Communicating Pathology Errors: Physicians’ Attitudes and Experiences
COMMUNICATING ABOUT MEDICAL ERRORS: PHYSICIANS’ ATTITUDES AND EXPERIENCES

General Attitudes About Medical Errors

Please use these definitions when answering the questions. The definitions are also listed at the bottom of each page.

**Adverse event** = an injury that was caused by medical management rather than the patient’s underlying disease.

**Medical error** = the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Medical errors include serious errors, minor errors, and near misses.

**Serious error** = error that causes permanent injury or transient but potentially life-threatening harm.

**Minor error** = error that causes harm which is neither permanent nor life-threatening.

**Near miss** = an error that could have caused harm but did not either by chance or timely intervention.

1. Medical errors are one of the most serious problems in health care.
   - [ ] Strongly Disagree
   - [ ] Disagree
   - [ ] Agree
   - [ ] Strongly Agree

2. For every 100 hospitalized patients, how many do you think will experience a SERIOUS error?
   - [ ] of 100 patients

3. For every 100 hospitalized patients, how many do you think will experience a MINOR error?
   - [ ] of 100 patients

4. For every 100 hospitalized patients, how many do you think will experience a NEAR MISS?
   - [ ] of 100 patients

5. For every 100 pathologists in your specialty, how many do you think will be sued for malpractice in the next year?
   - [ ] of 100 pathologists

6. What do you think the chances are that you will be named in a malpractice suit in the next year?
   - [ ]% chance of being named in suit

7. Medical errors are usually caused by failures of care delivery systems, not the failure of individuals.
   - [ ] Strongly Disagree
   - [ ] Disagree
   - [ ] Agree
   - [ ] Strongly Agree

Communicating About Pathology Errors

8. NEAR MISSES, including those due to pathology errors, should be disclosed to patients.
   - [ ] Strongly Disagree
   - [ ] Disagree
   - [ ] Agree
   - [ ] Strongly Agree

9. MINOR errors, including those due to pathology errors, should be disclosed to patients.
   - [ ] Strongly Disagree
   - [ ] Disagree
   - [ ] Agree
   - [ ] Strongly Agree

10. SERIOUS errors, including those due to pathology errors, should be disclosed to patients.
    - [ ] Strongly Disagree
     - [ ] Disagree
     - [ ] Agree
     - [ ] Strongly Agree

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11. Disclosing a SERIOUS error to a patient would damage a patient’s trust in my competence as a pathologist.
   ○ Strongly Disagree
   ○ Disagree
   ○ Agree
   ○ Strongly Agree

12. Disclosing a SERIOUS pathology error to a patient would make it less likely that the patient would sue the pathologist.
   ○ Strongly Disagree
   ○ Disagree
   ○ Agree
   ○ Strongly Agree

13. Disclosing a SERIOUS pathology error directly to a patient would be very difficult.
   ○ Strongly Disagree
   ○ Disagree
   ○ Agree
   ○ Strongly Agree

14. Which of the following factors might make it less likely that you recommend that a SERIOUS pathology error be disclosed to a patient? (Choose ALL that apply)
   ○ If the patient is unaware that the error happened.
   ○ If I think the patient would not want to know about the error.
   ○ If I think the patient would become angry.
   ○ If I didn’t know the patient very well.
   ○ If I think I might get sued.
   ○ If I think the patient would not understand what he or she was being told.
   ○ If I think the physician would not be able to explain the error clearly to the patient.

15. Which of the following factors might make it less likely that you would disclose a SERIOUS pathology error to the patient’s physician? (Choose ALL that apply)
   ○ If the physician is unaware that the error happened.
   ○ If I think the physician would not want to know about the error.
   ○ If I think the physician would become angry with me if I did so.
   ○ If I didn’t know the physician very well.

Clinical Scenario
A 72-year-old man with mildly elevated PSA undergoes prostate needle core biopsy performed at your institution which you report as positive for prostatic adenocarcinoma, Gleason's grade 3+3=6. You receive the patient's subsequent radical prostatectomy specimen which upon initial review reveals no adenocarcinoma. You submit the entire prostate for histologic evaluation. In addition, you review all reports and slides of prostate needle core biopsies performed on the day your patient was biopsied. You determine that your patient's biopsy was inadvertently switched with that of another patient. Your patient's actual biopsy is benign. The additional sections of prostate submitted from your patient demonstrate a microscopic focus of adenocarcinoma, Gleason's grade 3+3=6.

16. This situation is:
   ○ Not an error
   ○ A Near Miss
   ○ A Minor Error
   ○ A Serious Error

17. As the pathologist overseeing this case, how responsible are you for this error?
   ○ Not at all responsible
   ○ Somewhat responsible
   ○ Very responsible
   ○ Extremely responsible

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18. How upset would you be about this error?
- Not At All Upset
- Somewhat Upset
- Very Upset
- Extremely Upset

19. How concerned would you be that your reputation will be damaged due to this error?
- Not At All Concerned
- Somewhat Concerned
- Very Concerned
- Extremely Concerned

20. How likely do you think it is that you will be sued due to this error?
- Very Unlikely
- Somewhat Unlikely
- Somewhat Likely
- Very Likely

21. What would you recommend to the treating physician about error disclosure to the patient?
- Do not disclose the error
- Disclose the error only if asked by the patient
- Probably disclose the error
- Definitely disclose the error

22. What would you recommend that the patient's physician say about what happened? (Choose ONE)
- “You have a small focus of adenocarcinoma within your prostate which has been completely removed.”
- “Your original prostate needle core biopsy was incorrectly reported. However, you have a small focus of adenocarcinoma within your prostate which has been completely removed.”
- “Your original prostate needle core biopsy was mistakenly switched with another patient. Your actual biopsy showed no cancer and we would not have performed a prostatectomy based upon these results. However, your prostatectomy specimen does show a small focus of well differentiated cancer which has been completely removed.”

23. How much detail would you recommend the patient's physician give the patient about the error? (Choose ONE)
- "I would recommend the physician not volunteer any specific information about the details of the error unless asked by the patient."
- “A pathologist at our institution made an error in your original biopsy diagnosis.”
- “Your original prostate biopsy was switched with that of another patient. Your actual biopsy showed no evidence of cancer.”

24. What most closely resembles what you would recommend the patient's physician say about the cause of the error? (Choose ONE)
- [I would recommend the physician not volunteer a cause of the error unless the patient asked.]
- “This error occurred because your biopsy was inadvertently switched with that of another patient.”
- "The lab technologists properly processed and labeled your slides. However, all prostate needle core biopsied performed on that day were placed on a single tray for the pathologist. The error occurred because the pathologist picked up another patient's biopsy when he thought he was looking at yours.”

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25. What would you most likely recommend the patient’s physician say regarding an apology? (Choose ONE)
   ○ [I would recommend that the physician not volunteer that s/he was sorry or apologize.]
   ○ “I am sorry about what happened.”
   ○ “I am so sorry that you may have been harmed by the error in your biopsy diagnosis.”

26. What would you most likely recommend the patient’s physician say about how the error would be prevented in the future? (Choose ONE)
   ○ [I would recommend that the physician not volunteer anything about how similar errors will be prevented in the future.]
   ○ “We are looking into what happened to you and will try to make changes to prevent this from happening in the future.”
   ○ “We are looking into what happened to you. In the future, all patient slides will be labeled with both their names and identifying numbers to help prevent error. In addition, each prostate needle core biopsy will be inked a unique color which will be indicated in the report for the pathologist to check. Each patient's biopsies will be placed on separate slide trays.”

Personal Experience With Pathology Errors

27. Which pathology errors have you personally been involved with? (Choose ALL that apply)
   ○ A Near Miss
   ○ A Minor Error
   ○ A Serious Error
   ○ None

Some pathologists participate in disclosing errors directly to patients. The following questions pertain to participating directly in error disclosure to patients.

28. Have you ever disclosed a SERIOUS pathology error directly to a patient?
   ○ No (Skip to Question 32)
   ○ Yes

29. For the most recent SERIOUS pathology error you disclosed, how satisfied were you with how this disclosure conversation went?
   ○ Very Dissatisfied
   ○ Somewhat Dissatisfied
   ○ Somewhat Satisfied
   ○ Very Satisfied

30. How did disclosing this error impact your relationship with the patient?
   ○ Very Negatively
   ○ Somewhat Negatively
   ○ No Change
   ○ Somewhat Positively
   ○ Very Positively

31. I experienced relief after disclosing this error to the patient.
   ○ Strongly Disagree
   ○ Disagree
   ○ Agree
   ○ Strongly Agree

32. In the past 12 months, have you disclosed a MINOR pathology error directly to a patient?
   ○ No (Skip to Question 36)
   ○ Yes

33. For the most recent MINOR pathology error you disclosed, how satisfied were you with how this disclosure conversation went?
   ○ Very Dissatisfied
   ○ Somewhat Dissatisfied
   ○ Somewhat Satisfied
   ○ Very Satisfied

34. How did disclosing this error impact your relationship with the patient?
   ○ Very Negatively
   ○ Somewhat Negatively
   ○ No Change
   ○ Somewhat Positively
   ○ Very Positively
35. I experienced relief after disclosing this error to the patient.

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

36. Have you received any education or training on how to disclose errors to patients?

- No
- Yes, ____ years ago

37. How interested would you be in receiving general education or training on how to disclose errors to patients?

- Not At All Interested
- Somewhat Interested
- Very Interested

38. After a SERIOUS pathology error occurred, how interested would you be in receiving coaching from an error disclosure expert on how to disclose the error to the patient?

- Not At All Interested
- Somewhat Interested
- Very Interested

39. Hospitals and health care organizations adequately support pathologists in coping with the stress associated with medical errors.

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

40. Have errors that you have been involved with negatively impacted any of these areas of your life? (Choose ALL that apply)

- Your job satisfaction
- Your confidence in your ability as a pathologist
- Your professional reputation
- Your anxiety about future errors
- Your ability to sleep
- Other (please list): _____________________

41. How interested would you be in having access to counseling if you were involved with a serious error?

- Not At All Interested
- Somewhat Interested
- Very Interested

42. Would any of these be barriers to seeking out counseling services?

- Not wanting to take time away from my work.
- Concern that what I say won’t be kept confidential if I were sued.
- Concern that talking to a counselor would be placed in my permanent record.
- Concern that talking to a counselor would affect my malpractice insurance.
- Concern that my colleagues would judge me negatively if I received counseling.
- Concern that talking to a counselor would affect my malpractice insurance.
- Concern that talking to a counselor would not be helpful.
- Other (please list): _____________________

43. To improve patient safety, pathologists should report SERIOUS errors to their hospital or health care organization.

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree
### Communicating about Medical Errors: Physicians' Attitudes and Experiences

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
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| 44. To improve patient safety, pathologists should report MINOR errors to their hospital or health care organization. | - Strongly Disagree  
- Disagree  
- Agree  
- Strongly Agree |
| 45. To improve patient safety, pathologists should report NEAR MISSES to their hospital or health care organization. | - Strongly Disagree  
- Disagree  
- Agree  
- Strongly Agree |
| 46. To improve patient safety, pathologists should discuss their errors with colleagues. | - Strongly Disagree  
- Disagree  
- Agree  
- Strongly Agree |
| 47. Which of the following, if any, have you used to report errors to your hospital or health care organization in order to improve patient safety? (Choose ALL that apply) | - Called risk management  
- Reported to the patient safety program  
- Told a supervisor or manager  
- Told an executive of your hospital or health care organization  
- Told a physician chief or department chair  
- Completed an incident report or asked someone else to complete an incident report for you |
| 48. Which types of pathology errors have you reported to risk management? (Choose ALL that apply) | - A Near Miss  
- A Minor Error  
- A Serious Error  
- None |
| 49. Does your hospital or health care organization have an error reporting system for pathologists to use to improve patient safety? | - No (Skip to Question 51)  
- Yes  
- Don’t know (Skip to Question 51) |
| 50. If yes, which types of pathology errors have you reported to this patient safety program? (Choose ALL that apply) | - A Near Miss  
- A Minor Error  
- A Serious Error  
- None |
| 51. At my hospital or health care organization, system changes to improve patient safety occur after errors are reported. | - Strongly Disagree  
- Disagree  
- Agree  
- Strongly Agree |
| 52. Which types of pathology errors have you discussed with colleagues to improve patient safety? (Choose ALL that apply) | - A Near Miss  
- A Minor Error  
- A Serious Error  
- None |
| 53. Current systems for pathologists to report patient safety problems are adequate. | - Strongly Disagree  
- Disagree  
- Agree  
- Strongly Agree |

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54. Current mechanisms to inform pathologists about errors that occur in their hospitals or health care organizations are adequate.

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

60. What percentage of your time is spent in clinical practice?

- 0%
- 1-25%
- 26-50%
- 51-75%
- 76-100%

**Participant Demographics**

55. What is your age?

_____ years

56. What is your gender?

- Male
- Female

57. In what setting do you practice pathology?

- University Medical School
- Multispecialty Group
- Pathology Group
- Independent Laboratory
- Hospital Employee

58. What is your specialty (check more than one if appropriate)?

- Surgical pathology
- Breast pathology
- Hematopathology
- Dermatopathology
- Neuropathology
- Cytopathology
- Autopsy/Forensic pathology
- I cover all disciplines and do not specialize
- Other subspecialty (please specify): 

59. What is your terminal degree?

- MD
- PhD
- MD, PhD

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