College of American Pathologists Special Topic Symposium on Error in Pathology and Laboratory Medicine—Practical Lessons for the Pathologist

Introduction

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This article is an overview to the all-day special topic symposium on patient safety and error reduction, entitled “Error in Pathology and Laboratory Medicine: Practical Lessons for the Pathologist,” which was held at the College of American Pathologists annual meeting in Scottsdale, Ariz, on September 20, 2004. The intent of the symposium was to provide pathologists with useful take-home lessons related to error identification, reduction, and risk avoidance for adoption in practice. Error reduction in the laboratory has always been an implied, if not directly stated goal of laboratory quality management programs, but given the nature of humans to err, the call for redesign of the health care system, and the impending threat of national patient safety legislation calling for medical error reporting and disclosure, we believe that this topic of error will be one of continued interest to practicing pathologists for many years.

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With the publication of the Institute of Medicine’s report on medical error in 1999 and its report on the general state of quality in health care in 2001, the topic of error reduction in all phases of medicine has become one of the most important subjects in medicine today. Error reduction in the laboratory has always been an implied, if not directly stated goal of quality management programs in the laboratory. Additionally, the College of American Pathologists, through its Q-Probes and Q-Tracks programs, has defined benchmarks of performance in pathology and laboratory medicine and has also identified rates of error in most disciplines in the specialty. These efforts have provided a nascent framework for reducing error and for improving patient safety in pathology. However, because of the current importance of the topic, it was felt that more organized attention to the topic could benefit the specialty. To that end, at its annual meeting in Scottsdale, Ariz, on September 20, 2004, the College organized a day-long session devoted to patient safety and error reduction, entitled “Error in Pathology and Laboratory Medicine: Practical Lessons for the Pathologist.” The intent of the symposium was to provide pathologists with useful take-home lessons related to error identification, reduction, and risk avoidance for adoption in practice. The proceedings of this symposium are presented in this issue of the ARCHIVES.

In the first article, Ronald Sirota, MD, frames the issues of error in pathology and laboratory medicine from societal, professional, scientific, psychological, and patient perspectives. Next, David Troxel, MD, currently chief medical officer of The Doctors Company (Napa, Calif), covers pathology error from the insurer’s perspective, including organ-specific trends in pathology error. In the third manuscript, Richard Zarbo, MD, DMD, and colleagues review the context and magnitude of errors in anatomic pathology and the types of quality assurance procedures that may enable pathologists to reduce and prevent errors. They also present a proposed classification scheme to allow standardized measurements and documentation of errors in anatomic pathology and evaluation of their potential associated clinical impact. Next, Stephen Raab, MD, and colleagues outline their research conclusions from an anatomic pathology database funded by the Agency for...
Healthcare Research and Quality. They describe a shared Web-based database designed to benchmark practices and target for reduction specific high frequency errors or errors with high clinical impact. Consideration of error and error-reduction strategies in clinical laboratory disciplines is the focus of the next article, written by Peter Howanitz, MD. Frederick Meier, MDCM, and Bruce Jones, MD, then address the burgeoning issues of point-of-care and distributed testing error occurring at the laboratory’s boundaries. In the final article, Elliott Foucar, MD, focuses on pathology expert witness testimony, summarizing the topic in some depth with the aim of providing pathology organizations and pathologists with a comprehensive resource to the pertinent nonpathology literature on expert witness testimony.

Given the nature of humans to err, the call for redesign of the health care system, and the impending threat of national patient safety legislation calling for medical error reporting and disclosure, we believe that this topic of error will be one of continued interest to practicing pathologists for many years.

Note.—A new federal law was signed into legislation July 29 that would enable voluntary, confidential reporting of medical errors to a national database. The new law would allow medical care providers to report errors “without the risk of the information being used against them in lawsuits.” The goal of the new law would be to facilitate the development of best practices and thereby possibly reduce medical errors. Its impact on laboratory reporting, error reduction, and improvements in patient care is unknown at this time.

References