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OBSTETRICIAN-GYNECOLOGISTS' OPINIONS ABOUT PATIENT SAFETY
Costs and Liability Remain Problems; Are Mandated Reports a Solution?

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Background. **To elucidate the patient safety practices of obstetrician-gynecologists (OB/GYNs), the perceived barriers to patient safety improvements in obstetrics and gynecology, and OB/GYN's beliefs about mandated reporting.**

Methods. **A sample of 600 OB/GYNs was sent a survey from the American College of Obstetricians and Gynecologists about their beliefs and practice regarding patient safety.**

Results. **The response rate was 53.2%. More than 92% of respondents said that patient safety is important in women's health care. The most important barriers to improving patient safety were cost of new technologies and concern about liability. Half agreed that mandatory reporting would improve patient safety. Physicians who practice in states with mandated error reporting were no more or less likely to think that these mandates improve patient safety than physicians who do not work in states with mandates. Physicians who practice in states with "I'm Sorry" laws more strongly disagreed that mandates improve patient safety than physicians who do not work in states with "I'm Sorry" laws.**

Discussion and Conclusions. **It may be effective to aim at making patient safety activities more affordable to increase implementation. In addition, the effects of reporting and disclosure laws on physicians' concerns with liability should be examined more closely.**

Introduction

In 1999, a landmark report estimated that 44,000–98,000 deaths occur each year owing to errors in medicine (Kohn, Corrigan, & Donaldson, 1999). Since that time, there has been a paucity of evidence of widespread implementation of initiatives to prevent medical errors despite the dire findings cited in the report (Leape & Berwick, 2005; Longo, Hewett, Ge, & Schubert, 2005). One factor in this slow progress may be the barriers of implementing abstract principles into practical, concrete behavior in practice settings (Weingart & Page, 2003).

One concrete initiative to prevent future medical errors has been the implementation of mandated reporting of medical errors. Five states mandate that physicians report medical errors to their patients (Table 1) and other states, counties, and hospitals have created their own unique requirements about disclosure to patients (Weissmann, Annas, Epstein, Schneider, et al., 2005). Many believe that mandates will improve patients safety (Wood & Nash, 2005) and medical liability reform (Clinton & Obama, 2006), although 1 study found that health care leaders are skeptical

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Table 1. States That Have Enacted "I'm Sorry" Laws

Arizona A.R.S. 12-2605 (2005)
California Evidence Code 1160 (2000)
Colorado Revised Statute 13-25-135 (2003)
Connecticut Public Act No. 05-275 Sec.9(2005) amended (2006) Conn. Gen. Stat. Ann. 52-184d
Delaware Del. Code Ann. Tit. 10, 4318 (2006)
Florida Stat 90.4026 (2001)
Georgia Title 24 Code GA Annotated 24-3-37.1 (2005)
Hawaii HRS Sec.626-1 (2006)
Idaho Title 9 Evidence Code Chapter 2 .9-207
Illinois Public Act 094-0677 Sec. 8-1901, 735 ILL. Comp. Stat. 5/8-1901 (2005)
Indiana Ind. Code Ann.34-43.5-1-1 to 34-43.5-1-5
Iowa HF 2716 (2006)
Louisiana R.S. 13:3715.5 (2005)
Maine MRSA tit. 2908 (2005)
Maryland MD Court & Judicial Proceedings Code Ann. 10-920 (2004)
Massachusetts ALM GL ch.233, 23D (1986)
Missouri Mo. Ann. Stat. 538.229 (2005)
Montana Code Ann.26-1-814 (Mont. 2005)
Nebraska Neb. Laws L.B. 373 (2007)
New Hampshire RSA 507-E:4 (2005)
North Carolina General Stat. 8C-1, Rule 413
North Dakota ND H.B. 1333 (2007)
Ohio ORC Ann 2317.43 (2004)
Oklahoma 63 OKL. St. 1-1708.1H (2004)
Oregon Rev. Stat. 677.082 (2003)
South Carolina Ch.1, Title19 Code of Laws 1976, 19-1-190 (2006)
South Dakota Codified Laws 19-12-14 (2005)
Tennessee Evid Rule 409.1(2003)
Texas Civil Prac and Rem Code 18.061(1999)
Utah Code Ann. 78-14-18 (2006)
Vermont S 198 Sec. 1. 12 V.S.A. 1912 (2006)
Virginia Code of Virginia 8.01-52.1 (2005)
Washington Rev Code Wash 5.66.010 (2002)
West Virginia 55-7-11a (2005)
Wyoming Wyo. Stat. Ann. 1-1-130

Source: http://www.sorryworks.net/files/states_with_apology_laws.ppt; http://www.sorryworks.net/lawdoc.phtml

(Weissmann, Annas, Epstein, Schneider, et al., 2005). There is evidence that the number of medical errors reported under mandatory reporting are often not accurate (Marchev, Rosenthal, & Booth, 2003), and that unexpected consequences of mandatory reporting may have a negative effect on patient care, such as physician refusal to treat high-risk patients and prioritization of quotas over quality of care (Werner & Asch, 2005).

One drawback with these systems is that physicians fear that disclosure may lead to a lawsuit. Liability concerns have greatly impacted the practice of obstetrics and gynecology, threatening the quality of women's health care and the availability to women's health care providers (Anderson, Hale, Salsberg, & Schulkin, 2008). To address physicians' liability concerns, >35 states have enacted some sort of "I'm Sorry" laws, which exclude apologies and/or expressions of sympathy as a priori proof of liability (Sorry Works! Coalition, n.d.). Some experts suggest that "I'm Sorry" laws will decrease law suits (Cohen, 2004) whereas others suggest that the problem with medical error reporting is within professional norms outside the realm of law (Wei, 2007). No research to our knowledge has assessed the impact of these laws on the beliefs and practices of obstetrician/gynecologists (OB/GYNs), a medical specialty that has been experiencing a drastically increasing number of malpractice suits in recent years (American College of Obstetricians and Gynecologists [ACOG], 2006).

The present study was designed to elucidate the preventative patient safety practices of OB/GYNs, the perceived barriers to patient safety improvements in obstetrics and gynecology, and OB/GYN's beliefs about mandated reporting. We hypothesized that OB/GYNs would have implemented only some patient safety initiatives into their practice. We also hypothesized that OB/GYNs who work in states with mandates would be more likely to agree that mandates will improve patient safety.

Methods

Written questionnaires were sent to a total of 600 members of the ACOG. Half of the group ($n = 300$) surveyed were members of the Collaborative Ambulatory Research Network (CARN) and half were randomly selected ACOG members. Established in 1990, the CARN consists of a group of ACOG Fellows who voluntarily participate in surveys to help ACOG monitor prevailing clinical obstetric and gynecologic practices (4.7% of practicing ACOG Fellows and Junior Fellows currently belong to CARN). Members receive approximately 4 ACOG-sponsored surveys annually, on a range of topics. Participants have been chosen to reflect the age and gender distribution of all ACOG Fellows. CARN is demographically representative of ACOG members in average age, gender ratio, and geographic distribution (Table 2).

Three mailings were sent to both sample groups between September and December, 2006, and a 4th mailing was sent later to only the non-CARN group to increase the response rate of this group. The materials in the mailing included a cover letter, the survey, and a self-addressed stamped envelope. Informed consent was assumed to have been given by any physician who returned the survey and no compensation was given to those who participated. The Georgetown University Institutional Review Board approved this study.

The questionnaire included questions regarding the respondent's age, gender, practice location, number of years in practice, practice setting, and the primary

Table 2. Mean Birth Year and Gender Ratio of OB/GYNs in CARN Group Compared With the ACOG Membership in General

	CARN	ACOG Membership
Mean birth year	1958 (SD, 10.2)	1958 (SD, 10.9)
Male (%)	52	55