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Perceptions of Medical Errors Reporting and Management among Physicians in a Teaching Hospital in Northwestern Nigeria

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ABSTRACT

Background: Medical errors pose a significant threat to patient safety and healthcare quality worldwide, particularly in low- and middle-income countries. Physicians' perceptions of error reporting and management influence the effectiveness of patient safety initiatives, yet evidence from Northwestern Nigeria is limited. **Aim:** To assess physicians' perceptions of medical error reporting and management at a teaching hospital in Northwestern Nigeria. **Materials and Methods:** A hospital-based cross-sectional descriptive study was conducted among 191 physicians at Usmanu Danfodiyo University Teaching Hospital, Sokoto. Eight departments were selected using simple random sampling, and eligible physicians were recruited via systematic sampling. Data were collected using a structured, pretested, self-administered questionnaire and analysed with SPSS version 25. Descriptive statistics summarized sociodemographic characteristics and perceptions of error reporting and management. **Results:** The mean age of respondents was 36.3 ± 6.3 years, with a predominance of males (79.6%) and resident doctors (66.5%). Overwork, stress, and fatigue (63.9%), communication gaps (53.4%), and lack of teamwork (44.0%) were perceived as leading causes of medical errors. Laboratory-related (42.9%) and diagnostic errors (41.9%) were most commonly encountered. Key strategies for prevention included spending more time with patients (51.8%) and establishing structured reporting systems (45.0%). Most physicians supported constructive management responses, such as information-seeking (61.3%), reporting through appropriate channels (45.5%), and collegial discussion (36.1%), while avoidance and concealment behaviors were rare. **Conclusion:** Physicians generally hold positive views of medical error reporting and management, favouring learning-oriented, collaborative approaches. Strengthening structured reporting systems and supporting teamwork-based error management could further enhance patient safety in this setting.

Keywords: Medical errors, Physician perceptions, Patient safety, Error reporting and management, Northwestern Nigeria

INTRODUCTION

Medical errors remain a major global public health concern and constitute a significant threat to patient safety and the quality of healthcare delivery. A medical error is generally defined as the failure of a planned action to be completed as intended or the use of an incorrect plan to achieve a healthcare aim.[1] Such errors may occur at any stage of healthcare delivery, including diagnosis, treatment, laboratory investigations, medication administration, or surgical procedures. Globally, medical errors contribute substantially to preventable morbidity and mortality, particularly in low- and middle-income countries where healthcare systems often face workforce shortages, inadequate infrastructure, and limited safety monitoring systems.[1,2] Estimates suggest that millions of patients worldwide experience preventable harm during healthcare delivery each year, highlighting the urgent need for improved patient safety practices and stronger error reporting systems.[1,3]

Effective reporting and management of medical errors are central components of patient safety improvement strategies. Error-reporting systems allow healthcare institutions to identify systemic weaknesses, implement corrective measures, and prevent the recurrence of similar incidents.[4,5] Transparent disclosure and reporting of medical errors also promote organizational learning and foster a culture of accountability and safety within healthcare settings. However, despite the recognized benefits of reporting systems, underreporting of medical errors remains a persistent challenge in many healthcare institutions worldwide.[5,6]

Factors such as fear of litigation, professional stigma, punitive institutional cultures, and lack of clear reporting mechanisms often discourage healthcare professionals from reporting errors, thereby limiting opportunities for system-wide improvements.[4,6]

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In Nigeria and other low- and middle-income countries, the burden of medical errors may be particularly pronounced due to systemic challenges within healthcare systems. Overcrowded facilities, heavy workload, inadequate staffing, and limited resources often place significant pressure on healthcare providers, increasing the likelihood of errors occurring during patient care.[7,8] Studies conducted in Nigerian tertiary hospitals have identified factors such as excessive workload, communication failures among healthcare teams, and inadequate supervision as key contributors to medical errors.[7,9] Similar findings have been reported in other West African countries, where workforce shortages and infrastructural limitations have been linked to increased risk of patient safety incidents.[10,11] These contextual challenges highlight the importance of understanding how physicians perceive the causes, reporting practices, and management of medical errors within their clinical environments.

Physicians play a pivotal role in recognizing, reporting, and managing medical errors. Their perceptions regarding error causation, reporting processes, and appropriate management responses significantly influence whether errors are disclosed and addressed effectively within healthcare systems.[5,6] Positive perceptions toward error reporting have been associated with increased transparency, improved teamwork, and enhanced patient safety outcomes. Conversely, negative perceptions or a lack of awareness regarding reporting procedures may contribute to underreporting and the perpetuation of unsafe practices.[3,4] Understanding physicians' perceptions is therefore essential for designing targeted interventions to strengthen institutional safety cultures and improve reporting systems.

In addition, identifying commonly encountered types of medical errors and physicians' perceived strategies for preventing them can provide valuable insights for healthcare administrators and policymakers. Evidence from previous studies suggests that medication errors, diagnostic errors, laboratory-related errors, and delays in clinical interventions are among the most frequently reported patient safety incidents in hospital settings.[5,10] Preventive strategies such as improving communication among healthcare professionals, strengthening teamwork, enhancing supervision, and implementing structured reporting systems have been widely recommended to reduce medical errors.[6,8] However, the extent to which physicians perceive these strategies as effective may vary depending on institutional culture, training, and workload conditions.

Despite growing recognition of patient safety issues, empirical evidence on physicians' perceptions of medical error reporting and management in Nigeria remains limited. Most existing studies have focused primarily on specific types of errors or patient safety culture without exploring physicians' perspectives on the broader processes of error reporting and management.[7,9] Furthermore, data from the Northwestern region of Nigeria are relatively scarce, despite the presence of several tertiary healthcare institutions serving large populations. Understanding physicians' perceptions in this context is critical for identifying gaps in reporting practices and for developing effective institutional policies to reduce preventable harm. Therefore, this study aimed to assess physicians' perceptions of medical error reporting and management at a teaching hospital in Northwestern Nigeria. Findings from this study are expected to contribute to the growing body of evidence on patient safety in Nigeria and provide insights to strengthen error-reporting systems and improve the quality of healthcare delivery in tertiary healthcare institutions.

MATERIALS AND METHODS

Study Design, Population, and Area

This was a hospital-based cross-sectional descriptive study conducted among physicians at Usmanu Danfodiyo University Teaching Hospital, Sokoto metropolis, Northwestern Nigeria. The study population comprised medical doctors working in the hospital. Only physicians who had been in employment for at least six (6) months prior to the study were considered eligible and enrolled.

Sample Size Estimation and Sampling Technique

The sample size was estimated at 191 using the formula for calculating the sample size for a single proportion,[12] based on a 66.0% prevalence of self-reported medical errors in a study among doctors,[13] a precision level of 5%, and an anticipated 95% response rate. A multistage sampling technique was used to select participants. In the first stage, eight departments were selected from a total of 24 departments in the hospital using simple random sampling by balloting. In the second stage, a systematic sampling technique was used to select eligible physicians

within each selected department. The staff list of each department served as the sampling frame, and proportionate allocation was applied based on the number of physicians in each department to ensure adequate representation.

Data Collection

Data were collected using a structured self-administered questionnaire. The questionnaire was developed after a review of relevant literature on medical errors reporting and management, and it consisted of three sections designed to obtain information on respondents' sociodemographic characteristics and their perceptions of medical error reporting and management. The study instrument was reviewed by senior researchers in the Department of Community Health, Usmanu Danfodiyo University, Sokoto, Nigeria, to ensure content validity. The questionnaire was pretested among 20 doctors in two departments that were not selected for the study to identify potential ambiguities and ensure the clarity of the questions. Necessary modifications were made to the instrument following the pretest before the commencement of the main study.

Data Analysis

The collected data were reviewed for completeness and subsequently entered into the Statistical Package for the Social Sciences (SPSS) version 25.0 for analysis. Descriptive statistical methods were applied to summarize the data. Categorical variables were expressed as frequencies and percentages, whereas continuous variables, such as age, were summarized using means and standard deviations. The findings were presented in both textual and tabular formats, as appropriate, to enhance clarity and interpretation.

Ethical Consideration

Ethical approval for the study was obtained from the Ethical Committee of Usmanu Danfodiyo University Teaching Hospital. Permission to conduct the study was also obtained from the heads of the selected departments. The purpose of the study was explained to all participants, and they were assured that the information provided would be kept confidential. Participation was voluntary, and informed written consent was obtained from each respondent prior to data collection.

RESULTS

Sociodemographic characteristics of respondents

A total of 191 physicians participated in the study. The respondents' ages ranged from 25 to 56 years, with a mean age of 36.3 ± 6.3 years. The majority were in the 30–39 age group (62.3%), followed by those aged 40–49 (19.4%), 20–29 (14.1%), and only 4.2% were aged 50–59. Most respondents were male (79.6%), married (82.7%), and Muslim (70.7%), while 28.8% were Christian and 0.5% reported other religions. The duration of medical practice ranged from 1 to 27 years, with a mean of 9.4 ± 5.4 years. More than half of the respondents (57.1%) had 1–9 years of professional experience, 39.8% had 10–19 years, and 3.1% had 20–29 years. Respondents reported a median weekly working time of 60 hours, with working hours ranging from 8 to 168 hours. The majority (59.7%) worked 50–99 hours per week, while 28.8% worked fewer than 50 hours, 9.9% worked 100–149 hours, and 1.6% worked 150–199 hours. Regarding professional rank, resident doctors constituted the largest proportion (66.5%), followed by consultants (20.4%), while medical officers accounted for 13.1% of respondents [Table 1].

Table 1: Sociodemographic characteristics of respondents

Variables	Frequency (%) n = 191
Age group (years)	
20-29	27 (14.1)
30-39	119 (62.3)
40-49	37 (19.4)
50-59	8 (4.2)
Sex	
Male	152 (79.6)
Female	39 (20.4)
Marital status	
Single	31 (16.2)
Married	158 (82.7)
Widowed	2 (1.0)
Religion	
Islam	135 (70.7)
Christianity	55 (28.8)
Others	1 (0.5)
Length of practice (years)	
1-9	109 (57.1)
10-19	76 (39.8)
20-29	6 (3.1)
Working hours per week	
1-49	55 (28.8)
50-99	114 (59.7)
100-149	19 (9.9)
150-199	3 (1.6)
Rank	
Medical officers	25 (13.1)
Residents	127 (66.5)
Consultants	39 (20.4)

Perceived causes of medical errors by respondents

Respondents identified several factors they believed contributed to medical errors. The most frequently perceived cause was overwork, stress, and fatigue (63.9%). This was followed by communication gaps (53.4%) and communication failures (51.3%) among healthcare professionals. Other commonly perceived contributing factors included lack of teamwork (44.0%), absence of close patient monitoring (29.3%), and insufficient time spent with patients (28.8%). Less frequently reported causes included lack of patient cooperation (18.8%), superficial backup or consultation (16.8%), understaffing of nurses (16.2%), undertrained physicians (14.7%), and lack of strong leadership (12.6%) [Table 2].

Table 2: Perceived causes of medical errors by respondents

Causes of medical errors	Frequency (%) n = 191
Not having enough time with the patient	55 (28.8)
Overwork, stress, and fatigue	112 (63.9)
Communication failures among health professionals	98 (51.3)
Understaffing of nurses	31 (16.2)
Lack of cooperation from the patient	36 (18.8)
Absence of close monitoring	56 (29.3)
Lack of teamwork	84 (44.0)
Communication gap	102 (53.4)
Lack of strong leadership	24 (12.6)
Superficial backup and consultation	32 (16.8)
Undertrained physicians	28 (14.7)

Perceived strategies for preventing medical errors by respondents

More than half of the respondents (51.8%) believed that allowing physicians more time to spend with patients would significantly reduce medical errors. Nearly half (45.0%) also supported encouraging hospitals to voluntarily report serious medical errors to a state agency, reflecting recognition of the role of structured reporting systems in improving patient safety. However, fewer respondents endorsed procedural or staffing measures as key preventive strategies. Only 28.8% believed that counting surgical items during invasive procedures would reduce errors, while 22.5% considered increasing the number of nurses as an effective preventive strategy [Table 3].

Table 3: Perceived strategies for preventing medical errors by respondents

Strategies for preventing medical errors	Frequency (%) n = 191
Giving physicians more time to spend with the patient	99 (51.8)
Increasing the number of nurses	43 (22.5)
Counting surgical items during an invasive surgical procedure	55 (28.8)
Encourage hospitals to report errors voluntarily to the state agencies	86 (45.0)

Perceived commonly encountered medical errors by respondents

Respondents reported that laboratory-related errors were the most commonly encountered type of medical error (42.9%), closely followed by diagnostic errors (41.9%). Other frequently perceived errors included medication-related errors (28.3%) and delayed or late clinical intervention (24.1%). Less frequently reported errors were surgical-related (11.5%) and patient-related (11.5%), while transfusion-related errors were the least commonly reported (8.8%) [Figure 1].

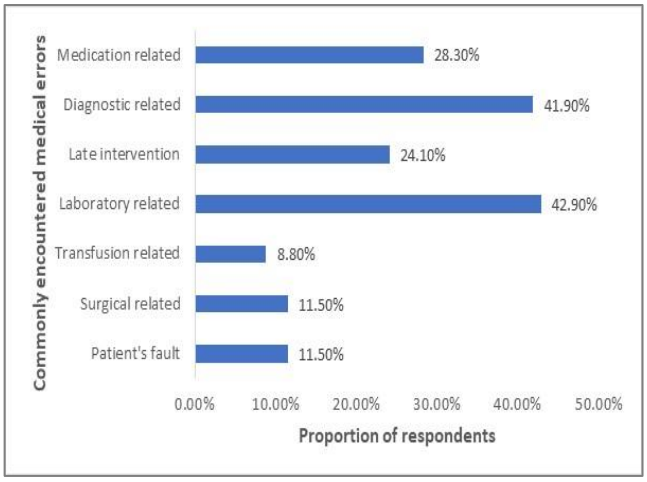

Figure 1: Perceived commonly encountered medical errors by respondents

Respondents' perception of the benefits of medical error reporting for patients

Most respondents (65.4%) believed that medical error reporting helps patients receive better quality treatment. Other commonly identified benefits included improved patient safety (40.8%), prevention of health hazards (39.8%), and saving patients' lives (38.7%). Approximately one-third of the respondents perceived additional benefits such as avoiding medico-legal implications (33.5%) and facilitating correction of errors (31.4%). Fewer respondents indicated that medical error reporting could reduce hospitalization duration (15.2%) or medical costs (13.6%) [Table 4].

Table 4: Respondents' perception of the benefits of medical error reporting for patients

Patients' benefits from medical error reporting	Frequency (%) n = 191
Helps receive quality treatment	125 (65.4)
Helps prevent health hazards	76 (39.8)
Reduces hospitalization	29 (15.2)
Saves a patient's life	74 (38.7)
Helps correct the errors	60 (31.4)
Reduction of medical bills	26 (13.6)
Improves patients' safety	38 (40.8)
Helps avoid medicolegal implications	64 (33.5)

Perceived management of medical errors by respondents

Regarding appropriate responses when medical errors occur, the majority of respondents (61.3%) believed physicians should increase information-seeking to better understand the error. Nearly half (45.5%) reported that errors should be reported through appropriate channels, while 36.1% recommended discussing the issue with colleagues. Conversely, very few respondents supported avoidance behaviors such as avoiding similar patients or circumstances (11.0%), and only 0.5% indicated that concealment of the error was appropriate [Table 5].

Table 5: Perceived management of medical errors by respondents

Actions to be taken by a physician when medical errors occur	Frequency (%) n = 191
Conceal it	1 (0.5)
Avoid similar patients or circumstances	21 (11.0)
Increase information seeking	69 (36.1)
Discuss with colleagues	87 (45.5)

DISCUSSION

This study provides important insights into physicians' perceptions of medical error reporting and management in a tertiary healthcare setting in Northwestern Nigeria. The predominance of relatively young, early-career physicians, most of whom were resident doctors with a mean practice duration of less than 10 years, reflects the workforce composition typical of teaching hospitals in Nigeria. The long working hours reported by respondents, with a median of 60 hours per week, highlight the demanding nature of clinical practice in such settings and may have implications for patient safety. Similar patterns of workforce strain have been reported in Nigerian and other sub-Saharan African settings, where high patient loads and limited staffing contribute to increased risk of errors.[7,11] Furthermore, evidence from Nigeria indicates that high workload and systemic pressures are closely associated with increased exposure to medical errors and adverse events among healthcare workers.[14,15]

The findings that overwork, stress, and fatigue were the most commonly perceived causes of medical errors align with global and regional evidence identifying human factors as major contributors to adverse events. Excessive workload has been consistently linked to reduced cognitive performance, impaired decision-making, and increased likelihood of clinical errors.[5,10] Additionally, communication gaps and failures among healthcare professionals were prominently reported, underscoring the critical role of effective teamwork and information exchange in ensuring patient safety. Previous studies have similarly demonstrated that poor communication is a leading cause of preventable harm in healthcare systems.[3,6] In sub-Saharan Africa, weak communication systems and hierarchical barriers have been shown to hinder effective error reporting and teamwork.[16,17]

In terms of preventive strategies, respondents emphasized the need for more time with patients and for establishing structured reporting systems. This suggests an appreciation of both patient-centered care and systemic approaches to error reduction. However, the relatively low endorsement of procedural safeguards, such as surgical counts, and staffing improvements, such as increasing the number of nurses, may reflect limited awareness of evidence-based safety interventions or contextual constraints within the health system. Studies in low- and middle-income countries have shown that strengthening institutional policies, including staffing

adequacy and adherence to safety protocols, significantly reduces medical errors.[1,8] Additionally, poor implementation of safety protocols and low awareness of standardized procedures have been reported among clinicians in Nigeria, further contributing to preventable errors.[14,18]

The predominance of laboratory-related and diagnostic errors reported in this study is noteworthy and may reflect systemic inefficiencies in diagnostic processes, including delays, inadequate infrastructure, or human error. This finding is consistent with reports from similar settings, where diagnostic errors constitute a substantial proportion of adverse events due to limited access to diagnostic tools and high patient volumes.[3,9] In many African healthcare systems, challenges such as inadequate laboratory capacity and delayed test results further exacerbate diagnostic inaccuracies.[14,15] Additionally, global evidence indicates that diagnostic errors are among the most common and harmful types of medical errors, particularly in resource-constrained settings where system-level weaknesses persist.[19,20]

Encouragingly, a substantial proportion of respondents recognized the benefits of medical error reporting, particularly in improving the quality of care and patient safety. This positive perception aligns with evidence that effective reporting systems facilitate learning from errors, enhance transparency, and promote safer clinical practices.[1,4] However, the relatively lower recognition of economic benefits, such as reduced hospitalization costs and duration, may indicate a limited understanding of the broader health system impact of patient safety initiatives. Previous studies in Nigeria have also shown that despite awareness of the importance of reporting, actual reporting practices remain suboptimal due to fear of blame and lack of supportive systems.[14,17] Recent global and regional evidence further highlights that well-implemented patient safety and incident reporting systems are associated with improved clinical outcomes and more efficient resource utilization, while persistent cultural and structural barriers continue to limit optimal reporting practices in low- and middle-income countries.[21,22]

Regarding error management, most physicians supported constructive responses such as increased information-seeking, reporting through appropriate channels, and collegial discussion. These findings suggest a generally positive attitude toward learning-oriented and systems-based approaches to error management. Notably, very few respondents endorsed concealment or avoidance behaviors, a promising sign of an emerging culture of openness and accountability. This is consistent with studies showing that fostering a non-punitive environment encourages healthcare workers to report errors and engage in corrective actions.[2,6] However, evidence from African settings indicates that blame culture and lack of psychological safety still persist and can negatively affect reporting behaviors.[15,16]

Overall, the findings highlight both strengths and gaps in physicians' perceptions of medical error reporting and management. While there is clear recognition of key contributing factors and the benefits of reporting, there is a need for enhanced training in evidence-based preventive strategies and institutional support for patient safety systems. Strengthening communication, reducing workload, and promoting a culture of safety through structured reporting mechanisms should be prioritized to improve patient outcomes in similar settings.[8,11]

STUDY LIMITATIONS

This study has some limitations. Its cross-sectional design precludes causal inference, and reliance on self-reported data introduces potential for social desirability and recall biases, particularly given the sensitive nature of medical errors. Additionally, the single-center setting may limit the generalizability of the findings to other healthcare contexts. Finally, the study focused only on physicians, excluding other healthcare professionals involved in patient care.

CONCLUSION

Physicians in this study generally held positive perceptions of medical error reporting and management, favoring learning-oriented and systems-based approaches. The predominance of constructive responses, such as information-sharing and collegial discussion, indicates an emerging culture of openness and professional accountability. Based on these findings, strengthening structured reporting systems and supporting collaborative error management strategies could further reinforce safe clinical practices in this setting.

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Nil.

Conflict of interest

None declared.

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