Letters to the Editor

The Institute of Medicine’s Report on Medical Error: Implications for Pathology

To the Editor.—The recent article by Sirota1 entitled “The Institute of Medicine’s Report on Medical Error: Implications for Pathology” was timely and exciting. Medical errors and patient safety are 2 of the most salient issues in health care today. Dr Sirota wrote, “A system is defined as a set of interdependent elements interacting to achieve a common aim.” In health care, all too often there is system failure secondary to suboptimal interactions between the various components. Good communication is a major ingredient of the adhesive that holds the various elements together.

We need to communicate better. For example, Powsner et al2 found a communication gap in pathologists’ written surgical pathology reports, because surgeons misunderstood the reports 30% of the time. Physical factors of the report, such as font, spacing, highlighting, and format, played a significant role in comprehension of the report, even if wording changed very little. In closing the communication gap between departments, or other microsystems, we need input from the end users of the report. Hammond and Flinner3 described an example of improving written surgical pathology reports for breast cancer, with input from both end users (oncologists) and pathologists. Battles et al4 also addressed the issue of including end users, as well as external experts, in designing an incident and error reporting system. Renshaw5 discussed how errors in data measurement and reporting compared across institutions. He found wide variation in reported surgical pathology error rates, with rates from 0.5% to 43%. Renshaw5 divided surgical pathology errors into 6 types: (1) false negative, (2) false positive, (3) error of threshold (eg, atypical hyperplasia vs carcinoma in situ), (4) differences of tumor type and grade, (5) missed margins, and (6) other. In health care in general, other common examples of communication constraints to patient safety are poor penmanship and medication names that look alike and/or sound alike.

There is opportunity for improvement in communication and in measuring and reporting errors. In health care, the key to creating both a culture of safety and a learning organization is commitment and accountability by physician leadership.

MARK A. BEST, MD, MBA, MPH
VA National Quality Scholars Fellowship Program
Education Office (14W)
Cleveland Veterans Affairs Medical Center
Cleveland, OH 44106-1782