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Ethical analysis of scandals in congenital heart surgery programs

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Research Abstract Title

Ethical analysis of scandals in congenital heart surgery programs

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IRB Number:

Describe role of Submitting/Presenting Trainee in this project (limit 150 words):

The role of the trainee in this project was research, data collection, data analysis, manuscript creation.

Background, Objectives/Goal, Methods/Design, Results, Conclusions limited to 500 words

Background:

In the last few decades, several pediatric heart surgery programs have been rocked by scandals involving attempts to cover up excessive mortality and morbidity.

Objectives/Goal:

To discover common factors in quality and safety problems in heart surgery programs.

Methods/Design:

Qualitative analysis, snowball sampling of publicly available sources.

Results:

Scandals in 5 programs were included for analysis.

2019: U of N Carolina - mortality rate was double the national average. Staff noticed problems; data were hidden. Administrative leaders rebuked staff. Frustrated cardiologists contacted The New York Times to expose the story.

2018: Johns Hopkins All Children's Hospital, FL - mortality rate was 4 times the national average. Staff spoke up to hospital leaders but were disregarded and demoted. Some resigned and left. The Tampa Bay Times broke the story.

2015: St. Mary's Hospital, FL - mortality rate was 4 times the national average. Concerned cardiologists reported problems to state regulatory agencies. A state investigation highlighted major problems. Problems reported by CNN.

1995: Bristol Royal Infirmary, UK - mortality rate was twice the national average. Staff concerns were initially ignored by hospital leaders. Problems led to a government inquest.

1994: Winnipeg Health Sciences Centre, Canada - mortality rate was 3 times the national average. Nurses brought concerns to leadership but were ignored. Surgeries were halted when the anesthetists refused to assist further. A government inquest highlighted major problems.

The factors discovered in this analysis were explained under two main themes, cultural and external. External factors such as low-volumes, competing programs, lack of external transparency and monitoring impacted administrators decisions that led to scandal. While these external factors had some causal influence, cultural factors presented the most common and influential causal factor towards scandal. These factors were disregarding of internal voices, lack of monitoring and accountability, unbalanced power dynamics leading to whistleblowing as the only way for internal staff to exercise moral agency.

Conclusions:

Problems in quality and safety create two types of ethical challenges – one for front-line clinicians, one for administrative leaders. Front-line clinicians must decide when to report problems and what to do if their reports are ignored. Administrative leaders must balance institutional pressures to grow programs quickly with the need to create a strong moral infrastructure and culture of safety.