Medical Xpress

Survey reveals reasons doctors avoid online error-reporting tools

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"Too busy," and "too complicated." These are the typical excuses one might expect when medical professionals are asked why they fail to use online error-reporting systems designed to improve patient safety and the quality of care. But, Johns Hopkins investigators found instead that the most common reason among radiation oncologists was fear of getting into trouble and embarrassment.

Investigators e-mailed an anonymous survey to physicians, nurses, radiation physicists and other radiation specialists at Johns Hopkins, North Shore- Long Island Jewish Health System in New York, Washington University in St. Louis, Missouri, and the University of Miami, with questions about their reporting near-misses and errors in delivering radiotherapy. Each of the four centers tracks near-misses and errors through online, intradepartmental systems. Some 274 providers returned completed surveys.

According to the survey, few nurses and physicians reported routinely submitting online reports, in contrast to physicists, dosimetrists and radiation therapists who reported the most use of error and near-miss reporting systems. Nearly all respondents agreed that error reporting is their responsibility. Getting colleagues into trouble, liability and embarrassment in front of colleagues were reported most often by physicians and residents.

More than 90 percent of respondents had observed near-misses or errors in their clinical practice. The vast majority of these were reported as

near-misses as opposed to errors, and, as a result, no providers reported patient harm. Hospitals have specific systems for reporting errors, but few have systems to accommodate the complex data associated with radiotherapy.

"It is important to understand the specific reasons why fewer physicians participate in these reporting systems so that hospitals can work to close this gap. Reporting is not an end in itself. It helps identify potential hazards, and each member of the health care team brings a perspective that can help make patients safer," says Johns Hopkins radiation oncology resident Kendra Harris, M.D., who presented an abstract of the data on October 2, 2011, at the 53rd Annual Meeting of the American Society for Radiation Oncology (ASTRO).

The good news, Harris says, is that few respondents reported being too busy to report or that the online tool was too complicated. "Respondents recognized that error events should be reported and that they should claim responsibility for them. The barriers we identified are not insurmountable," she added.

Harris says that online reporting systems should be simple and promoted as quality improvement tools, not instruments for placing blame and meting out sanctions. "These systems should not be viewed as punitive; rather, they're a critical way to improve therapy," says Harris. "You can't manage what you can't measure."

Most of the respondents said they would participate in a national reporting system for radiotherapy near-misses and errors.

"A national system that collects pooled data about near-misses and errors, which are thankfully rare, may help us identify common trends and implement safety interventions to improve care," adds Harris.