In her presentation entitled “The Ethical Dilemma of Adverse Event Disclosure” Denise M. Dudzinski, PhD MTS describes several ethical frameworks for disclosing errors and adverse events, especially large-scale adverse events (LSAEs). In recent years, there has been increased recognition that harmful errors and adverse events should be disclosed to patients. The rationale is based in commitments to quality improvement, honesty, and transparency. But what about events that potentially harm multiple patients (LSAEs), such as equipment failures and endoscope disinfection breakdowns? LSAEs are defined as: an individual event or series of related events that increase the risk that multiple patients have been injured due to medical management. When an adverse event affects a single patient, the treating providers normally disclose the error to the patient. When an LSAE occurs, disclosure falls to the institution, which then relies on various health care professionals to follow up with patients. LSAEs are complicated by the fact that initial disclosure often includes both ‘near miss’ and ‘harmed’ patients, since further testing and investigation is usually required to identify the subgroup of harmed patients. I will differentiate three types of LSAEs, provide case examples, and explain the various ethical frameworks used to support and oppose disclosure. I will also discuss strategies for disclosing to multiple patients. Pathologists play critical roles in adverse event identification and look-back investigations. By examining the ethical dimensions of LSAEs, pathologists can better deliberate about what role they should play in adverse event disclosure.