Doctors uncomfortable with procedures for reporting errors

By Heather Victorn

Most American doctors are uncomfortable with current methods for sharing and reporting information about mistakes. As a result, they rely on informal discussions with colleagues, often leaving hospitals and health care organizations in the dark about medical errors and ways of preventing them, according to a study funded by HHS’s Agency for Healthcare Research and Quality (AHRQ) and published in the January/February issue of Health Affairs.

“These findings shed light on an important question: how to create error-reporting programs that will encourage clinician participation,” notes AHRQ director Carolyn M. Clancy, M.D. “Physicians say they want to learn from errors that take place in their institution to improve patient safety. We need to build on that willingness with error-reporting programs that encourage their participation.”

To assess physicians’ attitudes about informing colleagues and health care organizations about mistakes, the study used a 68-question survey to poll a geographically diverse group of more than 1,000 physicians and surgeons in rural and urban areas of Missouri and Washington State. The survey was conducted between July 2003 and March 2004.

Most physicians reported that they had been involved in an error: 56 percent reported a prior involvement with a serious error, 74 percent with a minor error and 66 percent with a near miss. Fifty-four percent agreed that “medical errors are usually caused by failures of care delivery systems, not failures of individuals.”

Most physicians feel they should report errors to their hospital or health care organization to improve patient safety. Almost all agreed that they needed to know about errors in their organization to improve patient safety, and 89 percent agreed that they should discuss errors with their colleagues.

Eighty-three percent say they have used at least one formal reporting mechanism, most commonly reporting an error to risk management (68 percent) or completing an incident report (60 percent). Few physicians believe they have access to a reporting system designed to improve patient safety, and 45 percent do not know if one exists at their organization.

Sixty-one percent have used at least one informal mechanism to report an error to their hospital or health care organization, usually telling a supervisor or manager (40 percent) or physician chief or departmental chairman (38 percent). Physicians are more likely to discuss serious errors, minor errors and near misses with their colleagues than to report them to a risk management or patient safety official.

Only 30 percent consider current systems adequate for reporting patient safety events. When asked what would increase their willingness to formally report error information, physicians say they want:

1) information to be kept confidential and non-discoverable (88 percent);

2) evidence that such information would be used for system improvements (85 percent) and not for punitive action (84 percent);

3) the error-reporting process to take less than 2 minutes (66 percent); and

4) the review activities to be confined to their department (55 percent).