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TABLE E-1 Survey of Surgeon Opinions on Patient Safety Initiatives
Surgeon and Clinical Characteristics
Age [xx] years Sex
[] Man [] Woman
Where is the location of your practice? [] Africa [] Asia [] Australia [] Europe [] North America [] South America [] Other
Years in practice as an attending surgeon? [] Zero to ten years [] Eleven to twenty years [] Twenty-one to thirty years [] More than thirty years
Specialty [] General orthopedics [] Upper-extremity orthopedic surgery [] Lower-extremity orthopedic surgery [] Orthopedic traumatology [] Other, name
Your primary practice/institution setting [] Small/solo [] Private clinic/HMO (health maintenance organization) [] Non-teaching hospital [] Teaching hospital
Does your practice setting/institution have a quality/safety program? [] Yes [] No [] Unknown
Is the quality/safety program mandated by a local or federal government? [] Yes [] No [] Unknown
Does your practice setting/institution have a person in charge of championing quality and safety for surgery? [] Yes [] No
[] Unknown continued

TABLE E-1 (continued) Surgeon and Clinical Characteristics Compensation type [] Billing only [] Salary plus bonus [] Salary only		
Compensation type [] Billing only [] Salary plus bonus	TABLE E-1 (continued)	
[] Billing only [] Salary plus bonus	Surgeon and Clinical Characteristics	
[1	[] Billing only	

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TABLE E-2 Modified PSCHO Questionnaire					
	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
For the following statements, please answer if you "Strongly disagree," "Disagree," "Neither agree nor disagree," "Agree," or "Strongly agree"					
I am provided adequate resources (personnel, budget, and equipment) to provide safe patient care.					
Loss of experienced personnel has negatively affected my ability to provide high-quality patient care.					
Good communication flow exists down the chain of command regarding patient safety issues.					
Good communication flow exists up the chain of command regarding patient safety issues.					
Senior management does not hesitate to temporarily restrict clinicians who are under high personal stress.					
Senior management reacts well to unexpected changes to its plan.					
In my unit, there is significant peer pressure to discourage unsafe patient care.					
My unit uniformly prescribes performance standards to ensure patient safety.					
My unit follows a specific process to review performance against defined training goals.					
Individuals in my unit are willing to report behavior that is unsafe for patient care.					
In my unit, disregarding policy and procedure is rare.					
Patient safety decisions are made at the proper levels by the most qualified people.					
My unit closely monitors performance to ensure clinicians are qualified.					
People in leadership positions set the example for compliance with policies and procedures that promote safe patient care.					
Senior management provides a positive climate that promotes patient safety.					
Senior management provides adequate safety backups to catch possible human errors during high-risk patient care activities.					
This facility has a reputation for high-quality performance.					
Staff are provided with the necessary training to safely provide patient care.					
Supervisors conduct adequate reviews and updates of patient safety practices.					
Senior management is successful in communicating its patient safety goals to hospital or clinic personnel.					
Senior management has a clear picture of the risks associated with patient care.					
My unit does a good job of managing risk to ensure patient safety.					
My unit takes the time to identify and assess risks to patient safety.					
Staff is genuinely concerned about patient safety.					

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	No Responsibility	Some Responsibility	Major Responsibility
Please indicate the responsibility entities should have in improving patient safety:			
Government			
Health insurance companies			
Patients			
Physician professional societies			
Individual practicing surgeons			
Hospitals and health systems			
Employers			
Pharmaceutical and device manufacturers			
Trial lawyers			

mproving patient safety, assuming each is effective in improving patient safety: mplementation of effective patient safety programs in health-care organizations.		Not Enthusiastic	Somewhat Enthusiastic	Very Enthusiasti
Third-party rewards or recognition of safety and quality in health-care organizations. Independing licensing of health-care practitioners' competence and knowledge with espect to safety. In attornwide mandatory reporting system of adverse events. Indexing data related to patient safety and quality improvement more easily available for peer review. Indexing institutions or physicians for errors. Indexing institutions or p	Please indicate your degree of enthusiasm for the following potential means of improving patient safety, assuming each is effective in improving patient safety:			
Ongoing licensing of health-care practitioners' competence and knowledge with espect to safety. A nationwide mandatory reporting system of adverse events. Idaking data related to patient safety and quality improvement more easily available for peer review. Penalizing institutions or physicians for errors. P	Implementation of effective patient safety programs in health-care organizations.			
respect to safety. A nationwide mandatory reporting system of adverse events. Making data related to patient safety and quality improvement more easily Penalizing institutions or physicians for errors. Per cack progress in meeting these national goals. Per cack progress in meeting these national goals. Per cack progress on patient safety. Per cack pr	Third-party rewards or recognition of safety and quality in health-care organizations.			
Making data related to patient safety and quality improvement more easily available for peer review. Penalizing institutions or physicians for errors. Cet national goals for patient safety. Frack progress in meeting these national goals. Sesue an annual report to the government/President and Congress on patient safety. Cevelop knowledge and understanding of errors by developing a research agenda and funding of research in this field. Cestablish interdisciplinary team and simulation training. Cetandardize and simplify equipment and supplies. Change the medical hierarchy. Change the medical hierarchy. Change the medical hierarchy. Change the medical hierarchy. Celease provide us with your additional ideas on improving patient safety: Celease provide us with your additional ideas on improving patient safety: Celease provide us with your additional ideas on improving patient safety:	Ongoing licensing of health-care practitioners' competence and knowledge with respect to safety.			
available for peer review. Penalizing institutions or physicians for errors. Per national goals for patient safety. Per national goals for patient safety everyone's responsibility. Penalizing institutions or physicians for errors. Per national goals for patient safety everyone's responsibility. Penalizing institutions or physicians for errors. Per national goals for patient safety. Penalizing institutions or physicians for errors. Penalizing institutions or patient safety. Penalizing institutions or physicians for errors by developing a research agenda Penalizing institutions or patient safety. Penalizing institutions or patient	A nationwide mandatory reporting system of adverse events.			
Set national goals for patient safety. Frack progress in meeting these national goals. Sexue an annual report to the government/President and Congress on patient safety. Develop knowledge and understanding of errors by developing a research agenda and funding of research in this field. Establish interdisciplinary team and simulation training. Standardize and simplify equipment and supplies. Standardize procedures. Promote better communication. Change the medical hierarchy. Make patient safety everyone's responsibility. Shorten work shifts to reduce fatigue. Please provide us with your additional ideas on improving patient safety: 1. 2. 3.	Making data related to patient safety and quality improvement more easily available for peer review.			
Track progress in meeting these national goals. ssue an annual report to the government/President and Congress on patient safety. Develop knowledge and understanding of errors by developing a research agenda and funding of research in this field. Establish interdisciplinary team and simulation training. Standardize and simplify equipment and supplies. Commote better communication. Change the medical hierarchy. Make patient safety everyone's responsibility. Change the work shifts to reduce fatigue. Please provide us with your additional ideas on improving patient safety: L. 2. 3.	Penalizing institutions or physicians for errors.			
ssue an annual report to the government/President and Congress on patient safety. Develop knowledge and understanding of errors by developing a research agenda and funding of research in this field. Establish interdisciplinary team and simulation training. Standardize and simplify equipment and supplies. Chandardize procedures. Cromote better communication. Change the medical hierarchy. Make patient safety everyone's responsibility. Change the work shifts to reduce fatigue. Please provide us with your additional ideas on improving patient safety: 1. 2. 3.	Set national goals for patient safety.			
Develop knowledge and understanding of errors by developing a research agenda and funding of research in this field. Establish interdisciplinary team and simulation training.	Track progress in meeting these national goals.			
and funding of research in this field. Establish interdisciplinary team and simulation training. Standardize and simplify equipment and supplies. Standardize procedures. Promote better communication. Change the medical hierarchy. Make patient safety everyone's responsibility. Shorten work shifts to reduce fatigue. Please provide us with your additional ideas on improving patient safety: 1. 2. 3.	ssue an annual report to the government/President and Congress on patient safety.			
Standardize and simplify equipment and supplies. Standardize procedures. Cromote better communication. Change the medical hierarchy. Make patient safety everyone's responsibility. Shorten work shifts to reduce fatigue. Clease provide us with your additional ideas on improving patient safety: L. 2. 3.	Develop knowledge and understanding of errors by developing a research agenda and funding of research in this field.			
Standardize procedures. Promote better communication. Change the medical hierarchy. Make patient safety everyone's responsibility. Shorten work shifts to reduce fatigue. Please provide us with your additional ideas on improving patient safety: L. 2. 3.	Establish interdisciplinary team and simulation training.			
Promote better communication. Change the medical hierarchy. Make patient safety everyone's responsibility. Chorten work shifts to reduce fatigue. Please provide us with your additional ideas on improving patient safety: L. 2. 3.	Standardize and simplify equipment and supplies.			
Change the medical hierarchy. Make patient safety everyone's responsibility. Shorten work shifts to reduce fatigue. Please provide us with your additional ideas on improving patient safety: L. 2. 3.	Standardize procedures.			
Make patient safety everyone's responsibility. Shorten work shifts to reduce fatigue. Please provide us with your additional ideas on improving patient safety: L. 2. 3.	Promote better communication.			
Shorten work shifts to reduce fatigue. Please provide us with your additional ideas on improving patient safety: L. 2. 3.	Change the medical hierarchy.			
Please provide us with your additional ideas on improving patient safety: L. 2. 3.	Make patient safety everyone's responsibility.			
L. 2. 3. 3. 3. 3. 3. 3. 3. 3. 3. 3. 3. 3. 3.	Shorten work shifts to reduce fatigue.			
2. 3.	Please provide us with your additional ideas on improving patient safety:			
3.	1.			
	2.			
ı.	3.			
	4.			

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	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
For the following statements, please answer if you "Strongly disagree," "Disagree," "Neither agree nor disagree," "Agree," or "Strongly agree"					
General patient safety as experienced by surgeons					
Healthcare is not as safe as it should be.					
There is not enough emphasis on patient safety.					
A culture of safety does not exist in medicine.					
I would feel safe as a patient.					
We lack explicit and consistent standards for patient safety.					
Specific statements about patient safety					
Increased workload increases the likelihood of error.					
Patient safety is only discussed behind closed doors.					
A culture of blame exists and precludes patient safety.					
The hospital leadership structure precludes patient safety.					
Errors result from disorganized systems of care that lack clear lines of accountability.					
The greatest threat to patient safety is human error.					
Patient safety is a system problem, not an individual problem.					
Personal statements on safety					
I create an environment where people feel free to speak up when an error might occur.					
I am aware of the strategies for improving patient safety.					
It is my primary responsibility to ensure patients are safe.					
I never make errors.					
The potential for litigation influences my behavior in dealing with errors.					
I am too busy to worry about patient safety.					
Working in a safe environment is boring.					

	Not Important	Somewhat Important	Very Important
Please indicate the importance of each of the following personal factors of a surgeon in improving patient safety:			
Psychomotor skills			
Scientific knowledge			
Expertise			
Communication			
Leadership			
Behavior			
Attitude			
Workload or capacity balance			

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TABLE E-7 Survey on Specific "Common" Adverse Events					
	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
For the following statements, please answer if you "Strongly disagree," "Disagree," "Neither agree nor disagree," "Agree," or "Strongly agree"					
Most wrong-site surgeries can be prevented.					
The surgeon is primarily responsible for preventing wrong-site surgery.					
Most retained foreign bodies are avoidable.					
The surgeon is primarily responsible for preventing retained foreign bodies.					
Most surgical site infections can be prevented.					
The surgeon is the primarily responsible for preventing surgical site infections.					
Most thromboembolic complications can be prevented.					
The surgeon is primarily responsible for preventing thromboembolic complications.					
Most pressure ulcer complications can be prevented.					
The surgeon is primarily responsible for preventing pressure ulcers.					
Most medication errors are avoidable.					
The surgeon is primarily responsible for preventing medication errors.					