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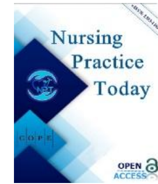

Letter to Editor

Fiduciary duty in error reporting

Yusrita Zolkefli

Pengiran Anak Puteri Rashidah Sa'adatul Bolkiah, Institute of Health Sciences, Universiti Brunei Darussalam, Brunei-Muara, Brunei Darussalam; School of Health in Social Science, The University of Edinburgh, Edinburgh, United Kingdom

Patient safety has garnered considerable attention and significance in healthcare in recent years, particularly in aspects of medication errors. One of the recommended ways to mitigate medication errors is through error reporting (1). However, underreporting is also widely reported (2), which prompts serious reflection on the moral obligation to report such errors. This commentary will address the fiduciary duties of both individual nurses and healthcare organizations to encourage such reporting.

Effective management of medication errors requires a comprehensive understanding of their causes and reporting practices (3). Despite this, nurses often encounter challenges when it comes to acknowledging and reporting such errors. A dilemma arises regarding the necessity of disclosing errors, particularly to unsuspecting healthcare professionals and patients, as well as concerns about potential repercussions from reporting these mistakes. This is where the concept of fiduciary duty becomes relevant. Individual nurses are at the forefront of this issue. The public's trust in healthcare professionals to prevent harm forms the foundation of this duty, as explicitly articulated in the principle of nonmaleficence. This principle implies that, in the event of clinical errors, individual nurses must embrace a sense of accountability that underpins safe practice (4). Such accountability is reflected in their obligation to consistently act in the best interests of both the patient and the organization. Consequently, it is expected that nurses will be honest and promptly report medication errors.

Furthermore, nurses must possess the moral courage to address medication errors by recognizing them and subsequently notifying the appropriate authority through responsible reporting. It is, however, troubling that nurses' responses to errors are reported to be influenced by the perceived repercussions of those errors. For example, nurses have indicated that they only inform the on-duty manager when the error or harm is deemed severe (3). Therefore, it can be argued that this approach leads to only a temporary and unreliable solution. Therefore, nurses must cultivate the moral courage to do what is right (5) and report any degree of error to prevent future incidents, thereby facilitating the establishment of a sustainable error-prevention strategy.

Secondly, the organization's fiduciary duty is paramount. This is particularly true when there is a consistent emphasis placed on the importance of fostering a culture that encourages the reporting of errors (6). Prioritizing patient safety is a crucial aspect of this supportive organizational culture. To effectively manage medication errors, organizations must first develop a clear understanding of the various types of errors classified as medication errors and identify which ones necessitate reporting. Therefore, to enhance nurses' ability to report medication errors, policymakers, managers, and nurses must collaborate to establish a unified definition of a medication error (7). Establishing a universally recognized

Corresponding Author: Yusrita Zolkefli, Pengiran Anak Puteri Rashidah Sa'adatul Bolkiah, Institute of Health Sciences, Universiti Brunei Darussalam, Brunei-Muara, Brunei Darussalam; School of Health in Social Science, The University of Edinburgh, Edinburgh, United Kingdom. Email: yusrita.zolkefli@ubd.edu.bn

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definition of a medication error and implementing straightforward and robust reporting mechanisms would represent a significant step toward improving patient safety.

The fiduciary duty of the organization includes the responsibility to evaluate whether its current culture promotes trust and fairness (8). For example, will nurses receive equitable treatment from nurse managers when they express concerns about medication errors? Nurses may be likely to be less inclined to report issues in an environment that feels unsupportive and punitive. Moreover, it can be particularly challenging to encourage nurses to report incidents if the organization continues to prioritize individual professional retribution and punishment over recognizing the broader implications of errors. The primary objective of reporting should be to enhance the quality of care and safety of practice, rather than to identify wrongdoers. Similarly, nurse managers must acknowledge the moral courage of nurses and emphasize the importance of accepting responsibility when errors occur (9). Additionally, a significant and insightful observation has been made regarding the complex system of monitoring health professionals and institutions. It is argued that the regulatory process should be kind, firm, and fair. In other words, regulation can be further refined to be more compassionate towards those affected through non-threatening and respectful communication (10).

In summary, this commentary highlights a concerning indication that various factors influence the decision to report medication errors. The current bleak practice of reporting medication errors serves as a wake-up call, necessitating a reevaluation of the fiduciary duty imposed on individual nurses through the principles of accountability and moral courage. Simultaneously, organizations must establish a unified definition of medication error and evaluate whether their current culture is both trusting and just in addressing these errors. A negative narrative surrounding error reporting would only discourage nurses from acknowledging mistakes and accepting moral responsibility. To foster a culture of safety and accountability, characterized by open reporting, both individual professionals and the organization as a whole must actively contribute to this environment. Ultimately, the fiduciary duty aligns not only with ethical principles but also emphasizes the importance of prioritizing the patient's interests.

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Conflicts of interest

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References

1. Coelho F, Furtado L, Mendonça N, Soares H, Duarte H, Costeira C, Santos C, Sousa JP. Predisposing factors to medication errors by nurses and prevention strategies: A scoping review of recent literature. Nursing Reports. 2024 Jun 26;14(3):1553-69. https://doi.org/10.3390/nursrep14030117
2. Svitlica BB, Konstantinidis G. Factors contributing to non-reporting of medication errors. Global Pediatrics. 2024 Jun 1;8:100144. https://doi.org/10.1016/j.gpeds.2024.100144
3. Saifan A.R, Dimitri A, Al-Yateem N, Shajrawi A, Hamdan K, Al-Habeis O.M, et al. Medication errors occurrence and reporting: A qualitative study of the Jordanian nurses' experiences. Nursing Practice Today. 2024; 11(2): 141-9. https://doi.org/10.18502/npt.v11i2.15405
4. Sharon I, Drach-Zahavy A, Srulovici E. The effect of outcome vs. process accountability-focus on performance: A meta-analysis. Frontiers in Psychology. 2022 Apr 27;13:795117. https://doi.org/10.3389/fpsyg.2022.795117
5. Kleemola E, Leino-Kilpi H, Numminen O. Care situations demanding moral courage: content analysis of nurses' experiences. Nursing Ethics. 2020 May;27(3):714-25. https://doi.org/10.1177/0969733019897780
6. Van Baarle E, Hartman L, Rooijakkers S, Wallenburg I, Weenink JW, Bal R, Widdershoven G. Fostering a just culture in healthcare organizations: experiences in practice. BMC Health Services Research. 2022 Aug 13;22(1):1035. https://doi.org/10.1186/s12913-022-08418-z

7. Afaya A, Konlan KD, Kim Do H. Improving patient safety through identifying barriers to reporting medication administration errors among nurses: an integrative review. BMC Health Services Research. 2021 Dec; 21(1): 1156. https://doi.org/10.1186/s12913-021-07187-5

8. Paradiso L, Sweeney N. Just culture: It's more than policy. Nursing Management. 2019 Jun 1;50(6):38-45. https://doi.org/10.1097/01.NUMA.0000558482.07815.ae

9. Hong N, Qichao N, Dong C, Chunling T, Dong P, Xinyu L, Yu S, Shilong L, Yuhuan Z. A study on different types of moral courage and coping styles of clinical nurses: based on potential profile analysis. BMC Nursing. 2023 Nov 8;22(1):418. https://doi.org/10.1186/s12912-023-01590-5

10. Jayasinghe S. Kind, Firm, and Fair Medical Regulation: A Systems Approach and Six Ethical Principles. Journal of Medical Regulation. 2024 Nov 1;110(3):33-7. https://doi.org/10.30770/2572-1852-110.3.33