Discussing errors and mistakes in pathology

Guidance to assist trainees when initiating discussions in their departments

Errors and mistakes can happen to anyone. It is part of being human. Just like all other medical specialties, errors can happen in pathology departments with varying levels of complexity and consequences.

Culturally in the healthcare profession, making a mistake has always been viewed with negative connotations and people feel that admitting to a mistake will mean that they will be judged as a 'bad doctor' or 'incompetent' at doing their job. It should be reiterated that making a mistake can happen to any doctor, irrespective of seniority and is likely to affect all of us at some stage in our careers.

However, one of the ways we can reduce the likelihood of this happening is to be vigilant to the potential errors that could happen. This can be done by talking about them in a safe, secure, open and non-judgemental environment. In this way, people can talk about their experiences or things they have witnessed, make others aware of them and prevent similar events from repeating themselves.

Most hospitals already have morbidity and mortality meetings. However, I feel that a small group of trainees sitting around a table informally talking about these situations can provide a much better learning outcome. The guidance below is to help trainees in pathology departments around the UK take the lead in setting up these discussions and allow all trainees to learn from errors and mistakes that have occurred in pathology to prevent future errors. Patient safety is of the highest priority; as trainees, we can help take steps to ensure that we change the culture of how errors and mistakes are viewed and encourage a more open discussion rather than hiding them away.

The setting

When talking about potentially sensitive experiences, it is important that these discussions take place in a safe, secure and private environment to help encourage trainee engagement. For example, discussing them in the staff coffee room or the hospital canteen is not going to encourage a positive turnout from trainees.

The rules

This exercise is not meant to have any negative impact on the trainees involved – there should be no judgement and rules of confidentiality should be maintained. It should also be stressed that all trainees are here for the same goal and there will be no negative consequences or judgement applied as a result of anything that is said. Trainees should contribute to the discussion of the cases in a constructive manner, but be very mindful of the impact their comments may have on those involved and avoid criticism. If a trainee feels they are going to be viewed negatively talking about their experience, they are unlikely to share these experiences – an undesirable outcome for all.

Discussing the story and outcomes

The first part of the discussion should involve the trainee volunteer describing the particular event that they experienced or witnessed. This description should include the main details of the error/mistake, what happened and the outcomes as a result of it, e.g. were there any negative impacts for the patient involved?

What were the factors that led to this error happening?

Errors and mistakes can be complex. There are often many 'human factors' that can result in an error, such as lack of knowledge or experience, fatigue, pressure and stress. Workforce issues can also be a major factor. Trainees should discuss what they think the factors were that are relevant to each particular example.

What are the learning points from this case?

This is a crucial part of the process; the learning points are what trainees can take away from this experience to prevent such an error happening again. It would also be useful for trainees to discuss how the error or mistake was handled or investigated by the departments or institutions involved and any outcomes from these experiences.

Constructing a summary of the case

This discussion process is not just of benefit to the group of trainees taking part, but can be invaluable to the wider trainee body. To assist this, trainees should formulate a summary document detailing the salient parts of the story (being careful to maintain confidentiality and exclude any identifiable details). The following are a list of the subheadings that could be included as part of the summary:

- Title
- The story
- The outcome
- Human factors that could have been involved
- What was learned from this event?

This summary can be distributed to trainees within the department and feature on the eCPD app to reach trainees across the UK. It could also feature in a Patient Safety Bulletin, which is published by the College. If successful, trainees should be encouraged to hold these discussions as regularly as is felt necessary. Junior trainees should be particularly encouraged to get involved from the beginning of their training.