Position Statement

Medical Error/Patient Safety Reporting Systems

This Position Statement was developed as an educational tool based on the opinion of the authors. It is not a product of a systematic review. Readers are encouraged to consider the information presented and reach their own conclusions.

In the years since the release of the Institute of Medicine report and subsequent Congressional hearings, public attention has focused on the need to improve patient safety and minimize medical errors. Proposals to achieve this objective include nationwide patient safety reporting systems.

The American Academy of Orthopaedic Surgeons (AAOS) is committed to ensuring patient safety and to decreasing medical errors.

Programs and initiatives of the AAOS directed towards reducing medical errors and improving patient safety to date include:

- A series of closed-claim professional liability insurance studies by the AAOS Committee on Professional Liability carried out since 1990 to determine common causes of orthopaedic error and resulting in the publication of the first and second editions of Managing Orthopaedic Malpractice Risk.
- The "Sign Your Site" initiative, which was developed as a result of a September 1997 AAOS task force study of preventable errors occurring in the operating room including surgery on the wrong site. The task force advised that surgery on the wrong site would rarely if ever occur when an awake and alert pre-operative patient and the surgeon mark the operative site immediately prior to surgery.
- A system of Continuous Quality Improvement, including clinical practice guidelines and performance measures, developed to improve quality and efficiency of care and focus on patient safety, which can be used to assist physicians in diagnosis and treatment decisions.
- Ongoing educational opportunities designed to educate orthopaedic surgeons in the best practice of orthopaedic care, including online education modules.

Medical error reporting should lead to improvements in patient safety. The AAOS believes the following principles are essential to ensure the success of a nationwide effort to reduce the number of medical errors:

- Public and private initiatives to ensure patient safety and reduce the number of medical errors.
- Ensuring patient confidentiality and appropriate legal protection of all information involved in patient safety reporting systems is critical.
- Patient access to their medical records should not be jeopardized by new initiatives.

- Before instituting new reporting systems, federal and state governments should first determine, through supporting research, whether and how existing reporting programs as well as public and private initiatives have led to a reduction in medical errors.

The AAOS urges that the goal should be to prevent patient harm and minimize health systems errors. An important goal of any reporting system should be to foster open dialogue and reporting. Systems with punitive undertones would defeat an open dialogue.

To encourage maximum reporting, all information developed in connection with reporting systems, at all phases of reporting activity, should be privileged for purposes of federal and state judicial proceedings, both in civil matters and in administrative proceedings including discovery, subpoenas, testimony, and other forms of disclosure. The submission of information to reporting systems, or the sharing of information with third parties for the purpose of improving patient safety should not be construed as waiving any privilege of confidentiality recognized under state or federal law or established as part of a reporting system. All such information should be exempt from the Freedom of Information Act.

The Patient Safety and Quality Improvement Act of 2005 (Public Law 109-41) provides for the creation of Patient Safety Organizations (PSOs) to protect information gathered in the pursuit of improved patient safety. The Academy anticipates the implementation of this Act will facilitate prospective data collection and encourage the reporting of medical errors in a non-punitive environment. The AAOS encourages initial, scientifically sound research into reporting programs, including those mandated in approximately 25 states, to determine whether and how they have led to a reduction in medical errors. Funding should be available to redesign systems based on research findings to prevent further errors. The costs to hospitals and other providers for implementing these systems should be considered. Research should not be disproportionately skewed to hospital-based errors but should target a broad range of practice settings.

Policies should encourage a constructive partnership between the federal government, hospitals, physicians, and other medical providers and personnel to initiate policies that can effectively decrease medical error in the United States. Federal government patient safety initiatives should involve a broad range of public and private organizations, including medical specialty societies, to continually advance efforts to improve patient safety.

The AAOS stands ready to work with a broad range of public and private agencies, including hospitals, medical professionals and others, to ensure safe patient practices. The AAOS has designated this initiative as a high priority in its policies and advocacy.