encourage non-responders to participate in the questionnaire. It was anonymous and responses could not be traced back to individual students.

The purpose of the study was to evaluate the levels of confidence around reporting concerns in a series of theoretical scenarios, such as issues concerning patient safety and attitude of staff towards a patient. Students were invited to rate their confidence at raising each type of concern using a six-point Likert scale, then asked to whom they would be most likely to report a concern while on a clinical placement, with a range of options being given. Finally, students were asked to outline why they might feel reticent to report incidents and how the School might facilitate this. Although demographic information was available for the whole student cohort surveyed, it was not collected within the survey in order to provide reassurance to the students that responses were totally anonymous. The questions asked in the survey are given in Table 1.

The information collected was analysed by descriptive statistics. Students were classified as 'confident' if they rated their level of confidence as 1-3 on the Likert scale and 'not confident' if they rated their level of confidence as 4-6. The mean and median ranking for each statement was also calculated. The free text data were subjected to thematic analysis by a single coder to identify and group common themes.[21]

Results

All students in Years 3, 4 and 5 were invited to participate (n = 920). There were 443 respondents (48%). The overall demographics of the cohort of students surveyed contained essentially equal proportions of male and female students (49.8% males and 50.2% females). The majority (93.3%) was UK students, the remainder being EU or International students (6.7%).

Whilst around 80% (355/443) of respondents felt confident to report patient safety issues, students were progressively less confident around issues of probity (291/443 or 66%), and the attitude and conduct either between staff and students (284/443 or 64%) or between fellow students (273/443 or 62%), the attitude of staff towards a patient (253/443 or 57%) and interactions between colleagues (189/443 or 43%) (Table 2). The detailed breakdown of levels of confidence around each of these areas is shown in Figure 1.

In terms of the type of individual that students stated they would be likely to share a concern with, this was more likely to be a fellow student or a junior doctor than a senior member of clinical or academic staff. This type of behaviour could include information sharing that might be terms 'exploratory' rather than making a clear report. In terms of reporting to a figure in authority, students were least likely to feel confident to report an incident to either their Personal Mentor or the Trust administrative staff (Table 3). Overall there were some limitations regarding confidence of students to raise concerns to figures of authority within the medical school, with 124/443 (28%) not confident (i.e. ranked 4-6 on a Likert scale of confidence) to report to a lead administrator, 133/443 (30%) not confident to report to head of year and 186/443 (38%) not confident to report to a personal mentor. The limitations appeared even greater for reporting to figures in authority in the NHS Trusts where students complete their clinical placements, with 37% not confident to report a concern to the lead clinician in their team and 44% not confident to report to a senior Trust administrator.

The free text was a rich source of information regarding the reasons cited by students for not raising concerns. Of significance were the comments around the perceived negative impact on training and future career, either their own or that of others.

"You rely on colleagues for your learning, a good relationship with one's peers, SHOs, registrars is essential for passing the year ... So if reporting a concern, may hinder that relationship, the risk may be considered to be too high."

"As a medical student I have had many doctors tell me that reporting certain things is inappropriate as it would damage a doctor's career"

Students were also worried that reporting concerns may provoke an angry reaction from staff or other students.

"*Stigma of whistleblowing, worry of not being liked by other members of staff affecting how I felt on the wards and the opportunities that would be available to me."*

"I think one major reason people might be unlikely to report things is out of worry that relationships with colleagues will be damaged."

There was profound sensitivity around reporting and its potential effect upon the 'sign-off' at the end of their clinical placement, and whether subsequent opportunities and teaching would be withheld.

There was worry about students' capacity to judge when a situation was concerning as well as a fear of over-reaction. Moreover the appropriateness of reporting at all by a student was queried.

"Being very new to the hospitals I feel my judgement is not necessarily better than others. It is difficult to point out and report issues when you are so new, unsure as to what it the norm. Reporting something seems a very extreme action, so I would want to be sure that what I was reporting was wrong."

"I'm just a medical student; presumably all these people who're actually getting paid to be here know what to do."

Some cited their lack of knowledge of how to raise a concern, self-perception of their limited authority to do so, or their previous experiences and reactions when they had done so.

"As medical students, I often feel as if we do not have the authority to correct potential mistakes or raise concerns in regards to the behaviour, practice or attitude of senior staff. I know that this should not be the case and that it is our duty to report anything that is compromising patient safety and I do hope that, in such a situation, I would be able to."

Around suggestions for improving when and how to report, a number of themes emerged. Students requested greater clarity around the nature of issues that should be raised, with clearer articulation of what constituted misconduct. There were also requests around more frequent training, greater availability of guidance documents and the provision of examples.

There was a wish for transparency around the consequences of raising a concern – students want to know that they would be provided with feedback on how the School addressed the issue.

"Take concerns seriously and provide written proof of the line of action taken."

Several suggestions included the need for greater reassurance around the consequences of reporting, particularly in the event of an error in reporting. Students wished to feel that they had acted responsibly in raising a concern, and that their education would not be compromised as a consequence.

"[would need] reassurances by the team that reporting concerns will not be frowned upon and that the medical school will work to protect you if you have legitimate concerns."

“State that reporting won't get anyone in trouble, reporter or reportee, if it turns out to have been a misunderstanding on the student's part.”

A number of students comment on the value of an online reporting system at medical school level, for ease, reduction of anxiety and clarity. Ideas for mechanisms included e-mail, a survey tool, the online course area or a dedicated online portal as well as a named member of staff, who might be able to provide advice about the legitimacy of a concern as well as on the process for reporting it.

“Online reporting – therefore the fear of face-to-face 'confrontation' would be eliminated, i.e. a place where you could query if your concern was legitimate as well as reporting.”

Many students indicated that anonymity would be important. However, there was little reflection on the relationship between the requests for availability of support and information for the individual raising concerns and how this might intersect with anonymity. There was also little reflection on the need for concerns to be validated and how this might fit with an anonymous system.

Discussion

Significant events in recent years within the United Kingdom have changed the landscape with respect to the perceptions of the roles of doctors and medical students in raising concerns about their peers and colleagues. It is increasingly important that students feel able to raise concerns and that medical schools support them to do so.

In this exploratory questionnaire study we have demonstrated that medical students during their clinical years have a reasonable level of confidence around raising a concern which they perceive to relate to patient safety. However confidence levels were lower when there were concerns relating to probity or to issues around clinical and professional relationships. In addition to the variation in confidence around raising concerns in different contexts there was also some variation in confidence about the type of person with whom students felt they could raise a concern. High levels of confidence were seen around raising concerns with fellow students or with junior doctors with whom they have contact but there were lower levels of confidence associated with formal reporting to figures of authority, both within the medical school and within the healthcare environment.

Previous studies showed that medical students were reluctant to report their peers when they exhibited unprofessional or unethical behaviour.[17,18] However these studies were limited in scope and focused mainly on academic misconduct rather than a broader range of clinical concerns. Very limited data are currently available around the degree to which students feel that it important to raise such concerns and the level of confidence that they would have in doing so.

In a national study of 564 third-year students in the USA, the majority of students (82%) agreed strongly or agreed somewhat that they feel obligated to report peers whose 'personal behaviours compromise their professional responsibilities.' The majority of students (84.7%) agreed strongly or agreed somewhat that they feel obligated to report peers whom 'they believed were seriously unfit to practice medicine'.[22] However in this study the students were not asked about their willingness to report (as opposed to their obligation) nor on any perceived barriers to making such a report. Likewise in the recent

GMC survey of student values, 71% of students felt it was acceptable for a student to draw patient safety concerns to their medical school; however 'acceptability' does not necessarily equate with confidence, and confidence is a prerequisite for translation into action. The GMC survey did not explore barriers or worries around acting on concerns in practice. In our study, the finding that 80% of respondents felt confident to report a patient safety issue is in line with the GMC survey results. However, students reported lower confidence levels around issues of probity, and attitude and conduct (between fellow students, towards a patient and interactions between colleagues). In addition there was also some variation in confidence about the type of person that students felt they could raise a concern with. High levels of confidence were seen around raising concerns with fellow students or with junior doctors on placement. This may be attributed, at least in part to students often talking with peers and junior members of the organisation in exploring whether others considered their concern reasonable, and indeed whether it was shared by others: this sometimes may be the first step in a more formal reporting process. The students in our study expressed limited confidence in taking concerns to figures in authority, both in the medical school and even more so to the senior clinicians and administrators in the NHS trusts of their placements. Some differences may relate to familiarity and comfort – students spend five or six years at medical school and develop relationships of trust with members of staff. This may be difficult to replicate in short term placements in a busy clinical environment. However, it is in this environment that patient safety issues most often presented and students need to feel empowered in their responsibilities to raise concerns in this environment, to understand the processes to do so, and to feel confident and supported in their duty of candour. It is clear that there is scope for more improvement in this area.

Our study has several limitations. We do not have information from non-responders to the survey, and while the response rate is good for a questionnaire of this type, response bias may have affected the findings. For example, it may be that, despite assurances of anonymity, students who had been previously reluctant to voice concerns were also reticent to complete the questionnaire. The fact that students' demographic information was not collected limits the depth of analysis that can be applied, such as correlations with gender or year of study at medical school, to evaluate whether attitudes and confidence change with increasing clinical experience. The questions did not elaborate in detail on specific examples

of the types of behaviours described and it may be that more detailed information would be helpful in this regard. It is not possible to determine at this stage whether the findings are generalisable to other medical schools either in the UK or beyond. Furthermore the data presented showed confidence as self-assessed by the student in relation to theoretical scenarios that they may or may not have experienced in practice. Triangulation with real reporting rates and other sources of information such as interviews or data collected from existing reporting systems would provide more evidence. In addition, no correlations were drawn in our study with other parameters such as measurable indices of moral foundations; however associations with such measures have been shown previously to be modest at best.[22]

Our findings, together with the perceived barriers and proposed support mechanisms for students raising concerns are important, not least because, in the proposed amended GMC guidance (currently under consultation), more weight is being given to the importance of students feeling able to raise concerns. The proposed guidance is now more prescriptive around the role of medical schools to provide support and clarity of process, and our qualitative feedback presents important contexts for how this might best be constructed. Future research might explore further the different levels of confidence of students in reporting specific types of concerns via particular routes, or might test the success and value of online or other mechanisms for reporting concerns.

Concluding Remarks

This is the first study in the 'post-Francis' era to report in detail on medical student confidence around raising concerns[3]. While the findings are encouraging compared with previous studies, there is still some way to go to increase confidence of medical students to enable and empower them to raise concerns where necessary, and to train them to be able to recognise concerns that are 'legitimate' as well as the mechanisms to report that they consider to be reasonable and acceptable.

Tables and Figures

Table 1: Questions in the Survey to students

Questions that measured confidence using a Likert scale (where 1 = very confident, and 6 was not at all confident)
1. How confident would you feel about reporting your concerns regarding the following incidents?
(a) An issue concerning patient safety
(b) An issue regarding attitude and conduct of Trust staff towards a patient
(c) An issue of probity regarding patients' records e.g. changing or misrepresenting information in patient's notes
(d) An issue regarding attitude and conduct between clinical colleagues e.g. an argument
(e) An issue regarding attitude and conduct of clinical colleagues towards a student
(f) An issue regarding attitude and conduct between fellow students
2. To whom would you be most likely to report an incident you have observed whilst on placement?
(a) Senior Medical School Academic
(b) Senior School Administrator
(c) Personal Mentor
(d) Lead clinical tutor in placement
(e) Lead administrator in placement
(f) Junior doctor in placement
(g) Fellow students
Free Text comments
3. If you feel it would be difficult to report a concern, please would you explain why (optional)
4. Is there anything your medical school could do to make it easier to report a concern? (optional)

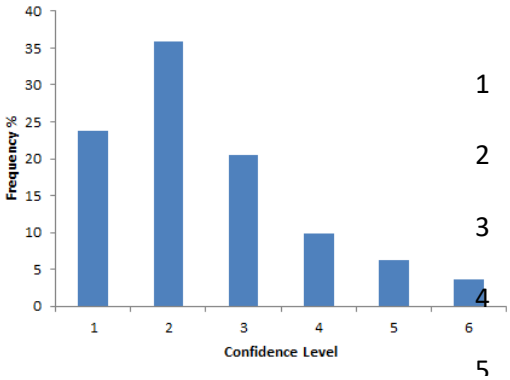
Table 2: Percentage of respondents listing level of confidence of students to report different issues using a self-reported Likert scale and categorized as 'confident' or 'not confident'

Issue	Confident (Ranked 1-3) Number (%)	Not Confident (Ranked 4-6) Number (%)
Patient Safety: Unspecified in the survey	355 (80.1%)	88 (19.9%)
Probity: Changing / misinterpreting information in patient notes	291 (65.7%)	152 (33.3%)
Attitude and conduct: Staff towards a student	284 (64.1%)	159 (35.9%)
Attitude and conduct: Between fellow students	273 (61.7%)	170 (38.3%)
Attitude and conduct: Trust staff towards a patient	253 (57.1%)	190 (42.9%)
Attitude and conduct: Between clinical staff e.g. an argument	189 (42.7%)	254 (57.3%)

Table 3: Level of confidence regarding individuals with whom students would feel confident sharing an incident witnessed on placement

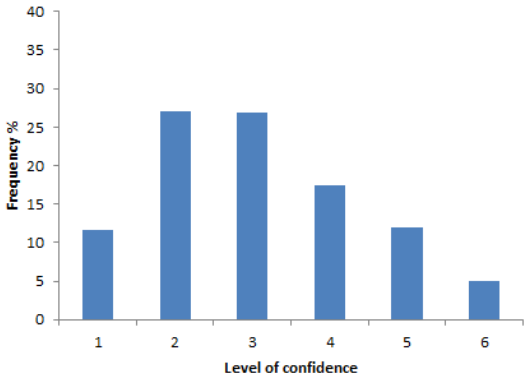
Issue	Confident (Ranked 1-3)	Not Confident (Ranked 4-6)
Fellow students on placement	91%	9%
Trust: Junior Doctor on placement	83%	17%
School: Head of Year	70%	30%
School: Lead Administrator	72%	28%
Trust: Lead Clinician	63%	37%
School: Personal Mentor	62%	38%
Trust: Lead Administrator	56%	44%

a)



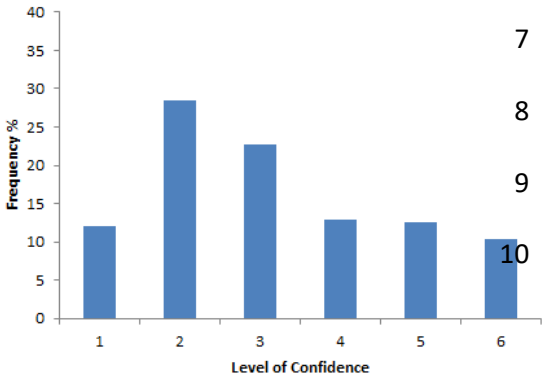
An issue concerning patient safety

b)



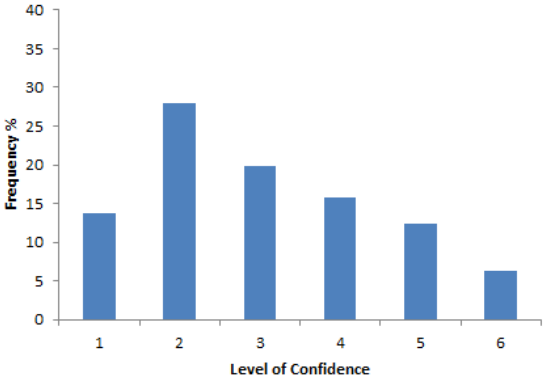
An issue of probity regarding patients' records

c)



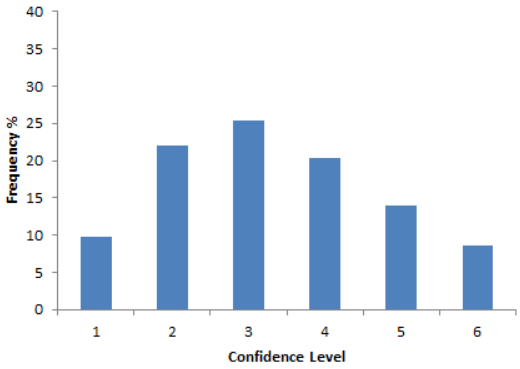
An issue regarding attitude and conduct of clinical colleagues towards a student

d)



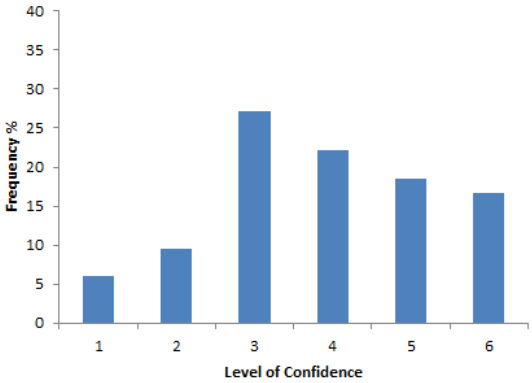
An issue regarding attitude and conduct between fellow students

e)



An issue regarding attitude and conduct of Trust staff towards a patient

f)



An issue regarding attitude and conduct between clinical colleagues

Figure 1: Self-reported level of confidence of students in raising concerns about specific issues using a Likert scale where 1 is 'Very confident' and 6 is 'Not at all confident' in the following areas: a) An issue concerning patient safety; b) An issue of probity regarding patients' records e.g. changing or misrepresenting information in a patient's notes; c) An issue regarding attitude and conduct of clinical colleagues towards a student; d) An issue regarding attitude and conduct between fellow students; e) An issue regarding attitude and conduct of Trust staff towards a patient; f) An issue regarding attitude and conduct between clinical colleagues e.g, an argument

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