Clinical Alert

Volume 2, Number 1
Spring 2003

Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
Spring Grove Center
55 Wade Avenue
Catonsville, MD 21228
410-402-8004

Robert L. Ehrlich, Jr.,
Governor
Michael S. Steele,
Lt. Governor
Nelson J. Sabatini,
Secretary, DHMH
Carol Benner
Director, OHCQ

Communication Failure Leads to Unnecessary Surgery

Not long ago, we were all shocked to hear of a 46 year old woman who had a double mastectomy purportedly to resolve a malignancy only to find out that she was cancer-free. A dictating and transcription error caused an erroneous report to be sent and acted upon. In Maryland, we experienced a similar case. I urge you to read the following and take any appropriate measures to prevent a similar event in your facility.

Carol Benner

Case Study

Jane Doe, in her 70s, visited her primary care physician for routine care. As part of her examination, she was referred for a screening mammogram. The mammogram revealed changes that suggested a follow up breast biopsy was needed. This was subsequently done at a radiology center in a physician's office complex on the grounds of hospital "A". The biopsy specimen was sent to the hospital's pathology department for interpretation.

The hospital routinely sends a hard copy of all pathology reports of breast biopsies to the radiology center. The reports are filed in the patient medical records and are reviewed by the radiologists. The pathology report for Mrs. Doe was received at the radiology center; however, it was misfiled and the results of another patient's biopsy report were filed in her record. This report indicated the patient had a breast cancer. As was the custom of this group, when the radiologist reviewed the biopsy results, he prepared an addendum to the original radiology report, quoting the pathology findings. The original pathology report did not accompany the radiologist's report and the addendum. As a result the addendum report contained erroneous pathology information that did not belong on the radiology report of Mrs. Doe.

The amended radiology report, without the original pathology report was sent to a surgeon at a second Hospital who was to carry out treatment on Mrs. Doe. The surgeon, based on the information in the amended radiology report from the radiology group, advised Mrs. Doe that she had breast cancer. Subsequently, Mrs. Doe's breast was removed. The breast was sent for routine pathological examination, but there was no evidence of cancer.

The Hospital obtained the original biopsy slides and pathology report from the first hospital and concurred with the original report. After further investigation, it was then determined that the radiologist's addendum report had been prepared using information on another patient that had been misfiled in Mrs. Doe's medical record.

The second patient to whom the pathology report actually belonged was located and treated appropriately. The patient who had had a normal breast removed tolerated that surgery and was subsequently informed of the error.

DISCUSSION:

There are two issues of immediate importance in this case.

First, the operating surgeon, located in a different hospital from the radiologists who did the biopsy, should have received a copy of the original pathology report. Learning of a suspected cancer on the basis of an addendum to a radiology report is not sufficient. If the pathology report had been sent separately from the radiology report, the fact that the patient names did not match might have been noted. The operating surgeon should not have had to rely on the addendum from the radiology department but should have seen the original pathology report as well.

Second, the radiology department did not have an internal, fail safe system to ensure that the pathology report sent to them from the hospital was correlated correctly with the radiology report.

It is not uncommon now for the care of individual patients to be divided up between facilities because of insurance or specialty requirements. It is critical that all the relevant information, in its original form, be gathered together into the patient's clinical chart and be reviewed, in toto, by the treating physician. In this unfortunate situation, the operating surgeon did not see Mrs. Doe's actual pathology report, which showed no evidence of cancer.

In order to ensure that all necessary patient information is available to the treating physicians, hospitals might wish to have pathology specimens done elsewhere reread in their own facility, where a procedure is to be done. This should decrease the probability of a medical error. The hospital in this case subsequently passed a medical staff bylaw requiring that all slides read outside of the institution be reevaluated before ANY treatment is instituted in the facility. This or some other option should be considered to avoid an error such as was experienced by Mrs. Doe.

The failure in the radiology office to recognize that the pathology report from the hospital and the radiology report were from different patients was a systems issue that has been corrected. The radiologists no longer report pathology results on reports with their letterhead and have instituted a policy that a cover letter with recommendations by the radiologist is sent to the referring physician with a copy of the pathology report.

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Questions or comments regarding this Clinical Alert should be directed to:

Joseph I. Berman MD, Medical Director –
Office of Health Care Quality
Phone: (410) 402- 8016;
E-mail: *Jberman@dhmh.state.md.us*

Renee Webster, Assistant Director
Phone: (410) 402-8016;
E-mail: *Rwebster@dhmh.state.md.us*

William M. Vaughan RN, Chief Nurse –
Office of Health Care Quality
Phone: (410) 402-8140;
E-mail: *Wvaughan@dhmh.state.md.us*

Clinical Alert
is published periodically by the
Office of Health Care Quality,
Maryland Department of
Health and Mental Hygiene

For additional information contact Joseph I. Berman MD
Medical Director,
Office of Health Care Quality
Phone: (410) 402-8016
E-mail: *Jberman@dhmh.state.md.us*