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 laboratory medical directors in your specialty, how many do you think will be sued for malpractice in the next year?
   _____ of 100 laboratory medical directors

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

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

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

10. SERIOUS errors, including those due to laboratory errors, should be disclosed to patients.
    - Strongly Disagree
    - Disagree
    - Agree
    - Strongly Agree
11. Disclosing a SERIOUS error to a patient would damage a patient’s trust in my competence as a laboratory medical director.
- ○ Strongly Disagree
- ○ Disagree
- ○ Agree
- ○ Strongly Agree

12. Disclosing a SERIOUS laboratory error to a patient would make it less likely that the patient would sue the laboratory medical director.
- ○ Strongly Disagree
- ○ Disagree
- ○ Agree
- ○ Strongly Agree

13. Disclosing a SERIOUS laboratory 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 laboratory 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 laboratory 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 59-year-old woman with a history of atrial fibrillation and stroke is maintained on coumadin with a target INR of 2.3. She is followed by her primary care physician, who checks her INR once every other month, and adjusts her coumadin dose based on the results. Her PT / INR has been stable for the last 2 years, and therefore she has been on the same dose of coumadin during this time. She stopped by the hospital outpatient laboratory on a Friday afternoon at 3:20 PM to get her INR checked. You are the primary laboratory director for this laboratory. An INR of 5.7 was resulted into the laboratory information system (LIS) at 4:05 PM. This is a critical (panic) value for your laboratory, however the critical value was not called by the technologist who works for you. At the time of this error, the laboratory was understaffed and the technologist who committed the error was very busy and distracted by the high work volume.

The failure to call the critical value was noticed by a lead technologist early Monday morning, and he immediately called a nurse at the physician’s office. The nurse knew the patient by name. She was alarmed that this result had not been called to the clinic last Friday and that the patient had not been notified. The nurse called the patient at home, but was told by the patient’s son that she had gone to the emergency department.

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department early that morning complaining of headache, difficulty speaking, and left-sided weakness and numbness in her arms, legs, and face.

Her INR at the time of her hospital admission was 7.2 and her coagulation status was normalized by administering fresh frozen plasma and Vitamin K. She was discharged to assisted living facility 3 weeks later with a stable hematocrit and therapeutic INR. Her long term medical problems consisted of modest difficulty speaking and swallowing, and severe left-sided weakness requiring a wheelchair.

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

17. As the laboratory medical director in charge of this laboratory, how responsible are you for this error?
   - Not at all responsible
   - Somewhat responsible
   - Very responsible
   - Extremely responsible

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 had another stroke. You will require long-term rehabilitation. “
   - “Your blood was too thin and this likely caused another stroke.”
   - “Your blood was too thin and this likely caused another stroke. An important contributing factor was that an error happened. The lab technologist properly entered your test result into the computer. However, your lab test was abnormal and indicated your blood was too thin, and there was a delay in the lab calling me with this critical, life-threatening result. In addition, I did not retrieve your lab result from the computer over the weekend. “

When Laboratory Medical Directors participate in error disclosures, they approach disclosing errors in many ways. Which of the following statements most closely resembles what you would recommend the patient’s physician VOLUNTEER to the patient in the clinical scenario described?

Survey questions 22-26.

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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.]
- “The lab usually calls critical results like yours directly to me. In your case, there was an inadvertent delay in the lab calling me about your critical laboratory result.”
- “The lab failed to follow their policy and procedure, and therefore there was a delay of more than 2 days in the lab calling me. On Friday, the lab tech had put your critical result in the computer, but they did notify our office of the abnormal results as they should have. Also, I did not retrieve your lab result from the computer over the weekend.”

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 occurred because of a problem in communicating your critical laboratory result to me.”
- “The lab technologist properly entered your test result into the computer. However, she failed to follow the procedure for rapidly calling me about your lab results, and therefore there was a delay of more than 2 days before I was called. The lab technologist forgot to call me because she was very busy and distracted due to high workload and understaffing of the laboratory. In addition, I failed to retrieve your lab result from the computer over the weekend.”

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 were harmed by the error in communicating your critical laboratory result.”

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, the lab director will reduce the chance of this happening again by having adequate staffing, and by managing their work flow so that the technologists do not become too busy and distracted. I have also changed my procedure for timely retrieval of results from my office.”

27. Which laboratory errors have you personally been involved with? (Choose ALL that apply)

- A Near Miss
- A Minor Error
- A Serious Error
- None

28. Have you ever disclosed a SERIOUS laboratory error directly to a patient?

- No (Skip to Question 32)
- Yes

29. For the most recent SERIOUS laboratory error you disclosed, how satisfied were you with how this disclosure conversation went?

- Very Dissatisfied
- Somewhat Dissatisfied
- Somewhat Satisfied
- Very Satisfied

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<table>
<thead>
<tr>
<th>Question</th>
<th>Response Options</th>
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<tbody>
<tr>
<td>30. How did disclosing this error impact your relationship with the patient?</td>
<td>- Very Negatively</td>
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<td></td>
<td>- Somewhat Negatively</td>
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<td></td>
<td>- No Change</td>
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<td>- Somewhat Positively</td>
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<td>- Very Positively</td>
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<td>31. I experienced relief after disclosing this error to the patient.</td>
<td>- Strongly Disagree</td>
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<td></td>
<td>- Disagree</td>
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<td></td>
<td>- Agree</td>
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<td></td>
<td>- Strongly Agree</td>
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<td>32. In the past 12 months, have you disclosed a MINOR laboratory error directly to a patient?</td>
<td>- No (Skip to Question 36)</td>
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<td></td>
<td>- Yes</td>
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<td>33. For the most recent MINOR laboratory error you disclosed, how satisfied were you with how this disclosure conversation went?</td>
<td>- Very Dissatisfied</td>
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<td></td>
<td>- Somewhat Dissatisfied</td>
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<td></td>
<td>- Somewhat Satisfied</td>
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<td></td>
<td>- Very Satisfied</td>
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<tr>
<td>34. How did disclosing this error impact your relationship with the patient?</td>
<td>- Very Negatively</td>
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<td></td>
<td>- Somewhat Negatively</td>
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<td>- No Change</td>
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<td>- Somewhat Positively</td>
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<td>- Very Positively</td>
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<td>35. I experienced relief after disclosing this error to the patient.</td>
<td>- Strongly Disagree</td>
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<td></td>
<td>- Disagree</td>
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<td></td>
<td>- Agree</td>
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<td></td>
<td>- Strongly Agree</td>
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<td>36. Have you received any education or training on how to disclose errors to patients?</td>
<td>- No</td>
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<td></td>
<td>- Yes, _____ years ago</td>
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<tr>
<td>37. How interested would you be in receiving general education or training on how to disclose errors to patients?</td>
<td>- Not At All Interested</td>
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<td></td>
<td>- Somewhat Interested</td>
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<td></td>
<td>- Very Interested</td>
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<td>38. After a SERIOUS laboratory error occurred, how interested would you be in receiving coaching from an error disclosure expert on how to disclose the error to the patient?</td>
<td>- Not At All Interested</td>
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<td></td>
<td>- Somewhat Interested</td>
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<td></td>
<td>- Very Interested</td>
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<td>39. Hospitals and health care organizations adequately support laboratory medical directors in coping with the stress associated with medical errors.</td>
<td>- Strongly Disagree</td>
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<td></td>
<td>- Disagree</td>
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<td></td>
<td>- Agree</td>
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<td></td>
<td>- Strongly Agree</td>
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<td>40. Have errors that you have been involved with negatively impacted any of these areas of your life? (Choose ALL that apply)</td>
<td>- Your job satisfaction</td>
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<td>- Your confidence in your ability as a laboratory medical director</td>
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<td>- Your professional reputation</td>
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<td>- Your anxiety about future errors</td>
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<td>- Your ability to sleep</td>
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<td></td>
<td>- Other (please list):_________________</td>
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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.
- Belief that talking to a counselor would not be helpful.
- Other (please list): ________________

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

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

44. To improve patient safety, laboratory medical directors should report MINOR errors to their hospital or health care organization.

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

45. To improve patient safety, laboratory medical directors should report NEAR MISSES to their hospital or health care organization.

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

46. To improve patient safety, laboratory medical directors 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 medical 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 laboratory medical directors to use to improve patient safety?

- No (Skip to Question 51)
- Yes
- Don’t know (Skip to Question 51)

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50. If yes, which types of laboratory 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 medical 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 laboratory medical directors to report patient safety problems are adequate.
   ○ Strongly Disagree
   ○ Disagree
   ○ Agree
   ○ Strongly Agree

54. Current mechanisms to inform medical laboratory physicians about errors that occur in their hospitals or health care organizations are adequate.
   ○ Strongly Disagree
   ○ Disagree
   ○ Agree
   ○ Strongly Agree

Participant Demographics

55. What is your age?
   _____ years

56. What is your gender?
   ○ Male
   ○ Female

57. Which institution are you affiliated with?
   ○ Washington University
   ○ University of Washington

58. What is your specialty?
   ○ Chemistry
   ○ Microbiology
   ○ Hematology
   ○ Blood Bank
   ○ Molecular
   ○ HLA
   ○ Flow Cytometry
   ○ I cover all disciplines and do not specialize
   ○ Other (please list):_____________________

59. What is your terminal degree?
   ○ MD
   ○ PhD
   ○ MD, PhD

60. What percentage of your time is spent in clinical practice?
   ○ 0%
   ○ 1-25%
   ○ 26-50%
   ○ 51-75%
   ○ 76-100%

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